Drug Users at Risk to HIV

Documenting our Experience
2000-2005

care®

CARE Bangladesh

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HIV Program
CARE Bangladesh

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CARE Bangladesh

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BSS	Behavioral Surveillance Survey
CARE B	CARE Bangladesh
CBO	Community Based Organization
DFID	Department for International Development
DIC	Drop-in-Center
DU	Drug User
GoB	Government of Bangladesh
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
NGO	Non Government Organization
SHG	Self-help Group
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection

TABLE OF CONTENTS

Table & Figure

The most commonly used drugs in Bangladesh have been nicotine, cannabis and alcohol. Injection drug use appeared gradually in limited areas and now has a significant presence (between 20,000-40,000, national estimates 2005) in Bangladesh and among its neighbors. Injected drugs are primarily pharmaceutical synthetic opiates (such as buprenorphine), tranquilizers (such as diazepam), antihistamines and opiate cocktails. Heroin is not widely injected (an estimated 2% of IDUs use it), primarily due to price.

To date the Government of Bangladesh has completed six rounds of National Serological and five rounds of Behavioral Surveillance surveys. Findings indicate that the HIV rates are below 1% in all those surveyed, such as sex workers, rickshaw pullers, injecting drug users (IDU) etc., except in one group of drug users in one neighborhood of Dhaka. In 2000 and 2001 the HIV rates in this one group were 1.4% and 1.7% respectively. However, in 2002 there was an increase to 4% among the IDUs in this one neighborhood in Dhaka. The fifth and sixth rounds of the National HIV Behavioral Surveillance reports[1] a rising trend of HIV prevalence amongst all IDUs from 4% HIV prevalence in the fifith round to 4.9% in the sixth round. By 2004, the one neighborhood in Dhaka reported a rate of 8.9%[2] , confirming the start of a concentrated epidemic among this particular population.

In 1995, Care Bangladesh (CARE B) initiated an HIV/AIDS intervention program called SHAKTI (Stopping HIV/ AIDS through Knowledge and Training Initiatives), which was funded by the United Kingdom's Department for International Development (DFID), to improve HIV and AIDS programming in Bangladesh. Although the project originally targeted rickshaw pullers, after several strategy meetings it was decided to begin an HIV/AIDS prevention program with female sex workers. SHAKTI eventually expanded to include some of the female sex workers' clients and injecting drug users (IDUs) as intervention target groups.

An initial activity for the drug users' HIV prevention intervention was a baseline study, conducted in 1997 among low-income drug users (DU) in the city slums of Dhaka. The objectives were to discover the nature and magnitude of injecting drugs, identify HIV-risk behaviors (injecting and sexual) of IDUs, determine the type of intervention needed and identify the factors that might facilitate or constrain the intervention. As with the baseline survey of street-based sex workers, DUs were research participants. It proved to be an effective approach as they could identify drug users in a particular locality. Within a month, the baseline was complete and had identified approximately 7,000 DUs, primarily working as rickshaw pullers, small shop or food stall owners, or daily wage laborers. Most were male, about 1% were female.

The aim of a harm-reduction framework is to minimize the damage that using drugs can do to an individual. Harm reduction has been a controversial model because it does not require abstinence, as do most other anti-addiction models. It accepts addiction as a medical condition, a disease that can be difficult and lengthy to cure. Harm reduction is an umbrella of services, including education, STD management, and safer injecting practices. HIV prevention is only one goal of a larger drug harm-reduction program. However, all the other aspects of harm reduction lead to a decrease in HIV risk as well.

1. National HIV Serological Surveillance, 2004-2005 Bangladesh, Sixth Round Technical Report, National AIDS/STD program, Ministry of Health and Family Welfare, Government of Bangladesh, September 2005

From the inception of the HIV Program, CARE received funding to collaborate with government, non-government and community-based organizations. The collaborative model was chosen to avoid duplicating existing services. Many of the project components (detoxification, needle disposal, clinical services) were not areas in which CARE had expertise. Marie Stopes was CARE's first partner, providing medical services at drop-in-clinics.

Outreach is conducted on the street and in the neighborhoods surrounding each drop-in-center. It bridges the gap between a service provider and a hard-to reach population that will otherwise avoid contact with mainstream organizations. Outreach activities include needle/syringe exchange, condom distribution, one-to-one and group education, and referral to drop-in-center services.

This document discusses CARE B's drug user intervention using a harm reduction framework. Over the course of the project, CARE learned lessons about its approach to project activities, including use of drop-in centers, peer outreach and partnerships. The purpose of this document is to describe CARE B's experience with regard to HIV prevention with IDUs in Bangladesh.

CHAPTER 1
BACKGROUND

Bangladesh has some of the most fertile land in the world: 90% of the country consists of rich alluvial plains fed by a vast network of waterways that culminate in the largest estuarine delta in the world. However, the low alluvial plains also leave the country vulnerable to rising water levels, and its location in a cyclone region results in some of the worst flooding in the world. On average, severe cyclones hit the country every three years.

Bangladesh is the most densely populated country in the world with approximately 1,000 people per square kilometer for a total population of almost 140 million people. The population growth rate has slowed considerably due to the country's family planning program. The total fertility rate (average number of children per woman) fell from 6.3 in 1975 to 3.0 in 2004[3]. Even with the decrease in the total fertility rate, the population is expected to double by 2040.

The country is also among the poorest in the world. Four-fifths of the populations earn under $2 a day and one-third earns less than $1 a day. Poverty is caused in part by natural disasters that are exacerbated by political unrest and instability. Harassment and violence towards women and other high-risk[4] groups add to the marginalization of these individuals in society.

1.1 HIV in Bangladesh

Amid this backdrop of frequent natural disasters, overpopulation and poverty, Bangladesh has carried out serological surveillance annually since 1998. Surveys suggest HIV prevalence rates of less than 0.1% in the general population and less than 1% among people engaging in high-risk behavior. From the inception of the surveillance surveys, HIV rates have existed and continued to rise within the injecting drug user (IDU) population. Although HIV prevalence remains low, less than 1% among vulnerable populations[5], active syphilis remains high, an indication of risky sexual behavior.

Data from South East Asia and Australia suggest that if the prevalence of HIV amongst high-risk behavior groups was kept below 5%, it would not exceed 1% in the general population. Unfortunately, the 2003 National HIV and Behavioral Surveillance Report[6] documented a prevalence rate of 4% amongst injecting drug users in Dhaka, the highest levels of any population in the country. By 2004, one area of Dhaka reported a rate of 8.9%[7] , confirming the start of a concentrated epidemic.

The spread of infection in other Asian cities, such as Manipur, Kathmandu, and Yangon, indicates that a predictable pattern will ensue: a first wave among IDUs, followed by female sex workers, then their clients, and finally the general population. The main routes of HIV transmission shift during the evolution of each wave of the HIV epidemic: new infections are concentrated among IDUs during the first 5-7 years, after

3. Bangladesh Fertility Survey conducted by National Institute of Population Research and Training (NIPORT) 1975 and 1989 and Bangladesh Demographic and Health Survey conducted under the supervision of NIPORT, 1993-2000 and 2004
4. High risk groups for HIV include injecting drug users, sex workers, and transport personnel to name a few
5. Female sex workers in brothels, hotel, streets and casual (part-time) sex workers, male sex workers, males who have sex with males, transgender (Hijras), heroin smokers and some groups of mobile men.
6. HIV in Bangladesh: Is Time Running Out? Background document for the dissemination of the fourth round (2002) of national HIV behavioral surveillance. National AIDS/STD program, Ministry of Health and Family Welfare, Government of Bangladesh, June 2003
7. HIV in Bangladesh: The present scenario. A summary of key findings from the fifth round of serological and behavioral surveillance in Bangladesh (2003-2004). Ministry of Health and Family Welfare

which the largest number of new infections occur among male clients of sex workers, followed by the general population of low-risk males and females. This sequence of waves is largely caused by sexual transmission accelerated by the multiple interactions of IDUs with female sex workers, IDUs fixed sexual partners, and eventually men who have sex with men. In contrast with Europe and the US, the at-risk populations in Asia are in no way isolated from each other. The overlap between injecting drug use and buying sex is striking. Between one-half and three-quarters of male injecting drug users in several cities of Bangladesh reported buying sex from women during the past year. Many of these men, as well as other male IDUs, have steady partners whom they expose to the virus.

Furthermore, despite program interventions, IDUs in Bangladesh continue to display high-risk behaviors and low levels of perceived risk for HIV. Thus, within the time span of the project, the HIV epidemic got underway among injecting drug users in the capital city of Dhaka. The reasons for this are complex and poorly understood.

1.2 Drug use in Bangladesh

Traditionally, the most commonly used drugs in Bangladesh have been nicotine, cannabis and alcohol. Injection drug use appeared slowly in limited areas and now has a significant presence in Bangladesh and among its neighbors. Injected drugs are primarily pharmaceutical synthetic opiates (such as buprenorphine), tranquilizers (such as diazepam), antihistamines and opiate cocktails. Heroin is not widely injected (an estimated 2% of IDUs use it), primarily due to price.

At the onset of drug use, typically around 15-19 years of age, the most commonly used drugs are cannabis and alcohol. Phensidyl, a codeine-containing cough syrup, is also widely used, often as the next stage of drug use (taken orally), as are sleeping pills and diazepam (Valium). At this stage, smoking heroin is relatively rare, and intravenous drug use is less than 1%. After an average of 5-6 years, users tend to switch to, or supplement their use, with heroin smoking. This can be due to drug resistance, the increasing cost of phensidyl, difficulty in hiding alcohol use (odor on the breath), or exposure to areas where heroin smoking is more common (peer pressure or dealer incentives). Users tend to switch from heroin smoking to injection of prescription drugs 4-5 years after the onset of heroin smoking, and in response to a decrease in the availability of heroin or an increase in its price. In some areas, IDUs will revert to heroin smoking in response to price changes, greater availability, or increased income levels during harvest time.

The drug of choice among IDUs is buprenorphine, also known as tidigesic, TD, Madras or Hyderabad (for its production origin). It is a semi-synthetic narcotic derived from thebaine in the 1980s as a substitute for methadone and is used in the treatment of addiction to smokeable heroin. Buprenorphine has 30-50 times the analgesic potency of morphine. Initially, it was very cheap (about Tk.35 per ampoule), although when buprenorphine production was interrupted in 2000, a four to sevenfold price increase on the streets of Bangladesh led to the use of mixed cocktails of sedatives and antihistamines (including diazepam, promethazine hydrochloride, and chlorpheniramine) and an increase in intravenous drug use (previously 50% of IDUs were intramuscular injectors). This shift to intravenous injection increased the risk of exposure to HIV and other blood-borne pathogens. The shift to cocktailing has increased the incidence of abscesses. Abscesses are also caused by lack of knowledge about hygiene. Users often clean needles by wiping them with a dirty cloth or by licking them. They may wipe the puncture site with their dirty fingers or cloths. Access to medical care is limited, either due to lack of information about the right to health care or by discrimination on the part of clinic staff.
Bangladesh is characterized by ongoing changes in drug use patterns. In December 2002, on discovering the common practice of users switching between injecting and non-injecting drug use, the program expanded its coverage to include heroin smokers and other non-injecting users. In some districts, many users have shifted from heroin smoking to injecting buprenorphine. One district reported hundreds of IDUs but no heroin smokers. Recent rapid situation assessments have found districts with thousands of heroin smokers but no IDUs.

Drug use seems to be increasing among 14-30 year olds and among women. Overall, drug use is increasing as opportunities for drug treatment are limited in all areas. The number of individuals quitting drugs occurs at a much lower frequency than initiation of new recruits, and most drug users who recover to abstinence are likely to suffer relapses.

Injections tend to be either self-administered, although in one town nearly all injections were administered by professional injectors, (called pushers) in "shooting galleries" (addas). Pushers may inject 40-50 people a day with 80-90 injections, using the same needle for 20 or more people, without sterilization. In some galleries, injectors may purchase half a syringe filling, with the other half taken by an unknown person.

Three main sharing practices transmit HIV: the first is drawing blood into the syringe after injecting to collect the entire the drug. The second is "front-loading" or "back-loading": transferring drugs from one syringe to another. The third is sharing a needle for injection. Nationally, 28-74% of IDUs share needles, either actively or passively. The size of needle-sharing networks varies widely; the larger the number of drug users sharing injecting equipment, the greater the risk of widespread infection.

Street-based users tend to purchase their drugs from one or two spots. They may form temporary partnerships to purchase and inject drugs. Because of their low levels of education, they have many misconceptions about drug use. Their perception of HIV risk is low, even among those living in intervention areas.

In contrast, upper- and middle-class drug users, about whom little is known, tend to use drugs at home, to share exclusively with friends/relatives in a small group, and to move around the country more. They buy drugs from the same spots as other socio-economic groups, and may share with unknown IDU partners when their resources decrease. They are not reached by any intervention and, therefore, have little or no sense of HIV risk.

In the capital city of Dhaka, the average age of drug injector is around 33 (range 12-70 years). The average monthly income is Tk.3000 although about one-third of all users earn this amount or less. About 40% of the street-based users are employed as cycle-rickshaw drivers; 25% are peddlers or very small business holders. About 10% are homeless (rag pickers) who earn a living sifting through rubbish for items to sell or barter. A number work as cart pullers, transporting goods around the city manually, or transport helpers, who load and unload goods from trucks, boats, etc. Around half have had no formal education at all.

Many users supplement their income by pick pocketing, thieving, or selling their blood. Voluntary blood donation is not common in Bangladesh and some of the blood used in transfusions comes from professional blood donors, primarily injecting drug users. Although guidelines suggest donating no more than three times each year, some users, in their desperation for funds, sell blood monthly. As in most countries, illicit drug use is highly stigmatized. Smoking cannabis is tolerated, but injecting or smoking opiates is not. Virtually all-habitual drug users in Bangladesh are marginalized and discriminated against. Many are targeted for extortion and beatings (one-third report physical harassment) by the police or street gangs; the problem is worse for women. Up to 70% of all drug users report having been in custody at least once.

To maintain their addiction they need money. At first they collect it from their family or employer. Over time, they need to increase the dose of the drugs to get same effect. When it becomes apparent that the person is wasting money on drugs, no one is willing to give him money. The users start stealing money or things to sell in the market and over time, they lose their jobs, contact with their families and they are thrown out of the house. Many of them ultimately find the streets as their living place. Being in the streets, they become the target for all sorts of violence by police, local goons and even local community members. They have to run from one place to another, they have to hide, and they always try to choose some place where people will not enter. Their options get narrower for safer practices and for better access to information and services.

CHAPTER 2
INTRODUCTION

2.1 The Beginning of CARE's HIV Program: SHAKTI

Launched in 1995, SHAKTI[8] (Stopping HIV/ AIDS through Knowledge and Training Initiatives) was funded by the United Kingdom's Department for International Development (DFID) to improve HIV and AIDS programming in Bangladesh. The project was initially funded for work with clients of sex workers, specifically rickshaw pullers; however, after a couple of months of information collection and strategy meetings amongst staff, SHAKTI shifted its focus from rickshaw pullers to brothel-based sex workers in a town called Tangail, a two-hour drive (90km) from Dhaka. Peer educators (volunteers) and outreach workers (sex workers who are paid by the project), played a crucial role in this project, providing knowledge on sexually transmitted diseases (STD), condom use and the distribution of condoms to their peers.

CARE established health clinics inside the town's brothel and provided clinical services directly to the sex workers. Tangail brothel-based sex workers planned clinic activities and provided limited clinical services. Within 18 months of the initial implementation phase of the project, the management of the clinic was handed over to the sex workers. Sex workers paid between Tk.3-5 per visit, and initially CARE collected the money and gave it to the brothel samaj[9] , who decided how to spend the money (for a sex worker's funeral or upkeep of the brothel after a heavy rain, for example). After almost two years, a self-help group was formed. Once the sex workers formed their group, which included the sardarnis (the madams who controlled the sex workers), the money from the clinic that originally went to the samaj went to the self-help group (SHG).

Almost 18 months into the project, SHAKTI expanded, providing the same type of intervention activities to street-based sex workers in Dhaka City. The project began with formative research and a bio-behavioral baseline study. As the street-based sex workers were on the street, establishing clinic services was challenging. After locating a facility that could serve as a clinic, community-based drop-in-centers (DICs) were established and run by CARE with clinical services provided by partners (i.e. Marie Stopes).

The base-line study of street-based sex workers conducted in 1997 indicated that sex workers negotiated with clients in many locations in the city. These locations included parks, railway stations, movie halls, street corners, around office buildings and in residential areas. Sex workers also used some of these locations to have sex with clients. Initially the project collected information from Cox's Bazaar, thinking there would be lots of drug users there because of its proximity to Myanmar. However, after initial information gathering excursions, no IDUs were found in the area. At the same time, information was being assessed from four other areas. After reviewing the information gathered by staff and double-checking it with the street-based sex workers, it became clear that Dhaka had a greater number of IDUs. These findings resulted in project activities beginning in Dhaka.

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8. Shakti means "power" or "strength" in Bengali

9. A samaj represents exclusive society governed by rules and regulations that are enforced by the group under the leadership of elites. Compliance on the part of marginalized groups does not necessarily ensure benefits though it certainly improves the chances of obtaining resources and employment. Yet opposition to samaj leaders or their decision in all likelihood, results in the denial of resources and benefits.

2.2 Harm Reduction as a Framework for HIV Prevention

The aim of a harm-reduction framework is to minimize the damage that using drugs can do to an individual. Harm reduction has been a controversial model because it does not require abstinence, as do most other anti-addiction models. It accepts addiction as a medical condition, a disease that can be difficult and lengthy to cure. A harm-reduction approach does not initially aim to change the drug habit itself; rather, it is concerned with minimizing the harmful implications of the activity. In the short term, this means keeping drug users alive and in relatively good health, until they are able to stop using drugs, if they choose to do so. Longer term goals include drug substitution and abstinence. Harm reduction is an umbrella of services, including education, STD management, and safer injecting practices. HIV prevention is only one goal of a larger drug harm-reduction program. However, all the other aspects of harm reduction lead to a decrease in HIV risk as well.

CHAPTER 3
THE DRUG USERS' INTERVENTION

In 1996 CARE expanded its HIV prevention program, which had been focused on sex workers, to include drug users. DFID welcomed the inclusion of an intervention to prevent transmission of HIV and sexually transmitted infections (STI) among injecting drug users.

An initial activity for the Drug Users HIV Prevention Project (DUHPP) was a baseline study, conducted in 1997 among low-income drug users in the city slums of Dhaka. The objectives were to discover the nature and magnitude of injecting drugs, identify HIV-risk behaviors (injecting and sexual) of IDUs, determine the type of intervention needed and identify the factors that might facilitate or constrain the intervention.

As with the baseline survey of street-based sex workers, drug users were research participants. It proved to be an effective approach as they could identify other drug users in a particular locality. Within a month, the baseline was complete and had identified approximately 7,000 drug users, working primarily as rickshaw pullers, small shop or food stall owners, or daily wage laborers. Most were male, about 1% were female.

Information was collected from various qualitative, quantitative, primary and secondary sources on neighborhoods fragmented by drug users. Secondary data included reports from antinarcotics and customs departments, activity reports of local NGOs and CBOs, data from medical institutions on deaths related to overdose, local newspaper clippings, mosque records, and prison admission records related to drug use. Primary data were usually collected through observation of sites used by drug users and interviews with a variety of local key informants. This included the size and structure and stability of the neighborhood, the number and mobility of IDUs, the number and type of NGOs and governmental services available, the likely level of cooperation by neighbors, the crime situation, and who controlled neighborhood activities and how.

There was concern about the risk of HIV for drug injectors based on the results of the rapid assessment and the baseline findings. These concerns focused on:

- Sharing of needles and syringes
- How, when HIV enters a drug-injecting network, it can infect half of all injectors in two years or less, if needle sharing is common.
- Why IDUs, many of whom are sexually active young men, are at risk of acquiring or passing on HIV sexually.

Other countries such as India and Thailand have shown a rapid spread between IDU and sex worker populations (UNAIDS / WHO, 2005). Once threshold prevalence is reached within IDUs, the infection will quickly spread to the general population through their non sex-worker partners.

3.1 Making Contact, Establishing Trust

The intervention in question is an HIV outreach, education, and service project for drug users (DU). It has grown slowly in response to new knowledge about the needs of drug users and the size of the population. Staff working on the sex worker HIV prevention project learned that when entering a community marginalized by society, it is necessary to be sensitive about engagement of activities and settin the tone, in order to establish a trusting relationship.

"I never tell them not to use drugs. I'm not their mother, and anyhow their mother has already tried that approach. I say, 'If you want to leave drugs there are ways, and we can help you. There are lots of options." - CARE field staff

Initially, community members did not support the idea of CARE providing assistance to the drug-using

A group education session for drug users at a park in Dhaka

community. Even after regular community meetings, resistance continued. Then the community experienced a flood, and CARE staff provided emergency assistance. This act won community support. Before the flood, a community-based DIC gave out needles and the community was not happy; after the flood, the community was fully supportive of the IDU HIV prevention activities. To assure continued community support, CARE conducted regular community meetings with key stakeholders including local NGOs, police and mastaans.

The most common approach is now to provide services that drug users want and need. Providing free needles to a drug user who really needs them makes first contact easier. However, a harm-reduction framework should go beyond the supply of materials. It requires staff to pay attention and show concern for the general well-being of a drug user. Attempts were made to create a safe space where drug users could articulate their needs and aspirations. Seeing peers who are drug users involved in planning and implementing the program facilitated the development of a trusting relationship. As trust and credibility builds, other services are implemented: HIV counseling and testing; treating abscesses, STIs and other infections; referral to drug treatment, health clinics, mental health services, legal help and social services.

3.2 Peer Educators

Ex-users are valuable as outreach workers (paid) and volunteer peer educators (unpaid) because they know the lifestyle and have a natural empathy for project participants. For this reason peers are better counselors to other drug users. Someone who has not used drugs has less credibility in local advocacy work. Ex-users are easier to work with: they have knowledge of drug sites, habits and modes of communication with none of the disadvantages that can come with drug use. As much as possible, the drug user intervention employs current and ex-drug users as outreach workers.

Outreach is conducted on the street, and in the neighborhood surrounding each DIC. It bridges the gap between a service provider and a hard-to-reach population that will otherwise avoid contact with mainstream organizations. Outreach activities include needle/syringe exchange, condom distribution, one-to-one and group education, and referral to drop-in-center services. In some areas, outreach workers take shifts, working either from 6.30 a.m. to 2 p.m. or from 2 p.m. to 9 p.m. In other areas, the workday lasts from 8 a.m. to 4 p.m. Every day at the beginning of the shift, each outreach worker collects a field kit from the DIC containing educational materials, condoms, and clean syringes and needles. All are distributed free of charge. Although the HIV Program has moved toward social marketing of condoms with other risk groups (sex workers and transport workers), this has not been found possible or desirable for drug users.

Peer educators attend a training session

Each group of outreach workers is based at a DIC. Each field trainer oversees the work of four to ten outreach workers. Field trainers rely heavily upon a well-designed training plan to maintain staff development and quality of services. The main role of the outreach worker is to educate, support, counsel and listen to the drug users' problems.

Peer outreach workers try to create an atmosphere in which all issues can be discussed. They may make small talk, get updates on street news, and distribute low literacy materials on HIV, STD, and drug-related harm. They may participate in street dramas to raise awareness. During one-to-one or group education sessions, they use illustrated flipcharts and an album of STD photos to identify possible STD patients for referral to the DIC.

Group education on STD/HIV for drug users in a DIC in Dhaka

On average outreach workers distribute about 10,000 condoms per month. They then follow-up with STD patients, assist in solving individual health problems, and monitor users' self-reported activities and behavior change.

Volunteer peer educators are drug users who agree to participate in two-day training sessions about HIV/STI prevention and in ongoing refresher courses. After training, they receive a certificate of completion and are asked to educate their friends, family, and fellow users, informally, in the course of their daily activities. They are paid for their time while in training; the remainder of their time is given as a contribution to community service. Each DIC holds monthly training for peer educators. Refresher training is held every 6 months.
Although it has been controversial in some ways (some activists have questioned why the poorest people in society should remain unpaid for their contributions), the peer educator model is valuable in a number of ways:

- It addresses the particular problems of scale that Bangladesh faces. Volunteer peer educators help supplement the sheer number of contacts that need to be made.
- It helps to disseminate the message about HIV through pre-existing, non-formal networks of neighbors and friends, rather than setting up another system or authority to supplant the friends.
- It supports the sustainability of HIV education work. The hope is that by taking the message out of the hands of paid educators, the viability of the work will be assured. It empowers individual members of society to express their concern for their community and gives them an avenue to help in the struggle against a disease that will affect their community. Rather than training individuals to promote them out of his working community, the peer volunteer model enriches the knowledge, skills, and leadership of that community without changing identity.
- Work as a peer educator allows some users to take an initial step toward the development of skills (cognitive, motivational) that they need as outreach workers. Outreach workers are often recruited among the more skilled peer educators.

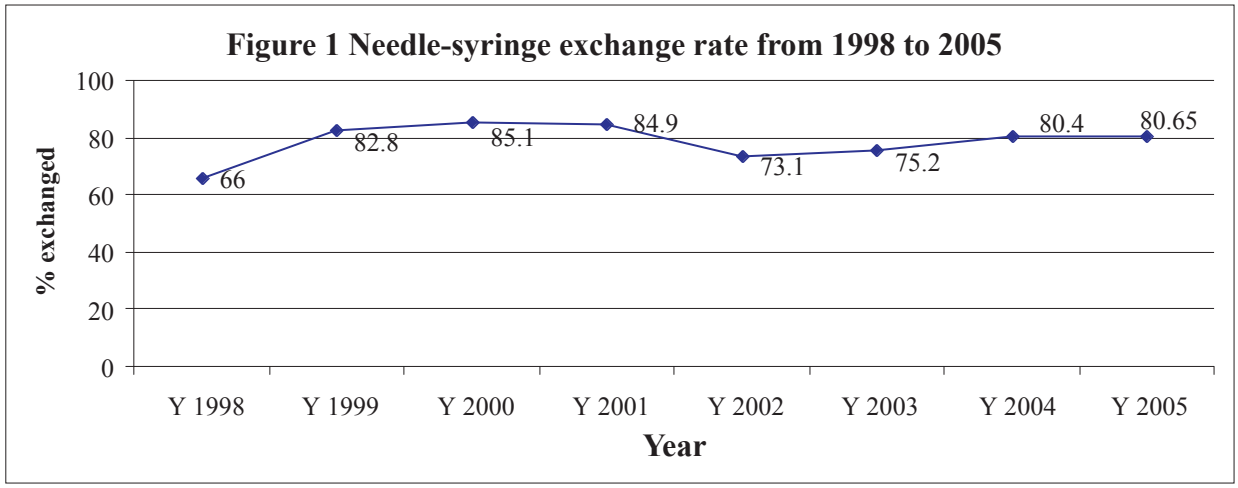
The peer educator training was new in Bangladesh, but it had been used for the sex worker project with great success. Every community has a peer education system. We learn most things from our peers. The goal was to make the peer's information scientifically sound. During outreach, workers are trained on the proper use of educational materials, condoms, identifying problems and skills in resolving them, referral and follow up of STD patients. Those who show an aptitude for data collection are asked to participate in bi-annual program monitoring and are trained to administer the monitoring tools.

3.3 Needle and Syringe Exchange

Needle and syringe exchange is the most well-known and controversial component of the harm- reduction approach. Sometimes it is interpreted as promoting drug use. The Narcotics Act of Bangladesh, which forbids possession of tools used for drug-taking practices, mandates a minimum punishment of six months in jail. The current harm-reduction program is running on the basis of strong advocacy from the government, as there is no law legalizing it.

Needle syringe exchange at a common drug site

The program utilizes outreach workers to distribute disposable syringe/needles among IDUs and collect used ones. Each drug user is given one needle and syringe and more if he asks for it. Used needles are collected in special puncture proof containers. To reduce the opportunity for sharing, the program monitors the exchange rate of new needles/syringes given out and the number of used syringes and needles collected from the drug users. It also helps take used needles and syringes out of circulation and facilitates proper disposal.



It was difficult to begin a syringe-needle exchange program, even though current and ex-drug users were recruited to help establish the program. It was challenging to find users in Dhaka as they are always changing places to avoid harassment by police and other local people. Initially, the project reached only 150 users per month, not much when an estimated 7,000 were in the city. However, the number grew steadily throughout the life of the project.

Staff also targeted "shooting galleries" or addas to introduce a syringe and needle exchange program. Several European countries have established injection centers for drug users, providing a clean, safe place for injection, with trained staff to supervise activities. In this way,

Addas in the city of Rajshahi

The city of Rajshahi, on the border with India, has addas (shooting galleries) throughout the city. An adda is a small room, usually at the back of the house or close to an open area with shade, where professional pushers administer injections. The pusher sells drugs and has the expertise to find veins easily. The whole family is usually involved in the wholesale purchase of these drugs; maybe the elder son is the pusher. He charges Tk.2 per injection, and he might do 50 injections in a day. He can earn Tk.3000 a month just sitting in his house

the harm caused by poor injection practices, needle sharing, overdose, etc. can be reduced. Along with drug substitution, this is one of the most controversial components of a harm-reduction framework.

In Rajshahi, the project involved the pusher's entire family. Staff trained family members and provided trained health advisors. Now the drug user who comes into the adda can then take an injection with a clean syringe. The pusher saves money on buying needles, and the injector feels better using a sharp, fresh needle. The interests of all three parties are served in this way. That is why the needle exchange rate in Rajshahi is around 95% and HIV prevalence is still below 1%. The addas were an ideal place to introduce a syringe exchange program, because the project did not need to seek out the IDUs. The project reached about 90% of the IDUs in the city.

Table 1 Needle-syringe exchange rates and number of detoxified patients 1998-2005

Year	Distributed	Collected	%	Number of patients Detoxified
1998	143929	94945	66.0	-
1999	664622	550451	82.8	-
2000	961235	817867	85.1	30
2001	908644	771880	84.9	30
2002	463297	338454	73.1	34
2003	813364	611864	75.2	66
2004	1042816	838510	80.4	72
2005	1011002	815401	80.6	
Total	6,008,909	4,839,372	80.5	232

Tracking needle-syringe sharing rates is an extremely important indicator for assessing the success of HIV prevention efforts. The annual behavioral monitoring survey reveals sharing among injecting drug users, despite the free needles provided. The National Behavioral Surveillance data also provides evidence of needle sharing among drug users.

The HIV Program monitored the status of needle sharing for both last day of drug use and last week of drug use. More than 60% of the respondents reported sharing during the baseline survey. The trend in sharing practices was declining until 2002 and 2003, when sharing increased both in last day and last week of drug use. The last monitoring survey conducted in 2004 revealed a lower rate of sharing (around 18%) among the respondents.

3.4 Abscess Management and STI Treatment through DICs

While street-based outreach is essential, baseline data suggested that a fixed site would also be important. Due to the forced mobility of most homeless drug users, a safe, indoor space to rest, conveniently located, is essential to the stability of project services. Therefore, DICs were established to provide a space for counseling, consultation with project staff or physicians, a "hang-out" with recreational facilities and room for informal interaction between project staff and drug users. Location, opening hours, and user-friendliness were important considerations when setting up the DICs. DICs provided abscess management, STD and other illness treatment, health education, and counseling. By 2004, the project had set up DICs in five

A drug user receiving abscess treatment at a DIC in Dhaka

districts, reaching 8,989 drug users. 700 peer educators have been trained and 146 peer outreach workers were providing HIV prevention services for drug users on the street and through the 27 DICs. By 2006 the number of DICs increased from 27 to 52 in 21 districts. Approximately 3,113 peer educators were trained and 349 peer outreach workers were providing services to 24,000 heroin smokers and 7,500 injecting drug users.

In Bangladesh, clinical consultation and treatment are not free or easily available to IDUs. The three biggest barriers to STI treatment[10] are cost, embarrassment and accessibility. Health clinics offer little privacy (i.e. a relatively soundproof space). Staff members are often judgmental and insulting. Few doctors have specific training in STIs and may prescribe inadequately, leaving the patient uncured. One-dose treatment is generally unavailable. Anal STIs are completely ignored, in both women and men, and are not mentioned in syndromic management guidelines.

To make medical services accessible, DICs were located within neighborhoods where drug users stay. The chief clinician in a DIC is the physician, provided by a partner NGO. Doctors are available according to patient load, from two half-days a week to six days a week. All DICs for the drug users have separate clinic rooms with an examination table. Clinic doctors provide STI care, but can also offer a few essential drugs for common symptoms (e.g. fever, back pain, anemia).

STI treatment meets one of the immediate needs of drug users and serves as a key strategy in reducing HIV transmission. Outreach workers refer drug users to the DIC for syndromic management of STIs, diagnosis and treatment based on signs and reported symptoms of disease, without laboratory confirmation. This approach has proven effective in situations where patients experience symptoms or pain. Its disadvantage is that many STDs are asymptomatic and can only be detected through laboratory screening.

Another important clinical need for drug users is treatment of abscesses. An abscess is an infected wound. Left untreated, an abscess can result in amputation of the infected limb, or death. Abscesses are common among those who inject in unhygienic settings. It also occurs more frequently among users who inject cocktail mixes of various drugs.

Because many street IDUs use unclean syringes, the puncture site becomes infected. One of the roles of the DICs was to manage abscesses, including washing abscesses thoroughly, starting a course of good antibiotics, and teaching IDUs how to avoid abscesses. Each DIC employs a dresser, a person trained in the painstaking task of washing and cleaning the abscess wound of its pus, changing bandages and dressings, and dispensing prescribed antibiotics to help control systemic infection. Many of the dressers are ex-users who have been chosen for their skill and patience. Many DIC doctors feel that cleaning and dressing wounds is the most important line of defense against infection; antibiotics can only work when the wound is kept clean.

Although a drug user's main HIV risk is in drug-use practices, most drug users also engage in casual sex. Most daily wage earners cannot afford to bring their wives and families with them, or to visit home very often. Initially, sexual transmission was not considered a risk behavior for drug users because data from the West showed that when users became addicted to opiates, their sex drive was reduced. In Bangladesh, however, the main substance is buprenorphine, made in India as a prescription sedative. It is a morphine analogue, but only weakly addictive, and so its influence on sexual urges is much less. Perhaps over 20 years it could affect the sex drive, but not in the first 5-10 years. A rapid survey of sex practices found that many

10. Knowledge of STI symptoms is low among men, primarily due to ignorance about sexual health. When asked about a history of STI symptoms, many men mention wet dreams as discharge. Traditional practitioners and quack doctors make a great deal of money treating premature ejaculation and impotence. Young men are taught that masturbation and nocturnal emissions will cause their penises to become distorted, or that they will lose erectility capacity and fertility. The main sources of STI treatment are drug shops (which are not tended by trained pharmacists), homeopathic doctors, and herbalists. Thirty percent of truckers did nothing in response to their last bout of STIs, 38% went to a traditional practitioner, 29% to private doctors, 24% to pharmacists and 8% to government hospitals. Twelve percent of long-distance truckers were infected with syphilis (Annual monitoring report, CARE 2004).

drug users have sex with street-based sex workers. Condom use is almost nil. The national sero-surveillance project found that syphilis infection among injecting drug users is 8-12%, which is high. Due to these findings, the project introduced condom promotion, then STD management.

Drug users play a game of Caroum at a DIC in Rajshahi

The DIC also offers recreational activities to counteract the boredom that can lead to increased drug use. Recreation helps develop a feeling of camaraderie among users and between users and staff. Even the bureaucratic necessity of registering new DIC visitors can have a therapeutic effect. For an impoverished, socially ostracized person to be asked to "sign in" can give a feeling of belonging, of being seen, recognized, and acknowledged, of being important to someone.

One staff member, called the DIC-in-charge, manages DIC activities. A field trainer, who may be responsible for more than one center, supervises the DIC-in-charge and outreach workers. Governance of the DIC is based on a philosophy of participation. In addition to staff from the CARE office and the clinical partner NGO, a DIC management committee includes all possible stakeholders: neighborhood homeowners, local business people, the ward commissioner, outreach workers, and representatives of self-advocacy groups. The committee may also include representatives from district and local administration and the health department. The committee meets monthly to discuss problems and solutions regarding outreach activities, service delivery, and problems of IDUs.

CARE feels that neighbors and other stakeholders must be involved in ownership and management of the DIC to ensure sustainability of the project and to advance the cause of advocacy. Indeed, inclusion has helped create a sense of ownership towards the project. To encourage social acceptance of the project, committee members are formally introduced to CARE as an organization, the HIV-prevention projects, objectives and methods.

3.5 Community-based Detoxification Camps

The traditional approach to detox is clinic-based. Government-run clinics offer medically assisted drug detoxification. But low availability, relatively high cost, and limited success make this option unrealistic for most poor people. As relapse rates are high, the government has been reticent to expand program capacity. Private treatment is prohibitively expensive; one six- month program costs Tk.5500.

Prison is cheaper than detox. Sometimes the family will send drug users to prison or the users will get themselves into prison just to get off drugs. Drugs, however, are widely available in prison. With nothing else to do in prison, there is an incentive to start using drugs again. Clean needles are not available in prison.

The Narcotics Control Act of 1990 created one government-run treatment center in Dhaka, which can treat 30-40 people at one time for a 6-12 week session. There may be 4,000 injecting drug users in Dhaka. But if you include those who are addicted to different substances, the number might be 100,000. There are 15 private drug treatment centers in Dhaka and two very small private treatment centers in Rajshahi, charging up to Tk.15,000. It would take a rickshaw puller or daily wage earner 6 consecutive months to earn that much money.

In 2000, with the help of the Bangladesh Department of Narcotics Control, a community-based 15-day medically supervised detoxification program was launched as part of the drug user project intervention. The programs are organized with the participation of community members, DICs, and self-help groups. Over five-weeks, outreach workers spoke regularly to potential patients to determine their commitment and will power, tracked the number of doses or injections, and helped reduce use of drugs in preparation for detox. Through this screening process, the drug user has to prove his or her willingness and ability over time. This test of ability is one of the building blocks of self-esteem that can help later in the struggle against relapse. During this time, BODAR[11] volunteers counseled the user's family and set up systems of social re-integration. BODAR volunteers are also involved in camp management, patient follow-up, and ongoing family counseling. While only 30-40% of camp participants remain free of drug use after one year, the costs associated with this strategy are much less than those of the clinic-based approach, with a net higher yield.


Drug users exercising in a detox camp in Rajshahi

Addiction is a medical problem and it needs management just like any other chronic illness. Getting off drugs is a process, and relapse may be part of it. The process can be a long one and it requires support and understanding throughout. In the future, CARE and its partners would like to increase the community-based clinics to a 4-week treatment, to address the effects of psychological withdrawal, which last much longer than physical withdrawal.

3.6 Partnership

From the inception of the HIV Program, CARE received funding to collaborate with government, non-government and community-based organizations. The collaborative model was chosen to avoid duplicating existing services. Many of the project components (detoxification, needle disposal, clinical services) were not areas in which CARE had expertise. Marie Stopes was CARE's first partner, providing medical services at the drop-in-clinics.

It proved more difficult to engage local and national NGOs to work with IDUs than it had with sex workers. This was due to the stigma of drug use and the lack of expertise among NGOs in working with DUs. Additionally, many of the NGOs in Bangladesh are involved with rural women and micro-credit schemes; expanding to include sex workers was seen as a small increase in the organization's mandate. To include harm reduction for drug users was too big a step for many.

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11. BODAR is an organization for former drug users in Dhaka. It was established in mid-2001 by Prochesta members who had completed drug treatment. BODAR is registered with the Department of Social Welfare. It has a fluctuating membership of about 35 recovering addicts (depending on rates of relapse and recovery) and an executive committee of 11 members. Its main activities are related to drug treatment and advocacy. BODAR has organized dozens of community-based detoxification camps, providing treatment for several hundred addicts. BODAR members work as volunteers during the camps. The group also manages post-camp rehabilitation support including peer-based counseling for individuals and families, follow-up home visits, and a monthly Narcotics Anonymous. It holds business meetings every two weeks to follow up on the progress of recent camp participants, to ensure that no one has fallen through the espouses. As a consequence, CARE found itself more involved in direct implementation of services to drug users, and for longer, than it had been with any of its other HIV-target groups (i.e. sex workers, transport workers etc). net, and tries to obtain job placements.

Drug treatment groups were natural allies. However, organizations based on a 12-step abstinence model of recovery had difficulties coming to terms with the tolerance towards ongoing drug use that harm reduction espouses. As a consequence, CARE found itself more involved in direct implementation of services to drug users, and for longer, than it had been with any of its other HIV-target groups (i.e. sex workers, transport workers etc).

Peer volunteers, outreach workers and SHG members at a social gathering

CARE provided self-help groups, founded by ex-users and current users, with technical assistance to form NGOs. Although these groups have yet to demonstrate organizational maturity and stamina, they are closely involved in drug detoxification. The recovering addicts have initiated their own partnerships with other NGOs.

3.7 Support for Social Integration

Recovery from drug addiction is a personal journey that cannot be made alone: social support is critical. The social reintegration of recovering users is the least developed aspect of this HIV prevention project.

Two-thirds of those who detox relapse after treatment. The reasons for this are many: when a user comes out of treatment he or she has no job, maybe no training or skill, no attachments except to those who are still taking drugs. The ex-drug users need to find alternative occupations and create new associations. They must be engaged in productive activities in society, so that they can become employed. Equally important, they need support to uplift their image and their self-esteem.

The family is one of the most important social structures that can support recovery. The family is crucial in the rehabilitation process.

3.8 Self-help Groups

The idea for creation of a self-help organization came up during the outreach workers' monthly meeting. The outreach workers had heard about self-help groups for sex workers, and they realized that drug users had important issues beyond AIDS, issues like harassment, discrimination, and day-by-day homelessness.

Two self-help groups were formed - Prochesta and BODAR. Prochesta, formed in 2000 by drug users, gave birth to BODAR in 2001, when a group of recovering addicts broke away. Due to relapse, the membership in the two groups overlaps. Some users undergo detoxification and others who have been free of drugs for some time relapse. The following sections describe some of the features, successes, and difficulties of these groups.

Given the amount of overlap in their organizational goals, some CARE staff encouraged BODAR and Prochesta to merge their groups. However, both groups felt their problems differed. Recovering addicts are concerned about preventing relapse and they feel the need to be away from the drug world as much as possible, when not at work. At present, the collaborative division of duties suits them both.

Prochesta

Prochesta (Endeavor - Self-Advocacy Organization for Drug Users) has a membership of 465 current drug users. Prochesta collects money through member subscriptions and other sources, including individual donations from community philanthropists and remuneration for sero-surveillance. It maintains a bank-based savings account. After its official formation, Prochesta advertised the idea of community-based detoxification camps. Since the formation of BODAR, both groups have become involved. Prochesta screens potential participants and selects the intake list. BODAR members work as volunteers to run the program.

The objectives of Prochesta are to:

- Become organized (drug users are often scattered and homeless), and build a hostel for drug users. Homelessness interferes with HIV risk reduction and general empowerment.
- Establish fundamental rights for drug users
- Increase and enhance drug users' skills, i.e. by collaborating with service providers and training institutions
- Ensure health education, treatment and rehabilitation
- Protest against harassment by police, local thugs etc.
- Communicate and liaise with governmental and non-governmental organizations
- Establish a climate of dignity and self-esteem for drug users in society
- Participate in HIV/AIDS prevention activities among IDUs
- Encourage IDUs who are willing to go on drug detoxification camp programs
- Participate in forums to learn more about HIV/AIDS prevention, harassment, dignity, rights etc.
- Be able to provide everyone with one good meal a day. This could also be done in the hostel, if we had it.
- Develop income-generating projects so that users would not have to steal for a living
- Start a fund to pay for the funerals of those users, especially women, who are homeless and destitute
- Start a substitution drug program.

The organization sought official status by registering with the Department of Social Welfare, as other community groups do. To register, an organization has to pay a registration fee of Tk.550 and elect an executive board. The entire registration process costs about Tk.15,000 to pay for different formalities, bribes, tips and extra charges. To meet these expenses, each member of Prochesta decided to save money from his or her daily dose to pay a weekly Tk.2 subscription for membership. For a street-based drug user Tk.2 is a lot of money. CARE facilitated their effort through the DICs by helping to administer the money collection.

To fill the requirements for an executive board, 11 members had to be elected. The candidates for the board came from the 10 DICs, each of which had a local Prochesta committee of five members. Of 50 committee members, 40 offered themselves to stand for election. There were 265 Prochesta members eligible to vote at this time. The election commission was made up of CARE staff and Prochesta members. Voting over two days in May 2001, voters elected the 11 members of the executive board.

The election process was important for it gave significance to individuals and what they thought. The act of voting also reinforced the role of the individual in the group and helped people understand that they are part of the greater society.

It took three years to register Prochesta. There were excuses and delays and re-applications, because Prochesta is a group of current drug users. The only way to get the application approved was to remove the reference to active drug use, and that is what happened.

BODAR

BODAR (Bangladesh Organization for Drug Addicts and Rehabilitation) is involved in advocacy, establishing links with governmental and non-governmental organizations and participating in national forums to raise awareness on drug-related harm and the need for civil rights and social justice for drug users.

Some of their organizational aspirations include:

- Improve follow-up of people after they leave detox. The scale of detox camps needs to be increased to accommodate the demand
- Organize all ex-users in Bangladesh in a big network of support, to show the rest of the world how many there are
- Establish a fixed clinic for rehabilitation --not just a medical clinic but one for vocational training and social reintegration
- Publicize activities in leaflets
- Visit other drug treatment sites to learn other methods and improve our skills
- Most important, stay drug-free and continue to be a role model for other users, so that they know another life is possible

Each strategy used during project implementation was important in its own right, but the intervention's significance lies in the integration of all strategies, which allow for a more comprehensive approach to HIV prevention with drug users.

CHAPTER 4
CHALLENGES AND LESSONS LEARNED

The lessons learned from this intervention with drug users should inform future CARE Bangladesh HIV prevention programs, particularly with regard to the overall strategic approach of using a harm-reduction framework. The operational approaches designed for working with drug users were community involvement, needle exchange, developing peer education and peer outreach, establishing DICs and community detox camps.

Community intolerance for IDU-related activities makes outreach work challenging and underscores the importance of community involvement. For example, in one community an outreach worker was conducting needle and syringe exchange activities when a mob of neighbors attacked him. They thought he was selling drugs and locked him in a room in a local club. Clearly, community members were not aware of the HIV prevention project activities in their communities. This type of reaction could be avoided by establishing a regular community forum in which community stakeholders and gatekeepers become familiar with project activities.

Needle exchange generally takes place at pre-arranged sites in the neighborhood. Outreach workers distribute one new syringe and two needles every day for each participant. Some amount of flexibility is necessary to match the changing needs of the IDUs and the instability of their social setting. Exchanges also take place at drug dealers' houses where IDUs congregate to buy and use drugs. Outreach workers coordinate exchanges on the street and bring used needles back to the DIC for disposal. Although this approach results in high rates of exchange, for some recently recovered IDUs, a continuing exposure to the drug world (the places, the people, and the habits, the physical and emotional triggers) can lead to relapse. Given that most peer outreach workers are recovering drug users, this approach comes with risks. For some of the recovering IDUs, however, exposure reminds them of what they have managed to leave behind.

Sadly, the increased earnings from a position with CARE as a peer outreach worker are sometimes a catalyst for drug relapse. For those outreach workers who are actively using drugs, drug use increases after the salary starts, and then levels off. After about two years, drug use is again reduced. The approach of paying drug-using individuals to do peer outreach should be reflected on before further implementation.

The major strategic approach of the drug users' intervention was establishment of DICs. During the intervention, the DICs provided a base for peer educators and outreach workers and a gathering point for clinical services and health education activities for the target group. However well intended, the DIC model fell far short of any hope of sustainability. For instance, the clinic services at the DICs are sub-contracted to a service provider outside the government system, which provides STI treatment centers. The sub-contracting created a parallel health service delivery system to that of the government system. All staff salaries at the DICs were from project funds, which further contributed to an unsustainable approach once the project ended.

Additionally, staffing DIC clinics presents its own difficulties. Clinic staff usually have limited tolerance towards drug users. This translates into inappropriate treatment of most of the clients at the DICs and reluctance on the part of the clients to seek health services, due to the way they are treated. Educational sessions provided by staff on harm-reduction theory and sexuality can help. But using project beneficiaries to

provide counseling on the social and psychological barriers to STI prevention and treatment may be the most effective aspect of HIV/STD prevention and treatment. However, this approach is generally viewed as social work, not medicine, and has to be developed with new clinic doctors. Doctors are re-trained to conduct patient examinations by physical contact, rather than from behind a desk. Changing the attitudes, bedside manner, and techniques of health care providers in DICs was and continues to be a major challenge.

The purpose of this document is to share CARE Bangladesh's experience with HIV/AIDS prevention with a broader audience. During documentation, the staff had an opportunity to reflect on the intervention outputs and processes. Through this reflection many of the lessons learned surfaced. For future interventions, reflective learning will become an integral part of the intervention in order to adjust approaches and achieve greater effectiveness.

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