CHAPTER I. INTRODUCTION

An Overview

'Drugs gave me wings to fly, but took away the sky:' the sign hung at one of the drug treatment centers in Kathmandu speaks volumes on what drug is and what it eventually does to an individual. The problem of drug abuse is not an entirely new phenomenon in Nepal; it pervasive and growing by the day. From *ganja* (marijuana), *bhang*, *charesh* (hashish), alcohol (used in Nepal for centuries and traditionally associated with cultural and religious occasions), to drugs like heroin (widely believed to be introduced by the 'hippies' in the 1960s), to buprenorphine (introduced in the early nineties), the drug culture in Nepal is growing to an astounding degree. Although service providers working in the field of drug abuse prevention estimate 60,000 drug users (DUs) in Nepal, there is widespread confirmation that the numbers are higher. The Drug Abuse Prevention Association Nepal (DAPAN), in its report of Urban Drug Abusers in Nepal (1992:3) however alerts us to be concerned on the growth rate rather than on the estimations of DUs in Nepal: "The alarming point is not the number of drug abusers but the rate at which the number of drug abusers is proliferating annually."

Reid and Costigan (2002:152) provide a short yet succinct historical overview on drug use in Nepal:

> Cannabis has been used in Nepal for centuries and was traditionally associated with religious festivals. In the 1960s the case of availability of cannabis, and a tolerant attitude to drug use, led to an image abroad of Nepal as a Shangri-La, which attracted foreign tourists: the so-called 'hippies.' By the mid 1970s this image was beginning to fade as stricter drug legislation and controls were enforced. Heroin was introduced to Nepal in the mid-1960s and was mainly smoked or chased. The first case of heroin abuse reported in 1976 and by 1985 it was estimated that there were 12,000 addicts in the Kathmandu Valley. In 1990 the introduction of buprenorphine changed the drug use culture and by 1991 it had replaced heroin as the drug of choice among opioid-dependents and initiates. Buprenorphine has been increasingly administered by injection; given the availability of the injectible form…By the mid 1990s Nepal experienced an explosive HIV epidemic, which impacted substantially upon the injecting drug using population (Reid and Costigan, 2002:152).

"Drug addiction is a complex disorder characterized by compulsive and often uncontrollable drug craving, seeking, and use that persists even in the face of extremely negative consequences. This is a chronic relapsing disorder, and treatment for drug addiction is about as effective as treatments for chronic medical conditions" (Leshner, 1998:3). Luekefeld and Tims (1990:1) explains the degree of complexity associated with drug addiction in the following way: "The high rate of relapse is an especially frustrating problem, and the notion of a 'cure' remains elusive. Substance abuse careers are episodic, with periods of abstinence, reduction of use, and relapse often with the course of events being influenced by external factors such as availability of drugs and societal pressures."

In general terms, relapse refers to regressing back to a prior state or event. Relapse is a common and often a term used by service providers and DUs alike, basically indicating resumption of drug use after a certain period of cessation (see Annex A for clarifications on drug related terminologies). Some loose terminologies generally associated with relapse in the Nepali drug abusing/recovery communities are: slip, back, *chiplanu, and fausnu.* However, the definition of relapse is understood more prudently in the academic and research communities.

> Relapse can be defined as a discrete event, which occurs at the moment a person resumes drug use or as a process, which occurs over time. In the latter view, it may mean resumption of addiction; return to drug use of the same intensity as in the past; daily drug use for a specified number of sequential days or a consequence of the drug use…Relapse rates are dependent on: (1) the definition of relapsed used, (2) the method of detecting relapse, and (3) the method used to compute them (Wesson et al. 1990:5).

There are principally two forms of treatment services available in Nepal for DUs wanting to abstain from drug use. Apart from the 'cold turkey' approach (abstinence without assistance from any forms of treatment), which DUs can apply personally at his/her home, short-term detoxification services (residential and non-residential) are available from hospitals and clinics. Treatment duration in such settings usually range from one to two weeks and may focus more on addressing immediate or protracted physical

withdrawal syndromes of DUs. The other service available is the residential rehabilitation treatment program provided by the drug rehabilitation centers (DRCs). Treatment programs in a majority of DRCs in Nepal encompass holistic and innovative treatment techniques. The treatment duration in DRCs is usually set for three months or more. An overwhelming majority of experts and DUs alike agree that DRC based treatment is most effective in helping DUs abstain from drug use.

The Problem and Rationale of the Study

1.2.1. Statement of the Problem

Experts working with DUs in Kathmandu agree that relapse rate faced by a majority of DRCs in Kathmandu could be as high as 70 percent! In other words, every 7 out of 10 DUs break their cessation efforts following their enrolment IN a DRC. Relapse is a recurring disease, and more relapse could translate to more negative social ramifications, leading to depreciation of relationships with the family and relatives. Furthermore, relapse could also translate to physiological ramifications leading to deteriorating health and possible exposure to chronic or life threatening diseases.

Professionals working with DUs confer to the fact that persons seeking external help have a better chance of recovering or abstaining from drugs than those not seeking such help. Although understanding drug relapse of those who don't seek external help can yield important information, more significant is the need to study drug relapse of those who have had external help in trying to recover from drug addiction. In specific, studying the issue of drug relapse of those who have stayed in a residential drug rehabilitation facility could yield important findings as such understanding bring into light the phenomena of drug relapse of those who are receiving the best external assistance available for abstinence.

There are more than twenty DRCs in Nepal (Sharma, 2001). They are in most cases the sole entities in the forefront, working as flag bearers in the fight against drug addiction in Nepal. A study conducted by Burrows et al. (2001:32) for the Center for Harm

Reduction also regards the DRCs in Kathmandu run by the non-governmental organizations (NGOs), as providing 'high-quality drug treatment.' With the passing of time and more exposure, the DRCs in Nepal are receiving more and more clients than ever. Even with the shortage of staff, material and financial resources, they are holding their stand to the best of their ability. However, it's a daunting challenge.

Although relapse among DUs is a recurring issue, it is still disheartening that people who have stopped drug use for a period of time regress back to drug use. This takes us to a set of logical queries: How and why does relapse occur? Why are treatment programs in Nepal not yielding encouraging results despite their sincere efforts? Are there bigger issues at play? Is there a lack of bridging between the controlled rehabilitation life in the treatment programs and life post treatment programs (i.e. adjusting back with society, its norms and values)? Are socio-cultural factors (traditionally ignored or overlooked in treatment settings) an important determinant of relapse among drug abusers?

It is important to comprehend issues related to drug dependence in the realms of socio-anthropology as the phenomenon is first and foremost rooted in a socio-cultural setting. Thomas E. Gaffney, a pioneering figure in Nepal's drug abuse prevention efforts also realized the socio-cultural issues as the root causes behind Nepali drug delinquency. In his article 'The Root Causes of Nepali Drug Delinquency', Gaffney (1988:137) identified four major causes behind the Nepali drug delinquency: parent-related causes; the absence of appropriate control; reactive patterns of misbehavior; and lack of inter-personal relationships and communications. Gaffney also supported the idea that the understanding of the socio-cultural environment provided a clearer perspective in comprehending the phenomena of drug abuse in Nepal.

> Perhaps the 'drug problem' is not a drug problem after all. In ability to adjust to social pressures and changing customs can lead to frustration, confusion, rebellious reactive behavior, and thus also to drug abuse. Parents, adults, teachers, counselors, social workers, doctors, psychiatrists, lawyers, police, psychologists, sociologists and all thinking must come to a new understanding and appreciation of what is happening with our traditional society as we are being overwhelmed by the on surge of influences alien to our traditions and

> values. There may not be turning back the tide; but there is the possibility of countering it by recognizing clearly what is happening to us (Gaffney, 1988:145).

Unlike the societies of the west, it is utterly important to analyze the socio-cultural context when we try to understand drug relapse in a Nepali society. To a larger extent, Nepali societies (including the urban societies) are collectivistic; emphasis is stressed on the loyalty to one's social group, which in turn looks after the interests of the individual. Group decisions are superior to individual decisions and personal identity is looked as one's place in the social group. Further, the immediate physical addiction, which can be addressed in treatment centers, leaves one to wonder on the probability of social and psychological factors (the latter, one can also argue as influenced by the socialization structure of a group) as critical determinants behind the success or failure of recovering DUs. Gates (1988:73) also realized this issue in the following way:

> If physical addiction was the only difficulty then 100 percent cure could be achieved rapidly. Sad to say, that is not the case. Man is more complex than just a body filled with vying chemicals. Man is a social being with a complex set of interpersonal relationships…it is the full, complete person that drug effects. And therefore, detoxification is only a partial treatment.

This study, realizing the importance of and utilizing the socio-anthropological perspective, attempts to comprehend the various socio-cultural intricacies or the social environment of drug users who have relapsed following their stay at a drug treatment rehabilitation center.

1.2.2. Rationale of the Study

It is a well established fact that drug relapse is a recurring phenomenon. Further, it has also been acknowledged that an effective termination of physiological dependence for a drug alone does not in any ways suggest a total recovery. Also, a successful drug treatment and rehabilitation cannot guarantee a life of total recovery in its completion. Coupling these facts with a strong probability that relapsed drug users (RDUs) maybe exposed to life threatening diseases, tragic physiological-mental and social consequences and growing mistrust from his/her community, brings into light the importance of understanding the phenomena of drug relapse.

Although different fields have different interpretation on the phenomena of relapse, the socio anthropological standpoint is probably the most wholistic and important. Humans are social beings, and what one decides or acts upon is dependent on cues from his/her social environment. Although it could be noted that the craving or compulsion to use drugs is an important factor behind relapse, it should also be noted that a person's decision to use drugs (knowingly or unknowingly for that matter) does not solely come from his/her actual intentions but that it is catalyzed by socio-cultural factors, his/her socialization process and cultural background of his/her social group. Relapse, therefore, is not just an event, but a result of various socio-cultural situations and antecedents. It is also a complex socio-cultural construct a DU confronts. The decision or the indecision leading to the breaking of cessation is the culmination of various overwhelming social-cultural and psychological processes.

An argument put forth by Goode (1972:1) on the need for understanding the social context, captures the basic premise of this study, the importance of understanding the social context (or environment) of RDUs.

> The sociological perspective stands in direct opposition to what might be called the chemicalistic fallacy-the view that drug A causes behavior X, that what we see as behavior and effects associated with a given drug are solely (or even mainly) a function of the biochemical properties of that drug, of the drug plus the human animal, or even of the drug plus a human organism with a certain character structure. Drug effects and drug-related behavior are enormously complicated, highly variable, and contingent on many things. And the most important of these things are social and contextual in nature. In the animal world, it is quire a bit easier to predict what drugs will do. But experiments with rats do not tell us very much about human behavior. This is why social context is so important" (Goode, 1972:1).

With the ever increasing numbers of DUs in Nepal and a growing concern for their well being and rehabilitation, it is imperative that issues surrounding the phenomena of drug abuse be taken to a greater investigative level, so that learnings, findings and experiences translate to better understanding and rehabilitation of DUs. Although initiatives related to the Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) prevention in Nepal have addressed the current phenomena of drug use to a

degree, the lack of credible and current research based information focusing solely on drug users and their social environment is clearly evident. Further, the soaring rise of HIV infection amongst IDUs and the high relapse rate of IDUs despite receiving abstinence intervention deemed best by experts, brings into light the urgency to understand the socio-cultural intricacies behind RDUs.

Objectives of the Study

The purpose of this study is to understand the social environment of Nepali DUs who have relapsed back to drug use following their enrolment at a DRC. In specific, the study, with the use of socio-anthropological perspective investigates the different factors and patterns that constitute the social environment of RDUs.

The objective of the study is to understand the various components that constitute the social environment of RDUs. In specific, the study utilizes the social environment paradigm of Cockerham (1986), and theoretical reinforcements of Phenomenology, Symbolic Interaction, and Alienation to investigate the following components of the social environment of RDUs.

- Investigate the actual living conditions that led the DUs to the state of relapse.
- Examine the norms, values and attitudes of RDUs.
- Explore the living conditions, social values and attitudes giving rise to a particular socio-cultural context of alienation amongst RDUs.
- Observe the social environment of different types of RDUs: married and single RDUs (observe possible differences in social environment by marital status), and RDUs living with Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome (HIV/AIDS).
- Examine on whether reinforcements provided by the DRCs, family, and peer groups were beneficial or limited for DUs' reintegration and recovery efforts following DRC enrolment.
- Explore the opinions and experiences of service providers working in the field of rehabilitation of DUs, on what they feel are the crucial components behind DUs' social environment.

Further, a latent purpose of this undertaking is also to present useful findings to organizations and professionals working in the field of drug prevention, control, and treatment. It is hoped that the findings will improve their understanding and execution of efforts in treatment rehabilitation and ultimately in successful recovery of DUs in Nepal.

Theoretical Perspectives

1.4.1. Defining 'Social Environment'

In simple understanding, the term 'social environment' could indicate the reality or the surroundings of an individual or a group of people as observed through a 'socio-cultural' point of view. The basic premises of this study also rest in this understanding. However, a definitive definition is needed, on which the research work stands valid, and at the same time succinctly covers the goals the researcher hopes to achieve with this study. Thus, the definition of a medical sociologist, William C. Cockerham, is used to put into play the term 'social environment.' The definition of Cockerham was preferred for its objectivity, simplicity and logical breakdown of the concept into researchable clauses.

In epidemiological research, 'social environment' refers to "actual living conditions, such as poverty or crowding, and also the norms, values, and attitudes that reflect a particular social and cultural context" (Cockerham, 1986:19). This definition, as written by Cockerham, served as a base for all analysis presented in this study.

There are three clauses attached with the above definition of social environment, which are:

Clause 1) Actual living conditions

Clause 2) Norms, values, and attitudes

Clause 3) Reflect a particular social and cultural context

Each of these three clauses is reinforced with the following theoretical concepts.

1.4.2. Phenomenology and Actual Living Conditions (Clause 1)

Concepts of 'phenomenological sociology' were used to comprehend the first clause: 'actual living conditions' of RDUs in the study. This strand of sociology analyzes and describes everyday life-world and its associated state of consciousness. As Ritzer (1992:273) explains, "it looks at the world in which people both create social reality and are constrained by the preexisting social and cultural structures created by their predecessors."

This perspective was ideal in understanding the living conditions of DUs who after living in treatment centers move into the 'real world.' With no controlled environment (like that of the treatment center) and physically drug-free, DUs have to assimilate with the social constructs of his/her family and community. This perspective provided an important base to understand how recovering DUs tried to create the social reality, which in a way facilitated or constrained their assimilation and recovery process.
Two major concepts of phenomenological sociology were used to understand in greater details the actual living conditions of RDUs.

Typifications. Ritzer, quoting Alfred Schultz, the major theorist behind phenomenological sociology, writes: "People develop and use typifications (first-order constructs) in the social world. In any given situation in the world of everyday life an action is determined by means of a type constituted in earlier experiences. Typifications ignore individual, unique features and focus on only generic and homogenous characteristics. While we routinely typify others; it is also possible for people to engage in self-typification. Men typify to a certain extent his own situation within the social world and the various relations he has to his fellow-men and cultural objects" (Ritzer, 1992:237).

Recipes. Like typifications, "recipes serve as techniques for understanding or at least controlling aspects…experience. Recipes, however, tend to deal with situations; people use recipes to handle the myriad routine situations that they encounter each day" (Ritzer, 1992:237).

The concepts of typifications and recipes provided a comprehensive overview on the everyday life of RDUs. In specific, the concepts provided a definitive understanding on how the subjects perceived people (family, peers, relatives, etc.), situations and relationships that were part of his/her everyday life. This understanding furnished a comprehensive insight into the actual living conditions of the RDUs. Further, the approach of these concepts also aligned with the stress given by social science experts working with DUs, to understand drug use and relapse from the perspective of the users themselves: "The user's experience is in fact the perception itself, and the perception is the phenomenon to be measured. The subjective grasp of the experience is the very reality itself" (Goode, 1972:13-14).

Further, Schultz and Luckmann (1973:231) also outline conditions under which situations become problematic and people have to create new ways of dealing with them (new recipes or typifications): "If there is no recipe available to handle a novel situation, or if a recipe does not allow one to handle the situation it supposed to deal with, a new one must be created. In other words, when the stock of knowledge currently available is inadequate, the person must add to it by creating new recipes (or typifications)." This phenomenon accommodated a unique platform for understanding the living conditions of RDUs, and the precarious crossroads all of them once stood at: the road to recovery or the road to relapse.

1.4.3. Symbolic Interaction Theory and Norms, Values and Attitudes (Clause 2)

In order to understand the norms, values and attitudes, and its reflection on the living conditions of RDUs, the use of work by important theorists within Symbolic Interaction (SI) seemed appropriate. In short, SI is based on the perspective of understanding socio-cultural issues through understanding the dynamics of social interaction at a micro level (i.e. in an individual basis). The use of SI theories also aligns with the theme of the study, which was to understand the situation from the perspectives of RDUs themselves, their norms, values and attitudes.

Self. George Herbert Mead's (a principle theorist within SI) idea of the 'self' and Morris Rosenberg's elaboration of the 'self' through his work on 'self-concept' were incorporated in this study. On defining the idea of 'self', Blumer (as quoted by Ritzer, 1992:214) writes; "self means merely that a human being can be an object of his own actions…he acts towards others on the basis of the kind of object he is to himself…the self is a process, not a thing." This idea of the 'self' holds a special importance in the theoretical sphere of SIs. Ritzer (1992:213) writes; "all other sociological processes and events revolve around that hub (self), taking from it their analytic meaning and organization." The SIs thus prefer to look at norms, values and attitudes as social constructs arising out of the 'self'.

Self-Concept. Morris Rosenberg looks at self-concept through understanding the 'self' in an objective sense, rather than in a generalized way. Rosenberg introduced the 'self-concept' terminology, which he defines as "the totality of the individual's thoughts and feelings having reference to himself as an objective" (quoted by Ritzer, 1992:215). Rosenberg further says that 'self-concept is the result of certain incommunicable information; it reflects the individual's unique body of information and point of view about himself or herself" (quoted by Ritzer, 1992: 215).

On analyzing the make up of 'self-concept', Ritzer (1992:215) identifies four factors, which are:

1. Contents (social identity/dispositions): The concept of self-concept is made up of 'social identities and dispositions'. Social identity as Rosenberg states are the 'groups, statuses, or categories' to which an individual is 'socially recognized as belonging'. Dispositions as Rosenberg writes is the way an individual sees himself or herself not only in terms of such categories but also as possessing certain tendencies to respond;
2. Structure: is the relationship among an individual's various social identities and dispositions;
3. Dimension: Refers to the attitudes and feelings one has about one self; and
4. Boundaries: These are objects outside the actor that lead him or her to feel pride and shame. Rosenberg also calls it ego extension.

These factors of self-concept provided a rather exhaustive platform through which the study tried to understand the norms, values and attitudes of RDUs.

Influence of Primary groups on RDUs' Norms, Values and Attitude. As discussed in the introduction section, the norms, values and attitudes of individuals in collectivistic societies are influenced or even overridden by the social group he or she belongs to. In this regard, it was also the interest of the study to understand the role of primary groups (such as family and peer groups) in order to understand their level of influence on shaping the norms and values of RDUs. Charley Horton Cooley, a chief theorist within SI, provides a clear definition of 'primary groups' in this way; "by primary groups I mean those characterized by intimate face to face association and cooperation. They are primary in several senses, but chiefly in that they are fundamental in forming the social nature and ideals of the individual" (quoted in Hassinger and Pinkerton, 1986:131). This explanation of Cooley also agrees to the fact that primary groups play an important role in influencing norms, values and attitudes of individuals.

On singling out the principle primary groups in any given society, Hassinger and Pinkerton (1986) refer to families, particularly those living in a single household; peer groups based on friendships; and neighborhoods where the interaction is dense and multi-stranded. From this understanding, the study defined family, peer circle during drug use, and peer circle during recovery (e.g. support groups), and the DRC itself (the people component) as the primary groups of RDUs.

Following characterizations provided by Hassinger and Pinkerton (1986:133-136) were looked upon to understand the functions of such groups and its influence on RDUs:

1. *Primary groups as places of socialization:* socialization is the process of learning the beliefs, skills, expectations, and knowledge of a society (or its subpart, a community). Through interaction in these kinds of groups, the moral code and common knowledge of community are internalized;
2. *Primary groups as bases of subcultures*: Subcultures emerge from interaction in small groups and are transferred through common boundaries of groups and overlapping membership. It is conceived of as emanating from group cultures (i.e. design for living). Cultural forms are created through the individual or collective manipulation of symbols. Cultural forms are created through the individual or collective manipulation of symbols. From its creation, the cultural form is communicated to others, and diffuses outward from the individual's own interaction partners. Thus,

primary groups could be producing a platform for development of subcultures;

3. *Primary groups as means of Social Control*: Small groups evaluate behavior of their members as well as that of outsiders. Sanctions are typical informal mechanisms for enforcing group norms. But such sanctions are meaningless unless individuals are immersed in the group and value the relationship. Social control is based on the internalization of the norms of the community, and it is vital to a social unit that its norms are understood and followed;
4. *Primary groups performing tasks-social support and mutual aid*: Primary groups are better suited to performing non-uniform tasks involving unique and idiosyncratic events (having so many contingencies) that require quick action dependent on complex but common information about particular situations. Primary groups are particularly common information about particular situations. Primary groups are particularly effective in providing social support and mutual aid. These are the people with whom he is in more or less daily, face to face contact, and whom he turns to for emergency aid, comfort, or support in times of need or crisis; and,
5. *Primary groups as channels of communication:* Primary groups serve as channels of communication and validators of information in the community. They are nodules of interaction within the community where information diffuse quickly. The importance of primary groups' role in evaluating information should not be overlooked. Information is shifted through the attitudes and past experiences of the group and interpreted accordingly.

1.4.4. Theory of Alienation and Particular Socio-Cultural Context (Clause 3)

The Hypothesis of Alienation. Based on the initial discussions on the three clauses of social environment, social values and attitudes of RDUs reflect a particular socio-cultural context. It was the interest of the study to understand what kind of socio-cultural context these clauses reflected upon.

A hypothetical assumption was taken to understand this context. The term 'socio-cultural context' normally relates to a certain design for living shared by members of a social group. Thus, based on literature reviews and opinions of the experts, it was only but natural to assume 'alienation' as the particular socio-cultural context of RDUs. Alienation denotes a particular state in which individuals develop a degree of estrangement from his/her society. Individuals feel they no longer are a vital part or an important member of the society.

The concept of alienation is widely used in many social-science studies. Coser and Rosenberg (1982) also state that the idea of alienation is a popular vehicle for virtually every kind of analysis. Further, Walter Gerson, as cited by Abraham (1982:200), also detail the usefulness of alienation concept in the following areas, including drug addiction: "The term alienation has been used by psychologists and sociologists to refer to an extraordinary variety of psychological disorders, including loss of self, anxiety states, anomie, despair, depersonalization, rootlessness, apathy, social disorganization, loneliness, atonomization, powerlessness, isolation, pessimism, and the loss of beliefs or values. Among social groups that have been described as alienated-in addition to those already mentioned-are women, migrant workers, immigrants, suicides, addicts, consumers, sex deviates, the prejudiced, bureaucrats, exiles, and recluses." Thus, this study, hypothetically assumed that the living conditions coupled with the norms, values and attitudes reflected a state of alienation amongst RDUs.

Types of alienation. Coser and Rosenberg (1982:379-382) on compiling Melvin Seeman's work (1959) on alienation provide useful forms or types of alienation. These forms or types provided a helpful insight in understanding alienation among RDUs, and along with it a logical framework to differentiate different forms of alienation amongst RDUs.

1. *Powerlessness*: powerlessness refers to the expectancy or probability held by the individual that his own behavior cannot determine the occurrence of the outcomes, or reinforcements;
2. *Meaninglessness*: the state of meaninglessness is prevalent when the individual is unclear as to what he ought to believe-when the individual's minimal standards for clarity in decision-making are not met;
3. *Normlessness*: denotes a situation in which the social norms regulating individual conduct have broken down or are no longer effective as rules for behavior. Robert Merton furthers this concept of 'broken down' as "the anomic situation that leads to low predictability in behavior, and anomic situation leading to the belief in luck";
4. *Isolation*: isolation refers to the apartness from society. Being isolated persons assign low reward value to goals or beliefs that are typically highly valued in the given society; and
5. *Self-Estrangement*: the most extended treatment of this version is found in the Sane Society, where Fromm writes: "by alienation is meant a mode of experience in which the person experiences himself as an alien. He has become, one might say, estranged from himself." It is some ideal human condition from which the individual is estranged.

Operation Conceptual Framework of the Study

In accordance to the theoretical framework discussed earlier, the research work for this study instigated the social environment of RDUs through comprehending the following crucial themes:

- Part I: the actual living conditions of RDUs;
- Part II: the norms, values and attitudes of RDUs, and the reinforcements and influences provided by the primary groups in this regard; and,
- Part III: the living conditions, norms, values and attitudes giving rise to a particular socio-cultural context of alienation amongst RDUs.

Further, the study, with the above-mentioned theoretical reinforcements, also included a synoptic understanding on the social environment of different types of RDUs, and on the works and understanding of service providers working with DUs:

- Part IV: comprehend the social environment of different types of RDUs: married and single RDUs (observe possible differences on RDUs' social environment by marital status), and RDUs living with HIV/AIDS (observe possible complexities following their knowledge of their HIV status).
- Part V: investigate the experiences and opinions of service providers concerning drug use, the lives of DUs, and services they provide.

The above five research themes stood as the basis on which the study executed its investigation. The following hypothesis and research queries were incorporated to explore the five themes further:

1.5.1 Part I. Living Conditions of RDUs

Investigation on the living conditions of RDUs was understood through the observation and analysis of 'typifications' and 'recipes' (Ritzer, 1992):

1. An account of major players in subject's life
   Understand/analyze:
   - Social, cultural, demographic, educational and economic status of RDUs and RDUs' family (father, mother, and spouse)
   - Characterization of RDUs' family's attitude and approach to deviance and drugs
   - Characterization of RDUs' user group
2. An account of own self
   Understand/analyze:
   - Antecedents of RDUs

- Daily activity/routine of RDUs
- Drug dependency background of RDUs

3. An account of contentious situations
   Understand/analyze:
   - Characterizations of drug use career
   - Arrest record
   - RDUs and life threatening diseases (such as HIV and Hepatitis)

1.5.2. Part II. Norms, Values, and Attitudes of RDUs

Investigation on the norms, values and attitudes of RDUs were understood through the four factors or 'self-concept' (Ritzer, 1992), and the characterizations of primary groups (Hassinger and Pinkerton, 1986).

1. Contents (Social identity/Dispositions)
   Understand/analyze:
   - Perceived attitude of neighborhood and relatives on RDUs
   - RDUs' reasons for use to abuse of drugs
   - RDUs' reasons for cessation of drug use
   - Characterization of RDUs' user group
   - RDUs' relapse record/history
   - Antecedents as shaping RDUs' norms and values
2. Structure
   Understand/analyze:
   - Relationships of RDUs with family, relatives and peers
   - RDUs' relationship with peer groups (user group and recovery group)
   - Support of family on RDU' cessation efforts
   - RDUs' beliefs and values on issues surrounding his/her life
3. Dimensions
   Understand/analyze:
   - Attitudes and feelings RDUs have on himself/herself
   - The state of mind of RDUs
4. Boundaries
   Understand/analyze:
   - DRC's role in RDUs' recovery efforts
   - Use of skills by RDUs learned at the DRC
   - RDUs' efforts in dealing with craving
   - Factors besides craving leading to RDUs' relapse
   - Factors that could have prevented RDUs from relapsing

1.5.3. Part III. Understanding of a Particular Socio-Cultural Context (Alienation)

The understanding of a particular socio-cultural context or what the study hypothetically assumed as 'alienation' was explored by investigating the possible presence of the five variants of alienation in RDUs' lives (Coser and Rosenberg, 1982):

1. Powerlessness
   Understand/analyze:
   - On what issues do RDUs find themselves helpless?
2. Meaninglessness
   Understand/analyze:
   - What events, actions, or circumstances portray meaninglessness in RDUs' life?
3. Normlessness
   Understand/analyze:
   - What events, actions or circumstances indicate normlessness in RDUs' life?
4. Isolation
   Understand/analyze:
   - What events, actions or circumstances indicate isolation in RDUs' life?
5. Self-estrangement
   Understand/analyze:
   - What events, actions or circumstances indicate self-estrangement in RDUs' life?

1.5.4. Part IV. Understanding the Social Environment of Different types of RDUs

This theme, incorporating all theoretical reinforcements used above, provides a synoptic understanding on the social environment of various subsets of RDUs. The following research queries were incorporated to explore this theme:

1. Social Environment of RDUs by marital status
   Understand/analyze:
   - Do the findings indicate differences of social environment for married and single RDUs?
2. Social Environment of RDUs living with HIV/AIDS (RUDWHA)
   Understand/analyze:
   - How complex or challenging were the lives of RUDWHAs when they relapsed (after knowledge of their positive status)?
   - How complex or challenging were the lives of RUDWHAs when they eventually stopped using drugs?

1.5.5. Part V. Understanding the Experiences and Opinions of Service Providers

Investigations on the experiences and opinions of service providers working with DUs incorporated the following research queries:

Understand/analyze:

- The current drug scenario of Kathmandu
- The setup and services rendered by the DRCs
- The works and effectiveness of self-help groups
- Issues involved in improving the lives of DUs

Review of Literature

1.6.1. Understanding Drug

What is a drug? A drug may be broadly defined as "any chemical agent that affects living processes" that may be ingested through the mouth, the rectum, by injection, or by inhalation (Richards 1982:1). The following understanding of the United Nations Office for Drug Control and Crime Prevention and Crime Control (UNODCCP) provides further perspective on the definition of a drug as held by various professionals, organizations, and conventions:

> In the various United Nations Conventions and in the Declaration on Drug Demand Reduction it (drug) refers to substances subject to international control. In medicine, if refers to any substance with the potential to prevent or cure disease or enhance physical or mental well being. In pharmacology, the term drug refers to any chemical agent that alters the bio-chemical or physiological processes of tissues and organisms. In common usage, the term often refers specifically to psychoactive drugs, and often, even more specifically, to illicit drugs. However, caffeine, tobacco, alcohol, and other substances in common non-medical use are also drugs in the sense of being taken primarily for their psychoactive effects (UNODCCP, 2000:22)

1.6.2. The Socio-Anthropological Definition of Drug and Drug Use

A generic definition of a drug leaves out much warranted issues, especially in light of investigating the phenomena of drug use in the realms of social-anthropology. A drug when looked through this perspective is a social manifestation, a social fact. Goode (1972) provides more understanding on this matter:

> When we turn to the social definition, we find that the concept 'drug' is a cultural artifact, a social fabrication. A drug is something that has been arbitrarily defined by certain segments of society as a drug. Although all substances called drugs do not share certain pharmacological traits that set them apart from other, nondrug substances, they do not share the trait of being labeled drugs by members of society…Society defines what a drug is, and the social definition shapes our attitudes toward the class of substances so described. The statement 'He uses drugs' calls to mind only certain kinds of drugs. If what is meant by that statement is 'He smokes cigarettes and drinks beer,' we are chagrined, since cigarettes and beer are not part of our stereotype of what a drug is, even though nicotine and alcohol are certainly drugs by at least criterion-they are both psychoactive…Nothing is a drug according to some abstract formal definition, but only within certain behavioral and social contexts. Which substances we elevate to examine in any discussion of drugs is always arbitrary and depends entirely on our purposes (Goode, 1972:9).

> Societies define not only the meaning of drugs but also the meaning of a drug experience; these definitions differ radically among different societies and among subgroups and subcultures within the same society. Social groups and cultures define what kind of drug taking is appropriate. They define which drugs are acceptable and which are not. They define who takes drugs and why. They decide what amounts of each drug are socially acceptable. They spell out which social situations are approved for drug use and which are not. They define what drugs do, what their actions and effects on people will be. Right or wrong, each of these social definitions and descriptions will have some degree of impact on actual people in actual drug-taking situations. Each will exert a powerful influence on what drugs actually do (Goode, 1972:2).

Drug use is not a modern phenomenon. The use of drugs was prevalent even in the ancient civilizations, and that the understanding of this 'ancient phenomena' could yield important indications behind the reasons of drug use in human societies, and on the continuity it receives till this day (see Annex B for characteristics and descriptions of frequently used drugs). Richards (1982:2-3) provides the following anthropological account on the historical use of drugs in various cultures:

> Drug use appears to be very ancient, sometimes appearing in forms that mix inextricably several or all of the therapeutic, religious, and recreational elements. The very ancient tradition of the shaman incorporated elements of drug use into rituals in which the shaman experienced mystical and ecstatic states that appear to have brought

> comfort to the sick and afflicted…Anthropological research into cultures that retain this tradition reveals a complex and often highly stylized set of experiences, embedded in a cultural setting of religion, therapy, medicine, and even political protest, in which drugs derived from native plants play a prominent role. In the ancient world, the drug soma, of uncertain identity, appears to have been integral to the mystical experiences of the divine celebrated in the ancient hymns of the Hindu *Rig-Veda*. Drug use in some form may have been central to the Greek mystery cults. While drug use as an adjunct to religious experience was thus driven underground in the west, recreational uses continued in the secular sphere. …When the use of caffeine and nicotine was introduced into western and other cultures, these drugs encountered cultural and some spirited political resistance, but were in time integrated into new forms of social and personal life.

1.6.3. Drug Abuse and Drug Addiction

Bishnu Sharma, director of the Richmond Fellowship Nepal, a DRC in Kathmandu explains the fine line between drug use and abuse in the following way: "When drugs are used to cure illness, prevent a disease or to improve the health conditions, it is termed as drug use. When drugs are taken for reasons other than medical, in an amount, strength, frequency or manner that damages the physical, central nervous system and mental functioning of an individual, it becomes drug abuse" (Sharma, 2001:2).

Drug addiction, (or 'drug dependency' as preferred by some) is a widely used term that denotes a state of compulsion to use drugs. The following World Health Organization's (WHO) approach to addiction provides more perspicuity in understanding the terminology:

> The repeated use of a psychoactive substance or substances, to the extent that the user (referred to as an addict) is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntary ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means. Key indicators of 'addiction' have traditionally been thought to be tolerance and experience of a withdrawal syndrome, i.e. it is often equated with physical dependence. More recently, some drug researchers have suggested that 'compulsion to use drugs' is a more central indicator of addiction (UNODCCP, 2000:3).

1.6.4. The Socio-Cultural Context of Abuse and Addiction

As increased medical breakthroughs have brought about greater understanding on the physiological processes behind a person's addictive nature, it is equally (if not more) important to understand the phenomena through a socio-cultural perspective. Goode (1972:12) explains the importance of understanding addiction in the socio-cultural realms:

> An addicting drug makes cells dependent-it makes them 'crave' that drug. When a pharmacologist says that a drug such as morphine or alcohol produces a physical dependence, he means simply that body cells respond in a certain way to continued administration of these drugs. However, it would be completely improper to say that as a direct consequence of this cellular response humans become addicted to the drugs in question. Whether humans do in fact become addicted is dependent largely on social and psychological factors…It should be clear, then, that there are two quite separable components in the addiction-dependence equation: one is the direct physical action of the drug; the other is how people respond, behaviorally, to the physical action. One component does not translate automatically into the other. The knowledge of what a drug is does not explain what humans will do in relation to the drug in question.

Culture is a design for living; a system of shared meanings, perceptions, and beliefs. Room (2003) explains that cultural constructs also have an important say on addiction, even if one is viewing the phenomena from the physiological or psychological dimensions.

> On physiological: There are two primarily biological criteria in current concepts of addiction. One centers on withdrawal symptoms…the other at least apparently biological criterion for addiction is tolerance…Needing a larger dose to get the effect sought from using the drug does not explain much at all about why the drug use would be continued despite adverse consequences or apparently against the will of the user. In many cultural milieus, having built up a tolerance is a valued attribute rather than a derogated personal attribute (Room 2003:227).
> On psychological: Here the master concept is of a craving or compulsion: the idea that there is something in the mind of the user that compels use, overriding apprehensions of the adverse consequences, the self-control of the user, and often even the user's will. We are again back in the territory where other centuries or cultures might invoke ideas of witchcraft or possession by evil spirits to explain what appears to be a compulsion that is not subject to the addict's control. Not all cultures would find congenial the assumption, built into ideas of craving and loss of control that desires

> are something distinct from the will…Craving appears to offer an explanation of loss of control over drinking or drug use. But it begs any questions it appears to answer. It is descriptive of what many heavy drinker or drug users report experientially, but it does not offer any explanation of the experience beyond a label for it. The mystery of addiction is still maintained (Room 2003: 228).

Compared to an individualistic society, the phenomenon of addiction can have different meanings for a collectivistic society, where individual control and decisions are often overridden by that of his/her social group. This argument holds a significant underpinning to the basic premise of the study, which is to look at the social environment and the context of socio-cultural factors behind relapsed drug users, in a collectivistic Nepalese society. Room (2003: 225-226) provides further understanding on this matter:

> Closely associated conceptually with this criterion for dependence is the criterion that is at the heart of addiction concepts: loss of control, or, in recent formulations, impairment of control…the ideas that good behavior is a matter of individual self-control, and that the individual is responsible for control of his or her own life, are very much embedded in a particular cultural matrix. They make sense in a culture where individuation and individualism are taken into granted, where each citizen has the right to life, liberty, and the pursuit of happiness. The idea of losing control over one's own life makes less sense in a cultural matrix where social control is more an external that an internalized matter and where individual aspirations and autonomy are subordinated, for instance, to the collective interests of the family (Room, 2003:225-226).

1.6.5. Addiction as a Disease

Addiction could have different meanings or could even serve different purposes for different groups; the understanding held by the pharmacists, clergies, and psychiatrists, for example, could significantly differ from each other. Similarly, the self-help groups of drug dependents (also known as the 'recovery movement'), such as the Narcotics Anonymous (N.A) and Alcoholics Anonymous (A.A), regard addiction as a disease. The website of NA (http://www.na.org/bulletins/bull17-r.htm) succinctly describes their position and reasons for such an understanding in the following way:

> There is much public debate over the question of whether addiction is a disease, and we do not choose to become involved in this debate. However, it is our fellowship's collective experience and understanding that addiction is, in fact, a disease…our experience with addiction is that

> when we accept that it is a disease over which we are powerless, such surrender provides a basis for recovery through the Twelve Steps. The number of NA members living in freedom from active addiction show that this philosophy has worked for us. So even though we as a fellowship are not in a position to argue what is or is not a disease in the strictest medical sense, we are fully confident that our use of the word "disease" in describing our condition is appropriate. This is the key point: professional people in fields like medicine, religion, psychiatry, law, and law enforcement define addiction in terms that are appropriate to their areas of concern. So do we. Narcotics Anonymous defines addiction for the purpose of providing recovery from it. We treat addiction as a disease because that makes sense to us and it works.

1.6.6. Importance of a Socio-Anthropological Investigation

Drug use is a human phenomena and any investigation that bars the socio-cultural perspective is only but half explained. The following simplistic explanation of Goode (1972) enlightens us on the importance of a socio-anthropological perspective:

> What can a sociologist tell us about drug use that we do not already know? If there is anything particularly distinctive about the sociologist's view, it is his emphasis on social context. It might appear that this concept seeped into the public consciousness long ago, that it is a banality. But if this were so, the stupendous blunders committed everyday by drug researchers and commentators would not occur. If the concept were really understood, a large part of the drug problem would also be understood (Goode, 1972:1).

How can investigative methodologies of socio-anthropology, which are often subjective in nature, be able to collect data in a more objective or valid (in eyes of some) fashion? Goode (1972) explains the importance of subjective analysis on issues of drug abuse and on how such investigations can approach issues objectively.

> The subjective view is not necessarily 'right'—whatever that might mean regarding one or another proposition—but it does merit understanding on its own ground, and for that purpose its truth of falsity in strictly empirical terms is more or less irrelevant. Because many subjective feelings have no 'scientific' or empirical validity, traditional positivistic pharmacology and behaviorist psychology have avoided levels of experience conveyed by the subject through language, through explanations of what he feels…Subjective feelings can be studied 'objectively'—that is, it is possible to attempt and understanding of the world as it appears to the subject, and to accomplish this

'scientifically.' There is no contradiction here. What the subject feels and says he feels is a field of data that can be investigated by means of the traditional canons of scientific method (Goode, 1972: 14).

1.6.7. Selective Research Findings on Drug Abuse

Maddux and Desmond (1990:65), provides the following findings on the general features of drug abuse careers, gathered from reviewing various research studies. They are (summarized) as follows:

- *Personal vulnerability:* only a small proportion of persons who use psychoactive substances become substance abusers. Some persons use alcohol throughout a lifetime without disability. A special vulnerability, genetic or acquired, seems important in the etiology of alcohol and opioids abuse and in relapse. The evidence for personal vulnerability seems less clear for tobacco dependence.
- *High risk environment*: increased accessibility of substances seems to be another important etiological factor. The much greater prevalence of alcohol abuse over opioid abuse may be a consequence of increased availability, the difference due to the greater legal control of opioids. Furthermore, considerable evidence points to factors in the family and social environment, especially those promoting social learning of substance abuse.
- *Wide variation*: substance abuse careers vary widely in duration and severity. Most alcohol and opioid abusers show irregular periods of abuse, abstinence, occasional use, daily non abusive use, hospitalization and outpatient treatment, and, especially with opioid uses, incarceration. Less is known about the tobacco users' career.
- *Substance substitution*: substitution of alcohol abuse for opioid abuse and the reverse occurs with noteworthy frequency. Concurrent, supplementary use of one while abusing the other also occurs. Tobacco dependence is seen with high frequency among both alcohol and opioid abusers.
- *High mortality:* death rates for alcohol and opioid abusers are approximately three times higher than expected rates. Death rates of smokers are 1.7 times higher than those of nonsmokers.
- *Frequent and rapid relapse*: alcohol dependence, opioid dependence, and tobacco dependence often seem refractory to treatment. Most treated persons relapse within one year after treatment.
- *Increasing abstinence*: with passage of years, increasing abstinence is found in alcohol dependence and opioid dependence. This also probably occurs in tobacco dependence, but long-term career studies of this disorder have not been reported.

- *Maintaining recovery*: the minority of alcohol and opioid abusers who maintain a recovery process for three years or longer seem to experience personal change with less emotional distress. Environmental conditions such as treatment to initiate and maintain the recovery, external coercion, and supportive social relationships seem useful in maintaining the recovery.

Further, Gordon et al (2004:10) points out that those who initiated substance use early were more likely to have multiple treatment episodes, tended to be involved in crime at an early age, dropped from school, and usually had poor academic performance. He further points that early substance use onset was associated with delinquency, crime severity, lifetime arrests, aggressive behavior, bullying people, being cruel to people, and being cruel to animals. A study conducted to investigate the triggering effects of alcohol, illegal substances and major classes of prescribed psychotropic drugs on criminal violence revealed that alcohol was a strong trigger of criminal violence, and benzodiazepines in regular doses and antidepressants may inhibit violence (Gram et al 2006). Further, a research work on family structure and substance use problems in adolescence and early adulthood came to a conclusion that respondents from single-parent families reported a significantly higher level of problematic substance use than those from mother–father families. The relatively high levels of substance use among adolescents from single-parent families that lack the protective presence of an additional relative were explained largely by their greater stress exposure and association with deviant peers (Barett and Turner, 2006).

1.6.8. Drugs and HIV/AIDS

The sharing of contaminated syringes is the most common mode of the spread of HIV/AIDS among DUs. Drug users, especially IDUs are at a greater risk of contacting HIV. A discussion paper prepared by Dave Burrows (2000:3) succinctly lays out the facts on HIV/AIDS and IDUs, and the gravity of the problem:

- There are likely to be more than 10 million IDUs worldwide, of whom at least 1 million have HIV or AIDS. Injecting drug use has now been reported in 129 countries, of which 103 have also reported HIV infection among IDUs.
- Injecting drug user living with HIV/AIDS (IDUWHA) have a higher death rate from causes unrelated to HIV infection than HIV-negative IDUs and a higher rate of non-AIDS mortality than other People living with HIV/AIDS

(PLWHA). Leading causes of pre-AIDS deaths among IDUs appear to be: pneumonia, liver disease (associated with HIV and hepatitis C and/or B co-infection), overdose, and suicide.

- Weight loss and physical wasting can be worse for IDUWHA than other PLWHA due to pre-existing malnutrition and poverty, as well as the effects of some street drugs such as amphetamines or cocaine on appetite and weight loss.
- IDUWHA are at greater risk for infections related to injecting drug use, including: abscesses; embolisms; septicemia; endocarditis; bacterial pneumonia; cellulitis; and phlebitis.
- IDUWHA seem to have a greater tendency to develop HIV encephalitis, and also are at high risk for tuberculosis.
- IDUWHA are likely to be co-infected with hepatitis C virus (HCV). Prevalence of HCV in IDUWHA in international studies ranged from 52% to 95%. HCV does not appear to affect progression to AIDS or severity of symptoms but there appears to be an increase in the severity of liver disease in co-infected people. Co-infection with HIV and hepatitis B (HBV) can cause ongoing liver damage, though HBV appears not to have an effect on the progression of HIV disease. Hepatitis D infection can lead to greater liver damage in IDUWHA. Co-infection with HIV and syphilis can cause problems in treating syphilis.
- IDUWHA are often unable or unwilling to access HIV/AIDS treatments or general medical care. This is due to inappropriately designed treatment services, stigmatization of IDUWHA, negative attitudes towards IDUWHA from medical and healthcare staff, and negative experiences among IDUWHA of health care.
- Methadone and other types of drug substitution are very useful in medical treatment of IDUWHA.
- Information is increasing on drug interactions, especially between methadone and HIV medications, but there is still much that is unknown. There is a wide range of interactions between street drugs and HIV treatments. Protease inhibitors may interact with a wide range of illicit and licit drugs. The strongest effect yet discovered is between ritonavir and methadone. Many HIV treatment drugs have potential effects on the liver. Due to the high rate of HIV and HCV co-infection and the greater level of liver damage in IDUWHA, these potentially toxic effects need to be taken into account.
- Pain management is a problem for all PLWHA, but is worse for IDUWHA, who usually have a very high tolerance for pain control drugs.
- The psychosocial aspects of IDUWHA' lives are generally under-researched.
- IDUWHA are more likely to experience stigmatization and discrimination from more sources than other PLWHA.
- IDUWHA are likely to experience more profound and more frequent depression, and more confusion about the sources of anger, frustration and stress than other PLWHA. The double stigma of drug use and HIV, may keep IDUWHA in the "shock" or "withdrawal" stages of responding to HIV infection, and the ability to feel accepted among other PLWHA and to

exhibit altruistic behavior may also not be possible unless there are specific programs established to foster these relationships and this work.

- Friends appear to be more important to women than to men IDUWHA, implying that peer support (from both other HIV positive women and from friends regardless of HIV status) is vital to women IDUWHA.
- General practitioners and HIV treatment doctors feel they have not received the training to address drug issues among IDUWHA, and are unwilling to treat them unless they quit using drugs. Drug and alcohol doctors and health workers often feel they are not equipped to deal with the additional physical, psychological and social issues affecting IDUWHA. Institutionally, there is a tendency for each group to think that IDUWHA should be treated by the other group, often resulting in an increased sense of frustration, rejection and hopelessness among IDUWHA.
- IDUWHA are likely to move through many periods of increased and decreased drug use and, possibly, abstinence during the course of their disease.
- The illegality of injecting drug use means that attempts are made to prevent IDUWHA from continuing to use drugs while in hospital or hospice. This can lead to severe problems within the hospital or hospice, especially if methadone or other substitution therapies are unavailable.
- Discovering that they are HIV positive can have a profound effect on PLWHA' sexual relationships. There is no evidence that these effects are different for IDUWHA.
- Families of IDUWHA often have to deal with both the drug use and treatment and HIV care needs of the IDUWHA, but also with stigmatization of the whole family once the IDUWHA's status (as both a drug user and HIV positive) becomes known in the community.
- The greatest difference in community effects of HIV/AIDS may lie in the double stigma attached to IDUWHA and pre-existing poverty of IDUs leading to greater impoverishment more quickly among IDUWHA than other PLWHA.
- Community tensions may be exacerbated by scapegoating of IDUWHA as being particularly "guilty" or "dangerous", which may lead to specific violence against IDUWHA.

The Socio-Cultural Context of HIV/AIDS. HIV/AIDS is much more than a medical disease; it is also a socio-cultural phenomena. Beine (2003:59-60) provides useful references of various literatures on how HIV/AIDS come with socio-cultural connotations:

> AIDS has a biomedical reality, yes, but it also has reality as a social construction. As Fee and Fox (1992:9) have claimed, "AIDS is a particularly good example of the social construction of disease." Further building on this hypothesis, they have contended that AIDS, the syndrome associated with the

> HIV virus, is more of a social construction than a biomedical reality (Fox and Fee, 1992:10). Various other authors, making this same claim to varying degrees, have also alluded to this social side of AIDS. Schoepf, for instance, commenting on her research in Zaire, has stated that "AIDS may be usefully viewed as socially produced" (1992:260). Farmer (1992:xi) contends that "the world pandemic of AIDS and social responses to it have been patterned by social arrangements." Herdt (1992:3) claims that "culture shapes our responses to the disease." And Susan Sontag (1988) has demonstrated how we used familiar metaphors to make meaning of AIDS when it first emerged. Medical anthropology has recognized that cultural models of health and illness are strongly influenced and shaped by cultural factors. AIDS is no exception. It has been said of the Western medical model, that a patient comes to the doctor's office with an illness, but departs with a disease (Treichler, 1992:75). Thus, illness is the "culturally defined feelings and perceptions of physical and mental ailments and disability in the minds of people in specific communities," while disease, is recognized as the "formally taught definition of physical and mental pathology from the point of view of the medical profession" (Peltro and Peltro, 1966:302).

1.6.9. Rehabilitation

The following description by UNDCP (2002:5) provides a clear picture on what rehabilitation for DUs mean, its different forms, and its basic intentions:

> Rehabilitation is appropriate for patients who are no longer suffering from the acute physiological or emotional effects of recent substance abuse. Goals of this phase of treatment are to prevent a return to active substance abuse, to assist the patient in developing control over urges to abuse drugs and to assist the patient in gaining or attaining improved personal health and social functioning. Short term residential programs are typically delivered over 30-90 days; residential therapeutic community programs usually range from three months to one year; outpatient, abstinence-oriented counseling programs range from 30 to 120 days; and methadone maintenance programs can have an indefinite time period. Many of the more intensive forms of outpatient treatment (e.g., intensive outpatient and day hospital) begin with full or half day sessions five or more times per week for approximately one month. As rehabilitation progresses, the intensity of the treatment is reduced to shorter sessions of one to two hours delivered twice a week and then tapering to once a week. The final stage of outpatient treatment is typically called 'continuing care' or 'aftercare', biweekly to monthly group support meetings (in association with parallel activities in self-help groups) continuing for as long as two years (UNDCP, 2002:5).

> Regardless of the specific setting, modality, philosophy or methods of rehabilitation, all forms of rehabilitation-oriented treatment for addiction have the following four goals: a) to maintain physiological and emotional

> improvements initiated during detoxification-stabilization; (b) to enhance and sustain reductions in alcohol and drug use (most rehabilitation programs suggest a goal of complete abstinence); c) to teach, model and support behaviors that lead to improved personal health, improved social function and reduced threats to public health and public safety; and d) to teach and motivate behavioral and lifestyle changes that are incompatible with substance abuse (UNDCP, 2002:5-6).

Residential Rehabilitation. The following evidences (UNDCP 2002:6) points out the effectiveness of residential rehabilitation programs for DUs.

> There is a sizeable and long-standing body of international research evidence for the positive impact of residential programs in the three outcome domains. By way of a typical example, results from the largest major evaluation of residential rehabilitation programs in the United States showed the following reductions in the proportion of patients using illicit substances at least once a week during the year prior to admission and during the year following departure from treatment: the proportion of patients using cocaine decreased from 66 to 22 percent; the proportion using cannabis, from 28 to 13 percent; and the proportion using heroin, from 17 to percent. Clients who complete treatment also achieve better employment and are substantially less likely to be involved in crime. However, dropout from residential rehabilitation does seem to be a common problem, and studies typical report attrition level of 25 per cent of patients within two weeks and 40 percent by three months (quoted in UNDCP, 2002: 6).

Entry to rehabilitation is often equally decided by individuals other than the DUs themselves. These decisions can either be ‘coerced treatment’ or ‘social pressures’. Wild (2006:40) indicates the need to understand the distinction between ‘coerced treatment’ and ‘social pressures’ and on how social pressures does not necessarily mean or translate to ‘coerced treatment.’ Wilde uses the term 'social pressures' and/or 'social controls' with reference to objective social circumstances surrounding treatment entry. Social pressure is a natural phenomenon with families and close surroundings who have a level of affinity with the DU, and is different from that of coerced treatment. Wild suggests the term ‘coerced treatment’ be used only with reference to client perceptions and decision-making processes.

1.6.10. Overview of Substance Abuse in Nepal

The synopsis provided by Chatterjee et al. (1996:2) depicts drug use in Nepal in the following way:

> Drug use began to be seen in the country for the first time in the mid 1960s and early 1970s with the influx of the hippies. Till then drug abuse in Nepal was not considered a serious concern…Gradually the use of heroin grew into an epidemic in Nepal from the 1980s onwards. In the early 1990s, psychotropic drugs were widely used by the drug users in Nepal. Rapid Assessment Survey in 1996 found rampant use of codeine based cough syrups (Phesidyl/Corex), opiates (Nitrazen/Diazen), buprenorphine (Tidijesic) among drugs used in Nepal. Drug related problems were also increasingly visible among the urban population (Lohar and Shrestha, 2002:2). The types of drugs or substances abused shifted from cannabis to synthetic opiates and sedatives-hypnotics, and their modes of administration also changed from smoking or ingesting to injecting.

The problem of drug abuse is not an entirely new phenomenon in Nepal. Although the exact number of drug abusers is not known, there is widespread confirmation that drug abuse in Nepal is pervasive and growing by the day. The official government view is that there are 50,000 illicit drug users in Nepal of whom 20,000 are IDUs, but it is likely that the number of IDUs is substantially higher (Reid and Constigan, 2002:152). The National Center for STD and AIDS Prevention estimates that there may be 40,000-50,000 drug users from a population of about 20.9 million people in Nepal (UNAIDS and UNDCP, 2000). A study conducted outside the Kathmandu Valley estimated the following figures on DUs and IDUs: Biratnagar (5,000 to 7,000 drug users of which an estimated >75% are IDUs); Birgunj (800 to 2,000 drug users of which an estimated 40-50% are IDUs); Damak (500 drug users of which an estimated 40% are IDUs); Dharan (4,000 to 5,000) drug users of which an estimated 80% are IDUs); Hetauda (1,000 to 1,500) of which 10-15% are IDUs); Kakarbhitta (200 drug users of which 40-50% are IDUs); Nepalgunj (2,500 of which are estimated 50% are IDUs); and Pokhara (5,000 to 10,000) of which an estimated 60-70% are IDUs) (Peak et al. 2001, cited in Reid and Costigan, 2002:154).

Current Legislations. Lohar and Shrestha (2002:2-3) provides following information on the current legislations regarding substance abuse, and its limitations in tackling drug abuse in Nepal (for further details on drug control initiatives of the government in terms of ratified acts and conventions, see Annex C).

> There are two specific laws that related to substance abuse. One relates to drugs, that is, The Narcotic Drug (Control) Act 2033. The other relates to alcohol, that is, The Alcohol Act and Seven other laws related to alcohol (Alcohol Act, (2031), Hotel Regulation and Sale and Distribution of Alcohol Act (2023), National Broad Casting Act (2049), Vehicle and Transportation Regulation Act (2049), Local Administration Act (2048), Alcohol Rules (2033), and Alcohol Act (2056). The Drug Law has proven to be insufficient in tackling the whole gamut of the drug problem as it is limited in its coverage of the various problems related to drug. On the other hand, the laws related to alcohol also fall short of tackling the entire problems as there is no formal institution to coordinate the activities of control and prevention. Further it does not recognize alcohol as matter of any social dimension other than economic concern.

1.6.11. Research Findings on Drug Use in Nepal

A rapid situation assessment conducted in early 1999 covering most of the urban area of Nepal showed HIV prevalence among IDUs nationwide as 40%, while in the Kathmandu valley the prevalence was 50%. Polydrug use was common and included marijuana, buprenorphine (tidigesic), codeine based cough syrups (phensidyl), heroin (brown sugar), and benzodiazepines (nitrazepam, diazepam) (FHI, 1999).

A rapid qualitative ethnographic research on IDUs of Kathmandu valley was conducted by Crepha (2002) which analyzed contextual information on the antecedents and characteristics of IDUs and their drug life style. Following were the major findings:

- *Number of IDUs and their concentration areas identified from mapping.* As per social mapping, there are 2138 IDUs (2050 male and 88 female) in Kathmandu valley. Altogether 92 major locations (Kathmandu-46, Lalitpur-28 and Bhaktapur-18) have been identified as concentration areas of IDUs (place for injecting drugs).
- *Smoking cigarettes and ganja triggers drug use.* Most IDUs mentioned that they started taking drugs through peer pressure or bad company. They started with cigarette or ganja smoking and progressed to sniffing brown sugar, taking Phesydyl and oral tablets.

- *IDUs inject in more than one group.* Most IDUs switch groups for injecting. Often they inject in their own group in the morning and move to another group in the evening. The group size ranges from 3 to 15 members.
- *There are multiple reasons for sharing syringes.* Lack of money, inexperience in preparing and injecting drugs and less enjoyment when fixing drugs alone are the main reasons that IDUs share drugs and syringes.
- *IDUs clean syringes inadequately.* IDUs clean syringes with water collected in containers (varying from plastic bags, bottle lids or covers, drinking glasses) to spit collected on palms, hand or tongue. Some clean the syringe by using urine collected in palm or plastic bags, bleach powder or distilled water, burning needle with matchstick and boiling syringes in water.
- *IDUs face wide range of problems.* The top five social problems faced by IDUs are 'police arrest/beat,' 'problem of money,' 'neglect by society,' 'ask for money by police/snatch' and 'scolded at home.' The top five health related problems faced by IDUs are 'abdominal pain,' 'HIV/AIDS,' 'insomnia,' 'pain in limbs,' and 'flow of tears.'
- *Most IDUs demonstrate a risky sexual behavior.* IDUs who have been taking drugs for a long time are less interested in sex as their concentration is always fixed on drugs. However, a significant number of them indulge in sex with wives and girl friends, and occasionally with sex workers. Use of condoms is infrequent during such sexual contacts.

A rapid assessment of drug abuse in Nepal was conducted at different sites, including eight municipalities in the five development regions of the country. The study (Chatterjee et al., 1996:1) revealed following findings:

- Sample of drug abusers had a mean age of 23.8 years and was overwhelmingly male. Most respondents lived with their families and were either unemployed or students. About 30 per cent of the sample was married. A large majority of the sample had a family member or a close relative outside the immediate family who smoked or drank alcohol and a friend who smoked, drank or used illicit drugs.
- Apart from tobacco and alcohol, the major drugs of abuse were cannabis, codeine-containing cough syrup, nitrazepam tablets, buprenorphine injections and heroin (usually smoked, rarely injected).
- The commonest sources of drugs were other drug-using friends, cross-border supplies from India or medicine shops.
- The commonest source of drug money was the family.
- There has been a clear trend towards the injection of buprenorphine by abusers who smoke heroin or drink codeine cough syrup. The reasons cited for switching to injections were the unavailability and rising cost of non-injectible drugs and the easy availability and relative cheapness of injectables.

- About a half of the IDUS commonly reported sharing injecting equipment inadequately cleaned with water. Over a half of IDUs reported visiting needle-exchange programs at two of the study sites where such programs were available.
- Infection by HIV appears to be low among IDUs, although systematic surveillance is absent. Two thirds of the sample had experienced sexual intercourse. The last sex partners reported by respondents were commercial sex workers, wives or girl friends. Condom use was low with primary partners and relatively high with sex workers.
- Treatment facilities, mostly located in the central urban areas of the country, were meager.
- An overwhelming majority of drug abusers felt the need to stop abusing drugs.
- Cost-effective drug treatment and HIV prevention programs for IDUs were urgently needed in all areas of the country.

1.6.12. Organizations Combating Drugs and Drug Abuse in Nepal

The Ministry of Home Affairs is the focal agency for drug-control activities in Nepal. A separate unit for narcotic drug law enforcement and six other satellite units have also been established. In all 75 districts of Nepal the chief district officer serves as drug control officer (Chatterjee et al., 1996:2).

There are more than twenty DRCs through out the country (See Annex D for details on DRCs). The major modalities of treatment are detoxification using the methods such as substitute/medicine, cold turkey, acupuncture and counseling. Several others, mostly non governmental organizations (NGOs) are contributing to the drug abuse prevention efforts by conducting campaigns to arouse public awareness of the problem and by promoting education on the subject of drugs as part of the basic school program (Sharma, 2001:1).

Drug Treatment and Rehabilitation. The following synopsis provided by Lohani (cited in Sinha, 2005:21) details the drug treatment and rehabilitation history, the factors behind successful treatment interventions, and the present challenges facing rehabilitation treatment providers in Nepal:

- In 1976, Fr. Gaffney, for the first time started treating substance abusers (home based treatment); in 1983 along with Rajendra Shrestha, Fr. Gaffney started a drug treatment center called the 'Freedom Center.'

- In 1985, Drug Abuse Prevention Association, Nepal (DAPAN) started a treatment center called the 'Nava Jivan Ashram,' and Nepal Drug abuse prevention Association (NEDAP) also opened a clinic. After operating for few years both organizations stopped their services due to various reasons.
- In 1986, the Youth Vision center started providing short-term detoxification and later started providing treatment and rehabilitation services. Youth Vision was the turning point of *drug* treatment services in Nepal with the introduction of holistic treatment and rehabilitation approaches.
- Treatment for drug users was further continued by the entry of Richmond fellowship Nepal in 1993. Many other treatment centers also followed suit: The Police Wife Organization started Ashara Sudhar Kendra; KYC Center in Dharan and INF in Pokhara started treatment centers out side Kathmandu. Navakiran, Nepal Youth, LALS, and many others started treatment centers. Now there are more than 20 Treatment Centers all over Nepal.
- The following components led to effective outcomes on treatment and rehabilitation in Nepal: holistic approach to drug treatment; better understanding of drug abuse as a disease concept; follow up and monitoring after treatment at least for one year; introduction of AA and NA; involvement of ex-users in the program; role models; and jobs/other opportunities.
- The following issues still remain as critical challenges for treatment and rehabilitation centers of Nepal: lack of professional people; lack of resources; lack of proper facilities; lack of occupying jobs and opportunities for the people finishing treatment; and, difficulty dealing with dual diagnosis (Drug/HIV).

Present Services Provided by Rehabilitation Centers. The paper presented by Pooja Niroula (cited in Sinha, 2005:34) on the First National Workshop on Drug Abuse and Drug led HIV, details the following services presently provided by a majority of DRCs in Nepal:

- Outreach: visiting different areas to expand programs, and to encourage for treatment and rehabilitation
- Rehabilitation: residential program
- Detoxification: varies with rehabilitation centers, some use substitution medicines, some use acupuncture, some use cold turkey approach
- Counseling: for target population and family
- In-house awareness: on drugs, HIV/AIDS, drug related harms, and reproductive health issues for women
- Yoga, meditation, and other spiritual programs
- Group sessions: on behavior modification, NA sessions
- Home visit: family counseling
- Work Therapy and working in groups

- Refreshment and entertainment programs
- Day Care; follow up; and, after care services
- Care and Support to HIV positive DUs
- Health Services and referrals
- Income Generation; skill development; and, job placement
- Referrals for further services, for women this constitutes referrals of their children and partners
- Awareness programs: provided in different schools

1.6.13. Observations from an Expert on Drug Addiction in Nepal

Following is an excerpt of a talk given by Late Fr. Tom Gaffney on 14th June, 1995 (source: Sakriya, 2002:2-6). Fr. Gaffney is regarded as an expert a pioneering figure in the field of drug abuse prevention in Nepal, and his ideas and experiences are still implemented in many treatment centers of Nepal. Although this talk program was held 10 years back, his (personal) insights on the reality of drug addiction and intervention efforts in Nepal still holds significance and warrants renewed attention from concerned stakeholders.

> *…In the drug scene, too, there is clear evidence of confusion of goals and means, of 'what' and how'; of 'who' and 'when'. What, exactly, are parents expected to do, where can they go, when they discover a drug problem at home? With all our machinery of committees, meetings, seminars, and programs, does it not seem strange that there are no clear-cut, well known procedures and guideline available through which people can get the assistance they need? Child-like, we seem to dance to others' tunes, imitating what is being done elsewhere, following others' initiatives, rather than respond with an informed awareness of what our situation requires…*
>
> ***Inside.*** *For me, the inside of the drug scene is where the problem exists. That is, with our psychologically troubled, drug abusing youth. This is the focus, which alone gives all our activities meaning. Those who are affected are people, person who are the proper objects of our local or national drug related efforts. Seeing things in this perspective, I think we have to say that the addict population around us are objects of neglect-ours! These youth hardly seem to be of any concern or importance in our anti-drug activities…we seem to have no idea of what is going on in their minds. An example of this is the often heard, negative maxim: Let's not take life-diminishing drugs! Such grim threats are, in the addict's eyes, a challenge rather than an incitement to change behavior. Our efforts, programs, activities, meetings, seminars, proposals, program policies, research and the activities of numerous NGO's*

and INGO's seems to have little or no impact in the lives of the persons who are the core of the problem. The reality of the problem in the lives of addicted persons hardly seems recognized in our multiple activities.

Outside. *If viewed carefully, the structure of activities relating to narcotic drugs in Nepal is both chaos and chaotic...We have a National Committee and an Executive Committee for Drug Abuse Control. But the bulk of their membership is people who have never knowingly seen a drug addict, unless perhaps, it was a member of their own family. Their professional competence does not include experience or understanding of this psycho-social phenomenon. Then we have the Master plan. With dubious wisdom the United Nations has offered Nepal more that five crores of rupees (a little more than a million dollars) for a Five-Year Master plan for drug abuse control. Discussions began in 1987, the agreement was finally signed in 1992, initiated in 1994, and an office established only in 1995. It should expire in 1997! Five different Ministries have been involved in efforts to decide who governs the fortune.*

International knowledge and experience favor demand reduction activities over supply reduction efforts. Experts realize that it is more effective to discourage drug use than attempt to catch those who traffic in drugs. But our Master plan (perhaps reflecting the trend when it was first conceived) grants 56% (US $ 560,7000.00) to legal assistance and law enforcement, and only 44% (US $ 443,000.00) to treatment and rehabilitation. Something like 45% of this million dollars returns to its United Nations source in salaries and payment for the services of experts and volunteers.

But the Master plan has been productive! Formerly there was virtually no one concerned about the drug problem, even after official policy was changed and the problem was acknowledged (alcohol remains officially a non-problem in Nepal). The Master plan has changed all that. Today there are (more than) fifty societies registered for anti-drug activities. Registration qualifies one to stand in line for a share of the $1,00,0000.00…Only God (but probably not the donors!) knows how the dollars, which enabled these registrations, are being used. Certainly addicts do not receive treatment or help through these organizations. Nor are addicts interested in cycle rallies, posters or talk shows. Some money is applies to public awareness activities, but much of it doesn't speak meaningfully to their actual thoughts and attitudes.

The actual nature of addiction, as a non-medical, psycho-social, reactive behavioral phenomenon does not seems to be commonly or properly understood, but the financial potential of working in the drug-problem scene, and the power to use the funds provided, seem of greater significance than the needs of addicted persons. The addict, surely, is not our highest priority. The tail is wagging the dog. Chaos, indeed, is our current scene.

Topside. *Besides money and rank, who actually directs Nepal's anti-drug scene…we have no local serving experts, who, with an understanding of Nepal's cultural concepts, counseling expertise and awareness of current sociological changes and trends, produce effective policy and meaningful activities. These we desperately need. Expertise is needed, not in one or other aspect only, but of the entire phenomenon of drug and substance abuse in Nepal today. Such people should be at the core of a team, guiding Nepal's drug policy meaningfully. The solution to people's problems would be their first priority. We need others to acknowledge our limitations and inexperience. We hear talk about upgrading the services of local agencies. It remains a mystery how training courses can be provided despite the absence of people who are deeply, profoundly acquainted with the phenomenon of drug abuse…*

…But the big problem now emerging is one of behavioral disorders, adjustment disorders. These are psychological difficulties occurring with increasing frequency. They are responsive not to medicine but to personal, informed counseling intervention. Young people have strong feelings, emotions, and pressures, tensions that they cannot handle. Parental inadequacy—failure of fathers and mothers to understand the inner feelings, needs and sensitivities of their children –this is where our greatest current problem seems to be. We need to be humble, sincerely to acknowledge our own lack of sufficient knowledge and understanding. Then only, without rancor or manipulation, without position seeking or jealousy, in a spirit of humble collaboration can we work together to solve the problems, which, despite huge sums of money already spent, we scarcely recognize or understand.

1.6.14. Nepal & HIV/AIDS

The projection of HIV/AIDS in Nepal, for the year 2000, is estimated to be crossing the 50,000 mark (UN, 1998). The Family Health International (FHI), one of the largest HIV/AIDS related donor agency in Nepal, summarizes the prevalence of HIV/AIDS in Nepal in the following way:

> First cases of HIV/AIDS were detected during the late 1980s and early 1990s in Nepal. Seroprevalence surveys during the 1990s have shown a very slow but gradually increasingly prevalence of among sexually transmitted disease (STD) patients. Since the mid-1990s, HIV prevalence surveys of injecting drug user (IDU) groups have shown marked increases and a national survey carried out in February 1999 indicate that close to half of the estimated 20,000 IDUs in Nepal are HIV positive. In addition to these increasing rates of HIV infection, it is believed that an undefined, but likely increasing number of HIV-infected Nepalese 'female sex-workers (FSWs) are returning or being returned from their place of work in India. Increasing HIV prevalence rates are also being found among young male truckers who frequent FSWs in Nepal and

> India. Based on these recent finding, the most current estimate of total HIV prevalence in Nepal range from 20,000 to 40,000 with a reasonable working estimate of about 30,000 (FHI: August, 1999).

HIV and IDUs. In Kathmandu, 1.6% of IDUs tested in 1991 were HIV positive. In 1993 and 1994, no evidence of the virus was found among IDUs tested at that time. However, by 1997, 50 % of IDUs tested in Kathmandu were HIV positive (UNAIDS 2000, Oelrichs et al. 2000, Furber et al. 2001, Burrows et al. 2001; Karki 2001, cited in Reid and Costigan, 2002:154).

Reid and Costigan (2002:154) further provide important figures as referred by other recent studies:

> The increase in HIV prevalence is believed to be due primarily to changes in the type of drug used that is the significant shift to the use of injectible buprenorphine (Chin, 1999). High risk injecting behavior is also reflected in the hepatitis C prevalence in Nepal: about 72% of drug users were found to be injecting and 94% of IDUs were hepatitis C positive (Oelrichs et al. 2000). The first case of AIDS in Nepal was reported in 1988. The estimated HIV prevalence at the end of 2000 is 34,000 and the number of those living with AIDS is 3,000; the number is expected to double by the year 2005 (UNAIDS 2000; WHO 2001). HIV prevalence among blood donors in Kathmandu has almost doubled from 1997 to 1998 from 0.28% to 0.48% (Reid and Costigan, 2002:154).

1.6.15. The Concept of Relapse

Synopsis of Relapse. The following excerpts from experts provides a broad understanding on the concept of relapse and considerations for its usage for research purposes:

> Relapse has been described as both an outcome-the dichotomous view that the person is either ill or well-and a process, encompassing any transgression in the process of behavior change. Essentially, when individuals attempt to change a problematic behavior, an initial setback (lapse) is highly probable. One possible outcome, following the initial set back, is a return to the previous problematic behavior pattern (relapse). Another possible outcome is the individual's getting back on track in the direction of positive change (prolapse) (Witkiewitz and Marlatt, 2004: 224). The high rate of relapse is an especially frustrating problem, and the notion of a 'cure' remains elusive. Substance abuse careers are episodic, with periods of abstinence, reduction of use, and relapse the prevailing pattern, often with the course of events being influenced

by external factors such availability of drugs and societal pressures. (Leuikefeld and Tims, 1990:1).

The definition of relapse may be shaded by the treatment modality and the goals of the treatment. For example, in a methadone maintenance client for whom the only realistic treatment goal is reduction in illicit drug use, relapse generally means resumption of frequent or daily opiate use…two time frames are in common use in computing relapse rates. One ascertains current drug use at specific time intervals following treatment termination (e.g., 1 year after the end of treatment). This does not capture intermittent drug use unless it is occurring at the time of follow-up. The other method ascertains whether there was drug use at any time during the follow-up period. Since drug abusers often have periods of abstinence interspread with use, the second method will generally produce higher relapse rates (Wesson et al. 1990:5-6).

Craving and Relapse. Witkiewitz and Marlatt (2004:227) provides the following evidences from various studies on the relationship between drug craving and relapse.

Craving is possibly the most widely studied and poorly understood concept in the study of drug addiction (Lowman, Hunt, Litten and Drummond, 2000). One common finding is that craving is a poor predictor of relapse (Kassel & Shiffman, 1992; Tiffany, Carter, and Singleton, 2000). Drummond, Litten, Lowman, and Hunt (2000) proposed that the subjective experience of craving may not directly predict substance use, but relapse may be predicted from the correlates and underlying mechanisms of craving. For example, Sayette, Martin, Hull, Wertz and Perrott (2003) experimentally demonstrated that cue exposure was predictive of nicotine craving, but only for smokers who were deprived of nicotine. These findings are consistent with previous research demonstrating that during abstinence, the perceived availability of a substance plays a large role in craving responses. Siegel, Baptistia, Kim, McDonald and Weise (2000) proposed that both craving and symptoms of withdrawal may act as drug-compensatory responses, which are conditioned by several exposures to drug-related stimuli (e.g., seeing and advertisement for a desired brand of cigarettes) paired with the physical effects of a drug. Therefore drug cues elicit a physiological response to prepare the individual for the drug effects. On the basis of this model, withdrawal and craving may be limited to situations in which preparatory responses to drug effects have been learned (Siegel et al., 2000; Wenger and Woods, 1984)…Studies (Carter and Tiffany, 1999; Rohsenow, Niaura, Childress, Abrams, and Monti, 1990) on the role of cue reactivity in addiction have demonstrated that drug-related stimuli elicit self-reported craving and increased physiological responding, but cue reactivity has not been shown to be a consistent predictor of relapse (Witkiewitz and Marlatt, 2004:227).

1.6.16. Relapse Theories and Areas for Further Research

Theory. There are numerous theories on relapse, which are often characterized by one's disciplinary background and specialization. Wesson et al (1990:5) explains: "Psychotherapists, drug abuse counselors, treatment program planners, and researchers have theories about what relapse is, why it occurs, and how it is prevented. Such theories are important because they shape the treatments provided to drug abusers. For example, a therapist who believes that drug abuse is a chronic, relapsing disease will treat a patient who has relapsed differently from one who views drug abuse as a secondary symptom of underlying psychopathology. A clinical researcher who accepts a theory of inherited endorphin deficiency will design and test treatments for relapse differently from a researcher who believes that drug abuse is learned behavior." With a variety of approaches taken in understanding relapse, a singular theory encompassing all disciplines is lacking. Leukefeld and Tims (1990:187) explains: "Numerous theoretical positions have been taken to explain relapse. Yet, a coherent, integrated theory is lacking. Discussion related to theory and theory development acknowledged the importance of theory as a guide to research and practice, but the lack of explanatory power in existing theory, and the lack of theoretical organization, was repeatedly cited as cause for concern. For example, it was noted that Lettieri et al. (1980) have identified over 43 theories to explain drug use."

Below are short characterizations on selective relapse theories, which could be relevant within the standpoint of social science:

> *1) Conditioning Theory.* Wikler (1961, 1965 and 1973) proposed the conditioned withdrawal model syndrome to explain why formerly addicted persons who appear to be 'cured' of their addiction while in treatment or in jail return to opiate use when no longer physically dependent. According to Wikler, environmental and social stimuli formerly associated with actual withdrawal and drug-seeking became classically conditioned stimuli for a conditioned withdrawal syndrome. A direct application of classical conditioning is aversion treatment of alcoholism with emetine. Patients have sessions in which they are given emetine, which produces severe nausea and sometimes vomiting, while being allowed to smell or taste their preferred alcoholic beverage. With repeated pairings of alcohol with nausea, instead of the usual pleasurable feelings, alcohol loses its appeal (Wesson et al. 1990:8).

2) Social Learning Theories. Social learning models of addiction and relapse acknowledge the role of classical and operant conditioning; however, they focus on cognitive-mediated processes in the acquisition, maintenance, and modification of behavior. The various social learning theories complement conditioning theory by focusing on the cognitive processes occurring between stimulus and behavior. A general model of relapse in a social learning framework has three components: first, the patient encounters a high-risk situation during abstinence; second, the patient has expectations about whether the situation can be handled without use of drugs; and third, the patient has a limited repertoire of behaviors and skills to cope with the high-risk situation. The work of social learning theorists contains specific formulations regarding relapse prevention. Treatment derived from social learning theories attempts to prevent relapse by intervening at different points in the chain of behaviors, beginning with antecedents to the high-risk situation and extending through actual relapse. The interventions are tailored to the particular stage in the sequence and to the particular person (Wesson et al. 1990:9).

3) Social Support. A dominant hypothesis in the literature is that social support functions as a buffer to stressful life experiences—i.e., the negative consequences of a stressful life events-are mitigated by social support…Another hypothesis is that social support has a generally beneficial effect, independent of whether persons have stressful events in their lives, and that those who revive social support have greater well-being. Of relevance to drug abuse treatment is how social support function in relation to relapse…Other important aspects of the role of support in relapse, though not necessarily mutually exclusive, include the possible negative consequences of social support, the issue of drug-specific versus general social support, and the role of support from family and significant others (Wesson et al. 1990:11-12).

4) Theories of Recovery. In the context of addictive behavior, the term 'recovery' can mean 'cure' of addiction, 'abstinence' from drug use, or 'remission' of the drug-dependent state. Theories about recovery usually describe a process of achieving and maintaining abstinence that is not necessarily related to any specific type of treatment. These theories reflect notions about influences of major life changes in producing and sustaining abstinence (Wesson et al. 1990:14).

5) Maturation Theory of Winick. Using 1955-60 data from the Federal Bureau of Narcotics registry, Winick (1962) noted that most opiate addicts began use in their late teens and early twenties and disappeared from the narcotics registry after age 35. From this observation, Winick hypothesized that, by age 35, most opiate addicts 'mature out' of the problems that originally led to heroin use. After 35 years of age, they find the drive to continue drug use not sufficiently compelling for them to continue the life-style necessary for opiate use (Wesson et al. 1990:14).

Areas for Further Research. Leukefeld and Tims (1990:187-88) suggest six general types of study areas that could yield greater understanding on relapse and recovery:

1. Longitudinal studies which clarify the natural history of addiction careers. Such studies would be designed to allow researchers to examine more closely relapse and recovery.
2. Descriptive studies to pinpoint who relapses. These studies would provide a clearer understanding of sex, age, and drug type variables as these variables impact on relapse. Similarly, studies of individual in recovery might provide a clearer picture and description of recovery processes.
3. Laboratory studies to examine physiological factors. Such studies would provide further insight into the nature of factors related to the clinical aspects of relapse and recovery. Limited information is currently available regarding the physiological aspects of those recovering.
4. Experimental studies to assess behavioral aspects of relapse, particularly the role of environmental stimuli, including both treatment and non-treatment factors. Such studies should enable understanding of the role of treatments as well as other variables in relapse processes for well-defined subgroups of clients.
5. Clinical studies which would clarify the role of psychopathology as a risk factor in relapse. This would extend already existing findings on psychopathology as a prognostic variable, and specify how subgroups of clients respond to treatment and to the other stimuli present in natural environment, as well as how changes in psychopathology moderate risk of relapse. In this connection, it is important to assess clients on a continuing basis at intake, during treatment, and during the post treatment period. Such studies might also address familial characteristics, as well as individual psychopathology, as predisposing factors.
6. Treatment evaluations are designed to incorporate relapse and recovery as a priori focus. Such treatment evaluations should include: 1) theoretical and operational definitions of relapse and recovery, 2) credible control group(s), 3) random assignment of groups to treatments, 4) well-defined patient groups, 5) standardized treatments which are adequately described in manuals, 6) specified treatment lengths and treatment doses as well as assurance that interventions are delivered, 7) use of consistent, reliable and valid outcome measures, and 8) specific therapist characteristics and training.

1.6.17. Relapse and Rehabilitation

Effective Patient-related Components in the Rehabilitation-Relapse Prevention. Following are the important patient-related factors, which serve as effective components in the rehabilitation–relapse prevention efforts (UNDCP, 2002: 7).

- *Severity of substance use.* A variety of studies of treatments in different national contexts have shown that the chronicity and severity of patients' substance use patterns have been reliably associated with poorer retention in treatment and more rapid relapse to substance use following treatment.
- *Severity of psychiatric problem.* A consistent finding across many studies and contexts is that severe psychiatric symptoms and disorders at intake to treatment are a reliable predictor of dropout and poorer follow-up outcomes.
- *Treatment readiness and motivation.* Patients who report being ready and motivated to receive treatment tend to engage more successfully with the therapeutic program and stay in treatment for longer periods of time. Interestingly, patients who have been mandated to enter substance abuse treatment have shown outcomes that are quite similar to those who are self-referred and supposedly more 'internally motivated.'
- *Employment.* Many people with drug abuse problems have enduring difficulties with obtaining and retaining paid employment. Unemployed patients are more likely to drop out of treatment prematurely and to relapse to substance of treatment prematurely and to relapse to substance abuse.
- *Family and social support.* Social supporters have been widely studied in the drug abuse and dependence field. Social support has been conceptualized variously as the availability of relationships that are not conflict-producing and supportive of abstinence; and the active participation in peer-supported treatments such as Narcotics Anonymous. Stressful life events…may exert a more powerful effect in determining individual outcomes that treatment itself. It follows that treatment goals may not be reached at all or may attenuate rapidly following treatment if the patient's environmental resources are limited. Effective treatments for substance abuse look beyond the program to assist the patient in becoming included in society and improving family relationships and personal resources.

Effective Treatment-related components in the Rehabilitation-Relapse prevention. Following are the important treatment-related factors which serve as effective components in the rehabilitation–relapse prevention efforts (UNDCP, 2002: 8).

- *Setting of treatment.* The general conclusions from this work are that, for most treatment systems, it is likely that patients who have sufficient personal and social resources and who present with no serious medical complications should be assessed for outpatient/day treatment. Given the typically high demand for residential care, it seems logical to prioritize that

setting for those with acute and chronic problems who have social stressors and/or environments that are likely to interfere with treatment engagement and recovery.

- *Treatment completion and retention.* There is a substantial amount of literature to support the assumption that patients who complete treatment will have better outcomes that those who leave prematurely. Generally, longer stays in outpatient maintenance and residential rehabilitation programs are related to better follow-up outcomes. Benefits increase with time in the program and retention is a fairly reliable proxy measure of success for most types of treatment. Given that most people who are staying in drug abuse treatment programs have chronic and diverse problems, it is to be expected that the longer they remain in treatment, the greater the likelihood that significant lifestyle improvements will be achieved and consolidated…Overall, the issue of how long patients are able to spend in treatment is a key fiscal issue for most treatment systems. The implications of this work are that treatment service personnel and the wider care coordination infrastructure should ensure that patients are retained in treatment for at least the minimum threshold for success, and where possible, treatment duration should be determined by patient need. There are also important implications for targeting people who leave treatment at an earlier point, since those individuals are characterized by substantially poorer outcomes.

Further, UNDCP suggests the following programs and management issues as vital for relapse prevention: "In planning to prevent relapse, many services are needed, including rehabilitation, community services and active follow-up. Successful programs require qualified staff, constant management, adequate resources and the flexibility to adapt to changing circumstances" (UNDCP, 1995:17).

Relapse After Treatment. Relapse not only occurs frequently after treatment, it also occurs rapidly after treatment. Maddux and Desmond (1990:55) summarizes research findings from various studies that depicts DUs' vulnerability to relapse:

> Gottheil and associates (1982) reported that only 19 % of 20 treated alcoholics remained abstinent during six months after treatment; 48% became relapsed drinkers during that time. The authors cited two other studies, having a combined total of 499 treated alcoholics, in which only 18 % remained abstinent during six months after treatment (Maddux and Desmond, 1990: 55). Frequent and rapid relapse after treatment also occurs in opioid dependence. Duvall et al. (1963) found that 97 % of 43 opioid users became readdicted at some time during five years of follow-up after treatment. An estimated 67 % became readdicted during the first six months after discharge. In our study

> (Maddux and Desmond, 1981) of careers of opioid users, we found that 70 % of 1653 treatment and correctional interactions over a mean period of 20 years were followed by less than one month of abstinence. Eighty-seven percent were followed by abstinence of less than six months. In their follow-up of 2,099 opioid addicts in the Drug Abuse Reporting Program, Simpson and Sells (1982) reported that 56% to 77% of opioid addicts in different treatment groups resumed opioid use within one year after completion of treatment (Maddux and Desmond, 1990: 55).

Maddux and Desmond provides further findings from their own studies: "In our study of careers of opioid users, we attributed relapse in part to protracted withdrawal, to conditioning, and to stress, such as the onset of marital conflict. Additionally, we inferred a subjective motivational state revealed more in action that in words. Our subjects came to most treatment interactions under external coercion, and they rarely seemed to have a desire persistent enough to overcome their opioid dependence (Maddux and Desmond, 1990: 56).

Organization of the Study

The study organized its work in forms of following chapters or sections.

1.7.1. Pre-Introduction

This part of study includes an abstract, acknowledgments, list of tables, list of figures, list of appendices and acronyms. The pre-introduction section lays out the organization of the study.

1.7.2. Chapter I. Introduction

This chapter introduces the study with an overview of drug abuse, drug relapse and drug treatment scenario in Nepal. This chapter also includes a 'statement of the problem' characterizing the important issues regarding drug relapse. Further, the chapter includes a section on the 'rationale of the study' which discusses on the significance of understanding the social environment of relapsed drug users. The chapter concludes with a section on the 'purpose and objectives of the study,' detailing the goals and objectives the study wishes to accomplish in its undertakings.

The first chapter (introduction) also discusses various 'theoretical perspectives' used by the study along with the details on how theoretical components were used to form a strategic basis to guide the study. Based on the theoretical guidance and research objectives, the chapter also discusses the 'conceptual frame-work of the study,' which details the framework set by the study in executing its goals and objectives.

Chapter I further present a review of various literatures, and provide sound background information on drug relapse and the social environment. The review of literature works as a knowledge base that reinforces the stance of the study. Chapter I conclude with information on the 'organization of the study' which details on ways the study and its findings are logically organized.

1.7.3. Chapter II. Methodology

The second chapter of the study deals with explaining and justifying the methodologies exercised by the study for gathering its data. The chapter starts with a discussion on the rationale behind the selection of drug rehabilitation centers – the principal focal point through which the study gathered its data. The chapter then discusses on the 'units of analysis' included by the study followed by detailed information on the 'design, size and selection of sample' in the study. The chapter then discusses on all tools and techniques used by the study for data collection.

Chapter two also details the use of ethnographic approaches to field observation. Further, the chapter also discusses on ways data analysis and interpretations were carried out by the study. The chapter also includes a section on the 'field research as a personal experience' of the researcher. The chapter ends with genuine discussions on the limitations of the study, with regards to the methodological and data collection issues encountered by the study.

1.7.4. Chapter III. The Setting

The findings of the study start from chapter three. This chapter sets the platform for the rest of the findings of the study and provides a detailed understanding on the current drug use scenario of Kathmandu and on the functioning of the DRCs included in the study.

1.7.5. Chapter IV. Actual Living Conditions of RDUs

The paradigm of social environment consists of 3 clauses. This chapter details the findings on the first clause of the social environment: the actual living conditions of RDUs. In specific, chapter IV details findings on the socio-cultural and demographic background of RDUs and their immediate surroundings, along with the drug career background of RDUs.

1.7.6. Chapter V. Norms, Values and Attitudes of RDUs

This chapter provides findings on the second clause of RDU's social environment: the norms values and attitudes. The chapter looks at the following issues to understand the norms, values, and attitudes of RDUs: a) beliefs and values of RDUs; b) relationships with families and relatives; c) reasons behind use to abuse and cessation of drugs; d) issues pertaining to relapse; e) use of skills learned at the DRC; f) RDU's change of DRCs; and g) relationship with DRC counselor.

1.7.7. Chapter VI. Alienation as Particular Socio-Cultural Context

This chapter details findings on the third clause of RDU's social environment: a 'particular' socio-cultural context. The study presupposes 'alienation' as the particular socio-cultural context of RDUs. This chapter provides justifications that the socio-cultural context of RDUs is that of alienation. The chapter discusses the presence of the 5 components of alienation among RDUs to rationalize its stance.

1.7.8. Chapter VII. Social Environment of Different RDU Types

This chapter details the social environment of RDUs by their marital status and of RDUs living with HIV/AIDS (RDUWHAs). The investigation on RDUs by marital status isolates selective findings to understand the possible differences on the social

environment of married and single RDUs. The investigation on the social environment of RDUWHAs seeks to gain understanding on the complexities and challenges faced by IDUWHAs, when they relapsed and when they eventually stopped using drugs.

1.7.9. Chapter VIII. Views from Service Providers

This chapter includes findings on the opinions and experiences of service providers working with DUs concerning drug use, the lives of DUs, and the services they provide. In specific, this chapter includes findings from a focus group session with the service providers on issues they felt were crucial in increasing the quality of lives of DUs. This chapter also details findings on the works and challenges of the only functional female DRC in Nepal. Further the works of Narcotics Anonymous (NA) and Recovering Nepal (a platform organization of recovering DUs), which are providing crucial services for active and recovering DUs are also covered by the chapter.

1.7.10. Chapter VIV. Summary, Major Findings and Recommendations

This chapter summarizes the major findings of the study with the aim of providing a clear and organized picture on the social environment of relapsed drugs users. The summary refers to all research objectives set forth by the study and reviews the findings accordingly. The chapter also discusses the major findings of the study and concludes with concrete recommendations for service providers working with DUs and for academicians eager to investigate the phenomena of drug use.

1.7.11. Bibliography and Annex

The study ends with an organized and complete reference to publications and authors referred by the study. The chapter ends with detailed listing of annexes, which provides information on various research tools used by the study, in addition to a glossary and other concepts used by the study.

CHAPTER II. METHODOLOGY

The Rationale for the Selection of DRCs

The DRCs of Kathmandu were the principal field setting for the study. The rationale behind selecting only the DRCs of Kathmandu is several folds. The study wanted to focus its work on area with highest concentration of DUs. All experts agree that Kathmandu has the highest concentration of DUs in Nepal. Second, the study had to be methodologically representative if DRCs outside Kathmandu were selected; there had to be a sound methodical explanation for the selection of research area outside Kathmandu. Coupling this issue with the fact that there are very few DRCs outside Kathmandu which could qualify on the prerequisites set by the study for selection of DRCs (discussed below), the study resorted to including only the DRCs in Kathmandu. Excluding areas other than Kathmandu did not mean that RDUs from other areas weren't included in the study. The study does include sizeable RDUs from areas outside Kathmandu who were attending various DRCs in Kathmandu.

Keeping in mind the rationale of the study, on learning about relapse of RDUs using best treatment intervention available, the study through consultation with various experts and review of relevant literatures devised the following requisites for the selection of DRCs. In specific, the DRCs had to have the following requisites in place for their selection in the study:

1. Basic infrastructure in place (dormitory, dining hall-kitchen, play ground-area, separate office room);
2. Non coercive environment;
3. A proper and acceptable detoxification system in place;
4. Proper rehabilitation setup approved or used in international settings;
5. Stricter implementation of rehabilitation program in place;
6. Designated counselors;
7. Trained staff;
8. Proper relapse prevention mechanisms in place;
9. Psychological support for clients;
10. Provision of after care program and support;
11. Some form of medical services or referrals in place;

12. Free or discounted treatment fee scheme for DUs who cannot afford;
13. Widely renowned among DUs; and,
14. Not facing severe financial crisis.

The above factors were utilized as the basis under which all organizations referring themselves as DRCs were scrutinized for selection. The researcher made use of literatures of various DRCs and consultations with DUs and experts, along with visitations of the DRCs to arrive at a final list of DRCs for the study.

Units of Analysis

The units of analysis for this study were as follows: RDUs; the DRCs-including staff and program coordinators; and professionals/immediate service providers related with DUs. The study regarded RDUs (who had relapsed following DRC enrollment) as the primary unit of analysis. It was the firm conviction of this study that RDUs themselves were the best source of information for understanding their social environment. Goode (1972:12) also stresses the same in the following lines: "The fact is that no one except the drug taker is capable of reporting the nature of the drug experience; thus it is absolutely essential to elicit his descriptions." The RDUs contacted for this study were capable in every aspect in relating and answering to issues the study investigated. Also, the RDUs were well versed with concepts and 'treatment languages' (such as: feelings, suffering, clean date, step workout, recovery, relapse, etc.) widely used in the centers.

The study interviewed program coordinators and observed behavior of staff of all DRCs included in the study to get a first hand insight on the functioning of DRCs. Since, DRC is an important component of RDUs' social environment, greater care was taken in understanding the functioning of DRCs. In a non-participant observation mode, the researcher took into account the environment of all DRCs in the study by spending considerable amount of time at the DRCs. Further, the study also gained perspectives of service providers working with drug users to understand the nature and impact of their services.

Design and Selection of Sample

Design

The study went through a series of rigorous exercises to effectively tackle the following prerequisites for a proper research design: 1) proper and comprehensive addressing of the themes and objectives of the study, and, 2) a valid research method to implement the study. The research design exercise consisted of various meticulous efforts. The researcher in the initial period sat with various service providers working in drug abuse prevention to understand: the drug scenario of Nepal; issues related with drugs and relapse; and the services available for DUs. The researcher also consulted various credible theories, literatures, and experts to come up with concrete, organized research queries and indicators to justify the main theme of the study. With the identification of a valid sample, proper research tools, and a data collection time frame, the study executed the research methodology into practice. The duration of research work and report writing were as follows: Research work – 4 years (including initial rapport building period), and data analysis and report writing –1 year). The research guide was constantly consulted and appraised on the developments made with the designing and the implementation of the study.

The designing of research methods also warranted concrete working definitions of concepts that were central to the research theme. The study in its designing stage considered the following working definitions for a coherent approach.

> *Relapse: Relapse is a state invited by various reasons in which a drug user who had stopped using drugs goes back to regular drug use and drug dependency.*
> *Lapse: Lapse can be understood as a slip in one's recovery process-not necessary a relapse state. It can mean use of drugs in an irregular or non-habitual way.*
> *Cessation: A complete stop on using drugs (except nicotine and caffeine) for more than 24 hours. For detoxification in medical settings, cessation meant complete stop of drug use after end of detoxification period (counting from night) for more than 24 hours. Resumption of drug use immediately after such detoxification is not regarded as cessation.*
> *Drug: Any substance (except tobacco and caffeine) that affects living processes. Alcohol is also considered a drug in this study.*

Selection of Sample

The study used a 'purposive sampling' technique to gather its data. A purposive sample is a form of non-probability sample in which the subjects selected seem to meet the study's needs (Baker, 1988:163). A major disadvantage behind such forms of non-probability sample is that its findings cannot be generalized to its universe. However, the researcher opted for this technique due to the following peculiar circumstances attached with this study. There were no records of properly calculated universe of drug abusers in Nepal. Estimations used by service providers and government organizations had serious validity flaws. There were no other alternatives for the researcher to attain a workable base to draw a sample as no prior researches have been conducted across the entire community or population of DUs in Kathmandu. Therefore, purposive sampling, as justified by Baker (1988), was the best way to derive sample for the study that focused on phenomena that were unexplored or had an untypical background. The DUs of Nepal inarguably fit in this category. Due to these reasons, purposive sampling was preferred. In total, the study included 153 RDUs, and four Injecting Drug Users with HIV/AIDS (IDUWHAs). A total of 6 DRCs were chosen for locating the subjects for the study.

The sample included only those RDUs who were enrolled with DRCs. The reasons are several folds. First, the intent of the study was to look only at RDUs who have had interventions in form of residential rehabilitation drug treatment. Second, investigation of queries had to take place in settings in which the subjects were not influenced by any addictive substances that could jeopardize their capacity for a comprehensive response. Third, the DRCs provided a controlled and non-interruptive environment, aiding the RDUs to respond to the intensive nature of the inquiries.

The study more or less followed a same pattern on locating the samples for the study. The coordinators of selected DRCs were contacted and upon their consent, the staff in charge of the centers was contacted to find out on the number of RDUs enrolled at the center. Apart from the 'in-house' or residential program, a majority of centers were also providing 'day-care' program (a morning to evening program attended by newly discharged DUs). The study also included RDUs attending day care programs.

Data Sources

Tools and Techniques Used for Data Collection

This study was qualitatively oriented; however a quantitative approach was also stressed whenever possible. The approach to data collection was through a) questionnaire filled by the RDUs; b) case studies of IDUWHAs; c) ethnographic observation of activities in the DRC; d) semi structured interviews with the staff of DRCs; and e) focus group sessions with service providers working with DUs.

1) The questionnaire. Questionnaire was the main tool in gathering data from RDUs for this study (questionnaire attached in Annex E). The questionnaire, consisting of multiple choices, open and close ended queries, were made in both English and Nepali for the subjects to write in whichever language they were most comfortable with. The questionnaire was designed to be 'user friendly', with use of terminologies and concepts familiar or frequently used by DUs. The questionnaire administered to RDUs, was a rather intensive tool, and considerable time was spent on explaining the nature of the questionnaire, explanations of major terminologies, and approaches on answering the questionnaire. The RDUs were not forced to answer all questions – their rights to not answer any of the questions for any personal reasons were respected. Further the study assured confidentially of the information shared by the RDUs by not sharing their information to their respective DRCs, and by not asking RDUs to put their first names on the questionnaire. For those with lesser writing skills, the researcher took over the writing, and the mode was changed more into a semi-structured interview.

For data gathering purposes, the researcher constantly kept in touch with the DRCs. Upon gathering a list of RDUs, the researcher would typically have a group meeting, in which the staff and interested RDUs (usually 5-6) were briefed on the study and its intentions. None of the respondents were coerced to take part in the study. Upon their consent, an appropriate time was fixed with the center staff for the researcher to administer the questionnaire. On the day fixed, the researcher sat with the respondents in

a comfortable area of the center and the questionnaire was administered. In an average, the researcher would return back to a particular DRC in every two to three weeks to administer questionnaires to newer RDUs enrolled at the center.

Developing of questionnaire and Pilot Testing (Pre-testing). As majority of data for this study relied on the questionnaire for RDUs, greater effort was taken to make it RDU friendly, reliable and valid. The questionnaire went through a rigorous process of formation and pilot testing before it was deemed appropriate for administration. The questionnaire was constructed following considerable consultations with DUs, DRC staff and experts. In addition, the publication of the National Institute on Drug Abuse (NIDA)-'Theories of Drug Abuse' (1980) was also widely consulted to derive proper variables and themes to be included in the questionnaire. After a first draft of the questionnaire was prepared, a meeting of experts from two DRCs was called, in which, the questionnaire was scrutinized for its effectiveness in gathering information central to the theme of this study. Useful feedbacks were received and were incorporated in a second draft. The second draft questionnaire was then administered to three RDUs as a form of pre-testing. Again, according to the comments and feedbacks of the subjects, useful comments were incorporated which was then accepted as the final version of the questionnaire.

2) Interviews. Series of formal interviews (in different periods of time) were conducted with the program coordinators of all DRCs, Narcotic Anonymous (NA) representatives and other relative service providers. The study during its period in the field also conducted informal interviews with DRC counselors and DRC staff working as outreach workers.

3) Observation. In ethnography, this method relates to the technique of learning a people's culture through active involvement in their everyday life over an extended period of time (Haviland, 1993). As an outsider (or as a non-participant), the researcher

meticulously observed RDUs, the working of DRCs, and various meetings and conference sessions of recovering drug users, service providers and other stake holders working in drug and drug led HIV issues.

4) Case Study. A case study analysis was used to understand the lives of IDUWHAs. Yin (1989:23) defines a case study as an empirical study which (1) "investigates a contemporary phenomenon within its real-life context; when (2) the boundaries between phenomenon and context are not clearly evident; and in which (3) multiple sources of evidence are used." The study regarded case study as the suitable approach in understanding the sensitive issues and subtleties within the real life context of IDUWHAs.

5) Focus Group Meeting. A focus groups meeting was conducted with recovering users and service providers working in areas of drug and drug led HIV. The meeting was based on the theme of 'improving the quality of life of drug users in Nepal.' The session was able to chart out a 'problem-objective tree' which focused on the micro and macro issues associated with improving the quality of life of DUs in Nepal. The meeting was facilitated by the researcher. The outcome of the meeting was also used in the strategic planning of a first national level workshop of key stakeholders working in drug and drug led HIV areas.

An Ethnographic Approach to Field Observation

The environment of DRCs as observed by the researcher provided useful insights in understanding the various obvious and subtle processes of interactions of RDUs among and with the staff of DRCs. Such observations gave useful insights on the cultural practices, belief systems and social customs of all actors in the DRCs. The researcher took considerable time in building rapport with the staff and DUs enrolled in the DRCs. The researcher on a weekly basis gave classes on music appreciation, music performance and on social reintegration in three DRCs.

Further, the researcher was also asked by Recovering Nepal (a network of drug abuse prevention and HIV related service providers) to help facilitate and provide inputs for organizing a national workshop of service providers working in drug and drug led HIV

issues. This opportunity provided the researcher with ample opportunities to observe intricate interactions and belief systems of service providers and recovering DUs from Kathmandu as well as from other areas of Nepal.

Data Analysis and Interpretation

Data analysis for the study was organized in three ways. Data derived from the questionnaire were organized in a data management and analysis computer software. Data derived from interviews and focus groups were scanned for commonalities from which findings were standardized and organized in a ranking matrix corresponding to relative research themes and sub themes. Data derived from observation of RDUs were organized in a diary like account, from which commonalities were sought to best describe and to add more substance to the overall findings on the social environment of RDUs.

Following the organization of data collected, data interpretations were carried out with the use of quantitative and qualitative data interpretation techniques. For quantitative data, the study exploited descriptive statistical techniques for data interpretation. As stressed by Goode (see literature review, page 22), the study believes in understanding subjective issues objectively, to an extent possible. The study, however, did not pursue advanced statistical techniques to preserve the socio-anthropological essence of the study. For qualitative data, commonalities, patterns and tendencies were noted and were organized as findings under various research themes of the study. Both qualitative and quantitative data were interpreted to complement each other for cohesive findings of the research.

Field Research as a Personal Experience

The field research for this study was intensive as the study had to rely more on primary data in absence of credible secondary data. Considerable time was spent to gain a comfortable relationship with the DRC staff. Further, the researcher gave great consideration in building rapport with the RDUs as the research aimed at gaining sensitive and personal information. Greater care was taken on all aspects regarding entry

to the research site to the execution of objectives. The researcher in his efforts used his background in social science and music performance in conducting input classes in some DRCs. The researcher was very comfortable with the reception received at the DRCs, which was cordial and one with trust.

Apart from conducting input classes, the researcher also tried to meet with the RDUs informally before administering the questionnaires. This, the researcher firmly believed yielded more commitment from the respondents in sharing their information. Many respondents also commented that the entire questionnaire exercise was an awakening moment for them (even therapeutic as felt by some), as it demanded very sensitive, closely guarded information and some soul searching from the respondents.

Limitations of the Study

The limitations attached with the study come in several folds. First, as the sampling technique used is based on non-probability sampling, findings of this research cannot be generalized to the greater universe. Secondly, the study only takes account of RDUs who were enrolled in DRCs; findings on those who relapsed after trying cessation modes other than DRC enrolment are not taken into account.

Further, the study only takes account of DRCs in Kathmandu. Although including DRCs outside Kathmandu could have given a more broader picture, the study decided to focus only on DRCs located in Kathmandu, as the city has the highest concentration of DUs in Nepal. However, the study does include RDUs outside of Kathmandu in the study, as many were enrolled in various DRCs in Kathmandu. Further, queries in the questionnaire regarding relapse history did shed some light on RDUs who had once enrolled in DRCs outside of Kathmandu.

The use of qualitative approach and subjective responses could also be restrictive when one warrants a quantifiable explanation to queries posed. However, the study has given considerable attention in structuring and interpreting subjective data for a comprehensive explanation to issues posed by the study.

The issue of treatment accessibility subsequently leading to biased sample is also acknowledged by the study. In other words, since a majority of DRCs charge money (the lowest being 5,000 Rupees per month, only those who can afford will enroll in the DRCs. This would pose a bias as the study is essentially looking at issues of only those RDUs who can afford treatment. The study realizing the existence of such bias used two requisites to negate its impact. First, the study incorporated only those DRCs which had free or discounted treatment schemes. Second, DRCs regarded as charging highly expensive fees where not included in the study. Further, the study also included 2 DRCs who were providing services free of charge and with sizeable subsidies from the center. It was unfortunate that the free treatment program initiated by a donor organization in partnership with various eligible DRCs had just started, as the data collection process for this study was about to end. However, apart from those receiving discounts in treatment fees, the study was able to include 19 percent of RDUs who were receiving free treatment from the DRCs.

The study, unfortunately was not able to provide a balanced view on the social environment of RDUs by gender. With only one active female DRC in Nepal, the study had to give up its earlier intention of including female RDUs in the study; the study could only contact negligible number of female RDUs. The study however does include findings on the general status of female drug users in relation to issues related with their DRC enrollment and relapse.

CHAPTER III. THE SETTING

The Drug Setting

3.1.1. The Drug Scenario of Kathmandu

The Early 1990's Period. A discussion paper presented by Mr. Jagdish Lohani (cited in Sinha, 2005:22), director of the Youth Vision Rehabilitation Center, depicts the drug scenario of the early 1990s in the following way:

> In the early 90's, a new group of people also started using codeine mixed cough syrup like 'phensedyl' and 'phencodin.' This form of dependency spread very fast. At the same period the availability of heroin became scarce and subsequently expensive. Buprenorphine (also known as Tidijesick), which was made in India, made its entry in Nepal as a substitution drug. Buprenorphine is a synthetic opiate like substance, a very potent analgesic for use among cancer patients and other operative cases. Buprenorphine use however, did not remain limited for therapeutic purposes, but became a drug of choice for many heroin addicts and newly drug using population. It came in ampoule and sublingual tablets but almost every body used the injectible form, intravenously. When drug users switched to injecting drugs, the tendency of sharing needle and syringes also increased. This was the most unfortunate period for Nepal as the use of Buprenorphine led to a wide epidemic of drug abuse and HIV/AIDS in Nepal. The epidemic was not limited to Kathmandu but spread to Pokhara, Biratnagar, Hetauda, Birgunj, Nepalgunj, Bhairahawa, and, Dharan. The HIV/AIDS epidemic could have been greatly lowered if interventions were made at that period. Although there are no means of verifications, sero-prevalence in 1990 was believed to be below five percent, and now it is thought to be more than 50 percent.

The Current Scenario. Experts agree that the use of drugs in Kathmandu is increasing day by day. In addition, experts also acknowledge that people are now using drugs at a much earlier age (12 or 13) compared to earlier figures (15 years or above). Further, experts also acknowledge an increasing number of DUs in colleges (also grades 11 and 12), including an increasing number of middle class female DUs. Drugs are more accessible in Kathmandu. Experts fear the fact that many initiating to drugs after the use of cannabis are going straight to using brown sugar these days. They believe that brown

sugar has made inroads into colleges of Kathmandu, and with the onset of modern communication means such as the mobile phones, locating brown sugar dealers have become easy.

Brown sugar is available in pouches with a pouch containing 1/3 of a gram. The current street value of a half gram of brown sugar is Rs. 1,000. The new comers have been found to be chasing (pulling) brown sugar rather than injecting it (pushing). In general, a half gram of brown sugar might be taken at a time and its trip (effect) generally last for 5 to 6 hours. Intake is dependent on the person and his/her stage in his/her drug career. Chronic drug users can take brown sugar for 4 to 5 times a day. Brown sugar is an expensive drug, and most of its users come from middle class to higher class economic background. White Sugar has become rarer in the drug market during the last five years. White Sugar is more expensive and used generally by those with very wealthy family background.

Buprenorphine (tidigesic) is widely popular among IDUs in Nepal primarily due to its affordability. A 5 ml. tidigesic in street value ranges from 60 to Rs 400 rupees (the latter price during shortage situations). Many IDUs in Nepal are currently using tidigesic in combination with diazepam or campos (tranquilizers) for more tripping. A normal dose would figure 2ml. of tidigesic and 1ml. of diazepam or campos. Further, the DRC experts have also witnessed the shortage of 1ml. syringe in the market leading DUs to using 2.5 ml or 5 ml. syringes. Some IDUs are also 'double-dosing' with these syringes.

The use of stimulant pills is also increasing in Kathmandu. Experts also point out DUs using stimulant pills ('tabs' in street terms) such as Nitrosun, Proxyvon, Nitrovet, etc. are found to be of 'different' types. Some are normally starters; using for enjoyment. Some use stimulant pills with other choice of drug for 'over-tripping' (to derive more high) and there are those DUs, who in shifting from brown sugar to tidigesic or vise-versa use stimulant pills as a constant in the change. There are also some DUs who in trying to quit brown sugar or tidigesic use stimulant pills. For many such DUs, stimulant pills are not regarded as drugs. The law authorities have become stricter in the past years for

controlling the sales stimulant pills in the pharmacies. However, a black market does exist, and many DUs also travel to bordering Indian towns to buy stimulant pills for personal consumption and for further selling.

The availability of drugs in Kathmandu, according to the experts is dependent on several factors. If there is a transportation strike on the national highways, or a national *bandh* (closure), the shortage of drugs is immediately on the streets. Even if strikes or vehicular movement is stopped for any reason in the bordering towns of India, the shortage of drugs is immediately felt on the streets of Kathmandu.

The IDU scenario. Many drop-in centers of Kathmandu have been witnessing an increase in cases of abscess among IDUs. Experts, among others attribute this to the quality of TD available now as not being as 'pure' as it was some years back. Due to this, IDUs have experienced their veins shrinking or disappearing faster, forcing them to inject in 'unusual' areas, such as veins close to the genitals.

The awareness on the harms of needle sharing depends on the type of DUs, according to the experts. There are some who share needles. There are some who contact needle exchange program for new needles and there are those who don't share needles. Experts believe that it all depends on availability of money and person's ability to handle craving (sickness) at a particular situation. With craving, a DU may not think about needle sharing; his/her priority is to first get a fix. DUs with money buy separate needle even when fixing in groups. In term of cleaning needles, DUs have mostly been found to be using water and saliva. Experts have however felt the rise of awareness among DUs on not sharing needles.

Experts have also found that some DUs don't view needle as being 'shared' if he/she is the first person using the needle in a group: the basic understanding being, 'I didn't use needle shared by others.' Experts also label some IDUs as being 'needle sick'; the use of needles is absolutely essential for them, and the paraphernalia is also a part of the trip.

Many DUs currently coming to DRCs have been those who haven't tried other external interventions such as the detoxification services rendered at various clinics. The experts also agree that DRCs are now on the frontline when comes to dealing with IDUs with HIV, and that the DRCs are facing an increasing brunt of dealing and rehabilitating IDUs with HIV and other chronic diseases.

The DRC Setting

This section details the findings on all DRCs included in the study. Findings include information on the various components of the DRC, including its program and treatment mechanisms.

3.2.1. Richmond Fellowship Nepal (Male)

Introduction. Richmond Fellowship Nepal Male (RFN-M) started with a drop-in and counseling center for the male DUs from September 1996. The increasing number of clients approaching the center demonstrated a clear need for a full-fledged DRC, and from February 1997, RFN-M started its rehabilitation program. From June 2000, RFN further extended its services to female DUs by opening a RFN Female Crisis Center in Kathmandu.

RFN-M is located in the southern city limits of Kathmandu valley occupying 3 ropanis of land. The center has 32 beds; however, with sheer volume of DUs wanting to enroll in RFN-M, the center has had to accommodate more clients. Within the six months of July to December 2004, RFN provided residential rehabilitation services to 119 clients. From January to June 2005, 84 new clients were admitted at the center. Among them, 47 clients were discharged positively, 12 negatively and 15 clients ran away from the center. Negative discharge included runaways, clients not returning back from outings, and clients who didn't cooperate with the 'program' despite several interventions. About 30 percent of DUs admitted in RFN-M came from areas outside Kathmandu, mostly from Pokhara, Dharan, Bhairahawa, and Birgunj. Such clients mostly came from well to do family background.

More than 70% of substance users treated in RFN-M are IDUs. The record keeping of the center showed that within the last six months 33% of the total clients were found to be HIV positive, 6% HBC positive, 10% HCV positive, 1% Tuberculosis and 23% with sound medical background.

RFN-M is run by 10 staff including 3 paid volunteers. Nine staff and all three volunteers are ex-drug users. The center apart from regular monthly salary provides provident fund and medical allowances to its staff. The program coordinator, associate program coordinator, outreach supervisor, and assistant outreach supervisor have had international training and exposure on various components of treatment rehabilitation. The program coordinator firmly believes that RFN-M has developed a firm rehabilitation management system that can sustain the center even in the case of personnel change.

Admission. Self-motivation is the main criteria RFN-M looks for when admitting DUs in the center. The center conducts a small interview session, in which the levels of motivation of clients are gazed. Further, the center also looks for the consent of parents/guardians for clients living with the family. The center maintains an official file for every client with important details regarding client's drug career, other background information, and contact address of parents/guardians.

The structured fee for rehabilitation set by RFN-M is 6,500 per month. However, 4 quotas are set aside for free treatment each time. People who genuinely lack money were said to have been given free treatment. Further a quarter of the client are usually on half payment, and another quarter are given some form of discounts. Around half of all clients provide full payment. Further, RFN-M also provides referral services to Sangati extended care services (a DRC providing free treatment services) to DUs who can't afford treatment. Recently, RFN-M qualified for the 'free treatment' scheme initiated by a donor organization and had just started providing free treatment to clients with deprived economic background.

Detoxification & Residential Program. RFN-M uses the psycho-social approach with medication for detoxification. During detoxification period (also termed by center as 'sick period'), the physical withdrawal syndrome of DUs is looked after with careful psychosocial support from the center. The sick period usually lasts for 7 to 10 days according to the center. The client is then ready to join the specified program of the center.

During residential rehabilitation, clients usually stay at the center for at least three months. However, program duration can also be longer for DUs with lack of coping skills, and inability in reshaping behavior and attitude. The center provides overnight 'outing' privileges to clients after one and half months, in which the attitude of clients and their interaction with their families are carefully noted. The center also stresses meditation and yoga exercises along with specific sessions for spiritual growth. The center has been using the "Peer Recovery Guidance" modality based on the approach of "Therapeutic Community" (T.C.) concept for rehabilitation since October 2001. The T.C concept stresses 'restructuring of thinking patterns', 'emotional management stability', 'behavioral changes', 'building vocational and survival skills', 'spiritual awakening' and 're-integration into society' (see Annex F for more details on the concept of TC). With the implementation of the TC model, the center has felt its rehabilitation process as more effective. The center has trained the staff to run the TC model.

Counseling. RFN-M regards individual and group counseling as essential components of the rehabilitation process. Individual counseling is provided in a weekly basis for the in-house members. Group counseling are also provided on a daily basis, according to the weekly schedule. The center also provides family counseling to the families of the in-house and day care clients. Besides, home based family counseling is also provided according to need. Family members of residential and day care clients also have meetings at the center on a regular basis. The center views that a problem of a single DUs affects the whole family and regards the family as 'co-addicts'.

Follow-up. RFN-M observes and investigates on the clients after discharge. The center stays connected with the client's families and guardians from admission to daycare. The center claims to do this for almost all clients.

RFN-M has also made it a policy to visit homes of the clients, before they are given permission for their first outing. For 90% of the clients, the center looks for ways of changing his home environment, so that triggers are minimized. The center is also in contact with the parents/guardians and suggest them to not 'act up' (or show 'damn care' attitude) once client comes home. The center also tells the parents on the importance of good communication, and to not raise suspicions without finding facts first, as client comes home.

Day Care facility is another key component of RFN-M. Since its establishment, RFN has been providing this service to the clients after their completion of residential program at the center. The main objective of the program is to provide continued care, concern, support and to prevent clients from relapse. The center feels that rehabilitation alone is not sufficient to prevent relapse and regards day care as a gradual reintegration mechanism as clients start 'testing the waters' under constant support and supervision of the center.

In the day care services, clients at the RFN-M obtain peer support, an opportunity to build up self–esteem, and skill development trainings. The center doesn't have special programs as such for day care clients; however, they are engaged with fellowshipping, voluntary works, sports and other chores at the center. The center also asks the day care clients to give back their learnings and experiences to the center, in forms of voluntary work with the in-house clients. The center and the in-house clients also recognize and respect day care clients for their recovery efforts. At the end of each day, a 'head count' gathering (acknowledgment of all present at the center) includes day care clients with a sense of respect. The center maintains communication with parents/guardians of day care clients. The day care program is compulsory for three months but some clients may go for long time as per their need.

Further, the center advises all its discharged clients to give at least a year for their recovery. If career issues are urgent, the center advises 6 months of recovery period; it its too urgent, the center sticks to 3 months of recovery period in forms of day care. In some cases when clients have to attend exams in schools and colleges, the center lets the client sit for examinations under the supervision of the DRC staff who drops off and picks up the client after examinations.

Discharge. Discharge of clients from RFN-M is dependent on the evaluation of the clients on various factors: evaluation of time spent by the client at the center; performance of the client at the center and during outing; and progress in attitudinal change. RFN-M also emphasizes fellowshipping and regards NA as a great mechanism for helping discharged clients stay focused on their recovery. The center says at least 90 % of its discharged clients attend NA meetings. Even in the discharge slip (given to parents and guardians during discharge), the center advises the parents that the client attend once a week NA meeting near their locality. The center respects the momentum NA is building in Nepal and also believes that the internal disciplinary issues in NA home groups have become a lot better.

Other programs. RFN-M has also been providing care and support program for DUs with life threatening diseases, in addition to its residential rehabilitation program. The qualified counselors provide voluntarily pre and post test counseling to the clients and referrals for the HIV, HBC and HCV testing.

Outreach activity is one of the major programs of the center, and entails reaching out to the target population in various communities. During the outreach visits, DUs are informed about the benefits of rehabilitation programs and are motivated to start treatment. They are also provided with awareness on drugs related harms along with issues like HIV/AIDS, reproductive health and Sexually Transmitted Infections (STIs). Other major responsibility of the outreach staff is to follow-up, provide aftercare services to the clients with home visits and to encourage clients in self help support group.

RFN-M in conjunction with the initiation of few PLWHAs and friends from IDU background has also opened an organization called 'Sparsha Nepal', next to its premises. Since November 2004, Sparsha Nepal has started its care and support program for PLWHAs. Initially, it was a closed network of PLWHAs and their friends, however, it has now grown to be a full fledged institution providing care and support, psychological support, treatment information and counseling for people infected and affected with HIV.

RFN-M has also been involved in various external projects such as the 'Peer Led Intervention' project supported by UNODC to reduce the risk of HIV infection among the IDUs groups in Lalitpur district. The center was also involved with the 'Leadership Training Project' conducted in both male and female RFN centers by the 'Policy Project' that focused on comprehensive approach in treatment and rehabilitation.

RFN-M has a strong network with other DRCs in and out of Kathmandu. The center is also involved with a federation like organization called 'Recovering Nepal,' a platform of various service providers working for greater justice of DUs in Nepal

RFN-M has felt the importance of providing skills trainings and possibly job placements to clients who show the desire. The center is also contemplating on starting a micro-credit program amongst recovering users on a trail basis. RFN-M has also used its networking with other service providers in referring their graduates for various job placements.

General Impression. RFN-M is regarded among DUs as a good DRC. The center is located in a serene environment of Chowbar, with plenty of indoor and outdoor space. The researcher in his visitations usually witnessed the center as packed to its capacity even during the onset of *Dassain,* a time, which according to service providers sees a decrease in new enrollment in DRCs.

The daily program in the center is very organized. The researcher didn't witness a lax environment at the center. The staff were strict in following the program set out for the day. The premises within the center are clean, and clients are also seen involved in various chores of the center. The center has created an environment which ensures greater involvement of the clients.

3.2.2. Youth Vision

Introduction. Established in 1988, Youth Vision (YV) is one of the older non-governmental DRCs in Kathmandu. The center, located at the eastern city limits of Kathmandu, covers an area of four ropanis, and has 28 bed capacity. YV provides rehabilitation treatment to about 150 clients per year. YV is funding all treatment and day care facilities from private contributions and from its own limited resources.

YV is supervised by an executive committee and a director who provides guidelines to 3 counselors, 2 junior counselors and 2 volunteers for the daily operations of the center. One of the senior counselors, and all junior counselors and volunteers come from previous drug usage background. The regular staff receive *Dassain* bonus, and medical support in addition to monthly salary. The center is also planning on setting up provident funds for its staff.

As a private NGO with no international affiliation for funding, the center is limited to recovery techniques and operational procedures that are not expensive to maintain. For the most part, YV works with a staff that volunteers their services. Although limited with expertise and budget to expand on, YV feels motivation and experience as often more valuable than knowledge. YV believes in keeping its approach simple, sensible and sensitive to cultural flash points. YV maintains a holistic approach to drug abuse, understanding the physiological, psychological, social and spiritual integrity of the clients. The center also believes that the clients themselves need to take major responsibility for their recovery.

Admission. Admission at YV center is done with a careful screening of client's motivation. The center also provides information on other centers if they hesitate on services the center has to offer. After admission, the client is further screened on his background, and is assigned to an appropriate counselor. The counselor then draws up a treatment plan for the client.

YV maintains a structured fee of 5,000 rupees per month for its clients. However, for those who cannot afford, the center is also providing free treatment. Up to 25 to 35 percent of its clients are receiving free treatment currently. Recently, YV qualified for the 'free treatment' scheme initiated by a donor organization and had just started providing free treatment to clients with deprived economic background.

Program. YV uses medications for detoxification as prescribed by a doctor for 7 to 10 days. The center uses medications as more of an incentive for a smoother transition to a life of cessation at the center. YV follows the TC concept with appropriate modifications to suit the Nepali culture. The director of the center has international experience on the TC concept. Residential program at YV is set for three months. The center has fixed routine for client rehabilitation. The routine is activated as clients come out of the 'sick period.'

Apart from a regular visit from a medical doctor, YV refers its clients to its own Voluntary Counseling and Testing (VCT) center for HIV referrals. YV at the same time also takes special care to insure that the client's right to privacy and non-disclosure is maintained.

Counseling. Counseling is considered an important asset of YV. Every week the center has individual and well as group counseling sessions. YV is also sensitive to following socio-cultural issues in client recovery: respect for age, fatalism, racial distinctions, sibling rivalries, bilateral family systems, male dominance, father-son relationships, and peer pressure. The counselors also meet with the parents individually,

during the rehabilitation period of the clients. The center feels the importance for the families to understand treatment concepts, and their roles, to strengthen the reintegration attempts of the clients.

Discharge. Although the program runs for three months, discharge is dependent on several factors at YV. First, the counselor monitors the client's recovery process. Home visits, which the clients receive after two months, are carefully scrutinized. The third month sees further attempts on recovery interventions. The three months are then evaluated by the counselor, and decisions are made. Discharges are based on personal basis and could be different for clients with different backgrounds. For example, some clients with HIV might need more time with rehabilitation.

Follow-up. YV uses its day-care facilities as an important follow-up period. Clients have to attend day-care for 3 to 4 months, which are said to have been strictly monitored. The counselors are also in touch with the families during day care period. The clients are assessed on how they handle money, manage time, and on their relationship with family members. YV regards day-care program as very vital for reintegration and recovery of clients and that day care experience build into the psyche of clients to stay clean. After 6 to 7 months of rehabilitation and day care, clients are directed towards a short term goal of celebrating their first birthday (a year of staying drug-free is celebrated in the center as the client's birthday).

Other programs. YV is one of the innovative DRCs, constantly approaching newer ideas to sustain itself and for providing meaningful solution to recovering DUs with income skills and job placement. YV during its course of running the center has tried its hands on many income/skill related projects such as, candle making, envelope making, screen-printing, and Internet cyber house. However, continuity could not be given due to marketing and limited financial resources. The center however, is successfully continuing the operation of its printing press, managed by ex-drug users.

YV is also planning on working on a new harm reduction project with the Asian Harm Reduction Project. The center is also running a fully functioning VCT program in the heart of Kathmandu, with the funding from FHI Nepal. The center is also planning to expand its services at Hetauda, by opening a self sustaining DRC. The center is planning on using the center for free treatment with innovative ideas for sustainability.

Networking. YV maintains informal network with 'like minded' DRCs and other service providers in Kathmandu. The center is of the view that it is more interested in working with committed organizations than spending time on the 'politics' and rhetoric meetings. Like other organizations, YV also realizes the lack of government support on DRCs. YV is also a member of a network called 'FORUM' which consists of grass roots organizations working in drug abuse prevention field in South Asia. The networking is said to be helpful as it provides a platform to learn on experiences of other DRCs in the region, and to share updated and relative information. YV also supports NA efforts in Nepal. YV encourages its clients to participate in any home groups, and feels such fellowshipping as very important tool for recovery.

General Impression. YV, being one of the oldest DRCs in Nepal, has tried and tested many rehabilitation techniques, which are also used or modeled by other DRCs in Nepal. Many of its clients are working as volunteers or staff in other DRCs and service providing organizations. Many YV clients also come from other metropolitan areas outside of Kathmandu, like Pokhara. YV recently moved to a new location, a little distance away from the city limits of Kathmandu.

3.2.3. Freedom Center (Mukti Kendra)

Introduction. In 1976, the late Fr. Thomas E. Gaffney, founder of the St. Xavier's Social Service Center (SXSSC), began to help Nepalese drug addicts with a detoxification program. But it was realized that addiction was more a psychological than just a physical dependency. In 1983, Fr. Gaffney and Mr. Rajendra Shrestha established the Freedom Center (FC), a rehabilitation center where young men can stay for several

months while they work through their problems and prepare themselves for a fruitful life. The goal was to help struggling drug dependants on their recovery and to raise their standard of life.

FC is the oldest DRC in Nepal. FC works under SXSSC, a part of the Nepali Jesuit Society. The center covers an area of 7 ropanis of land in the southern city limits of Lalitpur. At present FC has accommodation for 25 residents. FC has an annual intake of about 70 to 80 clients.

There are presently 7 staff at FC and all of them are full time workers. Two of the staff are ex-users. All staff have a minimum of college education and those working directly with drug dependants have received international and national drug specific trainings. The staff receive a basic monthly salary along with provident fund, medical allowance and education allowance for their children.

Admission. Though admission requires self motivation from the patients themselves, consent from parents or guardians is also needed for admission at FC. Only after a detailed interview with all the people concerned, is the DU accepted. Freedom center charges a fee of 5,100, rupees per month for its services. This according to the center is a subsidized rate in which the center adds another 2,000 rupees.

Program. FC uses acupuncture for detoxification. The center has a certified acupuncture staff. The center prefers acupuncture treatment to that of psycho tropical drugs as it is non chemical, and has no side effects (the center uses sterilized needles). The center follows the T.C. mode with an 'eclectic' approach – accommodating the Nepali culture and situation. All activities and therapies are designed to give the patient a sense of how he consciously and unconsciously interacts with his inner and outer world. A wide variety of approaches are envisioned to accommodate the wide range of patients that make use of these facilities at the center. Day outings and overnight outings are given as part of the therapy later in the program. The staff decides when these are appropriate.

The duration of rehabilitation at FC can range from 6 months to 1.5 years-depending on the clients, his background and progress. A daily routine is an important part of the healing process for the patients. It helps in coping with the mundane mental and physical challenges. The Freedom Center aims to guide patients under careful attention for self-realization with the following goals:

- To exercise better awareness of self
- To develop problem solving techniques
- To increase motivation for emotional management
- To empower one's ability to deal with confrontation and competition
- To develop teamwork and cooperation

Following are the important components of the rehabilitation treatment provided by FC:

- Yoga exercises/meditation
- Relaxation techniques
- Work therapy (daily chores, gardening, laundry, kitchen work etc.)
- Team sports
- Recreational activities (sports,T.V., picnics)
- Cognitive therapy
- Behavioral therapy
- Individual and group therapy
- Ex-boys meetings
- Parent's meetings
- Follow-up
- Acupuncture

Counseling is an important asset of FC. All counselors have had 8 to 10 years of experience and have received international and regional counseling trainings. All counselors have no drug abuse histories.

HIV cases remain confidential in FC and there is no forced testing at the center. The center provides pretest and post test counseling. The center refers its clients to Patan hospital for HIV tests and for any medical attention.

Other activities. The staff of FC are sometimes invited for their expertise on various programs and workshops on drug issues. However, the center isn't concomitant with external activities (workshops, meetings, etc.), and regards the work at the center as its top priority.

Follow-up. Follow up of clients after discharge is done for one year at FC, in which, the client has to visit the center once a week. Parents are also followed up intensively during this period.

Networking. FC is the member of the World Federation Therapeutic Community (WFTC) and Asian Federation Therapeutic Community (AFTC). FC is a pioneering organization, the very first to be working in the drug abuse prevention in Nepal. The center's clients are working in many DRCs in Kathmandu as volunteers and full time staff. The experiences garnered by the center have greatly helped other centers in Nepal to grow in their rehabilitation efforts.

General Impression. FC is the oldest DRC in Nepal. The center was the only organization opening its doors and services for DUs in Nepal for many years. The name of Fr. Gaffney who started FC is synonymous with all anti-drug initiatives in Nepal. Many of the DRCs in Nepal have at least one or more staff that have stayed in FC at one point in their drug career. FC although maintains a low profile, is widely respected as an institution with capable people, knowledge and experience. The center unlike many other DRCs does not have financial problems, thus DRC operations run smoothly. The center on a first hand observation can be readily identified as a well managed DRC with well maintained facilities.

3.2.4. Sangati Center

Introduction. Sangati Extended Care Center was established as a day drop-in center at *Nagpokhari*, Kathmandu, in June 26, 2005. It was opened with the intention of providing day care facilities for DUs discharged from the treatment courses of different

DRCs of Nepal. Sangati is a unit of Kathmandu Area Development Program of World Vision International-Nepal and is currently running a full fledged DRC in partnership with SXSSC.

Sangati has about 5 Ropanis land with rehabilitation cum skill development training center at *Rabibhawan,* Kathmandu. Sangati has a 16 bed capacity but can accommodate up to 20 clients. The center currently has 12 residential clients, 27-day care persons and 5 to 10 skill development trainees. As per the client's economical condition, the center serves the facilities for the payments of treatment expenses. Sangati provides referral services to different rehabilitation centers for clients who can pay for their treatment. Sangati also has around 50 percent of DUs originally from out of Kathmandu valley enrolled in its center. The center refers its target groups as economically poor and deprived DUs.

A total of 195 clients were enrolled at Sangati from October 2004 to September 2005. Out of this, 17 clients were discharged positively, 29 clients were in day care, 30 clients were referred for treatments at other DRCs, 28 clients still in treatment and rest in follow up programs.

Rehabilitation programs at the Sangati Extended Care Center are facilitated by skillful professionals with years of experience in their specialized fields of drug abuse. The center’s qualified staff includes counselors with recovering backgrounds, a family doctor (voluntarily visiting once a week), a certified acupuncturist, skills development supervisor, volunteers and administrators. Altogether, there are 11 paid staff, 8 paid volunteers and a trainee presently working at the center. In addition to a basic salary, the staff receive travel allowances and a festival bonus. Volunteer staff also get some incentives as per the nature of their work.

Sangati refers its staff as loving caring people committed to recovery. The center believes that quality care begins with a staff having minimum work related stress. The center runs once a week general meetings to discuss on working strategies and to help to staff insure quality care and a cohesive work environment.

Admission. Sangati works with DUs with deprived economic background and provides free or heavily subsidized treatment. The clients coming in at Sangati so far have mostly been based on its outreach work and referral from other service providers. The center carefully screens DUs on their motivation and willingness for recovery and for staying in a DRC. The center also meets with the family of DU to find out their willingness. Further, the center also looks for recommendations from credible organizations such as the government Ward office and social service organizations for free treatment eligibility. Only after such careful scrutiny are DUs admitted at the center.

Discharge. The decision for discharging a client at Sangati is based on the following criteria. First, the counselor on his interactions with the client decides on the discharge time frame. The counselor along with other staff are also in touch with the parents, and discussions with them also play a part in client's discharge. Further, the staff at the center also monitors the progress of the clients on his attitude and his stance on recovery.

Program. Sangati uses acupuncture techniques for detoxification and TC concepts and NA 12 steps for rehabilitation. The rehabilitation programs of Sangati are as follows:

Table 3.1. The Rehabilitation Program at Sangati

Detoxification	**De-addiction period**	**Rehabilitation**	**After care services/ Discharge**
2-4 weeks	6 weeks	8 weeks	6 weeks
Auricular acupuncture and cold turkey as per the condition of clients	Group therapy, individual counseling, group dynamics, NA steps, Lectures, encounters, consequences etc.	Follow up the program activities, counseling, family interventions, peer educators	
If medication required, referred to Detoxification centers like Teaching and Patan Hospitals.	Theory and practice		
Primary care	Secondary care		Tertiary care

Source: Sangati

Sangati has weekly parent's education sessions on Sundays in which every parent of the in-house clients, day care clients, and skill development trainees must have to attend. The center believes that such interactions are very effective to deal with behavioral issues and learn corrective measures for a proper recovery of the clients. A group parent/guardian meeting is conducted once a month (every first Saturday of the month-at the Sangati Mid Way Home).

Follow up Programs. Regular follow up scheme is developed for all clients following his discharge from the center. The center follows up on its day care clients and investigates on client's progress, on how he is following directions of the center. The center also meets with the families to investigate on the client's progress. If families maintain contact with the center, follow-up can go for 2 to 3 years. Follow-up is more intense on clients who don't contact the center regularly or on clients whom the center believes may have difficulties with his recovery.

Sangati also runs a day care program for its clients, who have to attend the program for 3 to 4 months on a mandatory basis. The center has set programs for day care and the day care clients also have joint programs with the 'in house' clients. The center uses TC concepts with the day care clients also. The clients with dire economic background are also encouraged to participate in skills development programs of the center.

Other Programs. As per the conditions of the clients and their level of interest, the center provides micro-skills to develop entrepreneurship skills of the clients. Mostly, the center provides opportunities on candle making, handicrafts, nursery, computer trainings, driving, and, cooking. Some clients who work hard and have learning attitude are kept on income generation programs for periods as per need. Sangati hopes that clients returning home can earn some money or even start a small business and use the money accordingly with the family. Sangati does not see this program as a business venture but rather as a learning opportunity for the clients. The center has contacts with more than 5 hotels in Kathmandu who have given them space to put up stalls to sell their

products. Sangati feels the marketing aspect of their products is also doing well. Most importantly, the center has had an overwhelming response from the clients and feels that such programs are having a positive impact on their recovery process.

Sangati encourages the clients for their recovery and celebrates the sobriety birthday of clients. The center also organizes various outing programs. Every year the center organizes camp out programs, refreshing orientations, recreations, and hiking trips as well. Sangati also encourages skills presentation of DUs on various platforms. Among others, the center has organized a Sangati Fair, fundraising event for HIV infected and affected women and children, inter-school quiz contest, inter-school art competitions, school education programs, and support group developments in the community. Sangati has also put up stalls at various hotels, exhibitions and other occasional events to sale the products and generate income for the clients.

Networks. Sangati Extended Care Center is working as a 'communication focal point' on the district network against drug and drug related HIV since October 2003. This network is coordinated with the Ministry of Home Affairs (MOHA), the CDO, UNODC representatives, various DRCs and other NGO working in drugs and HIV sectors in Kathmandu. Sangati Extended Care Center is also the active member of 'HIV/AIDS counselor network of Nepal' that started from July 2005 led by Sahara counseling center in coordination with the National Center for AIDS and STD Control, MOHA, and FHI-Nepal.

Sangati also maintains a healthy working relationship with many DRCs of Kathmandu. Sangati has two way referral partnerships with DRCs such as FC, YV, RFN-M, Nepal Youth and LALS. These DRCs are contacted for referral when DUs who can afford visit Sangati for treatment. These DRCs also contact Sangati for referrals of DUs with deprived economic background.

General Impression. Sangati although being one of the newest DRCs, is in experienced hands of SXSSC which also looks after the Freedom Center. Sangati is unique is a sense as their intake is prioritized for people from low socio-economic strata.

Treatment expenses at the center is free, however, the center is very mindful that the clients have a sense of ownership with whatever contributions they can make to the center. Sangati stresses that program interventions are also needed at the family level when working with clients with dire economic background.

A good balance of economic sustenance and recovery is felt by the center as very important for the clients. The center stresses on implementing income related activities and skills development for clients, which they feel has been very valuable. Sangati also stresses on parental meetings, and their follow-up is also good as reported by the clients. The center also encourages women to work as volunteers in the center. The center is sustained by financial aid from committed donors, thus, does not face financial problems like other DRCs in Nepal. Sangati has set a good example on how treatment can be used as a service for those who cannot afford, and thus bridging the genuine gap of treatment accessibility for people with deprived socio-economic background.

3.2.5. Life Giving & Life Saving Rehabilitation Center (LALS)

Introduction. LALS DRC was established in 25th April 2004. Although established recently, LALS, the parent organization, has been working in the field of drug prevention since 1991, especially in the area of harm and HIV reduction. LALS DRC started working in demand reduction realizing its importance in Nepal.

LALS DRC, located in the north-western part of Kathmandu, covers an area of 2.5 ropanis. Its first year saw 80 intakes, and has the capacity to accommodate 25 clients. Last year, LALS DRC saw 10 to 15% of negative discharge from the center. The reasons were mostly adjustment problems with the center's program, lack of self will (clients were enrolled solely on family pressure), and over confidence of clients leading to quitting the center before program duration ended.

LALS DRC has 6 full time staff and 2 volunteers. Both volunteers are ex-users and are given transportation allowances. Out of the 6 full time staff, one looks after administration, 3 are counselors, one outreach person, one night warden, and one

program coordinator. Five of the 6 full time staff are former drug users and feel their past struggles as a major source of inspiration for their service delivery. The counselors have received counseling training from Sahara Counseling Center. LALS DRC provides provident fund in addition to regular salaries for its staff. The staff regard self satisfaction as the most important benefit they receive from their work.

Admission. The intake process is based on consent of both the client and the parents. The center welcomes relapsed clients of other DRCs. Residential fee is set at rupees 6,000/month. One in 10, or 3 in 20 clients are given free treatment, dependent on the center's already tight budget.

Program. Rehabilitation at LALS is based on a 3 month intensive residential treatment program. The center uses light medications for detoxification. A certified doctor looks after the prescription of medicines. Medications are used for a maximum of 10 days. This initial period of 10 days, the 'sick period', is handled with care. Clients have an attendee, to take care of his needs. The clients are ready to join the center's daily programs after 10 days.

The center follows the TC concept and NA 12 steps as its rehabilitation mode. The center practices the TC concept based on what they have learned from other DRCs in Kathmandu. The center does not have networks with any TC federations, primarily due to its financial constraints.

Clients at LALS are engaged with various rehabilitation activities including meditation, yoga, morning meeting, personal hygiene time, sharing, etc. Input classes are also conducted by the center staff, and occasionally by outside resource persons. These classes focus on various issues related with recovery and drug use. The center provides group and individual counseling. Counseling services are provided once to twice a week, in addition to need.

The center gives outing privileges to the clients after one or one and half months of their stay. In a 3 month period, outings are generally administered 6 to 7 times. The center doesn't differentiate on outing frequencies or duration based on marital status.

The doctor visits the center once a month. HIV and Hepatitis cases are treated confidentially. There is no forced disclosure at the center. The Youth Vision VCT is referred for HIV testing.

Discharge. Discharge at LALS DRC is dependent on the evaluation made by the DRC staff on the client's progress during his stay at the center. Evaluation also includes looking at the behavior, attitude of the clients, and his coping abilities once he leaves the center. The monitoring of counselors on the progress through out the stay of the clients at the center is also another component for deciding on discharges. Normally, decisions on discharges are made after three months.

The center advises its clients to set aside one year solely for recovery. However, the center also acknowledges that there are special circumstances for some DUs with economic problems as they start working soon after being discharged.

The center encourages fellowships and meetings with fellow recovering users, and also encourages daycare clients to attend NA meetings. The center finds the NA 12 steps very helpful in its rehabilitation program. The center doesn't have any reservations with any of the present home groups of NA; their clients can join any home group meetings.

Follow-up. Day care is strictly followed at the DRC. The clients have to come for 3 months of mandatory day care. After day care, the clients have to come once or twice a week for 6 months. After 9 months, day care changes to occasional follow-up, through telephone or visits. The center also keeps in touch with the parents. The day care program is mostly for supporting, and fellowshipping with each other, which the center feels is very important. The center is also planning on school awareness programs with the day care clients.

In house parents/guardians meet once a month on which the center provides wide range of information to make them understand more on addiction, and on ways to deal with the clients once they come home. For day care clients, parents are also consulted when follow-up is conducted with the clients at their homes. The center also telephones the parents/guardians periodically and visits homes of almost all clients. Even with its limitations on human resources, the center is doing its best with follow-ups. Usually the center conducts many follow-ups initially, then, the frequency decreases. In the last 15 - 16 months, the center was successful in celebrating one year sobriety birthdays for 10 of their clients.

Other Programs. LALS, being just a year old in its operations is focusing its efforts mostly on the operation of the DRC. LALS doesn't have any skills development programs at the moment; however, the center is planning on starting such programs. The center although realizing the need for such programs, is limited on such ventures due to its stringent budget. So far, the center has given jobs to 4 clients, who are now working as outreach workers with the center.

Networking. LALS has good networking with other DRCs and agencies in the valley working with DUs. The center has good connections with LALS, the parent organization. With many years of working in the field of drug prevention efforts, LALS (the parent organization) is one of the older players in the field of drug abuse and prevention, and has good network and connection with experts and professionals working in the field of drug abuse prevention in Nepal.

General Impression. LALS has only been in operation for only 15 to 16 months. However, even in such a short period, LALS has shown considerable authority in the work it is doing. With the support from its parent organization and their years of experience, the treatment center is able to build a sound rehabilitation program for its

clients. The center accepts clients who have had stayed in different DRCs of Kathmandu. LALS look promising with the work it has been able to do in such a short period of time, with limited finance and human resources.

3.2.6. Nava Kiran

Introduction. Nava Kiran (NK) DRC started in 2000 by the current director of the center. The director, himself an ex-drug user, came to Nepal after attending the Nava Jyoti DRC in New Delhi, India, and realized the need for a DRC that looked on the needs of DUs in Nepal. Initially, a couple of like-minded people helped the efforts of the director in establishing the DRC, however, after some time their involvement ceased and the director is currently running the center with 3 full time staff and 5 volunteers.

NK is located in the northern city limits of Kathmandu. The center is situated in a 1.5 ropanis of land and has a bed capacity for 30 clients. Currently there are 30 clients in the center of which 12 clients are receiving free treatment. NK has a structured residential fee of Rs. 7,000. However, the center considers free or discounted fee for those who cannot afford to pay.

The center, apart from occasional and emergency situations, is not able to provide monthly salary to its staff. The staff however, are given free fooding and lodging at the center. The staff at NK consists of a director, a rehab in charge, kitchen in charge, and 5 volunteers.

NK sees its strength in the experience of its staff who are all ex-drug users. The director of the center also trains and shares his learnings from the Delhi DRC. Apart from the experiences gained through involvement in relative workshops and trainings organized within Nepal, the staff of NK mostly work with their prior experiences and training from the director.

Admission. Admission in NK is done with careful scrutiny of DUs background and his willingness in trying to quit drugs. The center also orients the DU on rules of the center and the need for the client to hold off his issues of career and to put all his priority on his recovery. Only after getting the consent is the client admitted to the center.

Program. NK uses medications for detoxification from a certified doctor. Medications are administered for 10 days, and dosage are gradually cut down from the 6th day onwards. After 10 days, the client is gradually integrated to the rehabilitation program of the center. The rehabilitation program at the center is based on the TC concept. The director of the center learned of the concept during his stay at the Delhi DRC. The center also focuses on behavioral and attitudinal change as a major a component of its rehabilitation program. The center has set programs for the enrolled clients starting from 6 in the morning which includes work therapy, various group sessions, sharing, input classes, meditation and counseling. There are 2 staff and 2 volunteers working as counselors in NK. The center has a group counseling session once a week, and individual counseling sessions twice a week.

The center doesn't believe in program rituals: following program for the sake of following. Rituals such as shaving one's head during entry or any other extreme measures are not followed by the center. The center believes in creating an environment in which clients feel accepted.

The center also believes in the importance of providing income generating skills to the clients, however, with shortage of funds, the center is not able to provide in-house sessions and trainings on income generation. The center however sends appropriate clients or staff for trainings if quotas for useful trainings come their way.

Discharge. Although the duration of rehabilitation is normally set for a minimum of three months at NK, discharge from the center mostly occurs after six months. NK specifically looks for attitudinal change in clients and bases their judgment on whether

the following attitudes of the clients are broken down: threatening, challenging, stubbornness, taking issues lightly, and dishonesty. The family/guardians are also made aware on what NK hopes to achieve from the clients as their qualification for discharge.

Follow-up. Follow up in NK is mostly conducted in forms of day care. Day care program, according to the center is followed very intensively. The center has 25 rules written out for clients attending day care program, which spells out the conditions and the needed efforts from the clients. The center also maintains communication with the parents/guardians after the termination of day care program. The clients also have to visit the center once a month after daycare in the initial period. Although the center doesn't have concrete programs for family meetings, encounters with parents/guardians during center visitations and during payment serve as an opportunity for the staff to consult with families on the client's recovery progress and efforts.

Health. NK has a doctor who visits the center. The center is well experienced on handling clients with HIV or other life threatening diseases. The center is in constant communication with its daughter organization, Nava Kiran Plus, which provides care and support for PLWHA. The center doesn't have mandatory rules for testing or for disclosure of HIV. For those who would want to go for HIV testing, the center provides counseling and referrals to the Youth Vision VCT or the government hospital at Teku.

Other Programs. The center is not involved with external activities and program, and reserves its efforts for running the DRC efficiently. The center has however, given birth to Nava Kiran Plus, an organization providing awareness, care and support for PLWHAs. Although Nava Kiran Plus has an individual steering committee for it's functioning, it maintains close working relationship with the Nava Kiran DRCs.

Networking. According to the director, NK likes to maintain a low profile when it comes to external interactions and programs as issues of running the DRC is more important agenda for them. The center is seriously facing funding problems, and the center until recently was not visible with the donor communities and other service

providers in relating its problems. The director shows general pessimism and admits that networking are for those who have enough time and close access with donors. The director has however started approaching donors for funds to sustain the DRC.

NK is in close contact with recovering users who were once clients of NK and have opened their own DRCs or providing services to DUs in areas such as Naryanghat, Jhapa, and Pokhara. The center maintains contacts with them and encourages them in their efforts.

General Impression. NK, unlike other DRCs, maintains a low profile with its work. The center is seriously facing financial problem and is sustaining the DRC with financial loans. The issue of sustainability is crucial for NK. The director of NK is knowledgeable on many issues related with management of a DRC. He is also accredited for introducing the concept of 'birthdays' of recovering users, along with the implementation of NA and various TC components in Nepal.

Commonalities amongst DRCs

The study in its interactions with the DRCs was able to observe following issues of commonalities amongst DRCs, in their work approach and experience.

- All DRCs had an 'open door' system, that an environment of coercion for making clients stay was not observed.
- All admissions in the DRCs were done with careful discussions and consent of the guardians and parents, and with the consent of the client.
- A majority of DRCs had many of its staff with previous drug use background, which the center felt gave them the benefit to understand the clients better. However, all centers regarded specialized trainings as very important for enhancing their service delivery.
- A majority of DRC staff in the Kathmandu didn't have specific trainings relative to their area of work.

- All DRCs had no system of forced disclosure or forced testing of HIV among their clients. All DRCs were well familiarized with the medical, psycho-social aspects regarding HIV and AIDS.
- A majority of DRCs felt that providing free treatment to those who could not afford would be their priority if they have had more budget.
- All DRCs had some provision for free or discounted treatment schemes for DUs who couldn't afford treatment.
- All DRCs had clients coming from areas outside of Kathmandu. Enrollment of such type of clients were constant throughout the year.
- All DRCs were found to be using the TC concept (with slight modifications and adaptations in accordance to the availability of resources at the center and cultural factors) for rehabilitation purposes. Four of the DRCs had staff with international exposure on the TC concept.
- All DRCs had some form of Eastern philosophy/teachings or spiritual exercises incorporated in their rehabilitation program. Meditation and yoga were used in all DRCs, and some DRCs also regularly invited specialized people to talk on spirituality and healing.
- A majority of DRCs feared on the way psychotropic drugs were being administered for detoxification purposes in the private clinics of Kathmandu. The DRCs had no idea on what guidelines the doctors followed and had come across cases where clients were receiving heavy dosages of medicines for long periods. All DRCs had little faith in detoxification services provided by private clinics in Kathmandu. They said such services only took care of physical withdrawal and not the psycho-social and spiritual dimensions of recovery. DRCs also defied the practice of dosage increase by the clinics, as soon as the clients showed withdrawal or craving syndromes following decrease in medications.
- All DRCs were of the view that detoxification with heavy use of psycho tropical drugs was not productive. Those DRCs using medication for detoxification purposes had also been administering medications in minimal amount-more as an incentive. All DRCs claimed that their clients are over their physical withdrawal syndrome within 7 to 10 days.

- All DRCs had incorporated a holistic approach to recovery, understanding the physiological, psychological, social and spiritual integrity of the clients. They accepted the fact that detoxification was just a part of their program, and it alone did not guarantee a life of recovery.
- Groupism, as admitted by a majority of the DRCs existed in the center, however, once noticed, the centers tried to dislodge it as it disturbed their participation in the program. Groupism in the center existed in forms of characteristics based on level of education (educated vs. non educated), and economic class. Groupism was also based on drug use background (street based vs. those with sound economic background), age groups and ethnic groups. Many DRCs also experienced a distinct group in their center that passed on negative vibes and influences to others.
- With the exception of two DRCs, outside funding was very minimum for all other DRCs. All DRCs were self sustained, or sustained by their parent organization. Donor funding were seen more on additional activities run by the DRCs such as outreach, and specific programs dealing with HIV/AIDS.
- A majority of DRCs had funding problems to sustain or enhance their service delivery and a majority of DRCs had no networking or mechanisms in place for searching external funds.
- All DRCs had volunteers in their staff taking major roles in the running of the DRCs. Such volunteers were given various incentives dependent on what the centers could afford.
- A majority of DRCs felt that income/skills trainings for their clients could be helpful only if the marketing aspect was good; they were of the view that the 'return' had to be good, or else, the program could not be sustained.
- All DRCs were found to be facing the brunt of dealing with IDUs with HIV. All centers showed ample experience on working with clients with HIV. A total of three DRCs had opened separate services that provided services to IDUs with HIV. All DRCs said that they had necessary pre and post test counseling mechanisms in place.
- The detoxification period, also known as the 'sick period', was handled with care in all DRCs. Clients had an attendee (either a staff or a volunteer), to take care of his/her needs.

- Outing privileges (1 to 2 nights stay with family) in all DRCs were given after one or one and half months. The centers didn't differentiate on married or single clients on deciding the frequency of outings.
- A majority of parents/guardians of clients in DRCs kept touch with the centers very regularly in the earlier periods after discharge, but after 7, 8 months, they would lose contact.
- On all DRCs, the winter period saw low enrollment of DUs.
- DUs from outside Kathmandu were enrolled in all DRCs. Most often such DUs came from sound economic background. The parents and guardians of such DUs found it more appropriate to enroll them in DRCs of Kathmandu to keep others from knowing that their sons/daughters have gone to a DRC.

Limitations of DRCs

The limitations of DRCs in any forms affect their service delivery. The study was able to observe the following limitations amongst the DRCs included in the study.

Financial Constraint

A major limitation that almost all DRCs felt was its budget constraint, which according to the centers resulted in lack of manpower and proper delivery of services. Budget constraints also raised the question of sustainability of DRCs and along with it the provision of good incentives and benefits for its staff. One of the DRCs wasn't able to pay its staff, and the other was totally uncertain how to sustain itself after funds ran out. Further, the DRCs felt they had a moral obligation to provide free treatment for those who couldn't afford and that limited budget was hampering them for such initiatives.

Shortage and Lack of Trained Human Resources

DRCs realized the need to increase its staff. With the rise of DUs seeking DRC's services, the centers were badly stretched with the staff they had. Many DRCs were unable to provide effective follow-up services due to limited staff, and some DRCs had staff doing double duties. The use of volunteers also reflected the constraints of DRCs.

Further, there was a great shortage of trained staff in all DRCs of Kathmandu (only a handful of DRC staff had internationally recognized trainings). The center also felt the need for specific training for its staff to build their capacity for more effective service delivery.

Shaky Relationship with Board or Executive Committee Members

Some DRCs also felt that the relationship with the board members or the executive committee of the DRCs were vital for smoother operation of the DRCs. DRCs felt that communication with such committees were not always clear, leading them to question each others motive and commitments. One DRC noted that the issue of commitment from the board and their indecisiveness also reflected on the motivation of the staff.

Lack of Sustainable Income Oriented Skills Development Program

The income oriented skills development programs were very limited in almost all DRCs. Although almost DRCs regarded such programs as very important for their clients, lack of funding, lack of networking, and lack of marketing hampered their efforts in sustaining such programs. Almost all DRCs have had skills programs such as candle making in their programs, however many had to discontinue it as they couldn't find proper market or funds to sustain it.

Lack of External Support

With the exception of few DRCs, a majority of DRCs were self sustained. Almost all DRCs have had no external support to enhance their treatment program. External support so far had come in forms of funds for specific HIV related activities. The DRCs insisted that the donor community should realize the need on tackling the root cause, in addition to looking at issues such as HIV. Further, the government agencies also had no support mechanisms in place for the DRCs.

Lack of National Regulation or Operational Guideline

There was no regulatory body to look after the operations of DRCs in Nepal. Further, there were no guidelines and a definition on what a DRC was and how they should operate. Such ambiguity meant that DRCs were not answerable or accountable to anybody. Many DRCs included in the study wanted the state agencies to at least evaluate all DRCs in Nepal to find out whether they all were providing quality services.

CHAPTER IV. ACTUAL LIVING CONDITIONS OF RDUs

The social environment of RDUs entails complex structures, belief patterns, situations, and events. It is important to analyze the social environment in a manner that would give us a comprehensive look on the various facets of its makeup. In this regard, the findings on the social environment of RDUs were divided into logical sections or intervals, in accordance with the definition of social environment used by the study.

The three clauses attached with the definition of social environment taken for this study were:

Clause 1) Actual living conditions
Clause 2) Norms, values, and attitudes
Clause 3) Reflect a particular social and cultural context (i.e. alienation)

The findings on clause 1 will detail the findings on the actual living conditions of RDUs. The study, with the theoretical underpinnings of Phenomenology will seek to gain understanding on how the RDUs perceived people, situations and relationships that were part of his/her everyday life. In specific, the study looks at the socio-cultural-demographic background of RDUs and their immediate surroundings, along with their drug carrier as perceived and typified by the RDUs themselves.

The Socio, Cultural and Demographic Background of RDUs

This section entails following findings on the socio-cultural and demographic background of RDUs in sample and their immediate surroundings.

4.1.1. Self

Caste/Ethnic Groups. Around 37 percent of RDUs in sample came from various mongoloid groups (Annex G.1). Close to 30 percent of the respondents identified themselves as *Newars*. Around 21.6 percent of the respondents identified themselves as *Chettris*, and around 13 percent identified themselves as *Brahmins*.

Sex. All 153 subjects in the sample were male RDUs. Although the study had initially planned on including both male and female RDUs, the study unfortunately resorted to include only male RDUs as only negligible number of female RDUs could be located (only 5 female RDUs could be located in a period of 6 months). Note: the study however, does include a section on female DUs, especially on the rehabilitation issues of female DUs (see Chapter 8).

Age. Close to 45 percent of RDUs included in the study were 20 to 25 years old, followed by 31.4 percent who were aged between 26 to 30 years (Annex G.1). The youngest age of RDU in sample was 18 years old and the oldest was 42 years old.

4.1.2. Demographic characteristics

Residence. Around 80 percent of the respondents resided in Kathmandu valley, followed by 6 percent who lived in Pokhara, and 2 percent who lived in Dharan (Annex G.2). Nearly 93 percent of the respondents mentioned that their homes were located in a metropolitan area, and about 8 percent in the 'villages.'

Brought Up (reared). An overwhelming majority (94.1 percent) of RDUs in sample were brought up (reared) in a metropolitan city (Annex G.2). Around 5 percent were brought up in the villages.

Living with. An overwhelming majority of RDUs (95.4 percent) in sample were living with their families (Annex G.2). Only a small proportion of RDUs (4.6 percent) were living separately.

Migration. Nearly half of all RDUs in sample mentioned that their families hadn't migrated from their original residence (Annex G.3). For those whose family had migrated, around 20 percent stated that their family migrated 11 to 20 years ago, followed by 11.1 percent who reported that their family migrated 21 to 30 years ago. Close to 35 percent of the respondents mentioned that they were not born when their families migrated. Similarly, close to 35 percent of the respondents stated their age to be around 1 to 10 years when their families migrated.

Originally from. Nearly half of the respondents (47.1 percent) indicated their original home (*muul ghar*) as Kathmandu (Annex G.4). The other half stated their location of 'mul ghar' as ranging from different areas within and outside Nepal.

4.1.3. Educational Characteristics

Attainment. Close to 40 percent of RDUs in sample had passed grades in between 7 to 10 (Annex G.5). Around 23 percent of respondents had finished School Leaving Certificates (SLC), followed by 14.1 percent who had 12th grade degree, and 7.4 percent who had Intermediate degree. Further, 5 respondents (3.3 percent) were literate, and only 1 respondent was illiterate.

Enrolment. Around 47 percent of RDUs in sample continued their education from their last educational attainment (Annex G.5). Of those who continued, 40 percent were last enrolled in 6th to 10th grade, and the same percentage were also enrolled in Intermediate (including 11 and 12 grades) and Bachelor level studies. Close to 5 percent of the respondents were enrolled in Masters degree studies.

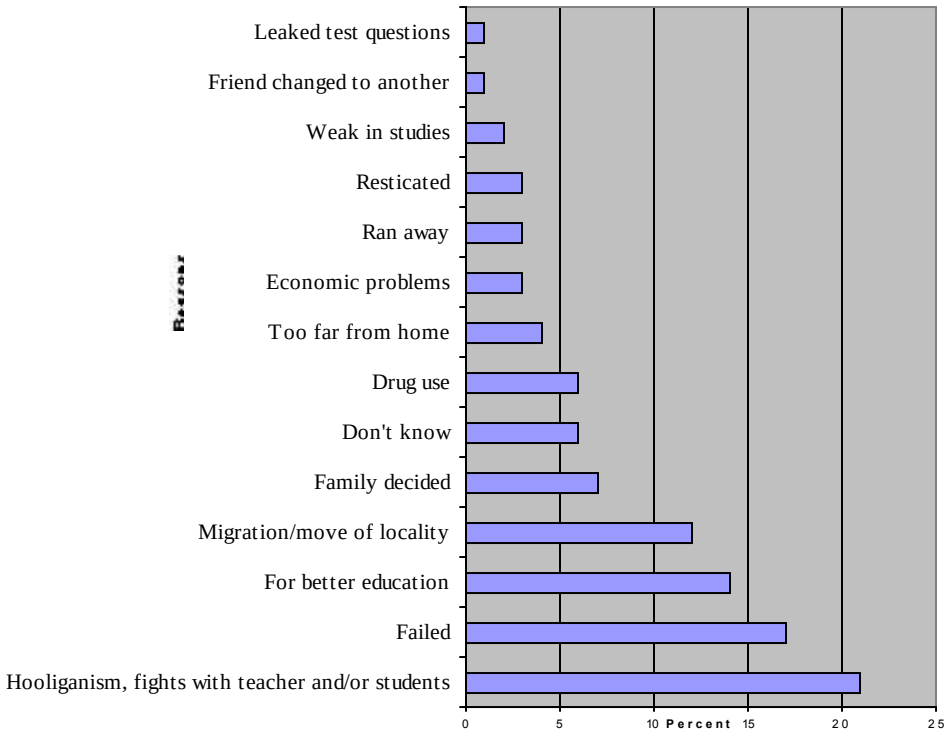
Plans to Go Abroad for Further Studies. Nearly 18 percent of the respondents had plans to go abroad for further studies (Annex G.5). They were mainly those who had finished their Intermediate (including grades 11 and 12) degrees or above.

High School Record. More than 90 percent of RDUs in sample had studied in high schools located in the metropolitan cities (Annex G.6). Nearly 55 percent of the respondents studied in private institutions and 40.9 percent in government high schools. Five respondents in the study went to high schools located outside Nepal. Nearly 35 percent of the respondents had passed their last high school grade or SLC with second division results. Around 26 percent passed with first division results, and 21.9 percent reported they had failed in their last high school exam.

Hostel Enrolment. Nearly 30 percent of RDUs in sample had lived in a hostel for more than 5 years, and 12.4 percent reported living partly in a hostel, for less than 5 years (Annex G.6).

Change of Schools. An overwhelming majority (73 percent) of respondents had changed schools (Annex G.7). When asked why, 21 percent gave the reason that they were involved in hooliganism, fights with teacher and/or students; 17 percent said they had failed, followed by 14 percent who mentioned that they had changed schools for better education (Figure 4.1). Twelve percent of the respondents said they changed schools as their family migrated or changed locality.

Figure 4.1. RDUs' Reasons for change of School(s)



Serious Disciplinary Actions. Nearly half of RDUs in sample had received serious disciplinary actions during their high school years (Annex G.8). Nearly 45 percent mentioned 'bullying/hooliganism/destroying school properties/fighting with students/teasing girls/ lighting fire crackers/fighting with class mates' as reasons for disciplinary action. Close to 20 percent reported 'drug use' (including alcohol) as reason for disciplinary action, followed by 16.7 percent who said 'beating up teacher,' and 12.1 percent who said 'bunking school/class' as reasons for disciplinary actions.

4.1.4. Marital Status

A majority of RDUs (60.1 percent) in the sample were not married (Annex G.9). There were 30 percent currently married RDUs in the sample. Around 8 percent of the respondents were either divorced or were not living together with their wives. Close to 3 percent of the respondents were not married but were living with their partners.

Type of Marriage. Around half of the married respondents termed their marriage as 'love marriage' and 40.7 percent termed their marriage as 'arranged' (Annex G.9).

Age when Married. Around half of the respondents got married around the age of 21 to 25 (Annex G.9). Nearly 25 percent stated their age to be around 26 to 30 years; and, close to 20 percent between 16 to 20 years, when they got married.

Length of Married Life. Nearly 45 percent of the married respondents reported their marriage to be 6 to 10 years old, followed by 25.9 percent with 2 to 5 years, and 13 percent with 16 or more years of married life (Annex G.9). Less than 10 percent mentioned their married life was less or equal to one year.

Divorce/Separation. Around 36 percent of divorced or separated respondents mentioned that they had been separated for 2 years (Annex G.9). Close to 20 percent had been separated for 7 years. An overwhelming majority mentioned drug use and its related harms as the reason for separation.

Use of Drugs prior Marriage. An overwhelming majority of married RDUs (92.6 percent) were using drugs prior to their marriage (Annex G.10). When asked on type(s) of drugs used before marriage, 'marijuana' scored highest with 72 percent, followed by 'alcohol' (64 percent), 'various stimulant pills' (50 percent), and 'brown sugar' (50 percent). Further details on drugs used are listed on Annex G.10.

4.1.5. Employment

Employment Status. Nearly 52 percent of RDUs in sample stated that they were once employed (Annex G.11). Of those, 38 percent were employed for 2 to 5 years. Close to 25 percent were employed for 1 year or less, followed by 20.3 percent who were employed for 6 to 10 years.

Type of Work. More than half of the respondents categorized their jobs as private, followed by 19 percent who said their jobs were family/relative owned businesses (Annex G.11). Close to 8 percent of the respondents said they had worked in government institutions.

Pay per Month. Close to 30 percent of the respondents stated their pay per month to be around 4,001 to 6,000 rupees (Annex G.11). This was followed by 21.5 percent of respondents who earned between 2,001 to 4,000 rupees. Further information detailed in Annex G.11.

Work Title or Nature. The nature of jobs held by the respondents varied from driver to legal advisor to press operator. Details on type of work once held by the respondents are detailed in Annex G.12.

Use of Drugs during Employment. Of those employed, an overwhelming majority (92.4 percent) of RDUs said they had used drugs during employment (Annex G.13). More than half of RDUs using drugs during employment reported using brown sugar. Similarly, around 53 percent used marijuana; and, 45.6 percent used alcohol and/or various stimulant pills.

4.1.6. Arrest Record

Arrest Record prior to Drug Use. Nearly half of RDUs in sample (44.4 percent) had arrest records prior to drug use (not including nicotine) (Table 4.1). A majority of such RDUs (61.8 percent) were arrested up to 2 to 4 times, and nearly two thirds of those arrested reported 'fights' as reasons for arrest (Annex G.14).

Arrest Record after Drug Use. More than two thirds of RDUs in sample had been arrested during their drug use career (Table 4.1). Nearly half were arrested for 2 to 4 times, followed by 26.9 percent arrested for 5 to 10 times (Annex G.15). Nearly 10 percent were arrested for more than 10 times. An overwhelming majority (52.9 percent) reported being arrested while in use and/or possession of drugs. This was followed by 22.7 percent arrested for 'fights.'

4.1.7. Health Background

HIV Status. Nearly 45 percent of respondents in sample stated that they didn't know of their HIV status (Annex G.16; Figure 4.2). This was followed by 35.3 percent who reported their HIV status as Negative. Close to 10 percent of sample reported that they were HIV positive. Of those who had tested positive, close to 30 percent reported that they found out the result one year ago. This was followed by 21.4 percent of the respondents who said they tested positive 2 years ago. Nearly half of those respondents who tested positive had disclosed their status to their families, followed by 21.4 percent who were thinking of disclosing it in the future.

Hepatitis Status. Around half of RDUs in sample reported that they were not aware of their Hepatitis status (Annex G.17; Figure 4.2). Of those who had checked, 22.2 percent reported negative and 10.5 percent reported positive to any forms of Hepatitis. Of those who tested positive, 31.3 percent found out the result a year ago, followed by 18.8 percent who found out 2 years ago.

Table 4.1. Question: Did the police, prior to or during drug career, ever arrest you?

Response	Prior to Drug Use		During Drug Career	
	Count	Percent	Count	Percent
Yes	68	44.4	119	77.8
No	84	54.9	33	21.6
No response	1	0.7	1	0.7
Total	153	100.0	153	100.0

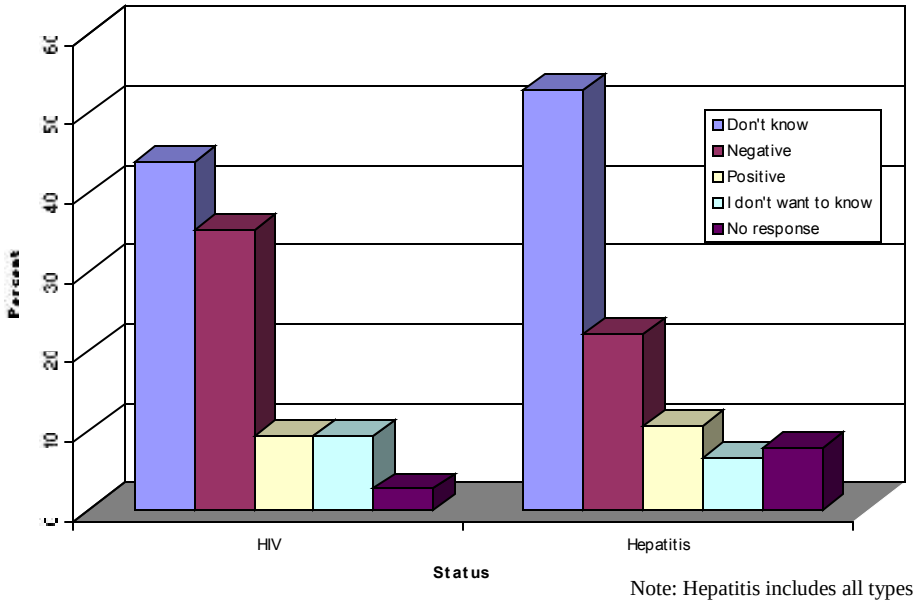
4.1.8. Father's Background

Father's Age. Nearly half of the respondents in the sample reported their father's age to be around 51 to 60 (Annex G.18). This was followed by 25.6 percent of respondents who reported their father's age to be around 40 to 50.

Father's Death. Around 23 percent of the respondents stated that their father had expired (Annex G.18). Of those, 34.3 percent stated that their fathers expired 11 to 20 years ago, and 25.7 percent said their fathers expired 6 to 10 years ago. Only 5.7 percent of the respondents said that their fathers had expired 1 to 2 years ago.

Father's Educational attainment. Close to 30 percent of RDUs in sample reported their fathers' educational attainment as only 'literate' (Annex G.18). Also, close to 30 percent didn't know or didn't respond to their fathers' educational attainment. Nearly 22 percent of the respondents said that their father had passed college or had higher degrees.

Figure 4.2. HIV and Hepatitis Status of RDUs



Note: Hepatitis includes all types

Father's Employment History. Around 31 percent of the respondents stated that their fathers were working on private jobs (Annex G.18). This was closely followed by 26.1 percent whose fathers were reportedly working in government offices.

Fathers' Average Earnings Per Month. When asked about father's average earnings per month, close to 25 percent said they 'didn't know' how much their fathers earned (Annex G.18). This was followed by 19.7 percent of the respondents who reported that their fathers earned in between 10 to 20 thousand rupees per month. Around 12 percent of respondents stated that their fathers earned between 1 to 5 thousand rupees per month.

Fathers' Work Title/Nature. The jobs of respondents' fathers varied in nature, ranging from socially dignified positions such as director general, Inspector General of Police (IGP), mayor, astrologer, mechanic and even thief (Annex G.19). Around 15 percent of the respondents stated that their fathers once served or were currently serving in the British army. This was followed closely by 13.4 percent who stated that their fathers were businessmen. Around 10 percent of sample reported that their fathers worked as drivers. Further details on work title/nature on respondents' fathers are listed on Annex G.19.

Father's Use/Abuse of Substances. Nearly two thirds of RDUs in sample reported that their fathers used/abused substances (including alcohol) (Annex G.20). Of those, 98.1 percent of the respondents reported that their fathers used alcohol. Around 32.7 percent also reported that their fathers used substances 'regularly' and 29.9 percent reported that their fathers used substances 'sometimes with friends.'

Father's Traditional Attitude. Close to 40 percent of RDUs in sample rated their fathers as 'average' on their attitude as being traditional (Annex G.21). Around 22.5 percent rated their fathers as 'very much' traditional. Around 10 percent rated their fathers as 'not traditional at all.'

Father's Tolerance of Drugs & Deviance. When asked on how tolerant their fathers were regarding drugs and deviance, 43 percent of the respondents said that their fathers 'couldn't tolerate if it was too much' (Annex G.21). This was followed by 31.7 percent who reported that their fathers 'couldn't tolerate at all.' Close to 25 percent said that their fathers were 'tolerant.'

Typical Nature when Father Breaks Down. Around 40 percent of the respondents stated that their fathers 'didn't talk for days' when they broke-down (Annex G.21; Figure 4.3). This was followed by 33.1 percent who said that their fathers 'got physical,' and 21.1 percent who said that their fathers 'cried softly or alone' they broke down. Note: the researcher used the following linguistic expressions to describe 'breaking down'- *'aati bhayo bhanae' 'obber bhaepachi'*

4.1.9. Mother's Background

Mother's Age. Around 41 percent of the respondents in sample stated their mother's age as between 41 to 50 years old (Annex G.22). This was followed by 31.5 percent of respondents who reported that their mothers were aged around 51 to 60 years old.

Death of Mother. Nearly 10 percent of the respondents reported that their mothers had expired (Annex G.22). Of those, 33.3 percent stated that their mothers died 11 to 20 years ago, followed by 26.7 percent who mentioned that their mothers expired 11 to 20 years ago.

Mother's Educational attainment. Close to 40 percent of the respondents in sample reported that their mothers were 'illiterate' (Annex G.22). Nearly a quarter of the respondents reported that their mothers were 'literate.' Only less than 10 percent of the respondents reported that their mothers had SLC or College degrees.

Mother's Employment History. A majority of RDUs in sample (74.1 percent) reported that their mothers were 'house-wives' (Annex G.22). Less than 10 percent of the respondents' mothers had 'private' jobs, and less than 5 percent had government jobs.

Mother's Average Earnings Per Month. Of those respondents whose mothers were earning, nearly half said that they didn't know how much their mothers earned per month (Annex G.22). Close to 20 percent of the respondents said their mothers in average earned between 5 to 10 thousand rupees and between 1 to 5 thousand rupees per month.

Mothers' Work Title/Nature. Around 6 percent of mothers of RDUs in sample were reportedly shopkeepers (cold store, *kirana*-general, tourist related) (Annex G.23). Further details on mothers' work title/nature are detailed in Annex G.23.

Mother's Use/Abuse of Substances. More than two-thirds of RDUs in sample reported that their mothers didn't use substances (including alcohol) (Annex G.24). Nearly a quarter of the respondents however stated that their mothers used alcohol. A majority (45.7 percent) of mothers as reported by the respondents used alcohol only during festivals, followed by 25.7 percent who said that their mothers used alcohol in an 'irregular' basis.

Mother's Traditional Attitude. More than 35 percent of RDUs in sample rated their mothers as 'very much' traditional (Annex G.25). Around 32 percent rated their mothers as 'average' where as only 5.5 percent rated their mothers as not traditional at all.

Mother's Tolerance of Drugs & Deviance. When asked on how tolerant were respondents' mothers regarding drug use and deviance, close to 40 percent said their mothers were 'tolerant' (Annex G.25). Around 26 percent reported that their mothers 'couldn't tolerate at all.'

Typical Nature when Mother Breaks Down. A majority of the respondents (62.3 percent) said that their mothers 'cry softly or alone' when they break down (Annex G.25; Figure 4.3). Close to 20 percent said their mothers 'wouldn't talk for days' and/or would 'cry heavily.' Around 15 of respondents also said that their mothers would 'tell the incident to the relatives' when they break down.

4.1.10. Spouse or Living Partner

Spouse's Age. Half of the married RDUs in sample (or those living with their partners for some time) mentioned their spouse's age as between 20 to 25 years (Annex G.26). Close to 25 percent said that their spouses were aged between 26 and 30. Also, none of respondents reported death of their spouses.

Spouse's Educational Attainment. Around 35 percent of married RDUs in sample reported that their spouses had not passed their SLCs (Annex G.26). Close to 30 percent reported that their spouse had college degrees, closely followed by 24.1 percent who reported that their spouses were literate.

Spouse's Employment History. A majority of RDUs in sample (42.6 percent) didn't mention their spouses' employment or mentioned them as either unemployed or supporting family business (Annex G.26). Close to 30 percent reported that their spouse's were 'house-wives.' Of those who stated employment of their spouses, 22 percent said that their spouses had 'private' jobs. More than 50 percent of the respondents also mentioned that it was uncertain (or didn't respond) on how much their spouses

earned per month. Around 16 percent said that their spouses earned 1 to 5 thousand rupees per month, followed by 13 percent who said that they didn't know how much their spouses earned.

Spouse's Use/Abuse of Substances. Around 20 percent of the married respondents reported that their spouses used substances (including alcohol) (Annex G.27). Of those, around half said that their spouses used substances only during festivals. Nearly 30 percent reported their spouses were 'dependent' on substances; more than half of the respondents mentioned 'alcohol' as the dependant of substance. Close to 20 percent mentioned that their spouses used marijuana, TD or brown sugar and various stimulant pills.

Spouse's Traditional Attitude. Nearly 60 percent of RDUs in sample rated their spouses as 'average' in their attitude as being traditional (Annex G.28). Around 16.7 percent rated their spouses as being 'very much' traditional. Close to 10 percent of the respondents rated their spouses as 'not traditional at all.'

Spouse's Tolerance of Drugs & Deviance. When asked on the tolerance level of RDUs' spouses on drugs and deviance, 35.2 percent said their spouses 'can't tolerate if its too much' (Annex G.28). Closely, 31.5 percent said their spouses were 'tolerant.'

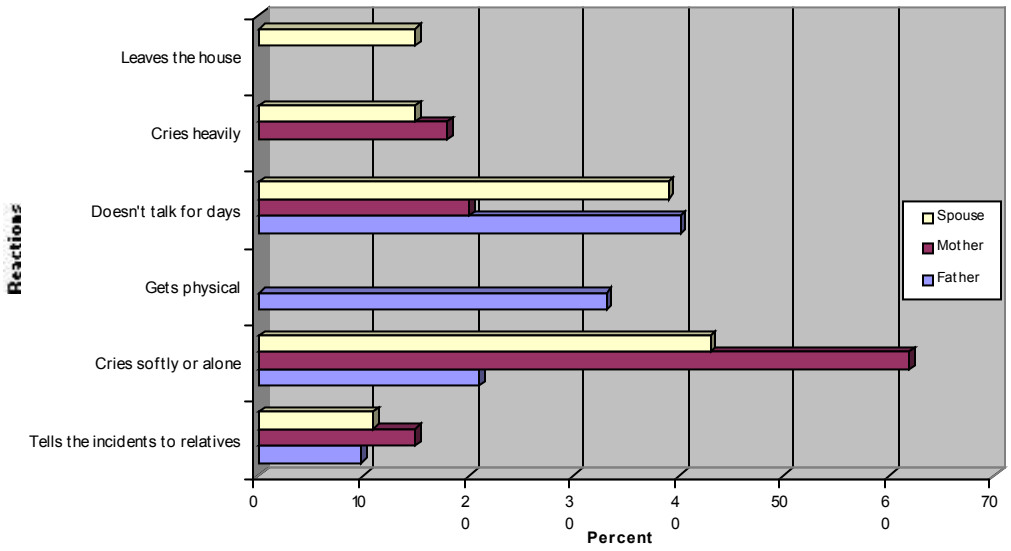
Typical Nature when Spouse Breaks Down. When asked on the typical nature of spouses when they 'break down,' around 42 percent of the married respondents said that their spouses 'cry softly or cry alone,' followed by 38.9 percent who said that their spouses 'wouldn't talk for days' (Annex G.28; Figure 4.3). Around 15 percent of respondents also stated that they would 'leave the house' and 'cry heavily' when they break down.

4.1.11. Family Characteristics

Family Composition. RDUs in sample were closely divided between 'joint' and 'nuclear' families (Annex G.29). Around 45 percent mentioned their families as 'joint' and 54.2 percent mentioned their families as nuclear. Around 53 percent of the respondents mentioned that their family consisted of 3 to 5 members. This was followed by 34.6 percent who mentioned their family as consisting of 6 to 10 members.

Family Situation when Growing Up. A majority of RDUs in sample (71.2 percent) regarded their families as 'normal' and around 15 percent of RDUs reported that they brought up by a single parent, followed by 7.8 percent who were brought up by their nearest relatives (Table 4.2). Around 5 percent of RDUs reported that their parents were separated or divorced.

Figure 4.3. Reactions of Parents and Spouse when they Broke Down



Economic Characteristics. A majority of RDUs (73.2 percent) in sample regarded their family as middle class (Annex G.30). Around 15.7 percent of RDUs regarded their family as higher-middle class. Around 5 percent and 3.9 percent regarded

their family as lower-middle class and lower class, respectively. Note: 29 respondents (i.e. 19 percent of the total respondents) were receiving free treatment at the DRCs (a provision set only for clients with deprived economic background).

Table 4.2. Family Situation when Growing Up

Response	Count	Percent
Normal	109	71.2
Single parent	24	15.7
Relatives looked after me	12	7.8
Divorced/separated parents	8	5.2
Abusing parents	7	4.6
Total	153	100.0

Type of Housing. An overwhelming proportion of respondents (85.6 percent) stated that their families were living in their own house (Annex G.30). Close to 15 percent said they were living in rented houses.

Source of Income. Close to half of RDUs in sample (45.1 percent) reported that 'jobs' were the source of income in their families (Annex G.30). This was followed by 39.9 percent who said 'house rent,' and 'family business' and 23.5 percent who said 'pension' as the source of income in their families.

Primary Earners. More than half of RDUs in sample (68 percent) reported that their fathers were the primary earners in the family, followed by 34 percent who said elder brothers, and 19.0 percent who mentioned mothers as the primary earners in the family (Annex G.30). Around 7 percent of the respondents stated that they themselves were the primary earners in the family.

Substance use/abuse history. In addition to the use/abuse of substances by the parents or spouse of the respondents, 27.5 percent of RDUs reported that other members of their families also used/abused substances (Annex G.31). Nearly 90 percent of such RDUs reported such members as their brothers (younger or older). The choices of substances were alcohol (50 percent), followed by brown sugar (35.7 percent), marijuana (28.6 percent), and TD (28.6 percent). When asked about the pattern of substance use of such family members, 40.5 percent said their pattern of use were 'irregular,' followed by 'regular' (31.0 percent), and 'dependent' (28.6 percent).

Smokers in Family. Nearly 60 percent of RDUs in sample reported that other members in the family smoked cigarettes beside themselves (Annex G.31).

Use of Alcohol in Family. Nearly 70 percent of RDUs in sample reported that alcohol was used or allowed in the family (Annex G.32). Of those, 52.4 percent of the respondents said alcohol was consumed on 'festive occasions', 44.7 percent said 'when guests visit', 26.2 percent said 'once in a while' and 23.3 percent said alcohol was 'regularly' used in the family.

Marriage of Siblings & Relation with In-laws. Nearly 65 percent of RDUs in sample reported that their siblings were married, whereas, 33.3 percent reported that their siblings were not married (Annex G.33). Of those whose siblings were married, a majority (58.3 percent) reported their relationship with the in-laws as 'okay.' Close to 30 percent of RDUs reported their relationship with the in-laws as 'very good,' and nearly 10 of the respondents reported their relationship as 'not good.'

Closest Family Member. Around half of RDUs in sample regarded their 'mother' as the closest family member, followed by their 'brothers' (17.1 percent), and 'sisters' (17.0 percent) (Annex G.34). Only 2 percent of RDUs said that no one in the family was closest to them.

Religiosity of family. Nearly 40 percent of RDUs in sample regarded their family as 'so-so' religious (Annex G.35). Around 20 percent of RDUs reported their families as 'very religious.'

4.1.12. Relatives

Close Family Relatives. Close to 30 percent of RDUs regarded their '*Mama/Maiju*' (mother's brother and his wife) as the close family relatives (Annex G.36). This was followed by nearly a quarter of respondents who said '*Fupu*' (father's sister) as the close family relative. Less than 5 percent of the respondents said that their families didn't have any close relatives.

Relation with Relatives. Around 45 percent of RDUs regarded their relationship with relatives as 'so-so' (Annex G.36). Around 22 percent of RDUs regarded their relationship as 'very close with only few'. Around 10.7 of RDUs in sample said that they were 'not close' with their relatives.

4.1.13. Neighborhood Composition

Economic Class. A majority of RDUs in sample (45.8 percent) regarded their neighborhood as composed of people from varying economic classes (Annex G.37). Nearly a quarter of RDUs regarded their neighborhood as composed of rich and middle class people.

Demography. Around 60 percent of RDUs in sample regarded their neighborhood as an old settlement *'purano basti'* (Annex G.37). Around 20 percent of RDUs regarded their neighborhood as a new settlement *'naya basti.'* Around 23 percent of RDUs reported that many houses in their neighborhood were on rent, and nearly 15 percent of the respondents said that many of the male members from the neighborhood had gone abroad.

Caste/Ethnic Composition. More that half of all RDUs in sample (62.7 percent) reported that their neighborhood was composed of people from different caste and/or ethnic groups (Annex G.37). Close to 20 percent of RDUs in sample reported their neighborhood as composed of people from similar caste/ethnic group. Nearly 20 percent of respondents didn't know about the caste/ethnic composition of their neighborhood.

Facilities. The list of facilities reported by the respondents as available in their neighborhoods were as follows: temple (66.0 percent), school (64.7 percent); sports/playing (58.8 percent); snooker house (51.0 percent) (Annex G.37). Close to 30 percent of the respondents said they didn't know about the facilities available in their neighborhood.

Deviant Activities. The highest reported deviant activities in RDUs' neighborhood were: 'many drug users' (47.7 percent); 'significant number of Bars/ Joint for gathering' (41.8 percent); 'junction/*adda* for gathering' (40.5 percent); 'lots of older brothers used to experiment with drugs' (39.9 percent); and, 'marijuana widely available' (37.3 percent). Further details on deviant activities are detailed in Table 4.3.

Table 4.3. Deviant Characteristics of Neighborhood

Response	Count	Percent
Many drug users	73	47.7
Significant numbers of Bars/Bhatti	64	41.8
Junction/adda for gathering	62	40.5
Lots of older brothers used to experiment with drugs	61	39.9
Marijuana widely available	57	37.3
Lots of young guys experimenting with drugs	54	35.3
Pharmacy selling drugs without prescriptions	44	28.8
Renowned as bad neighborhood	44	28.8
High number of police arrests	34	22.2
Don't know	4	2.6
No deviance in the neighborhood	11	7.2
Total	153	332.0

Note: total percent adds up to more than 100 due to multiple responses.

4.1.14. Neighborhood Awareness

Activities. Around 45 percent of RDUs in sample mentioned that religious festivals (*jatras*) were organized in their neighborhood (Annex G.38). Close to 40 percent also said that entertainment programs were organized in their neighborhood. Similarly, close to 40 percent of respondents didn't know on whether their neighborhood organized any social, cultural or religious activities.

Interaction. Around half of RDUs in sample mentioned that 'everybody knew everybody' in their neighborhood (Annex G.38). Around 7 percent of respondents said that 'nobody knew anybody' in their neighborhood.

Awareness on Neighborhood Happenings. Nearly 65 percent of RDUs in sample felt that they were not aware of what was happening in their neighborhood (Annex G.38).

Participation in Neighborhood Activities. Nearly 70 percent of RDUs in sample reported that they had never participated in any of the neighborhood activities. A majority of those having participated stated 'religious activities' and 'club programs' as activities they were engaged in (Annex G.38).

Dramatic Situations Witnessed by Neighborhood. Nearly two-thirds of RDUs in sample reported that they had been in dramatic situations (e.g., fights, blackouts), which were witnessed by people in the neighborhood (Table 4.4).

Neighborhood's Stance on Respondent's Drug Use. An overwhelming RDUs in sample (94.1 percent) said that their neighborhood knew they were using drugs (Annex G.39). Of those RDUs who thought their neighborhood knew of their drug use, 80.6 percent felt that the neighborhood viewed them in suspicion, 64.6 percent mentioned that the neighborhood labeled them as 'addicts' or 'junkies,' 54.2 percent felt that their neighborhood ignored or rejected them, and nearly half said that they were accused of introducing drugs to youngsters in the neighborhood.

Table 4.4. Question: Have you ever been in dramatic situations (e.g., fights, blackouts), which were seen by everyone in the neighborhood?

Response	Count	Percent
Yes	109	71.2
No	40	26.1
No response	4	2.6
Total	153	100.0

Drug Career Background

This section entails findings on important components of RDU's drug career as typified by the RDUs themselves. Findings include information on types of drugs RDUs were dependent upon (including length of dependency, the age at first use, and information on persons who initiated RDUs to their choice of drugs). This is followed by detailed information on drug intake frequencies of RDUs, their total dependency period on drugs,

drug cessation attempts, number of relapses, use and reasons of injecting drugs, initial age during use of 'gate-way' drugs, important characteristics of RDUs' drug career and that of RDUs' user group.

4.2.1. Background on Dependent Drug(s)

This findings section tried to derive information on types of drugs the RDUs in sample were dependent upon at any point of time during their drug use career.

Drug Types. Around 70 percent of RDUs in sample said they were dependent on brown sugar (pull mode); the same proportion of respondents also reported that they were dependent on TD during their drug career (Table 4.5). This was followed by around half of RDUs who said they were dependent on marijuana/hashish; and 33.3 percent who were dependent on brown sugar (injecting mode). Around 32 percent said they were dependent on alcohol, and 25.5 percent said they were dependent on various stimulant pills during their drug career.

Table 4.5. Types and forms of consumed mode of Dependent Drugs

Response	Count	Percent
Brown Sugar (pull mode)	108	70.6
TD	108	70.6
Marijuana/Hashish	77	50.3
Brown Sugar (injecting mode)	51	33.3
Alcohol	49	32.0
Stimulant pills	39	25.5
Total	153	282.4

Note: total percent adds up to more than 100 due to multiple responses.

Mono and Poly Drug Dependency. The study found out that only 20.9 percent of the respondents in sample were dependent on mono (single) drug during their drug use career (Annex G.40). A majority of mono drug dependents (37.5 percent) mentioned 'brown sugar (pull) and TD as their dependent drug. Close to 10 percent of the sample said they were dependent only on 'alcohol.' As for around 80 percent of poly drug dependents, 11.6 percent said that they were dependent on 'brown sugar (pull) and TD' and 10.7 percent said they were dependent on 'brown sugar (pull), TD and Marijuana' during their drug use career (details on poly drug dependency are available in Annex G.41).

4.2.2. Information on Dependent Drugs

Alcohol. Around 32 percent of RDUs in sample were dependent on alcohol during their drug use career. Following are the findings pertaining to RDUs' alcohol dependency:

Period of Dependency. Around 22 percent of RDUs were dependent on alcohol for 8 to 10 years (Annex G.42). Around 16 percent were dependent on alcohol for either 1 to 2 years or 5 to 7 years. About 13 percent said they were dependent on alcohol for 17 years or more.

First Introduced by. Around 30 percent of respondents dependent on alcohol said that it was first introduced to them by their own family (Annex G.42). Close to 15 percent said alcohol was first introduced to them by their '*tole'* (neighborhood) friends. Around 10 percent of alcohol dependents also specified that it was their father who first introduced them to Alcohol.

Age when First Used. Slightly more than 40 percent of alcohol dependents were aged between 16 to 20 years when they first tried alcohol (Annex G.42). This was closely followed by 38.8 percent who were aged between 10 to 15 years old when they first tried alcohol.

Brown Sugar (pull mode). Around 71 percent of RDUs in sample were dependent on brown sugar (pull mode) during their drug use career. Following are the findings pertaining to RDUs' brown sugar (pull mode) dependency:

Period of Dependency. Close to 40 percent of RDUs were dependent on brown sugar (pull mode) for 3 to 4 years (Annex G.43). This was followed by 26.9 percent who were dependent for 5 to 7 years. Close to 20 percent were dependent on brown sugar (pull mode) for 1 to 2 years.

First Introduced by. Close to 40 percent of RDUs dependent on brown sugar (pull) said that it was first introduced to them by their neighborhood (*tole*) friends (Annex G.43). Around 13 percent of RDUs preferred to say 'friends' as the ones introducing them to brown sugar (pull). Closely, 13 percent said it introduced to them by their school friends.

Age when First Used. Nearly 65 percent of RDUs dependent on brown sugar (pull mode) said that they were aged between 16 and 19 when they first the substance (Annex G.43). This was followed by 18.5 percent who were aged between 20 to 24 years old when they first tried it; 13 percent who first tried brown sugar (pull) said they were between the ages of 12 to 15.

Brown Sugar (injecting mode). Around 33 percent of RDUs in sample were dependent on brown sugar (injecting mode) during their drug use career. Following are the findings pertaining to RDUs' brown sugar (injecting mode) dependency:

Period of Dependency. Close to 25 percent of RDUs were dependent on brown sugar (injecting) for 1 to 2 years (Annex G.44). This was followed by 15.7 percent who were dependent for either 1 to 5 months or between 5 to 7 years. Close to 15 percent were dependent on brown sugar (injecting) for 3 to 4 years or between 8 to 10 years.

First Introduced by. Close to 45 percent of RDUs dependent on brown sugar (injecting) said that it was first introduced to them by their neighborhood (*tole*) friends (Annex G.44). Nearly 20 percent of RDUs preferred to say 'friends' as the ones introducing them to brown sugar (injecting). Around 8 percent said that it was introduced to them by their 'outside' friends (outside meaning not of the neighborhood).

Age when First Used. Around 45 percent of RDUs dependent on brown sugar (injecting) said that they were aged between 20 and 24 when they first injected the substance (Annex G.44). This was followed by 43.1 percent who said they first tried it when they were aged between 15 to 19 years.

Buprenorphine (TD). Around 71 percent of RDUs in sample were dependent on TD during their drug use career. Following are the findings pertaining to RDUs' TD dependency:

Period of Dependency. Close to 25 percent of RDUs were dependent on TD for 1 to 2 years (Annex G.45). This was followed by 19.4 percent who were dependent for 3 to 4 years. Closely following were 18.5 percent of RDUs who were dependent on TD for 5 to 7 years, or for 8 to 10 years.

First Introduced by. Close to 45 percent of RDUs dependent on TD said that it was first introduced to them by their neighborhood (*tole*) friends (Annex G.45). Nearly 20 percent of RDUs preferred to say 'friends' as the ones introducing them to TD. Around 6 percent said that it was first introduced to them by their 'user friends.'

Age when First Used. Around 42 percent of RDUs dependent on TD said they were aged between 14 and 19 when they first tried TD (Annex G.45). This was followed by 33.3 percent who first tried it when they were aged between 20 to 24 years. Nearly 15 percent of respondents dependent on TD said they first used it when they were aged between 25 to 29 years.

Marijuana/Hashish. Around 50 percent of RDUs in sample were dependent on marijuana/hashish during their drug use career. Following are the findings pertaining to RDUs' marijuana/hashish dependency:

Period of Dependency. Around 26 percent of RDUs were dependent on marijuana/hashish for 8 to 10 years (Annex G.46). This was followed by 20.8 percent who were dependent for 5 to 7 years. Nearly 15 percent of the respondents were dependent on marijuana/hashish for 14 to 16 years.

First Introduced by. Close to 45 percent of RDUs dependent on marijuana/hashish said it was first introduced to them by their neighborhood (*tole*) friends (Annex G.46). Around 26 percent of RDUs said 'school friends' as the ones first introducing them to marijuana/hashish.

Age when First Used. Nearly 55 percent of RDUs dependent on marijuana/hashish said they were aged between 15 and 18 when they first tried it (Annex G.46). This was followed by nearly 30 percent who first tried it when they were aged between 11 to 14 years. Nearly 15 percent of the respondents dependent on marijuana/hashish said they first used it when they were aged between 19 to 22 years.

Stimulant Pills. Around 26 percent of RDUs in sample were dependent on various stimulant pills during their drug use career. Following are the findings pertaining to RDUs' stimulant pills dependency:

Period of Dependency. Close to 30 percent of RDUs were dependent on stimulant pills for 1 to 2 years or for 3 to 4 years (Annex G.47). This was followed by 17.9 percent who were dependent for 5 to 7 years. Closely following were 15.4 percent of RDUs who were dependent on stimulant pills for 8 to 10 years.

Types of Stimulant pills. Nearly 60 percent of RDUs who were dependent on stimulant pills used 'Nitrosun' (Annex G.47). This was followed by 'Proxyvon' (33.3 percent), 'Nitrovet' (28.2 percent), and Codeine (17.9 percent).

First Introduced by. Around 41 percent of RDUs dependent on stimulant pills said it was first introduced to them by their neighborhood (*tole*) friends (Annex G.47). Nearly 25 percent of RDUs preferred to say 'friends' as the ones introducing them to stimulant pills. Around 10 percent said that it was first introduced to them by their school friends.

Age when First Used. Nearly two thirds of RDUs dependent on stimulant pills were aged between 14 and 19 when they first used it (Annex G.47). This was followed by 21.1 percent who first used it when they were aged between 20 to 24 years old.

4.2.3. Intake Frequency and Dependency Duration

An overwhelming majority of RDUs in sample reported using drugs daily (Annex G.48). Of those, more than half of RDUs (57.5 percent) used drugs for less than five times a day and 39.9 percent of RDUs for more than five times a day. Nearly 35 percent of RDUs in sample were dependent on drugs for 5 to 7 years. Close to a quarter of RDUs were dependent for 8 to 10 years. Nearly 15 percent of RDUs were dependent on drugs for 3 to 4 years.

4.2.4. Needle Use, Reasons and Duration

Close to 90 percent of RDUs in sample said they had used needles to inject drugs in their career (Annex G.49). When asked about the reasons for use of needles, more than half of RDUs (with needle use background) reasoned 'less money-more high'. Close to 20 percent said 'non-injecting drugs weren't available'- these were mostly brown sugar

(pull) users who on scarcity used TD. Around 18 percent of RDUs in sample with needle use background had been using needles for the past 5 to 7 years. Closely, 17.4 percent said that they had been using needles for the past 1 to 2 years or for 8 to 10 years.

4.2.4. Initial Age and 'Gate way' Drugs

This section of the query investigated on the initial age of RDUs in sample when they first used substances that are widely considered as 'gate way' drugs (Figure 4.4; Annex G.50). Following were the findings:

Tobacco (any forms). More than half of the respondents who had used tobacco said that they were 10 to 14 years old when they first tried it. Around 36 percent said they were aged between 15 and 19 when they first tried tobacco.

Beer/Wine/*Chyang*. Around 62 percent of the respondents who had used 'beer/wine/*chyang'* said they first used it when they were 15 to 19 years old. Around 30 percent said they first used 'beer/wine/*chyang'* when they 10 to 14 years old.

Alcohol. Close to 70 percent of the respondents who had used alcohol said that they were aged between 15 to 19 years old when they first tried it. Close to a quarter of respondents stated that they were 10 to 14 years old when they first tried alcohol.

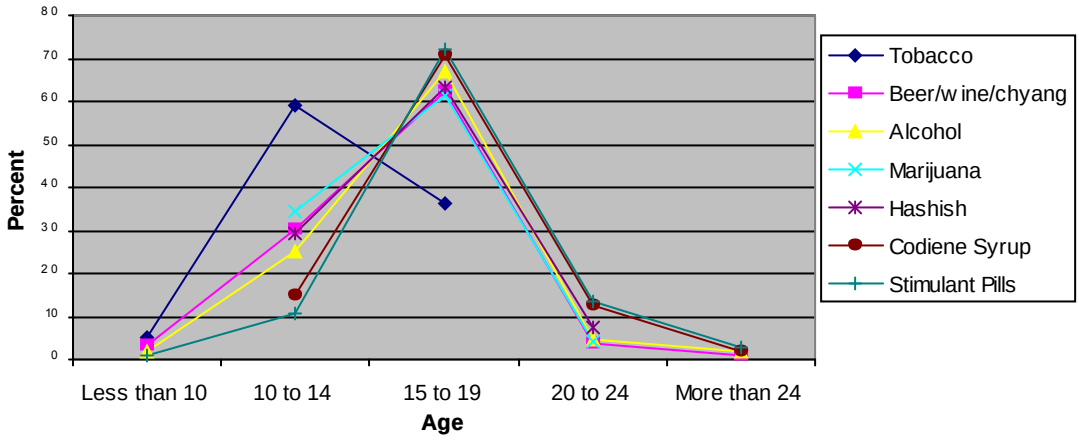
Marijuana. Around 61 percent of the respondents who had used marijuana said they were aged around 15 to 19 when first tried it. Close to 35 percent of the respondents said that they were aged around 10 to 14 when they first tried marijuana.

Hashish. Close to 65 percent of the respondents who had tried hashish said that they were aged between 15 and 19 when they first used it. Close to 30 percent said they were aged between 10 and 14 when they first tried hashish.

Tablets/Stimulant pills. Around 70 percent of the respondents who had used 'tablets/stimulant pills' said they first used it when they were aged between 15 to 19 years. Nearly a quarter of the respondents said they first used 'tablets/stimulant pills' when they were 10 to 14 years old.

Codeine based Cough Syrup. Nearly two thirds of the respondents who had used codeine-based cough syrup said that they first used it when they were 15 to 19 years old. Close to a quarter of the respondents said that they were between 20 to 24 years old when they first tried codeine-based cough syrup.

Figure 4.4. RDUs' Initial Age & Use of Gateway Drugs



4.2.5 Cessation Attempts

Number of Cessations Attempts. Around 36 percent of RDUs in sample had 3 to 5 cessation attempts (trying to stop using drugs) for more than 24 hours in their drug career (Table 4.6). This was followed by 26.1 percent who had 6 to 10 cessation attempts and 22.2 percent who had 1 to 2 attempts. Note: the definition of cessation used by the study is as follows: *complete stop on using drugs (except nicotine and caffeine) for more than 24 hours. For detoxification in medical settings, cessation meant complete stop of drugs after end of detoxification period (counting from night) for more than 24 hours. Resumption of drug use after immediately after such detoxification is not regarded as cessation.*

Means of Cessation. A majority of RDUs in sample had tried more than one method to stop drug use. Apart from enrolling in a DRC, nearly 60 percent of RDUs in sample had tried the 'self' cold turkey approach and stayed clean for more than 24 hours (Annex G.51). Around 36 percent of the respondents had tried doctor's medications

(including detoxification in a medical setting) and stayed clean for more than 24 hours. Close to 12 percent of the respondents said they utilized 'other' means (detailed below) for cessation of drug use.

Cessation through DRC enrolment. Around 60 percent of respondents mentioned that they had 2 cessation attempts by enrolling themselves in a DRC (Annex G.51). Around 22 percent said it was their third attempt, and 13.1 percent said it was their fourth to fifth attempt for cessation through enrolment in a DRC. Note: the highest number of cessation attempts through DRC enrolment was 14.

Table 4.6. Question: How many times did you completely stop using drugs for more than 24 hours after you became dependent on it?

Response	Count	Percent
3 to 5 times	56	36.6
6 to 10 times	40	26.1
1 to 2 times	34	22.2
11 to 15 times	11	7.2
21 to 25 times	4	2.6
16 to 20 times	3	2
More than 30 times	3	2
26 to 30 times	2	1.3
Total	153	100

Note: drugs for this query excludes Nicotine and Caffeine

Cessation through Self (cold turkey approach). Close to 45 percent of the respondents who had used the 'self' approach said they tried it for 2 to 4 times during their drug career (Annex G.51). Close to 30 percent said they tried it for one time, and close to 20 percent said they tried the self approach for 5 to 9 times.

Cessation through Doctor's Medication (including detox in a medical setting). Close to 20 percent of the respondents who had used doctor's medication said they tried it one time (and stayed clean for more than 24 hours after the last day of medication) (Annex G.51). Fifteen percent of the respondents said they tried cessation using doctor's medication for 2 to 4 times.

Cessation through 'Other' Means. More than half of the respondents who cited 'other means' said they stopped using drugs while inside jail or in police custody (most often due to coercive circumstances) (Annex G.51). Around 16 percent said they went to their 'villages' and tried cessation. Around 11 percent of the respondents said they 'self detoxed' in their efforts for cessation of drug use.

4.2.6. Number of Relapses after successive DRC enrolment

Apart from the first time RDUs in sample, around 56 percent had relapsed twice (after enrolment in two successive DRCs) (Table 4.7). Around 26 percent of the respondents said they had relapsed three times, 13.7 percent said they had relapsed four times, and 10.5 percent of respondents said they relapsed five times or more after 5 or more successive DRC enrolments.

Table 4.7. Number of Relapses after enrolment in DRC

Response	Count	Percent
1st time relapsed	153	100.0
2nd time relapsed	86	56.2
3rd time relapsed	41	26.8
4th time relapsed	21	13.7
5th time or more relapsed	16	10.5
Total	153	207.2

4.2.7. RDUs' Group Characteristics

Number of Users in Close Circle. During their drug career, a majority of RDUs in sample (68 percent) had a close 'user circle' consisting of 1 to 5 DUs (Annex G.52). When asked about drug use with the user circle during drug dependent stage, close to 90 percent said they would use drugs 'sometimes with friends, sometimes alone.' Nearly 15 percent said they used drugs with friends during their dependent stage.

Group's Economic Background. RDUs in sample had the following responses on the economic background of their user circle: mostly middle class (40.5 percent); rich & middle class (35.3 percent); middle & poor class (9.8 percent); mostly rich (7.8 percent); rich & poor (3.9 percent); and mostly poor (0.7 percent) (Annex G.53).

Group's Ethnic/Caste Background. A majority of RDUs in sample (79.1 percent) reported that their circle had DUs from varied ethnic/caste background (Annex G.53). Close to 20 percent of the respondents had DUs from same ethnic or caste background in their circle.

Group Activities after Drug Use. Following were the answers of RDUs in sample on activities their groups would normally be involved in after drug use: listening-playing music (57.5 percent); roaming around town (44.4 percent); hanging out in certain locations (37.3 percent); and, talking about weird things watching movies (22.2 percent). Close to 12 percent of RDUs in sample also stated that their circle had no such activities. Further activities are detailed in Annex G.53.

Group's Needle Sharing Activities. Around 46 percent of the respondents reported that needles were not shared in the circle (Table 4.8). Close to 30 percent of respondents said that needles were 'very rarely' shared in their circle. Nearly 25 percent of RDUs reported that needles 'were shared' in their group.

Table 4.8. Question: Were needles shared in your user circle?

Response	Count	Percent
No	70	45.8
Very rarely	42	27.5
Yes	38	24.8
No response	3	2.0
Total	153	100.0

note: respondents also include non IDUs

Group Traveling to Border Areas for Buying Drugs. Almost half of all RDUs in sample reported that their user circle had traveled to the 'border areas' (areas or towns bordering with India) for buying drugs (Annex G.54). Also, 19 percent of RDUs stated that their user circle had 'very rarely' traveled to the border areas.

Group Selling Drugs. Around 45 percent of RDUs in sample reported that their groups sold drugs (occasionally or continuously) (Annex G.54). Around 23 percent of RDUs also reported that their group sold drugs but 'very rarely.'

Financial Status of Group. A majority of RDUs in sample (80.4 percent) reported that their circle were 'sometimes loaded and sometimes broke'; followed by 15.7 percent of the respondents who reported that 'money was no problem' in their circle (Annex G.54). Less than 5 percent of RDUs in sample reported that their circle was 'always short of cash.' A majority of RDUs in sample (62.7 percent) reported that their circle was able to come up with the money by 'lying'; 'by asking close family' (51.6 percent); 'by stealing' (48.4 percent); 'by selling drugs' (48.4 percent); 'by threatening close family' (32 percent); and 'by working' (21.6 percent).

HIV Prevalence in Group. Close to 40 percent of RDUs in sample said that DUs in their circle were not HIV positive (Table 4.9). Around 35 percent of RDUs said that there were DUs with HIV in their circle. Close to 25 percent of RDUs reported that there 'maybe' DUs with HIV in their circle.

Table 4.9. Question: Is anybody in your circle HIV positive?

Response	Count	Percent
No	58	37.9
Yes	54	35.3
Maybe	36	23.5
No response	5	3.3
Total	153	100

Overdose Cases in Group. Around half of RDUs in sample stated that there had been case(s) of drug overdose in their circle (Annex G.55). Closely, 47.7 percent of RDUs said there were no cases of overdose in their circle. Of those with cases of overdose, close to 45 percent reported that DUs in their circle had died from drug overdose.

Arrest History in Group. An overwhelming RDUs in sample (74.5 percent) reported that their user circle had experienced police arrests (Annex G.55). A majority (87.7 percent) reported drug related cases as reasons for arrests.

Group Members in DRC. Around 35 percent of RDUs in sample reported that 'almost half' of DUs from their circle had been to DRCs, followed by 29.4 percent who reported that 'almost all' DUs from their circle had been to a DRC (Annex G.55).

Around 20 percent said that they were the only ones in the circle who were enrolled in a DRC. Of those whose friends had been to DRCs, nearly 60 percent reported that their friends were 'trying hard to recover', closely followed by 55.5 percent who reported that their friends had 'relapsed.' Around 26 percent of RDUs said their friends were 'recovering' and around 16 percent said that DUs from their user circle 'didn't find the DRCs as helpful.'

4.2.8. RDUs' Drug Use Characteristics

Needle Sharing. Close to 40 percent of RDUs in sample reported that they 'never shared' needles during their drug career (Annex G.56). This was followed by 29.4 percent of RDUs who stated that they 'very rarely' shared needles, and 28.1 percent who stated that they 'sometimes' shared needles. Less than 5 percent of RDUs in sample said they shared needles 'most of the time.'

Travel to Border Areas. Nearly half of all RDUs in sample reported traveling to the 'border areas' (areas or towns bordering with India) to buy drugs (Annex G.56). Nearly 35 percent of RDUs reported not having traveled to the border areas to buy drugs. Close to 20 percent of RDUs said that they 'very rarely' traveled to the border areas to buy drugs.

Selling of Drugs. More than 40 percent of RDUs in sample reported that they sold drugs in their career to support their habit (Annex G.56). Around 22 percent said they sold drugs but very rarely.

Financial Status. Nearly two thirds of RDUs in sample reported their financial status during drug use as 'sometimes loaded and sometimes broke'; followed by 15 percent who reported that 'money was no problem' (Annex G.56). Around 11 percent of RDUs reported that they were 'always short of cash' during their drug use career. Further, RDUs in sample reported that they were able to come up with the money by: 'asking close family' (66 percent); 'by lying' (62.1 percent); 'by stealing' (52.3 percent); 'by selling drugs' (33.3 percent); 'by working' (26.1 percent); and, 'by threatening close family' (24.2 percent). Further details are on Annex G.57.

Connection with Drug Dealers. Around 35 percent of RDUs in sample reported knowing only limited dealers (Annex G.57). Nearly 25 percent of RDUs reported that they knew almost all major dealers inside and outside the city, followed by 19 percent who said they knew almost all major dealers inside the city. Close to 20 percent of RDUs in sample said they only knew dealers in their neighborhood.

Enjoyed Activities after Drug Use. Following were the answers of RDUs in sample on activities they enjoyed doing after drug use: 'listening-playing music' (62.7 percent); 'roaming around town' (45.8 percent); 'hanging out in certain locations' (34.6 percent); 'watching movies' (32.7 percent); and, 'thinking about weird things' (28.1 percent). Further activities are detailed in Annex G.57.

Used Force or Hit Anybody in the Family or Close Ones. Around half of all RDUs in sample admitted that they had hit or used forced on family members or close ones during their drug career (Annex G.57).

Worst Incidence Ever Involved in. Close to 10 percent of RDUs in sample referred to 'fights with family member(s)' as the worst incident they were ever involved in during their drug career (Annex G.58). This was followed by 7.8 percent who said 'stealing family's gold,' and 7.2 percent for 'robbing/looting others' as their worst ever incidences. Further incidences are detailed in Annex G.58.

Summary of Findings on Clause I

4.3.1. Socio-cultural-demographic background

- A majority of RDUs in the study were fairly young, born, brought up, educated in the metropolitan cities, and were living with their families. There wasn't a wide majority of a single caste or ethnic group in the make up of RDUs; drug abuse, therefore, wasn't limited to a single caste or ethnic group.
- A majority of RDUs in the study hadn't finished their SLCs, and had an eventful schooling life: a majority had changed schools; half had received serious disciplinary actions, and half had also lived in a 'hostel'.

- Around 93 percent of the once married RDUs (60 percent of total sample) and once employed RDUs (52 percent of total sample) used drugs prior to their marriage, and during employment.
- More than two thirds of RDUs had been arrested during their drug use career, and close to half had arrest records prior to drug use.
- Nearly half of RDUs in sample didn't know of their HIV or Hepatitis status, and around 10 percent said they were HIV and/or Hepatitis positive. Many RDUs reporting negative status have had their tests done prior to their last relapse episode.

4.3.2 Immediate surroundings

- Less than a quarter of RDUs' fathers had passed college, and nearly two-thirds used/abused alcohol. The jobs of RDUs' fathers varied in nature, ranging from a mayor to a driver. Close to 65 percent of RDUs' mothers were either illiterate or only literate and a majority were housewives.
- Half of the spouses of married RDUs (or living partners) were fairly young and less than 30 percent had college degrees. Very few were 'dependent' on substances ranging from alcohol, marijuana, TD, Brown Sugar, and various stimulant pills. Majorities were not traditional and were in some form tolerant of drugs and deviance. Close to half would 'cry softly or cry alone,' or 'wouldn't talk for days' when they broke down.
- A majority of RDUs (including married RDUs) were closer to their mothers and felt that their mothers were easier to approach to than their fathers as they were more tolerant to their drug use and deviance. The fathers, according to the RDUs tended to shut down or got physical when things became tense. Further, very few RDUs had both parents with higher education; a majority of RDUs' mothers were either illiterate or just literate.
- A majority of RDUs regarded their family as middle class and without 'abnormal' characteristics. Alcohol was allowed in majority of the homes. A majority reported that their siblings were married and that their relationships with the in-laws were 'okay.' 'Mother' was the closest family member for a majority of RDUs (even for a majority of married RDUs); only 2 percent said that no one in the family was closest to them. Nearly half regarded their relationship with their relatives as 'so-so.'

- A majority of RDUs regarded their neighborhood as an old settlement and composed of people from varying economic and ethnic/caste background. Further, an overwhelming majority of RDUs also referred to high level of deviant activities, significant population of drug users and easy accessibility of drugs in their neighborhood. The locality does seem to have a tremendous impact on recovering DUs, as many referred to friends and accessibility of drugs as critical to their relapse. Further, a majority also had strained relationships with their neighborhood: their drug use and associated events/actions were widely known; majorities were unaware of their neighborhood happenings; and many felt the distancing/labeling towards them were prevalent in the neighborhood.

4.3.3. Drug Career

- An overwhelming number of RDUs were poly drug dependents and the dependency period for more than half ranged from 5 to 10 years. Close to 90 percent used needles to inject drugs in their career. Around 70 percent of RDUs said they were either dependent on brown sugar (pull mode) or TD during their drug career. Around half of RDUs said they were dependent on marijuana/hashish; 32 percent on alcohol, and 25.5 percent on various stimulant pills.
- An overwhelming majority (ranging from 62 to 75 percent) of RDUs stated that they used 'gate way' substances (with the exception of tobacco) when they were 15 to 19 years old. Around 25 to 30 percent also stated that they first used such substances at the age of 10 to 14.
- Besides enrolling in a DRC, a majority had tried the 'self' cold turkey approach to stop drug use. More than half had relapsed twice (after enrolment in two successive DRCs), around 26 percent for three times, 13.7 percent for four times, and 10.5 percent for 5 or more times.
- Almost all RDUs had a close circle of user friends in their career, which could be characterized as: mostly middle class; from varying caste/ethic background; sensitive on needle sharing practices; willing to travel to the border towns to buy drugs; willing to sell drugs; willing to steal; financially unstable; significant number of members

with possible HIV positive background, almost half with experiences of overdose related deaths, significant police arrests, and a majority of members with relapse episodes following DRC enrolment.

- The characteristics of RDUs regarding drug use can be summed up as: more than half with ‘very rarely’ or ‘sometimes’ needle sharing background; willing to travel to the border towns, willing to sell drugs; financially unstable; willing to steal; half with incidences of hitting or using force on close ones; and many with drug career marred with regrettable incidences.

CHAPTER V. NORMS, VALUES AND ATTITUDES OF RDUs

This findings section, with reinforcements of 'self' and 'self concept' from Symbolic Interaction theory, and Cooley's insights on primary groups, will look at the second clause of RDUs' social environment: the norms, values, and attitudes of RDUs. The findings are detailed under the following ideas/themes: RDUs' beliefs and values; relationships with families; RDUs' reasons behind use to abuse and cessation of drug use; details on relapse episodes; and, utilization of learnings from the DRCs.

Beliefs and Values

5.1.1. Beliefs and Values of RDUs

Higher Education. Close to 40 percent of RDUs in sample felt that higher education (studying more than current educational attainment) was either 'very important' or 'important' for them (Annex G.59). This was followed by 11.1 percent felt that higher education was 'maybe important,' and 8.5 percent who felt that higher education was 'not so important' for them.

Independence. Nearly half of RDUs in sample felt that the issue of independence was 'important,' followed by 32.7 percent who felt that independence was 'very important' for them (Annex G.59). Less than 10 percent of RDUs felt that independence was 'not so important' or 'not important at all' for them.

Support of Family & Close Ones. Around half of RDUs in sample felt that the support of family and close ones were 'very important' for them, followed by 34 percent who felt such support as 'important' (Annex G.59). Less than 5 percent of the respondents felt that support from parents/close ones as 'not so important' in their lives.

Learnings from the DRC. Close to 70 percent of RDUs in sample felt that the learnings they had received from the DRC was 'very important' for them (Annex G.59). This was followed by 23.5 percent who felt that the learnings were 'important' for them. Less than 2 percent of the respondents felt that learnings from the DRC were 'not important at all' or 'not so important' for them.

Friends (user & non user) as Important Part of Life. Almost half of RDUs in sample felt that friends were 'important' part of their lives followed by 17.6 percent of RDUs who felt that friends were 'not so important' part of their lives (Annex G.60).

Spirituality. Nearly 40 percent of RDUs in sample felt that spirituality was 'important' for them (Annex G.60). This followed 25.5 percent of RDUs who felt that spirituality was 'very important' for them. Close to 10 percent of the respondents felt that spirituality was 'not so important' or 'not important at all' for them.

Staying Clean and User Circle. Close to 35 percent of RDUs felt that it was 'very important' that, in order for them to stay clean, their user circle also had to be clean (Annex G.60). This was followed by 22.9 percent who felt such conditions as 'important' and around 20 percent who felt such conditions as 'not so important' in their lives.

Educational Level of Parents. Close to half of RDUs in sample felt that the educational level of parents (or the fact that their parents were more educated) was 'important' for them (Annex G.60). This was followed by 32 percent of RDUs who felt that educational level of parents were 'very important' for them.

RDUs' Relationship and Perception of Family and Close Relatives

5.2.1. Relationship with Families during Drug Use Career

Relationship with Parents/Spouse during Drug Use. Close to 35 percent of RDUs in sample felt that their relationships with their parents/spouse were 'good' during drug use (Annex G.61). Around 30 percent felt their relationships were 'okay,' and 23.5 percent felt their relationships as 'not good.' Less than 10 percent of the respondents felt that their relationships with their parents/spouse were 'very bad' during drug use.

Relationship with Parents/Spouse during Relapse. Close to 40 percent of RDUs in sample felt that their relationships with their parents/spouse were 'okay' when they relapsed (Annex G.61). Around 22 percent felt their relationships were 'good,' and 19.6 percent felt the relationship as 'not good.' Around 15 percent of the respondents felt that their relationships with their parents/spouse were 'very bad' when they relapsed.

Support of Parents/Spouse on RDU's efforts of Cessation. Nearly two thirds of RDUs felt that their parents/spouse were very supportive of their efforts on stopping drug use (Annex G.61). Around 20 percent felt the level of support as 'so-so', and less than 5 percent felt that their parents/spouse were 'not supportive' on their efforts of cessation.

Communication of Parents/Spouse during Cessation. Around half of RDUs in sample felt that their parents/spouse talked 'normally' when they stopped using drugs (Annex G.61). Nearly 45 percent felt that their parents/spouse talked 'very openly' during cessation period.

Relationship with Parents/Spouse during Cessation. Close to 35 percent of RDUs in sample reported that their relationship with their parents/spouse were 'good' when they stopped using drugs (Table 5.1). Closely, 31.4 percent felt the relationship as 'excellent.'

General Impression of Father. Close to 40 percent of the respondents stated that their fathers were 'loving but also strict' (Annex G.62). Similarly 37.3 percent of respondents stated that their fathers were 'understanding.' Around 10 percent said that they didn't get along with their fathers. Further, 4.9 percent of the respondents said that they didn't talk with their fathers.

General Impression of Mother. An overwhelming proportion of the respondents (66.4 percent) felt that their mothers were 'loving' (Annex G.62). Half of the respondents felt that their mothers were 'understanding', and more than 15 percent felt that their mothers were 'loving but also strict.'

General Impression of Spouse. More than 50 percent of married RDUs in sample felt that their spouses were 'loving' and/or 'understanding' (Annex G.62). Around 11 percent felt that their spouses were 'loving but also strict', and around 5 percent felt that their spouses were 'average spouses' or that they 'didn't get along.'

Table 5.1. Question: How was your relation with your parents/spouse during cessation?

Response	Count	Percent
Good	52	34
Excellent	48	31.4
Ok	44	28.8
Very bad	4	2.6
Don't know	3	2
Not good	2	1.3
Total	153	100

Payment of Fees at the DRC. An overwhelming majority (97.5 percent) of RDUs in sample, who were not receiving free treatment at the center, said that their parents or other family members paid for their treatment expenses at the center (Table 5.2). Less than 3 percent were paying by themselves for their stay at the DRC. Further, nearly 30 percent of the respondents said they 'didn't know' how difficult it was for their loved ones to come up with the money. Nearly a quarter felt that their parents had 'little bit difficulty' in pulling together the needed money. When asked about how much the parents had to pay as monthly fees at the center, 22.2 percent of the respondents said they didn't know.

5.2.2. Family Experiences

Psychological Scar. Around 54.2 percent of RDUs in sample reported that they still remembered incidences when their parents badly hit or scolded them in front of others, when they were growing up (Annex G.63).

Family Environment when Growing Up. More than 50 percent of RDUs in sample reported that they grew up in a 'strict but loving' family environment (Annex G.63). Close to 30 percent regarded their family environment as 'loose,' and 7.8 percent said they grew up in a 'very loose' family environment.

Presence of Father when Growing Up. Close to half of RDUs in sample reported that their fathers were present with them at all times when they were growing up (Annex G.63). Close to 30 percent said 'partly yes, partly no' in regards to their father's presence. Around 15 percent stated that they were in a hostel, and the same proportion said that their fathers were not present with them when they were growing up.

Table 5.2. Question: Is it difficult for you and well wishers to come up with the money?

Response	Count	Percent
I don't know	37	27.0
Little bit difficult	33	24.1
No	25	18.2
Maybe	25	18.2
Yes	17	12.4
Total	137	100.0

5.2.3. Relationship with Relatives

Relatives' Knowledge of RDUs' Drug Use. An overwhelming majority of RDUs in sample (79.9 percent) said their close relatives knew of their drug habits (Annex G.64).

Relatives' Gossiping/Rumor on RDUs. Around 42 percent of RDUs mentioned that there were lots of gossiping/rumor among their close relatives on their drug use (Annex G.64). Around 30 percent of RDUs in sample said there 'maybe' gossiping and rumor, where as 20.1 percent said that they didn't know of gossiping/rumor among their close relatives regarding their drug use.

Relatives' level of Support towards Cessation Efforts. Slightly more than half of RDUs in sample said that their close relatives were supportive of their cessation efforts (Annex G.64). Nearly 20 percent felt that their relatives as 'maybe' supportive and 8.7 percent said that their relatives 'didn't care' about their cessation efforts.

Relatives' 'Drug-Specific' Support. Of those RDUs who felt that their close relatives do support or 'maybe' support their quitting efforts, close to 60 percent said that their relatives were 'really supportive from the inside' (Annex G.64). Around 31 percent felt that their close relatives 'just say don't do drugs.'

Reasons behind Use to Abuse & Cessation of Drug Use

This section of the findings tries to comprehend the reasons behind RDUs' use to abuse of drugs and cessation of drug use. In order to cogently comprehend the reasons behind RDUs' use to abuse of drugs and cessation efforts, the study asked the respondents to respond in 5 categories. The categories were: 'self' reasons, 'availability' reasons, 'socio-cultural' reasons, 'friends and trends' reasons, and 'family' reasons. The respondents were also asked to rate or differentiate their reasons as 'major' (the very true reason) or 'minor' (reasons not major, but still noteworthy) for better reliability of answers.

5.3.1. Reasons behind Use to Abuse of Drugs

This section tries to comprehend the reasons that led the RDUs in sample from use (non-dependant) to abuse (or dependent) of drugs.

Major 'Self' Reasons for Use to Abuse. When asked on 'self' reasons that led the RDUs from use to abuse of drugs, the following 'major' reasons came into light: 'euphoria or ecstasy, immediate satisfaction' (45.9 percent); 'complicating factor of withdrawal problems' (35.8 percent); 'risk taker' (35.1 percent); 'drug controlled biological rhythm (e.g. sleep pattern)' (31.1 percent); 'low self-esteem' (27.7 percent); 'unable to cope with anxiety& conflict without drug' (27.7 percent); 'physical addiction' (26.4 percent); 'psychologically dependent' (23.6 percent); 'introverted or withdrawn individual' (23.0 percent); and, 'seeking some form of escape' (20.3 percent). All of these above reasons of 'self' crossed the 20 percent mark as 'major' reasons for use to abuse (for details see Annex G.65).

Minor 'Self' Reasons for Use to Abuse. The 'minor' reasons pertaining to 'self' and use to abuse were as follows: 'a thrill in not achieving anything in life' (26.2 percent); 'part of group who all have the same feeling of no achievement' (24.6 percent); 'drug controlled biological rhythm (e.g. sleep patterns)' (23.0 percent); 'introverted or withdrawn individual' (22.2 percent); 'euphoria or ecstasy, immediate satisfaction' (20.6 percent); and 'loneliness' (20.6 percent). All of these above 'self' reasons crossed the 20 percent mark as 'minor' reasons for use to abuse (for details see Annex G.66).

Major 'Availability' Reasons for Use to Abuse. When asked on major 'availability' reasons that led the RDUs from use to abuse of drugs, the following reasons came into light: 'locally available' (64.4 percent); 'close friend was using drugs' (63.7 percent); 'met users in everyday life' (45.9 percent); 'dealer lived in the neighborhood' (41.8 percent); 'surrounded by others who use drugs' (39.0 percent); and 'affordable, not expensive' (25.3 percent). All of these above 'availability' reasons crossed the 25 percent mark as 'major' reasons for use to abuse (for details see Annex G.67).

Minor 'Availability' Reasons for Use to Abuse. Similarly, the 'minor' reasons pertaining to 'availability' were as follows: 'met users in everyday life' (40.4 percent); and, 'affordable, not expensive' (38.4 percent). These 'availability' reasons crossed the 25 percent mark as 'minor' reasons for use to abuse (for details see Annex G.67).

Major 'Socio-Cultural' Reasons for Use to Abuse. When asked on the 'socio-cultural' reasons that led the RDUs from use to abuse of drugs, the following 'major' reasons came into light: 'location where there was dense group of IDUs' (42.9 percent); 'high degree of drug related activities in the neighborhood' (42.0 percent); 'lived in an environment broadminded or liberal about drug use' (35.3 percent); 'neighborhood disadvantage' (29.4 percent). All of these above 'socio-cultural' reasons crossed the 25 percent mark as 'major' reasons for use to abuse (for details see Annex G.68).

Minor 'Socio-Cultural' Reasons for Use to Abuse. The 'minor' reasons pertaining to 'socio-cultural' issues were as follows: 'neighborhood disadvantage' (32.9 percent); 'location where there was dense group of IDUs' (26.0 percent); and, 'high degree of drug related activities in my neighborhood' (26.0 percent). These 'socio-cultural' reasons crossed the 25 percent mark as 'minor' reasons for use to abuse (for details see Annex G.68).

Major 'Friends & Trends' Reasons for Use to Abuse. When asked on 'friends and trends' reasons that led the RDUs from use to abuse of drugs, the following 'major' reasons came into light: 'association with addicts' (58.7 percent); 'seeking a new 'high' every time' (44.7 percent); 'lots of free time' (40 percent); 'feeling that 'I won't get addicted' (38.7 percent); Closest friend was using (36 percent); sufficient peer support

(35.3 percent); 'knew many guys who were in drug networks' (30.7 percent); and, 'other sources of pleasures became less interesting' (26.0 percent). All of these above 'friends and trends' reasons crossed the 25 percent mark as 'major' reasons for use to abuse (for details see Annex G.69).

Minor 'Friends & Trends' Reasons for Use to Abuse. The 'minor' reasons pertaining to 'friend & trends' reasons were as follows: 'knew many guys who were in drug network' (32.3 percent); 'other sources of pleasures became less interesting' (31.5 percent); 'feeling that I won't be addicted' (29.8 percent); 'overall gain was greater than the overall cost' (28.2 percent); 'couldn't get along with normal friends' (25.8 percent); 'uninteresting, boring life' (25.0 percent); and, 'lots of free-time' (25.0 percent). All of these above 'friends and trends' reasons crossed the 25 percent mark as 'minor' reasons for use to abuse (for details see Annex G.69).

Major 'Family' Reasons for Use to Abuse. When asked on major 'family' reasons that led the RDUs from use to abuse of drugs, the following reasons came into light: 'family didn't blame me but blamed others' (34.8 percent); 'I was given sufficient money by parents as pocket expense' (33.3 percent); 'less supervision of family' (31.2 percent); 'to free myself from family and social responsibilities' (30.5 percent); and, 'quarrels with family members' (27.0 percent). All of these reasons scored more than 25 percent as 'major' family reasons for drug use to abuse (for details see Annex G.70).

Minor 'Family' Reasons for Use to Abuse. The only 'minor' reasons pertaining to 'family' that crossed the 25 percent mark was: 'family didn't blame me but blamed others' (35.9 percent) (for details see Annex G.70).

Most Important Reasons behind Use to Abuse. The tally of responses of categories for reasons behind use to abuse of drugs show that the major reasons of 'friends,' 'self,' and 'availability' scored 95 percent as reasons for use to abuse (Table 5.3). The highest scored reason for use to abuse, for all categories combined were: 'locally available' (64.4 percent) and 'close friend was using drugs' (63.7 percent).

5.3.2. Reasons behind Cessation of Drug Use

This section tries to understand the reasons behind cessation of drug use by RDUs.

Major 'Self' Reasons for Cessation. When asked on major 'self' reasons that led the RDUs to stop using drugs, the following reasons came into light: 'insightful and genuine realization that drugs are destructive' (51.0 percent); 'fear of losing health or life' (49.7 percent); 'I hit rock bottom' (49.0 percent); 'became disgusted by my own confused functioning' (49.0 percent); 'awareness of possible death' (34.4 percent); 'reduction in pleasure' (33.1 percent); 'rising physical discomfort' (30.5 percent); 'fear of HIV' (29.8 percent); and 'fear of psychological problems' (25.8 percent). All of these above 'self' reasons crossed the 25 percent mark as 'major' reasons for cessation (for details see Annex G.71).

Table 5.3. Categorical Reasons for Use to Abuse of Drugs

Response	Count	Percent
Friends- major reason	150	98.0
Self- major reason	148	96.7
Availability- major reason	146	95.4
Family issues-major reason	141	92.2
Self- minor reason	126	82.4
Friends- minor reason	124	81.0
Sociocultural issues-major reason	119	77.8
Family issues-minor reason	103	67.3
Availability- minor reason	99	64.7
Sociocultural issues-minor reason	73	47.7
Total	153	100.0

Note: total percent adds up to more than 100 due to multiple responses.

Minor 'Self' Reasons for Cessation. The 'minor' reasons on cessation for 'self' were as follows: 'to bring physiological rhythm back' (30.8 percent); 'reduction in pleasure' (25.6 percent); 'physical deterioration (collapse of veins etc.)' (25.6 percent); and, 'awareness of possible death' (25.6 percent). These 'self' reasons crossed the 25 percent mark as 'minor' reasons for cessation (for details see Annex G.71).

Major 'Friends' Reasons for Cessation. When asked on 'major' reasons concerning 'friends' that led the RDUs to stop using drugs, the following reasons came into light: 'my life was getting out of control' (64.6 percent); 'I was getting less and less high at higher and higher costs' (34.7 percent); 'unhappy about belonging to a group

viewed with strong suspicion & dislike' (28.6 percent); and, 'lost connection or ended friendships' (27.9 percent). All of these above 'friends' reasons crossed the 25 percent mark as 'major' reasons for cessation (for details see Annex G.72).

Minor 'Friends' Reasons for Cessation. When asked on 'friends' reasons for cessation, which the respondents felt were 'minor' in their view, the following reasons had more than 25 percent scores: 'unhappy about belonging to a group viewed with strong suspicion & dislike' (29.1 percent); and, 'lost connection or ended friendships' (26.5 percent) (for details see Annex G.72).

Major 'Family' Reasons for Cessation. When asked on 'major' reasons concerning 'family' that led the RDUs to stop using drugs, the following reasons came into light: 'genuine support from my family' (62.2 percent); 'developed a renewed sense of life' (48.6 percent); 'fear of losing a spouse and family' (42.6 percent); 'I didn't want to steal or do shameful actions to maintain my habit' (39.9 percent); 'I was no longer in control of the situation' (37.2 percent); 'rebirth of positive relationship with parents/loved ones' (32.4 percent); and, 'pressure from family and close circles' (28.4 percent). All of these above 'family' reasons crossed the 25 percent mark as 'major' reasons for cessation (for details see Annex G.73).

Minor 'Family' Reasons for Cessation. When asked on 'family' reasons for cessation, which the respondents felt were 'minor' in their views, the following reasons had more than 25 percent scores: 'pressure from family and close circles' (34.3 percent); 'fear of losing respect from peers' (31.5 percent); and, 'I was getting physically violent with my family members' (29.6 percent) (for details see Annex G.73).

Major 'Socio-Cultural' Reasons for Cessation. When asked on 'major' 'socio-cultural' reasons concerning reasons that led the RDUs to stop using drugs, the following reasons came into light: 'direct pressure from parents or spouse' (56.5 percent); 'arrested by police' (40.9 percent); 'forced treatment by the police, family, and close ones' (32.2 percent); and, 'because of limited financial resources' (30.4 percent). All of these above 'socio-cultural' reasons crossed the 25 percent mark as 'major' reasons for cessation (for details see Annex G.74).

Minor 'Socio-Cultural' Reasons for Cessation. When asked on 'socio-cultural' reasons for cessation, which the respondents felt were 'minor' in their views, the following reasons had more than 25 percent scores: 'because of limited financial resources' (36.1 percent); 'direct pressure from parents or spouse' (33.3 percent); 'arrested by police' (30.6 percent); and, 'forced treatment by the police, family, close ones' (27.8 percent) (for details see Annex G.74).

Major 'Availability' Reasons for Cessation. When asked on 'availability' reasons respondents felt were 'major' reasons for stopping using drugs, the following reasons came into light: 'decrease in availability of drugs' (52.3 percent); 'the dealers in our area were arrested' (43 percent); and, 'my close user friends left the country' (40.7 percent). These reasons on 'availability' crossed the 25 percent mark as 'major' reasons for cessation (for details see Annex G.75).

Minor 'Availability' Reasons for Cessation. When asked on 'availability' reasons for cessation, which the respondents felt were 'minor' in their views, the following reasons had more than 25 percent scores: 'decrease in availability of drugs' (47.5 percent); 'my close user friends left the country' (44.1 percent); and, 'the dealers in our area were arrested' (37.3 percent) (for details see Annex G.75).

Most Important Reasons behind Cessation. Tallying the responses of RDUs in sample, it was seen that 'self-major' reasons, 'family-major' reasons, and 'friends-major' reasons had more than 95 percent of scores (Table 5.4). It was also found out that 'socio-cultural-major' reasons scored lesser than 'self-minor' and 'friends minor' reasons for cessation amongst the RDUs in sample. Further, the highest scored reason for cessation for all categories combined were: 'my life was getting out of control' (64.6 percent), and 'genuine support from my family' (62.2 percent).

Issues Pertaining to Relapse

5.4.1. Relapse History of RDUs

The study tried to understand in detail the phenomena behind each relapse episodes of RDUs following their enrolment at a DRC (note: this study does not look into relapses that were preceded by cessation modes other than enrollment in a DRC). In specific, the study tried to comprehend the time of their relapse, clean date before relapse, duration of drug use after relapse, decision maker behind RDUs' enrolment in a DRC, duration of stay in the DRC, and the understanding of factors behind RDUs' relapse. The study investigated on a maximum of 5 relapses. For those with more than 5 relapses, the study looked at their 5 latest relapses.

Table 5.4. Categorical Reasons for Cessation of Drugs

Response	Count	Percent
Self - major reason	151	98.7
Family - major reason	148	96.7
Friends - major reason	147	96.1
Self - minor reason	117	76.5
Friends - minor reason	117	76.5
Socio/cultural - major reason	115	75.2
Family - minor reason	108	70.6
Availability - major reason	86	56.2
Socio/cultural - minor reason	72	47.1
Availability - minor reason	59	38.6
Total	153	832.2

Note: total percent adds up to more than 100 due to multiple responses.

Time of Relapse(s). Following were the findings on when relapse(s) occurred for the RDUs in sample (for details see Annex G.76).

First Time RDUs. Around 30 percent of RDUs in sample said that their first relapsed occurred 1 to 2 years ago. This was followed by 19 percent who stated that their 1st relapse occurred 3 to 4 years ago, and around 16 percent who mentioned that their 1st relapse occurred 7 or more than 7 years ago.

Second Time RDUs. Close to 35 percent of those who had relapsed twice said that their second relapse occurred 1 to 2 years. Close to 20 percent said that their second relapse occurred 3 to 4 years ago, and around 15 percent said that their second relapse occurred 7 years more than 7 years ago.

Third Time RDUs. Around 36 percent of those who had relapse thrice said that their third relapse had occurred 1 to 2 years ago. Close to 20 percent said that their third relapse occurred 3 to 4 years ago, and 12.2 percent said that their third relapse occurred 7 years or more than 7 years ago. Close to 10 percent of the respondents said that their third relapse occurred 3 to 4 months ago.

Fourth Time RDUs. Close to 50 percent of the respondents said that their fourth relapse took place 1 to 2 years ago. This was followed by close to 25 percent who said that their fourth relapse occurred 3 to 4 years ago.

Fifth Time RDUs. Close to 45 percent of the respondents stated that their fifth relapse occurred 1 to 2 years ago. Close to 20 percent said that their fifth relapse occurred 3 to 4 months ago, or 3 to 4 years ago.

Clean before Relapse(s). Following were findings on how long the RDUs in sample were clean after their discharge from the DRC (for details see Table 5.5)

First Time RDUs. A majority of the respondents reported that they remained clean (with the exception of nicotine and caffeine) for a period of 1 to 6 months prior to their first relapse. Of those, close to 20 percent of the respondents said they were clean for 1 to 2 months after being discharged (negatively/positively) from the DRC. Fifteen percent said they were clean for 3 to 4 months, and 11.1 percent said they were clean for 5 to 6 months, prior to their first relapse. Close to 10 percent said they didn't stay clean for one day after being discharged. Cumulatively, around 28 percent couldn't remain clean for more than 11 to 15 days, 50 percent for more than to 1 to 2 months, and 75 percent for more than 5 to 6 months, after their discharge from a DRC. Around 86 percent could not celebrate their sobriety 'birthday' (being clean for a year) before their first relapse.

Table 5.5. Question: How long were you clean before your relapse(s)?

Response	1st Relapse			2nd Relapse			3rd Relapse			4th Relapse			5th Relapse		
	Count	Percent	Cpercent*	Count	Percent	CPercent	Count	Percent	Cpercent	Count	Percent	Cpercent	Count	Percent	CPercent
0 days	14	9.2	9.2	8	9.3	9.3	4	9.8	9.8	2	9.5	9.5	1	6.3	6.3
1 day	9	5.9	15.1	2	2.3	11.6	2	4.9	14.6			9.5			6.3
2 to 5 days	3	2	17.1	6	7.0	18.6	2	4.9	19.5	2	9.5	19.0			6.3
6 to 10 days	9	5.9	23	5	5.8	24.4	1	2.4	22.0			19.0	1	6.3	12.5
11 to 15 days	7	4.6	27.6	7	8.1	32.6	3	7.3	29.3	1	4.8	23.8	1	6.3	18.8
16 to 20 days	6	3.9	31.5	2	2.3	34.9	3	7.3	36.6			23.8			18.8
21 to 24 days			31.5			34.9	1	2.4	39.0			23.8			18.8
25 to 29 days			31.5	3	3.5	38.4	1	2.4	41.5			23.8			18.8
1 to 2 months	28	18.3	49.8	13	15.1	53.5	6	14.6	56.1	7	33.3	57.1	7	43.8	62.5
3 to 4 months	23	15	64.8	18	20.9	74.4	2	4.9	61.0	1	4.8	61.9	1	6.3	68.8
5 to 6 months	17	11.1	75.9	6	7.0	81.4	4	9.8	70.7	4	19.0	81.0			68.8
7 to 8 months	11	7.2	83.1	2	2.3	83.7	2	4.9	75.6						68.8
9 to 11 months	4	2.6	85.7	3	3.5	87.2	1	2.4	78.0				1	6.3	75.0
1 to 2 years	11	7.2	92.9	5	5.8	93.0	7	17.1	95.1	4	19.0	100.0	3	18.8	93.8
3 to 4 years	5	3.3	96.2	5	5.8	98.8	2	4.9	100.0						
5 to 6 years	4	2.6	98.8	1	1.2	100.0									
7 years and above	2	1.3	100.1												
No response			100.1			53.5			56.1			57.1	1	6.3	100.0
Total	153	100		86	100.0		41	100.0		21	100.0		16	100.0	

Clean date-starting from discharge date from the center; *Cpercent = cumulative percentage

Second Time RDUs. A majority of the respondents reported that they remained clean for a period of 1 to 4 months prior to their second relapse. Of those, around 20 percent said that they didn't use drugs for 3 to 4 months after being discharged from the DRC. Around 15 percent said that they were clean for 1 to 2 months. Close to 10 percent said that they weren't clean for a single day after they were discharged form the center. Cumulatively, nearly a quarter couldn't stay clean for more than 6 to 10 days, 53.5 percent for more than 1 to 2 months, around 75 percent for more than 3 to 4 months, and 87 percent for more than 9 to 11 months, after their discharge from a DRC. Around 87 percent could not celebrate their sobriety 'birthday' before their second relapse.

Third Time RDUs. Close to 20 percent of the respondents who had relapsed for the third time said they were clean for 1 to 2 years, prior to their third relapse. Around 15 percent said that they were clean for 1 to 2 months, and around 10 percent said that they were clean for either 0 days or for 5 to 6 months prior to their third relapse. Cumulatively, 22 percent couldn't remain clean for more than 6 to 10 days, 56 percent for more than 1 to 2 months, and 75 percent for more than 7 to 8 months, after their discharge from a DRC. Around 78 percent could not celebrate their sobriety 'birthday' before their third relapse.

Fourth Time RDUs. Close to 35 percent of the respondents said that they were 'clean' for 1 to 2 months, after they were discharged from the center. Close to 20 percent said they were either clean for 5 to 6 months or for 1 to 2 years. Cumulatively, close to a quarter couldn't remain clean for more than 11 to 15 days, 57 percent for more than 1 to 2 months, and 81 percent for more than 5 to 6 months, after their discharge from a DRC. Around 81 percent could not celebrate their sobriety 'birthday' before their fourth relapse.

Clean before Fifth Relapse. Close to 45 percent of respondents stated that they were 'clean' for 1 to 2 months prior to their fifth relapse, after the discharge from the center. Close to 20 percent said they were clean for 1 to 2 years prior to their fifth relapse. Cumulatively, close to 20 percent couldn't remain clean for more than 11 to 15 days, 62.5 percent for more than 1 to 2 months, and 75 percent for more than 9 to 11 months, after their discharge from a DRC. Around 75 percent could not celebrate their sobriety 'birthday' before their fifth relapse.

Duration of Use After Relapse(s). Following were the findings on the duration of RDUs' drug use after relapse (Figure 5.1; and, Annex G.77).

First Time RDUs. Close to 40 percent of the respondents said that they used drugs for 1 to 2 years after their first relapse. Around 10 percent said they used drugs for 3 to 4 years, followed by 9.8 percent who used drugs for 5 to 6 months after their first relapse.

Second Time RDUs. Nearly 31 percent of 2nd time relapse respondents said they used drugs for 1 to 2 years after their second relapse. Around 15 percent said they used drugs for 5 to 6 months, and 14 percent said they used drugs for 3 to 4 months.

Third Time RDUs. Around 36 percent of 3rd time relapse respondents said they used drugs for 1 to 2 years after their third relapse. Nearly 15 percent said they used drugs for 3 to 4 months, and 12.2 percent for 1 to 2 months after their third relapse.

Fourth Time RDUs. Nearly 43 percent of the 4th time relapse respondents said they used drugs for nearly 1 to 2 years after their fourth relapse. Close to 15 percent said they used drugs for 1 to 2 months and around 10 percent said they used drugs for 3 to 4 months or for 7 to 8 months after their fourth relapse.

Fifth Time RDUs. Close to 40 percent of the 5th time relapse respondents said they used drugs for 1 to 2 years after their fifth relapse. Close to 20 percent said they used drugs for 3 to 4 months, and around 12 percent said they used drugs for 2 to 5 days or for 1 to 2 months after their fifth relapse.

Fifth Time RDUs. Close to 40 percent of the 5th time relapse respondents said they used drugs for 1 to 2 years after their fifth relapse. Close to 20 percent said they used drugs for 3 to 4 months, and around 12 percent said they used drugs for 2 to 5 days or for 1 to 2 months after their fifth relapse.

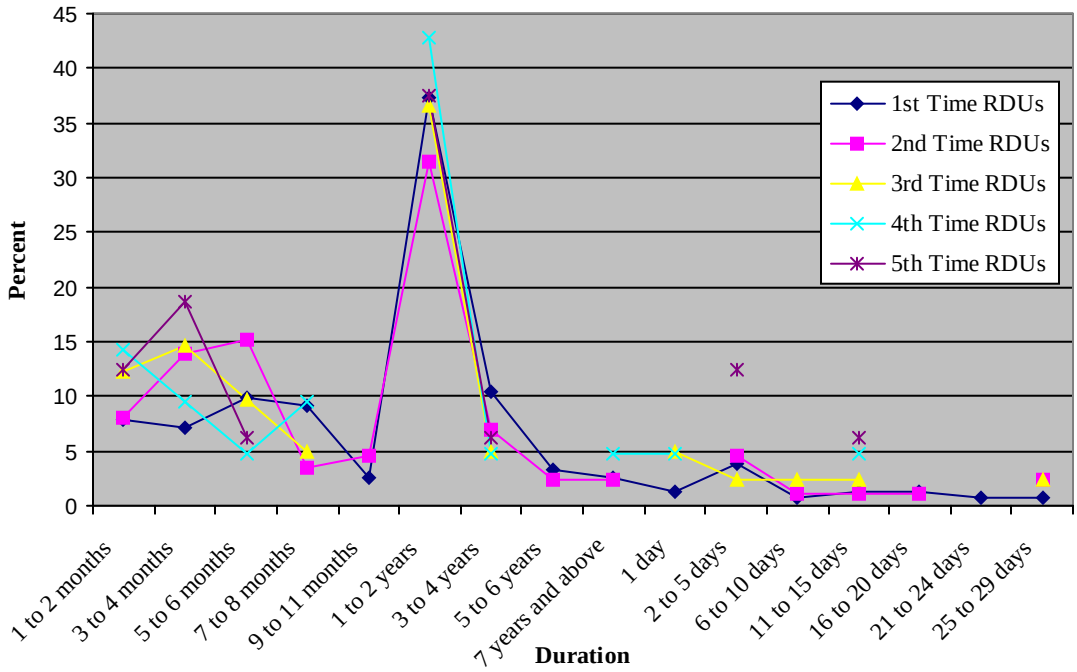
Decision Makers on RDUs' DRC Enrolment. Following were the findings on who decided on RDUs' enrolment in a DRC prior to their relapse (for details see Annex G.78).

First Time RDUs. Around 42 percent of the respondents said that it was the decision of the 'family and close ones' for them to enroll in a DRC, prior to their first relapse. Thirty four percent said it was their 'own' decision, and, close to 20 percent said that it was 'not 100% their own decision' to enroll in the DRC.

Second Time RDUs. Around 45 percent of second time relapse respondents stated that it was their 'own' decision to enroll at the DRC prior to their second relapse. Nearly 40 percent said that it was the decision of the family and close ones for the respondents to enroll at the DRC.

Third Time RDUs. Close to 45 percent of the respondents said that it was their 'own' decision to enroll at the DRC prior to their third relapse. Nearly 40 percent said it was the decision of the 'family and close ones,' and, 22 percent said it was 'not 100 % their own decision' to enroll at the DRC prior to their third relapse.

Figure 5.1. Duration of Drug Use after Relapse(s)



Fourth Time RDUs. Nearly 62 percent of the respondents said that it was their 'own' decision to enroll at the DRC prior to their fourth relapse. Close to 30 percent said that it was 'not 100% their own decision,' and, around 20 percent said that it was the decision of 'family and close ones' for them to enroll at the DRC prior to their fourth relapse.

Fifth Time RDUs. Half of the respondents stated that it was their 'own' decision to enroll at the DRC, prior to their fifth relapse. A quarter of the respondents said their 'family and close ones' made the decision, and nearly 20 percent said that it was 'not 100 % their own decision' to enroll at the center prior to their fifth relapse.

Duration of Stay at DRC prior to Relapse(s). Following were the findings on whether the RDUs stayed full time (time stipulated by the DRC), and reasons for not staying full at the DRC prior to their relapse(s).

First Time RDUs. Only around half of the respondents said that they stayed full time (usually 3 months or more) at the center prior to their first relapse (Annex G.79). Of those who didn't stay fulltime, the reasons varied widely, ranging from 'home sick' to 'argument or fights with clients or staff' (see Annex G.79 for details).

Second Time RDUs. Around half of 2nd time relapse respondents stated that they did not stay full time at the DRC prior to their second relapse (Annex G.80). The reasons for respondents not staying varied widely, ranging from 'no commitment/didn't surrender' to 'didn't like behavior of seniors at the center' (see Annex G.80 for details).

Third Time RDUs. Close to 60 percent of the respondents said that they stayed full time at the center, prior to their third relapse (Annex G.81). For those who didn't, issues ranged from matters of the center they didn't like to personal issues (see Annex G.81 for details).

Fourth Time RDUs. Close to 60 percent of the respondents said that they stayed full time at the center prior to their fourth relapse (Annex G.82). Of those who didn't, all referred various 'self' issues as compelling them to quit staying at the center (see Annex G.82 for details).

Fifth Time RDUs. Close to 45 percent of the respondents said that they didn't stay full time at the center prior to their fifth relapse (Annex G. 83). The reasons for not staying varied from 'center issues' to 'negative thoughts' (see Annex G.83 for details).

Factors Leading to Relapse(s). Following were the findings on factors that led the RDUs to their relapse(s).

First Time RDUs. Almost 25 percent of RDUs said that the 'overwhelming craving for drugs' led them to their first relapse (Annex G.84). Around 95 percent attributed their relapse to 'self' reasons, and 20 percent to 'friends.' Around 16 percent reasoned 'family' issues, whereas 7.2 reasoned 'center' issues as factors leading to their first relapse. Close to 8 percent stressed on 'availability' reasons, and 2 percent on 'socio-cultural' reasons as leading them to their first relapse. Further information on factors leading to first relapse are detailed in Annex G.85.

Second Time RDUs. Close to 20 percent of the respondents attributed their second relapse to the overwhelming 'craving for drugs' (Annex G.85). Around 81 percent mentioned factors related to 'self' and 16.3 percent referred to 'friends' as factors leading them to their second relapse. Similarly, close to 10 percent mentioned 'family' issues, 5.8 percent mentioned 'center' issues, 4.7 percent mentioned 'availability' issues, and 3.5 percent mentioned 'socio-cultural' issues as factors leading them to their second relapse. Further information on factors leading to second relapse are detailed in Annex G.86.

Third Time RDUs. Close to 22 percent of the respondents attributed their third relapse to the overwhelming 'craving for drugs' (Annex G.86). Around 102.4 percent (multiple response) mentioned factors related to 'self' and 9.8 percent referred to 'friends' factors as leading them to their third relapse. Similarly, close to 15 percent mentioned 'family' issues, 9.8 percent mentioned 'center' issues, 12.2 percent mentioned 'availability' issues, and none mentioned 'socio-cultural' issues as factors leading them to their third relapse. Further information on factors leading to third relapse are detailed in Annex G.87.

Fourth Time RDUs. Close to 25 percent of the respondents attributed their fourth relapse to the overwhelming 'craving for drugs' (Annex G.87). Around 142.9 percent (multiple response) mentioned various factors related to 'self' and 9.5 percent referred to 'friends' factors as leading them to their fourth relapse. Close to 19 percent mentioned 'family' issues, 4.8 percent mentioned 'center' issues, 9.5 percent mentioned

'availability' issues, and none mentioned 'socio-cultural' issues as factors leading them to their fourth relapse. Further information on factors leading to fourth relapse are detailed in Annex G.88.

Fifth Time RDUs. Close to 7 percent of the respondents attributed their fifth relapse to the overwhelming 'craving for drugs' (Annex G.88). Around 143.8 percent (multiple response) mentioned various factors related to 'self' and 6.3 percent referred to 'friends' factors as leading them to their fifth relapse. Similarly, close to 19 percent mentioned 'family' issues, 31.3 percent mentioned 'center' issues, 6.3 percent mentioned 'availability' issues, and 6.3 percent mentioned 'socio-cultural' issues as factors leading them to their fifth relapse. Further information on factors leading to fifth relapse are detailed in Annex G.88.

Names of DRCs Enrolled. Respondents prior to their relapse(s) had enrolled in various DRCs within and outside Kathmandu valley, and also those located outside Nepal. However, a majority of the respondents were enrolled at DRCs located in Kathmandu (see Annex G.89 for names of DRCs).

5.4.2. Reasons for Relapse

A section of the questionnaire had specific queries on understanding the reasons for RDUs' relapses (preceded by a DRC enrolment). Respondents for this query had to rate a set of relapse reasons provided by the study as whether they were: very true, true, maybe true, or not true to their lives.'

Very True' Relapse Reasons. Following were the reasons the RDUs in sample felt as being 'very true' to their relapses: 'I said I will never use drugs regularly again but only now & then, and then became re-addicted soon after' (61.4 percent); 'one last time!' (53.6 percent); 'craving was powerful and persistent' (51.0 percent); 'I didn't attend socially supportive & voluntary programs like N.A.' (44.4 percent); 'I had lots of free time and no concrete plans on what to do with it' (44.4 percent); 'I wasn't genuinely honest about discontinuing drugs' (41.8 percent); and, 'I was very excited to face life

when I left the center, but that excitement slowly died down as days passed by' (41.2 percent). All of these reasons scored more than 40 percent (for further details see Annex G.90).

'True' Relapse Reasons. Following were the relapse reasons which the respondents felt were 'true' to their lives: 'failing to build up a network of relationships, activities, and involvements that would act as a barrier against boredom, & depression' (38.6 percent); 'I started associating with addicts and their circles, only they could understand me' (37.9 percent); 'I tried the clean approach but I was more comfortable with my user friends, and their way of life' (37.3 percent); 'I was clearly aware of the warning signs…but then, it just happened (37.3 percent); 'association with other addicts' (35.3 percent); 'it was very tempting for me to believe that just enough substance can be taken to control distressing mood states without returning to the level of compulsive use' (35.3 percent); 'contact with active addicts even when my readjustment with my family/society was satisfactory' (34.6 percent); 'I didn't ask for anybody's help' (34.6 percent); 'things weren't going my way. The resulting rage & anger that grew out of such disappointment compelled me' (34.0 percent); 'I had difficulty in achieving new goals' (33.3 percent); 'failing to express my wants and needs-either they wouldn't listen or I couldn't tell them' (32.7 percent); and, 'I was very excited to face life when I left the center, but that excitement slowly died down as days passed by' (31.4 percent). All of these reasons scored more than 30 percent (for further details see Annex G.91).

'Maybe True' Relapse Reasons. Following were the reasons which the respondents felt were 'maybe true' behind their relapse episodes: 'failing to find alternative (drug free) outlets for my needs' (30.7 percent); 'prior suffering was remembered as being less intense & painful' (30.7 percent); 'I had nowhere to start my life. I couldn't restart my education, I had no job, no skills' (28.1 percent); 'my family didn't believe in me' (27.5 percent); I had difficulty in finding new circle of friends (27.5 percent); 'it was purely an accident' (27.5 percent); 'failing to build up a network of relationships, activities, and involvements that would act as a barrier against boredom, & depression' (26.8 percent); 'I decided to take it anyway-even though life was going well' (26.8 percent); 'I had no one to discipline me when I got out of the center' (26.8 percent);

and, ‘I didn't know how to cope or handle when confronted with a high-risk situation’ (26.1 percent). All of these reasons scored more than 25 percent (for further details see Annex G.92).

‘Not True’ Relapse Reasons. Following were the reasons, which the respondents felt were ‘not true’ to their relapses: ‘I thought I would make some money by selling drugs & not using’ (86.3 percent); ‘I am HIV positive. I could not bear the feeling that I was HIV positive’ (85.6 percent); ‘because of family crises (such as parents separating or a sibling developing problem, death, separation, etc.,)’ (68.0 percent); ‘I did whatever my parents told me to do, & that didn’t help my recovery’ (61.4 percent); ‘treatment programs did not provide enough skills on how to defend myself & how to satisfy my inner needs & wishes’ (60.8 percent); ‘I entered into treatment because of pressures from my family, cops in the first place’ (54.9 percent); ‘experiences of rejection from family & friends’ (52.9 percent); ‘no body cared on whether I was drug free or not’ (48.4 percent); ‘it started during festival season (dassain, tihar, fagu, shivaratri, new year, etc.)’ (44.4 percent); ‘I could not get any jobs’ (43.8 percent); and, ‘my families did not change their attitude & behavior, they were same as when I was using drugs’ (42.5 percent). All of these responses scored more than 40 percent (for further details see Annex G.93).

Respondents’ Own Relapse Statements. The respondents were given the opportunity to write their own ‘statements’ that best described their relapse(s). Of the total entries, following were the crucial relapse statements: ‘overconfidence, I understand program/know how to face situations (13.1 percent); ‘sex - use of drugs while having sex is very satisfying (13.1 percent); and, ‘break up with girl friend’ (6.0 percent). Other relapse statements are detailed in Annex G.94.

5.4.3. Common Reasons behind Multiple Relapses

The study tried to understand possible common reasons behind multiple relapse episodes of RDUs. Close to 65 percent of RDUs who had more than one relapses felt that there were commonalities in their multiple relapses (Table 5.6).

Table 5.6. Question: If more than one relapse, do you think there were same issues, events, risk factors, etc., present in all your relapses?

Response	Count	Percent
Yes	56	62.9
No	12	13.5
Maybe, but not 100 % confirmed	14	15.7
I don't know	7	7.9
Total	89	100.0

Around half of the respondents who felt there were or 'maybe were' similar factors behind their multiple relapses mentioned family and self reasons as the common issues (Table 5.7). Little more than half stated reasons concerning 'friends,' and close to 60 percent mentioned 'other' issues as common reasons behind their multiple relapses.

Table 5.7. Common Issues behind Multiple Relapses

Common Issues	Count	Percent
Family	35	50.0
Self	35	50.0
Friends	37	52.9
Others	41	58.6
Total	70	211.4

Note: total percent adds up to more than 100 due to multiple responses.

Family Issues & Multiple Relapse. Around 17.1 percent and 14.3 percent of respondents who had or thought they might have had common reasons behind multiple relapses felt that 'family' issues such as 'family didn't trust me-suspicious,' and, 'family's attitude towards me' as common factors behind their relapses (Annex G.96). Close to 10 percent had following issues as family reasons behind their multiple relapses: 'always fussy-*kachkach garnae;*' 'coercive family (wanted me to do things)'; and, 'tensed family life.' Further family issues are detailed in Annex G.95).

Friends Issues & Multiple Relapse. Nearly 70 percent of the respondents who referred to 'friends' as reasons for multiple relapse stated 'associating with suffering friends (couldn't avoid or detach, felt like using when seeing friends on high, and peer pressure)' as the common reason behind their multiple relapses (Annex G.95).

Self Issues & Multiple Relapse. Nearly 15 percent of the respondents who referred to 'self' reasons said that loneliness and isolation were common reasons behind their multiple relapses (Annex G.96). Nearly 12 percent said 'lack of patience' and around 9 percent stated the following reasons as common reasons behind their multiple relapses: 'couldn't increase self will/esteem/confidence;' 'craving for drug & negative feeling;' 'pleasure seeking;' 'sex problems/obsessions;' and, 'to relieve from tension.'

'Other' Issues & Multiple Relapse. Nearly a quarter of respondents who referred to 'other' issues stated 'sex' as the common issue behind their multiple relapses (Annex G.97).

5.4.4. Efforts in Dealing with Craving for Drugs

The study tried to understand on whether RDUs put any efforts to overcome the craving of drugs after they left the DRC. Following were the responses on what the RDUs did when they felt the craving: 'I tried to think of positive thoughts' (64.1 percent); 'watched movie' (63.4 percent); 'listened to music' (54.2 percent); and, 'talked with family members' (50.3 percent). Similarly, 43.8 percent said they 'blocked thoughts as much as possible' and 35.3 percent said they had 'no specific action.' Close to 35 percent of respondents said they 'just went on with life' and 19.6 percent said they 'couldn't do anything' (Annex G.98).

5.4.5. Factors of Relapse besides Craving

When asked on whether any factors besides craving invited relapse in the lives of the RDUs, the following factors came into light: 'lack of ability to make good decisions' (68.6 percent); 'thought I could control myself' (66.0 percent); 'friends' (65.4 percent);

'drugs available within my neighborhood' (49.0 percent); 'lack of confidence without use of drugs' (43.1 percent); 'locality' (34.6 percent); and, 'family issues' (26.8 percent). All of these factors scored more than 25 percent (Annex G.99).

5.4.6. Factors that could prevented Relapse

When asked on whether any factors would have prevented the RDUs from relapsing, 92.8 percent of the respondents indicated 'family support' followed by 90.2 percent who said that they may not have relapsed if they had decided/acted differently to 'one important incidence ' (Table 5.8). Nearly 90 percent of the respondents referred to 'social factors,' 73.9 percent to 'education' and, 67.3 percent to 'economic issues' as factors that could have prevented the respondents from relapsing. Details on each of these factors are discussed below.

Table 5.8. Issues that could have Prevented RDUs from Relapse

Response	Count	Percent
Family support	142	92.8
Reacting differently to 'one important incident'	138	90.2
Social	137	89.5
Education	113	73.9
Economy	103	67.3
Total	153	413.7

Note: total percent adds up to more than 100 due to multiple responses.

Family Support. The following factors had more than 25 percent of respondents' votes on issues concerning 'family support' that would have helped prevent them from relapsing: 'if I had asked for help' (89.4 percent); 'if my family had taken some trouble to accommodate & accept me by changing the family structure, attitude, behavior' (33.8 percent); 'if my dad had controlled his anger and negative behavior for my sake' (30.3 percent); and, 'if my family had loved me as I am' (28.2 percent) (Annex G.100).

Education. The following factors had more than 25 percent of respondents' votes on factors concerning 'education' that would have helped prevent them from relapsing: 'if had finished my studies' (60.2 percent); 'if I had gone out of this country for studies' (46.9 percent); and, 'if I had technical trainings' (38.1 percent) (Annex G.100).

Economy. The following factors had more than 25 percent of respondents' votes on factors concerning 'economy' that would have helped prevent RDUs from relapsing: 'if I had a job' (84.5 percent); and, 'if I had money to do things' (35.9 percent) (Annex G.100).

Social. The following factors had more than 25 percent of respondents' votes on 'social' factors that would have helped prevent RDUs from relapsing: 'if I had a counselor like friend in real life' (92.7 percent); 'if I had a supportive community of relatives' (35.0 percent); 'my wife/parents were more modern thinking' (31.4 percent); and, 'I had broken contacts with my user friends/circle' (29.9 percent) (Annex G.100).

One Important Incident. The following factors had more than 25 percent of respondents' votes on factors concerning 'one important incident' that would have helped prevent RDUs from relapsing: 'if I had said no to my friend (70.3 percent); 'if I had not left the house' (47.1 percent); 'if I had listened to my higher power- HE was very loud' (35.5 percent); and, 'if I had never been to that party/gathering' (33.3 percent) (Annex G.100).

5.4.7. Lapse to Relapse

This section of the findings tried to understand on whether RDUs in sample started using drugs irregularly (lapse) before they relapsed. Around 55 percent of RDUs in sample reported that they lapsed before they relapsed (Table 5.9). Nearly 45 percent of RDUs said that they went to regular use of drugs after their discharge from the DRC. Note: the study defines lapse as a slip in one's recovery process-not necessary a relapse state. It can mean use of drugs in an irregular or non-habitual way.

Drugs Used during Lapse Period. Close to 40 percent of RDUs in sample reported that they had used marijuana when they lapsed, followed by use of alcohol (30.6 percent), brown sugar (30.6 percent), various stimulant pills (25.9 percent), TD (24.7 percent), and Hashish (8.2 percent) (Annex G.101).

Table 5.9. Question: Did you relapse by regular use or irregular use of drugs?

Response	Count	Percent
Directly to regular use	68	44.4
First it was irregular use	85	55.6
Total	153	100

Duration of Lapse Period. Close to 35 percent of the respondents said that their lapse period went from 1 to 2 months, followed by 17.6 percent who said their lapse period went from 3 to 4 months (Annex G.101). Close to 10 percent of the respondents said they lapsed for 6 to 10 days before relapsing.

Search for Help during Lapse Period. When asked on whether 'lapsed' respondents looked for help realizing they might be on the verge of relapse, around 45 percent said 'no,' and, 34.1 percent said they 'thought they should but didn't' (Annex G.101). Twenty percent 'lapsed' respondents said they looked for help realizing they might be on the verge of relapse.

Hampering Factors against Reverting back to Cessation. Close to 70 percent of the respondents felt that the major hampering factor that led them to not revert back to cessation after lapse period was the thought: 'I will never become addicted' (Annex G.101). Similarly, other hampering reasons that scored more than 25 percent were as follows: 'I compromised on using only limited dosage of my preferred drug' (61.2 percent); 'I realized I could never be 100 % clean' (48.2 percent); 'I compromised on only using soft drugs from now on' (47.1 percent); and, 'psychologically/mentally dependent' (28.2 percent). .

Family Issues. Nearly a quarter of 'lapsed' respondents who felt 'family issues' as hampering them to not revert back to cessation, mentioned 'family didn't trust me (or became suspicious of me)' as a specific hampering issue (Annex G.102). Close to 10 percent of lapsed respondents who mentioned family issues said 'family didn't understand my situation' as the issue that led them to not revert back to cessation.

Self Issues. Around 11 percent of lapsed respondents who stated 'self' issues said that 'loneliness' played a role in their decision to not revert back to cessation (Annex G.102).

'Other' Specific Issues. Close to 20 percent of lapsed respondents who mentioned of 'other specific issues' stated 'body wasn't feeling good without drugs' as the issue that led them to not revert back to cessation (Annex G.103). Similarly, close to 15 percent mentioned 'separation with girlfriend,' as their issue for not reverting back to cessation.

RDUs and DRC

5.5.1. Use of Skills Learned at the DRC

A series of queries were posed to RDUs in sample to comprehend on whether the skills stressed at the DRCs were used by the RDUs as they were discharged. Following were the responses:

Meditation. Around half (52.3 percent) of RDUs in sample said that they didn't use meditation after they left the center (Figure 5.2; Annex G.104). Around 20 percent said they used meditation but not regularly. Around 16 percent said they didn't find meditation necessary.

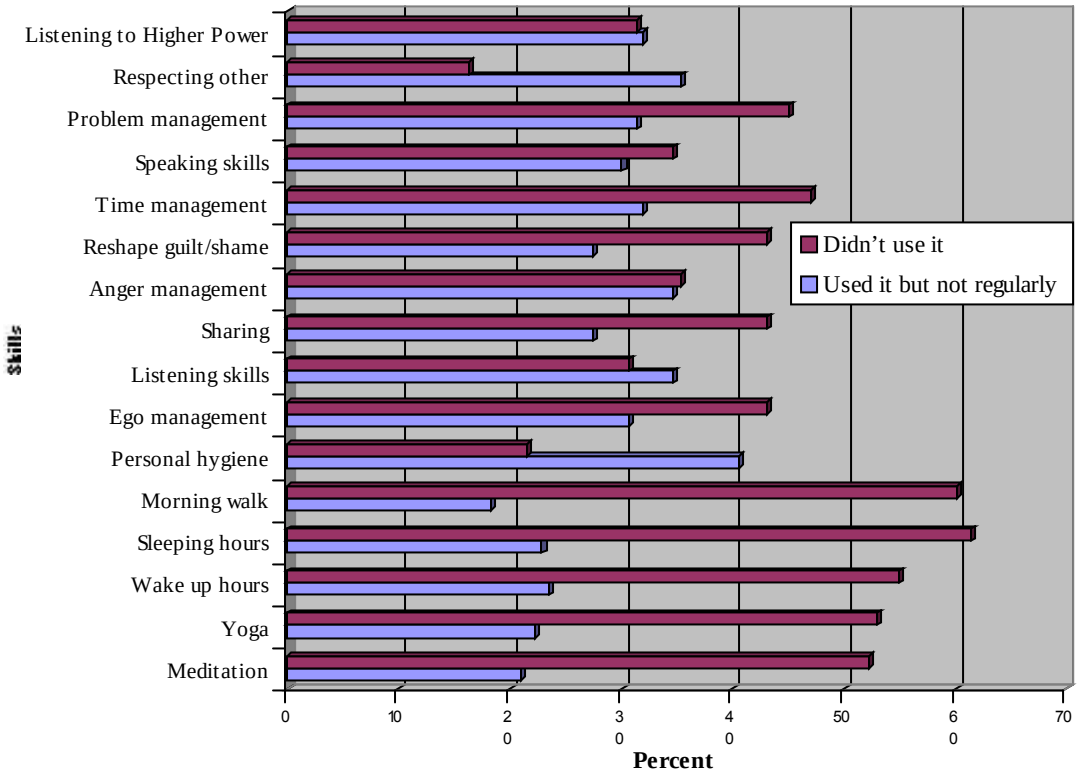
Yoga. Close to 55 percent of RDUs in sample said that they didn't use yoga after they left the center (Annex G.104). Around 22.2 percent said they used yoga but not regularly, and 13.7 percent said they didn't find it necessary.

Wake up Hour. Close to 55 percent of RDUs in sample said that they didn't use the 'wake up hour' after they left the center (Annex G.104). Around 23.5 percent said they used the 'wake up hour' but not regularly, and, 11.1 percent said they didn't find it necessary.

Sleeping Hour. A majority of RDUs in sample (61.4 percent) said that they didn't use the 'sleeping hour' after they left the center (Annex G.104). Around 25 percent said they used it but not regularly, and, 9.2 percent said they didn't find 'sleeping hour' necessary.

Morning Walk. A majority of RDUs in sample (60.1 percent) said that they didn't use 'morning walk' after they left the center (Annex G.104). Close to 20 percent said they used it but not regularly, and 7.8 percent said they didn't find morning walk necessary.

Figure 5.2. DRC Taught Skills RDUs Didn't Use or Used Irregularly



Personal Hygiene. Around 40 percent of RDUs in sample said that they used the personal hygiene skills but not regularly, after they left the center (Annex G.104). Around 35 percent said they used it, and, 21.6 percent said they didn't use personal hygiene skills.

Ego Management. Close to 45 percent of RDUs in sample said that they didn't use 'ego management' skills (Annex G.104). Around 30 percent said they used it but not regularly, and nearly 15 percent said they used 'ego management' skills.

Listening Skills. Nearly 35 percent of RDUs in sample said that they used the listening skills but not regularly, after they left the center (Annex G.104). Around 30 percent said they didn't use it, and 25.5 percent said they used listening skills.

Sharing. Close to 45 percent of RDUs in sample said that they didn't use 'sharing' skills (Annex G.104). Close to 30 percent said they used it but not regularly, and 17.6 percent said they used 'sharing' skills.

Anger Management. Around 35 percent of RDUs in sample said that they didn't use anger management skills (Annex G.104). Similarly, nearly 35 percent said they used it but not regularly. Around 20 percent said they used anger management skills.

Reshaping Guilt/Shame. Close to 45 percent of RDUs in sample said that they didn't use 'reshaping guilt/shame' skills after they left the center (Annex G.104). Around 27 percent said they used it but not regularly, and, around 16 percent said they used 'reshaping guilt/shame' skills.

Time Management. Close to half of RDUs in sample said that they didn't use time management skills after they left the center (Annex G.104). Around 32 percent said they used it but not regularly; and, 9.8 percent said they used time management skills.

Speaking Skills. Nearly 35 percent of RDUs in sample said that they didn't use speaking skills after they left the center (Annex G.104). Around 30 percent said they used it but not regularly, and, 28.1 percent said they used speaking skills.

Problem Management. Around 45 percent of RDUs in sample said that they didn't use problem management skills (Annex G.104). Around 31 percent said they used it but not regularly. Around 12 percent said they used problem management skills.

Respecting Others. Close to 45 percent of RDUs in sample said that they used the skills of respecting others after they left the center (Annex G.104). Around 35 percent said they used it but not regularly, and, around 16 percent said they didn't use the skills of respecting others.

Listening to Higher Power (Being). Around 32 percent of the respondents in sample said that they used the skills of listening to the Higher power but not regularly (Annex G.104). Close to 32 percent said they didn't listen to the Higher power, and, 22.2 percent said they listened to the Higher power.

5.5.2. RDUs' Selection of DRC

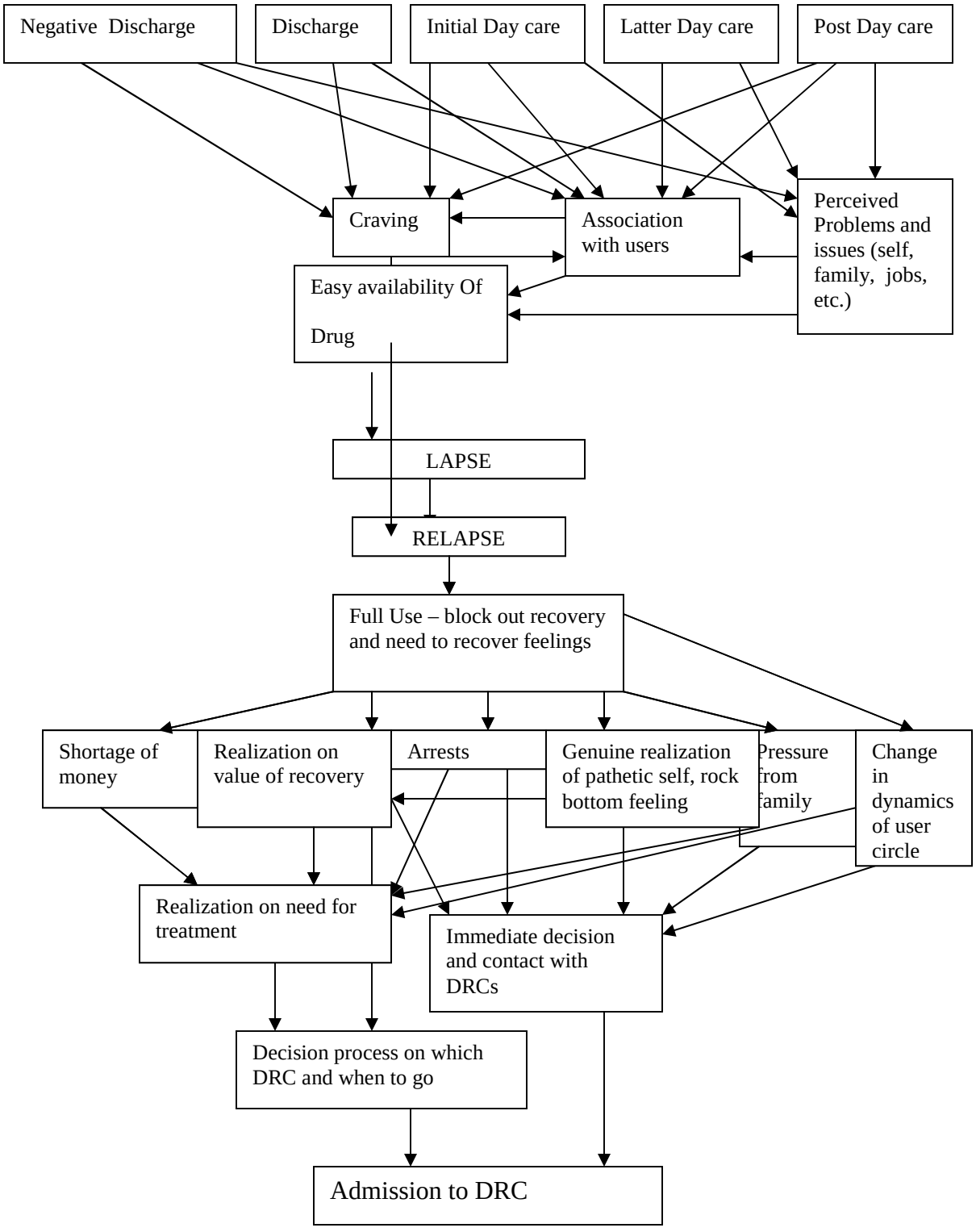
Selection of DRC for first time RDUs was mostly based on the information fed to them by their once enrolled DU friends-on the characteristics of DRCs (if its good, strict, loose, etc). Further, the family members of RDUs also seemed to find information from their sources on which DRC would suit their son better, for some the police would also take them to a DRC of their liking. For RDUs with DRC experience, choosing a DRC dependent on several factors: their liking of the previous DRC, financial situation of family, enrolment of their close friends in a particular DRC, and, whether they wanted to enroll in a 'tight' or 'loose' DRC.

5.5.3 RDUs' Change of DRCs

Change of DRCs. An overwhelming majority of RDUs in sample (70 percent) said they didn't go to the same DRC after their relapse (Annex G.105). Nearly 70 percent who had changed DRCs had been to at least two DRCs. Similarly, close to 25 percent of the respondents had been to 3 different DRCs.

Reasons for Change of DRC after Relapse. For those RDUs in sample who had been to more than one DRC in their carrier, a query was posed to understand why they changed DRCs. Close to 35 percent of RDUs attributed their decision to 'guilt and/or shame' for not going to the same DRC (Annex G.106). Nearly 8 percent said that the previous 'center wasn't effective or good,' and the same percentage of RDUs said there was 'no program in the center.' Figure 5.3 provides a general picture on the cycle of RDUs' DRC enrolment and relapse, as found out by the study.

Figure 5.3. The Cycle of DRC Enrolment and Relapse



5.5.4. Relationship with Counselor

Effective relationship with a counselor is seen as an integral part of client's recovery in all DRCs. All DRCs visited by the study had more than one counselor for individual as well as for group counseling services. This section tried to gaze the relationship of RDUs with their counselors.

Openness with Counselor. Close to 30 percent of RDUs in sample said that they were 'so-so' open with their counselors (Annex G.107). Nearly 20 percent said they were 'sometimes only' open with their counselors. Around 17 percent said that they were 'open' and 12.4 percent said they were 'very open' with their counselors. Nearly 7 percent (10 respondents) of RDUs in sample weren't assigned counselors or were not aware of who their counselors were. Note: the study sat with RDUs only after their 'sick period' (caring for RDUs' withdrawal syndromes), which is normally a week to 10 days after their enrollment.

Understanding from Counselor. When asked on how understanding the counselors were on respondent's problems and issues, around 30 percent said that they were 'understanding' (Annex G.107). Similarly, close to 30 percent also said that their counselors were 'so-so' understanding. Around 16 percent of RDUs said that their counselors were 'very understanding,' and 13.7 percent said that their counselors were 'sometimes understanding, sometimes not.'

Time Spent with Counselor. When asked on whether respondents found their time spent with the counselor as helpful, close to 45 percent of respondents said it was 'very helpful' (Annex G.107). Close to 30 percent said it was 'helpful,' and 13.1 percent said that the time spent with their counselor was 'may be helpful' for them.

5.5.5. Important Skills Center should teach to Avoid Future Relapse

When asked on what RDUs thought were the most important skills the center should teach them to avoid future relapses, around 15 percent of the respondents mentioned skills to change their attitude/behavior as very important (Annex G.108). Close to 15 percent of the respondents said they 'didn't know' or found it hard to respond to this query. Nearly 12 percent of were of the view that they themselves had to follow whatever skills already stressed by the center. Around 8 percent of the respondents felt

that the center had to encourage N.A. or any forms of fellowships, and, around 6 percent said job skills were important for them to avoid future relapses. Further suggestions of RDUs are detailed in Annex G.108.

5.5.6. Suggestions for a Well Functioning/Better DRC

When asked on what suggestions could the respondents based on their experience could provide for a better and well functioning DRC, close to 20 percent said 'good input classes (useful, practical, and by experienced people) as essential (Annex G.109). Nearly 18 percent mentioned issues related with the DRC staff (staff's behavior/attitude should be positive/be understanding/fulfill their responsibilities/ mingle with clients/ work on their attitudes/ no conflict between staff) as important. Fifteen percent said 'more fellowshipping/sharing,' and 13.7 percent said 'good counseling/counselor-one to one, and frequent counseling' as very important. Similarly, around 13 percent stressed the provision of 'games/sports and playground' as important means to help them relax. Around 11 percent of the respondents said 'love, care, concern at the center/family environment/feeling of service at the center' as important. Close to 10 percent of the respondents mentioned 'similar behavior towards clients/no partiality/discrimination' by the staff as very important. Further suggestions by RDUs are detailed in Annex G.109.

Summary of Findings on Clause II

5.6.1. Beliefs & Values of RDUs

- Apart from attaining higher education, a majority of RDUs placed higher values and importance on issues of: independence, higher education of parents, friends-as important part of their lives; the sobriety of user circle as helpful, learnings from the DRC and spirituality.

5.6.2. Family antecedents and Relationships

- More than half of the RDUs grew up in a 'strict but loving' family environment, and a majority reported that their fathers weren't present with them at all times when they were growing up. Half still remembered incidences when their parents badly hit or scolded them in front of others, when they were growing up.

- Relationships with family/spouse for a majority of RDUs were surprisingly good and didn't experience a downfall even during drug use or relapse. Further, relationships became even stronger during RDUs' cessation period. A majority of RDUs acknowledging their relatives' knowledge of their drug use and possible gossiping/rumors also felt that they were really supportive of their cessation efforts.

5.6.3. RDUs' Major Reasons for Use to Abuse & Cessation

- Issues related to 'availability' and 'friends' were the significant reasons that led RDUs from use to abuse of drugs. Issues related to 'self,' 'friends,' 'family,' 'socio-cultural,' and 'availability' were the significant reasons that led RDUs to stop using drugs.

5.6.4. Relapse History of RDUs (note: the study only accounts relapses following DRC discharge)

- A staggering number of RDUs couldn't celebrate their sobriety birthday prior to relapse(s), and reverted back to drug use very early after each DRC discharges. Looking at the 5 relapses, a staggering two thirds of RDUs couldn't remain clean for more than the following periods: for more than 5 to 6 months (first relapse); for more than 3 to 4 months (second relapse); for more than 7 to 8 months (third relapse); for more than 5 to 6 months (fourth relapse); and for more than 9 to 11 months (fifth relapse). Also, there was no clear trend to signify that increase in DRC enrolment meant increase in clean dates following successive DRC discharge.
- The study had worrying findings that a majority of RDUs used drugs for a period of around 1 to 2 years after each relapses. Again, there was no clear trend to suggest that increase in DRC enrolment meant decrease in drug use duration thereafter. The decision by RDUs themselves to enroll in a DRC after successive relapses increased from first to four time RDUs and decreased slightly for five time RDUs. But this increase in figures only accounted for about half of RDUs. For others, the families played some part, if not major, for RDUs to enroll in a DRC.
- Only around half of RDUs stayed full time (time stipulated by the DRC) in the center prior to their relapse(s). The reasons given for not staying full time varied widely, ranging from reasons of drug compulsion, personal attitude problems to DRC issues which RDUs didn't like.

- An overwhelming majority of RDUs attributed to various factors related to 'self' as leading them to their relapse(s). The 'overwhelming craving for drugs' remained a direct factor for around a quarter of first to fourth time RDUs, and decreased significantly to 7 percent for fifth time RDUs. Issues concerning 'friends' as major factor also decreased steadily after successive relapses (25 percent for first time RDUs to 6 percent for five time RDUs). Around 10 to 15 percent of first to third time RDUs referred to 'family' issues as a crucial factor, which slightly increased for fourth and fifth time RDUs to 19 percent. Issues related to 'center' stood around 5 to 10 percent for first to fourth time RDUs and increased significantly to 31 percent for fifth time RDUs. Less than 5 percent referred to 'availability' (with the exception of 12 percent for third and fourth time RDUs), and very few refereed to 'socio-cultural' factors as leading them to their relapse(s).
- A majority of RDUs referred to the following reasons as being 'very true' to their relapse: compromise with self for irregular use; craving; lack of participation in N.A. gatherings; free time and no concrete plans on what to do with it; not genuinely honest on discontinuing drugs; and depreciating drive to face life following DRC discharge. A majority referred to the following factors as not being true to their relapses: being HIV positive; family crisis; obeying family's directions, incompetent DRC; coercion by family and police to enter rehab; rejection from family and friends; and temptation to use during important festivals.
- Around 55 percent of RDUs lapsed before they relapsed with a majority using marijuana, alcohol or brown sugar in the process. The lapse period for a majority lasted from around 1 to 4 months and only 20 percent said they looked for help realizing they might be on the verge of relapse. A majority referred to 'overconfidence' (I will not become addicted) as the major hampering factor that led them to not revert back to cessation.
- A majority of multiple RDUs felt there were common reasons/issues behind each of their relapses. Around half attributed to issues regarding family, self and friends, and around 60 percent to 'other' issues ('sex' being the significant reason) as common reasons behind their multiple relapses.

- In dealing with craving, a majority thought of 'positive thoughts,' watched movies, listened to music, and talked with the family. Nearly 45 said they 'blocked thoughts as much as possible.' On significant factors besides craving that invited relapse, a majority felt 'lack of ability to make good decisions,' 'overconfidence-I could control myself,' 'friends' and 'availability of drugs in the neighborhood' as playing a major part in their relapse. Nearly 45 also felt 'lack of confidence without use of drugs' led them to relapse.

5.6.5. Factors that could have prevented Relapse

- Around 90 percent of RDUs felt that 'family support' (the major response being: 'if I had asked for help'); acting/deciding differently to 'one important incidence' ('if I had said no to my friend' and 'if I had not left the house' topping the responses); and 'social factors' ('if I had a counselor like friend in real life' topping the responses) could have prevented them from relapsing. Close to two thirds referred to 'education' ('if had finished my studies' topping the responses), and 'economic issues' ('if I had a job' topping the responses) as factors that could have prevented them from relapsing.

5.6.6. RDUs and DRC

- A majority didn't use skills learned at the center following their discharges; very few used the skills in an irregular fashion. The highest skill used regularly by the RDUs was that of 'respecting others.' Amongst a variety of responses on important skills, which the RDUs felt the center should teach, 'change of attitude/behavior' was rated as very essential. Further, close to 15 percent either found it hard to respond to this query or were of the view that they themselves had to follow whatever skills already stressed by the center.
- An overwhelming majority of RDUs didn't go to the same DRC after their relapse; a majority had been to at least two DRCs. A majority attributed the change to 'guilt and/or shame' of returning to the same DRC, and close to 10 percent also pointed out the incompetent factors of the center as prompting the change.
- Although a majority of RDUs felt that the time spent with counselors was important, very few said that they were open with their counselors, and very few felt that their counselors understood them. Further, nearly 7 percent weren't assigned counselors or were not aware of who their counselors were.

- Following are some of the significant responses, which the RDUs felt were crucial for a well functioning DRC: ‘good input classes (useful, practical, and by experienced people), issues related with the DRC staff (behavior/attitude should be positive/be understanding/fulfill responsibilities/ mingle with clients/ no conflict between staff); ‘more fellowshipping/sharing;’ ‘good counseling/counselor-one to one, and frequent counseling;’ provision of ‘games/sports and playground;’ ‘care, concern at the center/family environment/feeling of service at the center;’ and ‘similar behavior towards clients/no partiality/discrimination’ by the staff.
- The study found out that some DUs tended to block off their issues of vulnerability (e.g. issues regarding friends), and to not think of it while they were at the center. The centers teach clients to take one day at a time- and some even referred to this line for not thinking about their vulnerabilities. Many of such DUs were like ‘machines’ following the program of the center but not really understanding why.
- The limitations of DRCs, according to the study, chiefly consisted of: financial constraints, shortage and lack of trained human resources, shaky relationships with board or executive committee members, lack of sustainable skills development program, lack of external support (including that of the government), and lack of national regulation or operational guidelines for DRCs.

CHAPTER VI. 'ALIENTATION' AS A PARTICULAR CONTEXT

This section of the findings tries to analyze the supposition of the study that 'alienation' was the probable 'particular socio-cultural context' (the third clause of social environment) of RDUs. Alienation denotes a particular state in which individuals develop a degree of estrangement from his/her society. Individuals feel they no longer are a vital part or an important member of the society (for more on alienation, please see p.12).

When talking of alienation, drug use is a radical issue. The society at most times is quick to typify drug users: their physical appearance, their non-coherent actions and behavior. Further, society also surmises such peculiar behaviors and abnormal demeanors as outside the conformity zone of socially valued ideals. Therefore, it is but logical to assume that some form of distancing do exist between drug users and their society. However, what do the evidences gathered from this study say to this supposition?

The study tested the findings of the study using the five types or forms of alienation: powerlessness; meaningless; normlessness; isolation; and self-estrangement, to comprehend whether and to what level were the RDUs in sample alienated. These five forms of alienation, as found out by the study, were widely prevalent (often working in conjunction with one another) amongst the RDUs in sample. Following are some findings that the study felt were outstanding evidences, to justify that alienation was the probable socio-cultural context of RDUs in sample.

The Findings

- **Arrests during Drug Use Carrier.** More than two thirds of RDUs in sample had been arrested during their drug use career. Nearly half of those were arrested for 2 to 4 times, followed by 26.9 percent arrested 5 to 10 times. Nearly 10 percent were arrested for more than 10 times. An overwhelming majority (52.9 percent) reported being arrested while in use and/or possession of drugs. This was followed by 22.7 percent who said they were arrested for 'fights.' ***Normlessness***

- **Drug Use prior Marriage.** An overwhelming majority of married RDUs (92.6 percent) said that they were using drugs prior to their marriage. ***Powerlessness/ Normlessness***
- **Drug Use and Divorce/Separation.** An overwhelming majority of divorced or separated respondents mentioned drug use and the resulting depreciation of their relationship as the reason for separation. ***Meaninglessness/ Normlessness***
- **Drug Use during Employment.** Of those employed, an overwhelming majority (92.4 percent) of RDUs said they used drugs during employment. ***Normlessness/ Powerlessness***
- **Relatives' Knowledge & Gossiping of RDUs' Drug Use.** An overwhelming majority of RDUs in sample (79.9 percent) said that their close relatives knew of their drug use. Around 72 percent of RDUs also mentioned that there were/or maybe were lots of gossiping/rumor among their close relatives about their drug use. ***Isolation***
- **Relation with Relatives.** Around 45 percent majority of RDUs regarded their relationship with relatives as 'so-so.' Around 22 percent of RDUs regarded their relationship as 'very close with only few'. ***Isolation/ Meaninglessness***
- **Deviant Activities.** An overwhelming number of RDUs stated that deviant activities were present in their neighborhood. Only 7.2 percent of RDUs in sample reported that deviant activities didn't exist in their neighborhoods. ***Normlessness/ Powerlessness/ Meaningless***
- **Awareness on Neighborhood Happenings.** Nearly 65 percent of RDUs in sample felt that they were not aware of what was happening in their neighborhood. ***Isolation/ Meaninglessness***
- **Participation in Neighborhood Activities.** Nearly 70 percent of RDUs in sample reported that they had never participated in any of the neighborhood activities. ***Isolation/ Meaninglessness***
- **Dramatic Situations Witnessed by Neighborhood.** Nearly two-thirds of RDUs in sample reported that they had been in dramatic situations (e.g., fights, blackouts), which were seen by everybody in the neighborhood. ***Self-estrangement/ Normlessness***

- **Neighborhood's Knowledge on Respondent's Drug Use.** An overwhelming RDUs in sample (94.1 percent) said that their neighborhood knew they were using drugs. ***Self-estrangement/ Meaninglessness***
- **Suspicious Viewing of Neighborhood.** Of those RDUs who thought their neighborhood knew of their drug use, 80.6 percent felt that the neighborhood viewed them in suspicion. ***Isolation/ Powerlessness***
- **Labeling Respondents as 'Addicts.'** Of those RDUs in sample who thought their neighborhood knew of their drug use, 64.6 percent mentioned that the neighborhood labeled them as 'addicts' or 'junkies.' ***Isolation/ Powerlessness***
- **Rejection from Neighborhood.** Of those RDUs in sample who thought their neighborhood knew of their drug use, 54.2 percent felt that their neighborhood ignored or rejected them. ***Isolation/ Powerlessness***
- **Psychological Scar.** Around 54.2 percent of RDUs in sample reported that they still remembered incidences when their parents badly hit or scolded them in front of others, when they were growing up. ***Meaninglessness/Isolation***
- **Typical Nature when Father Breaks Down.** Around 40 percent of respondents stated that their fathers 'didn't talk for days' when they broke-down. This was followed by 33.1 percent who said that their fathers 'got physical,' and 21.1 percent who said that their fathers 'cried softly or alone' they broke down. ***Isolation/Self-estrangement***
- **Friends (user & non user) as Important Part of Life**. Almost half of RDUs in sample felt that friends were 'important' part of their lives. Nearly 15 percent mentioned that their friends were 'may be important,' and 13.7 percent said that friends 'very important' part of their lives. ***Powerlessness***
- **Staying Clean and User Circle.** Close to 35 percent of RDUs felt that it was 'very important' that, in order for them to stay clean, their user circle also had to be clean. This was followed by 22.9 percent who felt such conditions as 'important.' ***Powerlessness***
- **Intake Frequency.** An overwhelming majority of RDUs in sample reported that they used drugs daily. Of those using daily, more than half (57.5 percent) reported that they used drugs less than five times a day and 39.9 percent reported that they used

drugs more than five times a day. Many respondents also mentioned that their intake frequency (and dosage) would rise sharply, if they had plenty of drugs with them. ***Powerlessness***

- **Total Dependency Time.** Nearly 35 percent of RDUs in sample reported that they were dependents on drugs for 5 to 7 years. Close to a quarter reported that they were dependent for 8 to 10 years. ***Powerlessness***
- **Needle Use, Reasons and Duration.** Close to 90 percent of RDUs in sample said they had used needles to inject drugs in their career. ***Meaninglessness***
- **Group Coming up with the Money.** A majority of RDUs in sample (62.7 percent) reported that their circle was able to come up with the money by 'lying'; 'by asking close family' (51.6 percent); 'by stealing' (48.4 percent); 'by selling drugs' (48.4 percent); and 'by threatening close family' (32 percent). ***Powerlessness/ Normlessness***
- **HIV Prevalence in Group.** Around 60 percent of RDUs said that there 'were' or 'maybe were' DUs with HIV in their circle. ***Self-estrangement***
- **Arrest History in Group.** Nearly two-thirds of RDUs in sample reported that their user circle had experienced police arrests. A majority of those arrested (87.7 percent) were reportedly on drug related cases. ***Self-estrangement/ Normlessness***
- **Group Members in DRC.** Of those whose friends had been to DRCs, nearly 60 percent reported that their friends were 'trying hard to recover', closely followed by those whose friends had 'relapsed' (55.5 percent). ***Self-estrangement***
- **Travel to Border Areas.** Nearly half of all RDUs in sample reported they had traveled to the 'border areas' (areas or towns bordering with India) to buy drugs. Further, close to 20 percent of RDUs said that they had traveled to the border areas but 'very rarely.' ***Powerlessness/ Normlessness***
- **Selling of Drugs.** More than 40 percent of RDUs in sample reported that they sold drugs in their career to support their habit. Further, around 22 percent also said they sold drugs but very rarely. ***Powerlessness/ Normlessness/ Self-estrangement***
- **Coming up with Money.** RDUs in sample reported that they were able to come up with the money by 'asking close family' (66 percent); 'by lying' (62.1 percent); 'by stealing' (52.3 percent); 'by selling drugs' (33.3 percent); 'by working' (26.1

percent); and, 'by threatening close family' (24.2 percent). ***Powerlessness/ Normlessness***

- **Used Force or Hit Anybody in the Family or Close Ones.** Around half of all RDUs in sample admitted that they had hit or used forced on family members or close ones during their drug career. ***Normlessness***
- **Educational Level of Parents.** Close to half of RDUs in sample felt that the educational level of parents (or the fact that their parents were more educated) was 'important' for them, followed by 32 percent who felt that educational level of parents were 'very important' for them. ***Isolation/Self-estrangement***
- **Worst Incidence Ever Involved In.** Nearly all of the respondents stated that there were 'incidences' which they considered as highly regrettable events in their career. These incidences ranged from 'fights with family member(s),' 'stealing family's gold,' to 'robbing/looting others.' ***Normlessness***
- **Major 'Self' Reasons for Use to Abuse.** When asked on 'self' reasons that led the RDUs from use to abuse of drugs, the following reasons had more than 35 percent entries as 'major' self-reasons for use to abuse of drugs: 'euphoria or ecstasy, immediate satisfaction' (45.9 percent); 'complicating factor of withdrawal problems' (35.8 percent); and, 'risk taker' (35.1 percent). ***Powerlessness/ Normlessness/ Self-estrangement***
- **Major 'Availability' Reasons for Use to Abuse.** When asked on major 'availability' reasons that led the RDUs from use to abuse of drugs, the following reasons had more than 35 percent of entries: 'locally available' (64.4 percent); 'close friend was using drugs' (63.7 percent); 'met users in everyday life' (45.9 percent); 'dealer lived in the neighborhood' (41.8 percent); and, 'surrounded by others who use drugs' (39.0 percent). ***Powerlessness***
- **Major 'Socio-Cultural' Reasons for Use to Abuse.** When asked on the 'socio-cultural' reasons that led the RDUs from use to abuse of drugs, the following reasons had more than 35 percent of entries: 'location where there was dense group of IDUs' (42.9 percent); 'high degree of drug related activities in the neighborhood' (42.0 percent); and, 'lived in an environment broadminded or liberal about drug use' (35.3 percent). **Powerlessness/ *Self-estrangement***

- **Major 'Friends & Trends' Reasons for Use to Abuse.** When asked on 'friends and trends' reasons that led the RDUs from use to abuse of drugs, the following reasons had more than 35 percent of entries: 'association with addicts' (58.7 percent); 'seeking a new 'high' every time' (44.7 percent); 'lots of free time' (40 percent); 'feeling that 'I won't get addicted' (38.7 percent); Closest friend was using (36 percent); and, 'sufficient peer support' (35.3 percent). ***Powerlessness/ Meaningless/ Normlessness/Isolation***
- **Clean date after DRC discharge.** Looking at the 5 relapses, a staggering two thirds of RDUs couldn't remain clean for more than the following periods after DRC discharge: for more than 5 to 6 months (first relapse); for more than 3 to 4 months (second relapse); for more than 7 to 8 months (third relapse); for more than 5 to 6 months (fourth relapse); and for more than 9 to 11 months (fifth relapse). ***Powerlessness/ Meaningless***
- **Duration of Use after Relapses.** Following were the percentage of respondents who used drugs for more than 1 year after their relapses: 53.7 percent (1st Relapse); 43 percent (2nd Relapse); 41.5 percent (3rd Relapse); 52.4 percent (4th Relapse); and 43.8 percent (5th Relapse). ***Powerlessness/Normlessness/ Meaningless/ Self-estrangement/Isolation***
- **Decision making on DRC enrolment.** Following were the proportion of respondents who said that it wasn't their own decision or not 100 % their own decision to enroll at the DRC: 85.6 percent (1st Relapse); 73.2 percent (2nd Relapse); 78.1 percent (3rd Relapse); 66.7 percent (4th Relapse); and 68.8 percent (5th Relapse). ***Powerlessness/ Meaningless/ Self-estrangement***
- Around half of the RDUs didn't stay full time at the center prior to their first and second relapses. ***Powerlessness/ Meaningless/ Self-estrangement***
- **Factors Leading to First Relapse.**. Almost 25 percent of RDUs said that the 'overwhelming craving for drug' led them to their first relapse. Around 95 attributed their first relapse to 'self' reasons, and 20 percent to 'friends.' Around 16 percent reasoned 'family' issues, whereas around 8 reasoned 'center' and 'availability' issues as factors leading to their first relapse. The various forms of alienation were clearly

evident on the specific responses of the respondents in the categories mentioned above. ***Powerlessness/Normlessness/Meaningless/Self-strangement/Isolation***

- **Factors Leading to Second Relapse.** Close to 20 percent of the respondents attributed their second relapse to the overwhelming 'craving for drugs.' Around 81 percent mentioned factors related to 'self' and 16.3 percent referred to 'friends' as factors leading them to their second relapse. The various forms of alienation were clearly evident on the specific responses of the respondents in the categories mentioned above. ***Powerlessness/Normlessness/Meaningless/Self-strangement/Isolation***
- **Factors Leading to Third Relapse.** Close to 22 percent of the respondents attributed their third relapse to the overwhelming 'craving for drugs.' Around 102.4 percent (multiple response) mentioned factors related to 'self' and 15 percent referred to 'family' factors as leading them to their third relapse. Similarly, around 12 percent mentioned 'family' 'center' and 'availability' issues as factors leading them to their third relapse. The various forms of alienation were clearly evident on the specific responses of the respondents in the categories mentioned above. ***Powerlessness/Normlessness/Meaningless/Self-strangement/Isolation***
- **Factors Leading to Fourth Relapse.** Close to 25 percent of the respondents attributed their fourth relapse to the overwhelming 'craving for drugs.' Around 142.9 percent (multiple response) mentioned various factors related to 'self' and 19 percent referred to 'family' factors as leading them to their fourth relapse. Similarly, around 10 percent mentioned 'friends' and 'availability' issues as factors leading them to their fourth relapse. The various forms of alienation were clearly evident on the specific responses of the respondents in the categories mentioned above. ***Powerlessness/Normlessness/Meaningless/Self-strangement/Isolation***
- **Factors Leading to Fifth Relapse.** Around 143.8 percent (multiple response) mentioned factors related to various factors of 'self' and 31.3 percent referred to 'center' factors as leading them to their fifth relapse. Similarly, close to 19 percent mentioned 'family' issues as factors leading them to their fifth relapse. The various forms of alienation were clearly evident on the specific responses of the respondents

in the categories mentioned above. ***Powerlessness/Normlessness/Meaningless/Self-strangement/Isolation***

- **'Very True' Relapse Reasons.** Following were the reasons that had scores of more than 50 percent as reasons the respondents felt as being 'very true' to their relapses: 'I said I will never use drugs regularly again but only now & then, and then became re-addicted soon after' (61.4 percent); 'one last time!' (53.6 percent); and craving was powerful and persistent' (51.0 percent). ***Powerlessness/Self-estrangement***
- **Respondents' Own Relapse Statements**. The crucial relapse statements as felt by the respondents themselves were: 'overconfidence, I understand program/know how to face situations (13.1 percent); 'sex - use of drugs while having sex is very satisfying' (13.1 percent); and, 'break up with girl friend' (6.0 percent). ***Self-estrangement/ Normlessness//Isolation***
- **Friends Issues & Multiple Relapse.** Nearly 70 percent of the respondents who referred to 'friends' as reasons for multiple relapse stated 'associating with suffering friends (couldn't avoid or detach or felt like using when seeing friends on high and peer pressure)' as the common reason behind their multiple relapses. ***Powerlessness/ Normlessness***
- **Factors of Relapse besides Craving.** When asked on whether any factors besides craving invited relapse in the lives of the RDUs, the following factors had more than 50 percent of respondents' votes: 'lack of ability to make good decisions' (68.6 percent); 'thought I could control myself' (66.0 percent); and 'friends' (65.4 percent). ***Self-estrangement/Meaninglessness/ Powerlessness***
- **May not have Relapsed if…**When asked on whether any factors would have prevented the RDUs from relapsing, the following issues had more than 50 percent of all entries: 'if I had a counselor like friend in real life' (92.7 percent); 'if I had asked for help' (89.4 percent); 'if I had a job' (84.5 percent); 'if I had said no to my friend (70.3 percent); and, 'if had finished my studies' (60.2 percent). ***Self-estrangement/ Powerlessness***
- **Lapse to Relapse.** Around 55 percent of RDUs in sample reported that they lapsed before they relapsed. ***Powerlessness/ Self-estrangement***

- **Search for Help during Lapse Period.** Nearly 80 percent of the 'lapsed' respondents said that they 'didn't' or, 'thought they should but didn't' look for help, even though they had realized that they might be on the verge of relapse. ***Self-estrangement/ Powerlessness/ Meaninglessness***
- **Hampering Factors against Reverting back to Cessation.** Close to 70 percent of the respondents felt that the major hampering factor that led them to not revert back to cessation after lapse period was the thought that 'I will never become addicted.' Around 62 percent of the respondents reasoned: 'I compromised on using only limited dosage of my preferred drug' (61.2 percent). ***Self-estrangement/ Powerlessness***
- **Meditation.** Around half (52.3 percent) of RDUs in sample said that they didn't use meditation after they left the center. Around 20 percent of respondent said they used meditation but not regularly. Around 16 percent said they didn't find meditation necessary. ***Meaninglessness/ Isolation***
- **Ego Management.** Close to 45 percent of RDUs in sample said that they didn't use 'ego management' skills after they left the center. Around 30 percent said they used it but not regularly. ***Meaninglessness/ Isolation***
- **Listening Skills.** Nearly 35 percent of RDUs in sample said that they used the listening skills but not regularly, after they left the center. Around 30 percent said they didn't use it. ***Meaninglessness/ Isolation***
- **Sharing.** Close to 45 percent of RDUs in sample said that they didn't use 'sharing' skills. Close to 30 percent said they used it but not regularly. ***Meaninglessness/ Isolation***
- **Anger Management.** Around 35 percent of RDUs in sample said that they didn't use anger management skills. Similarly, nearly 35 percent said they used it but not regularly. ***Meaninglessness/ Isolation***
- **Reshaping Guilt/Shame.** Close to 45 percent in RDUs in sample said that they didn't use 'reshaping guilt/shame' skills after they left the center. Around 27 percent said they used it but not regularly. ***Meaninglessness/ Isolation***

- **Time Management.** Close to half of RDUs in sample said that they didn't use time management skills after they left the center. Around 32 percent said they used it but not regularly. **Meaninglessness/ Isolation**
- **Speaking Skills.** Nearly 35 percent of RDUs in sample said that they didn't use speaking skills after they left the center. Around 30 percent said they used it but not regularly. ***Meaninglessness/ Isolation***
- **Problem Management.** Around 45 percent of RDUs in sample said that they didn't use problem management skills after they left the center.. Around 31 percent said they used it but not regularly. ***Meaninglessness/ Isolation***
- **Listening to Higher Power (Being).** Around 32 percent of the respondents in sample said that they used the skills of listening to the 'higher power' but not regularly, after they left the center. Close to 32 percent said they didn't listen to the 'higher power.' ***Meaninglessness/ Isolation***
- **Openness with Counselor.** When asked about the level of openness of the respondents towards their counselors, close to 60 percent of RDUs in sample said that they were either 'so-so open,' 'open but sometimes only,' or 'not open with their counselors.' ***Isolation/ Meaninglessness***
- **Important Skills Center should teach to Avoid Future Relapse.** When asked on what RDUs thought were the most important skills the center should teach them to avoid future relapses, around 15 percent of the respondents mentioned skills for change of attitude/behavior as vital. Close to 15 percent said they 'didn't know' or found it hard to respond to this query. ***Self-estrangement/ Normlessness/ Meaninglessness***

Evidences on the Contrary

The study although establishing the fact that alienation was the probable socio-cultural context amongst RDUs, also discovered evidences that showed relationships between RDUs and their close ones as still 'living if not alive.' Further, evidences were also observed on the positive efforts made a majority of the RDUs on ways of bringing about

or getting the most out of their social skills and learnings from the DRC. The study felt the importance of understanding such issues when addressing alienation amongst the RDUs. Following were the findings that shed light this regard.

On Relationship between RDUs and their Close Ones

- **Relatives' level of Support towards Cessation Efforts.** Slightly more than half of RDUs in sample said that their close relatives were supportive of their efforts on quitting drugs. Nearly 20 percent felt that they were 'maybe supportive' and only 8.7 percent said that their relatives 'didn't care' on RDUs' cessation efforts. Of those RDUs who felt that their close relatives do or maybe do support their quitting efforts, close to 60 percent said that their relatives were 'really supportive from the inside.'
- **Support of Family & Close Ones.** Around half of RDUs in sample felt that the support of family and close ones were 'very important' for them, followed by 34 percent who felt such support as 'important.' Only less than 5 percent of the respondents felt that support from parents/close ones as 'not so important' in their lives.
- **Relationship with Parents/Spouse during Drug Use.** Close to 35 percent of RDUs in sample felt that their relationships with their parents/spouse were 'good' during drug use. Around 30 percent felt their relationships were 'okay,' and 23.5 percent felt their relationships as 'not good.' Only less than 10 percent of respondents felt that their relationships with their parents/spouse were 'very bad' during drug use.
- **Relationship with Parents/Spouse during Relapse.** Close to 62 percent of RDUs in sample felt that their relationships with their parents/spouse were 'okay' or 'good' when they relapsed.
- **Support of Parents/Spouse on RDU's efforts of Cessation.** Nearly two thirds of RDUs felt that their parents/spouse were very supportive of their efforts on stopping drug use. Around 20 percent of RDUs felt the level of support as 'so-so', and less than 5 percent felt that their parents/spouse were 'not supportive' on their efforts of cessation.

- **HIV Disclosure.** Nearly half of those respondents who tested HIV positive had disclosed their status to their families, followed by 21.4 percent who said they were thinking of disclosing their status in the future.
- **Communication of Parents/Spouse during Cessation.** Around half of RDUs in sample felt that their parents/spouse talked 'normally' when they stopped using drugs. Nearly 45 percent of RDUs felt that their parents/spouse talked 'very openly' during cessation period.
- **Relationship with Parents/Spouse during Cessation.** Close to 35 percent of RDUs in sample reported that their relationship with their parents/spouse were 'good' when they stopped using drugs. Closely, 31.4 percent of RDUs felt the relationship as 'excellent.'
- **General Impression of Father.** When asked on the general impression of their fathers, close to 40 percent of the respondents stated that their fathers were 'loving but also strict.' Similarly 37.3 percent stated that their fathers were 'understanding.' Around 15 percent said that they didn't get along or didn't talk with their fathers.
- **General Impression of Mother.** An overwhelming portion of respondents (66.4 percent) felt that their mothers were 'loving.' Half of the respondents also felt that their mothers were 'understanding.' More than 15 percent felt that their mothers were 'loving but also strict.'
- **General Impression of Spouse.** Almost all married RDUs in sample felt that their spouses were 'loving' or 'understanding.' Around 11 percent felt that their spouses were 'loving but also strict.' Only around 5 percent felt that their spouses were 'average spouses' or that they 'didn't get along.'
- **Closest Family Members.** Around half of RDUs in sample regarded their 'mother' as the closest family member, followed by their 'brothers' (17.1 percent), and 'sisters' (17.0 percent). Only 2 percent of RDUs said that no one in the family was closest to them.
- **Family Situation.** A majority of RDUs in sample (71.2 percent) regarded their family as 'normal' (i.e. they were not brought up by a single parent or by their nearest relatives, had abusive family, or had parents who had separated or divorced).

- **Major 'Self' Reasons for Cessation.** When asked on major 'self' reasons that led the RDUs to stop using drugs, the following reasons had more than 35 percent of entries: 'insightful and genuine realization that drugs are destructive' (51.0 percent); 'fear of losing health or life' (49.7 percent); 'I hit rock bottom' (49.0 percent); and, 'became disgusted by my own confused functioning' (49.0 percent).
- **Major 'Family' Reasons for Cessation.** When asked on major reasons concerning 'family' that led the RDUs to stop using drugs, the following responses had more than 35 percent of all entries: 'genuine support from my family' (62.2 percent); 'developed a renewed sense of life' (48.6 percent); 'fear of losing a spouse and family' (42.6 percent); 'I didn't want to steal or do shameful actions to maintain my habit' (39.9 percent); and, 'I was no longer in control of the situation' (37.2 percent).
- **Major 'Socio-Cultural' Reasons for Cessation.** When asked on 'major' 'socio-cultural' reasons concerning reasons that led the RDUs to stop using drugs, the following reason came into light: 'direct pressure from parents or spouse' (56.5 percent);
- **'Not True' Relapse Reasons.** Following were the outstanding reasons (having more than 35 percent of the total entries) as being untrue concerning RDUs' family and close surroundings: 'because of family crises (such as parents separating or a sibling developing problem, death, separation, etc.)' (68.0 percent); 'I did whatever my parents told me to do, & that didn't help my recovery' (61.4 percent); 'treatment programs did not provide enough skills on how to defend myself & how to satisfy my inner needs & wishes' (60.8 percent); ''experiences of rejection from family & friends' (52.9 percent); 'no body cared on whether I was drug free or not' (48.4 percent); 'I could not get any jobs' (43.8 percent); and, 'my families did not change their attitude & behavior, they were same as when I was using drugs' (42.5 percent).
- **Relation with In-laws.** Of those whose siblings were married, a majority of RDUs (58.3 percent) in sample reported that their relationship with the in-laws were 'okay,' and close to 30 percent reported that their relationship with the in-laws were 'very good.' Only around 10 percent of the respondents reported that their relationship was 'not good.'

On RDUs' Efforts

- **Learnings from the DRC.** Close to 70 percent of RDUs in sample felt that the learnings they had received from the DRC was 'very important' for them. This was followed by 23.5 percent who felt that the learnings were 'important' for them. Only less than 2 percent felt that learnings from the DRC were 'not important at all' or 'not so important' for them.
- **Higher Education.** Close to 80 percent of RDUs in sample felt that higher education (studying more than current educational attainment) was 'very important' or 'important' for them. This was followed by 11.1 percent who felt that higher education was 'maybe important.' Only 8.5 percent felt that higher education was 'not so important' for them.
- **Spirituality.** Nearly 40 percent of RDUs in sample felt that spirituality was 'important' for them. This was followed by 25.5 percent who felt that spirituality was 'very important' for them. Only around 10 percent felt that spirituality was 'not so important' or 'not important at all' for them.
- **Efforts in Dealing with Craving for Drugs**. The study tried to understand whether RDUs put any efforts to overcome the craving of drugs after they left the DRC. Following were the responses on what the RDUs did when they felt the craving: 'I tried to think of positive thoughts' (64.1 percent); 'watched movie' (63.4 percent); 'listened to music' (54.2 percent); and, 'talked with family members' (50.3 percent). Similarly, 43.8 percent said they 'blocked thoughts as much as possible' and 35.3 percent said they had 'no specific action.' Close to 35 percent of respondents said they 'just went on with life' and 19.6 percent said they 'couldn't do anything.'
- **Respecting Others.** Close to 45 percent of RDUs in sample said that they used the skills of respecting others after they left the center. Around 35 percent said they used it but not regularly.
- **Time Spent with Counselor.** Close to 75 percent of respondents said that the time spent with their counselor was 'very helpful' or 'helpful.'
- **Major 'Family' Reasons for Cessation.** When asked on 'major' reasons concerning 'family' that led the RDUs to stop using drugs, the following reasons came into light: 'genuine support from my family' (62.2 percent); 'developed a renewed sense of life'

(48.6 percent); ‘fear of losing a spouse and family’ (42.6 percent); ‘I didn't want to steal or do shameful actions to maintain my habit’ (39.9 percent); ‘I was no longer in control of the situation’ (37.2 percent); ‘rebirth of positive relationship with parents/loved ones’ (32.4 percent); and, ‘pressure from family and close circles’ (28.4 percent).

- **Major ‘Socio-Cultural’ Reasons for Cessation.** The most significant ‘major socio-cultural reason’ that led the married and single RDUs to stop using drugs was: ‘direct pressure from parents or spouse’ (52.1 percent for married RDUs, and 51.3 percent for single RDUs).

Initial Conclusion

The study with careful use of qualitative and quantitative facts was able to conclude that alienation indeed was the probable socio-cultural context of RDUs in sample. However, analyzing the evidences on relationships of RDUs with their close ones, and their current perceptions on recovery and life, the study also found out that for a majority of RDUs, their social environment had not reached a point where everything was in shatters. Evidences pointed out that the relationship of the majority of RDUs with their families and close ones was still not on the brink of a failure. Considering this and the efforts of RDUs on their recovery and building up of their social capital, the study concludes that alienation even as being the probable socio-cultural context of RDUs in sample, wasn’t present in its severest form amongst the RDUs in sample.

Chapter VII. Social Environment of Different RDU Types

This section of the findings investigated the social environment of RDUs by their marital status and of RDUs living with HIV/AIDS (RDUWHAs). The investigation on RDUs by marital status isolated selective findings to understand the possible differences on the social environment of married and single RDUs. This comparative exercise is by no means exhaustive, and does not exploit advanced statistical tools; rather, the exercise is meant to provide a synopsis on the possible differences of social environment between married and single RDUs.

The investigation on the social environment of RDUWHAs sought to gain understanding on the complexities and challenges faced by IDUWHAs, when they relapsed and when they eventually stopped using drugs. Further, the study, upon selecting the cases, did its best to include RDUWHAs from different backgrounds, so as to present varied lives and issues. Informal interviews, and ethnographic observations were used to derive the data for the case studies.

Social Environment of RDUs by Marital Status

There were 60.1 percent (n=92) of 'single' RDUs, and 39.9 percent (n=61) of once married RDUs (including those living with their life partners for some time) in the sample. Following were the findings:

Selective Findings on Clause 1: The actual living conditions

- A majority of RDUs in both subsets regarded their family as middle class. Around 11 percent of married RDUs and 6.2 percent of single RDUs regarded their family as either lower or lower-middle class. Further, nearly two thirds of married RDUs in sample were once employed, whereas only 37 percent of single RDUs in sample were once employed (Annex G.110).

- A majority of RDUs in both subsets didn't know of their HIV status or were HIV negative. Close to 12 percent of married RDUs and 8 percent of single RDUs were HIV positive (Annex G.111).
- A majority of married and single RDUs (41 to 45 percent) regarded their relationship with relatives as 'so-so,' and nearly 80 percent said that their close relatives knew of their drug use. Close to half of the married RDUs and 36 percent of single RDUs also mentioned that there were lots of gossiping/rumor amongst their close relatives regarding their drug use. Close to two thirds of RDUs in both the subsets said that their close relatives 'were or may be were' supportive of their efforts on quitting drugs, and that around 63 percent felt said that their relatives were 'really supportive from the inside' (Annex G.112).
- Around 55 percent of married RDUs and single RDUs regarded their 'mother' as the closest family member. This was followed by 'wife' for 34.4 percent of the married RDUs, and 'brother' for 20.7 percent of the single RDUs (Annex G.113).
- An overwhelming number of RDUs in both the subsets stated that deviant activities were present in their neighborhood. The type of deviant activities seemed mostly similar for both the subsets, except that the neighborhood of single RDUs seemed to have a higher number of drug users (73.8 percent) compared to that of the married RDUs (45.9 percent) (Annex G.114).
- Around 60 to 65 percent of both married and single RDUs in sample felt that they were not aware of what was happening in their neighborhood (Annex G.114).

Drug use Background

- Around 43 percent of married RDUs and 35 percent of single RDUs in sample reported that they 'never shared' needles during their drug career. Around 49 percent of married RDUs and 63 percent of single RDUs stated that they 'sometimes' or 'very rarely' shared needles (Annex G.115).
- Around 56 percent of married RDUs and 41 percent of single RDUs had traveled to the 'border areas' (areas or towns bordering with India) to buy drugs. Around 8 percent of married RDUs and 25 percent of single RDUs said that they 'very rarely' traveled to the border areas to buy drugs (Annex G.116).

- Around 44 to 48 percent of married and single RDUs had sold drugs in their career to support their habit (Annex G.116).
- Around two thirds of married and single RDUs stated that financially, they were 'sometimes loaded and sometimes broke.' Both of the subsets used similar mechanisms to come up with the money, however, the single RDUs seemed to have used these mechanisms more than the married RDUs: 'asking close family' (62 percent married and 83 percent single); 'by lying' (55.7 percent married and 86 percent single); and, 'by stealing' (52.3 percent married and 90 percent single). Further, 60 percent of single RDUs threatened close family to come up with the money whereas only a quarter of married RDUs resorted to this technique (Annex G.116).
- Around 36 percent of both married and single RDUs reported that they knew only limited dealers (Annex G.116).
- Close to 55 percent of both married and single RDUs admitted that they had hit or used forced on family members or close ones (Annex G.116).

Selective Findings on Clause 2: The norms, values and attitudes of RDUs

- Around 60 percent of married RDUs and 84 percent of single RDUs in sample felt that higher education (studying more than current educational attainment) was either 'important' or 'very important' for them (Annex G.117).
- Around 85 percent of married RDUs and 78 percent of single RDUs felt that the issue of independence was 'important' or 'very important' for them (Annex G.117).
- Around 82 to 87 percent of married and single RDUs felt that the support of family and close ones were 'very important' or 'important' for them (Annex G.117).
- Around 90 percent of married and single RDUs felt that learnings from the DRC were 'very important' or 'important' for them (Annex G.117).
- Around 67 percent of married RDUs and 61 percent of single RDUs felt that friends were 'important' or 'very important' part of their lives (Annex G.117).
- Around 72 percent of married RDUs and 61 percent of single RDUs felt that spirituality was 'important' or 'very important' for them (Annex G.117).

- Around 54 to 57 percent of married RDUs and single RDUs felt that it was 'very important' or 'important' that, in order for them to stay clean, their user circle also had to be clean (Annex G.117).
- Around 75 to 78 percent of married and single RDUs in sample felt that the educational level of parents (or the fact that their parents were more educated) was 'important' or 'very important' for them (Annex G.117).
- Around 62 to 67 percent of single and married RDUs felt that their relationships with their parents/spouse were 'good' or 'okay' during drug use, and around 67 percent of married RDUs and 57 percent of single RDUs felt that their relationships with their parents/spouse were 'good' or 'okay' when they relapsed. Close to 30 percent of married RDUs and 38 percent of single RDUs termed their relationship as 'not good' or 'very bad' (Annex G.118).
- Nearly 67 percent of married RDUs and 80 percent of single RDUs felt that their parents/spouse were very supportive of their efforts on stopping drug use. Close to 35 percent of married RDUs and 29 percent of single RDUs in sample reported that their relationship with their parents/spouse were 'excellent.' Around 59 to 65 percent of married and single RDUs mentioned that relationships were 'good' or 'okay' (Annex G.118).

Cessation Information

- Around 30 to 40 percent of married and single RDUs had 3 to 5 cessation attempts in their drug career. This was followed by 26 percent of married and single RDUs who had 6 to 10 cessation attempts (Annex G.119).
- Apart from enrolling in a DRC, nearly 55 to 59 percent of single and married RDUs had tried the 'self' cold turkey approach for more than 24 hours. Around 36 percent of married and single RDUs had tried doctor's medications (including detoxification in a medical setting) and stayed clean for more than 24 hours (Annex G.120).
- The reasons of 'self' reasons, 'family,' and 'friends' had more than 95 percent of scores for both married and single RDUs, and the reasons for 'availability' scored lowest amongst both married and single RDUs as reasons behind their cessation of drug use (Annex G.121).

Relapse History of RDUs (note: the study only accounts relapses following DRC discharge)

- The clean date for first and second time married and single RDUs were similar in nature, and a staggering 85 to 88 percent of them couldn't celebrate their sobriety birthday prior to their first and second relapse. For third time RDUs, 13 percent of married RDUs relapsed more than the single RDUs after 6 to 10 days, and around 84 percent of married RDUs and 73 percent of single RDUs couldn't celebrate their sobriety birthday, prior to their third relapse. For fourth time RDUs, a quarter of single RDUs relapsed more than married RDUs after 6 to 10 days. Around 75 percent of married RDUs and 89 percent of single RDUs couldn't celebrate their sobriety birthday prior to their fourth relapse. For fifth time RDUs, around 20 percent of fifth time married RDUs couldn't remain clean for more than 6 to 10 days, and none of the single RDUs relapse in this period. Around 90 percent of married RDUs and 50 percent of single RDUs couldn't celebrate their sobriety birthday prior to their fourth relapse (Annex G.122).
- The study had worrying findings that a majority of both married and single RDUs used drugs for a period around 1 to 2 years after almost all relapses. Again, there was no clear trend to suggest that increase in DRC enrolment meant decrease in drug use thereafter for both the subsets (Annex G. 123).
- The decision by RDUs themselves to enroll in a DRC after successive relapses increased slightly for first to third time married and single RDUs, and saw an increase and decrease on self decision for fourth to fifth time married RDUs. Similarly, the decision to enroll by themselves increased significantly for fifth time single RDUs (Annex G.124).
- More married first time RDUs (56 percent) didn't finish their treatment at the DRC compared to the 39 percent of single first time RDUs. Around 50 to 55 percent of second time RDUs (both married and single) didn't finish their treatment following second relapse. Around 40 percent of both married and single third time RDUs didn't finish their treatment after third relapse. More fourth time married RDUs (50 percent) didn't finish their treatment compared to 22 percent of fourth time single RDUs.

Similarly, more married RDUs (60 percent) on their fifth DRC enrolment didn't finish their treatment compared to single fifth time RDUs (17 percent) (Annex G.125).

- Referring to the reasons that were 'very true' to their relapses, a majority from both the subsets mentioned: compromise with self for irregular use; craving; and lack of participation in N.A. gatherings (for single RDUs only) (Annex G. 126).
- A majority from both the subsets referred to the following factors as not being true to their relapses: selling drugs to make money but not using; being HIV positive; family crisis; obeying family's directions; incompetent DRC; coercion by family and police to enter rehab; rejection from family and friends; temptation to use during important festivals (for single RDUs only), and unemployment (for single RDUs only) (Annex G.127)

Common Reasons behind Multiple Relapses

- Close to 70 percent of married RDUs and 57 percent of single RDUs felt that they were commonalities in their multiple relapses. Around 12 to 18 percent of married and single RDUs said that there 'maybe' were commonalities in their multiple relapses. Around 54 and 46 percent of the married and single RDUs referred to 'psychological situations,' 51 and 54 percent to 'friends,' and 45 to 54 percent to 'family situations' as reasons for multiple relapses (Annex G.128). Further, around 70 percent of married RDUs and 55 percent of single RDUs referred to 'other' issues (sex, pleasure seeking, and attractive 'trip' being the major reasons) as their common issues behind multiple relapses (Annex G.129).

Efforts in Dealing with Craving for Drugs

- Close to 50 percent of RDUs from both the subsets said they tried to think of positive thoughts as an effort in dealing with craving for drugs. This was the only response that stood out as significant amongst the married RDUs. Following were the other significant responses of the single RDUs on their efforts on dealing with craving: 'I tried to think of positive thoughts' (66.3 percent); 'watched movie' (65.2 percent); 'listened to music' (58.7 percent); and, 'talked with family members' (46.7 percent);

and, 'blocked thoughts as much as possible' (46.7 percent). Further, 33 percent of married RDUs and 29 percent of single RDUs said that they had 'no specific action' in dealing with craving for drugs (Annex G.130).

Factors of Relapse besides Craving

- Around 65 to 67 percent of married and single RDUs felt 'overconfidence-thought I could control myself,' and, 'friends' as factors besides craving that invited relapse in their lives. A significant proportion of married RDUs (around 61 percent) also referred to 'availability of drugs' in their neighborhood, and a significant proportion of single RDUs (72 percent) also alluded to 'lack of ability to make good decisions' as factors besides craving that invited relapse in their lives (Annex G.131).

Factors that could have prevented Relapse

- Around 90 to 95 percent of married and single RDUs felt that family support, social issues and, 'reacting differently to one important incidence ' could have prevented them from relapsing (Annex G.133). The significant issues within these factors for both the subsets were as follows: 'if I had asked for help' (around 90 percent of both RDUs); 'if I had a job' (80 to 86 percent of married and single RDUs); 'if I had broken contacts with my user friends/circle' (around 75 percent of married and single RDUs); 'if I had said no to my friends (62 to 76 percent of married and single RDUs); 'if I had finished my studies' (around 57 to 66 percent of single and married RDUs); and 'if I had not left the house' (around 45 to 49 percent of married and single RDUs) (Annex G.133).

Lapse to Relapse

- Around 61 percent of single RDUs and 47 percent of married RDUs reported that they lapsed before they relapsed. Around 35 percent of the married and single RDUs lapsed for 1 to 2 months, followed by 22 percent of married RDUs and 16 percent of single RDUs for 3 to 4 months (Annex G.134).
- Around 41 to 48 percent of married and single RDUs didn't look for help even realizing that they might be on the verge of relapse. Around 28 percent of married RDUs and 16 percent of single RDUs said they sought help (Annex G.135).
- Around 64 to 69 percent of single and married RDUs felt the thought 'I will never become addicted' as the major hampering factor that led them to not revert back to

cessation. Around 66 percent of single RDUs and 46 percent of married RDUs said: 'I compromised on using only limited dosage of my preferred drug,' and 52 percent of single RDUs and 34 percent of married RDUs said 'I compromised on only using soft drugs from now on' as the major hampering factor (Annex G.135).

On DRC

- A majority of married and single RDUs didn't use skills learned at the center following their discharges, and very few used the skills in an irregular fashion. The highest skills used regularly by the RDUs was that of 'respecting others' (47 and 39 percent of married and single RDUs), and 'personal hygiene' (42 and 38 percent of married and single RDUs) (Annex G.136).
- Around 44 to 48 percent of married and single RDUs said that they were 'so-so' open or 'sometimes only' open with their counselors. Around 15 percent of married and single RDUs said that their counselors were 'very understanding,' and around 68 and 76 percent of married and single RDUs said that the time spent with the counselor was 'helpful' or 'very helpful' (Annex G.137).

Clause III. Alienation as the particular Socio-cultural Context

- Based on the above findings, the study concludes that alienation was the particular socio-cultural context for both married and single RDUs. The study could not establish a definite trend to conclude that alienation was severe or lesser in either of the RDUs. Further, the evidences of RDUs' relationships with their families, which the study found out were not a 'failure' for both the subsets, and along with it the high values placed on recovery by both the subsets led the study to further conclude that alienation even being clearly evident wasn't present in its severest form for both married and single RDUs.

Initial Conclusion

Looking at some selective findings on the married and single RDUs, the study found that the social environment of single and married RDUs seemed more or less similar. Following were the findings, which the study deemed considerable (with at least a difference of 10 percent), but not highly significant to conclude differences on the social environment of married and single RDUs:

- There were more married RDUs employed than the single RDUs, and that they were more drug users in the neighborhood of single RDUs than that of the married RDUs. The needle sharing practices were observed slightly more (margin of 14 percent) amongst the single than the married RDUs. Around 15 percent more married RDUs had traveled to the border areas to buy drugs than single RDUs; however for nominal or rare traveling, single RDUs edged out by a difference of 17 percent. Both the subsets used similar mechanisms to come up with the money during their career; however, the single RDUs seemed to have used these mechanisms more. Further, 60 percent of single RDUs threatened close family whereas only a quarter of married RDUs resorted to this technique to come up with the money.
- The beliefs and values as explored by the study were equally important for both married and single RDUs. However, on issues regarding the importance of higher education, the single RDUs edged out married RDUs by a margin of 23 percent, and on spirituality, the married RDUs edged out the single RDUs by a margin of 10 percent. The relationships with parents/spouses during relapse period were slightly more (by a margin of 10 percent) 'good' or 'okay' for married RDUs than with single RDUs. However, parents of single RDUs were slightly more supportive of their cessation efforts than married RDUs (by a margin of 13 percent).
- The decision by RDUs themselves to enroll in a DRC after successive relapses increased and decreased for fourth and fifth time for married RDUs. Similarly, the decision to enroll by themselves increased significantly for fifth time single RDUs.
- The study showed that married RDUs tended not to stay full time at the center compared to the single RDUs. This tendency was especially evident among first, fourth and fifth time married RDUs.

- Referring to the reasons that were ‘very true’ to their relapses, a majority mentioned similar reasons, in addition the single RDUs also mentioned lack of participation in N.A. gatherings as being very true to their relapses.
- A majority of married and single RDUs referred to similar factors as not being true to their relapses, however, the temptation to use drugs during important festivals and unemployment were more significant for single RDUs.
- Slightly more single RDUs lapsed before they relapsed compared to the married RDUs (by a margin of 14 percent). Around 12 percent more of the lapsed married RDUs sought help compared to the single RDUs, realizing that they were on the verge of relapse. On use of drugs during lapse period, 20 percent more RDUs used limited dosage of their preferred drug, and 18 percent more single RDUs used ‘softer’ drugs.
- The single RDUs utilized more efforts in dealing with craving than the married RDUs before they relapsed. Further, a significant proportion of married users referred to availability of drugs in their neighborhood, and a significant proportion of single RDUs alluded to ‘lack of ability to make good decisions’ as major factors besides craving that invited relapse in their lives.
- Reflecting on factors that could have prevented RDUs from relapsing, the responses were similar for both the subsets, however, 14 percent more single RDUs said they might not have relapsed if they had said ‘no’ to their fiends.

The Social Environment of RDUWHAs

The study, understanding the sensitive nature of the query, used the case study methodology to gain perspective on the social environment of four RDUWHAs. Note: names of RDUWHAs have been changed and the names of DRCs are not mentioned to protect their identity

Research Query: How complex or challenging were the lives of RDUWHAs when they relapsed (after knowledge of their positive status) and when they eventually stopped using drugs?

Case1

"I have forgotten about HIV, but then, I am painfully awakened when I hear advertisements with the words HIV/AIDS on the radio"

Name: Bijay
Gender: Male
Age: 27
Original Residence: Dharan
Ethnic/Caste Background: Mongoloid
Date of Case Study: February 26th, 2003
Marital Status: Divorced
Education: Sent up passed
Family: Mother, son, sister in law (father expired, brother abroad)
Family economic class: middle class
Dependent drug: Tidijesick and Phensydel
Drug Dependency Duration: 9 years
Cessation Record: Clean for last 10 months; DRC enrolment 3 times (1 times after knowledge of positive status)
HIV Status identified: 4 years ago (1999)
Reasons for taking the HIV test: "I wanted to stay in a DRC (name withheld), and for that they required the blood test."
Medical Complications: Tuberculosis

Background

Bijay, a native of Dharan, says he has seen and done everything, and knows life and the bad things that one can face. Bijay is a divorcee, and has a five-year-old son. His wife left him because of his drug abuse-related harms. Bijay looks physically thin. He is suffering from tuberculosis. He also has mild flu and coughed often.

Bijay's personality looks that of an enlightened one; somebody who has understood life. He once was full of aggression, but no more he says. He has good relations with his family, especially his mother. Bijay now spends most of his time at a Dharan based rehab center helping other fellow brothers. He also values his close friends who have seen him during the hard times. Bijay loves reading and finding more about the disease; but he has toned down this habit, as he once got a fright with one of the local tabloid reporters reporting false information on the progression of the disease. "You can't trust what you read," says Bijay.

Bijay says he gets scared when minor bouts of diarrhea and flu hit his body. He feels death is ever so near. Bijay is also scared of broils and wounds which are starting to appear on his body. Somebody once told him that AIDS death was painful, full of broils and wounds. Bijay says he is

very sensitive and fears that the virus is going to take him soon. He figures he has 6 more years to live. However, in the midst of contemplating death, Bijay does have a sense of humor left in him. He has the guts to chuckle even after talking of things that scares him the most.

Life after Finding Status Positive

Bijay was at the rehab center in Kathmandu when he found out the result. Bijay mulls over what had led to it: "You know sharing needles was mostly out of carelessness, and the culture was that everybody shared. We had heard of the importance on using new needles, but there was really no awareness and concern on anyone, and the syringes were not easily available also." The test result did hit hard on Bijay; he was filled with fear and paranoia. He did not disclose his status to anybody except few staff at the center. But, Bijay had a company of fellow recovering brothers who were with him at all times and that helped him to take his mind off HIV to some extent. Sometimes he would forget that he even had HIV when in the company of friends. But the fear would grab Bijay during nights as he tried to sleep; the more he thought the more gripping his fears would be.

Bijay went back to Dharan after he finished his treatment. He recalls: "When I left for Dharan, I found myself lost and lonely. I was a solitary kind of man; I wanted to be alone. I didn't have any fellowship. The only like-minded guys that I knew were actively doing drugs. I relapsed immediately after I reached Dharan. Thoughts of disclosure were in my mind, and on what to say to my mother. This made me even more depressed and my drug habits just got worse. I was heavily addicted; I would need it as soon as I would get up. I did shoot with friends a few times but I told them not to use my needles. But I did it mostly alone, I would get upset with other people tripping around me."

Life After Relapse

Looking at his pathetic self, Bijay felt he had enough of the misery. A year after his prior discharge Bijay packed his bags and came back to a different DRC in Kathmandu. It was only then that he disclosed his status to his mother and later to his close relatives. Sobriety was Bijay's main agenda this time around and since has stayed clean for 10 months. While at the center, Bijay learned to face the virus; the psychotic fear began to lessen. He interacted with other IDULWHAs, and gained courage to live life. He also started reading books and tried to clear out the facts and fiction behind HIV. After discharge, Bijay went back to Dharan, but this time, he got involved in helping out and spending time at a local DRC in Dharan.

Bijya leads a struggling life, but he trudges along. He is saddened about the situation with his wife, who left him before because of his drug habit (before he was diagnosed with HIV). "I got married when I was on drugs; nothing worked out and she left me. I kept the child. I just worry about the future of my son," laments Bijay. The relationship with his mother is better though; Bijay shares his thoughts with his mother, who at the beginning found it tough to handle the news. But after discharge, Bijay's mother has accepted him quite nicely; she cares for him.

Bijay is scared of diseases, even if with bouts of diarrhea or flu, paranoia sets in: that it might kill him. Bijay laments on an incidence of a charismatic HIV positive brother at the center, whom they all looked up to: "We had a brother at the center, Suraj (name changed), we always looked highly upon him. He was living his life as cautiously as possible, yet he died. He was like an example for us. Well, if he died then what would be the situation for us, since we are not careful as he was?" Note: The death of Suraj lowered the self esteem of many IDULWHAs living at the center. Bijay further says, "also, whenever advertisements with the words HIV or AIDS in it gets played on the radio, I feel a chill run down my spine."

Bijay's life is also made up of regrets and worries, not so much because of HIV, but because of people still labeling him as a drug addict. He is worried about the future of his son. Sometimes Bijay feels like there is no point living a clean life, he feels its better getting back to drugs and free all tensions. But Bijay struggles on. "I am thinking of helping my family more with the poultry business. I'd like to live my life for my children, at least 5-6 years more."

"I am okay now, say Bijay, "Except I have physical pains and tuberculosis, for which I am taking medicine." "Yes I think a lot, but I seriously don't know what I think, I tend to get lost. I am a 'ekohoro' kind of person. "I don't want my status disclosed to everybody, I am scared of the stereotypes and rumors in the society. The center stresses that I have faith in God, but mostly, I am angry with God because of the helpless situation I am in. I have forgotten about HIV, but then, I am painfully awakened when there are advertisement on FM and Radios.

Conclusion

The initial phase of knowing about his HIV status was difficult for Bijay. However, the paranoia associated with HIV did lessen when he was in company of recovering DUs. The discharge period following DRC enrolment proved fatal for Bijay, as he was without

fellowship of recovering DUs. His association with active DUs coupled with the despair brought about by his HIV status led him to relapse. The life after relapse was a challenging for Bijay. His enrolment at the DRC helped him learn to live with the virus. Although with regrets, fear and setbacks, Bijay mended relationship with his mother, and has set out a meaningful goal of raising and taking care of his son.

Case 2

"I won't tell them my status, until or unless I become really sick"

Name: Prakash
Gender: Male
Age: 30
Original Residence: Kathmandu
Ethnic/Caste Background: Chettri
Date of Case Study: March 3rd, 2003
Marital Status: Single
Education: SLC
Family: Parents, younger brother and his wife
Family economic class: middle class (dad-retired banker; mother-job holder-SLC pass)
Dependent drug(s): Tidijesick, Brown Sugar (pull), Phensydel
Dependency Duration: 15 years
Cessation Record: Clean for last 10 months; DRC enrolment 4 times (2 times after knowledge of positive status)
HIV Status identified: 2 years ago (1999)
Reasons for taking the HIV test: "A guy in my group was found positive, so thought I'd check if I was ok."
Medical complications: Hepatitis C, detected 3 years ago

Background

Prakash is a day care client at a DRC in Kathmandu. Prakash was very articulate and extremely courteous in his answers, however, as the interview went forth and touched on sensitive issues, I saw his eyes moist. As we were talking about his relationship with his parents, the tears started to come out. He tried to hold it in as much as possible, but I guess he had so many things inside that it just came out. He was smoking continuously throughout the interview. I had to stop the interview and calm him down a couple of times.

Prakash is really hurt with the way his parents treats him. "They don't understand me," he says. He is also stuck with the fact that he has the virus and that he has really let his parents down. Prakash says: "I feel ashamed to ask for money, even for bus fare and cigarettes. I just live with

whatever they give. I was born after several miscarriages. I won't tell them my status, until or unless I become really sick. Prakash, after knowing his status attempted suicide one time, gulping down 160 tablets of Nitrosun.

Life after Finding Status Positive

After discharge from the DRC, Prakash was living a clean life for sometime. One day he heard that his friend was diagnosed with the virus. Prkash couldn't sleep that night because of fear. After few days of contemplation, on probabilities of whether he may or may not have the virus, and on whether testing would be the right thing to do, Prakash went for the test. He figured, instead of living with fear and suspicions forever, might as well take the test and get it over it. Prakash communicated this concern with the DRC and went for testing. The result was devastating, fear engulfed him. Prakash lost touch with the center, and went straight back to using drugs; that was the only answer he had to ease his anxiety and fear. Prakash tried to commit suicide by gulping down 160 tablets of Nitrosun tablets, and was in a hospital for 15 days. After getting out of the hospital, Prakash's drug life resumed, to a point where life was simply unmanageable. Prakash shared needles, but he would let others shoot first, and he last.

Life After Relapse

With the constant pressure of the parents, Prakash finally decided to enroll back at the DRC. The center welcomed him back. Prakash tried to forget about the virus during his stay at the center. However, during nights, the thoughts would make him depressed. Many times he would pass nights wide awake. However, time slowly healed him. With support and fellowshipping, Prakash was more accepting to the fact that he has to live the rest of his life with the virus. Prakash is thankful to the center for caring for him during those times.

Prakash has estranged relationship with his parents; he feels that his parents don't give him their time. With tears in his eyes, Prakash said: "They don't understand me. Sometimes they give me pocket money and sometimes they don't, sometimes I have to walk half way and then catch a tempo to come to the center. I just think of this and it makes me feel really bad. I can't ask them for money; and at the same time they won't give me either." During his high school years Prakash's parents decided that he should live with his uncle's family (for 5 years), and from that time onwards Prakash is not fond of his parents. Prakash describes himself as a loner and is extremely saddened that his family still hasn't trusted him. "They still doubt me. I am not consulted in any decisions, but I am bearing it," says Prakash.

Prakash's life is also full of regrets. He is terribly sad that he has added misfortune unto his family. "Even though I don't have good relations with my family, I don't want to make them feel bad anymore. I am depressed that all of this happened because of me. My dad is a (intestinal) cancer patient. I think I will not disclose them my status until I get terribly sick. They sometimes tell me to get married; or sometimes tell me to check blood, but I just decline. What can I tell them? I don't put demands or ask anything more than what they have given me. My brother, if he likes to eat eggs, he eats eggs, but me, I think, why spare more expenses of my family and don't eat. Even though I am the eldest, I am still treated as a junior and my brother as the senior, taking care of the house."

Prakash is also looking for a job, to take his mind off things, and earn some money as well.

I met Prakash after a gap of one year at the same DRC I first interviewed him. He seemed completely different from what I found when I first interviewed him. He has learned to live with the virus! Along with some DRC staff, we sat down for a cup of tea. Prakash was talking with everybody in a jolly fashion, mentioning his work chores-developing posters, and distributing HIV related newsletters (he is working with a PLWHA support group). With a pinch of humor he talks on the rights of PLWHAS, and says that some guys were floating the idea of 'euthanasia' as a rights issue! The others in the room comment that its just a lot of hogwash. The argument goes back and forth, all with a sense of humor!

Conclusion

Prakash went for his testing with fear, which engulfed him even severely him after his test came out positive. Prakash went straight back to drug use; the only way he knew to handling a crisis. Prakash tried to commit suicide but survived only to see himself getting more on drugs. His eventual enrolment to the DRC helped him gain some composure. Prakash's life is full of bitterness and regrets, on his estranged relationship with his family and on how he could not fulfill his responsibilities as a son. Prakash feels that it would be too damaging to reveal his status to his family, and says he would only do so if he became seriously ill.

A later encounter with Prakash showed that he was more open and in a more healthier state of mind. This leads to a strong assumption that the initial stages of finding about the virus was more severe for Prakash and that fellowshipping with like-minded people and time healed him out of his difficulties and made him learn to live with the virus.

Case 3

"Even though my family is now close to me, I fell very awkward. How can I act normal? Do I talk with them as if nothing had happened?"

Name: Asim
Gender: Male
Age: 26
Original Residence: Lalitpur
Ethnic/Caste Background: Chettri
Date of Case Study: August 16th, 2002
Education: Studying B.E. (engineering) 3rd year from Bangalore/dropped in '97
Family: Parents, younger sister (married)
Family Economic Class: Middle class
Dependent drug(s): Tidijesick and Phensydel
Drug Dependency Duration: 9 years
Cessation Record: Clean for last 4 months; DRC enrolment 8 times (1 time after knowledge of positive status)
HIV Status identified: 2 years ago (2000)
Reasons for taking the HIV test: "I talked with friends who tested positive; they suggested I should test as we did drugs together."

Background

Asim is a shy guy, and hesitates when speaking. He seemed clearly distressed and uncomfortable talking about his HIV status. Asim has been in the center for the past four months, prior to that, he had been in and out of treatment for 8 times. Asim was an intelligent student in his school days and was about to finish bachelors in engineering from Bangalore as drug dependency got the best of him. Asim has a spark of hope in his life as his fellow mates are running around with the PLWHA support group initiatives. He inquires on whether ARV treatment will be made available in Nepal in the near future.

Life after Finding Status Positive

"I was in the DRC when I found out the result," says Asim, who had a close friend in the same rehab that tested positive. Asim used to share needles with him, and upon his friend's advice Asim opted for his checkup, knowing full well that he might have contracted the virus. The result came out positive, however, with some pre and post counseling, he was able to hear out the result in one piece. It did not hit him, right there and them. "I felt numb and nervous, but that was it," said Asim. However, life started getting more complex as days went by, especially after his discharge from the center. Asim lived a life of denial for some time; he was contemplating on going for a second test. Asim came regularly for day care treatment for about a week or so,

however, the HIV in him and 'what ifs' stamped more prominence on his thoughts: "Am I going to die soon? I shouldn't have used his needles, my friend didn't look like he had HIV, thoughts of disclosure? No way, I don't have guts to tell them." These thoughts engulfed Asim, and drove him helpless and lonely. Right at that moment, Asim met some of his user friends. One thing led to another, and as Asim puts it, his miserable state of mind just won over his already fibble sobriety decision.

Life After Relapse

Asim relapsed right back to regular use of drugs, however, this time things were different. There was immense guilt and self-pity. Drugs became more of a solace agent-a patting on his back: "I was on trip all the time, and that made me forget that I had the disease, or at least that was the intention. I was too scared to sit down and think sanely on that matter" says Asim. But then, the cycle of addiction began and Asim continually used drugs, for two years. The patting on the back was no more; he had once again become a slave to drugs. During this episode, Asim was careful not to share needles with others. Around the end of his two year drug use, Asim finally managed to disclose his status to his parents, and says that the disclosure episode went easily than expected. His parents looked rational than emotional. However, Asim is certain that his parents felt really bad about the news, but they didn't want to show it in front of him. After a few days following this incidence, Asim, heeding to the pressures of his family, enrolled to a rehab.

Asim was a very good student from the beginning, and that his relationship with his parents had mostly been good. Asim is also aware that many things were expected of him. After disclosure, Asim's relationship with his parents has been good; the disease hasn't brought rejection in his family. The only thing, the family didn't do was talk openly with him on family issues. "But that is normal in our family" says Asim, "and I have always been a passive member." The family is not acting up either, trying to put a cheery face. "My parents aren't very expressive," says Asim, "but I know that there is lots of sadness inside. Even though my family is now close to me, I fell very awkward. How can I act normal? Do I talk with them as if nothing has happened? Do I talk of family issues, of which I had no interest from the very beginning?" But still, Asim has immense respect for his family, and is deeply distraught of the fact the he was the one who invited these calamities in the family.

Asim calls himself a sensitive person, and admits that he becomes highly depressed sometimes. "I still haven't got the guts to have a 'face to face' talk with myself," says Asim. Asim regrets a lot. He couldn't finish his studies. He also regrets the fact that he can never have sex, get

married and have children. Asim desperately hopes that ARV therapy starts in Nepal. "It feels bad," says Asim, "but my hope raises as I hear of medicines slowly coming to Nepal." Asim feels safer in the rehab, with the guys with similar problems and issues, and feels that he is not yet strong enough to face life and its problems.

Conclusion

Asim lived a life of denial for some time after he tested positive. His associations with his user friends led him to back to drug use, which fueled heavily with hard questions regarding his HIV status. Asim's family has been close with him following his status disclosure, however, Asim finds it hard to comprehend a normal relationship with them. Asim regrets the fact that he couldn't finish his studies, that he has let his family down, and that he couldn't have sex, get married and have children. He also realizes the fact that he still needs to gain composure and learn to live with the virus.

Case 4

"Pasang, just clinged on his mother a day before he died"

Name: Pasang (name has been changed to protect interviewee's identity)
Gender: Male
Age: 25
Original Residence: Kathmandu
Ethnic/Caste Background: Mongoloid
Date of Case Study: 18th May, 2001
Marital Status: Single
Education: Grade 9 passed
Family: Mother (four brothers and three sisters living abroad, father expired)
Family economic class: lower middle class/no income/sisters send money periodically from abroad/mother used to run a restaurant before.
Dependent drug(s): Tidijesick, Brown Sugar (pull), alcohol
Dependency Duration: 15 years
Cessation Record: Clean for last 10 months; DRC enrolment 2 times (1 time after knowledge of positive status)
HIV Status identified: 4 years ago (1997)
Reasons for taking the HIV test: I fell ill, the hospital wanted to check my blood
Medical complications: Cryptococcal meningitis (detected in October 2000) – taking life time precursor medicines

Background

Pasang is a soft spoken, thinker in type of a person. He opened up with me very easily; he has respect for people graduating from my school, and says that they are mischievous but also smart! Pasang is a no nonsense guy. Working with a PLWHA support group, Pasang is well informed on the local and global initiatives on HIV/AIDS and on the progress of HIV research. Pasang completely understood the intent of my studies and was open and genuine with his answers. There was an air of coolness in him. And I respect him, for his frankness.

Pasang is blessed to have a wonderful mother who understands him very well. Although not educated, Pasang's mother is also aware of the disease, the 'dos' and 'don'ts', and is always besides Pasang whenever he needs her. Pasang was recently diagnosed with 'cryptocoal meningitis' and is taking life long precursor medicines.

The interviews and periodic follow-ups brought us closer; and our talks even diverted around other issues of mutual interest. At the end, we became good friends. Pasang's health deteriorated severely after August 2002. He passed away in October 2002.

Life after Finding Status Positive

Pasang thought he would overdose if the test came positive, but with good counseling from the DRC, that did not happen. Pasang always thought he was at risk as one of his close had died and another had tested HIV positive. During 'sickness' they used to share needles; they couldn't afford to buy needles. Although Pasang was terrified of the result, the stay at the DRC helped him deal with the initial wave of fear and anxiety. He went on to disclose his status to his mother, who accepted him with open arms; her son was more important than the disease. After discharge from the center, life became overwhelming for Pasang. The family, consisting of him and his mother, went through a series of economic crisis. Pasang couldn't find work, and frustrations started to mount. The idle time led him to associating with his remaining user friends. "It was too tempting," says Pasang, "they were using in front of me." Pasang said he decided to use drugs for one last time, however, was soon readdicted. Pasang feels that craving rather than other issues played a major part in his relapse. Pasang's health deteriorated as his drug usage went from irregular to regular. One day Pasang was terribly ill, and had to be admitted to a hospital. One more sad news, Pasang had 'Cryptococcal meningitis' and had to take lifetime precursor medicines. After few days of rest following his hospital discharge, Pasang, with the consent from his mother, enrolled in a DRC, and remained clean ever since.

Life After Relapse

Pasang is really saddened by the fact that his life ended up this way due to his own carelessness. Pasang's family is struggling financially. His mother can't even afford money for his medications. A generous DRC manager took care of his medical expenses, 2,000 rupees per month. Pasang is extremely thankful that his mother is taking good care of him. "One time I cut myself when cutting vegetables, my mother calmly tells me to wash the blood," says Pasang, "she is not frightened or scared!" Besides, Pasang has also found a local PLWHA support group, where he diligently renders his services. Pasang's life is now occupied, and he gives whatever money he earns to his mother. The support group, whose members are all HIV positive have given him much support and courage. Pasang's relationship with his relatives is normal, as he hasn't disclosed his status to them. He plans on not to.

Pasang's life is however that of struggle and frustrations: "The craving is still there, but still I go on with one day at a time. Even though things are okay, negative feelings come in especially at night, they come in suddenly, not like I am meditating on it, sometimes I can't sleep- my thoughts just takes me to places, and I keep on thinking. Sometimes my mind is completely blocked, and I can't think of anything. Death is always like a shadow, and I feel it. I feel like I'll die soon…I can't have any children. Sometimes it takes one to two weeks to recover mentally, I think it about it so much that it goes away. I feel bad about mistakes I made, not HIV, but the misdeeds. I regret a lot when I see my other friends doing good," says Pasang. Pasang does feel that he lost out on lots of things that could have given him access to the highly valued goals of the society, but now, whatever he has, he wants to give it for the benefit of the society.

Pasang has found solace in the PLWHA support he is working on, and his relationship with his mother has grown closer.

The Final Stage

Below is an ethnographical account on the last stages of Pasang's life as witnessed by the researcher

August 27th 2002

I went to visit Pasang at his house following his discharge from the hospital. Pasang was sleeping and his mother was there. Pasang is without hair! Did he shave his head? I forgot to ask. I had brought some sterile gauges and pads for him. Pasang looks a lot fresher but has lot

weight. His face is more recognizable, but the blackness is not gone. The broils are still there, but much better than when he was at the hospital. Pasang's mom was happy to see me; she offered me a cola.

Pasang woke up after a while, and had a faint smile on his face. He says he is feeling much better except he can't stand and walk-he feels dizzy. However, his close friend (as told by Pasang's mother) visits Pasang often, and carries him to the patio to let him have some fresh air. Pasang's friend is really special. He has no hesitation carrying Pasang; Pasang's mother also says he massages Pasang's body. Its important for the blood to flow-she heard her say. What a friend to have!

Pasang also told me that Pramod Karki (name changed) was admitted at the hospital the day he was discharged. However, his stay at the hospital was very 'low key'. Pramod is a known figure in the 'HIV/AIDS circle' and that Pasang's mom was not happy with the way Pramod's mother was not allowing anybody to visit him at the hospital. She says: "At least the family members and 'chinaeko manche' (family friends) should visit; what's wrong with these people visiting Pramod?" Again, this shows the importance of connectivity for Pasang's family. They do have a strong networking and a feeling of togetherness with their own people or with people they call 'afno or chineko manche.'

I sat with them for around half an hour; all three of us were equally chatting. I put in some jokes once in a while. Pasang is visiting the hospital this Thursday, hope it'll be more encouraging, and hope he can keep on cheating death.

October, 2002

With my engagement in a DRC, I had, for a month and so stopped visiting Pasang. But I did think of him often, on how he was doing. A day ago (Saturday), I called up Prem (a hospital staff) to inquire if Pasang had visited the hospital for his checkups. Prem was also concerned, as Pasang hadn't come. Pasang's doctor (a foreigner) was also asking Prem on his whereabouts. So the next day, we decided to visit Pasang at his place We bought a bottle of Horlicks outside his home (we also thought of 'what if… but didn't think that would be the case). We entered Pasang's place, which was lit with numerous butter lamps. I had a weird feeling. Pasang's bed was empty. Pasang's mother took us to the other room, also filled with butter lamps and pictures of Buddha. We knew, Pasang was gone. Pasang's mother cried a bit and told us that Pasang died on Friday. Both of us were at awe; the thought of 'what if' came true.

Pasang's mother quickly gained composure and told us about the last days of Pasang: Pasang's health turned bad after a week or so he was discharged from the hospital. Pasang then insisted that he'd be taken to Teku hospital. He was saying-they cured me one time, they'll also cure me this time. Pasang's mother, with her daughter and son in law, took him there. He was admitted there for couple of days. But the doctor told Pasang's mother that it would be best for Pasang to be taken since the disease of other patients in the ward might infect him (his 'T count' were probably rock bottom). So, Pasang was discharged. The rest of the days were agonizing for Pasang. His chest pain and cough were excruciating. He would stop eating. Sometimes he would act weird and yell that he needed 'Smack' or 'Marijuana'! Pasang's mother, seeing the state of his son, went to see a Buddhist spiritual guide for suggestions. The guide told her that Pasang was possessed with 'Nepali deuta' (Nepali god) and hence the delusion.

A few days before his death everybody knew that Pasang's time had come. His health was getting worse. Pasang, couldn't speak. He wanted to say things to his mother. He was given a paper to write, but his writing was out of line. He wanted to eat his favorite food one time, but that was not available, as it was off-season. Pasang, just clinged on his mother a day before he died. He didn't want to let go of his mother. But she had to, Pasang's mother says, to go buy food and do the daily chores. It was desperate; he was choking, couldn't speak, and was literally dying. On the night of his death, a person from the 'guthi' was called upon to watch Pasang. It was around 2:00 am in the morning. Pasang was breathing hard. At the time Pasang's mother had gone to watch Pasang's undergarments downstairs, Pasang died. When she came up, the guthi person was sleeping. She looked at Pasang, and she knew that he was gone. She woke the person up and saying "Pasang is gone!" The person did not believe and causally looked at Pasang and said he was just sleeping!

Pasang's mother, really has the guts to say all this to us. A bold person, indeed. That morning, the Lamas were fetched. They told Pasang's mother, that the coming days were not so good; they suggested that Pasang be cremated the very day. Pasang was taken to Teku and was cremated.

According to Pasang's mother, nobody in Pasang's work circle was notified or aware of his death. Friends of Pasang from the PLWHA support group had visited him few weeks earlier, and had promised to come back with help, but didn't come.

Conclusion

Pasang was in good hands of the DRC when he tested HIV positive. His earlier thoughts of overdosing (if tested positive) went away with good counseling and support he received from the center. Life after the center however, was frustrating for Pasang. With no job and lots of free time, Pasang soon started associating with his user friends and began using drugs. After the diagnosis of cryptococcal meningitis, Pasang went back to the DRC and started his recovering life. The life after relapse was hard for Pasang yet he managed to stay clean till the very end. Thoughts of regrets and frustration engulfed him all the time, yet he found solace in the PLWHA support group he was involved in. Pasang's mother, his only immediate family, was always there besides him, caring and supporting him all times. Pasang died with only his mother beside him, caring till the last moment. The news remained unknown to his friends from the support group for some time; they were not with him when he died.

CHAPTER VIII. VIEWS FROM SERVICE PROVIDERS

This section includes findings on opinions and experiences of service providers concerning drug use, the lives of DUs, and services they provided.

Focus Group Meeting of Service Providers (SPs)

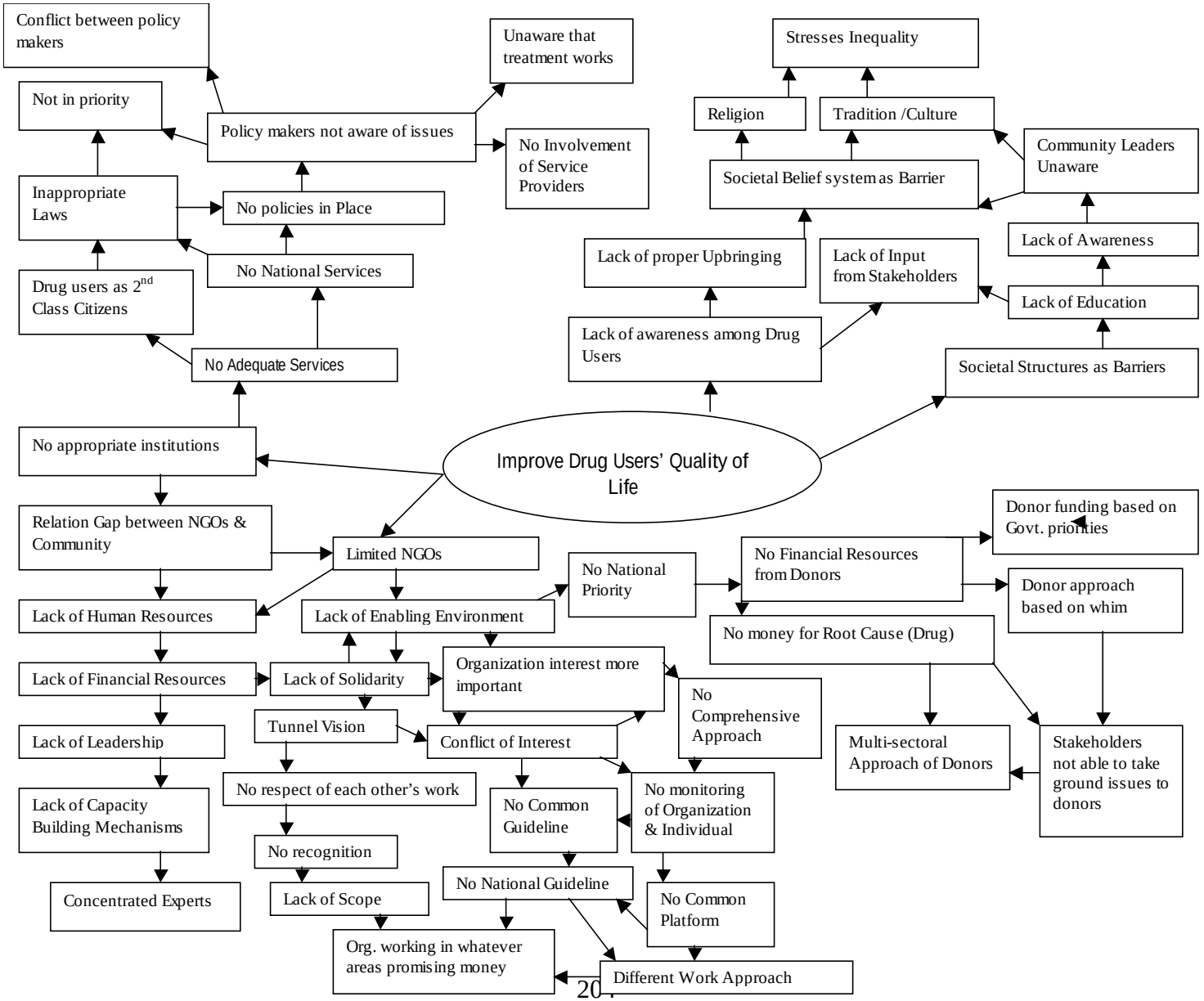
Under the aegis of RN, the researcher had an opportunity to sit with various SPs working with DUs in Kathmandu, to discuss on problems or issues that needed to be addressed for improving the quality of life of DUs in Nepal. The researcher used the 'objective tree' (a planning tool) for more coherent responses from the SPs. The exercise, which was attended by 10 SPs from 9 organizations, was very informative and comprehensive.

The exercise yielded its findings with four subsets of issues that were related to the main theme: ways of improving the quality of life of DUs in Nepal. The subsets were as follows: enhancement of national services; breaking down of negative social barriers; enabling environment for SPs; and coordination/collaboration with the donor communities. From these subsets, participants used series of thinking tools to logically uncover issues and sub issues. Figure 8.1 clearly lays out a picture on issues identified by the participants.

Narcotic Anonymous (NA) in Nepal

NA is an anonymous self-help group; its meetings are held only among recovering and active DUs. However, there are some open meetings in which, non-users can also attend. NA is a non-profit voluntary organization, which is starting out to be an effective tool for DUs in Nepal. Being an exclusive gathering of DUs, NA is able to provide a closely connected platform for people with similar issues to come together for fellowshipping. NA, as the study found out, is filling the void for recovering users discharged from various DRCs to share their problems and to encourage each other with their life of

Figure 8.1. Factors behind Improving the Quality of Life of DUs



recovery. The study found out that a majority of DRCs realized the opportunities and potential NA in Nepal could offer to their clients and encourage their clients to attend NA meetings.

NA started 15 years ago in Nepal as an offshoot of the Alcoholic Anonymous (AA) initiatives. Although NA meetings started from 1996, NA Nepal was officially registered with the parent organization, World Service Office (WSO) in 1998. All NA efforts in Nepal are voluntary. The initial years saw lack of continuity in NA operations, however, with in the last 5 years, it has been gaining grounds and more DUs are now aware of NA operating in Kathmandu and in other urban areas of Nepal. According to the NA volunteers, there are at least 150 users and recovering users regularly attending NA meetings in Kathmandu.

NA formation is based on a chain of structures of various groups and sub-groups. The NA meeting groups, which are attended by users and recovering users are also referred as 'home groups.' Several structures are needed for the formation of home groups. There needs to be at least 2 persons to form a group. The group must follow the tradition and the 12 steps and traditions of NA (see annex H for details on the 12 steps and traditions). Three service people are needed: a secretary, treasurer, and a group service representative (GSR). Their selection is based on group consent. The home groups raise money by themselves for tea, or rent and don't look for any outside contribution.

In Kathmandu valley, there are 8 home groups presently operating. Pokhara has 5 home groups, Dharan (including Damak, Jhapa) has 8 home groups, Chitwan has 4 home groups, and Butwal (including Hetauda) has 4 home groups. There is no bar on the frequency of meetings of the home groups. In Kathmandu, a majority of the home groups meet about twice a week.

The home group is governed by the Area Service Committee (ASC), which essentially looks after all home groups in a given area. There could be several home groups in one area. Presently, there are ASCs in Kathmandu, Chitwan, Dharan, Pokhara, and Butwal.

The Region Service Committee (RSC) looks over the ASC in a given area. In Nepal, there is only one RSC, which looks after all NA activities inside Nepal. In India, there are two RSCs presently operating. The RSCs are looked after by the parent group, World Service Office (WSO), which supports all the RSCs in the world by providing necessary print materials and literatures on NA.

The ASC members of Kathmandu are committed to their work with NA. Their belief on NA motivates them to spend considerable time with NA activities in Nepal. According to them, the benefits they have experienced being in NA make them more committed to this voluntary and worthwhile cause. They are not worried about the fact that they don't earn money from their services; "it has helped us stay clean, and we want to communicate this message of NA to others," they say.

The meeting attendees of NA come mostly through word of mouth. Many DRCs have also started encouraging their clients to attend NA meetings. DRCs using the TC concept are already using many of the NA principles in their center, therefore learnings of the NA ways are not difficult for the new joiners from such DRCs.

NA looks at relapse as a process, not an event. Relapse as the ASCs explain has two phases, first the mental relapse, where the users decide they will use drugs, and then the physical relapse, where the users actually use drugs. The NA treats addiction as an incurable disease that the sole reason for relapse among DUs lies with the self. NA helps people to unlock this truth, and lead them toward recovery. The ASCs say: "NA is more about leading a life of recovery, than quitting drugs.

There are very scant female DUs attending NA meetings. The ASC members think the home groups have yet to put up an encouraging environment for female DUs to join NA. The ASC also admit that getting female DUs to come to the meetings is tough. According to them, many female DUs find it hard to comprehend the usefulness of meetings, and as many female DUs are also supporting their family, they find it hard to

find time for meetings. The ASC further adds: “The life of female DUs is more severe compared to males. Many married users have drug user husbands, and they think meetings might expose them. Then there are those who are living the ‘life on the fast lane’. They earn lots of money from drugs and sex, and as long as they are earning money and living the high life, they don’t find meetings such as NA that important.”

The ASC members also admit to the fact that the NA approach maybe ‘foreign’ for many DUs in Nepal. In a society, where self realization is more overwhelmed by societal facts and group culture, DUs at the beginning may have difficulties understanding the concept of self realization. The ASC members also find the spiritual dimension of NA as something hard to comprehend initially for the young DUs. Many would think of it as a religious act or a ritual. However, as the ASC members have found out, the more DUs attend meetings, the more they are enlightened, and more conscious of their ‘self.’

Over this research period, the study encountered allegations from some quarters that attendees in NA meetings were using drugs in the premises, a place for users to meet and plan for their drug activities. However, the ASC members categorically deny this allegation and claim that they have not come across any home groups using drugs in their premises. “We welcome drug users however we don’t allow drugs to be used in the premises,” they say. An overwhelming majority of DRCs have also treat such allegations as untrue and are encouraging their clients to attend NA meetings after they are discharged.

Richmond Fellowship Nepal: The Female DRC

Following is a synopsis on the works and challenges of the only functional DRC currently providing services for female DUs in Nepal.

Introduction. In 1996, RFN started with a drop-in and counseling center for the male DUs. The increasing number of clients approaching the center demonstrated a clear need for effective treatment and rehabilitation program in Nepal. From June 2000, RFN

further extended its services to female DUs also. This extension began through the findings of a participatory research program of the Women Research Project, which amongst others pointed out the need for a female DRC. The Women Research Project was maintained as a Female Crisis and Care Center from June 2002.

RFN-Women (W) likes to identify itself as more of a crisis center than a full fledged DRC. For the last 3 years, the center in its own words admits of not being able to include the 'entire components' associated with a DRC. The primary hurdle was seen as that of limited human resources. However, RFN-W has been progressing from its initial phases, when only classes on behavioral change, and counseling for female drug users (FDUs) were provided. The center is now striving towards a DRC, with the inclusion of the TC concept, 12 steps of NA, in-house detoxification and residential rehabilitation for no less than 3 months. The center also provides outreach services for street based FDUs, family counseling, day care, and income generation, skills development programs for its clients.

RFN-W was initially funded by a British donor agency, the Department for International Development (DFID). Last year the British Embassy funded the center. This period is over, and the center is planning on approaching them again for more funding. Currently, the center has two donors, and their funds are spent on HIV care, rehabilitation, outreach activities, schooling, non-formal education, skills development for the children of the target population-especially those at high risk.

RFN-W is housed in an area of around one ropani of land. The center lacks enough space. The only building in the premises is small, and houses a dormitory, offices, and a meeting room. The outdoor space is also not big enough for games and outdoor activities.

The intake last year at the center was 45. The center can accommodate up to 10 clients, however, in average the center has 5 clients in every 3 month shifts. The clients at the center mostly come from deprived socio economic background; however, clients with

sound economic background and clients from Nepali speaking areas of India have also entered the program. RFN-W has a fee system for its services which is Rs. 7,000 for the first month, and Rs. 6,000 for the 2nd and 3rd month. The extra expenses on the first month are for acupuncture services. However, very limited FDUs were able to pay the center this year, and received treatment for free of cost.

RFN-W has a total of 10 staff and three consultants in the center. Of the 10 staff, three are outreach workers, one program coordinator, one assistant program coordinator, one administrator and finance, one night warden, two peer educators, and one caretaker for clients with medical consequences. All three outreach workers and two peer educators are ex-users. The consultants are utilized for the purposes of meditation, counseling and fellowship meetings. RFN-W provides provident fund, *Dassain* allowances, and leaves in addition to monthly salaries.

The program coordinators at RFN-W are certified social workers. There are one woman and two male counselors at the center, and all three have received short term counseling trainings.

The main focus of RFN-W now is to produce 'role models.' The enrollment of FDUs wanting to get into rehab is very minimal in Nepal. The center wants to show the FDU community that they can recover. The center realizes the importance of recovering FDUs to stand up and show others the way. The center has made a goal to have at least 3 role models per year.

Admission. FDUs admitted at RFN-W till now has mostly been through its outreach activities, however there have been few cases where FDUs directly contact the center. The center has very low intake rate, as FDUs wanting to enroll for treatment was very minimal. The center conducts a careful screening on client's background before they are admitted. The center hasn't barred anybody from admission based on their past relapse records or for any social-family background.

Program. RFN-W uses an eight-day acupuncture treatment for detoxification. An acupuncture specialist from the Freedom Centre comes to administer acupuncture (the center doesn't have trained staff). After 9 to 10 days the clients are ready to participate in the daily program of the center.

The center uses TC concept and the 12 steps of NA for rehabilitating FDUs. The clients are engaged with various rehabilitation activities including yoga, work therapy, input classes, and skills development. Counseling is provided twice in a week, plus, when needed. There is only one female counselor in the center; the other two counselors are male. There is no forced disclosure of HIV at the center. For referrals, the center uses the services of Youth Vision VCT.

RFN-W provides skills ranging from doll making, candle making, gardening, and sewing of children's clothes for its clients. The center also sell their products like candles and so far, the marketing is reportedly doing well. The center feels that income and skills programs are very important for FDUs, as they are more eager to come, when they know that center provide skills that can help them earn money after they leave. The center feels that skills development programs is an appropriate solution to the ever important query for FDUs: 'what after recovery?'

Discharge. RFN-W currently has very few discharges, simply because the clients don't have any place to go to, and no alternative skills to earn money. The center is certain that if they were to be discharged they would surely relapse. The center is not full on its intake capacity, thus giving space for the clients to live is not a problem. The center wants to make sure that the clients return to a better environment than previous, if that is not the case, then clients are not given their discharge.

Follow-up. RFN-W follows-up on all its clients. The center also follows up on the social environment of their clients. The center also encourages FDUs to participate in day care program. The center also keeps in touch with family, if needed the center asks the family to come for family meeting and counseling. The center investigates on clients who lose contact and are also in contact with at least 5 recovering FDUs.

The center in its experience has found that the families of FDUs with deprived socio-economic background find it hard to understand the program of the center. Some families try to understand and some simply don't care at all. Many according to the center find it hard to understand the need for programs like 'day care'. The families need the FDUs to stay home to look after kids, or to cook food. The center has faced families who lament that their problems were direr than their wife's or daughter's need to continue the program.

The families of FDUs coming from sound economic background also think that their daughters should detach from the program after three months. The center has experienced contact after discharge for such FDUs as very nominal. The center asks families to send their daughter for day care, but the response of most families is not very positive. The center hears familiar lines such as "*keti manchae- ghar mai bashnu parcha, bahira gaera bigruo, abha tyaha (rehab) gai rahanu pardaina"*(you are women, you have to stay in the house, your reputation was tarnished because you went out, and you don't need to go the rehab any more). Some parents also have the belief that if their daughter is doing okay then going to the center is not important. Overall the center thinks that on the surface level, the families are okay, but their attitudes on most of the cases have not been supportive or 'drug specific' supportive for the clients. These attitudes, as the center believes can be attributed to the social stigma attached with the family and the FDUs.

The center admits that there is a great lacking of fellowshipping amongst FDUs after discharge. Further, the center also admits that although NA meetings could prove very helpful, it's hard for the women to join NA groups after discharge as almost all groups are exclusively males. NA meetings are uncomfortable for the women when groups discuss on issues that are culturally 'sensitive' for women. However, the center, which has in-house NA meetings, is encouraging women to join NA fellowships. The center is also in touch a with NA volunteer, who also acknowledge the problem of low participation of FDUs in NA.

Other Programs. RFN-W provides outreach services to around 350 FDUs per year. Around 40 to 45 of the outreached FDUs establish further contact with the center for rehabilitation treatment. The center also conducts periodic school awareness programs in both male and female schools.

The center has had HIV related deaths in the center and is very aware of crisis related with HIV/AIDS. The center is currently providing ARVs to one of its clients, with whatever funds they have. The center has also enlisted the client in the roster for government ARV treatment plan. So far, the center has had no positive response.

Networking. RFN-W has good networking with other DRCs in KTM. It has working relationships with the FC, and RFN-M who provides them with manpower, and information. These centers help RFN-W with issues like locating doctors, taking FDUs to hospitals, administering acupuncture, etc.

The center is also referred by various social service organizations, should they come in contact with FDUs. The center has also given its phone numbers to couple of 'hotlines' (telephone help line services for various crises) operating in the city.

Exceptional Issues regarding FDUs. The center is facing overwhelming challenges working with FDUs, perhaps twice as hard then working with male DUs. RFN-W in its experience has felt that when FDUs come in the center they don't come alone; they come with their family problems, and issues, which are often very dire. Most often, their husbands are drug users, they have children, and they have no work or skills, or a sense of empowerment. When working with FDUs, the center feels that there is a need to essentially address these issues; recovery in essence was dependent on these issues. Majority of intakes that come to the center are found to be wanting to leave in a couple of days because of their overwhelming responsibilities at home. They worry about who is going to take of their family, children, and their education, etc. Some have children who are at the age of breastfeeding.

Experts referred by this study admit that FDUs coming for rehabilitation in Nepal is very few compared to the males. The clients at RFN-W are mostly those whom the center had known for the past couple of years. New clients compared to older clients were less in the center. The center in its experience has found several reasons to this problem. Even as some are willing, experts believe that the lack of role models (those who have finished treatment, and recovering and are doing nicely in society) have made FDUs unawares on the support and effectiveness of DRC. Further, the center also feels that some FDUs look for an 'easy way out' – they hear or know that if enrolled, they have to work, clean, and go by the center's rules, for which they are not ready to give up.

The center also feels that the concept of 'rehabilitation' have not really sunk in yet among FDUs in Nepal; those who come don't come ready at all. Also, when working with women with dire socio-economic background, the concepts of recognizing self and many other components of the program are completely foreign to the FDUs. Further, the center has also experienced the issue of 'center dependency' among the families of some FDUs; they want all the responsibilities of recovery to be taken by the center and shy away from their responsibilities. Even for day care clients, they want the center to give them money for cigarettes, transportation, etc. The center has even found families that can afford with such attitudes. They want the center to do everything for them, job, money, etc.

The center is receiving no support from any government agencies. There has been no evaluation or visits from any of the government agencies. The center however has received a draft version of a government drug policy, and had been had asked to 'look into it' for comments. The center however questions the exercise: why didn't they ask representatives from the FDU communities to be in the committee that made the policy in the first place. The center points out that there is no female participation or inclusion in any of the policy related undertakings on drug use in Nepal.

The center also has had shaky relationship with law enforcement agencies. The FDUs themselves also have harrowing stories to tell. The outreach workers also report similar stories, that the police do not understand that they are working with the DRC; they fear the police.

General Impression. It is clear that RFN-W is lagging behind, compared to their male counterparts in providing rehabilitation services to FDUs; however, they have just reasons. First, the center is fairly new in providing services to FDUs; male centers have been around for long time and comparisons can't be made. The center sees itself as in the same position as the male DRCs 20 years ago. The center admits that they still have a lot to learn and a lot to do.

Secondly, RFN-W is currently functioning on a very tight budget. Their primary concern is that of sustainability. The center admits to the fact that a majority of their efforts are now spent on looking for funds. The center hasn't had any exclusive external support for fund raising.

RFN-W is indeed working in a frontier territory. Of the two DRCs for FDUs, RFN-W is the only one carrying rehabilitation activities amongst FDUs (the other DRC reportedly has had no clients in its they for some time). In addition, the center with its minimum funds is not able to recruit more human resources to extend its services. Working with FDUs is very challenging. As felt by the center, the women of Nepal carry many social obligations; recovery of FDUs depends on adequately addressing such obligations. The center needs more than what it has if it wants to make a real impact on this overwhelming challenge.

Recovering Nepal

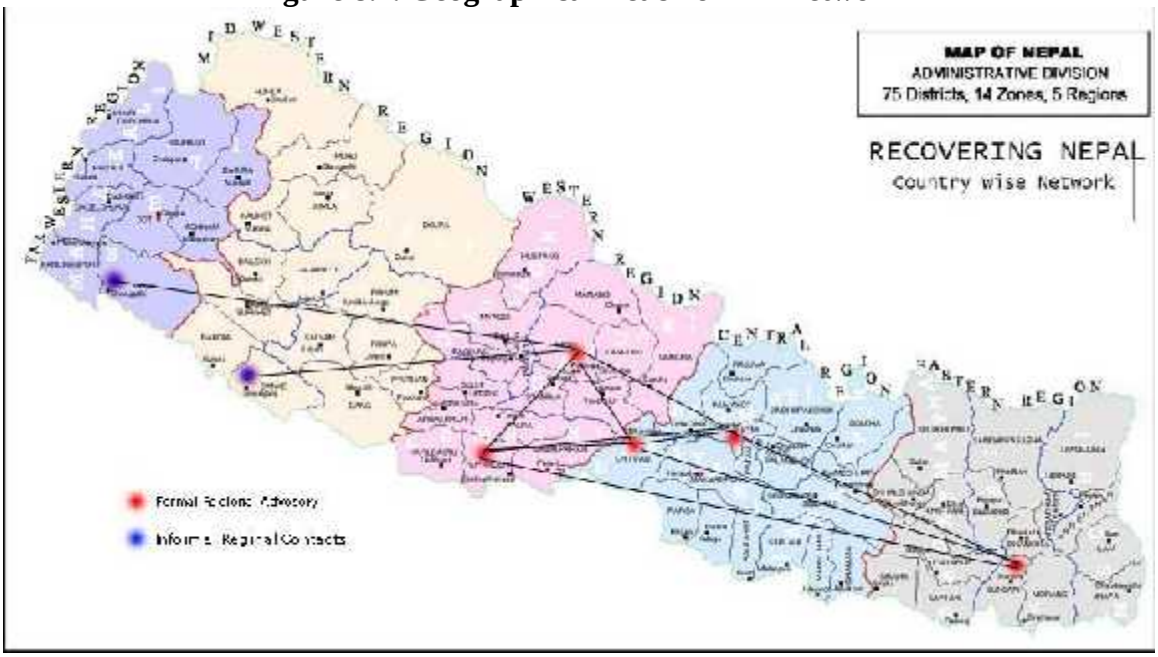
Recovering Nepal (RN) is a network of recovering DUs, which aims to influence the policies for improving the quality of lives of DUs, reinstate their rights and create a supportive environment for recovering users and service providers.

Since its establishment, RN has reached out to various support groups, and from its social observation, RN estimates of 3,000 recovering DUs in Nepal. Most of the ex-users and some active current IDUs are straightforwardly or indirectly involved in RN's network and with its help, recovering users are raising their voices to address the stigma discrimination against DUs, policy change and affordable and comprehensive treatment care for the DUs and PLHIV. To this effect, RN successfully organized a first ever national level workshop on drug abuse and drug led HIV. The workshop was able to bring together various stakeholders, ranging from the Ministry of Home affairs, support groups, and recovering users from different regions of Nepal on a single platform for vibrant discussions on various issues of drug abuse and drug led HIV.

RN has established seven regional advisory groups in all five developmental regions of Nepal (Figure 8.2). The advisory members are involved in advocacy and dialogues within their respective region. All of these advisory members are representatives of DRCs; support groups and NGO's working with or for DUs and PLWHAs in Nepal. RN has actively and meaningfully participated in various advocacy forums, including participation in government and donor-led policy bodies. RN has already demonstrated its capabilities with the successful execution of the following activities: the first national conference on drug abuse and drug led HIV; press conferences and releases; community meetings; interaction with community leaders; formation of joint committee in the regions; media workshops; and advocacy dialogue with the government and policy makers.

RN feels that the preventive programs in Nepal have not been that effective and also feels that there is no support for the drug treatment programs. It further feels that the overall program related to drug use and HIV/AIDS lacks of adequate information, effective advocacy, political commitment, adequate policy and program, and sustainable program planning.

Figure 8.2. Geographical Reach of RN Network



**5 formal regional advisory groups; *2 informal regional advisory groups*

RN (2005) issued a joint statement (position paper) from the recovering DUs' movement on March 13, 2004 and June 27, 2005, which focused on the current status of major stakeholders in the following way:

> ***Community:*** Does not have adequate information about drug users and are unable to define a role for themselves to support DUs. Not compassionate enough towards harm reduction programs, and high stigma and discrimination in the community.
> ***Target Groups:*** Does not have access to right information, continuum of care; DUs have no decision-making power and involvement in developing, designing and implementing programs/ policies.

Government: Unclear policy and guidelines, lack of commitment and priority to address IDU issues. Poor coordination and lack of mutual understanding between line ministries resulting in contradictory programs and policies.

Law: Lack of appropriate law to protect the rights of the IDUs, safeguard their access to equal quality health services, lack of job opportunities has restricted development and implementation of effective programs for IDUs. Interpretations of laws dealing with drug addicts have been used to criminalize drug addiction and drug addicts.

Policy Maker: Unaware of the in-depth problem and seriousness of drug addiction and its socio economic effects in the country. Lack of appropriate capacities at the policy and national program planning and implementation level to address drug and HIV related issues. Government lacks strategies to address the root cause of the problem and management of its effects.

Service provider: Untrained government service providers at all health facility level to serve the IDUs. Inadequate resources to run effective programs for IDUs. Service providers not fully oriented/trained on the rights-based approach

Donor: Lack of long term funding and technical support to develop continuum of care modality.

CHAPTER VIV. SUMMARY, MAJOR FINDINGS & RECOMMENDATIONS

Summary

The primary purpose of this study was to elucidate the social environment of RDUs who in one point of their drug career were enrolled in a DRC. The study, prescribing to Cockerham's paradigm of social environment and with theoretical reinforcements of phenomenology, symbolic interaction, and alienation, looked at the three components that comprised the social environment of RDUs: their actual living conditions; their norms, values and attitudes; and alienation, as their probable socio-cultural context. The study also looked at the social environment of RDUs according to their marital status and further investigated the social environment of RUDWHAs. The study selected 6 DRCs of Kathmandu for locating samples for the study and utilized questionnaires, ethnographic case studies, and interviews as its principle tools to derive the data.

The study found the social environment of RDUs as characterized by high degree of incarceration, risky behavior, discontinuity of education and employment, long and intensive drug career, easy access to drugs, high degree of prolonged association with user friends, early resumption of drug use following discharge from rehabilitation centers, long duration of drug use following relapse, and high level of regrets and self pity (among RDUs living with HIV/AIDS). Findings also showed no clear indications on the differences of social environment between married and single RDUs. Further, alienation, even as being clearly evident, wasn't present in its severest form amongst the RDUs. The study also found intact relationships for a majority of RDUs with their families, and high regards from RDUs on their recovery and on their family and social obligations.

Findings also showed that an overwhelming majority of RDUs didn't stay drug free for more than 7 to 8 months following their discharge from the DRCs. The study also found out that a majority of RDUs didn't internalize the recovery skills stressed during their

stay at the DRCs. Discharge from DRC and their routine and controlled environment was followed by a reversal of lifestyle and eventually relapse for a majority of RDUs. Even with programs such as 'day care,' the study still observed a genuine gap on the lack of continuity for recovery-based lifestyle following discharge of DUs from DRCs.

The study also showed that a majority of RDUs used drugs for a period of around 1 year after each relapse. Coupling this with about half a year of time spent in rehabilitation and some 'day care' involvement, the RDUs had significant time spent on the cycle of rehabilitation and relapse (adding to roughly 1.5 years). Also, the years doubled to 3 years for DUs with 2 cycles of relapse and treatment. In addition to the loss of such a significant time, more relapse also translated to diminishing relationships with close ones, lack of trust and more exposure to life threatening diseases.

The study, with all its findings surrounding the phenomena of relapse came to the conclusion that the revival of craving stood as a major factor, which for its compulsive and/or enticing attributes lead DUs to resume their drug career. However, craving itself was not the only factor. Various socio-cultural situations and antecedents, specific events, weaker defensive mechanisms of RDUs, their intensive drug use career, and gaps within intervention efforts (that of the DRC) seemed to have initialized, catalyzed or compounded the craving urge and thus creating a compulsion to use drugs. These findings and indications point to the fact that understanding the phenomena of relapse, and understanding the social environment of RDUs are crucial issues to be addressed by those working to improve the quality of lives of DUs in Nepal.

Major Findings

Below are the major findings of the study.

i) On Actual Living Conditions

A majority of RDUs experienced deviance early on in their adolescence. Many hadn't finished their SLCs, had changed schools, and half had received serious disciplinary actions in their school life. Also, the use of tobacco products and other 'gate way drugs'

started as early as between 10 to 14 years of age for many RDUs. The study sensed a possible connection between RDUs' earlier involvement in deviant activities and their 'use to abuse' of drugs, and ultimately their fragile resolve for abstinence. The RDUs themselves made the connection between their antecedents and relapse. Closed to two thirds referred to 'education' ('if had finished my studies' topping the responses), and 'economic issues' ('if I had a job' topping the responses) as factors that could have prevented them from relapsing. Further, lack of direction or purpose was also evident amongst RDUs; there seemed to be no starting point or enough career or educational capital to bank on as RDUs came out of the DRC. Most have had discontinued their education, or had no long term employment experiences. Due to these reasons, the study realized a gradual growth of pessimism and frustration as recovering users start living the life outside the DRC.

Around 93 percent of once married RDUs (60 percent of total sample) and once employed RDUs (52 percent of total sample) used drugs prior to their marriage, and during employment. Marriage and employment, often regarded as milestones in anyone's life didn't help RDUs' cessation efforts. The widely held belief that marriage and employment could help 'change' or aid in sustaining cessation efforts of DUs proved to be a fallacy. Further, the study also met DUs who related their relapse to their decision to begin work or finish education as soon as they were discharged from the DRC.

The drug career of RDUs were very intense, volatile and prone to maximum risks including exposure to life threatening diseases, overdose episodes, incarceration, use of unsafe or illegal means for securing drugs, regrettable events/actions and deterioration of relationships with close ones. The following findings on RDUs and their user circle explicitly back up these implications: 1) on characteristics of RDUs' drug use: more than half with 'very rarely' or 'sometimes' needle sharing background; willing to travel to the border towns, willing to sell drugs; financially unstable; willing to steal; half with incidences of hitting or using force on close ones; many with drug career marred with regrettable incidences, and, 2) on RDUs' user circle: significant number of members with

possible HIV positive background; willing to travel to the border towns to buy drugs; willing to sell drugs; willing to steal; financially unstable; almost half with experiences of overdose related deaths; significant police arrests; and a majority of members with relapse episodes following DRC enrolment.

ii) Norms, Values and Attitudes (Clause 2)

Only 20 percent of lapsed DUs sought help thinking they were on the verge of relapse. Further, only a quarter of RDUs contacted the DRC for help when the compulsion to use drugs became evident in their lives. Also, a majority of DUs said that 'if they had asked for help' from their family members, or had a 'counselor like friend' in real life they probably wouldn't have relapsed. RDUs, as the study found out, didn't share their precarious situation, ask for help or have no understanding person to confide their problems with when their abstinence stood on a knife's edge. This phenomenon highlights the need to comprehend the complexities surrounding the inability of RDUs to communicate or share their precarious situation.

Emotional outlet was also a critical factor for the well being of recovering users. Study showed that issues of 'pleasure seeking' and sex were major initiating factors leading DUs (married and single) to compromise their cessation efforts. Abstinence was in jeopardy whenever emotional outlet was needed – the definition of concepts such as 'fun', 'satisfaction', and 'relaxation' was most often overridden with experiences, understanding, and modus operandi of the prior drug use career, its lifestyle. Gathering with user friends, hanging out in high risk environment, using 'off the counter' pharmaceutical substances or drug of choice during sexual intercourse to increase duration, breaking abstinence to enjoy the party atmosphere of religious festivals, and compromise and/or overconfidence (I won't be addicted) over occasional use of marijuana/hashish, alcohol, stimulant pills or even their choice of drug were widely observed amongst the RDUs in the study.

Many RDUs (including those married) felt that association with active drug using friends played a critical role in their relapse. A majority of RDUs regarded friends as important part of their lives and that their sobriety was helpful for their own recovery. RDUs although realized that friends had an important stance on their resolve for abstinence, didn't have any alternatives or contingency mechanisms on dealing with active DU friends. Perhaps, more knowingly than unknowingly, the DUs felt the companionship of DU friends as more important or special than the possibility of resuming drug use because of such an association. The attachment of this kind is best explained by the characterizations of primary groups prescribed by Hassinger and Pinkerton, which the study found out, was explicitly manifested on RDUs' user group. The user groups were indeed the place of socialization; bases of subculture; means of social control; providing social support, mutual aid and channels of communications for RDUS. This attachment, the study reasons made it hard for RDUs to let go of their user circle.

A sizeable proportion of RDUs also felt that discontinuation of fellowship, such as the NA gatherings contributed to their relapse. Such RDUs strongly felt the need of support from like minded people as vital to keep them focused on their recovery. Further, reflecting on relapse and how it could have been prevented, a majority of DUs felt that acting or deciding differently to 'one important incidence' ('if I had said no to my friend' and 'if I had not left the house' topping the responses) could have prevented them from relapsing. In fact many RDUs pitied the fact that one moment of madness or indecision led them back to drug use.

The study also found that relapse was inevitable for those who didn't want to quit in the first place. For such DUs, the need to resume drug use far outweighed the possible fall outs associated with it. Many of such RDUs were those who were not in the DRC on their own will, didn't continue the program, and/or were not 'matured' enough to comprehend the necessity to quit drugs and its lifestyle. So once out of the DRC, such DUs were quickly back using drugs again.

Relationships with family/spouse as typified by a majority of RDUs were surprisingly good and didn't experience a downfall even during drug use or relapse. Further, relationships with families became even stronger during RDUs' cessation period. Again the fallacy that DUs are isolated, uncared for in their own homes, or labeling the entire family structure as a leading cause for DUs' inability to abstain from drugs are discredited by this study. Family was an important player, fulfilling its supportive and constructive role as a primary group (as referred by Cooley), even in dysfunctional homes of collectivistic Nepali societies.

RDUWHAs had two equally important issues in their lives – one of drug dependency and the other of the HIV virus. Further, the case studies showed that psycho-social and spiritual healing was critical for RDUWHAs, as setbacks in these areas could readily lure them back to drug use. Findings also showed that RDUWHAs lived life with extreme paranoia following their diagnosis, which seemed to lessen though as time passed. Further, the intervention of DRCs, especially fellowshipping, pre and post test counseling and other engagements, seemed to lessen the impact of paranoia amongs RDUWHAs. The study also showed that RDUWHAs lived a life of regrets, and self pity; from family responsibilities to having children, IDUWHAs regretted that they couldn't or can't fulfill such roles.

iii) Alienation as probable socio-cultural context (Clause 3)

The study was able to conclude that alienation indeed was the probable socio-cultural context of RDUs in sample. The five forms of alienation as referred by Seeman in his theoretical paradigm of alienation were widely evident amongst the RDUs. However, evidences also pointed out that the relationship of the majority of RDUs with their families and close ones was not on the brink of failure. Considering this and the efforts of RDUs on their recovery and towards building up of their social capital and values, the study came to a final conclusion that alienation even as being the probable socio-cultural context, wasn't present in its severest form amongst the RDUs in sample.

iv) On Relapse and DRC interventions

Looking at the 5 relapses, a staggering two thirds of RDUs couldn't remain clean for: more than 5 to 6 months (first relapse); for more than 3 to 4 months (second relapse); for more than 7 to 8 months (third relapse); for more than 5 to 6 months (fourth relapse); and for more than 9 to 11 months (fifth relapse). Also, there was no clear trend to signify that increase in DRC enrolment meant increase in clean dates following successive DRC discharge. Therefore it is essential for DRCs to look for ways to tackle the first 5 to 8 months of critical post discharge period, as relapse for a majority of recovering DUs seem to take place in this crucial period. This finding also indicates the lack of or ineffective bridging programs between DRC and post DRC life for DUs. Day care in this regard is a crucial intervention program. The study in its observation felt that 'day care' program in most DRCs were somewhat 'loose', unsupervised and without specific program or proper guidance. Further, the study found that many DUs seemed to lose interest in continuing day care-many saying that mere interactions and talking with people became insignificant for them after a while.

Although a majority of RDUs felt counseling sessions as extremely important for their recovery, they also pointed that they were not open with their counselors. RDUs felt that they were not full able to vent or share their inner issues and problems with the counselors. Because of this, one can only speculate that DUs are perhaps leaving the DRCs with some amount of unresolved issues. Proper counseling rendered by DRCs is extremely essential, for a culture of free sharing, quiet time within families and the openness when talking with the elders doesn't usually exist in Nepali culture.

Many RDUs following their regression to drug use didn't return back to the DRC right away. Although many felt about quitting early on in their carrier, they kept on using past their physical dependency. Some might have had failed attempts trying to quit on their own: by not using drugs for as much as they can, or by using the so called 'lighter' drugs such as ganja, hashish, stimulant pills, or alcohol. The actual and final decision for enrolment to a DRC, as realized by the study were dependent on several factors: pressure

from family, shortage of drugs, contemplation and decision on which DRC to go, whether close friends stopping use, etc. There seemed to be a considerable time gap between the thought and the decision to quit by enrolling in a DRC.

Recommendations

Based on the findings, the study makes the following recommendations under two sub-headings.

i. Recommendations for DRCs and other organizations working in the field of drug dependency prevention

- It is very important that sex education be taught at the DRCs as many married and also non-married RDUs pointed out sex as a leading factor for their relapse. Sexual education (at least for the married RDUs) should be more than surfacial and should delve into methods and techniques on how sex could be gratifying (long lasting-in the words of RDUs) without the use of substances. Further, promotion of safer sex skills is also very important, as study showed that many RDUs following their relapse used drugs for a period around one year.
- The study found that a majority of RDUs started using 'gate way' substances between the age of 15 to 19, and a sizable proportion used such substances at the age of 10 to 14. Use of tobacco for a majority of RDUs also started at the age of 10 to 14. Thus, it is imperative that prevention and awareness messages be spread out in schools, targeting earlier age groups of 10 to 14.
- Is three to four months stay enough to 'mold' the understanding, behavior and attitudes of RDUs? Findings show that a majority of RDUs didn't use the skills taught at the center. The logical reason for this would be that either they didn't realize its importance, or that they didn't internalize it even knowing its importance. The latter reason, if is the case, then, perhaps DRCs need to lengthen the stay for DUs so that they internalize the skills to a maximum degree, or DRCs should introduce a bridge program and along with it some form of supervision, so that discharged RDUs

learn to use the skills in a regular basis. One perfect set up would be to continue stressing such skills at the day care programs, and devise an evaluation/assessment scheme to understand on how DUs are putting the skills into practice in their post DRC life.

- In relation to the above point, the study felt the need for some form of 'self discipline model', as many DUs put a complete stop to the disciplinary models learned at the center as soon as they were discharged; the daily routine of RDUs were completely opposite to that they lived at the center. The study feels that some form of self discipline model (non-coerced, agreed by the DU and his family, and monitored) could help DUs to put their life under some form of routine and direction after their discharge from the center.
- Day care is a crucial intervention program since around two-thirds of RDUs relapsed after 5 to 6 months following their discharge from the center. The study feels that day care program in DRCs should be revitalized with concrete programs that aim at working and understanding the issues that are pertinent to the DUs who have started their reintegration process. The study also recommends a designated staff to look into the efficient implementation of day care programs.
- The study found that multiple enrolments in DRCs didn't translate to successive increase of 'clean dates' for RDUs. Thus, the study highly feels the need for a special intervention programs for RDUs, especially for those with more than one relapse episodes.
- A majority of RDUs in the study reported that counseling was an extremely important part of their recovery. However, a majority also reported that they weren't open with their counselors and also, that their counselors weren't very understanding of them. This reality warrants special attention to the dynamics between the counselor and the RDUs, and for the DRCs to reexamine their counseling structure, to introduce mechanisms that could increase efficiency of the counselors. It should also be realized that just a 'former drug user background' alone cannot make any body a counselor. Counselors have to be committed, experienced, trained, and given a manageable ratio of cases to limit overburdening.

- Many respondents said that association with user friends played a major role in their relapse. The study feels the importance for the DRCs to impart practical knowledge on ways DUs could positively distance themselves from their user friends.
- Follow-up of clients after discharge is vital, especially for those who stop coming for day care, or lose contact with the DRC. Besides gaining knowledge on the recovery progress of the clients, follow-ups can help DRCs understand possible threats to client's recovery so that early interventions can be made before clients are on the verge of lapse or even relapse. It is thus absolutely essential that DRC follow up with their clients.
- DRCs should formulate special approach for DUs who show signs of not continuing their stay at the DRC and also for RDUs with previous records of discontinuation. Special attention should be given to married DUs, as study showed that they tended to drop out more than the single RDUs. There is every chance that DUs discontinuing their DRC stay will resume drug use.
- As an overwhelming number of RDUs reported deviant activities and availability of drugs in their neighborhood, the study feels the need for like minded DRCs to team up with each other to help organize local communities, and law enforcement for discouraging such activities in areas with large concentration of their clients.
- Skills development trainings were stressed as an essential support the RDUs wanted from the DRCs. Although some DRCs have initiated their efforts in this regard, many have found them to be an overwhelming task to sustain over time (in terms of finance and manpower). It is thus recommended that interested DRCs team up with each other for a joint skills development program. It is further recommended that DRCs make a joint proposal to donor organizations and approach interested institutions providing technical/skills development trainings. A set up of a single committee could then look into the functioning of such programs for all DRCs. This could significantly take the load off of DRCs who are trying hard in their solo efforts of running skills development programs.

- The provision of family counseling services at DRCs is vital, so that the process of mending relationships have begun before RDUs are discharged. As shown by the study, RDUs in a Nepali context are not usually open to their close ones in the family. Most often they don't talk to their fathers openly and most of the time communications are channeled through RDUs' mothers. Thus, it is imperative that communication skills and relationships between RDUs and their family members are improved.
- It is vital that DRCs pay extreme attention to IDUWHAs following their discharge from the center, and that discharge could only be useful if they have received useful support and counseling and have learned to live with the disease. Further, referrals to PLWHA support group could also be beneficial as support mechanisms and fellowships helped IDUWHAs face life with courage and dignity.
- DRCs in Nepal are the major players working in the forefront with DUs and IDUWHAs, and have immense knowledge on the existing drug scenario of Nepal. Thus, its very important that DRCs are included in any decision making bodies formed to make policies and strategies on drug abuse prevention and drug led HIV issues. Further, it will be a fruitful contribution if national, governmental and international agencies invest their capacities in enhancing the service delivery of DRCs (e.g. capacity building of DRC staff, access for DUs who can't afford treatment).

ii. Directions for Further Research

- A comprehensive study on the social environment of DUs who are not living with their families, and/or have extremely poor economic background, could yield vital information on understanding the lives of DUs with lesser social and economic support (sometimes labeled as 'street based users').
- A comprehensive study on the social environment of female drug users could yield valuable information in an area, which has extremely limited research bearings.

- A comprehensive socio-demographical study on use and abuse of alcohol could be a useful research query to understand the severity of use/abuse of the most common and socially acceptable drug in Nepal.
- A nationwide study on use of drugs in high schools (including grades 11 and 12) could yield valuable information on understanding the level of drug use amongst the adolescent youths of Nepal.
- A qualitative study on the lives of recovering DUs who have stayed sober for more than one year could yield useful information on understanding components behind their successful recovery efforts.
- A comprehensive urban-based study on generation gap and on differences of cultural modes of parents and their children (focusing adolescent youths) could yield important understanding on the changing family dynamics of a fastly modernizing urban Nepal.

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ANNEXES

Annex A. Glossary

The glossary of terms is adopted from the United Nations Office for Drug Control and Crime Prevention (UNODCCP, 2000). Few glossaries are adopted from other resources - sources for such glossaries are disclosed in the glossary itself. Additional glossaries or elaborations on existing glossaries, written in italic format, are that of the researcher.

Abstinence

The term refers to the act of refraining from alcohol or other drug use, whether for health, personal, social, religious, moral, legal or other reasons.

Abuse

A term in wide use but of varying meaning. In international drug control convention 'abuse' refers to any consumption of a controlled substance no matter how infrequent. In international drug In the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994), 'psychoactive substance abuse' is defined as "a maladaptive pattern of pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following within a 12 month period: (a) recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home; (b) recurrent substance use in situations in which it is physically hazardous; (c) recurrent substance-related legal problems; (d) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance." It is a residual category, with dependence taking precedence whenever applicable.

Adverse drug reaction

Harmful, unintended or unwanted consequences of taking a drug. All types of drugs may produce adverse and unintended consequences especially when taken in very large doses and/or by persons with particular susceptibilities. Adverse reactions may be mild (headaches, nausea) and disappear with repeated use, or be of much greater severity, possibly leading to death.

Agonist

A substance that acts on receptor sites to produce certain responses; for example, both methadone and heroin are agonists for opioid receptors.

Alcohol

In chemical terminology, alcohols are a large group of organic compounds derived from hydrocarbons and containing one ore more hydroxyl (-OH) groups. Ethanol is the main psychoactive ingredient in alcoholic beverages. Alcohol is a sedative/hypnotic with effects similar to those of barbiturates…When taken in combination with other central nervous system depressants and opiates, alcohol contributes to the risk of death from overdose. *Chyang is a fermented drink with lesser alcohol content. The Nepali terminology for Alcohol is Raksi, and other jargons used are: Twaath, Khoyabirkae, and Quarter (associated a quarter of a liter alcohol bottle).*

Amotivational syndrome
According to the WHO Lexicon of Alcohol and Drug Terms, amotivational syndrome is defined as: a constellation of effects said to be associated with substance use (especially of cannabis), including apathy, loss of effectiveness, diminished capacity to carry out complex or long term plans, low tolerance for frustration, impaired concentration, and difficulty in following routines.

Analgesic
According to the WHO Lexicon of Alcohol and Drug Terms, analgesic is defined as: a substance that reduces pain and may or may not have psychoactive properties.

Antagonist
A substance that counteract the effects of another agent. Pharmacologically, an antagonist interacts with a neuronal receptor to inhibit the action of agents (agonists) that produce specific physiological or behavioral effects mediated by that receptor.

Antidepressant
According to the WHO Lexicon of Alcohol and Drug Terms, antidepressant is defined as: one of a group of psychoactive agents prescribed for the treatment of depressive disorders; also used for certain other conditions such as panic disorder.

Bad trip
According to the WHO Lexicon of Alcohol and Drug Terms, bad trip is defined as: in drug users' jargon, an adverse effect of drug use, consisting of any mixture of the following: feelings of losing control, distortions of body image, bizarre and frightening hallucinations, fears of insanity or death, despair, suicidal thoughts, and strong negative affect. Physical symptoms may include sweating, palpitations, nausea, and paraesthesias.

Barbiturate
According to the WHO Lexicon of Alcohol and Drug Terms, barbiturate is defined as: one of a group of powerful central nervous system depressants.

Benzodiazephine
According to the WHO Lexicon of Alcohol and Drug terms, benzodiazepine is defined as: one of a group of drugs used mainly as sedatives/hypnotic, muscle relaxants, and anti-epileptics, and once referred to as 'minor tranquilizers'.

Blood-borne virus
A virus which can be transmitted from an infected person to another person by blood-to-blood contact, such as through blood transfusion or the sharing of injecting equipment. The most notable blood-borne viruses are HIV, hepatitis B and hepatitis C.

Buprenorphine
Buprenorphine is a mixed agonist/antagonist which can be used in substitution treatment. It has been used extensively in many countries for the short term treatment of moderate to severe pain. The mixed opioid-action/blocking-action appears to make Buprenorphine safe in overdose and possibly less likely to be diverted that pure opioids. It may also provide an easier withdrawal phase, and due to a longer action, may allow for alternate day dosing. It is apparent from the research conducted to date that Buprenorphine is at least as effective as methadone as a maintenance agent. *Buprenorphine is a widely used drug in Nepal, and according to experts, its*

widespread use(injectible form) led to a sudden increase of HIV/AIDS in Nepal. Buprenorphine used in Nepal is manufactured in India under the name Tidijesick. The street name of Tidijesick is: TD, TT, and Saman (including the paraphernalia).

Caffeine
According to the WHO Lexicon of Alcohol and Drug Terms, caffeine is defied as: a mild central nervous system stimulant, vasodilator, and diuretic. Caffeine is found in coffee, tea, chocolate, cola and some other soft drinks.

Cannabis
According to the WHO Lexicon of Alcohol and Drug Terms, cannabis is defined as: a generic term used to denote the several psychoactive preparations of the marijuana (hemp) plant, *Cannabis sativa.* They include marijuana leaf (in street jargon: grass, pot, dope, weed or ganja), and hashish (derived from the resin of the flowering heads of the plant), and hashish oil. *Nepali terminologies for cannabis products are: Ganja, Charesh, and, Bhang. Nepali jargons for Marijuana are: 'G', tope, saagpath, ghas, grass.*

Center
A word widely used in Nepal referring to a DRC.

Chasing (pulling)
Also called 'chasing the dragon.' This is a method for using heroin. The user heats the substance on a metal foil or on a coin and inhales the fumes through a short pipe. Chasing is an efficient non-injecting method and the users often shift from smoking heroin mixed with tobacco in a cigarette to chasing. This method is the most frequent route for administration of 'brown sugar' (i.e. heroin) on the Indian subcontinent.

Clean/Clean date
Being clean refers to not using drugs (except Nicotine and Caffeine). Clean date is the duration of period the user managed to stay clean (also referred by some as Sobriety Date).

Cocaine
According to the WHO Lexicon of Alcohol and Drug Terms, cocaine is defined as: an alkaloid obtained from coca leaves or otherwise synthesized from the chemical compound ecgonine or its derivatives. Cocaine is a powerful central nervous system stimulant used nonmedically to produce euphoria or wakefulness.

Cold turkey
A commonly used slang term for the process of sudden drug withdrawal unassisted with any form of drug treatment.

Counseling and psychotherapy
Counseling is an intensive interpersonal process concerned with assisting normal people to achieve their goals or function more effectively. Psychotherapy is generally a longer-term process concerned with reconstruction of the person and larger changes in more fundamental psychological attributes such as personality structure. Psychotherapy is often restricted in conception to those with pathological problems.

Craving
Craving is a user's 'desire' or need to continue using a drug. It implies both physiological and psychological dependence. The term is often associated with withdrawal and is considered by some to be a main characteristic of addiction/dependence (Source: Drug Abuse: Glossary of Terms, Bhandari and Subba, 1992)

Client
Client is term widely used in the DRCs of Kathmandu for users who enrolls in the DRC.

Cross-tolerance
According to the WHO Lexicon of Alcohol and Drug Terms, cross-tolerance is defined as: the development of tolerance to a drug to which the individual has not previously been exposed, as a result of acute or chronic intake of a different drug. The two substances usually, but not invariably, have similar pharmacological effects.

Cryptococcal meningitis
A life-threatening infection of the membranes (meninges) that line the brain and spinal cord. Cryptococcal disease is caused by a fungus. Most people have been exposed to this organism, which is found in soil contaminated by bird droppings, but it usually does not cause disease in healthy people. The majority of people with cryptococcal meningitis have immune systems that are damaged by disease, such as AIDS, or suppressed by drugs. If people with cryptococcal meningitis are not treated, they may lapse into a coma and die. (Source: Health Newsflash; http://www.healthnewsflash.com/conditions/cryptococcal_meningitis.php)

Demand reduction
International drug control conventions use this term in relation to the aim of reducing consumer demand for controlled substances. Demand reduction strategies contrast with approaches which aim at reducing supply of drugs though in practice demand and supply reduction can be complementary. The success of demand reduction is conventionally measured by a reduction in the prevalence of use, i.e. by more abstinence, and hence is separate and distinct from harm reduction.

Depressant
According to the WHO Lexicon of Alcohol and Drug Terms, depressant is defined as: any agent that suppress, inhibits, or decreases central nervous system activity. The main classes of central nervous system depressants are the sedatives/hypnotics, opioids, and neurleptics. Examples of depressant drugs include alcohol, barbiturates, anesthetics, benzodiazepines, heroin and methadone.

Detoxification
The process by which a person who is dependent on a psychoactive substances ceases use, in such a way that minimizes the symptoms of withdrawal and risk of harm. While the term 'detoxification' literally implies a removal of toxic effects from an episode of drug use, in fact it has come to be used to refer to the management of rebound symptoms of neuroadaptation, i.e. withdrawal and any associated physical and mental health problems. The facility in which the procedure takes place is usually called a detoxification center. Traditionally detoxification has been provided on an in-patient basis either in a specific treatment facility or one the wards of a general or psychiatric hospital. There is an increasing trend to provide detoxification services in

informal settings including the clients' own homes. Home-based detoxification usually involves visiting medical staff and informal support provided by family or friends.

Dhaturo
A hallucinogen and native to Nepal. It is related to the Belladonna plant (Dhatura). (Source: Drug Abuse: Glossary of Terms, Bhandari and Subba, 1992)

Drug abuse
Current international drug control treaties do not define drug abuse but make reference to a variety of terms, including abuse, misuse, and illicit use. In the context of international drug control, drug abuse constitutes the use of any substance under international control for purposes other than medical and scientific, including use without prescription, in excessive dose levels, or over an unjustified period of time.

Drug abuse-related harm
Any adverse social, physical, psychological, legal or other consequence of drug use which is experienced as harmful to a drug user and/or those living with or otherwise affected by the actions of a drug user. This term is preferred by many to that of 'drug problem' because there is no implication of an enduring personal problem requiring treatment. It focuses on whether or not the use of a drug is related to measurable harm of some kind.

Drug policy
The aggregate of policies designed to affect the supply and/or the demand for illicit drugs, locally or nationally. Drug policy covers a range of strategies on such issues as education, treatment, drug laws, policing and border surveillance. In this context, 'drug policy' may include pharmaceutical, tobacco or alcohol policies.

Drug substitution
Treatment of drug dependence by prescription of a substitute drug for which cross-dependence and cross-tolerance exist. The term is sometimes in reference to a less hazardous form of the same drug used in the treatment. The goals of drug substitution are to eliminate or reduce use of a particular substance, especially if it is illegal, or to reduce harm from a particular method of administration, the attendant dangers to health (e.g. from needle sharing), and the social consequences. Examples of drug substitution are the use of methadone for the treatment of heroin dependence.

Epidemiology, epidemiological monitoring
The systematic monitoring of levels of health problems and risk behaviors in an entire community or population. Epidemiology is the study of the prevalence and incidences of illness in the population. Epidemiological monitoring of drug use and problems is not a precise science due to the illegal and clandestine nature of illicit drug use.

Fix
Injecting of a drug

Gateway (theory)
A model of the progression of drug use that has grown out of research with adolescents which has identified a sequential pattern of involvement in various legal and illegal drugs. Alcohol, cigarettes, and cannabis have been described as 'gateway drugs' for progression to other illicit drugs.

Hallucinogen
A chemical agent that induces alterations in perception, thinking, and feeling which resemble those found in persons with psychotic illness. Examples include lysergide (lysergic acid diethylamide, LSD), psilocybin, mescaline, and phencyclidine (PCP).

Harm reduction
In the context of alcohol or other drugs, harm reduction refers to policies or programs that focus directly on reducing the harm resulting from the use of alcohol or other drugs, both to the individual and the larger community. The term is used particularly for policies or programs that aim to reduce the harm without necessarily requiring abstinence. Some harm reduction strategies designed to achieve safer drug use may, however, precede subsequent efforts to achieve total abstinence. Examples of harm reduction include needle/syringe exchanges to reduce rates of needle sharing among injecting drug users. Harm reduction strategies can be distinguished from supply and demand reduction strategies.

Hashish
The term is used as a general term for cannabis in eastern Mediterranean areas, but is now reserved to cannabis resin. It is a potent product from the flowering tops and tips of the leaves of the cannabis plant. *The Nepali terminologies (including street names) for Hashish are: Charesh, Dhikka, and, Black.*

Heroin
A widely used opiate. It has the chemical names diacetylmorphine or diamorphine. It comes in different forms

Herion-brown
When brown, heroin is usually in the form of the base (as in 'acid' and 'base) and is hence capable of being smoked or 'chased' by inhaling vapors from the heated substance but in this form it is unsuitable for injection. The base form can be converted to the salt form by adding acid (usually citric in the from of lemon, or ascorbic in the form of vitamin C tablets, making it soluble in water and more easily injectable. *The terminologies used in Nepal (including street names) for Herion-brown are: Brown Sugar, Brown, Smack, Maal, and Stuff.*

Herion-white
When white, heroin is typically in the form of the water soluble salt diamorphine hydrochloride and is suitable for injection. White heroin has tended to originate from South East Asia and is referred to as 'Chinese heroin' or 'China white'.

Herion-pink
A pink form of heroin, heavily adulterated with caffeine powder, is found in some South East Asian countries.

IDU
An abbreviation for an injecting drug user or injecting drug use. Replaces IVDU (intervenous drug users), as injections may be intramuscular, subcutaneous, or intravenous.

Illicit (or illegal) drug
A drug listed in the schedules to the international drug control conventions can only be called an illicit (or illegal) drug if its origin was illicit. If the origin was licit, then the drug itself is not

illicit but only its production, sale or use in particular circumstances. The drug listed in the schedules to the various drug control conventions are under control and their use for solely medical or scientific purposes is licit.

Intoxication
According to the WHO Lexicon of Alcohol and Drug Terms, intoxication is defined as: a condition that follows the administration of a sufficient amount of a psychoactive substances and which results in disturbances the level of consciousness, cognition, perception, judgment, affect, behavior, or other psychophysiological effects of, and learned responses to, the substance and revolve with time, with complete recovery, except where tissue damage or other complications have arisen. The term is most commonly used with regard to alcohol use.

IV
An abbreviation for intravenous injection route, i.e. the injection of a substance into a vein in any part of the body. Regular injecting drug users may damage the veins on their arms and resort to injecting veins in other parts of their body.

Juction/Junction
A place designated by users to use drugs. In general, Juction are usually unfrequented or ambiguous to the general public.

Junkie
An old terminology mostly referring to IDUs. 'Junkie' is mostly used in Nepal as a negative labeling term indicating the 'pathetic' state of being of IDUs.

LSD (Lysergide)
LSD (D-lysergic acid diethylamid, lysergide) is a semi-synthetic drug derived from lysergic acid or from various alkaloids of the parasitic fungus ergot. It is the most powerful known hallucinogen.

Phencydel
A codeine based cough syrup, manufactured in India. Phencydel (referred as 'P' in slang terms) gained wide popularity amongst drug users in Nepal and is also regarded by many as a gateway drug to Brown sugar and Tidijesick. Phencydel was declared an illcit drug by the government, however, they are still smuggled in from India, and some Phecydel dependants have also shifted to other codeine based products.

Marijuana
See Cannabis.

Methadone
According to the WHO Lexicon of Alcohol and Drug Terms, methadone is defined as: a synthetic opiate drug used in maintenance therapy for those dependent on opioids. It has a long half-life, and can be given orally once daily with supervision. It is the most widely used treatment for opioid dependence in the developed world.

Mutual-help group (anonymous groups)
A group in which participants support each other in recovering or maintaining recovery from alcohol or other drug dependence or problems, or from the effects of another's dependence, without professional therapy or guidance. Prominent groups in the alcohol and other drug field

include Alcoholic Anonymous, Narcotics Anonymous, and Al-Anon (for members of alcoholics' families), which are among a wide range of twelve-step groups based on a non-denominational, spiritual approach. 'Self-help group' is a commonly used term, but 'mutual-help group' more exactly expresses the emphasis on mutual aid and support.

Narcotic drug
According to the WHO Lexicon of Alcohol and Drug Terms, narcotic drug is defined as: a chemical agent that can induce stupor, coma, or insensibility to pain. The term usually refers to opiates or opioids, which are called narcotic analgesics. It is also a term adopted by the Single Convention on Narcotic Drugs, 1961.

Needle exchange
Provision to reduce the transmission of infectious diseases by the repeated use and sharing of needles in order to reduce the transmission of blood-borne viruses.

Needle-sharing
The use by two or more people of the same needle and syringe for the injection of drugs. A major route for the transmission of blood-borne viruses such as HIV, hepatitis B and C among injecting drug users.

Nicotine
According to the WHO Lexicon of Alcohol and Drug Terms, nicotine is defined as: an alkaloid, which is the major psychoactive substance in tobacco. It has both stimulant and, subjectively, relaxing effects. It produces an altering effect in some individuals, an increased capacity to focus attention. In others, it reduces anxiety and irritability.

Occasional use
A preferred term for drug use which is both non-dependent and less than weekly. It is preferred to the term 'recreational use' as this implies all such use is for pleasure as opposed to controlling a negative emotional state.

Opiate
According to the WHO Lexicon of Alcohol and Drug Terms, opiate is defined as: one of a group of alkaloids derived from the opium poppy (Papaver somniferum) with the ability to induce analgesia, euphoria, and, in higher doses, stupor, coma, and respiratory depression. The term opiate excludes synthetic opioids such as heroin and methadone.

Opioid
According to the WHO Lexicon of Alcohol and Drug Terms, opioids is defined as: the generic term applied to alkaloids from the opium poppy, their synthetic analogues, and compounds synthesized in the body, which interact with the same specific receptors in the brain, have the capacity to relieve pain, and produce a sense of well-being (euphoria). The opium alkaloids and their synthetic analogues also cause stuport, coma, and respiratory depression in high doses. Opium alkaloids and their semi-synthetic derivatives include morphine, diacetylmorphine (diamorphine, heroin), hydromorphine, codeine, and oxymoron. Synthetic opioids include levorphanol, propoxyphene, fentanyl, methadone, pethidine (meperidine) and the agonist-antagonist pentazocine.

Opium
The crude mixture obtained by the air drying of the juice which oozes from incisions made in the ripened seedpod capsule of the opium poppy. It contains a number of important alkaloids such as morphine, codeine, and papaverine.

Outreach
A community-based activity with the overall aim of facilitating improvement in health and reduction of drug-related risk or harm for individuals and groups not effectively reached by existing services or through traditional health education channels. Peer (or indigenous) outreach projects use current and former members of the target group (such as IDUs) as volunteers and paid staff.

Overdose
According to the WHO Lexicon of Alcohol and Drug Terms, overdose is defined as: the use of any drugs in such an amount that acute adverse physical or mental effects are produced. Deliberate overdose is a common means of suicide and attempted suicide.

Peer education
The use of same age or same background educators to convey educational messages to a target group. Examples include the selection of peer group leaders in schools to be trained to deliver anti-drug messages to their friends and the use of current drug users to educate others about how to stop, cut down or use drugs more safely.

Peer influence
When applied to drug abuse, peer influence can be described as one of a set of external social environmental pressures which influence experimentation or continuation with drug consumption. Peer influence includes cognitive factors, such as the perception of the peers' behavior (modeling) and the perceived drug use norms of the peer group, as well as situational factors such as direct peer pressure and the importance of socializing and conformity in groups. Thus peer influence is a much broader and less unidirectional concept than 'peer pressure', which is one type of peer influence.

Peer pressure
When applied to drug abuse of adolescents or young adults, it is the notion that peers put pressure on individuals to conform to group norms which may include the illegal taking of drugs. The individual who is the focus of the presumed pressure is seen to be easily influenced and passive in the face of the active pressure.

Peer support
At one level, one of the components of a peer outreach relationship where the outreach worker provides some form of assistance to a peer. The assistance is usually ongoing rather than a single discrete episode. Example includes support provided by peer carers of PLWHA who may be unwell.

Pharmaceutical drug
In the present context, a pharmaceutical drug is a substance or various preparations there from manufactured by the pharmaceutical industry, or prepared in a pharmacy for medical purposes.

Pre and post test counseling
Personal counseling given to persons before (pre) and after (post) their (medical) HIV test. The general aim of a pretest counseling is to assure and inform on confidentiality, assessment of risk, meaning of results, informed consent issues, and the aim for post test counseling is to inform and make aware on the following issues: test result disclosure, meaning of results, risk reduction, protective health habits, psychological referral and support services.

Prevalence
A measure of the extent of a particular condition or illness usually expressed in terms of the numbers of cases per 10,000 people in a given population. The prevalence of drug use can usually only be imperfectly estimated in the general population from such means as household surveys and hospital and arrest records. This is especially the case for illegal drug use when levels of use are low and require very large samples to estimate prevalence accurately.

Prevention
Prevention is defined broadly as an intervention designed to change the social and environmental determinants of drug and alcohol abuse, including discouraging the initiation of drug use and preventing the progression to more frequent or regular use among at-risk populations. Prevention activities may be broad-based efforts directed at the mainstream population(s), such as mass media general public information and education campaigns, community focused initiatives and school-based programs directed at youth or students at large. Prevention interventions may also target vulnerable and at-risk populations.

Psychoactive substance
According to the WHO Lexicon of Alcohol and Drug Terms, psychoactive substance is defined as: a substance that, when ingested, alters mental processes, i.e. thinking or emotion.

Psychological dependence
Refers to dependence upon a drug in the absence of the development of either tolerance or withdrawal symptoms. Most modern uses of the term 'dependence' avoid a strict distinction between 'psychological' and 'physical' dependence. If this phenomenon exists at all, it is likely to be a characteristics of the user and not a property of the drug.

Psychotropic drug
According to the WHO Lexicon of Alcohol and Drug Terms, psychotropic is in its most general sense a term with the same meaning as 'psychoactive', i.e. affecting the mind or mental processes.

Recovery/Recovering
According to the WHO Lexicon of Alcohol and Drug Terms, recovery is defined as: the maintenance of abstinence from alcohol and/or other drug use by any means. The term is particularly associated with mutual-help groups. In Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and other twelve-step groups, recovery refers to the process of attaining and maintaining abstinence. Since 'recovery' is viewed as a lifelong process, AA or NA members always regard themselves as 'recovering.'

Rehabilitation
According to the WHO Lexicon of Alcohol and Drug Terms, rehabilitation is defined as: in the field of substance use, the process by which an individual with a drug-related problem achieves

an optimal state of health, psychological functioning, and social well-being. Rehabilitation typically follows an initial phase of treatment in which detoxification and, if required, other medical and psychiatric treatment occurs. It encompasses a variety of approaches including group therapy, specific behavior therapies to prevent relapse, involvement with a mutual-help group, residence in a therapeutic community or half-way house, vocational training, and work experience. There is an expectation of social reintegration into the wider community.

Relapse prevention
According to the WHO Lexicon of Alcohol and Drug Terms, relapse prevention is defined as: a set of therapeutic procedures employed in cases of alcohol or other drug problems employed in cases of alcohol or other drug problems to help individuals avoid or cope with lapses or relapses to uncontrolled substance use. The procedures may be used with treatment based on either moderation or abstinence, and in conjunction with other therapeutic approaches. Patients are taught coping strategies that can be used to avoid situations considered dangerous precipitants of relapse, and shown, through mental rehearsal and other techniques, how to minimize substance use once a relapse has occurred.

Residential treatment
Treatment programs which require participants to live in a hostel, home or hospital unit. These programs generally strive to provide a positive drug-free environment in which residents are expected to participate in a full-time program of counseling, and group work developing social and other life skills.

Risk reduction
Risk reduction describes policies or programs that focus on reducing the risk of harm from alcohol or other drug use. Risk reduction strategies have some practical advantages in that risky behaviors are usually more immediate and easier to objectively measure than harms, particularly those harms which have a low prevalence.

Stimulant
According to the WHO Lexicon of Alcohol and Drug Terms, stimulant is defined as: in reference to the central nervous system, any agent that activates, enhances, or increases neural activity; also called psychostimulant.

Stimulant pills
Pharmaceutical medicines (tablets) with stimulant characteristics. Stimulant pills have gained wide popularity among drug users in Nepal and also among school aged youths for occasional use. Stimulant pills which are sold through the pharmacies illegally (without prescription) are also sold now by dealers who smuggle them from India. Stimulant pills mostly used in Nepal are: Nitrosun, Nitrovet, Proxyvon, and Dormin, among others. Slang terms used in Nepal for stimulant pills are: tab, gedagudi, gotti, vet (for Nitrovet) and 'N' (for Nitrosun).

Therapeutic community
A structured environment in which individuals with drug-related problems live while undergoing rehabilitation. Such communities are often specifically designed for drug-dependent people; they operate under strict rules, are run mainly by people who have recovered from dependence, and are often geographically isolated. Therapeutic communities are also used for management of patients with psychotic disorders and anti-social personalities. Therapeutic communities are also used for management of patients with psychotic disorders and anti-social personalities.

Therapeutic communities are characterized by a combination of 'reality testing' (through confrontation of the individual's drug problem) and support for recovery from staff and peers. They are usually closely aligned with mutual-help groups such as NA.

Tobacco
Any preparation of the dried leaves of Nicotiana tabacum, a plant of the nightshade family which is now cultivated in may countries. The main psychoactive ingredient is nicotine. While usually smoked in the form of cigarettes or cigars, it may also be chewed, eaten and sniffed to achieve it mild stimulant effects.

Tolerance
A term for the well-established phenomenon of reduced drug effects following repeated drug administrations. Tolerance develops fastest with more frequent episodes of use and with larger amounts per occasion.

Treatment
Treatment may be defined as a comprehensive approach to the identification, assistance, and health care…with regard to persons presenting problems caused by the use of any psychoactive substance. *In the Nepali context, the word treatment is mostly referred to treatment services rendered by DRCs.*

Trigger
Environmental or social stimuli which kindle desire or craving for the drugs of dependence (Source: Drug Abuse: Glossary of Terms, Bhandari and Subba, 1992)

Trip
The experience of intoxication of a user following drug use. Other terminologies used in Nepal (and elsewhere) are: Tripping, Stoned and 'High on…'

Twelve-step group
According to the WHO Lexicon of Alcohol and Drug Terms, twelve-step group is defined as: a mutual-help group organized around the twelve-step program of Alcoholics Anonymous (AA) or a close adaptation of that program. AA's program of twelve steps involves admitting one is powerless over one's drinking and over one's life because of drinking, turning one's life over to a 'higher power', making a moral inventory and amends for past wrongs, and offering to help other alcoholics. A recovering alcoholic 'on the program' must never drink again, although this objective is accomplished one day at a time. AA is organized in terms of 'twelve traditions', which enjoin anonymity, an apolitical stance, and a non-hierarchical organizations structure. Other twelve-step groups vary in their adherence to the twelve traditions. There are now numerous organizations of twelve-step groups, each focused on one of a wide range of behavioral, personality, and relationship problems.

Withdrawal
A term used to refer to either the individual symptoms of, or the overall state (or syndrome), which may result when a person ceases use of a particular psychoactive drug upon which they have become dependent or after a period of repeated exposure. The level of central nervous system arousal and the accompanying mood state is usually directly opposite to the direct action of the drug. Thus withdrawal from central nervous system depressants typically involves increased anxiety and heightened arousal level (increased heart rate, blood pressure and perspiration). Withdrawal from central nervous system stimulants involves reduced arousal,

lethargy and depression. Withdrawal from central nervous system stimulants involves reduced arousal, lethargy and depression. Withdrawal states and symptoms exist in degrees as a direct consequence of the frequency, intensity and recency of drug use.

Withdrawal syndrome

According to the WHO Lexicon of Alcohol and Drug Terms, withdrawal syndrome is defined as: a group of symptoms of variable severity which occur on cessation or reduction of drug use after a prolonged period of use and/or in high doses. The syndrome may be accompanied by signs of both psychological and physiological disturbance. A withdrawal syndrome is one of the indicators of a dependence syndrome. It is also the defining characteristic of the narrower psycho-pharmacological meaning of dependence.

Withdrawal, conditioned

A syndrome of withdrawal-like signs and symptoms sometimes experienced by dependent individuals when they are abstinent and exposed to stimuli previously associated with alcohol or drug use…If the stimuli are presented without actual administration of the substance, the conditioned response is elicited as a withdrawal-like compensatory reaction.

Withdrawal, protracted

According to the WHO Lexicon of Alcohol and Drug Terms, withdrawal, protracted is defined as: the occurrence of symptoms of a withdrawal syndrome, usually minor but nonetheless discomforting, for several weeks or months after the acute physical withdrawal syndrome has abated...Psychic symptoms such as anxiety, agitation, irritability, and depression are more prominent than physical symptoms. Symptoms may be precipitated or exacerbated by the sight of alcohol or the drug of dependence, or by return to the environment previously associated with alcohol or other drug use.

Annex B. Characteristics and Descriptions of Frequently Used Drugs

#	Drug group	Principal drug	Route of administration	Short term of effect	Long term effect
1	Alcoholic Beverages	Ethyl alcohol (beers, wines, liquors, spirits)	Swallowed as a beverage.	Clumsiness and impaired judgment.	Risk of strokes, liver disease (Hepatitis, liver cirrhosis) high blood pressure, infertility, disease of the nervous system and physical dependency. Regular heavy drinking in pregnancy can cause lasting damage to the baby.
2	Minor Tranquilizers Benzodiazepines	Nitrazepam (Mogadon), Diazepam (Valium), Lorazepam (Ativan)	Swallowed as pills or capsules or injected	Drowsiness, lack of coordination	Chronic sedation, lethargy, physical dependency.
3	Opiates	Heroin(junk, skag, H, smack), Methadone (physeptone, amps linctus), Pethidine (pamergan, ethilorfan), Buprenorphine (tidijesick) Morphine (duromorph, cyclimorph, kaolin, morphine), Codeine (actifed, phensedyl, codeine linctus)	Heroin smoked, sniffed or injected. Most other opiates preparations are injected or swallowed.	Increase in dose day by day, unmanageable life, stressful, financial crisis, loss in job, hamper in study, health crisis, worse in behavior and attitude, physical compulsive	Psychological problem (low self-esteem, humiliation), Economic problem (financial crisis, joblessness, decrease in productivity), Psychiatric problem (depression, suicide tendency, mental disturbances, madness), Social problem (avoidance by the society, high family disintegration, isolation, break in relationship, lack of family support, lack of trust), Physical problem (high risk of getting hepatitis, HIV, drug dependency, custody and jail, death)
4	Amphetamines and Amphetamine –like drugs	Diethylpropion (apisate, tenuatedospan), Amphetamine sulphate-dexamphetamine (durophet)	Sniffed but also injected. Pills and capsules take by mouth.	Appetite lose,	

Annex B. Characteristics and Descriptions of Frequently Used Drugs (Continued)

#	Drug group	Principal drug	Route of administration	Short term of effect	Long term effect
5	Caffeine	Caffeine (tea, coffee, soft drinks, chocolate, analgesic pills, love hearts)	Swallowed as a beverage in confectionary or in pills.		
6	Tobacco	Nicotiana tabacum (tobacco), nicotiana rustica (cigarettes), Nicotiana persica (snuff)	Smoked. Snuff is sniffed.		
7	Hallucinogenic Mushrooms	Magic mushrooms	Swallowed raw, cooked or brewed into a beverage often after drying.		
8	Cannabis (Slang terms: pot, dope, blow, draw, smoke etc)	Herbal cannabis (grass, marijuana, ganja, weed, herbs, skunk), cannabis resin (hash, hashish), cannabis oil	Herbal cannabis is smoked. Resin or oil is smoked in cigarette (joint) with tobacco or their own through a pipe or other device. Resin sometimes eaten in cakes or other foods.	Feeling of relaxation ad talkativeness.	Psychological dependence and respiratory problems possible, including lung cancer.

Source: Sharma 2000:3

Annex C. Drug Control Initiatives in Nepal

1. Liquor Control Act, 1960: This act made compulsory licensing to produce and sell Cannabis.
2. Narcotic Drug (control) Act 1976: The act banned the production, storage; sell consumption and trade of all types of narcotics and psychotropic substances listed in the Act.
3. First Amendment of the Narcotic Drug (control) Act 1976: It made the provision to control certain morphine derivatives by prescription. This act introduced the concept of controlled substance Act. The amendment was made in 1981.
4. Second Amendment of the Narcotic Drug (control) Act 1976: It made the provision of panelizing the physicians who violate the Act. This amendment was made in 1987.
5. In the year 1991, HMG/Nepal became the party to the UN single Convention on Narcotic Drugs 1961 as amended by the protocol of 1972.
6. In the year 1991, HMG/Nepal became the party to 1988 UN Convention against illicit trafficking of narcotic drugs and psychotropic substances.
7. Revision and third amendment of the Narcotic Drug (control) Act 1976. This was done in 1992.
8. Bi-lateral agreement between UNDCP and HMG/N on the implementation of Drug Abuse Control Master Plan in Nepal. This was done in 1992.
9. A specialized narcotic drug control law enforcement unit as underlined in the Master Plan was established under the Narcotic Drug Control Division (NDCD), Ministry of Home Affairs. This was done in 1992.
10. Drug Abuse Demand Reduction Project (DADRP) was established to look into matter related to demand reduction activities. This was done in 1994.
11. Establishment of inter-departmental co-ordination committee on precursor control for effective control of precursor chemicals. This was done in 1988.

Source: Lohar and Shrestha, 2002: 48

Annex D. Drug Rehabilitation Centers in Nepal

No.	Name of DRC	Contact Person	Address	Method of Detoxification
1.	Richmond Fellowship Nepal(Male)	Bishnu Sharma	Chovar, Lalitpur	Psycho-social and cold turkey
2.	Richmond Fellowship Nepal (Female)	Pooja Niraula	Pulchowk, Lalitpur	Acupuncture and sleeping pills (if needed)
3.	Youth vision drug treatment and rehabilitation center	Jagdish Lohani	Chundevi, Maharajganj	Substitute/ medicine
4.	Nava Kiran drug treatment center	Bimal Thapa	Dhapasi, Ktm	Substitute/ medicine
5.	Nepal Youth	Rickson Bajracharya	Dhapasi, Ktm	Substitute/ medicine
6.	Freedom center	Rajendra Shrestha	Nakhipot, Lalitpur	Acupuncture
7.	Aasara Sudhar Kendra	Bidur Goutam	Ranibari, Maharajganj	Cold Turkey
8.	SANGATI(Drop in center)	Sampurna Maskey	Naxal, Ktm	Acupuncture
9.	Lifeline help Center	Guru Oli	Birtamod, Jhapa	Substitute/ medicine
10.	Punar Jeevan Kendra/KYC	Bijay Limbu	Balakchowk, Dharan	Substitute/ medicine
11.	Support & Care drug treatment center	Subin Pun	Bharatpur, Chitwan	Substitute/ medicine
12.	Sahara Drug Treatment center	Basanta Thapa	Butwal	Substitute/ medicine
13.	Serene Foundation	Manoj Gurung	Pokhara	Substitute/ medicine
14.	Youth Vision Branch	Binod Aryal	Bhairahawa	Substitute/ medicine
15.	Naulo Ghumti	Dharanji	Pokhara	Substitute/ medicine
16.	Addiction Recovery Center	Suman Karki	Dhamak	Cold Turkey
17.	Wisdom Foundation	Rahsan Rai	Dhamak	Substitute/ medicine
18.	Pratigya	Basanta Kunwar	Kathmandu	
19.	LALS Rehabilitation center	Rajan Rana		Substitute/ medicine
20.	Hope Foundation	Raju Dhamala	Birtamod	Substitute/ medicine
21.	Lumbini Support Group	Kishor Thapa	Bhairawa	Substitute/ medicine
22.	Nepalgunj Rehabilitation	Navaraj	Nepalgunj	Substitute/ medicine
23	Punarjeevan Kendra	Mr. Iswor Raj Panta	Mahendranagar	

Source: (Sharma, 2001:6)

Annex E. The Questionnaire for RDUs

Serial no……..

Date……Location……

1. Background Information – Self

1. A. I.D. Last Name (Surname): …… Sex: Male / Female Age……

1. B. Demography

- Where is your family house? Specify ……
- Is it located in a (please tick or circles): City - metropolis / Rural district capital / Village / Others (specify) ……..
- Where were you brought up? City- metropolis / Rural district capital / Village / Others (specify) …… ……
- Are you living with your family? Yes / No If yes, whom are you living with? Specify……
  If no, Whom are you living with? Specify ……
  - Specify type of housing: Own / Rented / Relatives' / Hostel / Other–specify ……..
  - Why did you leave your family home? Studies / Job / Ran away / Kicked out / Other-specify……

1. C. Education

- Schooling (last level passed) ……. Date (year when passed) …….. Only Literate / Illiterate
- Last enrolled in (which level) …….. Type: Government / Semi government / Private
- Are you planning to go outside of Nepal for further studies? Yes / No
- High School Record:
  - Location of the School: Metropolis-city / Village / District capital / Outside Nepal (specify) ……
  - Type of School: Government / Private / Semi government
  - Grade received on last high school class (or SLC): 1st Division / 2nd Division / 3rd Division / Failed
  - Were you a: Hostel Student / Day Scholar / Partly Hostel – from class……to class ……..
  - Did you change schools? Yes / No; If yes, why and at which grade?..... ……
  - Any major disciplinary action taken against you when at school? Yes / No
    - If yes, specify what were you alleged of ……

1. D Marital Status

Are you (pls.tick): Single / Married / Not married but living together / Divorced / Married but not living together

- If 'single' skip below and go to '1.E.Employment,' If married, answer below
  - Type of marriage: Love / Arranged / Court / Run off /; Age of marriage……
  - How old is your marriage (year / month) …… Were you using drugs before marriage? Yes / No.
  - If yes, what type: Alcohol / Marijuana / Hashish / Codeine / Tablets / TD/Brown Sugar/others (specify) ……
  - If divorced or married but not living together
  - How long have you been separated from your spouse (months/years)……. What was the reason? ……
- If living together but not married
  - How long have you been living together? Specify ……..months / years
  - What is the opinion of your family? They don't care/strongly object/Slowly accepting/They have accepted/Don't know

1. E Employment

- Were/Are you employed? Yes / No; If No, skip this section, please go to 'Arrest Record' section

If Yes, for how long? ……. (Total year/ months); Job title(s) …… (if more than one, start with latest)

- Pay/ month ……..(estimate, if more than one job, give the highest amount you received)
- What kind of job? Government / Semi government / Private / NGO-INGO / Family-Relative owned business
- Were you using drugs while being employed? Yes/No. If yes, what type: Alcohol/Marijuana/Hashish/Codeine Syrup/Tablets/TD/ Brown Sugar / others (specify) ……

1. F Arrest Record

If you don't have any arrest records, skip to '1.G. Current Medical Condition'

- Were you arrested by the police prior to drug use? Yes / No
  If Yes, how many times ……And for what reason (specify)? …… ……
- Were you arrested by the police in your drug abuse career? Yes / No
  If Yes, how many times …… And for what reason (specify)?……

1. G Current Medical Condition

- HIV: Positive/Negative/Don't know/ I don't want to know; If positive, when did you find out about it? ……(months or years)
  - Disclosure of HIV with family members: Already disclosed / I think I will in future / I won't disclose / Don't know
- Hepatitis: Positive /Negative/Don't know/ I don't want to know; If positive, when did you find out? ……months or years ago.

2. Background Information on Family

2.1 Father's Background

- Age: ……. If dead, mention how many months or years ago ……
- Education: Illiterate / Literate / Below SLC / College / Masters/ PhD / Don't know Job Title: ……
- Job: Private/ Governmental / Abroad / Farming / Family Business / Retired / Unemployed
- Earn (roughly per month): 50 thousand & over /30 to 50,000/20 to 30,000 / 10 to 20,000 / 5 to 10,000 / 1 to 5,000 / below 1,000/ Don't know
- Substance use (including alcohol): Yes / No; If yes: Dependent / Regular / Irregular / Sometimes with friends / Only on festivals
- Indicate what kind of substance (specify)……..
- Please rate how traditional are your father's beliefs: very much / only on some issues / average / not at all
- How tolerant is your father regarding drug use and violent behavior (deviance)? Tolerant / Can't tolerate if its too much / Can't tolerate at all
- What is the typical nature of your father when he breaks down? Cries softly or alone/ Doesn't talk for days/ Leaves the house / Faints / Cries heavily / Tells the incident to relatives / Gets physical / Other (specify) ……..
- General impression of dad: Understanding / Loving / Average Dad / Don't get along/Don't talk/Strict/Loving but also strict/Very traditional

2.2 Mother's Background

- Age: ……. If dead, mention how many months or years ago ……
- Education: Illiterate / Literate / Below SLC / College / Masters/ PhD / Don't know Job Title: ……
- Job: Private/ Governmental / Abroad / Full time house wife / Farming / Family Business / Retired / Unemployed
- Earn (roughly per month): 50 thousand & over /30 to 50,000/20 to 30,000/10 to 20,000 / 5 to 10,000 / 1 to 5,000 / below 1,000/ Don't know
- Substance use (including alcohol): Yes / No; If yes: Dependent / Almost regular / Irregular / Sometimes with friends / Only on festivals;
- Indicate what kind of substance (specify) ……
- Please rate how traditional are your mother's beliefs: very much / only on some issues / average / not at all
- How tolerant is your mother regarding drug use and violent behavior (deviance)? Tolerant /Can't tolerate if its too much/ Can't tolerate at all
- What is the typical nature of your mother when she breaks down? Cries softly or alone/Doesn't talk for days/Leaves the house/ Faints / Cries heavily / Tells the incident to relatives / Gets physical / Other (specify) ……..
- General impression of mom: Understanding /Loving/Average Mom/Don't get along/Don't talk/Strict/Loving but also strict/Very traditional

2.3 Spouse's / Living Partner's Background

- Age: ……. If dead, mention how many months or years ago ……
- Education: Illiterate / Literate / Below SLC / College / Masters/ PhD / Don't know Job Title: …….. ……..
- Job: Private/ Governmental / Abroad / Full time house wife / Farming / Family Business / Unemployed
- Earn (roughly per month): 50 thousand & over /30 to 50,000 / 20 to 30,000 / 10 to 20,000 /5 to 10,000/1 to 5,000 / below 1,000/ Don't know
- Substance use (including alcohol): Yes / No; If yes: Dependent / Regular / Irregular / Sometimes with friends / Only on festivals
- Indicate what kind of substance (specify) ……
- Please rate how traditional are your spouse's/ partner's beliefs: very much / only on some issues / average / not at all
- How tolerant is your spouse regarding drug use and violent behavior (deviance)? Tolerant / Can't tolerate if its too much / Can't tolerate at all
- What is the typical nature of your spouse when she/he breaks down? Cries softly or alone/Doesn't talk for days/Leaves the house/ Faints / Cries heavily / Tells the incident to relatives / Gets physical / Other (specify) ……..
- General impression of spouse: Understanding / Loving / Average / Don't get along/Don't talk/Strict/Loving but also strict/ Very traditional

2.4 Family Background

- What type of family do you have? Joint / Nuclear Number of members in the family: ……..
- Where is your family originally from? Specify ……..
  - If from outside, when did your family migrate to the current location? Specify (year/month ago) ……
  - How old were you when your family migrated? Specify age ……..
- What family situation were you brought up in? Single parent / Divorced Parents/ Relatives looked after me / Abusing parents / Normal
- What do you consider is the Economic class of your family? Higher / High-middle / Middle / Lower-middle / Lower
- The house your family is living on, is it: Own house / Rented / Other (specify) ……
- What are the sources of income in the family? Jobs / Family Business / Rent / Land / Pension

- Who are the primary money earners in the family? Specify ……
- Are there other members in the family who are abusing drugs? Yes / No
- If yes, Is he/she your Brother / Sister / Other (specify) ……..; What is (are) their drug of choice? Specify ……..
  - What is their use pattern? Irregular / Regular / Dependent
- Is alcohol allowed in family? Yes / No
  - If yes, how frequently is alcohol used? Once in a while / Only on festive occasions / When guests visit / Regularly
- Any there any smokers in family? Yes / No
- Are your siblings (brothers or sisters) married? Yes / No
  - If yes, how is your relationship with in-laws? Not good / Okay / Very good / Not in contact
- Which member of the family are you closest with? Specify ……..
- Do you still remember incidences when your parents badly hit you, or scolded you in front of others when you were a kid?Yes/No
- Religious level of family: Not religious / Only on occasions / So-so / Religious / Very Religious / Only one parent very religious
- What kind of family environment were you brought up in? Very strict / Strict but loving / Loose / Very loose
- Was your father present in the house in the years when you were growing up? Yes / No / Partly yes / Partly No / I was in hostel

2.5 Background of Relatives (including In-Laws)

- Who are considered as close relatives to your family (e.g., mama, sasura)? Specify…….. ……
- How close are you with your close relatives? Very close / Very close with only few / So-so / Not close / I hate them
- Do your close relatives know about your drug use? Yes / Maybe / No / Don't know
- Is there a lot of gossiping-rumor among your close relatives about your drug use? Yes / Maybe / No / Don't know
- Are your close relatives supportive of your efforts on quitting drugs? Yes / Maybe / No / They don't care / Don't know
- If Yes or Maybe, They just say 'don't do drugs' / They are really supportive from the inside

****

3. Background of Your Neighborhood (Tole)

3.1 Characteristics

How would you characterize your neighborhood (tick one or more that applies to your neighborhood):

- Class: Mostly rich people / Mostly middle class people/Mostly poor people/Rich & middle class/Middle & poor class/All mixed
- Demography: Naya basti / Purano basti / Many houses on rent / Most male members gone abroad
- Ethnicity : Mostly from same ethnic-caste / Mixed / Don't know
- Deviance: Many drug users / Pharmacy selling drugs without prescription / Significant number of Bars-Bhatti / Joint – adda for gathering / Marijuana widely available/Renowned as bad neighborhood/Lots of older brothers used to experiment with drugs / Lots of young guys experimenting with drugs / High number of police arrests / Don't know
- Facilities: School / Park / Temple / Club / Snooker house / Sports area / Don't know / Others (specify) ……
- Activities: Organizes jatra-religious festivals / Organizes entertainment programs / Don't know
- Interaction: Everybody knows everybody/Everybody doesn't know everybody/Nobody knows nobody/Strong community unity/ Don't know – I am new /

3.2 Neighborhood & You

- Are you usually aware of what is happening in your neighborhood? Yes / No
- Have you ever participated in neighborhood activities? Yes / No, If yes, specify ……..
- Have you been in dramatic situations (e.g., fights, unconscious) which was seen by everybody in the neighborhood? Yes / No
- Does your neighborhood know that you're using drugs? Yes / No

If yes, Do they view in suspicion? Yes / No; Do they ignore/reject you if you meet them? Yes / No
Do they label you as 'addict'? Yes / No; Are you accused of introducing drugs to youngsters? Yes / No

4. Your Beliefs and Values

This exercise is an attempt to understand your beliefs and values in various issues. Please circle or tick the answers you think best defines your position.

4.1) Academic achievement
Not important at all / Not so important / Maybe important / Important / Very important

4.2) Independence
Not important at all / Not so important / Maybe important / Important / Very important

4.3) Support from Parents/Close ones
Not important at all / Not so important / Maybe important / Important / Very important

4.4) Learnings from the Treatment Center
Not important at all / Not so important / Maybe important / Important / Very important

4.5) Friends are important part of my life
Not important at all / Not so important / Maybe important / Important / Very important

4.6) Spirituality
Not important at all / Not so important / Maybe important / Important / Very important

4.7) In order for me to stay clean, my entire close user circle has to be clean also
Not important at all / Not so important / Maybe important / Important / Very important

4.8) Education level of Parents
Not important at all / Not so important / Maybe important / Important / Very important

5. Drug Dependence Career Background

5.1Type of Drugs: On the box below, please provide information on drugs you became dependent on, as according to your case.

Drug	How long were you dependent?	First Introduced by	Age when first used
Alcohol			
Brown Sugar (pull)			
Brown Sugar (inject)			
T.D.			
Marijuana/Hashish			
Other (specify)			
Tablets (specify)……			

5.2 Intake Frequency

On the box below, please inform about the number of times you'd typically use drugs. Please tick on appropriate case.

Please Tick	Frequency
	1. Almost daily – More than 5 times a day
	2. Almost daily – Less than 5 times a day
	3. More than 5 times a week
	4. Less than 5 times a week
	5. More than 4 times a month
	6. Less than 4 times a month
	7. Very rarely
	8. Specify, if different from above choices …… .

5.3 Period of Drug Abuse

- In total, how many years/month/days did you become dependent or addicted on drugs? …….. Years / Months / Days

5.4 Switch of Mode for Taking Drugs

- Did you use the injection mode for taking drugs? Yes / No; If no, skip to '5.4. Drug User's Network'
- If yes, what were the reasons? My friends forced me into it/ I liked it better than non injection route/Less money-more high/Non injecting drugs were not available / Other / (specify) ……..
- How long have you been injecting drugs (please specify in years / months / days)? ……..years/months/days

5.5 Drug User's Network

On the box below, please inform about the size of your drug using work. Please tick on appropriate case.

Number	1. 0 (usually take drugs alone)	2. Between 1 to 5	3. Between 6 to 10	4. Between 11 to 15	5. More than 16
Please Tick					

- During your drug dependent stage did you typically take drugs: With friends / Sometimes friends, sometimes alone / Alone

If your answer to the above is 'Alone', please skip this section and go to '5.5. Self', or else please answer the following:

- Economic background of your circle? Mostly rich /Mostly middle class/Mostly poor/Rich & middle/Middle & poor class / Rich & poor /
- Ethnic/caste background of your circle : Mostly from same ethnic-caste / From different ethnic-caste /
- The most enjoyed activities in your circle when high on drugs? Watching movies/Listening-playing music/Roaming around town/ Talking about weird things / Hanging out in certain locations / No such activities / Others (specify) …… …… .
- Were needles shared in your circle? Yes / No / Very rarely
- Was your circle ever involved in traveling to the border areas to buy drugs? Yes / No / Very rarely
- Was your circle ever involved in selling drugs? Yes / No / Very rarely
- How was the financial status of your circle? Money was no problem/Sometimes loaded sometimes broke/Always short of cash
- How was your circle able to come up with the money? By asking close family/By threatening close family/By lying/By stealing/By selling drugs/Prostitution / Working / Others (specify) ……
- Did you know of anybody as HIV positive in your circle? Yes / No / Maybe
- Did your circle have any case of drug overdoses? Yes / No Did anyone in your circle died due to drug overdose? Yes / No
- Was there any case of arrests in your circle? Yes / No If yes, was it: drug related / non drug related

- How many in your circle have been in a treatment center? Almost all / Almost half / Only few / Only me /
- If any of your friends have been to a treatment center, how would you describe their recovery? Recovered/Trying hard to recover/ Relapsed / Don't find treatment center as helpful

5.6 Self Information

- What was the frequency of needle sharing in your career? Most of the time / Sometimes / Very rarely / Never shared
- Did you ever travel to the border areas to buy drugs? Yes / No / Very rarely
- Did you ever sell drugs to support your habit? Yes / No / Very rarely
- How was your financial state while on use? Money was no problem / Sometimes loaded sometimes broke / Always short of cash
- How were you able to come up with the money? By asking close family / By threatening close family / By lying / By stealing / By selling drugs / Prostitution / Working / Others (specify) …….. …
- How extensive was your connections with dealers? Only knew those in my neighborhood/Only knew limited persons/ Know almost all major dealers in the city / Know almost all major dealers in the city and also dealers outside my city
- What were the most enjoyed activities when you were high on drugs? Watching movies/Listening-playing music/Roaming around town / Thinking about weird things / Hanging out in certain locations / No such activities / others (specify) ……..
- Have you ever used force or hit anybody in the family or the close ones? Yes / No
- What was the worst action or incidence you were involved in when you were using drugs? Specify……
- How was your relation with your parents/spouse when you were using drugs? Excellent / Good / Ok / Not good / Very bad / Don't know
- How was your relation with your parents/spouse when you relapsed? Excellent / Good / Ok / Not good / Very bad/ Don't know

5.7 Initial Substances

On the box below, please indicate how old you were when you first tried the following substances. If you can't remember your exact age, please provide the closest age you think is correct.

Substance	Cigarette / Khaini	Beer/Wine/ Chyang	Hard liquor/Alcohol	Ganja	Hashish	Codeine Syrup	Tablets
Your Age							

USE TO ABUSE INFORMATION

6. Use to Abuse:

Directions for filling out the questionnaire: This exercise is to gain knowledge about reasons behind your move from drug use to abuse and dependence. This section gives you the option to choose 'reasons' from the reasons list or write your own. Please find the appropriate reasons (from the 5 types of 'reasons list' under self, availability, socio-cultural, friends & trends, and family provided below) that you think led you to abuse and dependence on the substance(s). Please write the appropriate number (bolded) of that particular reason (for example, 2 –meaning ''risk taker' on the 'Reasons Box') as whether they were major or minor reasons that encouraged you to abuse the substances. If you think the reasons provided on the list doesn't cover your reasons-then please write your own reasons on where it says 'specify.'

6.1. 'Self' Reasons & Use to Abuse

1. Low self-esteem	2. Risk taker	3. Seeking some form of escape
4. Unable to cope with anxiety and conflict without the drug	5. Seeking a more dramatic form for reducing tension	6. Psychologically dependent
7. Introverted or withdrawn individual	8. Gave me strength to face society	9. Fear and admission that I am an addict, junkie
10. No single point at which I suddenly became addicted	11. Relief of pain, anxiety, and fatigue	12. To protect me from a sense of failure
13. Euphoria or ecstasy, immediate satisfaction	14. To defend myself from insecurity	15. Physical addiction
16. Complicating factor of withdrawal problems	17. Drug controlled biological rhythm (e.g. sleep pattern)	
18. A thrill in not achieving anything in life	19. Part of group who all have the same feeling of no achievement	20. Loneliness
Your reason (if not in the list)		
21. Specify…… ……	22. Specify…… ……	23. Specify…… ……

6.1.1.'Self' Reason Box

Substances	Major reason(s) (write reason number below)								Minor reason(s) (write reason number below)					

6.2. Availability Reasons & Use to Abuse

1. Locally available	2. Dealer lives in the neighborhood	3. Close friend was using drugs
4. Affordable, not expensive	5. Surrounded by others who use drugs	6. Met users in everyday life
7. My close relative had access to drugs		
Your reason (if not in the list)		
8. Specify…… ……	9. Specify…… ……	10. Specify…… ……

6.2.1. Availability Reason Box

Substances	Major reason(s) (write reason number below)								Minor reason(s) (write reason number below)					

6.3. Socio-Cultural Reasons & Use to Abuse

1. Small area deprivation	2. Neighborhood disadvantage	3. Low income background
4. Recent immigration / change of locality	5. Lived in an environment broadminded or liberal about drug use	6. Location where there was dense group of IDUs
7. High degree of drug related activities in my neighborhood		
Your reason (if not in the list)		
8. Specify…… ……	9. Specify…… ……	10. Specify…… ……

6.3.1. Socio-Cultural Reason Box

Substances	Major reason(s) (write reason number below)								Minor reason(s) (write reason number below)					

6.4. Friends & Trend Reasons & Use to Abuse

1. Association with addicts	2. Seeking a new 'high' every time	3. Sufficient peer support
4. Uninteresting, boring life	5. Lots of free time	6. Feeling that 'I won't get addicted'
7. Couldn't get along with normal friends	8. Achieving and maintaining a feeling of freedom	9. It was the only source of reward for me
10. Gave importance and approval among friends	11. Overall gain was greater than the overall cost	12. Other sources of pleasures became less interesting
13. Closest friend was using	14. Large number of new guys like me entered the network	15. Knew many guys who were in drug networks
Your reason (if not in the list)		
16. Specify…… ……	17. Specify…… ……	18. Specify…… ……

6.4.1. Friends & Trend Reason Box

Substances	Major reason(s) (write reason number below)								Minor reason(s) (write reason number below)					

6.5. Family Reasons & Use to Abuse

1. Lack of supportive family	2. Dysfunction within the family	3. Death or loss of family member
4. Family hid drug use from relatives and others	5. Family didn't blame me but blamed others, such as my friends	6. To free myself from family and social responsibilities
7. Quarrels with family members (including spouse)	8. Silent protest against my family, community	9. Substance abusing parents (including alcoholism)
10. Less supervision of family	11. Family didn't care	12. Separation from family member
13. Single parent family	14. Low educational achievement of parent(s) or spouse	15. I given sufficient money by parents as pocket expense
Your reason (if not in the list)		
16. Specify…… ……	17. Specify…… ……	18. Specify…… ……

6.5.1. Family Reason Box

Substances	Major reason(s) (write reason number below)								Minor reason(s) (write reason number below)					

****

CESSATION (End of Drug Use) INFORMATION

7. Cessation: This section attempts to understand the various factors that led you to stop using drugs completely.

7.1 Cessation Attempts

- How many times did completely stop using drugs (for a certain time period) after you became dependent on it? …….no. of times
- How did you manage to stop using drugs? Rehab Center (…….of times) / Self (…….of times) / Doctor's prescription (……of times) / Other (specify) …… (no. of times)
  - If you used a doctor's prescription or detox medicines, were you using medicines during the entire period of cessation? Yes/No
- How supportive were your parents/spouse of your efforts of stopping drug use? Very supportive/So-so/Not supportive/Don't know
- How did your parents/spouse usually talk to you at the time you stopped using drug? Very openly / Normally / Angrily / Only occasionally / Didn't talk at all / Others (specify) ……..
- How was your relation with your parents/spouse when you stopped using drugs? Excellent/Good/Ok/Not good/Very bad/Don't know

7.2. Reasons for Cessation Please fill in the boxes in the same way as you did previously with the 'Use to Abuse' section.

7.2.1. Self Reasons & End of drug use

1. Reduction in pleasure	2. Fear of psychological problems	3. Fear of HIV
4. I hit rock bottom	5. Rising physical discomfort	6. Fear of losing health or life
7. Insightful and genuine realization that drugs are destructive	8. Medical complications: cirrhosis, hepatitis, HIV	9. Physical deterioration (collapse of veins, etc.)
10. Awareness of possible death	11. Frightened by a paranoid intoxication psychosis	12. To bring physiological rhythm back (sleep pattern, disa-pisab!!!)
13. Became disgusted by my own confused functioning		
Your reason (if not in the list)		
14. Specify…… ……	15. Specify…… ……	16. Specify…… ……

7.2.2 Self Reason Box

Substances	Major reason(s) (write reason number below)								Minor reason(s) (write reason number below)					

7.3.1. Friends & Fashion Reasons & End of drug use

1. Lost connections or ended friendships with users	2. Death from overdose among friends	3. Some in my circle were tested HIV positive
4. Introduction of another strong pleasurable experience	5. Genuine help from my suffering best friend	6. My life was getting out of control
7. My best friend decided to quit drugs	8. My user friends got arrested	9. Decline in interest to get involved with user circles
10. To kick the drug habit of my best friend	11. All of my user friends decided to quit at the same time	12. Growing relationship with non using friends
13. I was getting less and less high at higher and higher costs.	14. Even shorter period of stopping drugs brought back the same high as before	15. Unhappy about belonging to a group viewed with strong suspicion and dislike.
16. Maturity		
Your reason (if not in the list)		
17. Specify…… ……	18. Specify…… ……	19. Specify…… ……

7.3.2. Friends & Fashion Reason Box

Substances	Major reason(s) (write reason number below)								Minor reason(s) (write reason number below)					

7.4.1. Family Reasons & End of drug use

1. Genuine support from my family	2. Fear of losing a valued job	3. Fear of losing respect from peers
4. Decided to drink alcohol in small quantity instead	5. Fear of losing a spouse and family	6. Developed a renewed sense of life
7. Pressure from family and close circles	8. I was no longer in control of the situation	9. I was getting physically violent with my family members
10. I didn't want to steal or do shameful actions to maintain my habit	11. Assumption of adult roles such as marriage, parenthood, full time employment	12. New opportunities for self enhancement e.g. new job, education
13. Rebirth of positive relationship with parents and loved ones		
Your reason (if not in the list)		
14. Specify……. …….	15. Specify……. …….	16. Specify……. …….

7.4.2. Family Reason Box

Substances	Major reason(s) (write reason number below)								Minor reason(s) (write reason number below)					

7.5.1. Socio-Cultural Reasons & End of drug use

1. Arrested by police	2. Forced treatment by the police, family, and close circles	3. Because of limited financial resources
4. Direct pressure from parents or spouse	5. Alternative solutions through religious/spiritual activities, social activities, relationships	6. Geographic or locality change (we moved from one place to another)
7. I was selling my own body		
Your reason (if not in the list)		
8. Specify……. …….	9. Specify……. …….	10. Specify……. …….

7.5.2. Socio-Cultural Reason Box

Substances	Major reason(s) (write reason number below)								Minor reason(s) (write reason number below)					

7.6.1. Availability Reasons & End of drug use

1. Decrease in availability of drugs	2. The dealers in our area were arrested	3. My close user friends left the country for jobs, studies, or for other reasons
Your reason (if not in the list)		
4. Specify……. …….	5. Specify……. …….	6. Specify……. …….

7.6.2. Availability Reason Box

Substances	Major reason(s) (write reason number below)								Minor reason(s) (write reason number below)					

****

RELAPSE INFORMATION

7. Relapse: This section tries to understand the various factors that led to your state of drug relapse. The definition of Relapse used for this study is as follows- Relapse is a state invited by various reasons in which a drug user who had stopped using drugs goes back to regular drug use and drug dependency.

8.1. Relapse Record

10.1.1 Number of Relapses you've had so far …… (Number of times)

8.1.2 History of prior relapses:

Relapse # 1

When …… (Year/months/ days ago) How long were you clean before first relapse? …… (Year /month / days)

How long did you use drugs after relapse …… (Year/month / days) Which treatment center did you go to? ……

Was it your own decision or decision of others (please tick which ever applies to your case)? Own / Not 100% my decision / Family & Closed ones / User friend(s) / Cops /

Did you stay full time (time stipulated by center) at the treatment center? Yes / No; If no, why? ……

In brief, what factor(s) do you think caused relapse? Please be precise.……
……
If you have had more than one relapse, please fill below; if not, go to 'Common Issues Behind Multiple Lapses' section

Relapse # 2

When ……. (Year/months/ days ago) How long were you clean before second relapse? ……. (Year /month/ days)
How long did you use drugs after relapse ……. (Year/month/ days) Which treatment center did you go to? ……
Was it your own decision or decision of others (please tick which ever applies to your case)? Own / Not 100% my decision / Family & Closed ones / User friend(s) / Cops /
Did you stay full time (time stipulated by center) at the treatment center? Yes / No; If no, why? ……
In brief, what factor(s) do you think caused relapse? Please be precise. ……
……

Relapse # 3

When ……. (Year/months/ days ago) How long were you clean before third relapse? …… (Year /month/ days)
How long did you use drugs after relapse ……. (Year/month/ days) Which treatment center did you go to? ……
Was it your own decision or decision of others (please tick which ever applies to your case)? Own / Not 100% my decision / Family & Closed ones / User friend(s) / Cops /
Did you stay full time (time stipulated by center) at the treatment center? Yes / No; If no, why? ……
In brief, what factor(s) do you think caused relapse? Please be precise.……
……

Relapse # 4

When ……. (Year/months/ days ago) How long were you clean before fourth relapse? ……. (Year /month/ days)
How long did you use drugs after relapse ……. (Year/month/ days) Which treatment center did you go to? ……..
Was it your own decision or decision of others (please tick which ever applies to your case)? Own / Not 100% my decision / Family & Closed ones / User friend(s) / Cops /
Did you stay full time (time stipulated by center) at the treatment center? Yes / No; If no, why? ……
In brief, what factor(s) do you think caused relapse? Please be precise. ……
……

Relapse # 5

When ……. (Year/months/ days ago) How long were you clean before fifth relapse? …… (Year /month/ days)
How long did you use drugs after relapse ……. (Year/month/ days) Which treatment center did you go to? ……
Was it your own decision or decision of others (please tick which ever applies to your case)? Own / Not 100% my decision / Family & Closed ones / User friend(s) / Cops /
Did you stay full time (time stipulated by center) at the treatment center? Yes / No; If no, why? ……
In brief, what factor(s) do you think caused relapse? Please be precise. ……..
……

8.2. Common Issues Behind Multiple Relapses

Please fill questions below only if you have relapsed more than one time, or else, skip to '10.3.Reasons Behind Relapses' section

8.2.1) In your opinion, do you think there were same issues, events, risk factors, etc., present in all of your relapses? Yes / No / Maybe but not 100% confirmed / I don't know; If yes, or maybe, please specify the common factors present in all of your relapses under the following categories:

8.2.2.1) Family (situations or behavior of family member, etc.) Please specify: ……
8.2.2.2) Psychological (type of crisis/tension/ event etc.) Please specify: ……
8.2.2.3) Friends (situations, relations, events, etc.) Please specify: ……..
8.2.2.3.4) Other factors. (please specify): ……

8.3. Reasons Behind Relapses

Below are list of statements; please read them carefully and indicate how strongly they match your reasons for relapse. On the blank dot, at the beginning of each statement, indicate: 1, 2, 3, 4 (1=very true, 2=true, 3=maybe, 4=not true):

…… My families did not change their attitude and behavior; they were same as when I was using drugs 1
…… My whole lifestyle revolved around drugs. Didn't know what to do without it and its lifestyle. 2
……I repressed all my feelings-I didn't have anybody to share or understand my feelings. 3
……I didn't attend socially supportive and voluntary programs like N.A 4
……I did whatever my parents told me to do, and that didn't help my recovery. 5
……I had lots of free time and no concrete plans on what to do with it 6
……My family didn't believe in me 7
……No body cared on whether I was drug free or not 8
……My family was always suspicious of my activities-even though I was clean 9
……I didn't know how to cope or handle when confronted with a high risk situation 10
……I started associating with addicts and their circles, only they could understand me 11

.....I entered into treatment because of pressures from my family, cops in the first place 12
.....I thought I would make some money by selling drugs but not using it 13
.....I had difficulty in finding new circle of friends 14
.....I had difficulty in achieving new goals 15
.....I was very excited to face life when I left the treatment center, but that excitement slowly died down as days passed by 16
.....I tried the clean approach but I was more comfortable with my user friends, and their way of life 17
.....Once out of the treatment center, I immediately tried to do many things to get back on track (e.g. studies, job). I should have waited and given more time for recovery 18
.....Experiences of rejection from family and friends 19
.....Somehow deep inside, I thought I could never recover 20
.....Failing to find alternative (drug-free) outlets for my needs 21
.....Failing to build up a network of relationships, activities, and involvements that would acts as a barrier against boredom, and depression 22
.....Failing to express my wants and needs to my family-either they wouldn't listen or I couldn't tell them 23
.....Things weren't going my way. The resulting rage and anger that grew out of such disappointment compelled me 24
.....Craving was powerful and persistent. 25
.....I said I will never use drugs regularly again but only now and then, and then become re-addicted soon after. 26
.....Association with other addicts 27
.....I could not tolerate withdrawal distress. So I used it to relive withdrawal symptoms 28
.....Unsuccessful adjustment with my family/community 29
.....It was purely an accident. It just happened. 30
.....I compromised on using softer drugs or alcohol. 31
.....I always felt that something was missing from my life when I was not using drugs. 32
.....I could not get any jobs 33
.....Contact with active addicts even when my readjustment to my family/society was satisfactory 34
.....I decided to take it anyway-even though life was going well. 35
.....I had already made up my mind to use it one last time when I was in the treatment center 36
.....Treatment programs did not provide enough skills on how to defend myself and how to satisfy my inner needs and wishes 37
.....My family was constantly pressuring me to do something in life. 38
.....Return to an environment in which availability of drugs was greater. It was all over in my neighborhood, school, work, etc. 39
.....Prior suffering was remembered as being less intense and painful. 40
.....I was clearly aware of the warning signs…but then, it just happened. 41
.....The period when I was recovering was psychologically distressing (depression, anxiety, guilt, extreme anger, family tensions) 42
.....It was very tempting for me to believe that just enough substance can be taken to control distressing mood states without returning to the level of compulsive or habitual use. 43
.....I wasn't genuinely honest about discontinuing drugs. 44
.....Because of family crises (such as parents separating or a sibling developing a problem, death, separation, etc). 45
.....It started during the festival season (Dassain, Tihar, Fagu, Shivaratri, New Year, etc.). It was too tempting. 46
.....I had nowhere to start my life. I could not restart my education, I had no job. I had no skills. 47
.....I am HIV positive. I could not bear the feeling that I was HIV positive 48
.....I had no one to discipline me when I got out of the treatment center 49
.....I didn't ask for anybody's help 50
.....One last time! 51
If you want, write your own statement(s) that best describes your reasons for Relapse
..... (Your Statement)……52
..... (Your Statement)……53
..... (Your Statement)……54

8.4. Looking Back at Your Relapse….

8.4.1. Your Efforts

8.4.1.1 Dealing with Craving

What factors did you utilize when trying to subside the craving of drugs after you left the treatment center (please tick those suitable to your case)?

- o I tried to think of positive thoughts
- o Talked with my non user close friends (e.g., girlfriend)
- o Talked with family members
- o Got busy with housework
- o Listened to music
- o Watched movie
- o Played sports
- o Went to a gym
- o Talked & shared problems with my user friends

- o Masturbated
- o Called the treatment center/counselor
- o Blocked thoughts as much as possible
- o Meditated / Yoga
- o Slept
- o Just went on with life
- o No specific action
- o I couldn't do anything
- o Don't know
- o Others (specify)……
- o Others (specify)……

8.4.2. Besides Craving

What factor(s), besides craving, do you think invited relapse in your case?

- Friends
- Locality
- Family issues
- Family attitudes
- Lack of confidence without use of drugs
- Lack of ability to make good decisions
- Thought I could control myself
- Available within my neighborhood/tole
- Others (specify) ……

8.5. Looking Back Deeply

I may not have relapsed if… (Please tick any of the statements that fit your situation)

- o Family support
  - If I had asked for help
  - My family had took some trouble to accommodate & accept me by changing the family structure, attitude, behavior
  - My dad had supported me
  - My dad had controlled his anger and negative behavior for my sake
  - My in-laws had supported me
  - My parents/close ones didn't doubt me
  - My family had loved me as I am
- o Education
  - I had finished my studies
  - I had technical trainings
  - My parents were educated
  - I had gone out of this country for studies
- o Economic
  - I had a job
  - I had money to do things
- o Social
  - I had a 'counselor' like friend in real life
  - I had a supportive community of relatives
  - I had been living with my wife and/or parents
  - I had broken contacts with my user friends/circle
  - My wife/parents were more modern thinking
  - Drugs were not widely in around my neighborhood
  - All my close user friends decided to quit also
- o One Important Incident
  - I had never been to that party/gathering
  - I had listened to my higher power- HE was very loud
  - I had not answered the phone
  - I had not left the house
  - I had not gotten into a fight
  - I had said no to my friend

8.6. Understanding Lapse

Definition of Lapse: Lapse can be understood as a slip in one's recovery process-not necessary a relapse state. It can mean use of drugs in an irregular or non-habitual way.

- Did you go directly to regular use or did you irregularly use drugs before going to regular use (this includes alcohol, marijuana, and other 'soft' drugs)? Directly to regular use / First, it was irregular use

If, you started with irregular use, please answer the following, if not skip it

- o What drug (including alcohol) did you use when you lapsed? ……..
- o How long was the lapse period before you were addicted to drugs again?.....(months / years)
- o Did you look for help realizing you might be on the verge of relapse? Yes / No / Thought I should but didn't
- o What factors came in that hampered you to go back to not using drugs? (Please Tick and/or write)
  - i. I compromised on only using soft drugs from now on
  - ii. I compromised on using only limited dosage of my preferred drug
  - iii. I realized I could never be 100 % clean
  - iv. Family crises (please specify) ……
  - v. Psychological crises (please specify) ……
  - vi. Psychologically dependent
  - vii. Fear of losing friends
  - viii. I thought I'll never become addicted
  - ix. Specific crisis (please specify) ……..
  - x. Others (please specify) ……..

8.6. About the Treatment Center

What components you learned from the treatment center did you use or not use when you went home?

- Meditation Used it / Used it but not regularly / Didn't use it / Didn't find it necessary / Didn't teach at center
- Yoga Used it / Used it but not regularly / Didn't use it/ Didn't find it necessary / Didn't teach at center
- Wake up hours Used it / Used it but not regularly / Didn't use it/ Didn't find it necessary / Didn't teach at center
- Sleeping hours Used it / Used it but not regularly / Didn't use it/ Didn't find it necessary / Didn't teach at center
- Morning Walk Used it / Used it but not regularly / Didn't use it/ Didn't find it necessary / Didn't teach at center
- Personal Hygiene Used it / Used it but not regularly / Didn't use it/ Didn't find it necessary / Didn't teach at center
- Ego Management Used it / Used it but not regularly / Didn't use it/ Didn't find it necessary / Didn't teach at center
- Listening Skills Used it / Used it but not regularly / Didn't use it/ Didn't find it necessary / Didn't teach at center
- Sharing Used it / Used it but not regularly / Didn't use it/ Didn't find it necessary / Didn't teach at center
- Reshape Guilt/Shame Used it / Used it but not regularly / Didn't use it/ Didn't find it necessary / Didn't teach at center
- Time Management Used it / Used it but not regularly / Didn't use it/ Didn't find it necessary / Didn't teach at center
- Speaking skills Used it / Used it but not regularly / Didn't use it/ Didn't find it necessary / Didn't teach at center
- Problem Management Used it / Used it but not regularly / Didn't use it/ Didn't find it necessary / Didn't teach at center
- Respecting Others Used it / Used it but not regularly / Didn't use it/ Didn't find it necessary / Didn't teach at center
- Anger Management Used it / Used it but not regularly / Didn't use it/ Didn't find it necessary / Didn't teach at center
- Listening to Higher Power Used it / Used it but not regularly / Didn't use it/ Didn't find it necessary / Didn't teach at center

8.6.2 Different Treatment Centers

- Have you been going to a same treatment center after each of your relapses? Yes / No
- If no, how many different treatment centers have you been to? Specify ……..
- What is your reason for change of treatment center? Specify ……

8.6.3. Financing Your Stay

- How much money do you have to pay per month at the treatment center? Please specify ……../I don't know
- Who finances the money for you to stay at the treatment center? Please specify ……
- Was it difficult for your well wishers to come up with the money? Yes / No / Little bit difficult / May be / I don't know

8.6.4 You & the Counselor

- How open are you with your counselor? Very open / Open / So-so/ Sometimes only / Not open / Not given more time to be open
- How understanding is your counselor? Very understanding/Understanding/So-so/Sometimes understanding sometimes not/ Not understanding /
- Do you find your time with your counselor as helpful? Very helpful / helpful / Maybe helpful / Not helpful / Don't know

8.6.5 Most Important Skill

- What do you think is/are the most important skill(s) that treatment centers should teach you so that you don't relapse again? Specify ……
  ……
  ……

8.6.6. Your Ideas for Better Treatment Centers

What, according to your experience could be <u>improved, changed, or introduced</u> at the treatment center that you think could tremendously assist the recovery process of fellow recoverers like you. Please mention 5 such specific issues (concerns / ideas) along with concrete reasons as to why (it could be about facilities, management issues, behavior/attitude issues, specific programs, treatment techniques, etc.).

<u>YOUR COMMENTS</u> <u>REASONS (Please be precise)</u>

1. ……
   ……
2. ……
   ……
3. ……
   ……
4. ……
   ……
5. ……
   ……

Annex F. A Description of the TC Concept

4 structures of the TC Concept

- Behavior Management/Shaping: clients learn the techniques involved using tools of the house and effectively to utilize them.
- Emotional/Psychological: This is done through static groups, peer confrontations, emotional and specific religious values.
- Vocational/Survival skills: A context of a social learning environment where clients are assessed for eligibility in adopting vocational roles.

5 pillars of the TC program

- Family milieu concept: To sustain cohesiveness among the community to be together as part of a family
- Peer pressure: Process in which the group emphasis individual's role model by using the technique involving in the TC tools.
- Therapeutic Session: Sets of various groups to enhance self worth and personal growth as a recovery process.
- Religious Session: Process of enhancing religious values and beliefs.
- Role Model: Learning process in an individual to teach by example.

Norms of Living in TC

- Truthfulness
- Straightforwardness
- Sincerity
- Mutual Respect
- Graciousness
- Cooperation
- Concern
- Care
- Patience and Perseverance
- No Free Lunch
- Having Visions and Goals
- Consistency
- Responsible Love
- Empathy
- Preserve Self Image and Personal Qualities
- Ready to Listen
- Discipline
- Forgiveness
- Obedience
- Confidence
- Fairness
- Loyalty
- Tolerance
- Understand Rather Than Be Understood
- Respect the Feelings of Others
- Trust Worthiness
- Gratitude
- Positive Thinking
- Time Management
- Active

Tools and Concepts of TC

- **Confrontation**: basic conversation, asking question. For e.g.: why are you not carrying your walking papers?
- **Pull-up**: to address on negative attitudes, demand for awareness and immediate change in behavior.
- **Spoken to**: when a resident is approached in a caring and advisory fashion and admonitions.
- **Dealt With**: when a resident is dealt with for his action by a facilitator and two of his peers.
- **Haircut**: when a resident is reprimanded verbally for his action by a facilitator and four of his peers
- **Learning Experience**: another way of making residents aware of his/her negative behavior by assigning him/her to a learning experience like theme writing, task, image breaking as a case to case basis.
- **Encounter**: where residents focuses on expression on intense feeling of anger and rage in a safe environment and in a structured manner.
- **Evaluation**: when a person shows he is ready to come off a clean up or move up to the structure and request for out of facility, which he/she will be evaluated, by the coordinator and his peers.
- **Initial Interview**: when a resident being interviewed before admitting to the program.
- **Pre-Morning Meeting**: where the residents gives feedback on the general attitude of the house; problem, method and solution.
- **Morning Meeting**: bring pull-ups, address attitudes of the house and talk about certain themes (unwritten philosophies), image breaking and announcements.
- **Static Group**: conducted by counselors going over treatment plan, personal growth, and the talk about issues.
- **Pre Request**: staff on duty briefs the residents before they go out of the facility for outing or home leave.
- **Post Request**: resident gives feedback to the staff on duty regarding his/her outing or home leave
- **Seminar**: an intellectual meeting to exercise the brains where impromptu talks, various themes, series, philosophies are discussed among the residents.
- **General Meeting**: response to serious, often taboo, behaviors endangering the community.
- **House Meeting**: a family meeting to talk about general and domestic problems arising in the community like norms, implementation of new rules and others.
- **Probe Group**: a selected group that runs about 10-12 hours, probing deep into an individual issues.
- **Extended Group**: a selected group that runs about 24-36 hours, probing deep into an individual issues.
- **Marathon**: a selected group that run about 48-72 hours, probing deeper into an individual issues and finding more about the person.

Source: Therapeutic Community: Induction-Walking Paper. Pengasih Malaysia. Not dated.

Annex G. Questionnaire Data

Annex Table G.1. Ethnic/Caste & Age Background of RDUs

Response	Count	Percent
Ethnic/Caste Group of RDUs		
Mongoloids	57	37.3
Newars	43	28.1
Chettris	33	21.6
Brahmins	20	13.1
Total	**153**	**100.0**
Age Group of RDUs		
Age 20 to 25	67	43.8
Age 26 to 30	48	31.4
Age 36 to 40	18	11.8
Age 31 to 35	15	9.8
Age 15 to 19	3	2
Age 41 to 45	2	1.3
Total	**153**	**100**

Annex Table G.2. Socio-Demographic Information on RDUs' Home

Response	Count	Percent
Home District/Area		
Butwal	1	0.7
Chitwan	1	0.7
Hetauda	1	0.7
Kanchanpur	1	0.7
Kirtipur	1	0.7
Manang	1	0.7
Morang	1	0.7
Nawalparasi	1	0.7
Patan	1	0.7
Sunsari	1	0.7
Bhaktapur	2	1.3
Kaski	2	1.3
Dharan	3	2
Pokhara	9	5.9
Lalitpur	27	17.6
Kathmandu	98	64.1
Total	**153**	**100**
Location of Home		
City	142	92.8
Village	11	7.2
Total	**153**	**100**
Question: Where were you brought up?		
City	144	720.0
Rural district capital	1	5.0
Village	8	40.0
Total	**153**	**765.0**
Living with family?		
Yes	146	95.4
No	7	4.6
Total	**153**	**100**

Annex Table G.3. Migration Status of RDUs' Family

Response	Count	Percent
Question: Did your family migrate from original residence?		
Not migrated	74	48.4
11 to 20 years	31	20.3
21 to 30 years	17	11.1
1 to 10 years	12	7.8
31 to 50 years	12	7.8
More than 50 years ago	3	2
Don't know	2	1.3
Many years ago	2	1.3
Total	**153**	**100**
Age of RDUs During Family Migration		
Wasn't Born	27	34.2
1 to 10 years old	27	34.2
11 to 15 years old	11	13.9
16 to 20 years old	10	12.7
More than 20 years old	6	7.6
Total	**79**	**100.0**

Annex Table G.4. Question: Where is your family originally from?

Response	Count	Percent	Response	Count	Percent
Baglung	1	0.7	Damauli	2	1.3
Bahrabisae	1	0.7	Dhankuta	2	1.3
Biratnagar	1	0.7	Kapilbastu	2	1.3
Chitwan	1	0.7	Mustang	2	1.3
Darjeeling	1	0.7	Myagdi	2	1.3
Dhadhing	1	0.7	Nuwakot	2	1.3
Dhulikhel	1	0.7	Ramechap	2	1.3
Ghandruk	1	0.7	Rukum	2	1.3
Gulmi	1	0.7	Syangja	2	1.3
Hetauda	1	0.7	Kavre	3	2
Humla	1	0.7	Tibet	3	2
Kalikot	1	0.7	Dharan	4	2.6
Khotang	1	0.7	Gorkha	4	2.6
Mahendranagar	1	0.7	Lamjung	5	3.3
Manang	1	0.7	Pokhara	9	5.9
Narayanghat	1	0.7	Kathmandu Valley	72	47.1
Nawalparasi	1	0.7	**Total**	**153**	**100**
Okhaldhunga	1	0.7			
Palpa	1	0.7			
Sannkhu	1	0.7			
Sikkim	1	0.7			
Sindhupalchowk	1	0.7			
Solukhumbu	1	0.7			
Surkhet	1	0.7			
Syanja	1	0.7			
Tanahu	1	0.7			
Tansen	1	0.7			
Taplejung	1	0.7			
Terathum	1	0.7			
Trishuli	1	0.7			
Village	1	0.7			
Bara	2	1.3			
Bhojpur	2	1.3			

Annex Table G.5. Educational Attainment and Enrolment of RDUs

Response	Count	Percent
Educational Attainment		
Class 7 to 10	58	38.9
SLC	34	22.8
Class 11 to 12	21	14.1
Intermediate	11	7.4
Bachelor	9	6.0
Class 4 to 6	8	5.4
Class 1 to 3	5	3.4
Sent up	2	1.3
Lama Studies	1	0.7
Total	**149**	**100.0**
Literate Or Illiterate Status		
Literate	5	3.3
Illiterate	1	0.7
Total*	153	4.0
Last Grade/Level Enrolled in		
Grades 6 to 10	28	40.0
Intermediate	15	21.4
Bachelor	15	21.4
O/A Level	3	4.3
Masters degree	3	4.3
Grades 2 to 5	2	2.9
SLC	2	2.9
Lama Studies	1	1.4
Sent up	1	1.4
Total	**70**	**100.0**
Total Further Enrolled after last attainment**	**70**	**46.9**
Question: Any plans to go abroad for further studies?		
Yes	26	17.4
No	123	82.6
Total	**149**	**100.0**

*Total percent for Literate or Illiterate Status is the sum of category percentages **Total percent is derived from' total educational attainment' (149)

Annex Table G.6. School Record of RDUs

Response	Count	Percent
High School Location of RDUs		
Metropolis-city	127	92.7
Village	3	2.2
District capital	2	1.5
Outside Nepal	5	3.6
Total	**137**	**100.0**
High School Type		
Private	75	54.7
Government	56	40.9
Semi government	6	4.4
Total	**137**	**100.0**
Grades Received in Last Grade or SLC		
2nd Division	46	33.6
1st Division	36	26.3
Failed	30	21.9
3rd Division	18	13.1
No response	7	5.1
Total	**137**	**100.0**
Question: Were you a day scholar or hostel student?		
Day Scholar	80	58.4
Hostel Student	40	29.2
Partly hostel	17	12.4
Total	**137**	**100.0**

Annex Table G.7. Information on RDUs' change of Schools

Response	Count	Percent
Table 4.15. Question: Did you change schools?		
Yes	100	73.0
No	37	27.0
Total	**137**	**100.0**
Question: If yes, why did you change school(s)?		
Hooliganism, fights with teacher and/or students	21	21.0
Failed	17	17.0
For better education	14	14.0
Migration/move of locality	12	12.0
Family decided	7	7.0
Don't know	6	6.0
Drug use	6	6.0
Too far from home	4	4.0
Economic problems	3	3.0
Ran away	3	3.0
Resticated	3	3.0
Weak in studies	2	2.0
Friend changed to another	1	1.0
Leaked test questions	1	1.0
Total	**100**	**100.0**

Annex Table G.8. Question: Were there any disciplinary action taken against you in school?

Response	Count	Percent
Yes	66	48.2
No	69	50.4
No response	2	1.5
Total	**137**	**100.0**
Question: If yes, what were the reasons for disciplinary action?		
Bullying/hooliganism/destroying school properties/fighting with students/teasing girls/ lighting fire crackers	29	43.9
Drug use (including Alcohol, marijuana, stimulant pills)	12	18.2
Beating up teacher	11	16.7
Bunking school/class	8	12.1
Beating up school principle	4	6.1
Smoking cigarettes	4	6.1
Resticated (no reasons specified)	2	3.0
Leaking test questions	1	1.5
Robbing students	1	1.5
Total	**66**	**109.1**

Annex Table G.9. Marital Status of RDUs

Response	Count	Percent
Status		
Single	92	60.1
Married	45	29.4
Divorced	6	3.9
Married but not living together	6	3.9
Not married but living together	4	2.6
Total	**153**	**100**
Type of Marriage of Married RDUs		
Love	28	51.9
Arranged	22	40.7
Ran off	4	7.4
Total	**54**	**100.0**
Age of RDUs when Married		
21 to 25 years	27	50.0
26 to 30 years	13	24.1
16 to 20 years	10	18.5
10 to 15 years	2	3.7
31 to 35 years	1	1.9
No response	1	1.9
Total	**54**	**100.0**
Length of Married Life		
6 to 10 years	23	42.6
2 to 5 years	14	25.9
16 years or more	7	13.0
11 to 15 years	5	9.3
1 year or less	4	7.4
No response	1	1.9
Total	**54**	**100.0**

Annex Table G.9. Marital Status of RDUs (Continued)

Response	Count	Percent
Question: If Divorced or Separated, how long have you been Separated?		
2 years	4	36.4
7 years	2	18.2
10 to 14 months	2	18.2
4 years	2	18.2
3 years	1	9.1
Total	**11**	**100.0**

Annex Table G.10. Married RDUs' Drug Use before Marriage

Response	Count	Percent
Question: Did you use of drugs before marriage?		
Yes	50	92.6
No	4	7.4
Total	**54**	**100.0**
Question: If yes, what did you use?		
Marijuana	36	72.0
Alcohol	32	64.0
Stimulant pills	25	50.0
Brown sugar	25	50.0
Hashish	21	42.0
TD	20	40.0
Codeine	19	38.0
Total	**50**	**356.0**

Annex Table G.11. Employment Status of RDUs

Response	Count	Percent
Yes	79	51.6
No	74	48.4
Total	153	100.0
Duration of Employment		
2 to 5 years	30	38.0
1 year or less	19	24.1
6 to 10 years	16	20.3
11 to 15 years	7	8.9
16 years or more	5	6.3
No response	2	2.5
Total	79	100.0
Question: What kind of job did you have?		
Private	49	62.0
Family-Relative owned business	15	19.0
Government	6	7.6
Semi government	4	5.1
NGO-INGO	4	5.1
No response	1	1.3
Total	79	100.0

note: employment duration could be total of all employment duration.

Annex Table G.11. Employment Status of RDUs (Continued)

Response	Count	Percent
Pay Per Month (in Nepali Rupees)		
4,001 to 6,000	22	27.8
2,001 to 4,000	17	21.5
10,000 to 15,000	12	15.2
Uncertain*	9	11.4
More than 20,000	6	7.6
6,001 to 9,999	5	6.3
1,001 to 2,000	4	5.1
15,001 to 20,000	3	3.8
100 to 500	1	1.3
Total	**79**	**100.0**

** refers to the pay dependent on the volume of business, which RDUs referred as very unpredictable.*

Annex Table G.12. Work Title/Level/Nature of once Employed RDUs

Response	Count	Percent
No response	6	7.6
Assistant manager/Manager	5	6.3
Business (clothing, import, motor parts)	4	5.1
Shop (CD, Cold Store, Cosmetics, *Kirana*)	4	5.1
Administrative/Officer	4	5.1
Tourist/Handicraft shop	4	5.1
Cook	3	3.8
Director (Hotel, Manpower)	3	3.8
Abroad labor	3	3.8
Marketing/Salesman	3	3.8
Tour/Trek guide	3	3.8
Cashier	2	2.5
Computer Technician	2	2.5
Driver	2	2.5
Frame maker/Statue maker	2	2.5
Shop owner: Clothing/ Meat	2	2.5
Out reach/peer educator	2	2.5
Painting/Plumbing/Watch maker/Waiter	3	3.8
Press operator	2	2.5
Receptionist/Telephone operator	2	2.5
Teacher	2	2.5
Supervisor/Storekeeper	2	2.5
Laundry owner/Metal workshop owner	2	2.5
Police/Subba	2	2.5
Accounting	1	1.3
Bus owner	1	1.3
Butcher	1	13
Hotel Owner	1	1.3
Legal advisor	1	1.3
Bouncer, movie hall	1	1.3
Singer	1	1.3
Sweet Shop owner	1	1.3
Land broker	1	1.3
Tire shop	1	1.3
Total	**79**	**100.0**

Annex Table G.13. Employed RDUs' Drug Use During Employment

Response	Count	Percent
Yes	73	92.4
No	6	7.6
Total	79	100.0
Question: If yes, what did you use?		
Brown Sugar	44	55.7
Marijuana	42	53.2
Alcohol	36	45.6
Stimulant pills	36	45.6
Codeine	30	38.0
Hashish	27	34.2
TD	8	10.1
ICE	1	1.3
LSD, Speed	1	1.3
White Sugar	1	1.3
Total	79	286.1

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.14. Arrest Record of RDUs prior to Drug Use

Response	Count	Percent
Question: If you were arrested, how many times?		
2 to 4 times	42	61.8
1 time	13	19.1
5 to 10 times	8	11.8
More than 10 times	5	7.4
Total	68	100.0
Question: What were the reasons for arrest?		
Fights (including gang fights)	50	72.5
For inquiry	2	2.9
Late night	2	2.9
Pick pocketing/robbery	2	2.9
Vandalizing, public case	2	2.9
Police thought I was a dealer	1	1.4
Family dispute	1	1.4
Family had me caught	1	1.4
Teasing girls	1	1.4
For no reason	1	1.4
Hooliganism	1	1.4
I was small, can't talk further	1	1.4
Bike accident	1	1.4
Inquiry on murder	1	1.4
Shooting air gun at house owner's son	1	1.4
Total	**68**	**100.0**

Annex Table G.15. Arrest Record of RDUs During Drug Use Career

Response	Count	Percent
Question: If you were arrested, how many times?		
2 to 4 times	55	46.2
5 to 10 times	32	26.9
1 time	22	18.5
More than 10 times	10	8.4
Total	**119**	**100.0**
Question: What were the reasons for Arrests?		
Possession & Drug use	63	52.9
Fights (including gang fight)	27	22.7
Buying drugs	20	16.8
Hunting for drugs, meeting with dealer	12	10.1
Under influence of Alcohol	8	6.7
Selling drugs	5	4.2
Arrested by family's consent	5	4.2
Stealing/Robbing	4	3.4
Disturbing neighbors, hooliganism, vandalism	4	3.4
Hitting or tying to hit a police	3	2.5
Police checking, raids, breaking curfew	3	2.5
Don't want to mention	1	0.8
Firing weapon inside my house	1	0.8
Walking with users	1	0.8
Escaping from rehab center	1	0.8
Smuggling drugs from Birgunj	1	0.8
Walking around with fake gun	1	0.8
Total	**119**	**134.5**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.16. HIV Status of RDUs

Response	Count	Percent
HIV Status		
Don't know	67	43.8
Negative	54	35.3
Positive	14	9.2
I don't want to know	14	9.2
No response	4	2.6
Total	**153**	**100.0**
Question: If positive, when did you find out about it?		
1 yr.	4	28.6
2 yrs.	3	21.4
8 yrs.	2	14.3
5 to 6 months	2	14.3
22 days	1	7.1
6 yrs.	1	7.1
No response	1	7.1
Total	**14**	**100.0**
Question: If positive, have you disclosed your status with your family?		
Already disclosed	8	57.1
I think I will in future	3	21.4
Don't know	2	14.3
I won't disclose	1	7.1
Total	**14**	**100.0**

**note- many testing negative had their tests done prior to their last relapse*

Annex Table G.17. Hepatitis Status of Respondents

Response	Count	Percent
Hepatitis* Status		
Don't know	81	52.9
Negative	34	22.2
Positive	16	10.5
No response	12	7.8
I don't want to know	10	6.5
Total	**153**	**100.0**
Question: If with Hepatitis, when did you find out about it?		
1 yr.	5	31.3
2 yrs.	3	18.8
7 yrs.	2	12.5
15 yrs.	1	6.3
18 month	1	6.3
2 months	1	6.3
6 months	1	6.3
6 yrs.	1	6.3
9 yrs.	1	6.3
Total	**16**	**100.0**

**Any types of Hepatitis*

Annex Table G.18. RDUs' Father's Background

Response	Count	Percent
Fathers' Age		
40 to 50 years old	34	25.6
51 to 60 years old	65	48.9
61 to 70 years old	23	17.3
71 to 80 years old	11	8.3
Total	**133**	**100.0**
Question: If death of father, when did he die?		
11 to 20 years ago	12	34.3
6 to 10 years ago	9	25.7
3 to 5 years ago	6	17.1
21 years ago or more	6	17.1
1 to 2 years ago	2	5.7
Total*	**35**	**22.9**
Father's Educational Level		
Literate	41	26.8
Don't know/No response	40	26.1
Below SLC	27	17.6
College	23	15
Masters or PhD	14	9.2
Illiterate	8	5.2
Don't know/No response	40	26.1
Total	**153**	**100**

Annex Table G.18. RDUs' Father's Background (Continued)

Father's Type of Work		
Private	44	31.0
Governmental	37	26.1
Family business	29	20.4
Retired	29	20.4
Abroad	20	14.1
Farming	13	9.2
Total	**142**	**121.1***
Father's Average Earning's per Month		
Don't know	34	23.9
10 to 20 thousand	28	19.7
5 to 10 thousand	23	16.2
1 to 5 thousand	17	12.0
50 thousand & over	15	10.6
20 to 30 thousand	13	9.2
30 to 50 thousand	11	7.7
Below 1,000	1	0.7
Total	**142**	**100.0**

** Total Percent is derived from dividing total from 153. Note: Total percent adds up to more than 100 due to multiple responses*

Annex Table G.19. Work Title/Level/Nature of RDUs' Fathers' Work

Response	Count	Percent
British Army (retired & serving)	22	15.5
Businessman (clothing, stationary, antique, tourist, transport, carpentry, vegetable)	19	13.4
Driver	15	10.6
Shop owner (*kirana*, cold store)	9	6.3
Officer (incl. administration)	8	5.6
Manager, director, assistant director	8	5.6
Don't know	7	4.9
Nepal Army (incl. Major, Lieutenant)	5	3.5
Khardar/Subba	5	3.5
Company owner (carpet, trekking, or simply company)	5	3.5
CDO, Deputy general, IGP, Mayor, Pilot	5	35
Farmer	4	2.8
Land broker, and construction supervisor	4	2.8
Shop owner (clothing, meat)	4	2.8
Engineer (mechanical, chief)	3	2.1
Abroad	2	1.4
Home construction workers (*dakarmi*)	2	1.4
Health/Lab assistant	2	1.4
Tourist/trekking guide	2	1.4
Laundry/Mechanic	2	1.4
Politician/Secretary of government ministry	2	1.4
Astrologer	1	0.7
Thief	1	0.7
Bar supervisor	1	0.7
Journalist	1	0.7
Office peon	1	0.7
Police	1	0.7
School principal	1	0.7
Total	**142**	**100.0**

Annex Table G.20. Substance Use (including Alcohol) by RDUs' Father

Response	Count	Percent
Substance Use (including Alcohol) by Father		
Yes	107	74.3
No	37	25.7
Total	**144**	**100.0**
*Types of **Substances** Used by Father*		
Substances	Count	Percent
Alcohol	105	98.1
Alcohol, ganja	1	0.9
Marijuana, TD	1	0.9
Total	**107**	**100.0**
*Father's **Pattern** of Substance Use*		
Response	Count	Percent
Regular	35	32.7
Sometimes with friends	32	29.9
Only on festivals	18	16.8
Irregular	17	15.9
Dependent	8	7.5
Total	**107**	**102.8**

Note: total percent adds up to more than 100 due to multiple responses

Annex Table G.21. RDUs' Fathers' Attitude

Response	Count	Percent
***Question**: How traditional is your father?*		
Average	54	38.0
Only on some issues	35	24.6
Very much	32	22.5
Not at all	14	9.9
Don't know	7	4.9
Total	**142**	**100.0**
Question: How tolerant is your father regarding drugs and deviance?		
Can't tolerate if its too much	61	43.0
Can't tolerate at all	45	31.7
Tolerant	34	23.9
No response	2	1.4
Total	**142**	**100.0**
Typical nature of father when he breaks down		
Doesn't talk for days	57	40.1
Gets physical	47	33.1
Cries softly or alone	30	21.1
Tells the incidents to relatives	14	9.9
Leaves the house	10	7.0
Tries to convince/counsel me (*samjhaunae*)	8	5.6
Cries heavily	7	4.9
Scolds me (*galli garnae*)	4	2.8
Gets angry, tries to pick a fight, breaks things	3	2.1
Fights with or scolds mother or everyone	3	2.1
Gets depressed, sliently reacts, does not sleep at night	3	2.1
Does nothing, just tolerates	2	1.4
Sits alone or grumbles alone	2	1.4
Faints	1	0.7
Drinks alcohol	1	0.7
Total	**142**	**135.2**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.22. RDUs' Mothers' Background

Response	Count	Percent
Mother's Age		
41 to 50 years old	59	41.3
51 to 60 years old	45	31.5
30 to 40 years old	22	15.4
61 to 70 years old	16	11.2
71 years old or above	1	0.7
Total	**143**	**100.0**
Question: If death of mother, when did she die?		
11 to 20 years ago	5	33.3
6 to 10 years ago	4	26.7
3 to 5 years ago	3	20.0
1 to 2 years ago	2	13.3
21 years ago or more	1	6.7
Total	**15**	**100.0**
Mother's Educational Level		
Illiterate	60	39.2
Literate	37	24.2
Below SLC	22	14.4
Don't know	20	13.1
College	13	8.5
Masters	1	0.7
Total	**153**	**100**
Mother's Work Type		
Fulltime house wife	106	74.1
Farming	15	10.5
Private	10	7.0
Family business	7	4.9
Governmental	6	4.2
Retired	4	2.8
Abroad	3	2.1
Total	**143**	**105.6***
***Mother's** Average Earnings per Month*		
Don't know	21	47.7
5 to 10 thousand	8	18.2
1 to 5 thousand	8	18.2
50 thousand & over	3	6.8
Below 1,000	2	4.5
30 to 50 thousand	1	2.3
10 to 20 thousand	1	2.3
Total	**44**	**100.0**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.23. Work Title/Level/Nature of RDUs' Mother's Work

Response	Count	Percent
Housewife	106	74.1
Shopkeeper (cold store, *kirana*, tourist)	8	5.6
Business (clothing, rickshaw, trekking, hotel)	7	4.9
Farming	5	3.5
Cleaner (*aaya*)/ Gagri (metal container) shiner/ Laundry/ Tea shop owner	4	3.5
Cook/ hotel worker	3	2.1
Nurse/nurse teacher	3	2.1
Office staff	3	2.1
Abroad work	2	1.4
Politician/ Ward member	2	1.4
Social worker/ Teacher	2	1.4
Total	**143**	**102.1**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.24. Substance Use (including Alcohol) by RDUs' Mother

Response	Count	Percent
No	111	76.0
Yes*	35	24.0
Total	**146**	**100.0**
Mother's Pattern of Substance Use		
Substances	Count	Percent
Only on festivals	16	45.7
Irregular	9	25.7
Sometimes with friends	5	14.3
Regular	4	11.4
Dependent	1	2.9
Total	**35**	**100.0**

** all mothers were using alcohol*

Annex Table G.25. RDUs' Mother Attitude

Response	Count	Percent
Question: How traditional is your mother?		
Very much	53	36.3
Average	47	32.2
Only on some issues	33	22.6
Not at all	8	5.5
Don't know	5	3.4
Total	**146**	**100.0**
Question: How tolerant is your mother regarding drugs and deviance?		
Tolerant	58	39.7
Can't tolerate if its too much	49	33.6
Can't tolerate at all	39	26.7
Total	**146**	**100.0**
Typical Nature of Mother when she breaks down		
Cries softly or alone	91	62.3
Doesn't talk for days	29	19.9
Cries heavily	26	17.8
Tells the incident to relatives	22	15.1
Faints	13	8.9
Gets physical	10	6.8
Scolds me (*gali garnae*)	7	4.8
Convinces me (*samjhaunae*)	6	4.1
Leaves the house	5	3.4
Just tolerates	2	1.4
Depression	1	0.7
Heart pain	1	0.7
Keeps quiet	1	0.7
Won't eat food	1	0.7
Total	**146**	**147.3**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.26. Spouses' Background

Response	Count	Percent
Spouse's Age		
20 to 25 years old	27	50.0
26 to 30 years old	13	24.1
31 to 35 years old	9	16.7
36 to 40 years old	3	5.6
19 years old or lesser	1	1.9
41 years old or above	1	1.9
Total	**54**	**100.0**
Spouse's Educational Level		
Below SLC	19	35.2
College	16	29.6
Literate	13	24.1
Illiterate	3	5.6
Don't know	3	5.6
Total	**54**	**100.0**
Work Title/Level/Nature of RDUs' Spouse		
No response/ Unemployed/ Family business	23	42.6
Housewife	16	29.6
Farming	3	5.6
School teacher	3	5.6
Clothing shop/sewing knitting/ Handicraft	3	5.6
Cleaner/Dishwasher	2	3.7
Secretary	2	3.7
Abroad employee	1	1.9
Hotel operation	1	1.9
Total	**54**	**100.0**
Spouse's Average Earnings per Month		
No response/uncertain	31	57.4
1 to 5 thousand	9	16.7
Don't know	7	13.0
5 to 10 thousand	5	9.3
50 thousand & over	1	1.9
Below 1,000	1	1.9
Total	**54**	**100.0**

Annex Table G.27. Substance Use (including Alcohol) by RDUs' Spouse

Response	Count	Percent
Substance Use (including Alcohol) by RDUs' Spouse		
Yes	11	20.4
No	43	79.6
Total	**54**	**100.0**
Spouse's Pattern of Substance Use		
Only on festivals	6	54.5
Dependent	3	27.3
Sometimes with friends	2	18.2
Total	**11**	**100.0**
Types of Substances Used by Spouse		
Alcohol	7	63.6
Alcohol, TD, Brown	1	9.1
Chyang, beer	1	9.1
Drugs but clean now	1	9.1
Ganja, tabs, IDU, Brown sugar	1	9.1
Total	**11**	**100.0**

Annex Table G.28. RDUs' Spouse's Attitude

Response	Count	Percent
Question: How traditional is your spouse?		
Average	32	59.3
Very much	9	16.7
Only on some issues	8	14.8
Not at all	5	9.3
Total	**54**	**100.0**
Question: How tolerant is your spouse regarding drugs and deviance?		
Can't tolerate if its too much	19	35.2
Tolerant	17	31.5
Can't tolerate at all	16	29.6
No response/Don't know	2	3.7
Total	**54**	**100.0**
Typical Nature of Spouse when she breaks down		
Response	Count	Percent
Cries softly or alone	23	42.6
Doesn't talk for days	21	38.9
Leaves the house	8	14.8
Cries heavily	8	14.8
Tells the incident to relatives	6	11.1
Scolds & Fussy	2	3.7
Faints	1	1.9
Gets physical	1	1.9
Get angry	1	1.9
Goes to *maiti* (parent's house)	1	1.9
Just tolerates	1	1.9
Convinces me	1	1.9
Sharing	1	1.9
Total	**54**	**138.9**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.29. RDUs' Family Characteristics

Response	Count	Percent
Type of Family		
Joint	70	45.8
Nuclear	83	54.2
Total	**153**	**100**
Number of Family Members		
3 to 5 members	82	53.6
6 to 10 members	53	34.6
11 to 15 members	9	5.9
1 to 2 members	5	3.3
16 to 20 members	3	2
More than 20 members	1	0.7
Total	**153**	**100**
Other Members in Family		
Parents & siblings	45	30.8
Family	19	13.0
Wife & children	11	7.5
Mother, siblings	10	6.8
Parents	7	4.8
Parents, siblings, inlaws & their children	7	4.8
Parents siblings, wife & children	5	3.4
Parents, siblings & immediate cousins/relatives	5	3.4

Annex Table G.29. RDUs' Family Characteristics (Continued)

Response	Count	Percent
Other Members in Family		
Parents siblings, wife & children	5	3.4
Parents, siblings & immediate cousins/relatives	5	3.4
Mother, siblings & inlaws	4	2.7
Mother, siblings & grandparents	3	2.1
Mother, wife & children	3	2.1
Parents, grandparents, siblings, wife & children	3	2.1
Parents, siblings & inlaws	3	2.1
Parents, wife	3	2.1
Only one parent	3	2.1
Parents, grandparents & siblings	2	1.4
Father & young brother	1	0.7
Father, siblings & step mother	1	0.7
Father, siblings, wife, children & relatives	1	0.7
Father, wife & children	1	0.7
Grandma, siblings & aunt	1	0.7
Mother, siblings & wife	1	0.7
Parents, grandparents, wife, son	1	0.7
Parents, siblings & uncle aunt	1	0.7
Parents, siblings& wife	1	0.7
Parents, wife, children, sibling, inlaws	1	0.7
Siblings	1	0.7
Wife	1	0.7
Wife, siblings & inlaws	1	0.7
Total	**146**	**100.0**

Note: family are counted as those sharing a same kitchen

Annex Table G.30. Economic Characteristics of RDUs' Family

Response	Count	Percent
Economic Class of Family		
Middle	112	73.2
High-middle	24	15.7
Lower-middle	8	5.2
Lower	6	3.9
Higher	3	2.0
Total	**153**	**100.0**
Question: What type of house is your family living in?		
Own house	131	85.6
Rented	21	13.7
Guthi's house	1	0.7
Total	**153**	**100.0**
Sources of Income in the Family		
Jobs	69	45.1
Rent	61	39.9
Family business	60	39.2
Pension	36	23.5
Land	31	20.3
Total	**153**	**168.0**
Question: Who are the primary earners in the family?		
Father	104	68.0
Elder brother,*dai*	52	34.0
Mother	29	19.0

Annex Table G.30. Economic Characteristics of RDUs' Family (Continued)

Response	Count	Percent
Question: Who are the primary earners in the family?		
Sisters	20	13.1
Wife	12	7.8
Self	10	6.5
Bhai	6	3.9
Nobody (but could have house rent)	5	3.3
Younger sister, *bahini*	3	2.0
Sister in-law, *bhauju*	3	2.0
Uncles and aunty	3	2.0
Grand Father	2	1.3
Elder Son	1	0.7
Total	**153**	**160.8**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.31. Substance Abuse In Family (besides parents and spouse)

Response	Count	Percent
Question: Are there other members in the family using substances?		
Yes	42	27.5
No	111	72.5
Total	**153**	**100**
Question: If yes, what is your relation to him/her?		
Brother (younger or older)	37	88.1
Sister (younger or older)	3	7.1
Kaka (father's brother)	1	2.4
Mama (mother's brother)	1	2.4
Total	**42**	**100.0**
Question: If yes, what is/are their choice of substances?		
Alcohol	21	50.0
Brown sugar	15	35.7
Ganja	12	28.6
TD	12	28.6
Tabs	5	11.9
Ice	1	2.4
Phensydel	1	2.4
Total	**42**	**159.5**
Question: Are there any smokers in the family (besides you)?		
Yes	89	58.2
No	64	41.8
Total	**153**	**100**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.32. Use of Alcohol in RDUs' Family

Response	Count	Percent
Question: Is alcohol allowed in the family?		
Yes	103	67.3
No	50	32.7
Total	**153**	**100**
Question: If yes, what is the pattern of alcohol use?		
Only on festive occasions	54	52.4
When guests visit	46	44.7
Once in a while	27	26.2
Regularly	24	23.3
Total	**103**	**146.6**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.33. Information on RDUs' In-Laws

Response	Count	Percent
Question: Are your siblings married?		
Yes	96	62.7
No	51	33.3
No response/no siblings	6	3.9
Total	**153**	**100.0**
Question: If yes, how is your relationship with the in-laws?		
Okay	56	58.3
Very good	27	28.1
Not good	9	9.4
Not in contact	4	4.2
Total	**96**	**100.0**

Annex Table G.34. Question: Which member of the family are you closest with?

Response	Count	Percent
Mother	80	52.3
Brother (younger & older)	27	17.6
Sister (younger & older)	26	17.0
Wife	20	13.1
Bhai (younger brother)	13	8.5
Dad	11	7.2
Didi (older sister)	9	5.9
All	8	5.2
Bahini (younger sister)	6	3.9
Dai (older brother)	6	3.9
Grand parent(s)	3	2.0
No one	3	2.0
Bhauju (brother's wife)	2	1.3
Son & children	2	1.3
Bhanji (niece)	1	0.7
Cousin brother	1	0.7
Bhena (elder sister's husband)	1	0.7
Kaki (uncle)	1	0.7
Parents	1	0.7
Total	**153**	**144.4**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.35. Level of Religiosity in RDUs' Family

Response	Count	Percent
So-so	59	38.6
Very Religious	30	19.6
Religious	28	18.3
Only on occasions	23	15
Only one parent very religious	6	3.9
Don't know	4	2.6
Not religious	3	2
Total	**153**	**100**

Annex Table G.36. Information on RDUs' Relatives

Response	Count	Percent
Question: Who are considered as close relatives to your family?		
Mama/maiju (mother's brother, his wife)	44	28.8
Fupu (father's sister)	38	24.8
Kaka/kaki (father's younger brother, his wife)	23	15.0
Thul bau/ama (father's older brother, his wife)	14	9.2
Sasu/sasura (father and mother in law)	13	8.5
Sano ama (mother's younger sister)	13	8.5
Grand parent(s)	10	6.5
Bhena/didi (elder sister, her husband)	8	5.2
Aunty	5	3.3
No one	5	3.3
Bhauju (elder brother's wife)	2	1.3
Salo (brother in law)	2	1.3
Bhanja (niece)	1	0.7
Don't know	1	0.7
Step mother	1	0.7
Total	**153**	**117.6**
***Question**: How close are you with your relatives?*		
So-so	67	45.0
Very close with only few	33	22.1
Very close	22	14.8
Not close	16	10.7
I hate them	7	4.7
No response	3	2.0
Total	**149**	**100.0**

Annex Table G.37. Information on RDUs' Neighborhood

Response	Count	Percent
Economic Class of Neighborhood		
All mixed	70	45.8
Rich & middle class	38	24.8
Mostly middle class people	34	22.2
Mostly rich people	10	6.5
Mostly poor people	1	0.7
Total	**153**	**100.0**
Demographic Characteristics of Neighborhood		
Puranobasti (old neighborhood)	96	62.7
Many houses on rent	35	22.9
Nayabasti (recently established neighborhood)	32	20.9
Most male members gone abroad	22	14.4
Total	**153**	**120.9**
Ethnicity/Caste Characteristics of Neighborhood		
Mixed	96	62.7
Mostly from same ethnic-caste	30	19.6
Don't know	27	17.6
Total	**153**	**100**
Facilities in the Neighborhood		
Temple	101	66.0
School	99	64.7
Sports/Playing area	90	58.8
Snooker house	78	51.0
Don't know	44	28.8
Park	37	24.2
Bank, clinic, cyber house, hotel, market, apartment area, hospital, casino, disco, film hall	12	7.8
Total area	**153**	**300.7**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.38. RDUs' Awareness and Interaction with the Neighborhood

Response	Count	Percent
***Activities** in the Neighborhood*		
Organizes *jatra* (religious festivals)	69	45.1
Organizes entertainment programs	59	38.6
Don't know	57	37.3
Total	**153**	**120.9**
Level of Interaction in the Neighborhood		
Everybody knows everybody	77	50.3
Everybody doesn't know everybody	47	30.7
Nobody knows anybody	11	7.2
Strong community unity	13	8.5
Don't know/I am new	19	12.4
Total	**153**	**109.2**
*Question: Are you **usually** aware of what is happening in your neighborhood?*		
No	97	63.4
Yes	56	36.6
Total	**153**	**100**
*Question: Have **you** ever participated in neighborhood activities?*		
No	104	68.0
Yes	49	32.0
Total	**153**	**100.0**
Question: What neighborhood activities have you participated in?		
No response	16	32.7
Football/sports tournament, music concert, festival	10	20.4
Tole (neighborhood) development, volunteer, meetings, blood donation,	9	18.4
Religious activities	8	16.3
Club programs	6	12.2
Total	**49**	**100.0**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.39. Neighborhood's Stance on RDUs

Response	Count	Percent
*Question: **Does** your neighborhood know that you're using drugs?*		
Yes	144	94.1
No	9	5.9
Total	**153**	**100**
Question: If yes, does your neighborhood view you in suspicion?		
Yes	116	80.6
No	26	18.1
Don't know	2	1.4
Total	**144**	**100.0**
Question: If yes, does your neighborhood label you as an 'addict'?		
Yes	93	64.6
No	48	33.3
Don't know	3	2.1
Total	**144**	**100.0**
Question: If yes, do they ignore/reject you if you meet them?		
Yes	78	54.2
No	63	43.8
Don't know	3	2.1
Total	**144**	**100.0**
Question: If yes, are you accused of introducing drugs to youngsters?		
No	70	48.6
Yes	69	47.9
Don't know	5	3.5
Total	**144**	**100.0**

Yes- does not necessarily mean the whole neighborhood

Annex Table G.40.Types and Mode of Mono Dependent Drug

Dependent on	Count	Percent
Brown Sugar (pull)	12	37.5
TD	12	37.5
Alcohol	3	9.4
Brown Sugar (inject)	3	9.4
Marijuana	1	3.1
Stimulant pills	1	3.1
Total Mono Drug Dependents	32	20.9
Total Sample	**153**	

Note: percentage for 'Total Mono Drug Dependents' is derived from 'Total Sample'

Annex Table G.41. Types and Modes of Poly Dependant Drugs

Dependent on	Count	Percent
Brown Sugar (pull) and TD	14	11.6
Brown Sugar (pull), TD and Marijuana	13	10.7
Alcohol, Brown Sugar (pull), Brown Sugar (inject), TD & Marijuana	8	6.6
Brown Sugar (pull), Brown Sugar (inject), TD, Marijuana, Stimulant pills	6	5.0
Brown Sugar (pull) and Marijuana	6	5.0
Alcohol, TD and Marijuana	5	4.1
Alcohol, Brown Sugar (pull), Brown Sugar (inject), TD, Marijuana and Stimulant pills	5	4.1
Brown Sugar (inject) and TD	5	4.1
Brown Sugar (pull), Brown Sugar (inject), TD and Marijuana	5	4.1
Brown Sugar (pull), TD, Marijuana and Stimulant pills	4	3.3
Alcohol, Brown Sugar (pull), TD and Marijuana	3	2.5
Alcohol, Brown Sugar (pull), TD, Marijuana and Stimulant pills	3	2.5
Alcohol and TD	3	2.5
Brown Sugar (pull) and Brown Sugar (inject)	3	2.5
Brown Sugar (pull), Brown Sugar (inject) and TD	3	2.5
Brown Sugar (pull), Marijuana and Stimulant pills	3	2.5
Brown Sugar (pull) and Stimulant pills	3	2.5
Brown Sugar (pull), TD and Stimulant pills	3	2.5
Alcohol and Brown Sugar (pull)	2	1.7
Alcohol, Brown Sugar (pull), Brown Sugar (inject) and TD	2	1.7
Alcohol, Brown Sugar (pull) and Marijuana	2	1.7
Alcohol, Brown Sugar (pull) and TD	2	1.7
Brown Sugar (inject), TD and Marijuana	2	1.7
Brown Sugar (pull), Brown Sugar (inject), TD and Stimulant pills	2	1.7
TD and Marijuana	2	1.7
Alcohol and Brown Sugar (inject)	1	0.8
Alcohol, Brown Sugar (inject), TD and Marijuana	1	0.8
Alcohol, Brown Sugar (inject), TD, Marijuana, and Stimulant pills	1	0.8
Alcohol, Brown Sugar (pull), Brown Sugar (inject) and Marijuana	1	0.8
Alcohol, Brown Sugar (pull), Brown Sugar (inject), Marijuana and Stimulant pills	1	0.8
Alcohol, Brown Sugar (pull), Brown Sugar (inject), TD and Stimulant pills	1	0.8
Alcohol, Brown Sugar (pull), Marijuana and Stimulant pills	1	0.8
Alcohol, Brown Sugar (pull), TD and Stimulant pills	1	0.8
Alcohol and Marijuana	1	0.8
Alcohol, Marijuana and Stimulant pills	1	0.8
Alcohol, TD, Marijuana and Stimulant pills	1	0.8
TD, Marijuana and Stimulant pills	1	0.8
Total Poly Drug Dependants	**121**	**79.1**
Total Sample	**153**	

Note: percentage for 'Total Poly Drug Dependents' is derived from 'Total Sample'

Annex Table G.42. Alcohol Dependency Information

Response	Count	Percent
Dependency Period		
8 to 10 years	11	22.4
1 to 2 years	8	16.3
5 to 7 years	8	16.3
17 years or more	6	12.2
14 to 16 years	5	10.2
6 to 11 months	3	6.1
3 to 4 years	3	6.1
11 to 13 years	3	6.1
1 to 5 months	2	4.1
Total	**49**	**100.0**
First Introduced by		
Family	15	30.6
Tole friends	7	14.3
Father	5	10.2
Friend(s)	4	8.2
School friends	4	8.2
Self	4	8.2
Relatives, culture, in *Bhoj* (community party)	4	8.2
Senior bros, school friends	3	6.0
Outside friends and village friend	2	4.0
Girl friend	1	2.0
Total	**49**	**100.0**
Age when first used		
16 to 20 years old	21	42.9
10 to 15 years old	19	38.8
6 to 9 years old	3	6.1
No response	3	6.1
21 to 25 years old	2	4.1
26 years old or more	1	2.0
Total	**49**	**100.0**

Tole (neighborhood) friends also include senior brothers from the tole

Annex Table G.43. Brown Sugar (Pull mode) Dependency Information

Response	Count	Percent
Dependency Period		
3 to 4 years	40	37.0
5 to 7 years	29	26.9
1 to 2 years	20	18.5
8 to 10 years	11	10.2
17 years or more	3	2.8
Less than 11 months	2	1.9
14 to 16 years	2	1.9
11 to 13 years	1	0.9
Total	**108**	**100.0**
First Introduced by		
Tole friend(s)	42	38.9
Friends	15	13.9
School friend(s)	14	13.0
Cousin brother	9	8.3
College friend	7	6.5
Close friend	4	3.7

Annex Table G.43. Brown Sugar (Pull mode) Dependency Information (Continued)

Response	Count	Percent
First Introduced by		
Outside *tole* friend(s)	3	2.8
Senior brother	3	2.8
Mama (mother's brother) *Kaka's* (father's brother) friend, *kaka*	3	2.8
A person that I don't know well, foreigner friend	2	1.9
Friend who lived in my house	1	0.9
Girl friends	1	0.9
Local dealer	1	0.9
Recovering friend	1	0.9
Co-worker	1	0.9
Total	**108**	**100.0**
Age when first used Brown Sugar (pull)		
16 to 19 years old	69	63.9
20 to 24 years old	20	18.5
12 to 15 years old	14	13.0
25 to 30 years old	3	2.8
No response	2	1.9
Total	**108**	**100.0**

Tole friends also include senior brothers from the tole

Annex Table G.44. Brown Sugar (Injecting Mode) Dependency Information

Response	Count	Percent
Brown Sugar (Inject) Dependency Period		
1 to 2 years	12	23.5
1 to 5 months	8	15.7
5 to 7 years	8	15.7
3 to 4 years	7	13.7
8 to 10 years	7	13.7
6 to 11 months	3	5.9
17 years or more	3	5.9
11 to 13 years	2	3.9
14 to 16 years	1	2.0
Total	**51**	**100.0**
Brown Sugar (inject) first Introduced by		
Tole friend(s)	22	43.1
Friend(s)	10	19.6
Outside friend, friend's friend	6	11.8
Cousin brother, senior *dai*	3	5.9
School friend, *tole* friends	2	3.9
Co-worker	2	3.9
Close friend	2	3.9
Dealer	1	2.0
Girl friend	1	2.0
Mama	1	2.0
Total	**51**	**100.0**
Age when first used Brown Sugar (inject)		
20 to 24 years old	23	45.1
15 to 19 years old	22	43.1
25 to 29 years old	4	7.8
30 to 34 years old	1	2.0
35 to 36 years old	1	2.0
Total	**51**	**100.0**

Tole friends also include senior brothers from the tole

Annex Table G.45. TD (Buprenorphine) Dependency Information

Response	Count	Percent
TD Dependency Period		
1 to 2 years	24	22.2
3 to 4 years	21	19.4
5 to 7 years	20	18.5
8 to 10 years	20	18.5
11 to 13 years	7	6.5
1 to 5 months	6	5.6
6 to 11 months	5	4.6
14 years or more	5	4.6
Total	**108**	**100.0**
TD first Introduced by		
Tole friend(s)	48	44.4
Friend(s)	21	19.4
User friend	7	6.5
Cousin brother	6	5.6
Friend(s) outside tole	5	4.6
Senior brother, far cousin brother	4	3.7
Tole, school friends, village friends	4	3.7
Friend(s) from Rehab, self	4	3.7
Close friend	3	2.8
Co-worker	2	1.9
Kaka's friend, *mama*	2	1.9
Dealer	1	0.9
Girl friend	1	0.9
Total	**108**	**100.0**
Age when first used TD		
14 to 19 years old	46	42.6
20 to 24 years old	36	33.3
25 to 29 years old	16	14.8
No response	4	3.7
30 to 34 years old	3	2.8
35 to 36 years old	3	2.8
Total	**108**	**100.0**

Tole friends also include senior brothers from the tole

Annex Table G.46. Marijuana/Hashish Dependency Information

Response	Count	Percent
Marijuana/Hashish Dependency Period		
8 to 10 years	20	26.0
5 to 7 years	16	20.8
14 to 16 years	11	14.3
3 to 4 years	10	13.0
11 to 13 years	7	9.1
1 to 2 years	6	7.8
More than 16 years	6	7.8
Less than one year	1	1.3
Total	**77**	**100.0**
Marijuana/Hashish first Introduced		
Tole friends	32	41.6
School friends	20	26.0
Friends	16	20.8
Close friend, cousin brother, elder brother	7	9.1

Annex Table G.46. Marijuana/Hashish Dependency Information (Continued)

Response	Count	Percent
Marijuana/Hashish first Introduced		
Saw uncle use it	1	1.3
Self	1	1.3
Total	**77**	**100.0**
Marijuana/Hashish: Age when first used		
15 to 18 years old	42	54.5
11 to 14 years old	23	29.9
19 to 22 years old	10	13.0
23 to 25 years old	2	2.6
Total	**77**	**100.0**

Tole friends also include senior brothers from the tole

Annex Table G.47. Stimulant Pills Dependency Information

Response	Count	Percent
***Stimulant** pills Dependence Period*		
1 to 2 years	11	28.2
3 to 4 years	11	28.2
5 to 7 years	7	17.9
8 to 10 years	6	15.4
Less than one year	2	5.1
11 to 15 years	2	5.1
Total	**39**	**100.0**
*Names of **Stimulant** pills Used by Dependents*		
Nitrosun	23	59.0
Proxyvon	13	33.3
Nitrovet	11	28.2
Codeine	7	17.9
Dormein	4	10.3
Diazepam	4	10.3
Effidrine and valium	2	5.1
Cinol	2	5.1
Phenart	1	2.6
Hipnotex	1	2.6
Tripex	1	2.6
Corex	1	2.6
Spyams	1	2.6
Total	**39**	**182.1**
Stimulant pills first Introduced by		
Tole friends	16	41.0
Friends	9	23.1
School friends	4	10.3
Close friend	3	7.7
College friend and self	3	7.7
Friends outside *tole*	2	5.1
Cousins and friends	2	5.1
Total	**39**	**100.0**
*Age **when** first used Stimulant pills*		
14 to 19 years old	28	73.7
20 to 24 years old	8	21.1
25 to 29 years old	1	2.6
No response	1	2.6
30 years or older	1	2.6
Total	**38**	**100.0**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.48. Drug Intake Frequency and Dependency Duration

Response	Count	Percent
Intake Frequency		
Almost daily-less than 5 times a day	88	57.5
Almost daily-more than 5 times a day	61	39.9
Less than 4 times a month	2	1.3
Very rarely	1	0.7
Whenever I had it	1	0.7
Total	**153**	**100.0**
Dependency Duration		
5 to 7 years	53	34.6
8 to 10 years	37	24.2
3 to 4 years	21	13.7
More than 16 years	15	9.8
11 to 13 years	13	8.5
14 to 16 years	8	5.2
1 to 2 years	6	3.9
Total	**153**	**100**

Annex Table G.49. Information of RDUs' Use of Needles

Response	Count	Percent
Question: Did you use needles to inject drugs in your career?		
Yes	132	86.3
No	21	13.7
Total	**153**	**100**
Reasons for use of Needles		
Less money-more high	74	56.1
Non injecting drugs weren't available	24	18.2
I liked it better than non injection route	15	11.4
My friends forced me into it	12	9.1
For experience/ for fun	6	4.5
Accepting friend's advice	2	1.5
Curiosity, not satisfied with pull trip	2	1.5
Started drugs with needles	2	1.5
Alternate drug use	1	0.8
Friends were using needles	1	0.8
Long lasting, durable	1	0.8
Step by step all rounder	1	0.8
To quit brown sugar	1	0.8
Tragedy with girl friend	1	0.8
When in need of heavier dose	1	0.8
Total	**132**	**109.1**
Duration of Needle Use		
5 to 7 years	24	18.2
1 to 2 years	23	17.4
8 to 10 years	23	17.4
3 to 4 years	22	16.7
More than 10 years	12	9.1
1 to 5 months	9	6.8
Less than 1 month	8	6.1
6 to 11 months	7	5.3
No response/Don't know	4	3.0
Total	**132**	**100.0**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.50. Question: How old were you when you first tried gateway substances?

Response	Count	Percent
Tobacco (any forms, including Khaini)		
10 to 14 years old	88	59.1
15 to 19 years old	54	36.2
Less than 10 years old	7	4.7
Total	**149**	**97.4**
Beer/Wine/Chyang -rice beer		
15 to 19 years old	82	62.1
10 to 14 years old	40	30.3
20 to 24 years old	5	3.8
Less than 10 years old	4	3.0
More than 24 years old	1	0.8
Total	**132**	**86.3**
Alcohol		
15 to 19 years old	88	67.2
10 to 14 years old	33	25.2
20 to 24 years old	6	4.6
Less than 10 years old	2	1.5
More than 24 years old	2	1.5
Total	**131**	**85.6**
Marijuana (Ganja)		
15 to 19 years old	87	61.3
10 to 14 years old	49	34.5
20 to 24 years old	6	4.2
Total	**142**	**92.8**
Hashish		
15 to 19 years old	78	63.4
10 to 14 years old	36	29.3
20 to 24 years old	9	7.3
Total	**123**	**80.4**
Tablets (Stimulant pills)		
15 to 19 years old	72	70.6
10 to 14 years old	15	14.7
20 to 24 years old	13	12.7
More than 24 years old	2	2.0
Total	**102**	**66.7**
Codeine based Cough Syrup		
15 to 19 years old	96	72.2
20 to 24 years old	18	13.5
10 to 14 years old	14	10.5
More than 24 years old	4	3.0
Less than 10 years old	1	0.8
Total	**133**	**86.9**

Note: Percentage for 'Total' of each substance category is derived from total sample -153; Percentages for age groups are based on the 'total' count for respective substances.

Annex Table G.51. RDUs' Means and Number of Cessation Attempts

Response	Count	Percent
Means of Cessation		
DRC	153	100.0
Self (cold turkey approach)	87	56.9
Doctor's medication (including detox. in medical settings)	56	36.6
Other	18	11.8
Total	**153**	**205.2**
Through DRC		
2 times	93	60.8
3 times	34	22.2
4 to 5 times	20	13.1
6 to 7 times	4	2.6
More than 7 times	2	1.3
Total	**153**	**100**
Through Self (cold turkey approach)		
2 to 4 times	37	42.5
1 time	26	29.9
5 to 9 times	15	17.2
15 to 19 times	4	4.6
More than 19 times	3	3.4
10 to 14 times	2	2.3
Total	**87**	**100.0**
Through Doctor's Medications (incl. detox in medical settings)		
1 time	28	18.3
2 to 4 times	23	15
More than 9 times	3	2
5 to 9 times	2	1.3
Total	**56**	**36.6**
Through Other Means		
In jail/custody	10	55.6
Going to village	3	16.7
Self detoxification	2	11.1
Sick with Tuberculosis	1	5.6
Moved residence	1	5.6
HIV Care and Support Center	1	5.6
Total	**18**	**100.0**

Cessation through self = more than 24 hours clean with exception of nicotine and/or caffeine
Note: total percent adds up to more than 100 due to multiple responses.
Detoxification cessation = staying 24 hours clean after the last day of medication
The highest cases of cessation through custody/jail for a single respondent was 14 times

Annex Table G.52. RDUs' Network with User Friends/Circle

Response	Count	Percent
Number of Users in Close Circle		
Between 1 to 5	104	68.0
0 usually takes alone	44	28.8
Between 6 to 10	3	2.0
Between 11 to 15	2	1.3
Total	**153**	**100.0**
Use of Drugs with during Dependent Stage		
Sometimes friends, sometimes alone	133	86.9
With friends	19	12.4
No response	1	0.7
Total	**153**	**100.0**

Annex Table G.53. Characteristics of RDUs' Close Circle (Part I)

Response	Count	Percent
Economic Background of Circle		
Mostly middle class	62	40.5
Rich & middle	54	35.3
Middle & poor	15	9.8
Mostly rich	12	7.8
Rich & poor	6	3.9
No response	3	2
Mostly poor	1	0.7
Total	**153**	**100**
Ethnic/Caste Background of Circle		
From different ethnic-caste	121	79.1
Mostly from same ethnic-caste	30	19.6
No response	2	1.3
Total	**153**	**100**
Activities of Circle after Drug Use		
Listening-playing music	88	57.5
Roaming around town	68	44.4
Hanging out in certain locations	57	37.3
Talking about weird things	34	22.2
Watching movies	26	17.0
No such activities	18	11.8
Fights	2	1.3
Talking	2	1.3
Work	2	1.3
Any fun stuff	1	0.7
Bike riding with friends	1	0.7
Deep sharing about love & life	1	0.7
Disco, playing basketball	1	0.7
Collecting money from shops forcefully (*Hapta uthaunae*)	1	0.7
More hunting, look for money	1	0.7
Sitting in a room	1	0.7
Slept	1	0.7
Total	**153**	**199.7**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.54. Characteristics of RDUs' Close Circle (Part II)

Response	Count	Percent
Question: Was your circle involved in traveling to border areas to buy drugs?		
Yes	76	49.7
No	48	31.4
Very rarely	29	19
Total	**153**	**100**
Was your circle involved in selling drugs?		
Yes	70	45.8
No	47	30.7
Very rarely	36	23.5
Total	**153**	**100**
Financial Status of Circle		
Sometimes loaded sometimes broke	123	80.4
Money was no problem	24	15.7
Always short of cash	6	3.9
Total	**153**	**100**
Question: How was your circle able to come up with the money?		
By lying	96	62.7
By asking close family	79	51.6
By stealing	74	48.4
By selling drugs	52	34.0
By threatening close family	49	32.0
Working	33	21.6
Coercing people from *tole/* Money collection from shop (*hapta uthaunae)*	4	2.6
Robbing, selling personal stuff	2	1.3
Asking friends in & out of circle, friends bring in money	2	1.3
Total	**153**	**255.6**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.55. Characteristics of RDUs' Close Circle (Part III)

Response	Count	Percent
Question: Does your circle have any cases of drug overdose?		
Yes	78	51
No	73	47.7
No response	2	1.3
Total	**153**	**100**
Question: Did anybody in your circle die due to drug overdose?		
No	85	55.6
Yes	66	43.1
No response	2	1.3
Total	**153**	**100**
Question: Was there any cases of arrests in your circle?		
Yes	114	74.5
No	38	24.8
No response	1	0.7
Total	**153**	**100**
Question: If there were cases of arrests, were they drug related?		
Drug related	100	87.7
Non-drug issues	31	27.2
Total	**114**	**114.9**
Question: How many in your circle have stayed in a DRC?		
Almost half	54	35.3
Almost all	45	29.4
Only me	31	20.3
Only few	20	13.1
No response	3	2
Total	**153**	**100**

Annex Table G.55. Characteristics of RDUs' Close Circle (Part III Continued)

Response	Count	Percent
Question: If friends have stayed in DRC, how would you describe their recovery?		
Trying hard to recover	71	59.7
Relapsed	66	55.5
Recovering	31	26.1
Didn't find center as helpful	20	16.8
Total	**119**	**158.0**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.56. Characteristics of RDUs' Drug Use Career (Part I)

Response	Count	Percent
Question: *What was the frequency of needle sharing in your career?		
Never shared	58	37.9
Very rarely	45	29.4
Sometimes	43	28.1
Most of the time	6	3.9
No response	1	0.7
Total	**153**	**100**
Question: Did you ever travel to the border areas to buy drugs?		
Yes	72	47.1
No	53	34.6
Very rarely	28	18.3
Total	**153**	**100**
Question: Did you ever sell drugs to support your habit?		
Yes	63	41.2
No	55	35.9
Very rarely	35	22.9
Total	**153**	**100**
Question: How was your financial status while in use?		
Sometimes loaded sometimes broke	113	73.9
Money was no problem	23	15
Always short of cash	17	11.1
Total	**153**	**100**
Question: How were you able to come up with the money?		
By asking close family	101	66.0
By lying	95	62.1
By stealing	80	52.3
By selling drugs	51	33.3
Working	40	26.1
By threatening close family	37	24.2
Collection of money from shops (*Hapta uthaunae*)	2	1.3
Selling own clothes & personal items	2	1.3
Asking credits for fake reasons	1	0.7
Family gave me money	1	0.7
Asking friend	1	0.7
Putting valuables on collateral (D*hik*)	1	0.7
Selling dealer's drugs	1	0.7
Total	**153**	**269.9**

** respondents also include non-IDUs*
Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.57. Characteristics of RDUs' Drug Use Career (Part II)

Response	Count	Percent
Question: How extensive were your connections with dealers?		
Only knew limited persons	55	35.9
Know almost all major dealers in & outside my city	38	24.8
Know almost all major dealers in the city	29	19
Only knew those in my neighborhood	27	17.6
Don't know	4	2.6
Total	**153**	**100**
Most Enjoyed Activities when High on Drugs		
Listening-playing music	96	62.7
Roaming around town	70	45.8
Hanging out in certain locations	53	34.6
Watching movies	50	32.7
Thinking about weird things	43	28.1
No such activities	10	6.5
Having sex (single or multiple partners)	5	3.3
Being alone (or liked to be alone)	4	2.6
Fights	2	1.3
Sleeping	2	1.3
Disco, sports, video games	2	1.3
Criminal activities	1	0.7
Deep sharing, reading	1	0.7
Future planning with girlfriend	1	0.7
Just enjoy the trip- smoke *ganja*	1	0.7
Liked to study write	1	0.7
Masturbating	1	0.7
Planting flowers	1	0.7
Talk about fun things	1	0.7
Total	**153**	**225.5**
Question: Have you ever used force or hit anyone in the family or close ones?		
Yes	83	54.2
No	69	45.1
No response	1	0.7
Total	**153**	**100**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.58. Worst action/incidence ever involved in during Drug Carrier

Response	Count	Percent
Fight with family member	14	9.2
Stealing family's gold	12	7.8
Robbing/looting others	11	7.2
Stealing	10	6.5
Caught by police/arrests	9	5.9
Fight	8	5.2
Hitting and vandalizing	5	3.3
Use abused language on mom and family	5	3.3
Vehicle accident on use	4	2.6
Dealing drugs	4	2.6
Lying to those who believed in me	4	2.6
Beating and bullying	3	2.0
Accused of fraud	3	2.0
Pick pocket	2	1.3
Attempted rape	2	1.3

Annex Table G.58. Worst action/incidence ever involved in during Drug Carrier (Continued)

Response	Count	Percent
Bike and house stuff on *dhik* (collateral)	2	1.3
Caught while stealing (one-garlanded with shoes)	2	1.3
Don't know/don't remember	2	1.3
Jailed	2	1.3
Selling own gold	2	1.3
Selling things from temple	2	1.3
Separating with wife	2	1.3
Separation from family	2	1.3
Stealing had me arrested	2	1.3
Angry personality/bursts	1	0.7
Asking money from family	1	0.7
Beating my wife	1	0.7
Breaking curfew	1	0.7
Bunking school	1	0.7
Caught by police on possession of fire arm	1	0.7
Caught my hands in front of parents	1	0.7
Didn't care of others	1	0.7
Drank dettol	1	0.7
Unconscious on the street	1	0.7
Finding out I was HIV+	1	0.7
Fired from office	1	0.7
Firing a gun recklessly inside my house	1	0.7
Hitting a cop	1	0.7
Giving problems to family	1	0.7
Hurt mom's feelings	1	0.7
My body deformed	1	0.7
My business was ruined	1	0.7
My current situation	1	0.7
My father died	1	0.7
My friend overdosed in front of me	1	0.7
Nearly stabbed my father	1	0.7
Nearly went mad in front of my mom	1	0.7
Public beat me up	1	0.7
Quitting job	1	0.7
Betraying relatives	1	0.7
Robbing own house	1	0.7
Selling things from house	1	0.7
Sold didi's property	1	0.7
Sold family's gold/land	1	0.7
Stealing cousin's gold	1	0.7
Sister had me arrested	1	0.7
Stole gold	1	0.7
Stole son's money	1	0.7
Shamed father in front of society	1	0.7
Tried to burn the whole family	1	0.7
Unmanageability	1	0.7
Writing out mother's bank cheque	1	0.7
Total	**153**	**100.0**

Annex Table G.59. Beliefs and Values of RDUs (Part I)

Response	Count	Percent
On Academic Achievement*		
Very important	57	37.3
Important	57	37.3
Maybe important	17	11.1
Not so important	13	8.5
Not important at all	9	5.9
Total	**153**	**100**
On Independence		
Important	74	48.4
Very important	50	32.7
Maybe important	17	11.1
Not so important	9	5.9
Not important at all	2	1.3
Don't know/No response	1	0.7
Total	**153**	**100**
On Support from Parents/Close ones		
Very important	78	51
Important	52	34
Maybe important	13	8.5
Not so important	6	3.9
Don't know/No response	4	2.6
Total	**153**	**100**
On Learnings from the DRC		
Very important	104	68
Important	36	23.5
Maybe important	10	6.5
Not important at all	1	0.7
Not so important	1	0.7
Don't know	1	0.7
Total	**153**	**100**

**Achievement meaning studying more than current attainment*

Annex Table G.60. Beliefs and Values of RDUs (Part II)

Response	Count	Percent
On 'friends** are Important part of my Life'		
Important	70	45.8
Not so important	27	17.6
Maybe important	23	15
Very important	21	13.7
Not important at all	12	7.8
Total	**153**	**100**
On Spirituality		
Important	61	39.9
Very important	39	25.5
Maybe important	36	23.5
Not so important	12	7.8
Not important at all	4	2.6
Don't know/No response	1	0.7
Total	**153**	**100**

Annex Table G.60. Beliefs and Values of RDUs (Part II Continued)

Response	Count	Percent
On 'In order for me to stay Clean, my User Circle also has to be Clean'		
Very important	50	32.7
Important	35	22.9
Not so important	31	20.3
Maybe important	22	14.4
Not important at all	13	8.5
Don't know/ No response	2	1.3
Total	**153**	**100**
On Educational level of Parents/Spouse		
Important	69	45.1
Very important	49	32
Maybe important	18	11.8
Not so important	8	5.2
Don't know/ No response	5	3.3
Not important at all	4	2.6
Total	**153**	**100**

***Friends as both users and non users*

Annex Table G.61. Relationships of RDUs with Parents/Spouse

Response	Count	Percent
Relation with Parents/Spouse when during Drug Use		
Good	53	34.6
Ok	47	30.7
Not good	36	23.5
Very bad	11	7.2
Don't know	3	2
Excellent	2	1.3
No response	1	0.7
Total	**153**	**100**
Relation with Parents/Spouse during Relapse		
Ok	59	38.6
Good	34	22.2
Not good	30	19.6
Very bad	23	15
Don't know	5	3.3
No response	2	1.3
Total	**153**	**100**
Question: How supportive were your parents/spouse on your cessation efforts?		
Very supportive	114	74.5
So-so	32	20.9
Not supportive	4	2.6
Don't know	3	2
Total	**153**	**100**
Question: How did your parents/spouse usually talk to you during cessation?		
Normally	82	53.6
Very openly	65	42.5
Angrily	7	4.6
Didn't talk at all	4	2.6
Only occasionally	4	2.6
Suspicious	2	1.4
I didn't want to talk	1	0.7
They didn't care for me	1	0.7
They seemed scared, afraid	1	0.7
Total	**153**	**109.2**

Annex Table G.62. RDUs' General Impression of Father, Mother, and Spouse

Response	Count	Percent
General Impression of Father		
Loving but also strict	54	38.0
Understanding	53	37.3
Loving	45	31.7
Average dad	22	15.5
Don't get along	15	10.6
Strict	9	6.3
Don't talk	7	4.9
Very traditional	7	4.9
Total	**142**	**149.3**
General Impression of Mother		
Loving	97	66.4
Understanding	76	52.1
Loving but also strict	24	16.4
Average mother	12	8.2
Very traditional	11	7.5
Don't get along	3	2.1
Strict	2	1.4
Don't talk	0	0.0
Total	**146**	**154.1**
General Impression of Spouse		
Loving	31	57.4
Understanding	30	55.6
Loving but also strict	6	11.1
Average spouse	3	5.6
Don't get along	3	5.6
Very traditional	2	3.7
Don't talk	1	1.9
Total	**54**	**140.7**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.63. RDUs' Family Experiences

Response	Count	Percent
Question: Do you still remember incidences when your parents badly hit you, or scolded you in front of others when you were a kid?		
Yes	83	54.2
No	70	45.8
Total	**153**	**100**
Question: What kind of family environment were you brought up in?		
Strict but loving	87	56.9
Loose	43	28.1
Very loose	12	7.8
No response	6	3.9
Very strict	5	3.3
Total	**153**	**100.0**
Question: Was your father present with you when you were growing up?		
Yes	71	46.4
Partly yes, partly no	43	28.1
I was in hostel	24	15.7
No	22	14.4
Total	**153**	**104.6**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.64. Close Relatives' Knowledge and Reaction on RDUs' Drug Use

Response	Count	Percent
Question: Does your close relatives know of your drug use?		
Yes	119	79.9
Maybe	22	14.8
Don't know	4	2.7
No	3	2.0
No response	1	0.7
Total	**149**	**100.0**
Question: Is there lots of gossiping/rumor among your close relatives about your drug use?		
Yes	63	42.3
Maybe	46	30.9
Don't know	30	20.1
No	10	6.7
Total	**149**	**100.0**
Question: Are your close relatives supportive of your cessation efforts?		
Yes	83	55.7
Maybe	29	19.5
They don't care	13	8.7
Don't know	12	8.1
No	11	7.4
No response	1	0.7
Total	**149**	**100.0**
Question: If yes or maybe, are they really supportive?		
They are really supportive from the inside	67	59.8
They just say don't do drugs	35	31.3
No response	10	8.9
Total	**112**	**100.0**

Annex Table G.65. 'Self' Reasons for Use to Abuse of Drugs: Major Reasons

Response	Count	Percent
Euphoria or ecstasy, immediate satisfaction	68	45.9
Complicating factor of withdrawal problems	53	35.8
Risk Taker	52	35.1
Drug controlled biological rhythm (e.g., sleep pattern)	46	31.1
Low Self Esteem	41	27.7
Unable to cope with anxiety& conflict without drug	41	27.7
Physical addiction	39	26.4
Psychologically dependent	35	23.6
Introverted or withdrawn individual	34	23.0
Seeking some form of escape	30	20.3
Seeking a more dramatic form for reducing tension	28	18.9
Loneliness	28	18.9
To protect me from a sense of failure	25	16.9
Fear and admission that I am an addict, junkie	24	16.2
Relief of pain, anxiety, and fatigue	22	14.9
A thrill in not achieving anything in life	22	14.9
No single point at which I suddenly became addicted	20	13.5
To defend myself from insecurity	19	12.8
Part of group who all have the same feeling of no achievement	18	12.2
Inspired by friends, to appear macho, to become active, normal, slim	4	2.7
Breakup with girlfriend	2	1.4
To get into music, to study, to kill time	2	2.7
Wanted to find out the trip, wanted to taste it one time	2	2.7
Family didn't understand me	1	0.7
Total	**148**	**443.9**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.66. 'Self' Reasons for Use to Abuse of Drugs: Minor Reasons

Response	Count	Percent
A thrill in not achieving anything in life	33	26.2
Part of group who all have the same feeling of no achievement	31	24.6
Drug controlled biological rhythm (e.g. sleep patterns)	29	23.0
Introverted or withdrawn individual	28	22.2
Euphoria or ecstasy, immediate satisfaction	26	20.6
Loneliness	26	20.6
Risk Taker	25	19.8
Seeking a more dramatic form for reducing tension	25	19.8
Relief of pain, anxiety, and fatigue	25	19.8
Low Self esteem	24	19.0
Seeking some form of escape	21	16.7
Complicating factor of withdrawal problems	21	16.7
Psychologically dependent	18	14.3
To protect me from a sense of failure	18	14.3
Physical addiction	18	14.3
No single point at which I suddenly became addicted	17	13.5
Fear and admission that I am an addict, junkie	14	11.1
Unable to cope with anxiety & conflict without drug	13	10.3
To defend myself from insecurity	13	10.3
Pleasure seeking	2	1.6
Betrayal by girlfriend	1	0.8
Curiosity	1	0.8
Wasn't happy inside	1	0.8
Total	**126**	**100.0**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.67. 'Availability' Reasons for Use to Abuse of Drugs

Response	Count	Percent
Major 'Availability' Reasons		
Locally available	94	64.4
Close friend was using drugs	93	63.7
Met users in everyday life	67	45.9
Dealer lives in the neighborhood	61	41.8
Surrounded by others who use drugs	57	39.0
Affordable, not expensive	37	25.3
My close relative had access to drugs	12	8.2
The guard of my dad provided me drugs	1	0.7
Own friends were dealers	1	0.7
Total	**146**	**289.7**
Minor 'Availability' Reasons		
Met users in everyday life	40	40.4
Affordable, not expensive	38	38.4
Surrounded by others who use drugs	24	24.2
Close friend was using drugs	22	22.2
Locally available	21	21.2
Dealer lives in the neighborhood	17	17.2
My close relative had access to drugs	14	14.1
Total	**99**	**177.8**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.68. 'Socio-Cultural' Reasons for Use to Abuse of Drugs

Response	Count	Percent
Major 'Socio-Cultural' Reasons		
Location where there was dense group of IDUs	51	42.9
High degree of drug related activities in the neighborhood	50	42.0
Lived in an environment broadminded or liberal about drug use	42	35.3
Neighborhood disadvantage	35	29.4
Small area deprivation	23	19.3
Low income background	19	16.0
Recent immigration/change of locality	17	14.3
Alcohol was acceptable in caste	1	0.8
Didn't get help when tried to quit	1	0.8
Lived near border easily available	1	0.8
Seniors using drugs	1	0.8
Total	**119**	**202.5**
Minor 'Socio-Cultural' Reasons		
Neighborhood disadvantage	24	32.9
Location where there was dense group of IDUs	19	26.0
High degree of drug related activities in my neighborhood	19	26.0
Low income background	18	24.7
Small area deprivation	17	23.3
Lived in an environment broadminded or liberal about drug use	12	16.4
Recent immigration/change of locality	8	11.0
Neighborhood folks only watched my drama	1	1.4
Total	**73**	**161.6**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.69. 'Friends & Trends' Reasons for Use to Abuse of Drugs

Response	Count	Percent
Major 'Friends & Trends' Reasons		
Association with addicts	88	58.7
Seeking a new 'high' every time	67	44.7
Lots of free time	60	40.0
Feeling that 'I won't be addicted'	58	38.7
Closest friend was using drugs	54	36.0
Sufficient peer support	53	35.3
Knew many guys who were in drug networks	46	30.7
Other sources of pleasures became less interesting	39	26.0
Uninteresting, boring life	35	23.3
Achieving and maintaining a feeling of freedom	35	23.3
Gave importance and approval among friends	33	22.0
Overall gain was greater than the overall cost	31	20.7
Couldn't get along with normal friends	28	18.7
Large number of new guys like me entered the network	25	16.7
It was the only source of reward for me	16	10.7
Trying to copy friends to be cool	1	0.7
Total	**150**	**446.0**

Annex Table G.69. 'Friends & Trends' Reasons for Use to Abuse of Drugs (Continued)

Response	Count	Percent
Minor 'Friends & Trends' Reasons		
Knew many guys who were in drug network	40	32.3
Other sources of pleasures became less interesting	39	31.5
Feeling that 'I won't be addicted'	37	29.8
Overall gain was greater than the overall cost	35	28.2
Couldn't get along with normal friends	32	25.8
Uninteresting, boring life	31	25.0
Lots of free time	31	25.0
Sufficient peer support	30	24.2
Closest friend was using	30	24.2
Large number of new guys like me entered the network	29	23.4
Achieving and maintaining a feeling of freedom	25	20.2
Gave importance and approval among friends	25	20.2
Seeking a new 'high' every time	21	16.9
Association with addicts	18	14.5
It was the only source of reward for me	12	9.7
Total	**124**	**100.0**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.70. 'Family' Reasons for Use to Abuse of Drugs

Response	Count	Percent
Major 'Family' Reasons		
Family didn't blame me but blamed others	49	34.8
I was given sufficient money by parents as pocket expense	47	33.3
Less supervision of family	44	31.2
To free myself from family and social responsibilities	43	30.5
Quarrels with family members (including spouse, step mother)	38	27.0
Family hid drug use from relatives and others	29	20.6
Dysfunction within the family	27	19.1
Death or loss of family member	21	14.9
Substance abusing parents (including alcohol)	18	12.8
Lack of supportive family	17	12.1
Low educational achievement of parent(s)	17	12.1
Silent protest against my family, community	16	11.3
Family didn't care	16	11.3
Single parent family	11	7.8
Separation from family member	9	6.4
Family gave me everything (over loving)	2	1.4
Very strict environment	1	0.7
Total	**141**	**287.2**
Minor 'Family' Reasons		
Family didn't blame me but blamed others	37	35.9
Family didn't care, not supportive	22	21.4
I was given sufficient money by parents	23	22.3
Silent protest against my family, community	22	21.4
Less supervision of family	22	21.4
Death, loss or separation of family member, single parent family	21	20.1
Family hid drug use from relatives and others	20	19.4
Low educational achievement of parent(s)	20	19.4
Quarrels with family members (including spouse, step mother)	17	16.5
To free myself from family and social responsibilities	14	13.6
Dysfunction within the family, father has two wives	14	13.6
Substance abusing parents (including alcohol)	11	10.7
Total	**103**	**100.0**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.71. 'Self' Reasons for Cessation of Drug Use

Response	Count	Percent
Major 'Self' Reasons		
Insightful and genuine realization that drugs are destructive	77	51.0
Fear of losing health or life	75	49.7
I hit rock bottom	74	49.0
Became disgusted by my own confused functioning	74	49.0
Awareness of possible death	52	34.4
Reduction in pleasure	50	33.1
Rising physical discomfort	46	30.5
Fear of HIV	45	29.8
Fear of psychological problems	39	25.8
Physical deterioration (collapse of veins, etc,.)	27	17.9
To bring physiological rhythm back	24	15.9
Medical complications: cirrhosis, hepatitis, HIV	22	14.6
Frightened by a paranoid intoxication psychosis	21	13.9
Didn't want to use anymore	1	0.7
I couldn't get an answer from drugs to some important questions of my life	1	0.7
Self motivation	1	0.7
Too much, I surrendered	1	0.7
Total	**151**	**417.2**
Minor 'Self' Reasons		
To bring physiological rhythm back	36	30.8
Reduction in pleasure	30	25.6
Physical deterioration (collapse of veins etc.,)	30	25.6
Awareness of possible death	30	25.6
Became disgusted by my own confused functioning	28	23.9
Fear of psychological problems	23	19.7
Rising physical discomfort	23	19.7
Frightened by a paranoid intoxication psychosis	23	19.7
Fear of HIV	18	15.4
Fear of losing health or life	17	14.5
I hit rock bottom	14	12.0
Insightful and genuine realization that drugs are destructive	13	11.1
Medical complications: cirrhosis, hepatitis, HIV	10	8.5
Total	**117**	**252.1**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.72. 'Friends' Reasons for Cessation of Drug Use

Response	Count	Percent
Mzajor 'Friends' Reasons		
My life was getting out of control	95	64.6
I was getting less and less high at higher and higher costs	51	34.7
Unhappy about belonging to a group viewed with strong suspicion & dislike	42	28.6
Lost connection or ended friendships	41	27.9
Some in my circle were tested HIV positive	33	22.4
Genuine help from my suffering best friend	32	21.8
My best friend decided to quit drugs	29	19.7
Death from overdose among friends	28	19.0
Even shorter period of stopping drugs brought back same high as before	23	15.6
Decline in interest to get involved with user circles	22	15.0
Introduction of another strong pleasurable experience	17	11.6
All my user friends decided to quit at the same time	15	10.2
Growing relationship with non user friends	15	10.2
My user friend got arrested	13	8.8
To kick the drug habit of my best friend	13	8.8
Maturity	4	2.7
Fellowship	1	0.7
Friends told me I was too 'junkie'	1	0.7
Seeing a friend who quit	1	0.7
Support from recovering friends	1	0.7
Total	**147**	**324.5**
Minor 'Friends' Reasons		
Unhappy about belonging to a group viewed with strong suspicion & dislike	34	29.1
Lost connection or ended friendships	31	26.5
Decline in interest to get involved with user circles	28	23.9
Genuine help from my suffering best friend	24	20.5
Growing relationship with non user friends	20	17.1
My best friend decided to quit drugs	19	16.2
Some in my circle were tested HIV positive	17	14.5
My life was getting out of control	15	12.8
I was getting less and less high at higher and higher costs	15	12.8
Even shorter period of stopping drugs	15	12.8
Introduction of another strong pleasurable experience	13	11.1
My user friend got arrested	12	10.3
All my user friends decided to quit at the same time	12	10.3
Death from overdose among friends	10	8.5
To kick the drug habit of my best friend	10	8.5
Maturity	4	3.4
Total	**117**	**238.5**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.73. 'Family' Reasons for Cessation of Drug Use

Response	Count	Percent
Major 'Family' Reasons		
Genuine support from my family	92	62.2
Developed a renewed sense of life	72	48.6
Fear of losing a spouse and family	63	42.6
I didn't want to steal or do shameful actions to maintain my habit	59	39.9
I was no longer in control of the situation	55	37.2
Rebirth of positive relationship with parents/loved ones	48	32.4
Pressure from family and close circles	42	28.4
I was getting physically violent with my family members	28	18.9
Fear of losing respect from peers	26	17.6
New opportunities for self enhancement, e.g., new job, education	18	12.2
Decided to drink alcohol in small	17	11.5
Fear of losing a valued job	13	8.8
Assumption of adult roles such as marriage, parenthood, full time employment	12	8.1
Aware of my family responsibilities	2	1.4
Miserable family relationship	2	1.4
For my family's happiness	1	0.7
Love for family and children	1	0.7
Realization that my study was very important	1	0.7
Total	**148**	**373.0**
Minor 'Family' Reasons		
Pressure from family and close circles	37	34.3
Fear of losing respect from peers	34	31.5
I was getting physically violent with my family members	32	29.6
I was no longer in control of the situation	26	24.1
I didn't want to steal or do shameful act to maintain my habit	25	23.1
Rebirth of positive relationship with parents and loved ones	25	23.1
Developed a renewed sense of life	18	16.7
Genuine support from my family	15	13.9
Fear of losing a spouse and family	14	13.0
New opportunities for self enhancement, e.g., new job, education	14	13.0
Decided to drink alcohol in small	11	10.2
Fear of losing a valued job	5	4.6
Assumption of adult roles such as marriage, parenthood, full time employment	5	4.6
Brother despised me	1	0.9
Relatives shamed me	1	0.9
Total	**108**	**243.5**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.74. 'Socio-cultural' Reasons for Cessation of Drug Use

Response	Count	Percent
Major 'Socio-cultural' Reasons		
Direct pressure from parents or spouse	65	56.5
Arrested by police	47	40.9
Forced treatment by the police, family, and close ones	37	32.2
Because of limited financial resources	35	30.4
Alternative solutions through religious/spiritual, social activities, relationships	12	10.4
Geographic or locality change (we moved)	7	6.1
Afraid that family's prestige may be lost	1	0.9
Shameful in font of society	1	0.9
Thought that society was ignoring me	1	0.9
Total	**115**	**179.1**
Minor 'Socio-cultural' Reasons		
Because of limited financial resources	26	36.1
Direct pressure from parents or spouse	24	33.3
Arrested by police	22	30.6
Forced treatment by the police, family, close ones	20	27.8
Alternative solutions through religious/spiritual activities, relationships	14	19.4
Geographic or locality change (we moved)	3	4.2
Total	**72**	**151.4**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.75. 'Availability' Reasons for Cessation of Drug Use

Response	Count	Percent
Major 'Availability' Reasons		
Decrease in availability of drugs	45	52.3
The dealers in our area were arrested	37	43.0
My close user friends left the country	35	40.7
Hard to get money	7	8.1
Dealer went abroad	1	1.2
M user brother wants to quit	1	1.2
Not available when needed	1	1.2
Not easily available	1	1.2
Only brown was available	1	1.2
Shortage of money	1	1.2
Total	**86**	**151.2**
Minor 'Availability' Reasons		
Decrease in availability of drugs	28	47.5
My close user friends left the country	26	44.1
The dealers in our area were arrested	22	37.3
Price was expensive	2	3.4
Difficult to work & hunting	1	1.7
Duplicate drug were available	1	1.7
Total	**59**	**135.6**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.76. Question: When did your relapse(s) occur?

Response	1st Relapse		2nd Relapse		3rd Relapse		4th Relapse		5th Relapse	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
3 to 4 months	3	2	5	5.8	4	9.8			3	18.8
5 to 6 months	9	5.9	4	4.7	3	7.3	1	4.8	1	6.3
7 to 8 months	8	5.2	7	8.1	2	4.9	1	4.8	1	6.3
9 to 11 months	6	3.9	2	2.3		0.0	1	4.8		
1 to 2 years	47	30.7	29	33.7	15	36.6	10	47.6	7	43.8
3 to 4 years	29	19	16	18.6	8	19.5	5	23.8	3	18.8
5 to 6 years	21	13.7	7	8.1	2	4.9	2	9.5	1	6.3
7 years and above	25	16.3	13	15.1	5	12.2	1	4.8		
11 to 15 days	1	0.7								
16 to 20 days	1	0.7								
1 to 2 months	3	2	3	3.5	2	4.9				
Total	**153**	**100**	**86**	**100.0**	**41**	**100.0**	**21**	**100.0**	**16**	**100.0**

Annex Table G.77. Question: How long did you use drugs after your relapse(s)?

Response	1st Relapse		2nd Relapse		3rd Relapse		4th Relapse		5th Relapse	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
21 to 24 days	1	0.7								
3 to 4 months	11	7.2	12	14.0	6	14.6	2	9.5	3	18.8
5 to 6 months	15	9.8	13	15.1	4	9.8	1	4.8	1	6.3
7 to 8 months	14	9.2	3	3.5	2	4.9	2	9.5		
9 to 11 months	4	2.6	4	4.7						
1 to 2 years	57	37.3	27	31.4	15	36.6	9	42.9	6	37.5
3 to 4 years	16	10.5	6	7.0	2	4.9	1	4.8	1	6.3
5 to 6 years	5	3.3	2	2.3						
7 years & above	4	2.6	2	2.3			1	4.8		
1 day	2	1.3			2	4.9	1	4.8		
2 to 5 days	6	3.9	4	4.7	1	2.4			2	12.5
6 to 10 days	1	0.7	1	1.2	1	2.4				
11 to 15 days	2	1.3	1	1.2	1	2.4	1	4.8	1	6.3
16 to 20 days	2	1.3	1	1.2						
25 to 29 days	1	0.7	2	2.3	1	2.4				
1 to 2 months	12	7.8	7	8.1	5	12.2	3	14.3	2	12.5
No response			1	1.2	1	2.4				
Total	**153**	**100**	**86**	**100.0**	**41**	**100.0**	**21**	**100.0**	**16**	**100.0**

Annex Table G.78. Decision of Enrolment and Duration of Stay at DRC prior to Relapse(s)

Response	1st Relapse		2nd Relapse		3rd Relapse		4th Relapse		5th Relapse	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Question: Was it your decision or of others to stay in a DRC prior to your relapse(s)?										
Own	52	34.0	38	44.2	18	43.9	13	61.9	8	50.0
Not 100 % my decision	30	19.6	15	17.4	9	22.0	6	28.6	3	18.8
Family and closed ones	65	42.5	32	37.2	16	39.0	4	19.0	4	25.0
User friend(s)	15	9.8	10	11.6		0.0			1	6.3
Cops	15	9.8	5	5.8	3	7.3			1	6.3
No response	4	2.6								
Total	**153**	**118.3**	**86**	**116.3**	**41**	**112.2**	**21**	**109.5**	**16**	**106.3**
Question: Did you stay full time at the DRC prior to your relapse(s)?										
Yes	81	52.9	38	44.2	24	58.5	12	57.1	8	50.0
No	70	45.8	44	51.2	17	41.5	8	38.1	7	43.8
No response	2	1.3	4	4.7			1	4.8	1	6.3
Total	**153**	**100**	**86**	**100.0**	**41**	**100.0**	**21**	**100.0**	**16**	**100.0**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.79. Reasons for not staying full time at the DRC prior to First Relapse

Response	Count	Percent
Home sick	5	7.1
Thought I could manage myself	4	5.7
Didn't like to stay	4	5.7
Couldn't understand program	3	4.3
Over confident, I won't use	3	4.3
Just went for the sake of family (family pressure, not of my own will)	3	4.3
Used inside the center	3	4.3
Argument or fights with clients or staff	3	4.3
I became ill (epilepsy, stomach problems)	3	4.3
Used on outing	3	4.3
Thought I knew all things of my recovery and program	2	2.9
Bored with the program	2	2.9
Center didn't have program	2	2.9
No commitment or I didn't surrender	2	2.9
Didn't like the behavior of staff	2	2.9
Didn't really want to quit	2	2.9
Had to work in office	2	2.9
Frustrated of not being free	2	2.9
I thought I got better/clean	2	2.9
Thought I will quit myself at home	2	2.9
Center too strict, I had to follow orders	2	2.9
Close friends in center one last time, I agreed	1	1.4
Didn't change my attitude	1	1.4
Dad expired	1	1.4
Had to take care of official document regarding our land	1	1.4
Didn't consider myself an addict	1	1.4
Didn't give outing after 2.5 months	1	1.4
Didn't want to stay for more than one month	1	1.4
Didn't have the faith in program	1	1.4
Frustrated with staff behavior	1	1.4
I had to study	1	1.4
Too many negative thoughts	1	1.4
I just couldn't do it	1	1.4
Lots of ragging at the center	1	1.4
Money reason	1	1.4
My family didn't want me to stay for long	1	1.4
My own stupidity	1	1.4
My wishes didn't come true	1	1.4
Negative discharge	1	1.4
Tested HIV+	1	1.4
Too young to understand drugs	1	1.4
Thought of my user friends	1	1.4
Missed my wife	1	1.4
Sexual obsession	1	1.4
Thought I could use in managed way	1	1.4
Total	**70**	**114.3**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.80. Reasons for not staying full time at the DRC prior to Second Relapse

Response	Count	Percent
No commitment/didn't surrender	3	6.8
Parents forced me (wasn't there by my will)	3	6.8
Argument, fight with staff or clients	3	6.8
Reservation, still wanted to use	3	6.8
Couldn't pay money	2	4.5
Didn't like behavior of seniors at center	2	4.5
Fellow brothers were using inside the center	2	4.5
Overconfident I won't use	2	4.5
Relapsed on outing	2	4.5
Sex reasons	2	4.5
Couldn't adjust at center; didn't find the environment suitable	2	4.5
Center didn't have program	1	2.3
Didn't take treatment/program seriously	1	2.3
Didn't think program would help me	1	2.3
Didn't want to stay	1	2.3
Encounter and blasting - didn't like	1	2.3
Felt my stay was enough	1	2.3
Worried about my girl friend who is also suffering	1	2.3
Guilty of coming back to same center	1	2.3
Homesick	1	2.3
Hooked on medicines	1	2.3
I had a job	1	2.3
Thought I wasn't fully prepared	1	2.3
I was brought directly from custody	1	2.3
Wasn't getting enough medicines at detox period	1	2.3
I was still 'sick' drug wise	1	2.3
I was heavily detoxed, my friends took me out	1	2.3
Negative thoughts	1	2.3
Overconfident I was fine	1	2.3
Disturbed on girl friend issues	1	2.3
Got bored	1	2.3
Felt like a culprit inside hell	1	2.3
Went to work abroad, but used drugs there	1	2.3
Total	**44**	109.1

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.81. Reasons for not staying full time at the DRC prior to Third Relapse

Response	Count	Percent
Didn't like to stay	2	11.8
Homesick	2	11.8
Didn't understand treatment/program	2	11.8
Got restless, uncomfortable, negative thoughts	2	11.8
Thought I could be clean by myself	2	11.8
Couldn't avoid circle	1	5.9
Girl friend issues/problems	1	5.9
Didn't believe in program	1	5.9
Didn't like behavior of seniors	1	5.9
From outing didn't feel like going	1	5.9
Not my wish to stay	1	5.9
Sexual obsession	1	5.9
Total	**17**	100.0

Annex Table G.82. Reasons for not staying full time at the DRC prior to Fourth Relapse

Response	Count	Percent
Couldn't understand the meaning of treatment center	1	12.5
Felt I had recovered	1	12.5
Frustration of not being able to go to Germany	1	12.5
I was hopeless, didn't want to give up drugs	1	12.5
Negative discharge	1	12.5
Negative thoughts	1	12.5
Sex problem	1	12.5
Use one last time	1	12.5
Total	**8**	100.0

Annex Table G.83. Reasons for not staying full time at the DRC prior to Fifth Relapse

Response	Count	Percent
Question: If you didn't stay full time at the center prior to your fifth relapse, why?		
Couldn't adjust, fought inside the center	1	14.3
Didn't like the medicinal treatment, gave medicine for 10 days -made me insane	1	14.3
Felt I won't use now	1	14.3
Found that I could get drugs on the streets Malaysia, so left the center	1	14.3
Had already decided to stay for only 1 month just to kill sickness	1	14.3
Negative thoughts	1	14.3
Used when I was given outing	1	14.3
Total	**7**	**100.0**

Annex Table G.84. Question: What factor(s) do you think led to your first relapse?

Response	Count	Percent
Overwhelming Craving for Drugs		
Couldn't forget good trip and desire to use	39	100.0
Total Craving	***39***	***25.5***
Self		
Pleasure seeking	18	12.6
Sex (Obsession, frustration)	16	11.2
One last time	7	4.9
Boring life (boredom)	6	4.2
Overconfident I won't use	6	4.2
Stubborn/ego problems/selfish	5	3.5
Physical craving gone, felt I had enough treatment	5	3.5
Didn't follow program	5	3.5
Didn't find program important or take it seriously	4	2.8
Wasn't fully motivated/no commitment	4	2.8
Had money/couldn't handle money	4	2.8
Didn't believe in self	4	2.8
Loneliness	4	2.8
Drug 'sick' not cured (physical discomfort)	3	2.1
Anger (got angry easily)	3	2.1
Didn't know drug was a disease	3	2.1
Felt myself a failure	3	2.1
Used ganja/alcohol/stimulant pills, thought they were not drugs	3	2.1
Manage use	3	2.1
No realization, carelessness	3	2.1
Unhappy	2	1.4
Wanted to enjoy *dashain* and *tihar*	2	1.4
Used in outing	2	1.4

Annex Table G.84. In Brief, what Factor(s) you think Led to your First Relapse? (Continued)

Response	Count	Percent
Couldn't say no to friends	2	1.4
Death of loved one	2	1.4
Couldn't understand program, didn't open myself at center	2	1.4
Decided to use only twice a month, use occasionally only	2	1.4
I wanted to work; I wanted to study	2	1.4
Couldn't control self, didn't know self better	2	1.4
Couldn't do anything whereas my friends were recovering, low will power	2	1.4
Negative thoughts inside the center, fight	2	1.4
King baby attitude, lying attitude	2	1.4
Didn't keep myself occupied	1	0.7
Girl friend issues	1	0.7
Couldn't face others	1	0.7
I was found HIV+	1	0.7
Couldn't cope with recovering brother	1	0.7
Tried to help user friend	1	0.7
Thought I was drug free	1	0.7
Couldn't handle, simple ups and downs	1	0.7
Just happened jokingly	1	0.7
Lack of faith in NA	1	0.7
Total Self	**143**	**93.5**
Friends		
Association with users (couldn't detach from user friends)	17	54.8
Close friends still using, I felt I could manage use	6	19.4
Friends used in front of me	4	12.9
Couldn't say no to friends	2	6.5
Tried to help user, over helpful for friends	2	6.5
Total Friends	**31**	**20.3**
Family		
Family/wife misunderstanding (or reasons, rejection, tension)	9	36.0
Went to center on force, for family's sake	7	28.0
Family didn't change their attitude towards me	4	16.0
Family fully trusted me (I got everything)	2	8.0
Death of loved one	2	8.0
Low income family	1	4.0
Total Family	**25**	**16.3**
Center		
No program instilled in me/no program in center or lack of program	7	63.6
Used drugs in the center (Loose environment)	3	27.3
No support from center	1	9.1
Total Center	**11**	**7.2**
Availability		
Friends used in front of me	4	33.3
Drug easily available	3	25.0
Couldn't change my attitude	2	16.7
Dealer lived in rent in my own house	1	8.3
Still had stuff in my house	1	8.3
Money easily available	1	8.3
Total Availability	**12**	**7.8**
Socio-cultural		
Wanted to enjoy *dashain* and *tihar*	2	66.7
Couldn't adjust with outside environment	1	33.3
Total Socio-cultural	***3***	***2.0***

Some causes appear more than once, as they could be associated with more than one category. Note: total percent for each category are derived from dividing total of each category from total relapse cases. Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.85. Question: What factor(s) do you think led to your second relapse?

Response	Count	Percent
Overwhelming Craving for Drugs		
Didn't want to quit (good trip)	17	94.4
"Drug" sick	1	5.6
Total Craving	**18**	**20.9**
Self		
Sex	14	20.0
Pleasure seeking	6	8.6
Anger	4	5.7
Ego/stubborn	3	4.3
No change in behavior/attitude (didn't work out)	3	4.3
Break up with girl friends or GF issues	3	4.3
No emotional growth/maturity	3	4.3
Over confidence	3	4.3
Boredom	2	2.9
Didn't take treatment seriously	2	2.9
Didn't use the tools center program taught me	2	2.9
Overconfidence – thought I could manage drugs	2	2.9
Free time, no engagement	2	2.9
Low will power	2	2.9
Unhappy/ Frustration	2	2.9
One last time	2	2.9
Low level of acceptance power	1	1.4
Couldn't understand the program	1	1.4
Didn't follow direction from my counselor	1	1.4
Didn't fully surrender	1	1.4
Divorce from wife	1	1.4
Guilty of coming back to same treatment	1	1.4
No commitment/realization	1	1.4
Homesick	1	1.4
Compromised on using alcohol	1	1.4
Loneliness	1	1.4
Tried to help my partner quit	1	1.4
Helping my friend's drug business	1	1.4
Compromised on periodic use	1	1.4
Used in outing	1	1.4
Very emotional behavior - got happy or sad easily	1	1.4
Total Self	**70**	**81.4**
Friends		
Association with active users or not avoiding them	10	71.4
Close friend used in front	1	7.1
One last time; as friends asked me	1	7.1
Used in center - couldn't say no to friend	1	7.1
Tried to help my partner quit	1	7.1
Total Friends	**14**	**16.3**
Family		
In center for sake of family	2	25.0
Expectation of parents (pressures)	2	25.0
Family didn't believe in me	2	25.0
Family tricked me and took me to rehab	1	12.5
Family and relative quarrels	1	12.5
Total Family	**8**	**9.3**

Annex Table G.85. Question: In Brief, what Factor(s) led to your Second Relapse? (Continued)

Response	Count	Percent
Center		
Couldn't understand the program	1	20.0
Guilty of coming back to same treatment	1	20.0
Received global hair cut	1	20.0
Used in center - couldn't say no to friend	1	20.0
"Drug" sick	1	20.0
Total Center	**5**	**5.8**
Availability		
No shortage of money	2	50.0
Chemical at home	1	25.0
Visiting place where drugs are available	1	25.0
Total Center	**4**	**4.7**
Socio-cultural		
Cops coercion	2	66.7
My office boss didn't understand my problems	1	33.3
Total Socio-cultural	**3**	**3.5**

Some causes appear more than once as they could be associated with more than one category
Note: total percent for each category are derived from dividing total of each category from total relapse cases.
Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.86. Question: What factor(s) do you think led to your third relapse?

Response	Count	Percent
Overwhelming Craving for Drugs		
Still wanted to use/craving strong	7	77.8
Used inside center	2	22.2
Total Craving	***9***	***22.0***
Self		
Pleasure seeking	6	14.3
Sex	4	9.5
Over confidence	3	7.1
Anger	2	4.8
Isolation/loneliness	2	4.8
Hopelessness/powerlessness	2	4.8
No happiness	2	4.8
Low self esteem and inferiority complex	2	4.8
Didn't follow program, didn't follow counselor's direction	2	4.8
Carried away with temptation	1	2.4
Didn't go to NA	1	2.4
Didn't realize I had to quit for myself	1	2.4
Didn't understand addiction as disease	1	2.4
Lack of problem	1	2.4
Escaping problem	1	2.4
Wanted easy way out	1	2.4
Don't know	1	2.4
Stayed at center just to be occupied	1	2.4
Couldn't go abroad	1	2.4
Not satisfied with life	1	2.4
One last time	1	2.4
No fellowship	1	2.4
Ego	1	2.4
Too minimize tension	1	2.4
Outing	1	2.4
No maturity	1	2.4
Total Self	**42**	**102.4**

Annex Table G.86. Question: What factor(s) you think led to your third relapse (Continued)?

Response	Count	Percent
Friends		
Association with users	2	50.0
Used inside center	2	50.0
Total Friends	**4**	**9.8**
Family		
Family misunderstanding	4	66.7
Family forced me into center	1	16.7
Family pressure to work	1	16.7
Total Family	**6**	**14.6**
Center		
Used inside center	2	50.0
Felt like in jail	1	25.0
Stayed at center just to be occupied	1	25.0
Total Center	**4**	**9.8**
Availability		
Access of money/no money problem	2	40.0
Chemicals at home	2	40.0
Dealers around	1	20.0
Total Availability	**5**	**12.2**
Socio-cultural		
Total Socio-cultural	**0**	**0.0**

Some causes appear more than once as they could be associated with more than one category
Note: total percent for each category are derived from dividing total of each category from total relapse cases. Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.87. Question: What factor(s) do you think led to your fourth relapse?

Response	Count	Percent
Overwhelming Craving for Drugs		
Desire to use/couldn't forget trip	5	100.0
Total Craving	**5**	**23.8**
Self		
Sex	4	13.3
Felt I was recovered/over confident	3	10.0
Loneliness	3	10.0
Hopelessness/emptiness	3	10.0
Didn't follow program seriously	2	6.7
Lazy	2	6.7
Anger problem	2	6.7
Ego/stubborn	2	6.7
1.5 years clean, thought nothing wrong by taking alcohol	1	3.3
Homesick	1	3.3
Lack of faith in self	1	3.3
Not being able to go abroad	1	3.3
No money problem	1	3.3
Pleasure seeking	1	3.3
People pleasing	1	3.3
Fear of rejection	1	3.3
Insecurity	1	3.3
Total Self	**30**	**142.9**

Annex Table G.87. Question: What factor(s) you think led to your fourth relapse (Continued)?

Response	Count	Percent
Friends		
Association with addicts	2	100.0
Total Friends	**2**	**9.5**
Family		
Family didn't understand my wishes	1	25.0
Family misunderstanding	1	25.0
Mother expired	1	25.0
Not being able to go abroad	1	25.0
Total Family	**4**	**19.0**
Center		
Felt like I was in jail	1	100.0
Total Center	**1**	**4.8**
Availability		
Not avoiding places	1	50.0
No money problem	1	50.0
Total Availability	**2**	**9.5**
Socio-cultural		
Total Socio-cultural	**0**	**0.0**

Some causes appear more than once as they could be associated with more than one category.
Note: total percent for each category are derived from dividing total of each category from total relapse cases. Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.88. Question: What factor(s) do you think led to your fifth relapse?

Response	Count	Percent
Overwhelming Craving for Drugs		
Still wanted to use	1	100.0
Total Craving	**1**	**6.3**
Self		
Sex	2	8.7
Pleasure seeking	2	8.7
Over confidence	2	8.7
Used in outing	2	8.7
Couldn't understand myself	1	4.3
Decided to use other chemicals	1	4.3
Didn't like center and its environment	1	4.3
Frustration	1	4.3
Lack of faith in self	1	4.3
Lack of faith in NA	1	4.3
Hopelessness	1	4.3
No application of program	1	4.3
Over confidence	1	4.3
Loneliness	1	4.3
Followed seniors in going outing and using and coming back to center	1	4.3
Myself to blame	1	4.3
Low self esteem	1	4.3
Over confidence on managing alcohol, marijuana	1	4.3
Girl friend issues	1	4.3
Total Self	**23**	**143.8**
Friends		
Followed seniors in going outing and using and coming back to center	1	100.0
Total Friends	**1**	**6.3**

Annex Table G.88. Question: What factor(s) do you think led to your fifth relapse (Continued)?

Response	Count	Percent
Family		
Family misunderstanding	2	66.7
Wife requested me to drink in wedding ceremony	1	33.3
Total Family	**3**	**18.8**
Center		
Center too loose	2	40.0
Didn't like center and its environment	1	20.0
Followed seniors in going outing and using and coming back to center	1	20.0
Counselor was shit - I had to teach him which was shameful	1	20.0
Total Center	**5**	**31.3**
Availability		
Money no problem	1	100.0
Total Availability	**1**	**6.3**
Socio-cultural		
Wife requested me to drink in wedding ceremony	1	100.0
Total Socio-cultural	**1**	**6.3**

Some causes appear more than once as they could be associated with more than one category
Note: total percent for each categories are derived from dividing total of each category from total relapse cases. Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.89. DRC Enrolled by RDUs in Sample

KTM Valley	Out of Valley	Out of Country
Ashara	Care n' Support	Heling chow, Hong Kong
Freedom	Naulo Ghumti	Sanjivani Detoxification
LALS	Serene Foundation	Suraj Treatment Center, Delhi
My Home	Support and care	Kripa, Darjeeling
Navajyoti	Care foundation	Sewayan, India
Navjivan	Clean society	Om sai Sahara, Delhi
Navkiran	Dharan Youth Center	Welcome community, Malaysia
Nepal Plus	Life support	
Nepal Youth	Punar jivan Kendra	
Pratigya	Sahara	
Richmond Fellowship		
Sangati		
Youth Vision		

Annex Table G.90. 'Very True' Reasons Behind Relapse(s)

Response	Count	Percent
I said I will never use drugs regularly again but only now & then, and then became re-addicted soon after	94	61.4
One last time!	82	53.6
Craving was powerful and persistent	78	51.0
I didn't attend socially supportive & voluntary programs like N.A.	68	44.4
I had lots of free time and no concrete plans on what to do with it	68	44.4
I wasn't genuinely honest about discontinuing drugs	64	41.8
I was very excited to face life when I left the center, but that excitement slowly died down as days passed by	63	41.2
I didn't ask for anybody's help	59	38.6
I had already made up my mind to use it one last time when I was in the treatment center	58	37.9
Once out of the center, I immediately tried to do many things to get back on track (e.g., studies, job). I should have waited any given more time for recovery	56	36.6
I repressed all my feelings. I didn't have anybody to share or understand my feelings.	49	32.0
Somehow deep inside, I thought I could never recover	48	31.4
Association with other addicts	47	30.7
I didn't know how to cope or handle when confronted with a high-risk situation	45	29.4
Contact with active addicts even when my readjustment with my family/society was satisfactory	45	29.4
I had no one to discipline me when I got out of the center	45	29.4
I always felt that something was missing from my life when I was not using drugs	44	28.8
M whole lifestyle revolved around drugs. Didn't know what to do without it and its lifestyle	43	28.1
I started associating with addicts and their circles, only they could understand me	43	28.1
I tried the clean approach but I was more comfortable with my user friends, & their way of life	43	28.1
I compromised on using softer drugs or alcohol.	43	28.1
Return to an environment in which availability of drugs was greater. It was all over in my neighborhood, school, work, etc.	43	28.1
I was clearly aware of the warning signs…but then, it just happened	42	27.5
My family was always suspicious of my activities-even though I was clean	41	26.8
I had difficulty in achieving new goals	41	26.8
Things weren't going my way. The resulting rage & anger that grew out of such disappointment compelled me.	40	26.1
I decided to take it anyway-even though life was going well	38	24.8
Failing to express my wants and needs-either they wouldn't listen or I couldn't tell them	35	22.9
My family was constantly pressuring me to do something in life	35	22.9
Failing to build up a network of relationships, activities, and involvements that would act as a barrier against boredom, & depression	34	22.2
My families did not change their attitude & behavior, they were same as when I was using drugs	33	21.6
I entered into treatment because of pressures from my family, cops in the first place	32	20.9
It started during festival season (dassain, tihar, fagu, shivaratri, new year, etc.)	32	20.9
I had nowhere to start my life. I couldn't restart my education, I had no job, no skills	32	20.9
I could not tolerate withdrawal distress. So I used to relieve withdrawal symptoms	30	19.6
The period I was recovering was psychologically distressing (due to depression, extreme guilt, anger & family tensions)	28	18.3
I could not get any jobs	27	17.6
Failing to find alternative (drug free) outlets for my needs	26	17.0
It was purely an accident.	25	16.3
It was very tempting for me to believe that just enough substance can be taken to control distressing mood states without returning to the level of compulsive use	25	16.3

Annex Table G.90. 'Very True' Reasons Behind Relapse(s) (Continued)

Response	Count	Percent
I had difficulty in finding new circle of friends	24	15.7
My family didn't believe in me	22	14.4
Treatment programs did not provide enough skills on how to defend myself & how to satisfy my inner needs & wishes	21	13.7
Prior suffering was remembered as being less intense & painful	20	13.1
No body cared on whether I was drug free or not	16	10.5
Unsuccessful adjustment with my family/community	16	10.5
Because of family crises (such as parents separating or a sibling developing problem, death, separation, etc.,)	14	9.2
I did whatever my parents told me to do, & that didn't help my recovery	12	7.8
Experiences of rejection from family & friends	12	7.8
I thought I would make some money by selling drugs & not using	6	3.9
I am HIV positive. I could not bear the feeling that I was HIV positive	6	3.9
Total	**153**	**100.0**

Annex Table G.91. 'True' Reasons behind Relapse(s)

Response	Count	Percent
Failing to build up a network of relationships, activities, and involvements that would act as a barrier against boredom, & depression	59	38.6
I started associating with addicts and their circles, only they could understand me	58	37.9
I tried the clean approach but I was more comfortable with my user friends, and their way of life	57	37.3
I was clearly aware of the warning signs…but then, it just happened	57	37.3
Association with other addicts	54	35.3
It was very tempting for me to believe that just enough substance can be taken to control distressing mood states without returning to the level of compulsive use	54	35.3
Contact with active addicts even when readjustment with my family/society was satisfactory	53	34.6
I didn't ask for anybody's help	53	34.6
Things weren't going my way. The resulting rage & anger that grew out of such disappointment compelled me.	52	34.0
I had difficulty in achieving new goals	51	33.3
Failing to express my wants and needs-either they wouldn't listen or I couldn't tell them	50	32.7
I was very excited to face life when I left the center, but that excitement slowly died down as days passed by	48	31.4
The period I was recovering was psychologically distressing (due to depression, extreme guilt, anger & family tensions)	47	30.7
M whole lifestyle revolved around drugs. Didn't know what to do without it and its lifestyle	46	30.1
I decided to take it anyway-even though life was going well	46	30.1
I had lots of free time and no concrete plans on what to do with it	45	29.4
Failing to find alternative (drug free) outlets for my needs	45	29.4
I always felt that something was missing from my life when I was not using drugs	45	29.4
Unsuccessful adjustment with my family/community	44	28.8
Return to an environment in which availability of drugs was greater. It was all over in my neighborhood, school, work, etc.	43	28.1
I compromised on using softer drugs or alcohol.	42	27.5
My family was constantly pressuring me to do something in life	42	27.5
I repressed all my feelings. I didn't have anybody to share or understand my feelings.	41	26.8
Somehow deep inside, I thought I could never recover	41	26.8
I had difficulty in finding new circle of friends	40	26.1
Once out of the center, I immediately tried to do many things to get back on track (e.g., studies, job). I should have waited any given more time for recovery	39	25.5

Annex Table G.91. 'True' Reasons behind Relapse(s) (Continued)

Response	Count	Percent
I didn't know how to cope or handle when confronted with a high-risk situation	36	23.5
I said I will never use drugs regularly again but only now & then, and then became re-addicted soon after	35	22.9
Prior suffering was remembered as being less intense & painful	35	22.9
I didn't attend socially supportive & voluntary programs like N.A.	32	20.9
My family didn't believe in me	32	20.9
My family was always suspicious of my activities-even though I was clean	31	20.3
Craving was powerful and persistent	31	20.3
No body cared on whether I was drug free or not	29	19.0
I could not tolerate withdrawal distress. So I used to relieve withdrawal symptoms	29	19.0
I had already made up my mind to use it one last time when I was in the treatment center	29	19.0
I had no one to discipline me when I got out of the center	29	19.0
Experiences of rejection from family & friends	28	18.3
It started during festival season (dassain, tihar, fagu, shivaratri, new year, etc.)	28	18.3
I wasn't genuinely honest about discontinuing drugs	27	17.6
It was purely an accident.	26	17.0
I could not get any jobs	26	17.0
I had nowhere to start my life. I couldn't restart my education, I had no job, no skills	26	17.0
I entered into treatment because of pressures from my family, cops in the first place	21	13.7
One last time!	21	13.7
Family didn't change their attitude & behavior, they were same as when I was using drugs	19	12.4
Treatment programs did not provide enough skills on how to defend myself & how to satisfy my inner needs & wishes	17	11.1
I did whatever my parents told me to do, & that didn't help my recovery	16	10.5
Because of family crises (such as parents separating or a sibling developing problem, death, separation, etc.,)	16	10.5
I thought I would make some money by selling drugs & not using	4	2.6
I am HIV positive. I could not bear the feeling that I was HIV positive	2	1.3
Total	**153**	**100.0**

Annex Table G.92. 'Maybe' Reasons Behind Relapse(s)

Response	Count	Percent
Failing to find alternative (drug free) outlets for my needs	47	30.7
Prior suffering was remembered as being less intense & painful	47	30.7
I had nowhere to start my life. I couldn't restart my education, I had no job, no skills	43	28.1
My family didn't believe in me	42	27.5
I had difficulty in finding new circle of friends	42	27.5
It was purely an accident.	42	27.5
Failing to build up a network of relationships, activities, and involvements that would act as a barrier against boredom, & depression	41	26.8
I decided to take it anyway-even though life was going well	41	26.8
I had no one to discipline me when I got out of the center	41	26.8
I didn't know how to cope or handle when confronted with a high-risk situation	40	26.1
M whole lifestyle revolved around drugs. Didn't know what to do without it and its lifestyle	39	25.5
Things weren't going my way. The resulting rage & anger that grew out of such disappointment compelled me.	39	25.5
I always felt that something was missing from my life when I was not using drugs	38	24.8
I had difficulty in achieving new goals	37	24.2
Family did not change their attitude & behavior, they were same as when I was using drugs	36	23.5
My family was always suspicious of my activities-even though I was clean	36	23.5

Annex Table G.92. 'Maybe' Reasons Behind Relapse(s) (Continued)

Response	Count	Percent
Unsuccessful adjustment with my family/community	36	23.5
The period I was recovering was psychologically distressing (due to depression, extreme guilt, anger & family tensions)	36	23.5
I repressed all my feelings. I didn't have anybody to share or understand my feelings.	35	22.9
Somehow deep inside, I thought I could never recover	35	22.9
Failing to express my wants and needs-either they wouldn't listen or I couldn't tell them	35	22.9
It was very tempting for me to believe that just enough substance can be taken to control distressing mood states without returning to the level of compulsive use	35	22.9
No body cared on whether I was drug free or not	33	21.6
I could not tolerate withdrawal distress. So I used to relieve withdrawal symptoms	33	21.6
I could not get any jobs	33	21.6
Contact with active addicts even when my readjustment with my family/society was satisfactory	33	21.6
Experiences of rejection from family & friends	32	20.9
I was clearly aware of the warning signs…but then, it just happened	32	20.9
I started associating with addicts and their circles, only they could understand me	31	20.3
I wasn't genuinely honest about discontinuing drugs	31	20.3
I did whatever my parents told me to do, & that didn't help my recovery	30	19.6
Association with other addicts	30	19.6
Return to an environment in which availability of drugs was greater. It was all over in my neighborhood, school, work, etc.	30	19.6
Once out of the center, I immediately tried to do many things to get back on track (e.g., studies, job). I should have waited any given more time for recovery	25	16.3
My family was constantly pressuring me to do something in life	25	16.3
I was very excited to face life when I left the center, but that excitement slowly died down as days passed by	24	15.7
It started during festival season (dassain, tihar, fagu, shivaratri, new year, etc.)	24	15.7
I didn't attend socially supportive & voluntary programs like N.A.	23	15.0
I tried the clean approach but I was more comfortable with my user friends & their way of life	23	15.0
Craving was powerful and persistent	23	15.0
I compromised on using softer drugs or alcohol.	22	14.4
I didn't ask for anybody's help	22	14.4
I had lots of free time and no concrete plans on what to do with it	21	13.7
Treatment programs did not provide enough skills on how to defend myself & how to satisfy my inner needs & wishes	21	13.7
Because of family crises (such as parents separating or a sibling developing problem, death, separation, etc.,)	18	11.8
One last time!	17	11.1
I entered into treatment because of pressures from my family, cops in the first place	16	10.5
I had already made up my mind to use it one last time when I was in the treatment center	16	10.5
I thought I would make some money by selling drugs & not using	11	7.2
I said I will never use drugs regularly again but only now & then, and then became re-addicted soon after	11	7.2
I am HIV positive. I could not bear the feeling that I was HIV positive	11	7.2
Total	**153**	**100.0**

Annex Table G.93. 'Not True' Reasons Behind Relapse(s)

Response	Count	Percent
I thought I would make some money by selling drugs & not using	132	86.3
I am HIV positive. I could not bear the feeling that I was HIV positive	131	85.6
Because of family crises (such as parents separating or a sibling developing problem, death, separation, etc.,)	104	68.0
I did whatever my parents told me to do, & that didn't help my recovery	94	61.4
Treatment programs did not provide enough skills on how to defend myself & how to satisfy my inner needs & wishes	93	60.8
I entered into treatment because of pressures from my family, cops in the first place	84	54.9
Experiences of rejection from family & friends	81	52.9
No body cared on whether I was drug free or not	74	48.4
It started during festival season (*dassain, tihar, fagu, shivaratri*, new year, etc.)	68	44.4
I could not get any jobs	67	43.8
Family did not change their attitude & behavior, they were same as when I was using drugs	65	42.5
I could not tolerate withdrawal distress. So I used to relieve withdrawal symptoms	61	39.9
It was purely an accident.	60	39.2
My family didn't believe in me	57	37.3
Unsuccessful adjustment with my family/community	57	37.3
I had nowhere to start my life. I couldn't restart my education, I had no job, no skills	51	33.3
My family was constantly pressuring me to do something in life	50	32.7
Prior suffering was remembered as being less intense & painful	50	32.7
I had already made up my mind to use it one last time when I was in the treatment center	49	32.0
I had difficulty in finding new circle of friends	47	30.7
I compromised on using softer drugs or alcohol.	46	30.1
My family was always suspicious of my activities-even though I was clean	45	29.4
The period I was recovering was psychologically distressing (due to depression, extreme guilt, anger & family tensions)	41	26.8
It was very tempting for me to believe that just enough substance can be taken to control distressing mood states without returning to the level of compulsive use	38	24.8
Return to an environment in which availability of drugs was greater. It was all over in my neighborhood, school, work, etc.	36	23.5
I had no one to discipline me when I got out of the center	36	23.5
Failing to find alternative (drug free) outlets for my needs	35	22.9
Once out of the center, I immediately tried to do many things to get back on track (e.g., studies, job). I should have waited any given more time for recovery	33	21.6
I didn't know how to cope or handle when confronted with a high-risk situation	32	20.9
Failing to express my wants and needs-either they wouldn't listen or I couldn't tell them	32	20.9
One last time!	32	20.9
I didn't attend socially supportive & voluntary programs like N.A.	30	19.6
I tried the clean approach but I was more comfortable with my user friends & their way of life	30	19.6
I wasn't genuinely honest about discontinuing drugs	30	19.6
Somehow deep inside, I thought I could never recover	29	19.0
I repressed all my feelings. I didn't have anybody to share or understand my feelings.	28	18.3
I decided to take it anyway-even though life was going well	27	17.6
I always felt that something was missing from my life when I was not using drugs	26	17.0
M whole lifestyle revolved around drugs. Didn't know what to do without it and its lifestyle	25	16.3
I had difficulty in achieving new goals	24	15.7
Things weren't going my way. The resulting rage & anger that grew out of such disappointment compelled me.	22	14.4
Association with other addicts	22	14.4

Annex Table G.93. 'Not True' Reasons Behind Relapse(s) (Continued)

Response	Count	Percent
Contact with active addicts even when my readjustment with my family/society was satisfactory	22	14.4
I started associating with addicts and their circles, only they could understand me	21	13.7
Craving was powerful and persistent	21	13.7
I was clearly aware of the warning signs…but then, it just happened	21	13.7
I had lots of free time and no concrete plans on what to do with it	19	12.4
Failing to build up a network of relationships, activities, and involvements that would act as a barrier against boredom, & depression	19	12.4
I was very excited to face life when I left the center, but that excitement slowly died down as days passed by	18	11.8
I didn't ask for anybody's help	18	11.8
I said I will never use drugs regularly again but only now & then, and then became re-addicted soon after	13	8.5
Total	**153**	**100.0**

Annex Table G.94. RDUs' Own Statements that best described their Relapses

Response	Count	Response
Overconfidence, I understand program/know how to face situations	11	13.1
Sex: use of drugs while having sex is very satisfying	11	13.1
Break up with girl friend	5	6.0
No knowledge on disease of addiction	3	3.6
Loneliness	3	3.6
Not following program in real life	3	3.6
Pleasure seeking	3	3.6
Ego/Stubbornness	2	2.4
Couldn't handle money	2	2.4
Visiting places where drugs was available	2	2.4
Thought I could never be addicted, thought I will manage the use	2	2.4
I didn't take drug seriously, used it as a joke and forgot I was an addict	2	2.4
Self pity, looking at my friends	1	1.2
Family told me not stay home and not find work	1	1.2
I had no recovering friends	1	1.2
I only quit drugs physically	1	1.2
I was always attracted to fun & having good time	1	1.2
Met dealer friend as soon as I came home	1	1.2
No patience	1	1.2
No program in the center	1	1.2
Separation of my mom and dad	1	1.2
Tension on land issues	1	1.2
Uncooperative relatives as both my parents expired	1	1.2
Being sensitive, I used to think weird in different way & as a outcome I got frustrated	1	1.2
Easy availability of money	1	1.2
Family forced me to get married	1	1.2
Fed up with my daily routine	1	1.2
Felt treatment as just physical well-being	1	1.2
I didn't keep in touch with my center for support	1	1.2
I gave up easily to problems	1	1.2
I got angry very easily	1	1.2
I was very confused	1	1.2
Parents weren't strict	1	1.2

Annex Table G.94. RDUs' Own Statements that best described their Relapses (Continued)

Response	Count	Response
Superiority complex	1	1.2
No self confidence	1	1.2
Unhelpful treatment center, no learnings at all	1	1.2
Wanting something immediately, no self control	1	1.2
Wasn't capable of managing my inner feelings & turmoil, this always made me unhappy	1	1.2
Won't use but fight with others	1	1.2
Worries of child and wife	1	1.2
Didn't understand about recovery	1	1.2
I couldn't adjust with my surroundings	1	1.2
My hearing is not good	1	1.2
Not working on my attitude	1	1.2
Own brother was recovering	1	1.2
Shortage of money on clean date	1	1.2
To get away from problems	1	1.2
Depression	1	1.2
Total Entries	**84**	**100.0**

Annex Table G.95. Family and Friends Issues & Multiple Relapse

Response	Count	Percent
Family Issues		
Family didn't trust me (suspicious)	6	17.1
Family's attitude towards me	5	14.3
Always fussy *'kachkach garnae'*	3	8.6
Coercive family and pressure (wanted me to do things)	3	8.6
Tensed family life	3	8.6
Bad relation with family, unsupportive family	3	8.6
Family doesn't understand my problems	2	5.7
Family misunderstanding	2	5.7
Over concerned family, caring too much	2	5.7
Lack of communication with family or I wasn't close	2	5.7
Both of my parents expired, one after another	1	2.9
Didn't get along with father	1	2.9
Family always forced me to stay in rehabs	1	2.9
Family responsibilities	1	2.9
I wasn't capable, matured	1	2.9
Many relapses, so hard to gain trust	1	2.9
Quarrels between mother & father, always fights	1	2.9
Family thought I had no desire to quit & didn't try at all	1	2.9
Total	**35**	**111.4**
'Friends' Issues		
Associating with suffering friends (couldn't avoid or detach or felt like using when seeing friends on high and peer pressure)	25	67.6
Can't say no to close friend(s)	6	16.2
Friends relapsed, brother abusing drugs	2	5.4
All friends came to recovery & relapsed at same time	1	2.7
Desire to earn money from selling drugs	1	2.7
My daughter is not open with me (she has seen me use)	1	2.7
Separation from loved one	1	2.7
Total	**37**	**100.0**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.96. 'Self' Issues & Multiple Relapse

Response	Count	Percent
Loneliness and isolation	5	14.3
Lack of patience	4	11.4
Couldn't increase self will/esteem/confidence	3	8.6
Craving for drug & negative feeling	3	8.6
Pleasure seeking	3	8.6
Sex problems/obsessions	3	8.6
Drug use to relieve from tension	3	8.6
Couldn't do anything (degrading feeling of self)	3	8.6
Couldn't face others	2	5.7
Ego	2	5.7
Over confidence	2	5.7
All sorts of thoughts come in my mind	1	2.9
Always wanted others to think nice of me	1	2.9
Boredom	1	2.9
Death of a very close friend	1	2.9
Couldn't control feelings	1	2.9
Didn't give time to family/wife	1	2.9
Divorce or separation with wife	1	2.9
Excitement & restlessness when leaving house	1	2.9
Thought I could use once & not get addicted	1	2.9
Depression, no inner happiness	2	5.7
Couldn't stay in rehabs - felt it was like jail	1	2.9
My love relationship	1	2.9
Damn care attitude	1	2.9
Police beatings – I never forget	1	2.9
Pressure of responsibilities	1	2.9
I could never please my family	1	2.9
Total	**35**	145.7

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.97. 'Other' Issues and Multiple Relapse

Response	Count	Percent
Sex	10	24.4
Didn't really want to quit	3	7.3
Pleasure seeking	3	7.3
Didn't know/couldn't handle money	2	4.9
Divorce, loved my wife very much	2	4.9
Attractive trip	2	4.9
Thought I was smart and knew symptoms	2	4.9
Boring life without drugs	2	4.9
Frustration and depression	2	4.9
Thought could manage drugs, thought I can't get addicted	2	4.9
Thought I could never quit, all times thought was to use drugs	2	4.9
Unsatisfied when clean, couldn't accept I had to be clean for ever	2	4.9
Enjoyment with friends, not avoiding bad circles	2	4.9
Helplessness	2	4.9
Couldn't get along with any fellowship	1	2.4
Dealer lived in my area	1	2.4
Expect many things from self	1	2.4

Annex Table G.97. 'Other' Issues and Multiple Relapse (Continued)

Response	Count	Percent
For experience	1	2.4
Forgetting crisis and suffering	1	2.4
Unemployment	1	2.4
Wanted to be extra	1	2.4
One last time	1	2.4
Lack of support	1	2.4
No cooperation from relatives	1	2.4
No mature thinking	1	2.4
Not following direction of center	1	2.4
Over confidence in self	1	2.4
No program in center	1	2.4
Total	**41**	**126.8**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.98. Question: What factors did you utilize to subside the craving of drugs after you left the DRC?

Response	Count	Percent
I tried to think of positive thoughts	98	64.1
Watched movies	97	63.4
Listened to music	83	54.2
Talked with family members	77	50.3
Blocked thoughts as much as possible	67	43.8
Talked with my non user close friends (incl. girl friend)	60	39.2
Got busy with housework	55	35.9
No specific action	54	35.3
Just went on with life	53	34.6
Talked & shared problems with my user friends	51	33.3
Slept	45	29.4
Masturbated	40	26.1
Played sports	38	24.8
Called the treatment center/counselor	38	24.8
I couldn't do anything	30	19.6
Meditated	21	13.7
Went to gym	14	9.2
Don't know	12	7.8
Attended/Shared at NA	3	2.0
Did the step work out	1	0.7
Reading books	1	0.7
Sex with wife	1	0.7
Think, think, think	1	0.7
Tried to do some creative task	1	0.7
Went out of country to stay with sister	1	0.7
Worked	1	0.7
Tried to continue studies	1	0.7
Walked on just for today	1	0.7
Total	**153**	**617.6**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.99. Question: What factor(s), besides craving, do you think invited relapse?

Response	Count	Percent
Lack of ability to make good decisions	105	68.6
Thought I could control myself	101	66.0
Friends	100	65.4
Available within my neighborhood/tole	75	49.0
Lack of confidence without use of drugs	66	43.1
Locality	53	34.6
Family issues	41	26.8
Family attitudes	34	22.2
Sex, sexual obsession and pleasure seeking	8	5.2
My behavior attitude	4	2.6
Separation or break up of relations with loved ones	3	2.0
Closeness or proximity with dealers	2	1.3
Not able to face problem	1	0.7
Loneliness	1	0.7
Frustration as I am HIV positive	1	0.7
Money handling	1	0.7
No fellowship	1	0.7
Total	**153**	**375.8**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.100. Factors that could have Prevented RDUs from Relapsing

Response	Count	Percent
Family support		
If I had asked for help	127	89.4
My family had took some trouble to accommodate & accept me by changing family structure, attitude, behavior	48	33.8
My dad had controlled his anger and negative behavior for my sake	43	30.3
My family had loved me as I am	40	28.2
My dad had supported me	35	24.6
My parents/close ones didn't doubt me	34	23.9
My in-laws had supported me	13	9.2
Total	**142**	**239.4**
Education		
I had finished my studies	68	60.2
I had gone out of this country for studies	53	46.9
I had technical trainings	43	38.1
My parents were educated	14	12.4
Total	**113**	**157.5**
Economy		
I had a job	87	84.5
I had money to do things	37	35.9
Total	**103**	**120.4**
Social		
I had a 'counselor' like friend in real life	127	92.7
I had a supportive community of relatives	48	35.0
My wife/parents were more modern thinking	43	31.4
I had broken contacts with my user friends/circle	41	29.9
I had been living with my wife and or parents	35	25.5
All my close user friends decided to quit also	34	24.8
Drugs were not widely available in and around my neighborhood	13	9.5
Total	**137**	**248.9**

Annex Table G.100. Factors that could have Prevented RDUs from Relapsing (Continued)

Response	Count	Percent
One important incident		
I had said no to my friend	97	70.3
I had not left the house	65	47.1
I had listened to my Higher Power-HE was very loud	49	35.5
I had never been to that party/gathering	46	33.3
I had not gotten into a fight	30	21.7
I had not answered the phone	20	14.5
Total	**138**	**222.5**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.101. Information on RDUs' Lapse Episode

Response	Count	Percent
Drugs Used During Lapse Period		
Marijuana	33	38.8
Alcohol	26	30.6
Brown sugar	26	30.6
Stimulant pills	22	25.9
TD	21	24.7
Hashish	7	8.2
Beer/wine	5	5.9
Phensydel	2	2.4
D-cold	1	1.2
Total	**85**	**168.2**
***Duration** of Lapse Period*		
1 to 2 months	28	32.9
3 to 4 months	15	17.6
6 to 10 days	8	9.4
5 to 6 months	6	7.1
1 to 2 years	6	7.1
2 to 5 days	6	7.1
11 to 15 days	5	5.9
16 to 20 days	5	5.9
7 to 8 months	4	4.7
1 day	1	1.2
25 to 29 days	1	1.2
Total	**85**	**100.0**
Question: Did you look for help realizing you might be on the verge of relapse?		
No	39	45.9
Thought I should but didn't	29	34.1
Yes	17	20.0
Total	**85**	**100.0**
Question: What factors came in that hampered you to go back to not using drugs?		
I thought I will never become addicted	58	68.2
I compromised on using only limited dosage of my preferred drug	52	61.2
I realized I could never be 100 % clean	41	48.2
I compromised on only using soft drugs from now on	40	47.1
Psychologically/mentally dependent	24	28.2
Fear of losing friends	20	23.5
Psychological crises	18	21.2
Family crises	16	18.8
Total	**85**	**316.5**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.102. 'Family' and 'Self' Factors hampering RDUs' Cessation Efforts

Response	Count	Percent
Family Issues		
Family didn't trust me (suspicious)	5	23.8
Family didn't understand my situation	2	9.5
About to be separated from family	1	4.8
Could talk only after use of drugs	1	4.8
Couldn't take care of my wife/children	1	4.8
Didn't get along with father	1	4.8
Father thought I was still using drugs	1	4.8
Fights in family	1	4.8
Sister with mental disease	1	4.8
Hate to hurt my mother's feelings	1	4.8
I created problems in family	1	4.8
Kachkach (fussy) family	1	4.8
Family strict in giving money	1	4.8
Lack of communication	1	4.8
Mom's health	1	4.8
Family pressured me to get job	1	4.8
Total	**21**	**100.0**
Self Issues		
Loneliness	2	11.1
Couldn't sleep	1	5.6
Couldn't think properly without drugs	1	5.6
Criminal mentality	1	5.6
Fear and worries about future	1	5.6
Didn't consider alcohol as drugs	1	5.6
HIV positive	1	5.6
Obsessed with drugs	1	5.6
Pleasure seeking	1	5.6
Pressures	1	5.6
Psychologically dependent on drugs	1	5.6
Restlessness	1	5.6
Divorce with wife	1	5.6
Tension - no work	1	5.6
Family didn't understand me	1	5.6
Too much negative thoughts	1	5.6
Tragedy with girl friend	1	5.6
Total	**18**	**100.0**

Annex Table G.103. 'Other' specific issues hampering RDUs' Cessation Efforts

Response	Count	Percent
My body wasn't feeling good without drugs	4	18.2
Separation with girl friend	3	13.6
Always in need of money	2	9.1
Too dependent on friends	2	9.1
Couldn't commit self to quit	2	9.1
Felt life was incomplete and boring, no entertainment	2	9.1
Family environment	2	9.1
Insecurity and fear	2	9.1
Sex	2	9.1
Regret that I couldn't finish studies	1	4.5
My father has second wife	1	4.5
Total	**22**	**100.0**

Annex Table G.104. Question: What skills did you use after discharge, which you had learned from the DRC ?

Skills/Components Leaned At the centers	Used it	Percent	Used it but not regularly	Percent	Didn't use it	Percent	Didn't find it necessary	Percent	Didn't teach at the center/ Wasn't used	Total
Meditation	12	7.8	32	20.9	80	52.3	25	16.3	8	153
Yoga	7	4.6	34	22.2	81	52.9	21	13.7	14	153
Wake up hours	16	10.5	36	23.5	84	54.9	17	11.1	1	153
Sleeping hours	9	5.9	35	22.9	94	61.4	14	9.2	2	153
Morning walk	11	7.2	28	18.3	92	60.1	12	7.8	10	153
Personal hygiene	54	35.3	62	40.5	33	21.6	1	0.7	3	153
Ego management	22	14.4	47	30.7	66	43.1	11	7.2	7	153
Listening skills	39	25.5	53	34.6	47	30.7	9	5.9	5	153
Sharing	27	17.6	42	27.5	66	43.1	15	9.8	3	153
Anger management	30	19.6	53	34.6	54	35.3	10	6.5	6	153
Reshape guilt/shame	25	16.3	42	27.5	66	43.1	11	7.2	9	153
Time management	15	9.8	49	32.0	72	47.1	12	7.8	6	153
Speaking skills	43	28.1	46	30.1	53	34.6	6	3.9	5	153
Problem management	19	12.4	48	31.4	69	45.1	10	6.5	7	153
Respecting other	65	42.5	54	35.3	25	16.3	6	3.9	3	153
Listening to Higher Power	34	22.2	49	32.0	48	31.4	14	9.2	8	153

Annex Table G.105. RDUs' Change of DRCs

Response	Count	Percent
Question: Have you been going to the same DRC after each of your relapses?		
Yes	45	29.4
No	108	70.6
Total	**153**	**100**
Question: If you're not going to the same DRC, how many different centers have you been enrolled to?		
2 Centers	72	66.7
3 Centers	23	21.3
4 Centers	6	5.6
5 Centers	3	2.8
7 Centers	2	1.9
8 Centers	1	0.9
14 Centers	1	0.9
Total	**108**	**100.0**

Annex Table G.106. Question: What was your reason for change of DRC?

Response	Count	Percent
Shame/guilt	37	34.3
Center wasn't effective/good	8	7.4
No program in the center	8	7.4
Couldn't afford	4	3.7
Family decided/forced	3	2.8
For new experience	3	2.8
Free treatment	3	2.8
Tight program	3	2.8
For better treatment	3	2.8
Because I relapsed (too many relapses)	2	1.9
Didn't like it/services	2	1.9
Looking for easy treatment	2	1.9
Stayed in out of - town center - too far	2	1.9
Very expensive	2	1.9
Police took me there	1	0.9
Used drugs at previous center	1	0.9
Center does not exist now	1	0.9
Compulsion	1	0.9
Wanted to try new environment	1	0.9
No satisfying program	1	0.9
Desperate for a good program	1	0.9
Didn't have faith in the program of last center	1	0.9
Didn't learn anything from last center	1	0.9
Didn't want to go there	1	0.9
Don't know	1	0.9
Felt uneasy to stay in same rehab	1	0.9
For my own comfort	1	0.9
Had to wake up early and do yoga	1	0.9
More faith in KTM based center	1	0.9
My friend stayed in another center	1	0.9
My parents fooled me into coming here	1	0.9
Friends told me this center was good	1	0.9
No reasons	1	0.9
This center has a sister organization with PLWHA	1	0.9
Too long program stay	1	0.9
They didn't care for clients, money minded	1	0.9
This center is best - know people who have stood up	1	0.9
To get into sticker center	1	0.9
Not to relapse again	1	0.9
Took my friend's advice	1	0.9
Total	**108**	**100.0**

Annex Table G.107. RDUs' Interaction with the Counselor

Response	Count	Percent
Question: How open are you with your counselor?		
So-so	42	27.5
Sometimes only	29	19.0
Open	27	17.6
Very open	19	12.4
Not given more time to be open	15	9.8
Not open	11	7.2
Haven't got counselor yet	10	6.5
Total	**153**	**100.0**
Question: How understanding is your counselor?		
Understanding	47	30.7
So-so	45	29.4
Very understanding	25	16.3
Sometimes understanding, sometimes not	21	13.7
Haven't got counselor yet	10	6.5
Not understanding	5	3.3
Total	**153**	**100.0**
Question: Do you find your time with your counselor helpful?		
Very helpful	67	43.8
Helpful	42	27.5
Maybe helpful	20	13.1
Don't know	11	7.2
Haven't got counselor yet	10	6.5
Not helpful	3	2.0
Total	**153**	**100.0**

Annex Table G.108. Important Skills DRCs should Teach to prevent Relapse

Response	Count	Percent
Attitude/behavior change	24	15.7
Don't know/no response	21	13.7
I have to do it/understand it myself/follow program seriously - up to me	18	11.8
Encourage NA/fellowship	11	7.2
How to control anger; how to have or build patience	10	6.6
Job skills (for uneducated & educated)	9	5.9
Good counseling (regular counseling, availability of counselor)	8	5.2
Understanding self (inventory) & responsibilities	8	5.2
How to divert mind as craving comes / how to stay clean	8	5.2
Good input classes	7	4.6
Time management and value	7	4.6
Motivation (or how to) to carry out 12 steps	7	4.6
Knowledge on disease of addiction	7	4.6
Sharing (openly/habit)	6	3.9
ABCs of life/Skills of Life/ Lifestyle management	6	3.9
Ego management	5	3.3
Self discipline/control	5	3.3
How to be honest/open	5	3.3
Money handling	4	2.6
Aware on the harms/fall out of drug use	4	2.6
How to build self esteem/respect self/not feel inferior	4	2.6
Problem solving skills	4	2.6

Annex Table G.108. Important Skills DRCs should Teach to prevent Relapse (Continued)

Response	Count	Percent
Help face reality/cope with daily life	4	2.6
Help us find jobs	3	2.0
Family counseling	3	2.0
How to avoid bad circle	3	2.0
On Higher power (accepting)	3	2.0
How to face society practically	3	2.0
Prioritizing, decision making, rationalizing	3	2.0
How can family trust us/handle family problems/communication	3	2.0
How to deal with feelings/emotions/frustrations	3	2.0
Create willingness/ give courage/support	3	2.0
Point out/work on my weakness	2	1.3
How to overcome psychological, spiritual deterioration	2	1.3
Identify reasons & learnings of relapse	2	1.3
How to decide what is wrong or right	2	1.3
Personal attention/interaction	2	1.3
Help grow self confidence	2	1.3
Help follow directions	2	1.3
How to never give up	2	1.3
Listening skills	2	1.3
Aware & not think of negative issues	2	1.3
Computer training/English classes	2	1.3
How to be self dependent/matured	2	1.3
Directions after discharge	2	1.3
Teach to forget past and focus on present	1	0.7
How to apply program in life	1	0.7
How to reshape guilt shame	1	0.7
How to open up with counselor	1	0.7
How to handle sex, as many relapse from it	1	0.7
How to disclose issues	1	0.7
How to humble self	1	0.7
Figure out hidden talents	1	0.7
No over treatment for relapsers	1	0.7
How to accept things	1	0.7
How to deal with problems that come unknowingly accidentally	1	0.7
How to get rid of pleasure seeking behavior	1	0.7
How to give up my over confidence	1	0.7
More knowledge on what happens when you quit	1	0.7
Regularize my outing since sex is my relapse reason	1	0.7
How to make ambitions	1	0.7
Hard work therapy	1	0.7
How to not remain idle	1	0.7
New thoughts	1	0.7
Total	**153**	**172.5**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.109. Suggestions for a Well Functioning/Better DRC

Response	Count	Percent
Good input class (Useful, practical, by experienced people)	29	19.0
Staff behavior/attitude should be positive/understanding/fulfill their responsibilities/ mingle with clients/ work on their attitudes/ no conflict between staff	27	17.6
More fellowship/sharing (encourage)	23	15.0
Good counseling/counselor, one to one, frequent counseling is very important	21	13.7
Games/sports and play ground -relaxes us	20	13.1
Love, care, concern at the center/family environment/feeling of service at the center	17	11.1
Similar behavior towards clients/no partiality/discrimination by staff	14	9.2
Family counseling (compulsory or very important)	14	9.2
Good/balanced/hygienic food	13	8.5
Individual caring from staff/understand client's feelings/don't make fun of us	13	8.5
Skills (job related) development	13	8.5
Outing planning more acceptable/regularized	12	7.8
Counselor should be open, friendly, understanding, non-judgmental, approach clients first	12	7.8
Center to keep in touch/follow up	9	5.9
Some form of entertainment/music once in a while	8	5.2
Center should not be money minded/money charged too expensive	7	4.6
More stricter environment/tight center/disciplined	7	4.6
Bring new program/creativity to learn new things treatment techniques	7	4.6
Regular Yoga/Meditation	7	4.6
Daycare clients should be able to attend outside NA meetings	6	3.9
Respect client's feelings/don't forget we are humans	6	3.9
More facilities at center	5	3.3
Need good/strict center management	5	3.3
Creative works to enhance creativity/to cut monotony	5	3.3
Relapse & recovery education/Interact with clean brothers who haven't used for a long time	5	3.3
NA meetings	5	3.3
Special attention to isolated/withdrawn individuals by staff & counselors	5	3.3
Morning walk (regularized)	4	2.6
Water problem/clean drinking water (facilities needed)	4	2.6
Good Day care program should be available	4	2.6
Free time shouldn't be irregular /More free time	4	2.6
Take us to society, exposure visits	4	2.6
Awareness program/ Information on transmission of STDs/physiology/side effect of drugs	4	2.6
Counselor should always be at the center/anytime	3	2.0
Implement/follow T.C. program	3	2.0
Help find jobs	3	2.0
Staff shouldn't forget they were once addicts	3	2.0
Center should not be too tight	3	2.0
Celebrate birthday for all eligible clients, gives us courage	3	2.0
Problem/Anger management skills	3	2.0
More systematic of sleeping and wake up hours	2	1.3
Don't coerce against one's wishes	2	1.3
Limit classes - we can't remember all things	2	1.3
Make stay from 3 to 6 months	2	1.3
Don't punish on small mistakes	2	1.3
Increase faith in Higher power	2	1.3
Program should be systematic – we shouldn't be labored *'ghottaune'* from the morning	2	1.3
More encounter sessions	2	1.3
Special care during sick period	2	1.3
Show concern for new comers	2	1.3
Provide fruits	2	1.3

Annex Table G.109. Suggestions for a Well Functioning/Better DRC (Continued)

Response	Count	Percent
No groupism	2	1.3
Honesty and humiliation from all	2	1.3
Lesson work therapy	2	1.3
No wide area to walk – feels like jail/ area to hold meetings	2	1.3
Free treatment	2	1.3
Engage minds of clients more/ keep us very busy, so there's no time to think	2	1.3
Tell us why we have to stay for more than 3 months if that's the case	2	1.3
Wrap up class' is a joke, instead do 'postmortem'/ 'blasting' to be compulsory	2	1.3
Rule for blasting those who made mistakes in encounter class	1	0.7
Counselor should not betray clients	1	0.7
Eating routine should be fixed	1	0.7
Counselor should be little patient	1	0.7
Don't change counselors for a client	1	0.7
Give us space to talk of things we don't like at the center	1	0.7
Good behavior from day care clients	1	0.7
Good care and attention for alcoholics at the center	1	0.7
Limit too much love and concern, some of us need to realize pain	1	0.7
Parent clients meetings	1	0.7
Recovering brothers not talk of past episodes (glorifying)	1	0.7
Care for personal and group hygiene	1	0.7
Concept of addiction disease to understand better	1	0.7
Duty to guard clients should be stopped, gives a jail feeling	1	0.7
More effective teachers for input class	1	0.7
Phone facilities to talk with family	1	0.7
Program should be set according to center's income	1	0.7
Sexual desires need to be fulfilled	1	0.7
Staff should arrive on time at the center	1	0.7
Intake shouldn't be beyond capacity of center	1	0.7
Discharge after 3 months	1	0.7
Give responsibilities	1	0.7
Shouldn't be any hard and fast rules	1	0.7
Teach us discipline in good way	1	0.7
Time management	1	0.7
Outing for out of valley clients	1	0.7
Pull up for counselor also	1	0.7
Life skills	1	0.7
Fix duration of stay so we don't change mind/get bored	1	0.7
More educated and experienced staff	1	0.7
Availability of fans in summer	1	0.7
Treat in house and day care as same	1	0.7
No physical touch	1	0.7
Staff should not ventilate negative vibe to us	1	0.7
Provision of security	1	0.7
Mostly feel bored in the evenings, we talk only negative in the evening, so entertain with music, TV etc	1	0.7
No power play by seniors	1	0.7
Intensely check difference (change/growth), so that I can analyze better	1	0.7
Center shouldn't be involved in many activities and forget its main objectives	1	0.7
Trees on the premises for greenery	1	0.7
Total	**153**	**286.9**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.110. RDUs' Economic Background, by Marital Status

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Question: Were you employed ever?				
Yes	45	73.8	34	37
No	16	26.2	58	63
Total	**61**	**100**	**92**	**100**
Economic Class of Family				
Middle	41	67.2	72	78.3
High-middle	11	18.0	13	14.1
Lower	4	6.6	2	2.2
Lower-middle	3	4.9	4	4.3
Higher	2	3.3	1	1.1
Total	**61**	**100.0**	**92**	**100**

Annex Table G.111. HIV Status of Respondents, by Marital Status

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Don't know	24	39.3	43	46.7
Negative	22	36.1	32	34.8
Positive	7	11.5	7	7.6
I don't want to know	6	9.8	8	8.7
No response	2	3.3	2	2.2
Total	**61**	**100.0**	**92**	**100.0**

**note- many testing negative had their tests done prior to their last relapse*

Annex Table G.112. RDUs' Interaction with Close Relatives, by Marital Status

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Question: How close are you with your relatives?				
So-so	25	41.0	42	45.7
Very close with only few	13	21.3	20	21.7
Very close	11	18.0	11	12.0
Not close	6	9.8	10	10.9
No response	5	8.2	3	3.3
I hate them	1	1.6	6	6.5
Total	**61**	**100.0**	**92**	**100**
Question: Does your close relatives know of your drug use?				
Yes	48	78.7	71	77.2
Maybe	7	11.5	15	16.3
No	2	3.3	1	1.1
Don't know	2	3.3	2	2.2
No response	2	3.3	3	3.3
Total	**61**	**100.0**	**92**	**100**
Question: Is there lot of gossiping/rumor among your close relatives about your dug use?				
Yes	30	49.2	33	35.9
Maybe	17	27.9	29	31.5
Don't know	7	11.5	22	23.9
No	5	8.2	5	5.4
No response	2	3.3	3	3.3
Total	**61**	**100.0**	**92**	**100**

Annex Table G.112. RDUs' Interaction with Close Relatives, by Marital Status (Continued)

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Question: Are your close relatives supportive of your efforts on quitting dugs?				
Yes	34	55.7	49	53.3
Maybe	9	14.8	20	21.7
Don't know	6	9.8	6	6.5
They don't care	5	8.2	8	8.7
No	5	8.2	6	6.5
No response	2	3.3	3	3.3
Total	**61**	**100.0**	**92**	**100**
Question: If yes or maybe, are they really supportive?				
They just say don't do drugs	16	37.2	25	36.2
They are really supportive from the inside	27	62.8	44	63.8
Total	**43**	**100.0**	**69**	**100**

Annex Table G.113. Question: Which member of the family are you closest with? (By Marital Status)

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Mother	33	54.1	53	57.6
Brother (younger & older)	7	11.5	19	20.7
Sister (younger & older)	8	13.1	16	17.4
Wife	21	34.4	0	0.0
Dad	1	1.6	6	6.5
All	2	3.3	5	5.4
Grand parent(s)	0	0.0	3	3.3
Noone	0	0.0	3	3.3
Bhauju (elder brothers' wife)	0	0.0	2	2.2
Son & children	3	4.9	0	0.0
Bhanji (uncle's daughter)	0	0.0	1	1.1
Cousin brother	1	1.6	0	0.0
Bhena (elder sister's husband)	1	1.6	0	0.0
Kaki (uncle's wife-father's side)	1	1.6	0	0.0
Parents	2	3.3	3	3.3
Total	**61**	**131.1**	**92**	**120.7**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.114. Neighborhood's Deviant Characteristics & Awareness, by Marital Status

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Deviant Characteristics of Neighborhood				
Significant numbers of Bars/*Bhatti*	30	49.2	34	55.7
Many drug users	28	45.9	45	73.8
Junction/*adda* for gathering	28	45.9	34	55.7
Lots of older brothers used to experiment with drugs	27	44.3	34	55.7
Marijuana widely available	23	37.7	34	55.7
Lots of young guys experimenting with drugs	21	34.4	33	54.1
Renowned as bad neighborhood	20	32.8	24	39.3
Pharmacy selling drugs without prescriptions	15	24.6	29	47.5
High number of police arrests	13	21.3	21	34.4
No deviance in the neighborhood	6	9.8	5	8.2
Don't know	2	3.3	2	3.3
Total	**61**	**349.2**	**61**	**483.6**
Question: Are you usually aware of what is happening in your neighborhood?				
No	36	59	61	66.3
Yes	25	41	31	33.7
Total	**61**	**100**	**92**	**100.0**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.115. RDUs' Needle Sharing frequency, by Marital Status

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Never shared	26	42.6	32	34.8
Sometimes	16	26.2	27	29.3
Very rarely	14	23	31	33.7
Most of the time	4	6.6	2	2.2
No response	1	1.6		
Total	**61**	**100**	**92**	**100**

Annex Table G.116. RDUs' Drug Use Characteristics, by Marital Status

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Question: Did you ever travel to the border areas to buy drugs?				
Yes	34	55.7	38	41.3
No	22	36.1	31	33.7
Very rarely	5	8.2	23	25
Total	**61**	**100**	**92**	**100**
Question: Did you ever sell drugs to support your habit?				
No	29	47.5	26	28.3
Yes	23	37.7	40	43.5
Very rarely	9	14.8	26	28.3
Total	**61**	**100**	**92**	**100**
Question: How was your financial status while in use?				
Sometimes loaded sometimes broke	46	75.4	67	72.8
Money was no problem	13	21.3	10	10.9
Always short of cash	2	3.3	15	16.3
Total	**61**	**100**	**92**	**100**

Annex Table G.116. RDUs' Drug Use Characteristics, by Marital Status (Continued)

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Question: How were you able to come up with the money?				
By asking close family	38	62.3	76	82.6
By lying	34	55.7	79	85.9
By stealing	24	39.3	83	90.2
Working	22	36.1	18	19.6
By selling drugs	21	34.4	30	32.6
By threatening close family	15	24.6	55	59.8
Collection of money from shops (H*apta uthaunae*)	1	1.6	1	1.1
Asking credits for fake reasons	1	1.6		
Family gave me money	1	1.6		
Selling dealer's drugs	1	1.6		
Selling own clothes & personal items		0.0	1	1.1
Asking friend		0.0	1	1.1
Putting valuables on collateral (*dhik*)		0.0	1	1.1
Total	**61**	**259.0**	**92**	**375.0**
Question: How extensive were your connections with dealers?				
Only knew limited persons	22	36.1	33	35.9
Only knew those in my neighborhood	14	23	13	14.1
Know almost all major dealers in the city	11	18	18	19.6
Know almost all major dealers in the city & outside my city	11	18	27	29.3
No response	3	4.9	1	1.1
Total	**61**	**100**	**92**	**100**
Questions: Have you ever used force or hit anybody in the family or close ones?				
Yes	33	54.1	50	54.3
No	27	44.3	42	45.7
No response	1	1.6		
Total	**61**	**100**	**92**	**100**

Annex Table G.117. RDUs' Beliefs and Values, by Marital Status

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
On Academic Achievement*				
Important or Very important	37	60.7	77	83.7
Maybe important	10	16.4	7	7.6
Not so important	8	13.1	5	5.4
Not important at all	6	9.8	3	3.3
Total	**61**	**100.0**	**92**	**100.0**
On Independence				
Important or Very important	52	85.2	72	78.3
Maybe important	5	8.2	12	13.0
Not so important	2	3.3	7	7.6
Not important at all	1	1.6	1	1.1
Don't know/No response	1	1.6		
Total	**61**	**100.0**	**92**	**100.0**

**Achievement meaning studying more than current attainment*

Annex Table G.117. RDUs' Beliefs and Values, by Marital Status (Continued)

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
On Support from Parents/Close ones				
Important or Very important	50	82.0	80	87.0
Maybe important	5	8.2	8	8.7
Not so important	3	4.9	3	3.3
Don't know/No response	3	4.9	1	1.1
Total	**61**	**100.0**	**92**	**100.0**
On Learnings from the DRC				
Important or Very important	55	90.2	85	92.4
Maybe important	4	6.6	6	6.5
Not important at all	1	1.6		
Not so important			1	1.1
Don't know	1	1.6		
Total	**61**	**100.0**	**92**	**100.0**
On 'Friends** are Important part of My Life				
Important or Very important	41	67.2	56	60.9
Maybe important	6	9.8	17	18.5
Very important	5	8.2	16	17.4
Not important at all	9	14.8	3	3.3
Total	**61**	**100.0**	**92**	**100.0**
On Spirituality				
Important or Very important	44	72.1	56	60.9
Maybe important	11	18	25	27.2
Not important at all	3	4.9	10	10.9
Not so important	2	3.3	1	1.1
Don't know	1	1.6		
Total	**61**	**100**	**92**	**100**
'In order for me to stay Clean, my User Circle also has to be Clean'				
Important or Very important	33	54.1	52	56.5
Not so important	12	19.7	19	20.7
Not important at all	8	13.1	16	17.4
Maybe important	6	9.8	5	5.4
Don't know	2	3.3		
Total	**61**	**100**	**92**	**100**
On Educational level of Parents/Spouse				
Important or Very important	46	75.4	72	78.3
Maybe important	8	13.1	10	10.9
Not so important	3	4.9	5	5.4
Don't know	3	4.9	2	2.2
Not important at all	1	1.6	3	3.3
Total	**61**	**100.0**	**92**	**100.0**

***Friends as both users and non users*

Annex Table G.118. RDUs' Relationships with Parents/Spouse, by Marital Status

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Question: How was your relation with parents/spouse when you were using drugs?				
Good	26	42.6	27	29.3
Not good	14	23	22	23.9
Ok	12	19.7	35	38
Very bad	5	8.2	6	6.5
Excellent	2	3.3		
Don't know	2	3.3	2	2.3
Total	**61**	**100**	**92**	**100**
Question: How was your relation with parents/spouse when you relapsed?				
Ok	26	42.6	33	35.9
Good	15	24.6	19	20.7
Not good	10	16.4	20	21.7
Very bad	8	13.1	15	16.3
Don't know	1	1.6	4	4.3
No response	1	1.6	1	1.1
Total	**61**	**100**	**92**	**100**
Question: How supportive were your parents/spouse on your efforts of cessation?				
Very supportive	41	67.2	73	79.3
So-so	16	26.2	16	17.4
Not supportive	3	4.9	1	1.1
Don't know	1	1.6	2	2.2
Total	**61**	**100**	**92**	**100**
Question: How was your relation with your parents/spouse during cessation?				
Excellent	21	34.4	27	29.3
Good	20	32.8	32	34.8
Ok	16	26.2	28	30.4
Not good			2	2.2
Very bad	2	3.3	2	2.2
Don't know	2	3.3	1	1.1
Total	**61**	**100.0**	**92**	**100.0**

Annex Table G.119 RDUs' Number of Cessation attempts, by Marital Status

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
3 to 5 times	18	29.5	38	41.3
6 to 10 times	16	26.2	24	26.1
1 to 2 times	13	21.3	21	22.8
11 to 15 times	7	11.5	4	4.3
21 to 25 times	2	3.3	2	2.2
More than 30 times	2	3.3	1	1.1
26 to 30 times	2	3.3		
16 to 20 times	1	1.6	2	2.2
Total	**61**	**100.0**	**92**	**100.0**

Annex Table G.120. RDUs' Means and Number of Cessation Attempts, by Marital Status

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Means of Cessation				
DRC	61	100.0	92	100.0
Self (cold turkey approach)	36	59.0	51	55.4
Doctor's medication (including detox. in medical settings)	22	36.1	34	37.0
Total	**61**	**100.0**	**92**	**100.0**
Through DRC				
2 times	33	54.1	60	65.2
3 times	15	24.6	19	20.7
4 to 5 times	9	14.8	11	12.0
6 to 7 times	2	3.3	2	2.2
More than 7 times	2	3.3	0	0.0
Total	**61**	**100.0**	**92**	**100.0**
Through Self (cold turkey approach)				
2 to 4 times	17	47.2	20	39.2
1 time	7	19.4	19	37.3
5 to 9 times	7	19.4	8	15.7
15 to 19 times	2	5.6	2	3.9
More than 19 times	2	5.6	1	2.0
10 to 14 times	1	2.8	1	2.0
Total	**36**	**100.0**	**51**	**100.0**
Through Doctor's Medications (incl. detox in medical settings)				
1 time	9	40.9	19	55.9
2 to 4 times	10	45.5	13	38.2
More than 9 times	2	9.1	1	2.9
5 to 9 times	1	4.5	1	2.9
Total	**22**	**100.0**	**34**	**100.0**

Note: total percent adds up to more than 100 due to multiple responses. Cessation through self = more than 24 hours clean with exception of nicotine and/or caffeine. Detoxification cessation = staying 24 hours clean after the last day of medication

Annex Table G.121. Reasons for Cessation of Drugs, by Marital Status

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Self – major reason	61	100.0	91	98.9
Family - major reason	59	96.7	89	96.7
Friends - major reason	59	96.7	88	95.7
Socio/cultural – major reason	48	78.7	78	84.8
Availability – major reason	37	60.7	49	53.3
Total	**61**	**100.0**	**92**	**100.0**

Annex Table G.122. Clean Dates of RDUs following DRC discharge, by Marital Status

Response	1st Relapse			2nd Relapse			3rd Relapse			4th Relapse			5th Relapse		
	N	%	Cum.%	N	%	Cum.%	N	%	Cum.%	N	%	Cum.%	N	%	Cum.%
Married RDUs															
0 days	5	8.2	8.2	4	10.8	10.8	2	10.5	10.5	1	8.3	8.3	1	10.0	10.0
1 day	5	8.2	16.4	0	0	10.8	1	5.3	15.8			8.3			10.0
2 -5 days	2	3.3	19.7	2	5.4	16.2	0	0	15.8	0	0.0	8.3			10.0
6 -10 days	3	4.9	24.6	1	2.7	18.9	1	5.3	21.1			8.3	1	10.0	20.0
11-15 days	3	4.9	29.5	4	10.8	29.7	1	5.3	26.3	1	8.3	16.7	1	10.0	30.0
16-20 days	4	6.6	36.1	1	2.7	32.4	3	15.8	42.1			16.7			30.0
21-24 days			36.1			32.4	0	0	42.1			16.7			30.0
25-29 days			36.1	1	2.7	35.1	0	0	42.1			16.7			30.0
1-2 months	8	13.1	49.2	5	13.5	48.6	2	10.5	52.6	6	50.0	66.7	6	60.0	90.0
3-4 months	9	14.8	64	7	18.9	67.6	2	10.5	63.2			66.7	0	0	90.0
5-6 months	3	4.9	68.9	5	13.5	81.1	4	21.1	84.2	1	8.3	75.0			90.0
7-8 months	7	11.5	80.4	0	0	81.1	0	0	84.2			75.0			90.0
9-11months	3	4.9	85.3	2	5.4	86.5	0	0	84.2			75.0	0	0	90.0
1-2 years	3	4.9	90.2	3	8.1	94.6	3	15.8	100.0			75.0	1	10.0	100.0
3-4 years	4	6.6	96.8	1	2.7	97.3	0	0	100.0	3	25.0	100.0			100.0
5-6 years			96.8	1	2.7	100.0			100.0			100.0			100.0
7 yrs+	2	3.3	100.1			100.0			100.0			100.0			100.0
No response			100.1			100.0			100.0			100.0	0	0	100.0
Total	**61**	**100**		**31**	**83.8**		**19**	**100.0**		**12**	**100.0**		**10**	**100.0**	
Single RDUs															
0 days	9	9.8	9.8	4	8.2	8.2	2	9.1	9.1	1	11.1	11.1	0	0	0.0
1 day	8	8.7	18.5	2	4.1	12.2	1	4.5	13.6			11.1			0.0
2 -5 days	1	1.1	19.6	4	8.2	20.4	2	9.1	22.7	2	22.2	33.3			0.0
6 -10 days	2	2.2	21.8	4	8.2	28.6	0	0	22.7			33.3	0	0	0.0
11-15 days	1	1.1	22.9	3	6.1	34.7	2	9.1	31.8	0	0.0	33.3	0	0	0.0
16-20 days	4	4.3	27.2	1	2.0	36.7	0	0	31.8			33.3			0.0
21-24 days			27.2			36.7	1	4.5	36.4			33.3			0.0
25-29 days			27.2	2	4.1	40.8	1	4.5	40.9			33.3			0.0
1-2 months	14	15.2	42.4	8	16.3	57.1	4	18.2	59.1	1	11.1	44.4	1	16.7	16.7
3-4 months	20	21.7	64.1	11	22.4	79.6	0	0	59.1			44.4	1	16.7	33.3
5-6 months	4	4.3	68.4	1	2.0	81.6			59.1	4	44.4	88.9			33.3
7-8 months	14	15.2	83.6	2	4.1	85.7	2	9.1	68.2			88.9			33.3
9-11months	4	4.3	87.9	1	2.0	87.8	1	4.5	72.7			88.9	1	16.7	50.0
1-2 years	4	4.3	92.2	2	4.1	91.8	4	18.2	90.9			88.9	2	33.3	83.3
3-4 years	6	6.5	98.7	4	8.2	100.0	2	9.1	100.0	1	11.1	100.0			83.3
5-6 years			98.7	0	0	100.0			100.0			100.0			83.3
7 yrs+	1	1.1	99.8			100.0			100.0			100.0			83.3
No response			99.8			100.0			100.0			100.0	1	16.7	100.0
Total	**92**	**100**		**49**	**100.0**		**22**	**100.0**		**9**	**100.0**		**6**	**100.0**	

Annex Table G.123. Duration of Drug Use after Relapse, by Marital Status

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Question: How long did you use drugs after your relapse(s)?				
First time RDUs				
1 to 2 years	23	37.7	34	37
3 to 4 years	7	11.5	9	9.8
7 to 8 months	6	9.8	8	8.7
5 to 6 months	5	8.2	10	10.9
5 to 6 years	5	8.2	0	0
9 to 11 months	3	4.9	1	1.1
2 to 5 days	3	4.9	3	3.3
3 to 4 months	2	3.3	9	9.8
1 day	2	3.3	0	0
1 to 2 months	2	3.3	10	10.9
7 years and above	1	1.6	3	3.3
6 to 10 days	1	1.6	0	0
16 to 20 days	1	1.6	1	1.1
11 to 15 days	0	0	2	2.2
21 to 24 days	0	0	1	1.1
25 to 29 days	0	0	1	1.1
Total	**61**	**100**	**92**	**100**
Second time RDUs				
1 to 2 years	13	35.1	14	28.6
5 to 6 months	7	18.9	6	12.2
7 to 8 months	4	10.8	0	0
3 to 4 years	4	10.8	2	4.1
1 to 2 months	4	10.8	3	6.1
2 to 5 days	2	5.4	2	4.1
3 to 4 months	1	2.7	11	22.4
7 years or more	1	2.7	1	2.0
25 to 29 days	1	2.7	0	0
9 to 11 months	4	8.2	0	0
5 to 6 years	2	4.1	0	0
6 to 10 days	1	2.0	0	0
11 to 15 days	1	2.0	0	0
16 to 20 days	1	2.0	0	0
25 to 29 days	1	2.0	0	0
Total	**37**	**100.0**	**49**	**100.0**
Third time RDUs				
3 to 4 months	2	10.5	4	18.2
5 to 6 months	1	5.3	3	13.6
1 to 2 years	9	47.4	6	27.3
1 day	1	5.3	1	4.5
2 to 5 days	1	5.3	0	0.0
6 to 10 days	0	0.0	1	4.5
11 to 15 days	1	5.3	0	0.0
25 to 29 days	1	5.3	0	0.0
1 to 2 months	0	0.0	6	27.3
7 to 8 months	2	10.5	0	0.0
3 to 4 years	1	5.3	1	4.5
Total	**19**	**100**	**22**	**100.0**

Annex Table G.123. Duration of Drug Use after Relapse, by Marital Status (Continued)

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Fourth time RDUs				
1 to 2 years	5	41.7	4	44.4
1 to 2 months	2	16.7	1	11.1
7 to 8 months	2	16.7	0	0.0
3 to 4 years	1	8.3	0	0.0
7 years and above	1	8.3	0	0.0
1 day	1	8.3	0	0.0
3 to 4 months	0	0.0	2	22.2
5 to 6 months	0	0.0	1	11.1
11 to 15 days	0	0.0	1	11.1
Total	**12**	**100.0**	**9**	**100.0**
Fifth time RDUs				
1 to 2 years	4	40.0	2	33.3
2 to 5 days	2	20.0		
1 to 2 months	1	10.0	1	16.7
5 to 6 months	1	10.0		
3 to 4 years	1	10.0		
11 to 15 days	1	10.0		
3 to 4 months			3	50.0
Total	**10**	**100.0**	**6**	**100.0**

Annex Table G.124. Decision Makers for RDUs' DRC enrolment, by Marital Status

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
For First time RDUs				
Family and closed ones	26	42.6	39	42.4
Own	20	32.8	32	34.8
Not 100 % my decision	12	19.7	18	19.6
User friend(s)	5	8.2	10	10.9
Cops	5	8.2	8	8.7
No response	4	6.6		
Total	**61**	**118.0**	**92**	**116.4**
For Second time RDUs				
Own	16	43.2	22	44.9
Family and closed ones	12	32.4	20	40.8
Not 100 % my decision	6	16.2	9	18.4
User friend(s)	3	8.1	6	12.2
Cops	3	8.1	2	4.1
Total	**37**	**108.1**	**49**	**120.4**
For Third time RDUs				
Own	8	42.1	9	40.9
Not 100 % my decision	6	31.6	5	22.7
Family and closed ones	3	15.8	9	40.9
Cops	2	10.5	1	4.5
Total	**19**	**100.0**	**22**	**109.1**
For Fourth time RDUs				
Own	9	75.0	4	44.4
Not 100 % my decision	2	16.7	4	44.4
Family and closed ones	4	33.3	2	22.2
Total	**12**	**125.0**	**9**	**100.0**

Annex Table G.124. Decision Makers for RDUs' DRC enrolment, by Marital Status (Continued)

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
For Fifth time RDUs				
Own	3	30.0	5	83.3
Family and closed ones	3	30.0	1	16.7
Not 100 % my decision	2	20.0	1	16.7
User friend(s)	1	10.0		
Cops	1	10.0		
Total	**10**	**100.0**	**6**	**116.7**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.125. Question: Did you stay full time at the DRC prior to your relapse(s)? (By Marital Status)

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
First time RDUs				
No	34	55.7	36	39.1
Yes	27	44.3	54	58.7
No response			2	2.2
Total	**61**	**100**	**92**	**100**
Second time RDUs				
No	18	48.6	27	55.1
Yes	18	48.6	20	40.8
No response	1	2.7	2	4.1
Total	**37**	**100**	**49**	**100.0**
Third time RDUs				
Yes	11	57.9	13	59.1
No	8	42.1	9	40.9
Total	**19**	**100.0**	**22**	**100.0**
Fourth time RDUs				
Yes	6	50.0	6	66.7
No	6	50.0	2	22.2
No response			1	11.1
Total	**12**	**100.0**	**9**	**100.0**
Fifth time RDUs				
No	6	60.0	1	16.7
Yes	3	30.0	5	83.3
No response	1	10.0		
Total	**10**	**100.0**	**6**	**100.0**

.

Annex Table G.126. Table 'Very True' Reasons Behind Relapse(s), by Marital Status

Response	Count	Percent
Married RDUs		
I said I will never use drugs regularly again but only now & then, and then became re-addicted soon after	37	60.7
Craving was powerful and persistent	34	55.7
One last time!	33	54.1
I didn't attend socially supportive & voluntary programs like N.A.	30	49.2
I had lots of free time and no concrete plans on what to do with it	27	44.3
I wasn't genuinely honest about discontinuing drugs	27	44.3
I had already made up my mind to use it one last time when I was in the treatment center	27	44.3
I didn't ask for anybody's help	26	42.6
Once out of the center, I immediately tried to do many things to get back on track (e.g., studies, job). I should have waited any given more time for recovery	26	42.6
I was very excited to face life when I left the center, but that excitement slowly died down as days passed by	25	41.0
I compromised on using softer drugs or alcohol.	25	41.0
Total	**61**	**1409.8**
Single RDUs		
I said I will never use drugs regularly again but only now & then, and then became re-addicted soon after	57	62.0
One last time!	49	53.3
Craving was powerful and persistent	44	47.8
I had lots of free time and no concrete plans on what to do with it	41	44.6
I didn't attend socially supportive & voluntary programs like N.A.	38	41.3
I was very excited to face life when I left the center, but that excitement slowly died down as days passed by	38	41.3
I wasn't genuinely honest about discontinuing drugs	37	40.2
Total	**92**	**1135.9**

Note: this table only includes responses that had more than 40 percent of total responses from married and single RDUs.

Annex Table G.127. Table 'Not True' Reasons Behind Relapse(s), by Marital Status

Response	Count	Percent
Married RDUs		
I thought I would make some money by selling drugs & not using	53	86.9
I am HIV positive. I could not bear the feeling that I was HIV positive	50	82.0
Because of family crises (such as parents separating or a sibling developing problem, death, separation, etc.,)	39	63.9
Treatment programs did not provide enough skills on how to defend myself & how to satisfy my inner needs & wishes	37	60.7
I entered into treatment because of pressures from my family, cops in the first place	36	59.0
Experiences of rejection from family & friends	35	57.4
I did whatever my parents told me to do, & that didn't help my recovery	34	55.7
No body cared on whether I was drug free or not	30	49.2
Unsuccessful adjustment with my family/community	27	44.3
I had nowhere to start my life. I couldn't restart my education, I had no job, no skills	26	42.6
I could not get any jobs	25	41.0
My family didn't believe in me	25	41.0
I had difficulty in finding new circle of friends	25	41.0
Total	**61**	**1588.5**

Annex Table G.127. Table 'Not True' Reasons Behind Relapse(s), by Marital Status (Continued)

Response	Count	Percent
Single RDUs		
I am HIV positive. I could not bear the feeling that I was HIV positive	81	88.0
I thought I would make some money by selling drugs & not using	79	85.9
Because of family crises (such as parents separating or a sibling developing problem, death, separation, etc.,)	65	70.7
I did whatever my parents told me to do, & that didn't help my recovery	60	65.2
Treatment programs did not provide enough skills on how to defend myself & how to satisfy my inner needs & wishes	56	60.9
I entered into treatment because of pressures from my family, cops in the first place	48	52.2
Experiences of rejection from family & friends	46	50.0
It started during festival season (dassain, tihar, fagu, shivaratri, new year, etc.)	46	50.0
No body cared on whether I was drug free or not	44	47.8
I could not get any jobs	42	45.7
I could not tolerate withdrawal distress. So I used to relieve withdrawal symptoms	39	42.4
My families did not change their attitude & behavior, they were same as when I was using drugs	38	41.3
Total	**92**	**1484.8**

Note: this table only includes responses that had more than 40 percent of total responses from married and single RDUs.

Annex Table G.128. Common Issues behind Multiple Relapses, by Marital Status

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Question: Do you think there were same issues, events, risk factors, etc., present in all your relapses?				
Yes	28	70.0	28	57.1
No	6	15.0	6	12.2
Maybe but not 100 % confirmed	5	12.5	9	18.4
I don't know	1	2.5	6	12.2
Total	**40**	**100.0**	**49**	**100.0**
Common Issues behind Multiple Relapses				
Other' issues	23	69.7	18	48.6
Psychological situations	18	54.5	17	45.9
Friends	17	51.5	20	54.1
Family situations	15	45.5	20	54.1
Total	**33**	**100.0**	**37**	**100.0**

Annex Table G.129. 'Other' Issues and Multiple Relapse, by Marital Status

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Sex	7	30.4	3	16.7
Didn't know/couldn't handle money	2	8.7	0	0
Divorce, loved my wife very much	2	8.7	0	0
Attractive trip	2	8.7	3	16.7
Dealer lived in my area	1	4.3	0	0
Expect many things from self	1	4.3	0	0
For experience	1	4.3	0	0
Thought could manage drugs	1	4.3	0	0
Thought I could never quit	1	4.3	0	0
One last time	1	4.3	0	0
No cooperation from relatives	1	4.3	0	0
Enjoyment with friends	1	4.3	0	0
Myself	1	4.3	0	0
Not avoiding bad circles	1	4.3	0	0
Not following direction of center	1	4.3	0	0
No program in center	1	4.3	0	0
Thought I can't get addicted	1	4.3	0	0
Didn't really want to quit	0	0	2	11.1
Pleasure seeking	0	0	3	16.7
Thought I was smart and knew symptoms	0	0	2	11.1
Boring life without drugs	0	0	2	11.1
All the time my thought was to use drugs	0	0	1	5.6
Couldn't get along with any fellowship	0	0	1	5.6
Forgetting crisis	0	0	1	5.6
Frustration	0	0	1	5.6
Depression	0	0	1	5.6
Unemployment	0	0	1	5.6
Thought I could never quit	0	0	1	5.6
Wanted to be extra	0	0	1	5.6
Unsatisfied when clean	0	0	1	5.6
Couldn't accept I had to be clean for ever	0	0	1	5.6
No mature thinking	0	0	1	5.6
Not avoiding bad circles	0	0	1	5.6
Over confidence in self	0	0	1	5.6
Total	**23**	100.0	**18**	100.0

Annex Table G.130. Question: What factors did you utilize to subside the craving of drugs after you left the center? (By Marital Status)

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
I tried to think of positive thoughts	30	49.2	61	66.3
Talked with family members	27	44.3	43	46.7
Watched movies	26	42.6	60	65.2
Listened to music	22	36.1	54	58.7
No specific action	20	32.8	27	29.3
Just went on with life	19	31.1	28	30.4
Talked with my non user close friends (incl. girl friend)	18	29.5	40	43.5
Got busy with housework	18	29.5	31	33.7
Slept	18	29.5	23	25.0
Blocked thoughts as much as possible	17	27.9	43	46.7
Talked & shared problems with my user friends	11	18.0	11	12.0
I couldn't do anything	10	16.4	17	18.5
Masturbated	9	14.8	29	31.5
Played sports	9	14.8	28	30.4
Called the treatment center/counselor	7	11.5	15	16.3
Don't know	6	9.8	6	6.5
Went to gym	2	3.3	11	12.0
Did the step work out	1	1.6	0	0
Sex with wife	1	1.6	0	0
Think, think, think	1	1.6	0	0
Went out of country to stay with sister	1	1.6	0	0
Attended/Shared at NA	0	0	2	2.2
Tried to do some creative task	0	0	1	1.1
Worked	0	0	1	1.1
Reading books	0	0	1	1.1
Total	**61**	**447.5**	**92**	**578.3**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.131. Factor(s), besides craving, that invited Relapse (By Marital Status)

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Thought I could control myself	40	65.6	61	66.3
Friends	40	65.6	62	67.4
Available within my neighborhood/tole	37	60.7	38	41.3
Lack of ability to make good decisions	35	57.4	71	77.2
Lack of confidence without use of drugs	28	45.9	38	41.3
Locality	20	32.8	33	35.9
Family issues	20	32.8	20	21.7
Family attitudes	14	23.0	20	21.7
Sex, sexual obsession	4	6.6	2	2.2
Pleasure seeking	2	3.3	1	1.1
My behavior attitude	1	1.6	1	1.1
Closeness or proximity with dealers	1	1.6	1	1.1
Money	1	1.6	0	0
Divorce with wife	1	1.6	0	0
Not able to face problem	0	0	1	1.1
Frustration as I am HIV positive	0	0	1	1.1
Girl friend breakup	0	0	1	1.1
No fellowship	0	0	1	1.1
Separation of mom dad	0	0	1	1.1
Total	**61**	**400.0**	**92**	**383.7**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.132. Factors that could have Prevented RDUs from Relapse, by Marital Status

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Family support	58	95.1	84	91.3
Reacting differently to 'one important incident'	56	91.8	82	89.1
Social	55	90.2	84	91.3
Education	41	67.2	72	78.3
Economy	40	65.6	64	69.6
Total	**61**	**100.0**	**92**	**100.0**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.133. Issues that could have Prevented RDUs from Relapsing, by Marital Status

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Family support				
If I had asked for help	51	87.9	76	90.5
My family had took some trouble to accommodate & accept me by changing the family structure, attitude, behavior	24	41.4	24	28.6
My dad had controlled his anger and negative behavior for my sake	20	34.5	23	27.4
My family had loved me as I am	14	24.1	26	31.0
My dad had supported me	17	29.3	18	21.4
My parents/close ones didn't doubt me	14	24.1	20	23.8
My in-laws had supported me	9	15.5	4	4.8
Total	**58**	**256.9**	**84**	**100.0**
Education				
I had finished my studies	27	65.9	41	56.9
I had gone out of this country for studies	18	43.9	35	48.6
I had technical trainings	18	43.9	25	34.7
My parents were educated	6	14.6	8	11.1
Total	41	168.3	72	151.4
Economy				
I had a job	32	80.0	55	85.9
I had money to do things	14	35.0	24	37.5
Total	**40**	**115.0**	**64**	**123.4**
Social				
I had a 'counselor' like friend in real life	32	58.2	55	65.5
I had a supportive community of relatives	19	34.5	30	35.7
My wife/parents were more modern thinking	9	16.4	20	23.8
I had broken contacts with my user friends/circle	41	74.5	64	76.2
I had been living with my wife and or parents	11	20.0	9	10.7
All my close user friends decided to quit also	30	54.5	43	51.2
Drugs were not widely available in and around my neighborhood	33	60.0	48	57.1
Total	**55**	**318.2**	**84**	**320.2**
One important incident				
I had said no to my friend	35	62.5	62	75.6
I had not left the house	25	44.6	40	48.8
I had listened to my Higher Power-HE was very loud	17	30.4	32	39.0
I had never been to that party/gathering	16	28.6	30	36.6
I had not gotten into a fight	16	28.6	14	17.1
I had not answered the phone	5	8.9	15	18.3
Total	**56**	**203.6**	**82**	**235.4**

Annex Table G.134. Question: Did you relapse by regular use or by irregular use of drugs?

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Directly to regular use	32	52.5	36	39.1
First it was irregular use	29	47.5	56	60.9
Total	**61**	**100**	**92**	**100**

Annex Table G.135. Information on RDUs' Lapse Episode, by Marital Status

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Question: How long was the lapse period before you were addicted to drugs again?				
1 to 2 months	10	31.3	19	33.9
3 to 4 months	7	21.9	9	16.1
1 to 2 years	4	12.5	3	5.4
11 to 15 days	4	12.5	1	1.8
2 to 5 days	2	6.3	4	7.1
16 to 20 days	2	6.3	3	5.4
7 to 8 months	2	6.3	2	3.6
6 to 10 days	1	3.1	7	12.5
Total	0	0.0	0	0
5 to 6 months	0	0.0	6	10.7
1 day	0	0.0	1	1.8
25 to 29 days	0	0.0	1	1.8
Total	32	100.0	56	100.0
Question: Did you look for help realizing you might be on the verge of relapse?				
No	13	40.6	27	48.2
Thought I should but didn't	10	31.3	20	35.7
Yes	9	28.1	9	16.1
Total	32	100.0	56	100.0
Question: What factors came in that hampered you to go back to not using drugs?				
I thought I will never become addicted	22	68.8	36	64.3
I compromised on using only limited dosage of my preferred drug	15	46.9	37	66.1
I realized I could never be 100 % clean	14	43.8	27	48.2
I compromised on only using soft drugs from now on	11	34.4	29	51.8
Fear of losing friends	7	21.9	13	23.2
Family crises	7	21.9	9	16.1
Psychologically/mentally dependent	4	12.5	20	35.7
Psychological crises	3	9.4	15	26.8
Total	**32**	**259.4**	**56**	**332.1**

Note: total percent adds up to more than 100 due to multiple responses.

Annex Table G.136. Question: What skills did you use after discharge that you had learned from the DRC? (By Marital Status)

Skills/Components Leaned At the centers	Used it	Percent	Used it but not regularly	Percent	Didn't use it	Percent	Total
Married RDUs							
Meditation	6	9.8	13	21.3	33	54.1	61
Yoga	3	4.9	16	26.2	33	54.1	61
Wake up hours	8	13.1	13	21.3	33	54.1	61
Sleeping hours	6	9.8	10	16.4	41	67.2	61
Morning walk	4	6.6	11	18.0	40	65.6	61
Personal hygiene	23	37.7	23	37.7	14	23.0	61
Ego management	9	14.8	21	34.4	24	39.3	61
Listening skills	15	24.6	18	29.5	20	32.8	61
Sharing	13	21.3	14	23.0	29	47.5	61
Anger management	12	19.7	18	29.5	22	36.1	61
Reshape guilt/shame	13	21.3	14	23.0	23	37.7	61
Time management	6	9.8	23	37.7	27	44.3	61
Speaking skills	18	29.5	17	27.9	21	34.4	61
Problem management	6	9.8	18	29.5	27	44.3	61
Respecting other	29	47.5	20	32.8	8	13.1	61
Listening to Higher Power	16	26.2	15	24.6	21	34.4	61
Single RDUs							
Meditation	6	6.5	19	20.7	47	51.1	92
Yoga	4	4.3	18	19.6	47	51.1	92
Wake up hours	8	8.7	23	25.0	50	54.3	92
Sleeping hours	3	3.3	25	27.2	53	57.6	92
Morning walk	7	7.6	17	18.5	51	55.4	92
Personal hygiene	31	33.7	39	42.4	18	19.6	92
Ego management	13	14.1	26	28.3	40	43.5	92
Listening skills	24	26.1	35	38.0	26	28.3	92
Sharing	14	15.2	28	30.4	37	40.2	92
Anger management	18	19.6	35	38.0	29	31.5	92
Reshape guilt/shame	12	13.0	28	30.4	39	42.4	92
Time management	9	9.8	26	28.3	45	48.9	92
Speaking skills	25	27.2	29	31.5	31	33.7	92
Problem management	13	14.1	30	32.6	37	40.2	92
Respecting other	36	39.1	33	35.9	12	13.0	92
Listening to Higher Power	18	19.6	33	35.9	25	27.2	92

Annex Table G.137. RDUs' Interaction with the Counselor, by Marital Status

Response	Married RDUs		Single RDUs	
	Count	Percent	Count	Percent
Question: How open are you with your counselor?				
So-so	14	23	28	30.4
Sometimes only	13	21.3	16	17.4
Very open	10	16.4	9	9.8
Open	10	16.4	17	18.5
Not given more time to be open	8	13.1	7	7.6
Haven't got counselor yet	4	6.6	6	6.5
Not open	2	3.3	9	9.8
Total	**61**	**100**	**92**	**100**
Question: How understanding is your counselor?				
So-so	18	29.5	29	31.5
Understanding	17	27.9	30	32.6
Very understanding	10	16.4	14	15.2
Sometimes understanding, sometimes not	8	13.1	12	13.0
Haven't got counselor yet	4	6.6	6	6.5
Not understanding	4	6.6	1	1.1
Total	**61**	**100.0**	**92**	**100.0**
Question: Do you find your time with your counselor as helpful?				
Very helpful	27	44.3	42	45.7
Helpful	14	23.0	28	30.4
Maybe helpful	9	14.8	10	10.9
Don't know	7	11.5	4	4.3
Haven't got counselor yet	4	6.6	6	6.5
Not helpful			2	2.2
Total	**61**	**100.0**	**92**	**100.0**

Annex H. The Twelve Steps and Traditions of NA

The Twelve Steps

1. We admitted that we were powerless over our addiction, that our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God *as we understood Him.*
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed, and became willing to make amends to them all.
9. We made direct amends to such people wherever possible except when to do so would injure them or others.
10. We continued to take personal inventory and when we were wrong promptly admitted it.
11. We sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to addicts, and to practise these principles in all our affairs.

The Twelve Traditions

1. Our common welfare should come first; personal recovery depends on NA unity.
2. For our group purpose there is but one ultimate authority – a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for membership is a desire to stop using.
4. Each group should be autonomous except in matters affecting other groups or NA as a whole.
5. Each group has but one primary purpose – to carry the message to the addict who still suffers.
6. An NA group ought never endorse, finance, or lend the NA name to any related facility or outside enterprise, lest problems of money, property or prestige divert us from our primary purpose.
7. Every NA group ought to be fully self-supporting, declining outside contributions.
8. Narcotics Anonymous should remain forever nonprofessional, but our service centres may employ special workers.
9. NA, as such, ought never be organised, but we may create service boards or committees directly responsible to those they serve.
10. Narcotics Anonymous has no opinion on outside issues; hence the NA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities.

Source: Narcotics Anonymous. Website: http://www.na.org/ips/an/an-IP1.htm