

COST ANALYSIS AND EFFECTIVENESS OF OPIOID AGONIST THERAPY IN NEPAL 2026

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Harm Reduction International (HRI) is a leading non-governmental organisation (NGO) dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. Through research and advocacy, we promote the rights of people who use drugs and their communities to help achieve a world where drug policies and laws contribute to healthier, safer societies. The organisation is an NGO with Special Consultative Status with the Economic and Social Council of the United Nations.

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Foreword from the Director

This study represents the first comprehensive assessment of opioid agonist treatment (OAT) in Nepal. It was undertaken by the National Centre for AIDS and STD Control (NCASC), in collaboration with Harm Reduction International (HRI), Recovering Nepal, the national network of people who use drugs in Nepal, and the Network of Asian People Who Use Drugs (NAPUD), with the objective of assessing the coverage, quality, and cost of OAT services in the country.

I would like to acknowledge the valuable contribution of the study team and partners who supported the planning, implementation, analysis, and preparation of this report. As Principal Investigator, I appreciate the technical support and oversight provided by the NCASC team, which contributed to ensuring that the study was conducted systematically and to an appropriate scientific standard. I particularly acknowledge Mr. Bikas Gurung for leading the field implementation and for preparing the report.

I also acknowledge the important contributions of Ms. Asmita Ojha, Section Chief of the Monitoring, Evaluation, Surveillance and Research (MESR) Section, NCASC; Mr. Prawchan KC, Senior Programme Manager, SPARSHA Nepal; and Mr. Ujjwal Karmacharya and Mr. Bishnu Fueal Sharma of Recovering Nepal. Their collective efforts were instrumental to the successful completion of the study. My sincere appreciation goes to Mr. Gaj Gurung and Ms. Catherine Cook of HRI for their background research, technical support, and guidance throughout the design, implementation, and development of the study.

I extend my sincere gratitude to the OAT service providers, national stakeholders, experts, and advocates whose information, experience, and cooperation made this study possible. In particular, I acknowledge SPARSHA Nepal; Saarathi Nepal; NCASC, Nepal; the World Health Organization (WHO) Nepal; UNAIDS Nepal; Dr. Sagun Ballav Pant, Tribhuvan University Teaching Hospital (TUTH); and Mr. Rajan Bhattarai. I also appreciate Ms. Sneha Mishra for her assistance with data collection. Above all, I express my gratitude to all OAT clients and service providers who generously shared their experiences and perspectives during the data collection process.

Finally, I gratefully acknowledge the financial contribution of the AIDS Healthcare Foundation, which supported the completion of this important study.

Dr. Sarbesh Sharma

Director

DIRECTOR

LIST OF ABBREVIATIONS

NSP	Needle and Syringe Programme
OAT	Opioid Agonist Therapy
MCU	Medical Care Unit
SSU	Social Support Unit
HIV	Human Immunodeficiency Virus
HCV	Hepatitis C Virus
WHO	World Health Organization
NHRC	Nepal Health Research Council
NCASC	National Center for AIDS and STI Control
NAPUD	Network of Asian People Who Use Drugs
MOHFS	Ministry of Health and Food Safety
MOHA	Ministry of Home Affairs
ART	Antiretroviral treatment/therapy
UNAIDS	Joint United Nations Programme on HIV/AIDS
NGO	Non-governmental organisation
UNODC	United Nations Office on Drugs and Crime
HRI	Harm Reduction International
USD	United States Dollar (\$)
SSP	HIV Standard Service Package for Key Populations 2020 (Guideline)

EXECUTIVE SUMMARY

This study provides the first comprehensive assessment of opioid agonist therapy (OAT) in Nepal. It was conducted by Harm Reduction International (HRI), Recovering Nepal (the national network of people who use drugs in Nepal), the Network of Asian People Who Use Drugs (NAPUD) and the National Centre for AIDS and STI Control (NCASC) to assess the coverage, quality and cost analysis of OAT in the country.

OAT is a globally recognised harm reduction intervention endorsed by the World Health Organization. It is identified as essential for:

- HIV prevention
- reducing non-medical opioid use
- reducing mortality and morbidity (including due to opioid overdose, HIV and viral hepatitis)
- lowering the risk of crime and incarceration
- better retention in HIV and HCV treatment
- improved quality of life and overall wellbeing.¹

Despite Nepal's early adoption of harm reduction in South Asia, the country's OAT programme has stagnated, remains geographically limited and is constrained by structural, regulatory and financing barriers.

This study used a mixed-methods research design to assess current OAT coverage and access in Nepal. It utilised qualitative approaches, such as focus group discussions and key informant interviews, alongside quantitative financial OAT costing data.

KEY FINDINGS

OAT coverage and access in Nepal

- Current OAT coverage stands at 13%, which is significantly below the Nepal government's target of 40% coverage by 2026.
- Services are available in only 10 of the country's 77 districts, and 40% of all OAT clients live in sites within the Kathmandu Valley, resulting in inequitable access. Several key cities with high concentrations of people who inject drugs have no OAT sites.
- The coverage gap is not driven by a lack of demand but by political neglect, policy contradictions between punitive and public health approaches, and diminishing external funding alongside minimal domestic investment.

¹ World Health Organization, (9 February 2025), 'WHO updates guidelines on opioid dependence treatment and overdose prevention' [online article, accessed May 2026]. Available from www.who.int/news/item/09-02-2025-who-updates-guidelines-on-opioid-dependence-treatment-and-overdose-prevention.

- Nepal's OAT programme is guided by outdated, 12-year-old drug policies and guidelines, which fail to fully uphold OAT principles from a public health perspective. Other key drug-related policies, including the Narcotic Drugs (Control) Act 1976 and the Drug Control Policy 2006 require revisions.
- The absence of a national coordination mechanism among relevant stakeholders, along with negative perceptions of OAT among the general public and policymakers, hinders programme scale-up. Additional barriers to expansion include the lack of take-home doses, high-threshold service models which particularly limit access for women and young people, and hidden costs that increase out-of-pocket expenses for clients.

The performance and quality of OAT programmes in Nepal

The performance and quality of OAT sites are compromised by inadequate human resources, poor infrastructure, frequent drug stockouts and the reduction of social and behavioural activities due to limited funding. The Global Fund to Fight AIDS, Tuberculosis and Malaria is the only international funder for Nepal's OAT programme, and its reporting indicators, particularly those related to retention, overshadow broader programmatic achievements and fail to capture the wider health and social benefits of OAT, which reinforces negative narratives about site performance.

The Global Fund's rate of retention indicator classifies people as having left treatment (i.e., dropped out) if they do not attend an OAT site visit for more than four consecutive days in a month. In practice, this requirement is difficult for many people to meet, particularly those who must travel long distances to access services. NGO-led and community-led sites generally provide more accessible and acceptable services than their government counterparts; however, funding reductions have placed significant constraints on these programmes.

Cost analysis and sustainability of OAT in Nepal

The OAT programme in Nepal is inexpensive compared with those in other low- and middle-income countries.

The annual cost per person was:

- USD 284 for the NGO-run main site
- USD 284 for the NGO-run satellite site 1
- USD 258 for the NGO-run satellite site 2
- USD 312 for a government-run social support unit site.

By comparison, a systematic review of the cost-effectiveness of harm reduction programmes found the annual unit cost of OAT was USD 368 in Vietnam, USD 405 in Indonesia and USD 543 in Kenya.²

² Harm Reduction International, (updated 2024), Making the investment case: Cost-effectiveness evidence for harm reduction. Available from <https://hri.global/publications/making-the-investment-case-economic-evidence-for-harm-reduction-2024-update>

Another systematic review³ reported that the global average annual unit cost of OAT in low- and middle-income countries is USD 522, which is almost double the cost in Nepal.

In line with cost-effectiveness research worldwide, key stakeholders interviewed for this study consider OAT programmes cost-effective because they prevent HIV infection and have broader benefits in relation to health, education, employment and reduced incarceration.

Unit costs for OAT in Nepal are expected to decrease further with national-level expansion and scale-up of services. However, the OAT programme remains heavily dependent on Global Fund financing and has minimal domestic funding, undermining its financial sustainability. In the context of shifting global health financing and reduced funding under the Global Fund's eighth replenishment, the long-term sustainability of OAT in Nepal will largely depend on increased domestic commitment and investment. The country's HIV treatment programme proves what is possible. Antiretroviral treatment was initially donor-funded, but the Nepal government has now taken ownership, procuring medicines through domestic resources. There is no reason this cannot happen with OAT.

RECOMMENDATIONS

The study recommends the following to ensure the sustainability of Nepal's OAT programme:

- The Global Fund principal recipient, in consultation with NCASC, should assess the OAT programme's sustainability in the context of the transition from Global Fund funding.
- Informed by the proposed OAT sustainability assessment, the Ministry of Health should formulate a multi-year action plan to guide the country's transition from the Global Fund, which includes a clear commitment to, and co-financing for, the OAT programme from the Nepal government.
- The Global Fund should allocate funding for budget advocacy to ensure community and civil society representatives are equipped to advocate for government investment and social contracting for harm reduction.

³ Vo, AT et.al, (2025), 'Unit costs of opioid agonist therapy: a global systematic review and cost extrapolation', AIDS, 39 (12), p.1794-1802. Available from <https://doi.org/10.1097/qad.0000000000004263>

INTRODUCTION

Key harm reduction interventions in Nepal, aligning with World Health Organization (WHO) guidelines⁴ include opioid agonist therapy (OAT), needle and syringe programmes (NSPs) and limited naloxone, in addition to other prevention interventions such as HIV testing, counselling and outreach programmes. OAT services have been available to people who use opioids since 2007 through a limited number of sites across the country. The Nepal government has set an OAT coverage target of 40% by 2026; however, data reported by UNAIDS in 2024 indicated coverage was below 5%.⁵ The poor coverage of OAT in Nepal has been associated with several structural barriers.⁶

NSP is the most cost-effective intervention for preventing HIV among people who inject drugs, while OAT is the most cost-effective for achieving long-term health, social and economic benefits, including HIV prevention. Despite compelling studies from across the world showing that harm reduction interventions are cost-effective and can be cost-saving in the long-term, policymakers in Nepal often consider OAT an expensive intervention.

There are far fewer studies on the cost-effectiveness of harm reduction interventions in low- and middle-income countries compared with high-income countries,⁷ indicating a strategic need for more evidence from low- and middle-income countries. Ensuring value for money, efficient allocation of resources and cost-effectiveness are central to government and donors' budget decision-making processes. Yet there has been no study on the cost-effectiveness of OAT in Nepal, nor are there any comprehensive independent reviews of OAT performance.

For this reason, Harm Reduction International (HRI), Recovering Nepal (the national network of people who use drugs in Nepal), the Network of Asian People Who Use Drugs (NAPUD) and the National Centre for AIDS and STI Control (NCASC) conducted a study on the cost analysis and effectiveness of OAT as an HIV prevention intervention in Nepal. The aim was to generate evidence to inform policymakers and national stakeholders, and encourage them to undertake policy reform and scale up, expand and decentralise Nepal's OAT programme.

⁴ World Health Organization, (2022), Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations. Available from www.who.int/publications/i/item/9789240052390

⁵ Joint United Nations Programme on HIV/AIDS, (2024), 2024 global AIDS report — The Urgency of Now: AIDS at a Crossroads. Available from www.unaids.org/sites/default/files/media_asset/2024-unaids-global-aids-update_en.pdf

⁶ The Global Fund, (2022), Nepal Mid-term Assessment: Global Fund Breaking Down Barriers Initiative. Available from www.theglobalfund.org/media/11688/crg_2021-midtermassessmentnepal_report_en.pdf

⁷ Harm Reduction International, (updated 2024), Making the investment case: Cost-effectiveness evidence for harm reduction. Available from <https://hri.global/publications/making-the-investment-case-economic-evidence-for-harm-reduction-2024-update>

The study had four objectives:

1. Identify factors associated with the low coverage of and access to OAT.
2. Analyse the cost per person per year (cost analysis) for selected OAT sites.
3. Evaluate the added value (reduced cost per unit) of satellite OAT sites.
4. Provide recommendations on policy reform, cost-effective OAT scale-up strategies, OAT information systems and service delivery.

MATERIALS AND METHODS

The study employed a mixed-methods research design which incorporated both quantitative and qualitative methods.

STUDY SITES AND PARTICIPANTS

To achieve the study's objectives, the following sites and participants were included:

- All 14 OAT sites, including the two satellite sites, were selected as study sites for OAT coverage and access.
- For the cost analysis, Kathmandu Valley was selected as a study area due to the availability of comprehensive harm reduction services and limited study funding. Two OAT sites in Kathmandu Valley were selected based on the following criteria:
 - STUDY SITE 1: An NGO-run OAT site with a medical care unit (MCU) and social support unit (SSU) under the same roof, with extended satellite dispensing sites.
 - STUDY SITE 2: A government-run OAT site with an SSU.
 - OAT sites that were willing to provide written consent to take part in the study and would cooperate by providing full access to their financial records/reports and client details required for this study.

Study participants included representatives from the government (the Ministry of Home Affairs and Ministry of Health), technical agencies (UN partners, the then Global Fund Principal Recipient, bi-lateral and multi-lateral organisations), the national network of people who use drugs, the main OAT service providers (working in MCUs, SSUs and, satellite OAT sites) and male and female OAT clients.

Eight in-depth interviews were conducted with a representative of each agency under the first three categories (i.e., policy, the national HIV programme and OAT service delivery). Three focus group discussions were held with 18 OAT clients (i.e., 16 Male and 2 Female) in different OAT sites in Kathmandu Valley.

MATERIALS (TOOLS)

The study team developed Microsoft Excel tools for collecting data on OAT coverage, access and financial costs. The tools were adapted from Global Fund budgeting and reporting templates which are used in Nepal.

For OAT coverage and access, the latest available data (as of 31 May 2025) was collected from all 14 OAT sites in Nepal. The cost analysis was based on retrospective

financial data (actual expenses) collected from the two study sites in Kathmandu Valley (including the two satellite sites) between 15 January 2024 to 14 January 2025 (12 months).

The FGDs and interviews checklist broadly covered thematic areas, such as OAT context, coverage, performance, barriers to access, policy and regulatory barriers, coordination and partnerships, and OAT cost analysis and sustainability.

ETHICAL CONSIDERATIONS

This study was approved by the Nepal Health Research Council (NHRC).⁸ Further details on methodology, including operational definitions, can be found in *Annex 1*.

⁸ Registration number 271/2025.

RESULTS

The study findings are discussed in three major themes, which are further categorised into several sub-themes. The primary themes presented are:

- OAT coverage and access in Nepal
- The performance and quality of OAT programmes in Nepal
- Cost analysis and sustainability of OAT programmes in Nepal

THEME 1: OAT COVERAGE AND ACCESS IN NEPAL

There are 12 OAT main sites and 2 satellite sites spread across 10 districts out of a possible 77 in Nepal. Geographically, these OAT sites are located in five out of seven provinces. Half of the OAT sites (i.e., including five main sites and two satellite sites) are located within Kathmandu Valley. The geographical coverage of all sites is provided in *Annex 2*.

1.1. CURRENT COVERAGE OF THE OAT PROGRAMME IN NEPAL

“...[the] OAT programme in Nepal is one of the first and oldest programmes in South Asia.... However, its development [expansion] has not progressed as expected. Even though the national strategy clearly defines OAT as a national initiative, its growth has lagged behind other programmes for various reasons.”

– Interview respondent, technical partner

The study found that the current coverage of OAT in Nepal is at 13%, which is significantly lower than the Nepal government’s target of 40% OAT coverage by 2026. However, coverage reaches 28% if the denominator (total population of people who inject drugs) is restricted to only the 10 districts where OAT is available. Significant district-wise variances in coverage were found, ranging from as low as 10% in Banke District and 12% in Kaski District, to as high as 40% in Kathmandu Valley and 52% in Jhapa District. Half of the total coverage was within the three districts of Kathmandu Valley. The current coverage is summarised in *Tables 1 and 2*.

Table 1: Current coverage of OAT in Nepal (per district)

SN	District	Estimated number of people who inject drugs in each district (NCASC, 2024) ⁹	Current coverage (ever enrolled as of 31 May 2025) ¹⁰	Current coverage (%)
1.	Jhapa	1,422	742	52%
2.	Morang	2,028	534	26%
3.	Parsa	1,737	297	17%
4.	Kathmandu Valley*	8,189	3,235	40%
5.	Chitwan	1,609	279	17%
6.	Kaski	3,791	459	12%
7.	Rupendehi	1,901	668	35%
8.	Banke	2,680	257	10%
	TOTAL	23,357	6,471	28%

*Data from Kathmandu, Lalitpur and Bhaktapur districts have been merged into Kathmandu Valley.

Table 2: Current coverage of OAT in Nepal (national)

Estimated number of people who inject drugs in Nepal ¹¹	Total coverage of OAT (ever enrolled)	National coverage (%)
48,856 (maximum)	6,471	13%

Interview participants shared their concerns about the low coverage of OAT despite its long history in Nepal. One interview participant expressed serious unease about the evolution of OAT in Nepal, stating that the programme still feels like a pilot project even after 15-16 years of implementation and does not seem to meet the real needs of people across the country.

“Overall, I don’t think the program has seen much evolution. For a long time, it has been running in the same traditional way, following the same old service package and delivery model. This approach doesn’t match the growing and changing needs of people who use drugs (PUD) or people who inject drugs (PWID). It seems like no one in authority has seriously thought about reviewing or redesigning the program in response to the increasing number of drug users or the shifting patterns of drug use in the country.” - Interview respondent, the then Global Fund Principal Recipient

⁹ NCASC, (2024), Mapping and size estimation of key populations. Available from, www.ncasc.gov.np/uploads/frontend/publication/673c5434868b0.pdf

¹⁰ Reports of all OAT sites in Nepal (as of 31 May 2025).

¹¹ NCASC, (2024), Mapping and size estimation of key populations. Available from, www.ncasc.gov.np/uploads/frontend/publication/673c5434868b0.pdf.

1.2. CHALLENGES IN OAT COVERAGE AND ACCESS

The study found numerous challenges affecting OAT coverage and access. These are categorised into the following sub-themes:

- Expansion, scale-up and decentralisation
- Perception and OAT awareness
- Coordination and referral mechanism
- Burden on OAT clients
- Policy and regulatory barriers

1.2.1 EXPANSION, SCALE-UP AND DECENTRALISATION

“From my perspective, one of the most significant milestones in OAT’s development occurred between 2012 and 2016. However, after 2016, we’ve all observed that the pace of development slowed significantly. Aside from the two satellite clinics run by SPARSHA Nepal, there hasn’t been any notable site expansion or scale-up since then.” – [Interview respondent, service provider](#)

One of the most common issues relating to OAT coverage, highlighted by all study participants, was the lack of expansion and scale-up programmes, resources and efforts to decentralise OAT programmes in Nepal, despite the increased number of people who inject drugs (estimated to have increased from 34,487 people in 2017 to 48,856 people in 2024) and advocacy efforts. The major expansion of Nepal’s OAT programme took place between 2012 and 2016 in key urban locations, such as Nepalgunj, Butwal, Chitwan and Birgunj, and importantly included the establishment of an NGO-led OAT service delivery model. However, since 2016, the programme has not been expanded, except for two satellite sites in Kathmandu District. These existing OAT sites are expected to reach and serve a large number of people who inject drugs, but this is highly insufficient to meet the increasing demand.

The majority of participants agreed that, to some extent, OAT sites in Kathmandu Valley can be considered decentralised. There is at least one site in each of the valley’s three districts. However, the OAT sites are not decentralised nationally and are not strategically located according to the population density of people who inject drugs. For instance, opioid use and the number of people injecting drugs is very high in Dhanghadi, while Dharan is known as a traditional heroin injecting hub. However, there are no OAT sites in either district.

“Even in cities like Kathmandu, Biratnagar and Nepalgunj there are only a few OAT sites, and they are expected to serve a large number of people who inject drugs. This has made overall coverage very low, and insufficient to meet the actual demand.” – [Interview respondent, technical partner](#)

“In Kathmandu, we could say services are relatively decentralised, but when it comes to other provinces, having just a single site per province doesn’t really meet the needs.” – Interview respondent, technical partner

Study participants highlighted that the barrier to expansion and scale-up stems from contradictory perceptions of the OAT programme held by the Ministry of Health and Food Safety (MOHFS) and the Ministry of Home Affairs (MOHA). While the MOHFS primarily approaches the programmes from ‘a public health perspective’, the MOHA views it more from a regulatory or punitive approach. These differing perspectives have resulted in two distinct approaches, creating a bottleneck which has hindered the government’s ability to scale up the OAT programme as originally planned.

1.2.2 PERCEPTION AND OAT AWARENESS

“There is a lack of information flow and advertisement about OAT among people who use drugs. In the past, there used to be programmes at Basantapur that would inform some community members. There are no programmes or any other information flow now. So, most people don’t know about OAT. There should be marketing.” – OAT client

OAT has gradually become more known and acceptable over the past decade among many communities, law enforcement authorities and government officials. However, misconceptions and misinformation persist, contributing to fear and stigma about OAT among people who use drugs, their families, law enforcement authorities and policymakers.

The study found that perception and awareness of OAT is low among the general public, including OAT clients. Information on OAT is inadequate, and often the narrative on OAT is shaped by rumours and misleading information. OAT clients fear that OAT centres are under government scrutiny and could be closed at any time, leaving no option for OAT in the future. OAT clients participating in our focus groups stated that the flow of information about OAT and platforms to access it has decreased in recent years, since 2022.

“There is also a rumour that OAT centres will be closed down by the government someday, and all of us who need them daily will have to suffer.” – OAT client

Some study participants shared that doctors and peer workers lack ethical and evidence-based information on OAT. Our findings suggest that doctors are using language and practices which go against harm reduction principles¹² and often act in discriminatory ways, both of which can hinder access to OAT. For instance, participants reported how some doctors convey the message that OAT is merely a way to taper down medication

¹² Harm reduction principles include a commitment to evidence, respecting the rights of people who use drugs, a commitment to social justice and collaborating with networks of people who use drugs, and the avoidance of stigma. For more, see Harm Reduction International, ‘What is harm reduction?’ [web page, accessed May 2026]. Available from <https://hri.global/what-is-harm-reduction>

and eventually lead an abstinent life, which reflects a lack of sufficient knowledge and training about OAT. Similar messages are delivered by peer workers, who often advise clients not to stay on OAT for more than two years and to be drug-free within that time span. These messages leave clients confused, and they contribute to people stopping OAT.

Importantly, the benefits and importance of OAT have not been strategically shared with OAT clients or the general public. OAT is understood through a narrow frame of the HIV response, while its broader benefits for overall individual health and wellbeing and for the wider community are not discussed. Respondents felt that there is a dire lack of visibility around the positive impact of OAT or the progress the OAT programme has made which makes it harder to defend the programme or to push for its expansion. This has also resulted in the lack of confidence among key authorities (e.g., policymakers). Some still seem unsure whether the programme is truly effective or successful, which signals a need for stronger policy-level work to reinforce the credibility and long-term vision of the OAT programme.

1.2.3. COORDINATION AND REFERRAL MECHANISM

“There is a lack of policy or guidelines on integration between harm reduction programmes and rehabilitation or treatment programmes. This inability to regulate and integrate services has made it very difficult to meet the goals of the OAT programme.” – Interview respondent, service provider

Most of the OAT clients who participated in our focus group discussions identified the role of abstinence-focused drug treatment and rehabilitation centres as a contributing factor in hindering access to OAT services. They described a high level of stigma towards OAT clients from drug rehabilitation centre representatives, who tend to be people who formerly used drugs. Focus group participants reported that families of people who use drugs are more likely to prefer abstinence over OAT, meaning that rehabilitation centres are able to convince families to avoid OAT. Notably, OAT clients explained that it is not police officers who harass or arrest them while they are accessing OAT, rather it is rehabilitation centre representatives who wait outside OAT sites, which clients find intimidating.

“Rehabs brainwash the families into taking their family member to rehabs. They give negative information about the OAT programme. They get money from each person they enrol, whereas OAT is free. It is their business.” – OAT client

Interview respondents also highlighted how the lack of coordination and integration between rehabilitation centres and OAT providers was fuelled by stark ideological differences on abstinence vs harm reduction principles and directly affects advocacy efforts to expand or scale-up the OAT programme. The abstinence approach is more appealing to policymakers, bureaucrats and the general public, so instead of placing value on the range of options available to people who use drugs, including both abstinence-based treatment and OAT, an ‘either-or’ narrative has emerged which impedes

OAT expansion.

Surprisingly, it was found that coordination and referral between harm reduction services, in particular between NSP and OAT sites, is not well established or practiced due to the isolated nature of the programmes, each of which has its own grant-related targets and performance indicators to achieve. The OAT provider we interviewed outlined how every site has a grant target, which are near-on impossible to reach, and this is prioritised over programme quality and cross-referrals. Participants felt that, ideally, almost 50% of people accessing NSP should be referred to OAT for better results and alignment with harm reduction principles.

1.2.4 BURDEN ON OAT CLIENTS

“On policy and guidelines, even though the OAT service is free of charge, the hidden costs for service users are very high. These hidden costs include time, travel expenses and other associated burdens. So, in reality, none of the [service] users are receiving services free of charge. The out-of-pocket expenses to access the service are significant. It is not a free service.” – Interview respondent, service provider

The study found OAT clients experienced numerous hidden burdens while accessing the service due to the limited and centralised location of OAT sites and the lack of take-away doses.

The majority of OAT sites in Nepal are located in government-run hospitals. While the hospitals may be strategically located for the general population of that area, these locations were found to have no strategic benefit in terms of increasing access to OAT among people who inject drugs. For instance, many OAT sites are located far away from the main roads, which makes them difficult to get to. Accessing OAT daily requires a high level of effort and time to reach the sites and additional travel expenses and meals, which are considered out-of-pocket health expenses. Accessing an OAT site every day also limits employment and education opportunities and affects family responsibilities (opportunity costs). The notion of free OAT services is undermined by these non-medical and opportunity costs.

The current OAT site locations, combined with the lack of take-away doses, severely hinders access to these services. For instance, one OAT client from Ilam (Eastern Nepal) has to travel 80-90 kilometres every day to reach their closest OAT site, which is in Bhadrapur, Jhapa. As the OAT site is located inside the hospital, even clients who live in the district have to travel 12-13 kilometres from the main highway to reach the site. OAT clients thus expressed their desire to discontinue OAT because it had become difficult for them to cover such long distances to appear every day for their medication.

The lack of take-away doses was identified as one of the major barriers to increasing OAT coverage and access and retaining clients. Nepal's current national OAT guidelines only recommend providing take-away doses only in special cases, such as when a client needs to attend a funeral or is hospitalised. Respondents highlighted those other special

conditions, like pregnancy or simply being a woman who uses drugs, make it significantly harder to visit an OAT site for daily medication, but do not meet the criteria for take-home dosing.

“In terms of accessibility, many people face challenges due to long distances and inconvenient service hours. The OAT programme follows a hospital-like schedule, which is not flexible or client-friendly. It doesn’t consider the individual needs or daily routines of the community, and it is not operated as a differentiated service delivery model.” – [Interview respondent, technical partner](#)

OAT site opening hours were described as inconvenient. OAT clients felt that OAT services should be open for longer hours, especially on Saturdays. The limited opening hours particularly affect OAT clients who were employed or engaged in business. Similarly, the mandatory requirement to bring a family member and citizenship card when enrolling at an OAT site created significant barriers to women and young people in accessing the service.

“It is difficult for females to communicate at home that they will be joining OAT. My own family – parents as well as in-laws – don’t know that I used drugs or take OAT, or that I smoke even. Only my husband knows. We tell them we are going to the office when coming to the OAT site every day... Female drug users are not as free as men. It is uncomfortable to let people know even at home, so it is more difficult if society knows. We’ll have to face humiliation if society finds it out.” – [OAT client](#)

1.2.5. POLICY AND REGULATORY BARRIERS

“On guideline, we talk about OAT being a low-threshold programme, female-friendly, comprehensive and offering multiple entry points. But in practice, I feel we’re mostly just focused on adjusting the dose – either increasing or decreasing it – and not fully implementing what those principles actually mean.” – [Interview respondent, service provider](#)

The study found that the OAT programme in Nepal continues to face significant policy and regulatory barriers to expand, scale-up and decentralise, despite the country’s National HIV Strategic Plan recognising OAT as an essential HIV prevention intervention for people who inject drugs.

The OAT programme is guided by an outdated, 12-year-old drug policy (i.e., OAT guidelines), which do not truly take a public health approach to OAT. The learning, reflections and experience gained from implementing the OAT programme in Nepal have not been captured by the policy. As a result, a high-threshold programme is in operation, with numerous structural and policy barriers that hinder access to the service, particularly for the most marginalised, such as women and young people.

The study identified a few obstacles to policy reform. Recovering Nepal reported that a bill and policy to revise the existing policy have been drafted in consultation with the MOHA. However, political instability, which has led to frequent changes of government and among bureaucratic officials, has made it challenging to achieve the desired progress on policy reform. The contradictory roles and understanding between the MOHFS and MOHA on approaches to drug use have further slowed the policy revision process and overall OAT evolution in Nepal.

One of the interview respondents highlighted that the coordination on drug policy issues between the MOHFS and MOHA is fluid and ad-hoc, and the lack of accountability mechanisms has led to significant delays in the policy approval process. The power dynamics between the two ministries enable the MOHA to often dominate decision-making and overshadow the MOHFS's public health perspective with its punitive approach. Respondents observed that the MOHFS often has limited influence and struggles to convince the MOHA of the OAT programme's sustainability and the need to scale it up. Recovering Nepal highlighted how the MOHFS's effort to expand OAT to six new main sites and eight satellite sites in 2021 was unsuccessful due to hesitation from the MOHA.

“Right now, the programme continues to operate under the punitive approach of MOHA. Ideally, the MOHFS shouldn't just be the implementing agency – it should also have regulatory authority, not the MOHA. But the communication gap and the lack of alignment between the two ministries have made things complicated and, honestly, problematic.” – Interview respondent, technical partner

During this study, the MOHA representative was positive about OAT as one of the options for the treatment of opioid dependence, but suggested that the ministry requires more evidence on the effectiveness of OAT and a clear rationale for scale-up. However, the representative stressed that a one-page letter seeking approval to scale up OAT may not be sufficient, as there are a number of officials who are opposed to OAT within the MOHA.

THEME 2: THE PERFORMANCE AND QUALITY OF OAT PROGRAMMES IN NEPAL

2.1. UNPACKING THE STANDARD SERVICE PACKAGE GUIDELINES: SETTING THE PERFORMANCE EXPECTATION FOR OAT SITES IN NEPAL

“The existing number of staff won't be adequate if the sites are scaled up. We have heavy workloads, and we also need adequate training. The people who are now involved in the [OAT] programme should be empowered and motivated – and new people should be brought into the workforce.” – Interview respondent, service provider

The HIV Standard Service Package for Key Populations 2020 (SSP),¹³ a national document, provides specific guidance on the minimum standards that every OAT site in Nepal should meet to ensure the programme is of acceptable quality. For instance, a site with up to 100 clients requires one counsellor and two outreach workers, while a site with more than 100 clients requires at least two counsellors and three outreach workers, in addition to other staff, including a nurse, pharmacist, clinician, monitoring and evaluation officer and a social mobiliser. The full details of the staff-to-client ratio for an OAT site can be found in *Annex 4*.

Even though minimum staffing standards and training requirements are not strictly adhered to, the study found that the current OAT sites are equipped with enough staff to provide optimal coverage for up to 100 clients. However, sites with a high flow of clients reported stretched staffing and delivering more services than their human resources had capacity for. We identified a worrying trend of reduced staff numbers due to decreased funding. One interview participant warned that the current OAT workforce cannot handle more clients unless additional staff are hired.

Participants reported that, in particular, government-run sites have poor infrastructure and are less appealing to the clients than NGO-run sites. A recurring challenge raised and observed in different sites was the lack of regular training and refresher courses for OAT staff. There was no funding allocated or training planned for newly recruited doctors or service providers, and this had an effect on the quality of services and on staff turnover. One interview participant observed that doctors from Nepalgunj, Biratnagar and Lumbini had not received any training after they were recruited.

“I have visited two sites, and one common issue raised by the staff is that they haven’t received any training for a long time. In both of the sites I visited, they shared that they are in need of refresher training. I also believe there should be regular refresher training because staff need to stay updated, and there can also be staff turnover, so regular capacity building is necessary.” – [Interview respondent, technical partner](#)

2.2. CURRENT PERFORMANCE¹⁴ OF OAT AGAINST THE STANDARD SERVICE PACKAGE

The HIV Standard Service Package for Key Populations 2020,¹⁵ a national guiding document, has defined a set of harm reduction measures for people who inject drugs. The document also provides specific guidance on the minimum standards that every OAT site should ensure for the acceptability (quality) of the program.

The study found that the overall performance of OAT is consistent with the optimal coverage defined by the SSP. As of 31 May 2025, 1,616 people were regularly accessing OAT across all sites. Nearly two-thirds (64%) of the clients accessing OAT were in

¹³ NCASC, (2020), HIV Standard Service Package for Key Populations.

¹⁴ Performance here refers to both quality and coverage of OAT.

¹⁵ NCASC, (2020), HIV Standard Service Package for Key Populations.

Kathmandu Valley, indicating inequitable service access in other parts of the country. The three sites in Parsa, Chitwan and Rupendehi districts were found to be under-performing (i.e., the number of clients regularly accessing OAT was below 50). However, the majority of OAT sites were serving more than 50 clients and so had adequate performance in terms of coverage. The full details of OAT sites and their coverage can be found in *Annex 5*.

2.3. CHALLENGES IN THE PERFORMANCE AND QUALITY OF OAT

The study found numerous challenges affecting the performance and quality of OAT, which are categorised into the following sub-themes:

- Global Fund grant reporting: indicators of success
- Regular stockouts
- The quality of services

2.3.1 REPORTING INDICATORS OF SUCCESS

“[The] retention indicator is one of the reasons for the OAT programme being deemed a failure or not cost effective.” – [Interview respondent, OAT provider](#)

Despite the overall performance of OAT in Nepal being consistent with optimal coverage (as defined by the SSP), participants repeatedly stated that the OAT programme was deemed a failure in Nepal in relation to Global Fund grant-related reporting indicators.¹⁶ The current Global Fund reporting indicator on rate of retention classifies ‘drop-out’ as a client not attending an OAT sits for more than four consecutive days in a month. However, service providers participating in our study argued that many clients experience practical difficulties which make it challenging to consistently attend OAT sites, especially those who have to travel long distances to access the service. Service providers also expressed their frustration over having retention as the sole indicator to measure the performance of the OAT programme.

“It is difficult to retain even 50% of the clients in the OAT programme. Also, we have managed to reduce the dosage to zero for many clients who wished to move on to an abstinent life, and it should be considered our success; however, it will be considered a failure. It’s an individualised treatment; however, we try to motivate people to be in the programme for at least two years.” – [Interview respondent, service provider](#)

Target setting and success indicators within the reporting system have changed over time. Previously, around 2014, the target or success indicator for the Global Fund grant was to increase enrolment, so the sites heavily focused on identifying and enrolling new people. Now, the target or success indicator is to increase retention, but without expansion existing sites are neither able to enrol more clients nor able to retain the

¹⁶ The Global Fund is the only funding agency for the OAT programme in Nepal.

majority of those ever enrolled. The total number of people ever enrolled as OAT clients has become the denominator of reporting, thus making the retention rate negligible; something that will only be rectified with significant scale up.

The performance of OAT as the result of the indicators of success is illustrated in *Tables 3 and 4*.

Table 3: Current practice of evaluating the performance of Nepal's OAT programme

SN	OAT implementers	Type of site	District	Ever enrolled (as of 31 May 2025)	No. of clients accessing OAT (as of 31 May 2025)	Rate of retention (%)
1.	Richmond Fellowship Morang	Government-run	Jhapa	742	166	22%
2.	Richmond Fellowship Morang	Government-run	Morang	534	141	26%
3.	BIJAM	Government-run	Parsa	297	45	15%
4.	Saarathi Nepal	Government-run	Kathmandu	665	197	30%
5.	Saarathi Nepal	NGO-run	Kathmandu	629	190	30%
6.	SPARSHA Nepal*	NGO-run	Lalitpur	1,207	448	37%
7.	Aavash Samuha	Government-run	Lalitpur	309	89	29%
8.	Aavash Samuha	NGO-run	Bhaktapur	425	110	26%
9.	Nirnaya Nepal	NGO-run	Chitwan	279	41	15%
10.	Community Support Group	Government-run	Kaski	459	114	25%
11.	Aastha Samuha	Government-run	Rupendehi	668	14	2%
12.	Change Team	Government-run	Banke	257	61	24%

* SPARSHA Nepal's main site and two satellite sites are merged.

When applying the current retention criteria to evaluate the performance of all OAT sites, the study found that none have more than a 50% retention rate. SPARSHA Nepal has the highest retention rate at 37%, while all the remaining sites have retention rates of 30% or less, and the Rupendehi site's retention rate is just 2%.

A further deep dive into the Rupendehi OAT site revealed that, as of 31 May 2025, it had served 668 clients, of which most had either stopped using drugs, moved outside Nepal for employment or study or transferred to another OAT site. The current enrolment suggests 14 clients are regularly accessing OAT, but the reporting indicates only 2% retention, negating all other benefits the service provides to its current clients.

The findings suggest that the current practice of evaluating OAT performance does not provide a complete picture. The only thing that could be derived from the data in *Table 4* with absolute certainty was the rate of drop-out in Rupendehi District, which is 42%.

Table 4: Detailed breakdown of ever-enrolled OAT clients in Rupendehi District¹⁷

Total no. of clients ever enrolled (as of 31 May 2025)	668
Detailed break-down of ever enrolled clients:	
No. of clients accessing OAT (as of 31 May 2025)	14
No. of clients whose dose was tapered down to zero and discharged	34
No. of clients who are now abstinent	158
No. of clients who have enrolled themselves in a rehab for abstinence	48
No. of clients who went abroad for employment or higher studies	121
No. of clients who are in prison	32
No. of clients who have died	8
No. of clients who were transferred to another OAT site	2
No. of clients who dropped out from OAT and are currently using drugs	251
TOTAL	668

Note: The number of OAT clients who are employed or students is not mentioned because they are sub-groups of many of the above categories.

The current practice of evaluating OAT performance does not allow the broader health, social and legal benefits to be considered. This has caused an intense burden on OAT providers and clients, and it has created a missed opportunity in promoting the benefits of OAT to potential clients and broader stakeholders. For instance, between 2022 and 2025, 165 people who inject drugs have been successfully treated for the hepatitis C virus (HCV) from the NGO-run OAT site in this study.¹⁸ An operational tool by UNODC and the WHO¹⁹ links OAT to improved health and social outcomes, including reducing drug-related deaths by half, preventing HIV and HCV infections, reducing injecting drug use by half, increasing linkage to and retention on antiretroviral treatment (ART) and other services, reducing crime and improving mental health, social integration and functioning.

“There are many benefits of OAT to each individual in terms of their health and social quality of life. For example, due to OAT, 60% of our clients have achieved stability in their jobs; around 25% are students who can attend school or college regularly, and many have moved on to an abstinent lifestyle. However, none of these are ever considered while evaluating the performance of the OAT programme.” – Interview respondent, service provider

¹⁷ Data taken from Aastha Samuha monthly report (as of 30 May 2025).

¹⁸ SPARSHA Nepal, (YEAR), Annual Report 2022-2025

¹⁹ UNODC and WHO, (2022), Establishing and delivering evidence-based, high-quality opioid agonist therapy services: An operational tool for low- and middle-income countries. Available from www.unodc.org/documents/drug-prevention-and-treatment/22-10821_eBook_OAT_implementing_tool.pdf

A study conducted by the NHRC in 2020²⁰ found improvement in socio-economic status, mental health and quality of life (i.e., based on the WHO QOL BREF tool) after starting OAT, and the majority of clients reported having an increased quality of life after initiating OAT. The same study reported a significant decrease in criminal behaviour (i.e., crime reduction), improvement in social integration, and that over 70% of clients reported being involved in full-time jobs after initiating OAT.

A striking finding was that the MOHA representative was more interested in knowing how OAT programmes have performed in terms of helping people to transition into an abstinent and productive life than they were in the retention rate.²¹

The study identified a high level of stress and struggle among OAT providers to maintain their rate of retention. There was a clear pattern of introducing new rules, including the mandatory presence of a family member during enrolment (discussed in Section 1.5) and testing a potential client's commitment to OAT by asking them to visit the OAT site for at least three to four days without medication before making a decision about their enrolment. Findings indicate that current practices have turned the OAT programme into a high-threshold and gender-insensitive programme, putting an increased burden on OAT providers, and especially on clients.

“The system of keeping new clients in follow-up for three days before enrolling is not a good practice, as it is the most difficult time for the client. That might be a criteria here, but how will the person survive for three days without drugs for someone taking hardcore drugs?” – OAT client

“We had to keep following-up for three to four days before they would enrol [us] and start the medicine, after a half-hour counselling session from the doctor where the doctor would talk about what substances we were using before and things like that. We had to bring two copies of the citizenship certificate and fill out a form.” – OAT client

2.3.2 REGULAR STOCKOUTS

“It is depressing that stockouts of OAT medicines happen frequently. Last year, it happened two times, and this year already once, and it may happen again soon because the buprenorphine in stock is expiring soon. We inform[ed] the concerned authorities on time; however, the process of procurement and supply always gets stuck at some point due to the lack of regular coordination.” – Interview respondent, national network of people who use drugs

²⁰ Nepal Health Research Council, (2020), Report on evaluation of OST program in Nepal.

²¹ During the interview, the MOHA representative asked: “How many people are drug-free and able to get employed or continue their education?”

The regular stockouts of OAT medicines was identified as one of the biggest challenges in maintaining the programme's performance and quality. Over the past three to four years, stockouts of OAT medicines have been quite frequent, and there is no accountability mechanism to track stock disruptions. Participants reported that stockouts happened twice in 2024, and it has already happened once in 2025. The key reason identified was a lack of timely coordination among concerned government agencies, OAT providers and donors, resulting in delayed procurement and supply of OAT medicines.

“The main issue is coordination. Because of poor coordination, timely procurement doesn't happen. That, in turn, affects medicine availability and results in supply chain management problems.” – Interview respondent, technical partner

Both methadone and buprenorphine are procured from abroad, and the process is lengthy. The approval process includes multiple ministries and their concerned departments, such as the MOHFS, the MOHA, the Department of Drug Administration and the International Narcotics Control Board, and is massively time consuming. However, there is no fast-track approval system, perhaps due to a poor government supply chain management system or OAT drugs being categorised as controlled substances.

The consequences of stockouts include people ceasing OAT, mistrust between OAT clients and service providers, which affects service quality, and frequent shifts of clients to different OAT sites, which affects programme surveillance. Eventually, stockouts will also contribute to new HIV and viral hepatitis infections. The study found that stockouts lead to programmatic and personal risks and place an unnecessary burden on service providers. Interview participants described these frequent stockouts as violating OAT clients' human rights as they directly hamper people's right to health, which the constitution of Nepal safeguards.

“The stockouts create instability and raise concerns among patients about the programme's reliability.” – Interview respondent, service provider

2.3.3 THE QUALITY OF SERVICES

“The OAT programme used to be a lot better in the past. There is no engagement [activity] right now. For people who are employed, this is alright. But for those of us who are unemployed, we don't know what to do all day.” – OAT client

OAT clients reported that the quality of OAT-related services has fallen in recent years. They recalled previously having access to different social, inter-personal and group activities through a drop-in centre integrated into the OAT sites, which had dedicated activity rooms. Such rooms would engage people for hours with different games such as chess and table tennis. OAT clients said these activities boosted their mental health and wellbeing and provided them with quality time. They considered such spaces as their safe place, free from prejudice and discrimination. OAT sites also had self-help group meetings every week, and OAT clients described these meetings as providing a crucial platform

to share and learn from each other, which also boosted their confidence and emotional wellbeing.

An OAT provider explained that external donor dependence and a consistent reduction in funding have resulted in all such activities being reduced. They were highly concerned that such activities would cease overall due to the significant budget reduction caused by US funding cuts and the Global Fund funding reduction. They reported not having sufficient budget for staff training, or regular coordination meetings with stakeholders.

Participants associated the quality of OAT programmes with the site's environment and infrastructure. It was observed that NGO-run sites are significantly better in terms of infrastructure and enabling a safer environment than any government-run OAT site. The government sites are usually located in the most neglected spaces within hospitals, such as unmaintained rooms near the mortuary or in corner spaces, with minimal infrastructure and without proper hygiene. Standard practices set out in OAT guidelines, such as medicine storage and safety lockers, are not followed properly. The respondents also reported that government-run sites are still regarded as NGO programmes with minimal supervision and ownership by hospital management.

“The location of the OAT medical unit was not appropriate in terms of health, hygiene and overall infrastructure. In fact, I would say it was questionable whether that building was suitable at all from an infrastructural perspective. I have visited two sites so far, and I personally didn't find them to be up to standard.” – [Interview respondent, technical partner](#)

“Even though OAT services are physically located in hospitals, they are still regarded as NGO programmes with less supervision and ownership by hospital management. OAT is not integrated as a core service within hospital operations.” – [Interview respondent, technical partner](#)

The majority of the OAT clients also found NGO-run OAT sites to be superior for service delivery, counselling, health staff and creating an enabling environment than government-run sites. The availability of key health personnel, such as doctors and psychiatrists, was better in NGO-run sites. OAT clients also reported being able to have remote consultations with doctors through the NGO-run sites when needed, but that it was difficult to consult with doctors at government-run sites. They also felt staff and health workers in NGO-run sites were more supportive, accommodating and offered better counselling.

OAT clients considered the quality of the government-run OAT sites, particularly the medical units at government hospitals, as unacceptable from the perspective of both infrastructure and location within the hospital. This finding suggests that the poor quality of medical units at government-run OAT sites is contributing to stigma and is a barrier to access. A Global Fund report also found this to be the case.²²

²² The Global Fund, (2021), Nepal mid-term assessment: Global Fund Breaking Down Barriers Initiative.

“... in government-run sites, it is very difficult to meet the doctors. If we ask the doctor here [in an NGO-run site], the staff coordinate and let us talk to the doctor, even when they are not physically present at the site.” – OAT client

THEME 3: COST ANALYSIS AND SUSTAINABILITY OF OAT IN NEPAL

“Compared to developed countries, the unit cost of OAT in Nepal is relatively low; we are definitely not on the higher end. However, when compared to other prevention services, like programmes for sex workers and migrants, many people consider the unit cost of OAT programmes to be high. Considering the nature of the programme, its structure and the services it provides, I don’t think the unit cost is actually that high.” – Interview respondent, technical partner

3.1. COST ANALYSIS OF NGO-RUN AND GOVERNMENT-RUN OAT SITES

The study conducted a cost analysis of SPARSHA Nepal’s²³ main site and two satellite sites (NGO-run sites) and Saarathi Nepal’s SSU (government-run site), using data from 15 January 2024 to 14 January 2025.

The annual cost of running the NGO-run main site was USD 149,937, while the cost of running the two NGO satellites sites was USD 49,053 and USD 32,521, respectively. The majority of funding (between 82-88%) was spent on human resources and commodities/ medicines, such as methadone, buprenorphine and naloxone.

In comparison, the annual cost of running an SSU within the government-run OAT site was USD 93,502. This amount does not include any costs incurred by its MCU. In 2022, a study on harm reduction financing in Nepal²⁴ found the annual human resources cost of the OAT MCU at a government hospital was NPR 2,425,100 (USD 18,234).

On average, the costs of running two satellite sites were significantly lower than both the NGO-run main site (67% and 78% lower, respectively) and the government-run SSU (48% and 65% lower, respectively). Combined, the total cost of running the two satellite sites was 46% lower than the NGO-run main site and 13% lower than the government-run SSU.

A summary of the cost analysis of different OAT sites is provided in *Annex 7*.

3.2. UNIT COST ANALYSIS: COST PER PERSON SERVED PER YEAR

The number of clients who accessed OAT from each study site between 15 January 2024 and 14 January 2025 is presented in *Table 5*. For the unit cost analysis, clients who

²³ SPARSHA Nepal is a non-profit, community-focused NGO dedicated to health and human rights in Nepal with expertise in prevention, diagnosis, treatment, care and support programmes. See <https://sparshanepal.org>.

²⁴ Harm Reduction International, (2022), Harm reduction financing landscape in Nepal. Available from https://hri.global/wp-content/uploads/2023/04/NEPAL-DESIGN_FINAL-1.pdf.

received guest doses (meaning they were not enrolled at that site) were excluded.

Table 5: Total number of OAT clients served by each OAT site (15 January 2024 – 14 January 2025)

OAT sites	No. of OAT clients served (incl. guest doses)	No. of OAT clients served (excl. guest doses)
NGO-run main site	617	529
NGO-run satellite site - 1	255	190
NGO-run satellite site - 2	203	145
Government-run SSU site	395	300

The unit cost analysis found that the cost per person served per year was:

- USD 284 for the NGO-run main site
- USD 258 for the NGO-run satellite site 1
- USD 224 for the NGO-run satellite site 2
- USD 312 for the government-run SSU.

The study found that the unit cost of the NGO-run main site is significantly lower than government-run site. The addition of NGO-run satellite sites 1 and 2 to the NGO-run main site reduced the cost per person served per year from 2-5%, which, compared to the government-run site, was cheaper by 11% and 14%, respectively. The NGO-run OAT sites serve more clients and can be considered more cost-effective than the government-run site. It is important to note that the cost of the government-run SSU does not include costs incurred by its MCU. The addition of MCU-related costs would significantly increase the total cost of the government-run site, and therefore the unit cost per person served per year.

While these findings are not generalisable to all OAT sites in Nepal, they still indicate that, overall, the OAT programme in Nepal is inexpensive compared to other low- and middle-income countries. A systematic review of the cost-effectiveness of harm reduction²⁵ found that the annual unit cost of running the OAT programme was USD 368 in Vietnam, USD 405 in Indonesia and USD 543 in Kenya. Another systematic review found that the global average unit cost of OAT in low- and middle-income countries is USD 522 per year,²⁶ which is almost double the unit cost in Nepal.

3.3. COST ANALYSIS AND SUSTAINABILITY OF OAT PROGRAMMES IN NEPAL: STAKEHOLDER PERSPECTIVES

Most of the interview participants described the OAT programme as inexpensive as well as being lifesaving. Participants acknowledged that the OAT programme costs more

²⁵ Harm Reduction International, (updated 2024), Making the investment case: Cost-effectiveness evidence for harm reduction. Available from <https://hri.global/publications/making-the-investment-case-economic-evidence-for-harm-reduction-2024-update>.

²⁶ Vo, AT et.al, (2025), 'Unit costs of opioid agonist therapy: a global systematic review and cost extrapolation', AIDS, 39 (12), p.1794-1802. Available from <https://doi.org/10.1097/qad.0000000000004263>.

than other HIV prevention programmes for key populations, but because it has broader implications and benefits, they felt the unit cost is warranted. Participants observed that one of the main factors that make the OAT programme relatively expensive is the need to procure medication from other countries.

Another factor that adds to this expense is the low coverage of OAT in Nepal. However, participants observed that with expansion and scale-up, the OAT programme will be increasingly cost-effective. Anecdotal reports suggest that OAT sites in the Kathmandu Valley can be considered cost-effective due to the high flow of clients. However, this is not the case for other sites outside Kathmandu Valley, which are located in difficult locations to access and have fewer clients.

“It is important to understand that the more clients enrolled in the programme, the more cost-effective it becomes. Until each service site reaches a minimum threshold or client volume, the programme remains expensive. As the number of clients increases, it becomes more cost-effective. Therefore, emphasis should also be placed on increasing the number of clients at each service site.” – Interview respondent, technical partner

One of the most common concerns raised by interview participants was that the OAT programme is fully donor-dependent, and programme sustainability is at risk. All the participants expressed the need for budget advocacy to push for domestic funding for harm reduction. Donor funding is consistently reducing, and unlike Nepal’s HIV treatment programme, government funding for HIV prevention and harm reduction has not increased to keep pace. Nepal’s current funding model for harm reduction is based on a partnership between the government and donors, but domestic funding is not proportionally increasing and requires more advocacy.

“The current funding modality is based on a partnership between the government and donors. The government should proportionately increase its ownership and domestic resource allocation for the OAT programme. Likewise, NGOs should also widen their role in advocacy and service delivery by seeking technical support from the government, and simultaneously work on the sustainability of the programme.” – Interview respondent, technical partner

However, interview participants felt that the current model, which has two separate units (SSUs and MCUs) is not feasible for the government to fully finance domestically. In general, public healthcare and treatment interventions in Nepal operate under financial and human resource constraints, so there is a need to brainstorm for a feasible OAT model that the government could be convinced to take over. For budget advocacy to succeed, it must comprehend the government’s reality. A few interview participants suggested integrating the two units into one, which would reduce human resource costs, while the main site can oversee and manage sub-sites and provide necessary support. Such a model could reduce the unit cost. Limited ideas were suggested for tapping into domestic funding, yet most interview participants felt that the existing two-unit model should be continued. The integration of OAT into district and provincial-level hospitals

could open up possibilities for allocating government health budget, including funding from other line ministries. Such integration also offers options to include SSUs²⁷ in a hospital setting and for community health workers (outreach and counsellors) to play a coordinating role in supporting the programme. In addition, developing a mechanism to dispense OAT through designated pharmacies, with a prescription from psychiatrists, physicians or doctors trained on OAT, can also reduce logistical expenses by including it in existing government hospital costs. Nepal's current national health insurance scheme could also provide resources to pay for the integration model, if harm reduction interventions can be included within the scheme's benefit package.

“To make the [OAT] programme more cost-effective, we should integrate OAT into district and provincial-level hospitals...which can then allocate cost from the health budget, including funds directed by various ministries toward health development programmes. We should also explore how Social Support Units can be integrated into hospital settings and play a coordinated role in supporting the programme.” – Interview respondent, OAT provider

“To date, OAT has been treated as a vertical programme, but gradually it should be integrated as part of the overall health system. We cannot just keep opening one site after another without systematising the approach. For example, the ART programme started with a few main centres, then expanded to sub-centres and dispensing sites, eventually making it accessible across most districts. Similarly, HIV testing is now available even at the local health post or sub-health post level. Applying this approach to OAT, building the capacity of government sites and supplying medicines there would make the programme more cost-effective.” – Interview respondent, technical partner

Such an integration process should be conducted cautiously through effective coordination and by meaningfully engaging all concerned stakeholders, including the government, technical partners, OAT providers and clients, and drug user advocacy groups/networks. One of the interview participants proposed a five-year action plan roadmap for transitioning OAT from donor funding to national ownership. This will require strong coordination between the MOHA, NCASC (MOHFS), communities and donors. The HIV treatment programme proves what is possible. ART was initially donor-funded, but the Nepal government now has ownership, procuring medicines through domestic resources. There is no reason this cannot happen with OAT.

To ensure sustainability, participants suggested introducing OAT through the private sector as well. They highlighted national policies and good practices from high-income countries in this regard.

²⁷ Both NGO-run and government-run OAT models have SSUs. In an NGO-run OAT, SSU and MCU are integrated and operate from the same building. However, in a government-run OAT, MCU is located inside the public hospital and SSU is located outside the hospital and led by communities.

“In developed countries, harm reduction commodities, like syringes and OAT medications, are available at local pharmacies through social marketing approaches, where they are sold at minimal margins. We could adopt similar models here, especially in areas where opening new sites or adding staff is not feasible. Although OAT is a controlled substance and cannot be made universally available, designated points can be explored, reducing costs and increasing service acceptability locally.” – [Interview respondent, technical partner](#)

“We always knew that donors would end their funding one day. Therefore, when developing the national operational guidelines for OAT, we ensured the inclusion of a provision that NGOs and the private sector can continue OAT programmes through minimal charges to clients.” – [Interview respondent, national network of people who use drugs](#)

RECOMMENDATIONS

Based on the findings, the study recommends the following actions for short, medium and long-term impact.

INCREASING OAT COVERAGE AND ACCESS IN NEPAL

- Policymakers from the MOHFS and MOHA should review laws and policies on drug use, drug control and harm reduction to meet the current needs and realities in Nepal, grounded in human rights, justice and public health. The aim should be to expand and scale-up the OAT programme in strategic locations, guided by data and evidence, to ensure availability and easier accessibility to the service.
- The MOHFS should strengthen and institutionalise coordination efforts among key stakeholders (e.g., development partners and representatives from the government, criminal justice system, community/service providers and the national network of people who use drugs) by establishing an OAT coordination platform, which includes multiple government ministries and diverse communities, to discuss resources, policy, service delivery and quality assurance.
- Policymakers from the MOHFS and MOHA should ensure the provision of take-away doses to improve accessibility to OAT, increase retention and reduce programme drop-out.
- Harm reduction activists, champions and programme managers, in collaboration with the MOHFS and MOHA, should change the narrative around OAT. There is a need to emphasise the broader personal, health and socio-economic wellbeing benefits of OAT, and to promote and raise OAT awareness by forming strategic partnerships with media outlets and running campaigns with positive narratives.

For advocacy purposes, more detailed recommendations on increasing OAT coverage and access, including full explanations for the recommendations, can be found in *Annex 3*.

IMPROVING THE PERFORMANCE AND QUALITY OF OAT PROGRAMMES

- The Global Fund and technical partners should develop a comprehensive set of reporting indicators for Nepal's OAT programme to replace the current reporting indicators. These indicators should be developed in consultation with service providers and should measure the wider strengths and benefits of OAT.
- The Global Fund and funding agencies should allocate budget within OAT programmes for activities and capacity-building opportunities for clients.
- Service providers should create safe, community-friendly spaces within OAT sites to engage clients and foster their confidence and emotional wellbeing, and

integrate other essential health services relevant to people who use drugs into OAT programmes.

- Concerned policymakers, led by the MOHFS and including Global Fund principal recipients and OAT providers, should develop a centralised procurement and supply management system.
- Funding agencies, technical partners and the government should scale-up NGO-run OAT sites.

For advocacy purposes, details of recommendations on improving the performance and quality of OAT programmes, including full explanations for recommendations, can be found in *Annex 6*.

COST-EFFECTIVENESS AND SUSTAINABILITY OF OAT PROGRAMMES IN NEPAL

- The Global Fund principal recipient, in consultation with NCASC, should assess the OAT programme's sustainability in the context of the transition from Global Fund funding.
- Informed by the proposed OAT sustainability assessment, the MOHFS should formulate a multi-year action plan to guide the country's transition from the Global Fund, which includes a clear commitment to, and co-financing for, the OAT programme from the Nepal government.
- The Global Fund should allocate funding for budget advocacy to ensure community and civil society representatives are equipped to advocate for government investment and social contracting for harm reduction.

ANNEXES

ANNEX 1: STUDY METHODOLOGY DETAIL

1.1 DATA COLLECTION TOOLS (ADDITIONAL INFORMATION)

Separate checklists were developed for each study participant category with questions adjusted under each thematic area to the participant's role in the national OAT programme. All checklists were devised in such a way that participants had equal opportunity to provide their opinions, both positive and negative. For instance, if participants were asked, "what are the benefits of the OAT programme in your perspective", then they were given equal opportunity to express their views on the disadvantages or negative aspects of the OAT programme with a follow-up question. Both closed ended and leading questions were avoided as much as possible. All interviews were recorded using an audio recorder app on smartphones.

1.2 OPERATIONAL DEFINITIONS

Some of the key words or phrases that are building blocks of the study are defined as per the general definitions; however, the following operational definitions are inferred for this study:

Cost-analysis is defined as the cost per person served per year or "unit cost", compared to the unit costs of other low- and middle-income countries.

Coverage of OAT is defined as the total number of clients ever enrolled in the OAT programme as of 31 May 2025.

Access is defined as the total number of clients regularly accessing OAT in May 2025.

A **Government-run OAT site** refers to an OAT delivery model in which the medical care unit (MCU) or OAT dispensing unit (i.e., medical doctor and nurses) of the programme is located within a government hospital, and the social support unit (SSU) is led by a community-based/community-led organisation outside hospital premises to support the medical unit through outreach, referral, psychosocial counseling, and follow-up. In many instances, they are often mentioned as 'Government-run site/s' or 'SSU site'.

An **NGO-run OAT site or "main site"** refers to an OAT delivery model in which both medical care and social support units of the OAT programme are run together, fully led by a community-based/community-led organisation outside the hospital setting. In other words, it is a community-based OAT site.

A **satellite site** refers to an extended dispensing unit under an NGO-run OAT site or "main site".

An **under-performing OAT** site indicates that the ‘number of clients regularly accessing OAT’ from the site was below 50 in May 2025.

1.3 DATA ANALYSIS

Based on the monthly reports of all fourteen OAT sites for May 2025, data related to OAT coverage, access, and performance were entered into the Microsoft Excel template (i.e., the tool developed for this study) and analysed against the minimum standards for OAT defined by the HIV Standard Service Package for Key Populations, 2020 guideline.²⁸

Data collected from monthly financial reports, budget plans, and any other supporting documents (i.e., from 15 January 2024 to 14 January 2025) were categorised into eight ‘cost headings’, such as costs of commodities/OAT medicines, human resources, investments, operation costs, programme/activities costs, capacity building costs, M&E and support costs, and any other domestically resourced expenses. They were then entered into the Microsoft Excel template to calculate the ‘total annual cost’ of each study site. Moreover, OAT medicine dispensing data was analysed for unique client codes to obtain the total number of clients (individuals) who accessed OAT during the study period. The unit cost was calculated by dividing the total annual cost of each study site by the total number of clients who accessed OAT during the study period from the respective site.

Finally, this study used thematic content analysis, adapted from Glaser and Strauss,²⁹ to analyse qualitative data. The audio recordings of the interviews were first transcribed and then translated into English for comprehensive analysis and interpretation purposes. Then, through iterative processes of reading, highlighting, generating a matrix with quotations, cross-checking, and adjustments, interview transcripts were categorised into broader themes and sub-themes.³⁰

1.4 DATA COLLECTION AND RESULT

Data related to OAT coverage, access, and performance were collected from all fourteen OAT sites in Nepal. The cost analysis of the selected study sites was conducted utilising financial costs (actual expenses) and parameters provided by SPARSHA Nepal for its main and two satellite OAT sites, and Saarathi Nepal’s social support unit (SSU) OAT site operating in Kathmandu Valley. Financial data (i.e., 15 January 2024 to 14 January 2025) was collected using the standard format developed by researchers.

Whereas, for qualitative data, eight participants were interviewed using a semi-structured in-depth interview checklist, and eighteen OAT clients in three focus group discussions (FGDs) sessions. The participants of the in-depth interviews and FGDs are summarised in *Table 6*.

²⁸ NCASC. HIV Standard Service Package for Key Populations 2020

²⁹ Glaser BG, Strauss AL. The discovery of grounded theory. Adline, New York 1967.

³⁰ Burnard P. A method of analysing interview transcripts in qualitative research. Nurse Education Today. 1991;11:461

Table 6: Summary of participants in the in-depth interviews and FGDs

Study population	# of participants
Key Informant Interviews (KII) – Total	8
Ministry of Home Affairs (MOHA) – Drug Control Section	1
UNAIDS Nepal	1
Save the Children (the Global Fund GC6 principal recipient)	1
WHO Nepal	1
Recovering Nepal – the national network of people who use drugs	1
Tribhuvan University Teaching Hospital (TUTH) - Psychiatrist, National consultant for the OAT programme	1
Saarathi Nepal (OAT provider) – Management level	1
SPARSHA Nepal (OAT provider) – Management level	1
Focus Group Discussions (FGDs) – Total	3 FGDs (Participants: Male-15; Female-3, total=18)
Saarathi Nepal (Social Support Unit) – Chandol, Kathmandu District	1 FGD (Participants: Male-4; Female-2)
SPARSHA Nepal (Main site) – Sanepa, Lalitpur District	1 FGD (Participants: Male-5; Female-1)
SPARSHA Nepal (Satellite site - 2) – Shankhamul, Kathmandu District	1 FGD (Participants: Male-6; Female-0)

ANNEX 2: GEOGRAPHICAL COVERAGE OF OAT IN NEPAL

Table 7: Geographical coverage of OAT in Nepal

SN	OAT Service Providers	Type of site	City, District	Province
1.	Richmond Fellowship Morang	Government-run	Bhadrapur, Jhapa	Koshi (Province 1)
2.	Richmond Fellowship Morang	Government-run	Biratnagar, Morang	Koshi (Province 1)
3.	BIJAM	Government-run	Birgunj, Parsa	Madhesh (Province 2)
4.	Saarathi Nepal	Government-run	Chandol, Kathmandu	Bagmati (Province 3)
5.	Saarathi Nepal	NGO-run	Kathmandu	Bagmati (Province 3)
6.	SPARSHA Nepal	NGO-run	Sanepa, Lalitpur	Bagmati (Province 3)
7.	SPARSHA Nepal	Satellite site -1	Baneswor, Kathmandu	Bagmati (Province 3)
8.	SPARSHA Nepal	Satellite site -2	Shankhamul, Kathmandu	Bagmati (Province 3)
9.	Aavash Samuha	Government-run	Patan, Lalitpur	Bagmati (Province 3)
10.	Aavash Samuha	NGO-run	Bhaktapur	Bagmati (Province 3)
11.	Nirnaya Nepal	NGO-run	Bharatpur, Chitwan	Bagmati (Province 3)
12.	Community Support Group	Government-run	Pokhara, Kaski	Gandaki (Province 4)
13.	Aastha Samuha	Government-run	Butwal, Rupendehi	Lumbini (Province 5)
14.	Change Team	Government-run	Nepalgunj, Banke	Lumbini (Province 5)

ANNEX 3: RECOMMENDATIONS FOR INCREASING OAT COVERAGE AND ACCESS IN NEPAL

Recommendations	Quote	Explanation
Review law and policy pertaining to drug use, control and harm reduction to meet the current needs and realities grounded on human rights, justice and public health	“It’s clear that this policy doesn’t reflect the current needs and realities, and it’s definitely time for a review.” – KII Respondent, Service Provider “If we can integrate provisions into the Narcotic Drug Control Act that reflect the needs of the OAT programme, it would go a long way in helping it grow.” – KII Respondent, Technical Partner “Right now, the OAT is not included in the existing Public Health Act. But during its revision there’s an opportunity to include it. Doing so would also make it easier for MOHA to support site expansion and align their agenda accordingly. When OAT is clearly recognised within these frameworks, it becomes easier to push the agenda forward.” – KII Respondent, Technical Partner	The introduction of National Drug (Control) Policy 2063 and the Operational Guidelines for Opioid Substitution Treatment 2070 were historical achievements that ensured the provision of harm reduction services in Nepal. However, there is very little room for further progress that can be achieved within the framework of current drug law and policies. Therefore, while keeping drug and policy reform as a primary advocacy agenda, it is imperative that OAT is recognised by other public health laws and policies, including the Public Health Act and Mental Health Policy.
Expand and scale-up OAT programme in strategic locations guided by the data and evidence to ensure availability and easier accessibility to the service	“OAT sites should be increased as it would be easier for us to travel. Right now, there is a low chance that the place we are traveling to has an OAT site for guest dose.” – FGD Participant, OAT client “The number of OAT sites all over Nepal is also very less. It should be expanded to main cities.” – FGD Participant, OAT client	Almost all OAT sites have exhausted their capacity and resources for coverage in their respective districts. At the current scale, it is absolutely impossible to increase OAT coverage and access in Nepal. Expansion and scale-up of OAT programme will reduce the burden on clients as well as OAT providers.

Strengthen and institutionalise coordination efforts amongst key stakeholders (development partners, government and community/service providers) including inter-ministerial, diverse communities as enabling platform to discuss resource, policy, service delivery and quality assurance.	“For better results, we need stronger coordination among all three key stakeholders: development partners or donors, the government, and the community/service providers. Creating space for joint discussions among these groups would lead to more favorable outcomes for the OAT programme.” – KII Respondent, Technical Partner “If we can institutionalise regular coordination—maybe through a formal mechanism or task force—it could really help bridge that gap. It’s not that willingness isn’t there, but without structured, ongoing communication, the policy-level challenges don’t always get the attention or resolution they need. So, I’d say coordination is happening, but there’s definitely room to strengthen and streamline it.” – KII Respondent, Technical Partner	Coordination can lead to powerful and lasting change, however, the lack of regular coordination between MOHFS and MOHA, within sub-groups of people who use drugs, and among communities, government, and other partners has directly impacted the evolution of OAT programmes in Nepal. Regular coordination helps reduce stigma and prejudice against one another by combining lived experience, technical expertise, and political influence. Coordination is also one of the instruments for shared responsibility, monitoring, and accountability. In the context of Nepal, strengthening and institutionalising ongoing coordination efforts is essential—more now than ever.
Ensure provision of take-away doses to ensure accessibility, increase retention and reduce the drop-out	“There should be take-away doses for regular clients who need to travel [from long distances] as it will also prevent them from dropping out of OAT programme.” – FGD Participant, OAT client “In the near future, the current DOT (Directly Observed Therapy) modality of OAT service needs to be challenged. Even if clients are required to visit the site daily in the initial phase—say, for the first two months—once treatment criteria are fulfilled, there should be flexibility with three-day to one-week dispensing.” – KII Respondent, Service Provider	The OAT operational guideline has provisioned take-away dose for special cases of funerals and hospitalisation. Take-aways doses of OAT medicines were temporarily allowed during the COVID-19 pandemic. Take-away doses can significantly increase coverage, access, and retention of OAT clients. For starters, the provision of take-away doses could be introduced for clients that meet certain criteria, such as long-term OAT clients.

Change the narrative around OAT with broader personal, health and socio-economic well-being of an OAT client	“We must also shift the narrative: the OAT programme is not just about giving an alternative to drug users. It is a comprehensive life-saving programme. It helps service users become productive, economically responsible, and socially reintegrated into families and society—leading to overall individual and societal growth. This is how we should work, both nationally and internationally.” – KII Respondent, Service Provider	People who use drugs have always been associated with problems, disease, or crimes. Similarly, OAT has often been narrated as a medical intervention of last resort. Therefore, strength-based messaging should be adopted when communicating about people who use drugs and OAT. Humanising the issue and promoting success stories of OAT can reduce stigma and misconceptions around OAT.
Promote and raise OAT awareness through strategic outlet and campaigns with its positive narratives	“Awareness programmes and events must be planned to increase awareness on OAT. The programmes should get people together in groups.” – FGD Participant, OAT client “Social media can be used to disseminate information. They could create pages or websites and boost it. It would be better if it was done by the government. Community awareness programmes are also as much needed.” – FGD Participant, OAT client	A lot of misconceptions or misleading information on OAT persists across all relevant stakeholders, including people who use drugs and their families, health workers, police, media, and policymakers. Therefore, OAT-related awareness raising campaigns and promotional events should be organised regularly. These campaigns can be cost-effective when digital or online platforms are utilised. Since OAT is a national programme, it is important that the government shows ownership to the programme. Moreover, OAT clients should be actively involved in the design and implementation of these activities.

Strengthen and strategise community-led advocacy	“While communities have been advocating for OAT, it seems that current advocacy efforts have either been too limited, not sufficiently strategic, or not impactful enough to shift institutional perspectives. An important point of reflection is that the initial momentum and activism that helped launch OAT services appear to have weakened over time. This is a reality we must acknowledge. Without renewed energy, coordinated advocacy, and stronger evidence-based communication, the programme risks stagnation. That advocacy effort must continue. If we keep pushing in that direction, with improved coordination and active community engagement, I believe we’ll start seeing real improvements in coverage and accessibility.” – KII Respondent, Technical Partner	All the above recommendations may never come to reality without unrelenting community-led advocacy. When people with lived experiences and people most affected by unjust laws, stigma, and exclusion lead the fight for their rights, change becomes not only possible—but unstoppable. However, there is a need to strengthen advocacy efforts through coordination within different sub-groups with the community, capacity and leadership-building, evidence generation, and meaningful engagement and participation. Moreover, advocacy efforts should also focus on forging strategic alliances and often require a combination of diplomacy and hardcore activism.
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ANNEX 4: STAFF-TO-CLIENT RATIO FOR AN OAT SITE AS DEFINED BY THE STANDARD SERVICE PACKAGE

Table 8: Staff-to-client ratio for an OAT site as defined by the Standard Service Package

No. of clients	Medical Care Unit (MCU)			Social Support Unit (SSU)							Optimal coverage
	Dispensing Nurse	Pharmacist	Clinician	Site in-charge/ M&E Officer	Finance Assistant	Social Mobiliser	Guard	Office Assistant	Counselor	Outreach	
Up to 100	2	1	1	1	1	1	1	1	1	2	100
More than 100									2	3	200
Counselor and Outreach for every additional 100 clients									1	1	300

Note: The staffing structure should be as recommended by OAT guidelines of the Ministry of Home Affairs, Nepal.

Table 9: Other minimum standards for an OAT site

Outreach to peer educator ratio	1:4
Provision of satellite sites to increase access (Subject to MOHA approval)	Yes
Provision of overdose management	Yes
No. of counters in a dispensing room	2
Commodities	Methadone, Buprenorphine, and Naloxone
Minimum training requirements for each relevant staff (outreach, peer educator, community-led testing, STI management, Counseling, stigma and discrimination reduction, and OAT literacy)	Yes

ANNEX 5: CURRENT PERFORMANCE OF OAT AGAINST THE STANDARD SERVICE PACKAGE (SSP)

Table 10: Current performance of OAT against the Standard Service Package (SSP)

SN	District	Total PWID in each district (NCASC, 2024)	Optimal coverage at scale (as per SSP)	Optimal coverage % (district-wise)	No. of clients accessing OAT (as of 31 May 2025)	OAT access % (district-wise)
1.	Jhapa	1,422	100	7%	166	12%
2.	Morang	2,028	100	5%	141	7%
3.	Parsa	1,737	100	6%	45	3%
4.	Kathmandu Valley*	8,189	900*	11%	1,034	13%
5.	Chitwan	1,609	100	6%	41	3%
6.	Kaski	3,791	100	3%	114	3%
7.	Rupendehi	1,901	100	5%	14	1%
8.	Banke	2,680	100	4%	61	2%
Overall performance		23,357	1600	6.85%	1616	6.92%

*In Kathmandu Valley, there are currently 8 counselors and 11 in-reach/outreach workers. Therefore, the optimal coverage at scale is calculated based on the number of counselors.

ANNEX 6: RECOMMENDATIONS FOR IMPROVING THE PERFORMANCE AND QUALITY OF OAT PROGRAMMES IN NEPAL

Recommendations	Quote	Explanation
Develop a comprehensive set of reporting indicators for the OAT programme and replace it with the current reporting indicators	“We should also acknowledge the positive impact the existing service sites have had. Many of the beneficiaries currently enrolled are now able to access Hepatitis C services, ART for HIV, and a range of other health services. These interventions have certainly helped improve their overall health and quality of life, and that’s something to build on as we look forward.” – KII Respondent, OAT provider	OAT programme evaluation should move beyond basic indicators such as client retention or dropout rates and requires a robust and standardised set of reporting indicators developed through a scientific and consultative process. These should include clinical, behavioral, mental health, and social integration metrics. A well-defined M&E framework will enable evidence-based decision-making, facilitate adaptive programming, and demonstrate the public health value of OAT
Build in activities and capacity-building opportunities within OAT programmes for clients	“There should be more programmes such as skills programmes such as plumbing and others. I was so interested the last time there was such an opportunity for mobile repair training.” – OAT client “We should be creating an environment that offers vocational training, networking opportunities, and inclusion in leadership forums. These added supports can influence and improve the lives of clients and will attract more of them to join the programme. This kind of environment can help us achieve the goal of 40% coverage.” – KII Respondent, OAT Provider	To enhance the effectiveness of OAT, it must evolve from a medical-only model to a holistic, client-centered intervention. Incorporating vocational training, leadership development, and psychosocial support not only improves clients’ economic prospects and self-worth but also contributes to long-term recovery and reduced relapse risk. These components are critical to fostering reintegration into society and align with a rights-based, recovery-oriented approach.

Create a safe community-friendly space within OAT sites for clients to engage and foster their confidence, emotional well-beings	“It would have been better if there was a table tennis board or indoor games. I’ve heard that there used to be such facilities in the past.” – OAT client “It would really help us if there are more engagement programmes at the OAT site for all clients such as meetings, sessions, movie screening, or games.” – OAT client	The presence of safe, inclusive, and engaging community spaces within OAT sites enhances the therapeutic environment and supports client well-being. Recreational and peer-led activities foster social bonding, reduce isolation, and increase programme adherence—especially among clients who are unemployed or marginalised. These spaces also serve as informal points for health education and behavioral support.
Integrate other essential health services relevant to people who use drugs into OAT programmes	“Through the OAT programme, clients are also able to access services related to opioid use-related harm—such as treatment for abscesses, overdose prevention, as well as hepatitis C and HIV care... the mental health component must be integrated into the current OAT programme. Without this, the programme cannot be considered comprehensive, nor can it produce the desired outcomes.” – KII Respondent, OAT provider	A comprehensive OAT model should integrate co-located services addressing clients’ wider health and psychosocial needs, including mental health care, wound and abscess treatment, HIV/HCV services, overdose prevention, and legal aid, among others. This integration strengthens the continuum of care, reduces service fragmentation, and enhances client trust in health systems.
Develop a centralised procurement and supply management system	“The problem seems to lie in quantification and logistics management. due to the lack of a real-time updates on stock levels at various sites, and there is no centralised system or tools for logistics management to monitor balance or actual stock. To know the current stock, the center must call individual sites and ask for updates. This approach is unscientific and will never be able to ensure efficient supply chain management.” – KII Respondent, Technical Partner	The current fragmented supply chain—lacking real-time visibility—leads to frequent stockouts and inefficiencies. Establishing a centralised, digitalised procurement, inventory, and supply chain management system will improve quantification, ensure timely restocking, and support equitable distribution across sites. This reduces abrupt disruptions in services and strengthens programme credibility and trust, especially among clients vulnerable to treatment interruptions.

Scale-up NGO-run OAT sites	“At least there are community/ NGO OAT sites, which have played significant roles in reducing the stigma and discrimination against PUD/ PWID and drug use. It will also help to increase the level of trust, providing a confidential environment to increase service accessibility. Considering this, while working in this field, we started with 4 NGO-run OAT sites, which I think need to be scaled up in the long run.” – KII Respondent, Technical Partner	NGO- and community-led/ based OAT models often provide more flexible, confidential, and culturally sensitive services—reducing stigma and improving access for hidden or marginalised populations, such as young people and women who use/ inject drugs. Scaling up these models, including satellite dispensing sites, can enhance coverage and retention.
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ANNEX 7: COST ANALYSIS OF DIFFERENT OAT SITES

Table 11: Cost analysis of NGO-run OAT main site (Sanepa, Lalitpur District)

Cost headings	Total cost (NPR)	Total cost (in USD)
OAT medicine costs	7,357,781	\$ 55,397
Human resources costs	9,065,605	\$ 68,162
Investments (Setup/IT)	520,000	\$ 3,910
Operational costs	1,736,628	\$ 13,057
Activity costs	845,653	\$ 6,358
Capacity-building costs	227,000	\$ 1,707
M&E and support costs	183,710	\$ 1,381
Domestic support	0	\$ 0
Total Cost	19,946,377	\$ 149,937

Table 12: Cost analysis of NGO-run satellite site -1 (Baneshwor, Kathmandu District)

Cost headings	Total cost (NPR)	Total cost (in USD)
OAT medicines costs	4,659,344	\$ 35,033
Human resources costs	1,081,683	\$ 8,133
Investments (Setup/IT)	290,000	\$ 2,180
Operational costs	445,757	\$ 3,352
Activity costs	0	\$ 0
Capacity-building costs	47,250	\$ 355
M&E and support costs	0	\$ 0
Domestic support	0	\$ 0
Total Cost	6,524,034	\$ 49,053

Table 13: Cost analysis of NGO-run satellite site -2 (Shankhmul, Kathmandu District)

Cost headings	Total cost (NPR)	Total cost (in USD)
OAT medicines costs	2,450,981	\$ 18,428
Human resources costs	1,081,683	\$ 8,133
Investments (Setup/IT)	290,000	\$ 2,180
Operational costs	455,427	\$ 3,424
Activity costs	0	\$ 0
Capacity-building costs	47,250	\$ 355
M&E and support costs	0	\$ 0
Domestic support	0	\$ 0
Total Cost	4,325,341	\$ 32,521

Table 14: Cost analysis of Government-run OAT SSU site (Chandol, Kathmandu District)

Cost headings	Total cost (NPR)	Total cost (in USD)
OAT medicines costs	7,024,368	\$ 52,815
Human resources costs	3,416,026	\$ 25,684
Investments (Setup/IT)	429,950	\$ 3,233
Operational costs	1,446,125	\$ 10,837
Activity costs	0	\$ 0
Capacity-building costs	119,250	\$ 897
M&E and support costs	0	\$ 0
Domestic support	0	\$ 0
Total Cost	12,435,719	\$ 93,502

Important notes:

- The exchange rate applied is USD 1 = NPR 133.
- Investment-related costs at all sites were not investments made during the specific timeline of the study; however, the total investment costs have been considered for this analysis.
- In *Table 14*, the total cost includes the cost of the social support unit (SSU) only. The medical unit of a Government-run OAT site is located in a government hospital, and costs related to the medical unit were not accessible to this study.
- OAT medicines cost includes costs of medicines, shipping/freight costs, and courier costs.

