National Harm Reduction Strategy for Drug Use and HIV 2004-2010

National AIDS/STD Programme
Directorate General of Health Services,
Ministry of Health & Family Welfare

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Strategic Direction:

- Dr. Kazi Shahadat Hossain, Line Director, National AIDS/STD Programme & SBTP
- Dr. Ferdous Alam Shibib, Programme Manager, National AIDS/STD Programme
- Dr. Md. Hanif Uddin, Deputy Programme Manager, National AIDS/STD Programme
- Dr. Hasan Mahmud, Deputy Programme Manager, National AIDS/STD Programme
- Dr. Shamsul Hoq Gazi, Deputy Programme Manager, National AIDS/STD Programme
- Dr. Nizam Uddin Ahmed, Director, HIV/AIDS Sector and South Asia Program Advisor, Save the Children- USA
- Dr. Tasnim Azim, Scientist and Head, Virology Laboratory and HIV/AIDS Program, ICDDR,B
- Dr. Rebeka Sultana, National Programme Officer, UNFPA

Prepared by:

- Gary Reid, Macfarlane Burnet Institute for Medical Research and Public Health, Australia
- Dr. M. Ziya Uddin, Drug User Intervention Specialist, Consultant, National AIDS/STD Programme

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Executive Summary

In Bangladesh it is widely acknowledged that drug use is increasing and accompanied with this are various risk behaviors. Particular concerns are injecting drug use and adverse health consequences such as blood borne viruses specifically HIV/AIDS and Hepatitis C.

In 2000-2001 the HIV prevalence rate among injecting drug users (IDUs) ranged from 1.4 - 1.7%. By 2005-2006 the HIV prevalence had increased to 7 % among IDUs in Central Bangladesh. The National Strategic Plan for HIV/AIDS 2004 - 2010 has as an objective of the need to Provide Support to the Priority Groups of People and one focus is to Provide Support and Services to Drug Users. Five strategies for drug users had been developed and endorsed.

It was felt that based on the five strategies, a comprehensive harm reduction strategy is needed to address the situation. The National AIDS/STD Programme of Bangladesh took initiative to develop a draft National Harm Reduction Strategy (NHRS) with technical assistance from UNFPA. A core of different key stakeholders facilitated the strategy development.

While there are differences between the approaches of supply, demand and harm reduction, international research evidence shows they should compliment each other - resulting in a favorable environment in which it is possible to contain illicit drug use and address public health problems such as HIV/AIDS among IDUs. **Harm reduction gives priority to the more urgent and practical goals of reducing harm for drug users who do not have the capacity and/or resources to stop using drugs at the present time.** Harm reduction interventions have been shown to be safe, and research evidence has shown that it does not lead to an increase in number of drug users, or the frequency of drug use.

The aim of harm reduction is to keep drug users alive, well, and productive until treatment works or they grow out of their drug use. There is always an emphasis on the dignity and human rights of all members of a society, including drug users. Harm reduction aims to protect the community by engaging with drug users - rather than excluding them from the wider community - by making targeted efforts to address their often multiple needs. The wider community is also protected from the sexual/vertical transmission of HIV as harm reduction is focused also on the sexual partners of IDUs and to reduce the risk of mother to child transmission of HIV.

Based on analysis of the drug and HIV/AIDS situation and vulnerability factors to the drug induced HIV epidemic and ongoing responses, **"The National Harm Reduction Strategy 2004-2010"** prioritized following strategies with individual implementing strategies;

Strategy 1: Strengthen understanding of drug using patterns, locations, and strengthen expand research on drug use. This strategy address the continued learning of different aspects of drug use in Bangladesh and need of research capacity and networking.

Strategy 2: Strengthen and expand programmes to reduce and eliminate the harm caused by drug injecting practices throughout the country. This strategy describes the essential elements of comprehensive quality programming with focused areas.

Strategy 3: Better understand the ways in which drug use influences sexual behavior and to ensure access to protection.

Strategy 4: Slow down entry into drug use. This strategy addresses how to delay or prevent entry of potential users in to drug use. Special focus has been given to adolescent and youths, focusing intervention in to early part of the cycle.

Strategy 5: Generate political, bureaucratic and legal support required for an effective programmatic response to drug use and HIV in a human

Strategy 6: Develop multi-stakeholder coordination to harmonize and integrate HIV/AIDS and drug use prevention, care and treatment policies of government agencies, private sector community, NGOs and the community to achieve desired objectives effectively and efficiently

Strategy 7: To develop a capacity for sustainable response to drug use and HIV at all levels of administration through high commitment and strong leadership with information and resources to support it

Strategy 8: Enhance monitoring and evaluation on impacts of drug use related HIV/AIDS prevention and care programs in the country

Strategy 9: Provide access to necessary HIV/AIDS treatment and care services to drug users, their families and partners living with HIV/AID

Strategy 10: Introduce harm reduction measures into prisons that can significantly bolster preventing the transmission of HIV/AIDS in the prison community and the wider community in the interests of public health

Strategy 11: To develop a partnership between law enforcement and the health sector to improve the effectiveness and efficiency HIV/AIDS prevention and control measures targeting drug users

Introduction

In Bangladesh it is widely acknowledged that drug use is increasing and accompanied with this are various risk behaviors. Particular concerns are injecting drug use and adverse health consequences such as blood borne viruses specifically HIV/AIDS and Hepatitis C. Research evidence show that there is wide spread sharing of contaminated needles and syringes and with regards to sexual behaviors the majority of drug users visit sex workers and condoms are seldom used. Drug users are not an isolated community and their ability to transmit HIV/AIDS to the wider community is not in doubt.

In 2000-2001 the HIV prevalence rate among injecting drug users (IDUs) ranged from 1.4 - 1.7%. By 2003-2004 the HIV prevalence had increased to 4 % among IDUs in Central Bangladesh. In one neighborhood of Dhaka it was 8.9% and this indicates a concentrated epidemic of HIV among IDUs in Dhaka City has commenced. The National Strategic Plan for HIV/AIDS 2004 - 2010 has as an objective of the need to Provide Support to the Priority Groups of People and one focus is to Provide Support and Services to Drug Users. Five strategies for drug users had been developed and endorsed. It was felt that based on the five strategies, a comprehensive harm reduction strategy is needed to address the situation. The National AIDS/STD Programme of Bangladesh took initiative to develop a draft National Harm Reduction Strategy (NHRS) with technical assistance from UNFPA. The completed draft NHRS will provide the impetus and guidance to seek solutions to address the rapidly rising prevalence of HIV/AIDS among drug users and in turn will attempt to prevent the virus from spreading outwards to the wider community.

Methodology

A core group comprised of different key stakeholders was formed to facilitate the strategy development. The core group develop the guideline and process of strategy development and decided to appoint a consultant with significant international experience to facilitate the process. An international consultant (IC) was recruited by UNFPA on behalf of the National HIV/STD Programmed (NASP) to develop a draft National Harm Reduction Strategy over a period of 21 days. The first task by the IC was to review the collected documents (see appendix 1). Two workshops were conducted with core group stakeholders. The first workshop held on June 9th and a key objective was to discuss the strengths and weaknesses of the multiple harm reduction strategies and suggested frame work of the strategy. A series of individual and group interviews with all stakeholders (see appendix 2) was conducted by the consultant in association with representative of UNFPA and NASP. Two field visits were undertaken to the drop-in-centre in Dhaka and Narayangonj. A draft version of National Harm Reduction Strategy (NHRS) was sent out to stakeholders prior to the second workshop on June 22nd. Discussion and comments on the draft NHRS was documented and suggestions for improvement was incorporated during the refinement of the draft document. (Full methodology see appendix 3)

Drug Use and HIV/AIDS in Bangladesh: Setting the Scene

As with other South Asian nations Bangladesh has a long history and tradition of illicit drug use, particularly of opium and cannabis. From the British period until 1984 registered opium users were provided with opium through government regulated licensed vendors. Following the prohibition of particular drugs such as opium and cannabis other illicit substances appeared on the market. Heroin addiction was first identified in the mid to late 1980s. At the same time injecting drug use was emerging but it was not until the mid 1990s that such practices became common place mainly in the cities of Dhaka and Rajshahi. During the mid 1990s successful law enforcement efforts against heroin supplies led to the price escalation of heroin with the unintended consequence of drug users turning towards alternative pharmaceuticals such as buprenorphine and phensidyl.

Currently the main drugs trafficked and used in Bangladesh include alcohol, heroin, cannabis, codeine phosphate (Phensidyl), buprenorphine, pethadine and various tranquilizers. The mostly porous borders that Bangladesh shares with India are well suited to the smuggling of drugs and various trafficking routes have been identified. Various social and economic factors have likely contributed to conditions favorable to the spread and rise of drug use. Epidemiological data available does suggest that drug use of all types is increasing throughout the country - one study in 2001 found drug injecting in 19 of the 24 districts surveyed. The estimates of total drug users in the country vary with figures ranging from 500,000 to 4.6 million. Of these 20,000 to 40,000 are believed to be injecting drug users (IDUs). It has been reported that there are likely to be 7,000 IDUs in Dhaka alone. How accurate these estimates are remain a moot point but what is not denied is an agreement the number of drug users is increasing

Bangladesh has undertaken many situation assessments since the late 1990s in various districts. However a nationwide study has yet to be conducted and as a consequence there are limitations of the current estimated size of drug users in the country. The findings of the situation assessments have provided a better understanding of the demographic, social and economic characteristics of drug users and of the various types of risk behaviors. The majority of drug users are male but female drug users have been identified more so in recent years[1]. Most drug users are aged from 18- 30 years, many are married and have children. Literacy levels vary but among the street based drug user this tends to be poor. Most drug users do have occupations but many have a modest to poor income and a sizeable number are unemployed. Overall IDUs tend to have lower socio-economic status. Generally there is a paucity of information of those drug users belonging to the middle and higher socio-economic sectors of society.

[1] *Drug injecting and potentials for continuing spread of AIDS: A baseline assessment in Dhaka city, 1998. Chatterjee A, SHAKTI-Project, CARE-Bangladesh*

Most drug users are not injectors and the favored method of consuming heroin is smoking. However, it has been found that many heroin smokers have had experience of injecting and while the transition period from smoking to injecting heroin is reported between four to ten years, the trend is for a shortening of this time frame. It has been reported that over the past five years approximately 10-20% of drug users are starting to inject with each passing year[2] . Among IDUs there is a tendency to mix other substances, commonly various sedatives, with their drug of choice and consequently increasing the risk of drug overdose which is commonly reported.

The sharing of injecting paraphernalia, including contaminated needles and syringes, is generally undertaken between one to three other drug users but greater numbers have been documented. Although the rates of sharing injecting equipment is lower among those receiving intervention measures compared to those that are not, the overall rates of reported sharing commonly range between 50% - 70%. However, it is important to emphasize that there is strong evidence that intervention activities where implemented do work in reducing in drug related risk behaviour. Many drug users are found to be mobile in their search of drugs and research in other districts has shown Dhaka tends to be the most frequented destination. Cleaning techniques of injecting equipment is overall poor and mainly ineffective for decontamination purposes. The majorities of drug users are found to be sexually active with married partners, with sex workers as well as with other males but condoms are seldom used.

Most drug users have experienced regular episodes of harassment and violence from a broad range of people that includes the local people and those from the law enforcement. Imprisonment is a common experience among drug users, mostly related to drug related issues but also for safe custody for addiction. The desire to be free of addiction is strongly felt among drug users with most - commonly 80-90% - attempting several times to abstain. Various approaches are sought for the cessation of drug use and these mainly include self-treatment, assistance from private doctors and NGO clinics. Few seek assistance from government health care providers.

The number of drug treatment beds is considered completely inadequate for the number of drug users seeking help. The expansion of increasing drug treatment beds is currently a major challenge which is not just related to the cost involved but also the lack of capacity among drug treatment workers to service the number of drug users in the country. Drug treatment programs are mainly limited to the process of detoxification over a period of two weeks and the overall follow up aftercare is regarded as erratic to poor. The relapse rate for those completing drug treatment in Bangladesh is on average more than 80%.

[2] *Drug injecting and potentials for continuing spread of AIDS: A baseline assessment in Dhaka city, 1998. Chatterjee A, SHAKTI-Project, CARE-Bangladesh*

Rationale for the National Harm Reduction Strategy

All the successive sero-surveillance data show that Bangladesh is still a low HIV prevalence country, <1% prevalence in all the high risk behavior population groups except the injecting drug using population. Drug users are as a result of their risk behaviours increasingly vulnerable to life threatening blood borne viruses such a HIV/AIDS and Hepatitis C. The 2nd Round of HIV Surveillance in Bangladesh in 2000-2001 found the HIV prevalence rate among IDUs ranged from 1.4 - 1.7%. By the 4th Round (2003-2004) the HIV prevalence had increased to 4 % among IDUs in Central Bangladesh. In the 5th Round of the HIV Surveillance, there were continued 4% HIV prevalence among IDUs and one neighborhood of Dhaka found 8.9% of the IDUs were HIV positive. A concentrated epidemic of HIV among IDUs in Dhaka City has commenced. Rates of Hepatitis C are often high among IDUs with prevalence rates of 60- 80% commonly found. As research has shown IDUs are not an isolated population and they mix directly and indirectly with other sectors of the community.

It was observed that most of the identified high prevalence HIV/AIDS location sites had needle and syringe exchange programs (NSEP) for couple of years, yet needle and syringe sharing remained significantly high and prevalence has been increasing. The Joint Review Mission (October 2004) of HIV/AIDS Prevention Project (HAPP) of NASP also proposed to strengthen the effort in IDU intervention so as to contain the further increase of HIV infection among IDUs and decrease needle sharing significantly in Dhaka and there by preventing the spread of HIV infection to other part of Bangladesh.

Considering the epidemiology of the HIV infection, the National Strategic Plan for HIV/AIDS, 2004-2010, has an emphasis on drug use related interventions and articulated the issues as sub component of objective one. With that background, there has been a growing consensus that IDU intervention needs a comprehensive package of intervention beyond NSEP. Injecting drug users are currently the most vulnerable group in the country and as part of a national response concerted targeted efforts to avert a potential explosive HIV epidemic have been deemed necessary. A core national expert group has suggested the need for a national harm reduction strategy as a first step to guide the development of comprehensive service package for IDU intervention.

The Role of Harm Reduction in HIV/AIDS Prevention and Control

While there are differences between the approaches of supply, demand and harm reduction, international research evidence shows they can also compliment each other - resulting in a favorable environment in which it is possible to contain illicit drug use and address public health problems such as HIV/AIDS among IDUs. Harm reduction gives priority to the more urgent and practical goals of reducing harm for drug users who do not have the capacity and/or resources to stop using drugs at the present time. The approach acknowledges that no method to totally eliminate drug use has been demonstrated in any part of the world and that HIV/AIDS presents a more serious global threat than the drug itself. In many parts of the world HIV/AIDS is considered a public health emergency impacting upon drug using communities. It is under these circumstances that harm reduction can be viewed as a short term measure to achieve the long term goals of reducing the level of HIV/AIDS in the community and working towards keeping drug users alive and free of drug use. Harm reduction approaches have demonstrated to be both effective and cost effective in reducing the spread of HIV among and from people who inject drugs. Harm reduction interventions have been shown to be safe, and international research evidence has shown that it does not lead to an increase in number of drug users, or the frequency of drug use.

The aim of harm reduction is to keep drug users alive, well, and productive until treatment works or they grow out of their drug use. There is always an emphasis on the dignity and human rights of all members of a society, including drug users. Harm reduction aims to protect the community by engaging with drug users - rather than excluding them from the wider community - by making targeted efforts to address their often multiple needs. The wider community is also protected from the sexual/vertical transmission of HIV as harm reduction is focused also on the sexual partners of IDUs and to reduce the risk of mother to child transmission of HIV.

The philosophy of harm reduction is to encourage drug users to progress towards reduced harm and improved health at a speed, which is more acceptable to their existing values, standards and circumstances. Importantly it does not stigmatize those who practice high-risk behavior, recognizing such behaviors result from various complex social, environmental, economic, cultural and personal factors.

Harm reduction approaches are increasingly adopted and adapted to the needs of different countries or communities providing an alternative approach and framework to deal with drug using problems. An increasing number of Muslim nations - Iran, Indonesia, Malaysia, Pakistan, Tajikistan, and Kyrgyzstan - have also

implemented various harm reduction interventions including either or both substitution therapy programs and needle and syringe distribution. Controversy is often in the shadow of harm reduction yet it has a long history of producing meaningful benefits for individuals and communities. Harm reduction principles are shown to be pragmatic, humane, effective and holistic and as a result have provided many opportunities for further interventions to reduce adverse health, social and economic consequences.

Scope of the National Harm Reduction Strategy

Drug users are often socially marginalized or disadvantaged. As a result of the criminalization of their behaviours there is a need to challenge the often discriminating and misinformed attitudes in the local community and to create understanding and, if possible, acceptance of the various harms reduction interventions. This generally requires the development and/or review of current policies related to drug use and HIV/AIDS as well as examining the public health service delivery systems in place to address the needs of drug users. The role and reactions of the law enforcement bodies and local government officials can be critical to the achievement of the various harm reduction objectives and consequently their participation and partnership requires considered focus. Building partnerships between health and law enforcement as well as enhancing alliances with other sectors of the government, community based organizations and industry based bodies will be identified as a priority for the National Harm Reduction Strategy.

The multiple strategies of harm reduction approaches that are implemented in various environments and cultures are based on scientific evidence. The various harm reduction strategies for Bangladesh will include advocacy and policy adjustment; HIV prevention and information and education; access to the means of prevention (condoms, needles and syringes and cleaning materials); voluntary HIV counseling and testing; the availability of, and referral to a range of drug dependence treatment options including the exploration of drug substitution therapy; and treatment care and support services including antiretroviral therapy for drug users living with HIV/AIDS.

Taking the National Strategic Plan for HIV/AIDS 2004-2010 as the basis and considering the current situation of drug use and HIV in Bangladesh and on going programme initiatives following strategies are formulated.

Goal of the National Harm Reduction Strategy

To prevent initiation of drug related HIV epidemic in Bangladesh, control use of drug and improve the quality of life of drug users through comprehensive package of intervention generating sustainable commitment and support among multi-sectoral stakeholders

Strategy 1: Strengthen understanding of drug using patterns, locations, and strengthen expand research on drug use.

Implementing strategy:

1.1 To develop a national research programme on drug use with systematic process for identifying research gaps and priorities on drug use and provision of relevant and emerging operational research (e.g costing, effectiveness and impact of intervention)

1.2 Strengthen research networks between the Department of Narcotics, Ministry of Health and Family Welfare, Law Enforcement, Ministry of Education and Centres for HIV and drug use, research organizations, nationally and internationally

Strategy 2: Strengthen and expand programmes to reduce and eliminate the harm caused by drug injecting practices throughout the country

Implementing strategies:

2.1 To increase local community understanding and acceptance of harm reduction, detoxification and rehabilitation programmes.

2.2 To strengthen and expand the involvement of drug users, former drug users, and SHG of ex and current drug users in programme development, implementation and evaluation.

2.3 To ensure access to harm reduction and elimination interventions including information including paralegal, access to sterile equipment, abscess management, drug substitutes, primary health care services, VCT, detoxification, rehabilitation programmes, and assist in the development of protective sharing practices.

2.4 To increase the coverage to the optimum level by reaching out to more injecting and other drug users - Focus should not just be on IDUs but include non-injectors who have the potential to become injectors as has been demonstrated by research evidence

2.5 To advocate for a comprehensive public health approach towards illicit drug use and HIV- To ensure that harm reduction can form a legitimate and balanced partnership with supply and demand approaches - a public health approach de-stigmatizes drug use so that drug users have greater access to a wider variety of health and education services and resources that are often denied either due to fear of exposure or ignorance of the resources available

2.6 To explore and create innovative approaches to reach out beyond the street based drug user scene - This is a need to seek ways of accessing those from more affluent backgrounds that often remain hidden and fear exposure

2.7 To develop where necessary services specifically and separately for adolescent/children and female drug users - Adolescent/children and female drug users often present with various other needs e.g reproductive health, - many female drug users face intense discrimination and stigma as a result of their behaviour further alienating them from seeking health services. Services for adolescent should address their context and needs.

2.8 To ensure that there are mechanisms in place for systematic and periodical review of the approaches of outreach, peer education, DIC to respond to changes in the drug using environment by the programme and independent reviewer.

Needle and syringe distribution:

2.9.1 To ensure that the drug injecting equipment available is varied, appropriate, at all time and accepted by the drug injecting community to prevent further risk behaviors - This would provide more options for IDUs and decrease the opportunity to share injecting equipment. Creating secondary sources (flexible and innovative) of clean needle/syringe at night or early mornings

2.9.2 To ensure concerted advocacy efforts are undertaken by different wings of GoB (MOHA, MOH, DNC, NASP, Prisons, Police) and key stakeholders to support the implementation of such programs - There is a need to work towards a policy and legislative shift to create an enabling environment that officially allow crucial HIV prevention programs to operate and target efforts towards IDUs and non -injecting drug users without threat of cessation or obstruction of programs such as needle and syringe distribution. An intensive educational effort involving multi-sectorial Ministerial participation is required. Any consensus reached by the ministries, should be disseminated to the various sectors and levels of each Ministry such as street level law enforcement personal. Advocacy efforts can include exposure to similar international site where needles and syringe distribution is successfully implemented such as Iran, India and Malaysia.

2.9.3 To ensure cleaning guidelines of injecting equipment is developed and widely disseminated - Practical training of techniques could be implemented inside the DIC and/or in the environment of the drug users when or where socially and culturally appropriate

2.9.4 Develop clear policies and guidelines on occupational health and safety issues, timely and appropriate disposal of used equipment - Suitable disposable containers must be provided for the use of staff and clients. Need to consider feasible means (incinerators) to destroy used needles and syringes either on the premises or a hospital. Collection should be undertaken by outreach workers, peer educators and/or DIC staff in order to maintain good relations with the local community and to prevent indiscriminate disposal of used needle and syringe.

Outreach Work:

2.10.1 To further develop the skills, knowledge capacity and diversity of outreach workers to ensure effective and efficient targeting of drug users from varied socio-economic backgrounds - Outreach work is a critical component of harm reduction to reach out and attract drug users as many remain hidden from public view. Outreach workers should provide condoms, injecting equipment and forwarding of educational messages to reduce risk behaviours but when the opportunity arises they should be skilled to know how to offer referrals ranging from drug treatment to serious abscess management that can addressed by the DIC. Capacity building can be achieved through intensive training programs and ongoing training to increase skills as staff members of the DIC. Technical capacity building assistance from regional and/or international technical organizations could be considered. This situation impacts upon cost effectiveness and efficiency of this crucial harm reduction approach. Selecting the most appropriate outreach workers is crucial in order to develop good rapport with the drug users, to be effective and to improve the quality of the service

2.10.2 To explore the ratio of outreach workers and number of drug users from both cost effectiveness and coverage and sustaining outreach workers - Service provision and quality diminishes when an outreach workers is required to meet an excessive number of drug users when it recognized that they often multiple needs Linked to this is a need to review the wage structure of the outreach workers during the process of 'professionalizing' their status. There should be provision for adequate physical, financial and legal support for the OWs.

2.10.3 To ensure the operational hours of the outreach workers are appropriate and suited to the needs of drug users - A degree of flexibility in working hours need to be considered when taking into the account the often unconventional life style of many drug users. Hours of work need to be reviewed on a regular basis in order to respond appropriately to the changing drug scene.

Peer Education:

2.11.1 To strengthen peer education programs - With careful training, appropriate supervision and an ability to debrief about the situation of the environment a positive impact for them and the program can emerge. Although peer educators are mostly recruited on voluntary basis a criteria for selecting a peer educator should be in place. Using technical capacity from regional and/or international technical organizations need to be considered for training programs for peer educators.

Drop -in- Centre:

2.12.1 To strengthen the capacity of the DIC in order to provide a more holistic approach to dealing with the multiple needs of drug users - A good DIC providing services (PHC, STD, VCT etc.) requires attention to the nature of the drug user culture, it must be flexible and responsive to their specific needs and can provide a non-judgmental, caring and accessible environment. Guidelines as to how a DIC should be operational could be developed and where skills of the staff are lacking training should be offered. Exposure site visits outside of Bangladesh should be considered.

2.12.2 To create demand for services of DIC among the drug users. Create adequate mobilization and develop appropriate IEC materials to motivate the drug users to visit and use DIC regularly. So that DIC could act as center of action as well as could be cost effective.

2.12.3 To develop the capacity of counseling skills of staff working with drug users and their families and to strengthen the emotional capacity among staff to undertake the task effectively - Training skills related to drug counseling should be sought nationally, regionally and internationally. Drug dependency and the psycho-social needs of drug users is most often misunderstood and training in this area is required

2.12.4 To develop an official agreement between each DIC and local police station and street level police personal to operate with minimal harassment - Ongoing advocacy and educational capacity building of those from the law enforcement sector in order to form an alliance with the DIC should be

pursued. Seeking an official document/letter by an influential law enforcement member to ensure a reduction or potential harassment of DIC staff to fulfill their duties should remain an ongoing agenda item for any harm reduction program.

2.12.5 To ensure the operational hours of the DIC are appropriate and suited to the needs of drug users - A relative degree of flexibility needs to be considered when taking into the account of the often unconventional life style of many drug users

2.12.6 To ensure that each DIC has the mechanisms in place to facilitate a constructive relationship, partnership and involvement of the community and local leaders - This will require the development of a DIC working group that has participation of DIC representation, the local police commissioner, representation of the business sector, a medical person and other high community profile figures. This will allow an opportunity for discussions about the operations of the DIC, to hear about problems and to seek out solutions for ongoing operations.

Drug treatment and rehabilitation:

2.13.1 To improve and expand physical structure/capacity, accessibility, availability, effectiveness and quality of drug dependence treatment and rehabilitation services. The services that address a range of needs, from detoxification to long term rehabilitation (institutional, potential home based and community based camps). There should be a system of coordination between the organization providing services at the street and the detox and rehabilitation centers.

2.13.2 To develop and build upon the capacity of the staff working in drug treatment services - This can be achieved through a series of training programs - currently there is a considerable lack of skilled staff in drug treatment and this will need to be addressed. Training would considerably raise the awareness of drug issues and the capacity of the existing drug treatment organizations to meaningfully participate in the national response to HIV/AIDS. Technical capacity building from regional and/or international technical organizations need to be considered.

2.13.3 To ensure that the management approach of drug dependant patients involves a combination of medical, psycho-social, social and religious approaches following evidence based drug treatment principles and that they are culturally appropriate

2.13.4 To ensure community acceptance of drug treatment services - This will also include the development of services for specific population groups such as young people, women, those from different socio-economic backgrounds and those from rural areas or of ethnic/tribal backgrounds.

2.13.5 To increase the involvement of mainstream health services - This can include professional such as general medical practitioners and hospitals in early intervention and relapse prevention. This will require an advocacy educational awareness program to inform them of the current situation of drug use and HIV/AIDS issues of Bangladesh

Relapse prevention programs:

2.14.1 To explore the introduction of pilot drug substitution programs as a part of the continuum of drug treatment, using evidence based guidelines involving medical supervision - Drug substitution therapy is not available in Bangladesh and classified as unlawful unless read into the exception as a medically prescribed narcotic treatment issued by a registered doctor. This area should be examined further. Substitution therapy aims to treat drug dependency, reduce negative health consequences, provide the opportunities for counseling and intervention in health and social problems faces by drug users - substitution therapy medications have recently been sanctioned by the World Health Organization as part of its essential drug list. Substitution therapy if supported should be available to IDUs who are currently HIV positive - to remove them from the active drug scene and minimize their risk behaviors - and to those drug users who have experienced a series of relapse episodes. Exposure visits to countries where it is implemented such as Iran, India, China, Indonesia, and Malaysia should be viewed as necessary. Appropriate representation from the Ministry of Home Affairs, Department of Narcotics, Ministry of Health and Social Welfare and NASP attending such study tours require attention. If accepted into Bangladesh, evidence based guidelines will need to be created, and training for medical practitioners prescribing substitution therapy will be necessary.

2.14.2 To develop the capacity of drug treatment staff to undertake evidence based drug user and family counseling and support - This is a requirement as part of a client's drug treatment and rehabilitation program. Drug treatment staff need to be informed of various aspects of addiction and relapse education theory. Research evidence highlights high risk sexual behaviors among drug users thus sexual health education for all clients should be provided during the counseling sessions. Technical capacity building from regional and/or international technical organizations may need to be considered.

2.14.3 To encourage all drug treatment facilities and services to explore the feasibility of introducing or linking to employment training, employment opportunities, access to micro-credit for former and recovering drug users - Drug treatment centres should be encouraged to work closer with health and social service agencies to provide former and recovering drug users to acquire job skill training and employment in order to maintain healthier and productive lives.

2.14.4 To develop a Narcotic Anonymous network and the creation of operational guidelines suited to the social and cultural context of Bangladesh

2.14.5 Create a drug detoxification and rehabilitation network that could link all the agencies currently providing services to formulate and implement a uniform minimum standard of service - The network could work towards the creation of considered uniformed accepted minimum standards of service, treatment and criteria guidelines for those gaining entry into drug treatment. There is a need to review the guidelines used by the various treatment centres and to ensure that what is offered to the clients is evidence based.

Strategy 3: Better understand the ways in which drug use influences sexual behaviour and to ensure access to protection

Implementing strategies:

3.1 To monitor changing patterns of drugs in use and promote research on drug related factors influencing sexual behavior among drug users.

3.2 To ensure that drug users and their partners have access to the means of protection in their sexual behavior and are provided with STI treatment as available

3.3 To raise the knowledge of individual risk perception in both IDUs, including non-injectors, and their sex partners of their vulnerability to HIV/AIDS.

3.4 To develop interventions that focus on individual risk appreciation and negotiation skill for safer sex practices through individual (for women or men as well and not just for IDUs) and couple-oriented sessions.

Strategy 4: Slow down entry into drug use

Implementing strategies:

4.1 To strengthen peer group norms and practices based on awareness of the potential harm of drug use.

4.2 To strengthen interpersonal communication and conflict resolution in the families - This could be assisted by the creation of appropriate IEC materials that are targeted towards families and communities

4.3 To develop school based drug education programs that are evidence based and designed to prevent harmful drug use - This should be a multi-sectorial effort involving the NASP, Department of Narcotics, Ministry of Education and Department of Youth Affairs (?)

4.4 Develop the capacity and encourage individuals, families and various community based organizations to take ownership and participate in efforts to reduce drug use and drug related harm - Communities should be assisted to develop local responses and should not be simply a target audience for public health campaigns.

Strategy 5: Generate political, bureaucratic and legal support required for an effective programmatic response to drug use and HIV in a human rights sensitive way

Implementing strategies:

5.1 To strengthen understanding of the need for effective programming, in particular harm reduction strategies.

5.2 To strengthen the mechanisms currently place to facilitate an ongoing dialogue among the health/law/narcotics control and police - This will require the enhancement of a multi-sectorial coordinating mechanism between health/law/narcotics control and the police to foster continuous dialogue in order to improve interventions on drug use and HIV/AIDS prevention. It will be the role of NASP to initiate and maintain this coordination mechanism

5.3 To work towards legislative and departmental policy change that currently hinder the effective implementation of HIV prevention strategies for drug users- There is a need to create an environment that fully supports the implementation of HIV/AIDS prevention and comprehensive care for drug users in the community. This can prove more effective with the NASP engaging more closely and regularly with political leaders and civil society.

5.4 To ensure that different wings of GoB (MOHA, MOH, DNC, NASP, Prisons, and Police) and other key stakeholders are in consensus to the endorsement of the National Harm Reduction Strategy and widely disseminated- Some interventions for IDUs are specific and often controversial but they need to be pursued Provide evidence and experience from other countries in the region that have implemented harm reduction strategies and its benefits to the community. An agreement to National Harm Reduction Strategy by all the major Ministries should be followed by a joint statement.

Strategy 6: Develop multi-stakeholder coordination to harmonize and integrate HIV/AIDS and drug use prevention, care and treatment policies of government agencies, private sector community, NGOs and the community to achieve desired objectives effectively and efficiently

Implementing strategies:

6.1 Strengthen the existing coordination mechanism between the NASP, HIV/AIDS working groups, all NGOs servicing high risk groups, Self Help Groups comprised of current and ex-drug users and HIV/AIDS focal persons within the different Ministries

6.2 Strengthen and enhance the role of existing HIV/AIDS Focal Points of the ministries and incorporate specific HR initiative within the action plan of the different ministries - These groups need to have greater involvement in broadening the understanding of harm reduction intervention and HIV/AIDS prevention strategies. Where appropriate establish HIV/AIDS Working Groups at the district level.

6.3 Create a strategic multi-agency Harm Reduction Working Group (HRWG) to allow for more effective coordination of policy, planning, budgeting and improve implementation on drug use and HIV prevention approaches - The HRWG would have representatives of NASP, Ministry of Health and Family Welfare, Ministry of Home, Department of Narcotics, Police, appropriate United Nation organizations, donors, research organizations, NGOs and representation of the affected community.

6.4 Ensure greater coordination and communication between all stakeholders through regular and ad hoc meetings of institutions from central to district level as well as through national meetings - Coordinate with international agencies to ensure that their resources can be used in an efficient and effective manner.

Strategy 7: To develop a capacity for sustainable response to drug use and HIV at all levels of administration through high commitment and strong leadership with information and resources to support it

Implementing strategies

7.1 To ensure that NASP secure a full time staff member to act as a foci resource person to lead the advocacy interventions at all levels of administration with regards to drug use and HIV/AIDS - Capacity building of this person needs to

occur in order for them to work effectively and efficiently with all the major stakeholders. Gradually a harm reduction unit within the NASP will need to be created to address the multiple challenges associated with HIV/AIDS and drug use intervention activities.

7.2 To ensure that advocacy efforts are intensified in order for the goals of drug use and HIV/AIDS prevention and care to be accomplished - NASP must advocate for community stakeholder support for HIV/AIDS and drug use prevention responses. Advocacy efforts must continue to target the mass media, community groups, religious leaders and Ministry of Home Affairs, Department of Narcotics and Police

7.3 To improve access to knowledge and skills development through professional education and training (Bangladesh adaptation of the Manual for Reducing Drug Related Harm in Asia, University credited course in Bangladesh on harm reduction, Centre of Excellence focused on programmatic harm reduction delivery) - There is a need to conduct targeted education and training programs which focus on aspects of drug use and HIV/AIDS prevention, care and treatment appropriate to the needs of the stakeholders. Currently there are an increasing number of people who are newly exposed to the area of harm reduction and to those that experience drug related harm. However, many of those in the field dealing with drug users do not have the skills, training and confidence to directly respond to the health, social and psychological harms caused by drug use.

7.4 To develop adequate funding mechanisms and resource mobilization to effectively implement and expand drug use related HIV/AIDS prevention and care programs - NASP will work with appropriate authorities in mobilizing resources from within the country and international communities for effective and sustainable development of drug used and HIV/AIDS prevention and care projects and the needed technical, financial, political and human resources

Strategy 8: Enhance monitoring and evaluation on impacts of drug use related HIV/AIDS prevention and care programs in the country

Implementing strategies:

8.1 To develop and formulate specific guidelines to ensure that activities of all programs focused on drug use and HIV/AIDS proceed effectively and efficiently

8.2 To strengthen the capacity of DIC regarding monitoring and evaluation of its activities and to improve its effectiveness based on the M&E findings (including cost effectiveness).

8.3 To communicate to all levels of appropriate Ministries, key stakeholders and the wider community the successes, problems and challenges of the National Harm Reduction Strategy

Strategy 9: Provide access to necessary HIV/AIDS treatment and care services to drug users, their families and partners living with HIV/AID

Implementing strategies:

9.1 To advocate for the availability of antiretroviral (ARV) medications as part of the prevention approach

9.2 To ensure HIV/AIDS treatment and care services to drug users their families and partners are available at appropriate and accessible settings

9.3 To develop the capacity and reorientation of existing health services to improve access by drug users to access treatment and care services - To assist in this process outreach workers and the DIC services can be deployed.

Strategy 10: Introduce harm reduction measures into prisons that can significantly bolster preventing the transmission of HIV/AIDS in the prison community and the wider community in the interests of public health

Implementing strategies:

10.1 To strengthen and/or create drug detoxification facilities inside prisons of a standard that is available to that in the wider community - Rehabilitation could come in the form of self-help groups modeled on the same principles as narcotic anonymous.

10.2 To ensure that prison guards and all prisoners are provided with basic health promotion materials and knowledge related to HIV/AIDS, other blood borne viruses and STDs and how they spread - The development of a peer education program inside the prison would be an efficient and effective means of disseminating information and knowledge. To involve prisoners in the development, design and delivery of health education materials in order to increase their appropriateness and range of reach

10.3 To develop the capacity and resources of doctors and nurses to ensure the delivery of appropriate and an acceptable standard of care for prisoners

10.4 To develop a pre-release program for drug users to prepare them for re-entry into the general community and linkage to drug treatment services and voluntary counseling and testing facilities - Program information would be about drug use, HIV/AIDS and STDS, and associated risk behaviours

10.5 To explore and develop the means to introduce vocational training and educational programs to assist in prisoner reintegration to the wider community upon release

Strategy 11: To develop a partnership between law enforcement* and the health sector to improve the effectiveness and efficiency HIV/AIDS prevention and control measures targeting drug users

Implementing strategies:

11.1 To ensure that all harm reduction programs have a consultative approach with law enforcement implementers from the outset - This includes the tabling of written agreements with authorities at the initiation of any harm reduction activities and that regular meetings, communication and community education is ongoing.

11.2 To ensure that law enforcement implementers at the street level are able to identify outreach workers and others linked with the DIC and that their role is clear as health workers and as public health educators - It is vital to keep up liaison with the police and to ensure that they understand the role of the program and the reasons for its introduction. It would be best for DIC to invite police members to be on the board or to be part of an advisory group of HIV prevention programs targeting IDUs and non injecting drug users. From this the DIC may be able to obtain police permission, or an amnesty in writing, for programs attempting to make clean needles and syringes available

11.3 To develop an curriculum on HIV/AIDS and drug use including harm reduction to be incorporated in to the professional training of law enforcing agencies- Training needs to be conducted by peers, other police, and needs to be presented in a manner so as to address the "What's in it for me?" question. Rather than presenting from the health perspective, the best approach in training police is to involve a police person. The process needs to have consultation with senior stakeholders representing both health and law enforcement sectors as this will lead to acceptance of the proposition to conduct training at a senior level. Local level workshops need to be conducted in all the areas specially the places known as "hot spots". The strength in training within police academies is the potential to influence law enforcement practice from the institutional core. This builds a strategic base within these institutions, where training on supply and harm reduction can take place. Seeking regional/international assistance to undertake this strategy will be required.

**The term 'law enforcement' encompasses a large number of stakeholders including police, prosecutors, judges, customs staff, border guards, military personnel, local council inspectors and so on.*

Appendix 1

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Appendix 2

List of People Consulted/Interviewed

NAME	DESIGNATION	ORGANIZATION
GOVERNMENT OFFICIALS		
Kamaluddin Ahmed	Director General	Dept. of Narcotics Control
SM Jahrul Islam	Additional Secretary	Ministry of Home Affairs
Col. Md. Shirajul Karim	Additional Directorate General	Directorate of Prisons
Alamgir Sikder	Director (T&R)	Dept. of Narcotics Control
Md. Siddiqur Rahman	Senior Assistant Secretary	Ministry of Home Affairs
Technical Committee of National AIDS Committee		
Maj. Gen. Dr. A S M Matiur Rahman (Rtd.)	Chairman	Technical Committee of National AIDS Committee
National AIDS/STD Programme		
Professor Dr. Fatima Parveen Chowdury	Line Director	National AIDS/STD Programme
Dr. Hasan Mahmud	Programme Manager	National AIDS/STD Programme
Dr. Mozammel Hoque	Deputy Programme Manager	National AIDS/STD Programme
Drug Treatment Services		
Prof. Dr. Nazmul Ahsan	Director	Central Drug Addiction Treatment Centre
Dr. Md. Akhtaruzzaman		Central Drug Addiction Treatment Centre
Bro. Ronald Drahozal	Director	APON
United Nations Agencies		
Evaristo Marowa	Country Coordinator	UNAIDS
Ivonne Cameroni	Project Officer, HIV/AIDS	UNICEF
Dr. Rebeka Sultana	National Programme Officer	UNFPA
AH Towfique Ahmed	APO	UNICEF
Md Zafor Ullah Nizam	National UNV Project Officer	UNODC

NAME	DESIGNATION	ORGANIZATION
Development Partners		
Dr. Muhammod Abdus Sabur	Health & Pop Sector Manager	DFID
Farzana Ishrat	Nutrition Specialist	World Bank
Rifat Shahpar Khan	Senior Program Officer	AusAID
Implementing Agencies		
Dr. Munir Ahmed	Team Leader, IDU Package	CARE Bangladesh
Md. Shakawat Alam	Program Development Officer- IDU	CARE Bangladesh
Md. Abu Taher	Program Development Officer- IDU	CARE Bangladesh
Mukta Sharma	Sr. Technical Officer - IDU	FHI
Khondker Zakiur Rahman	Program Officer - IDU	FHI
Dr. Farzana Amin	Program Officer	Marie Stopes Clinic Society
H.M Asaduzzaman	Program Officer	Marie Stopes Clinic Society
Iqbal Ahammed	Executive Director	Padakhep
Shamim Rabbani	Team Leader, IDU Package	Padakhep
Research Organization		
Dr. Tasnim Azim	Scientist & Head of Virology & HIV Program	ICDDR,B

Appendix 3

Methodology

An international consultant (IC) was recruited by UNFPA on behalf of the National HIV/STD Programmed (NASP) to develop a draft National Harm Reduction Strategy over a period of 21 days. The first task by the IC was to review the collected documents (see appendix 2). The first workshop with a core group of stakeholders was conducted on June 9th. A presentation of a global, Asia and Bangladesh overview of drug use and HIV/AIDS was conducted by the IC. The National Strategic Plan for HIV/AIDS 2004 - 2010 has as an objective of the need to Provide Support to the Priority Groups of People. A subcomponent of this objective states the need to Provide Support and Services to Drug Users. This subcomponent was briefly reviewed and followed by a discussion among the stakeholders of strengths and weaknesses of the multiple harm reduction strategies implemented as prevention measures against HIV/AIDS among drug users. Multiple harm reduction strategies included the following: pprovision of sterile needles and syringes, distribution and disposal programs; drug treatment; substitution therapy programs; information, education and communication; outreach, peer education; voluntary counselling and testing; primary health care; targeting special groups in the community such as prisoners or sex workers. Documented comments of the stakeholders were sent out to each participant with a request for any further remarks.

A series of individual and/or group interviews with all stakeholders (see appendix 1) was conducted by the IC in association with a representative of UNFPA and NASP. All interviews/discussions focused on the current constraints of implementing the multiple harm reduction strategies, suggested solutions to these constraints and to enquire as to what areas should be the covered in the draft National Harm Reduction Strategy (NHRS). Each discussion also incorporated a high degree of advocacy by the IC on various issues of harm reduction. Two field visits were undertaken by the IC and associates by visiting a drop-in-centre (DIC) run by CARE, Bangladesh in Dhaka and a DIC run by Marie Stoppes in Naraoingonj, outside of Dhaka.

All information collected over a seven day period was reviewed by the IC and incorporated during the writing period of drafting the NHRS. A draft version of NHRS was sent out to stakeholders prior to the second workshop conducted on the June 22nd. Discussion of the draft NHRS was documented and stakeholders were encouraged to email the IC for any further comments. Suggestions for improvement were incorporated during the refinement of the draft document.

A matrix outlining all of strategies and implementing strategies was created with a tick box to prioritize in a systematic manner the NHRS what needs to occur in the short term, medium term and long term. Much of this will be determined by resources and capacity to implement. This will be sent out for further discussion upon the completion of the IC assignment. Based upon the NHRS a draft Action Plan was designed. It provides a brief outline of some suggested planned actions. This will be further completed by the stakeholders involved in the development of the NHRS

Appendix 4

Prioritizing of the National Harm Reduction Strategy (based on 5 Year Plan):

Strategy	Short Term (0 - 12)	Medium Term (12-36)	Long Term (36-60)
1. Strengthen understanding of drug using patterns and locations, and strengthen and expand research on drug use			
Implementing Strategy			
1.1 To develop a national research programme on drug use with systematic process for identifying research gaps and priorities on drug use and provision of relevant and emerging operational research (e.g costing, effectiveness and impact of intervention)	+		
1.2 Strengthen research networks between the Department of Narcotics, Ministry of Health and Family Welfare, Law Enforcement, Ministry of Education and Centres for HIV and drug use, nationally and internationally		+	
2. Strengthen and expand programmes to reduce and eliminate the harm caused by drug injecting practices throughout the country			
Implementing Strategy			
2.1 To increase local community understanding and acceptance of harm reduction, detoxification and rehabilitation programmes		+	
2.2 To strengthen and expand the involvement of drug users, former drug users, and organizations of drug users in programme development, implementation and evaluation.	+		
2.3 To ensure access to harm reduction and elimination interventions including access to sterile equipment, abscess management, drug substitutes, health services, detoxification, rehabilitation programmes, and assist in the development of protective sharing practices	+		
2.4 To increase the coverage to the optimum level by reaching out to more injecting and other drug users	+		
2.5 To advocate for a comprehensive public health approach towards illicit drug use		+	
2.6 To explore and create innovative approaches to reach out beyond the street based drug user scene		+	
2.7 To develop where necessary services specifically for female drug users	+		
2.8 To ensure that there are mechanisms in place for systematic and periodical review of the approaches of outreach, peer education, DIC to respond to changes in the drug using environment		+	
Needle and syringe distribution			
2.9.1 To ensure that the drug injecting equipment available is varied, appropriate, at all time and accepted by the drug injecting community to prevent further risk behaviours		+	

Strategy	Short Term (0 - 12)	Medium Term (12-36)	Long Term (36-60)
2.9.2 To ensure concerted efforts are undertaken by different wings of GoB (MOHA, MOH, DNC, NASP, Prisons, Police) and key stakeholders to support the implementation of such programs	+		
2.9.3 To ensure cleaning guidelines of injecting equipment is developed and widely disseminated	+		
2.9.4 Develop clear policies and guidelines on occupational health and safety issues especially about the disposal of used equipment			
Outreach Work			
2.10.1 To further develop the skills, knowledge capacity and diversity of outreach workers to ensure effective and efficient targeting of drug users from varied socio-economic backgrounds	+		
2.10.2 To explore the ratio of outreach workers and number of drug users from both cost effectiveness and coverage.	+		
2.10.3 To ensure the operational hours of the outreach workers are appropriate and suited to the needs of drug users.		+	
Peer Education			
2.11.1 To strengthen peer education programs	+		
Drop -in- Centre			
2.12.1 To strengthen the capacity of the DIC in order to provide a more holistic approach to dealing with the multiple needs of drug users	+		
2.12.2 To create demand for services of DIC among the drug users.	+		
2.12.3 To develop the capacity of counseling skills of staff working with drug users and their families and to strengthen the emotional capacity among staff to undertake the task effectively	+		
2.12.4 To develop an official agreement between each DIC and local police commissioner and street level police personal to operate with minimal harassment	+		
2.12.5 To ensure the operational hours of the DIC are appropriate and suited to the needs of drug users.		+	
2.12.6 To ensure that each DIC has the mechanisms in place to facilitate a constructive relationship, partnership and involvement of the community and local leaders		+	
Drug treatment and rehabilitation			
2.13.1 To improve accessibility, availability, effectiveness and quality of drug dependence treatment and rehabilitation services. The services that address a range of needs, from detoxification to long term rehabilitation (institutional, potential home based and community based camps)		+	

Strategy	Short Term (0 - 12)	Medium Term (12-36)	Long Term (36-60)
2.13.2 To develop the capacity of the staff working in drug treatment services		+	
2.13.3 To ensure that the management approach of drug dependant patients involves a combination of medical, psycho-social, social and religious approaches following evidence based drug treatment principles and that they are culturally appropriate		+	
2.13.4 To ensure community acceptance of drug treatment services			+
2.13.4 To increase the involvement of mainstream health services			+
Relapse prevention programs			
2.14.1 To explore the introduction of pilot drug substitution programs as a part of the continuum of drug treatment, using evidence based guidelines involving medical supervision.	+		
2.14.2 To develop the capacity of drug treatment staff to undertake evidence based drug user and family counseling and support	+		
2.14.3 To encourage all drug treatment facilities and services to explore the feasibility of introducing or linking to employment training and employment opportunities for former and recovering drug users.			+
2.14.4 To develop a Narcotic Anonymous network and the creation of operational guidelines suited to the social and cultural context of Bangladesh		+	
2.14.5 Create a drug detoxification and rehabilitation network that could link all the agencies currently providing services to formulate and implement a uniform minimum standards of service		+	
3. Better understand the ways in which drug use influences sexual behaviour and to ensure access to protection			
Implementing Strategy			
3.1 To monitor changing patterns of drugs in use and promote research on drug related factors influencing sexual behavior among drug users.	+		
3.2 To ensure that drug users and their partners have access to the means of protection in their sexual behavior and are provided with STI treatment as available	+		
3.3 To raise the knowledge of individual risk perception in both IDUs, including non-injectors, and their sex partners of their vulnerability to HIV/AIDS	+		
3.4 To develop interventions that focus on individual risk appreciation and negotiation skill for safer sex practices through individual (for women or men as well and not just for IDUs) and couple-oriented sessions.		+	

Strategy		Short Term (0 - 12)	Medium Term (12-36)	Long Term (36-60)
4.	**Slow down entry into drug use**			
Implementing Strategy				
4.1	To strengthen peer group norms and practices based on awareness of the potential harm of drug use.	+		
4.2	To strengthen interpersonal communication and conflict resolution in the families		+	
4.3	To develop school based drug education programs that are evidence based and designed to prevent harmful drug use.			+
4.4	Develop the capacity and encourage individuals, families and various community based organizations to take ownership and participate in efforts to reduce drug use and drug related harm.			+
5.	**Generate political, bureaucratic and legal support required for an effective programmatic response to drug use and HIV**			
Implementing Strategy				
5.1	To strengthen understanding of the need for effective programming, in particular harm reduction strategies.	+		
5.2	To strengthen the mechanisms currently in place to facilitate an ongoing dialogue among the health/law/narcotics control and police	+		
5.3	To work towards legislative and departmental policy change that currently hinder the effective implementation of HIV prevention strategies			+
5.4	To ensure that different wings of GoB (MOHA, MOH, DNC, NASP, Prisons, and Police) and other key stakeholders are in consensus to the endorsement of the National Harm Reduction Strategy and widely disseminated.	+		
6.	**Develop multi-stakeholder coordination to harmonize and integrate HIV/AIDS and drug use prevention, care and treatment policies of government agencies, private sector community, NGOs and the community to achieve desired objectives effectively and efficiently**			
Implementing Strategy				
6.1	Strengthen the existing coordination mechanism between the NASP, HIV/AIDS working groups, all NGOs servicing high risk groups, Self Help Groups comprised of current and ex-drug users and/or HIV/AIDS foci representatives within the different Ministries	+		
6.2	Strengthen and enhance the role of existing HIV/AIDS Focal Points of the ministries and incorporate specific HR initiative within the action plan of the different ministries		+	
6.3	Create a strategic multi-agency Harm Reduction Working Group (HRWG) to allow for more effective coordination of policy, planning, budgeting and improve implementation on drug use and HIV prevention approaches.	+		

Strategy		Short Term (0 - 12)	Medium Term (12-36)	Long Term (36-60)
6.4	Ensure greater coordination and communication between all stakeholders through regular and ad hoc meetings of institutions at central and district level as well as through national meetings.		+	
7.	**To develop a capacity for sustainable response to drug use and HIV at all levels of administration through high commitment and strong leadership with information and resources to support it**			
Implementing Strategy				
7.1	7.1 To ensure that NASP secure a full time staff member to act as a foci resource person to lead the advocacy interventions at all levels of administration with regards to drug use and HIV/AIDS	+		
7.2	To ensure that advocacy efforts are intensified in order for the goals of drug use and HIV/AIDS prevention and care to be accomplished	+		
7.3	To improve access to knowledge and skills development through professional education and training (Bangladesh adaptation of the Manual for Reducing Drug Related Harm in Asia, University credited course in Bangladesh on harm reduction, Centre of Excellence focused on programmatic harm reduction delivery)		+	
7.4	To develop adequate funding mechanisms and resource mobilization to effectively implement and expand drug use related HIV/AIDS prevention and care programs.	+		
8.	**Enhance monitoring and evaluation on impacts of drug use related HIV/AIDS prevention and care programs in the country**			
Implementing Strategy				
8.1	To develop and formulate specific guidelines to ensure that activities of all programs focused on drug use and HIV/AIDS proceed effectively and efficiently	+		
8.2	To strengthen the capacity of DIC on the principles of monitoring and evaluation and how to improve effectiveness (including cost effectiveness. This will require a review and refinement of performance indicators	+		
8.3	To communicate to all levels of appropriate Ministries, key stakeholders and the wider community the successes, problems and challenges of the National Harm Reduction Strategy		+	
9.	**Provide access to necessary HIV/AIDS treatment and care services to drug users, their families and partners living with**			
Implementing Strategy				
9.1	To advocate for the availability of antiretroviral (ARV) medications as part of the prevention approach	+		

Strategy		Short Term (0 - 12)	Medium Term (12-36)	Long Term (36-60)
9.2	To ensure HIV/AIDS treatment and care services to drug users, their families and partners are available at appropriate and accessible settings	+		
9.3	To develop the capacity and reorientation of existing health services to improve access by drug users to access treatment and care services.		+	
10.	**Introduce harm reduction measures into prisons that can significantly bolster preventing the transmission of HIV/AIDS in the prison community and the wider community in the interests of public health**			
Implementing Strategy				
10.1	To strengthen and/or create drug detoxification facilities inside prisons of a standard that is available to that in the wider community.		+	
10.2	To ensure that prison guards and all prisoners are provided with basic health promotion materials and knowledge related to HIV/AIDS, other blood borne viruses and STDs and how they spread.	+		
10.3	To develop the capacity and resources of doctors and nurses to ensure the delivery of appropriate and an acceptable standard of care for prisoners		+	
10.4	To develop pre-release program for drug users to prepare them for re-entry into the general community		+	
10.5	To explore and develop the means to introduce vocational training and educational programs to assist in prisoner reintegration to the wider community upon release		+	
11.	**To develop a partnership between law enforcement and the health sector to improve the effectiveness and efficiency HIV/AIDS prevention and control measures targeting drug users**			
Implementing Strategy				
11.1	To ensure that all harm reduction programs have a consultative approach with law enforcement implementers from the outset	+		
11.2	To ensure that law enforcement implementers at the street level are able to identify outreach workers and others linked with the DIC and that their role is clear as health workers and as public health educators	+		
11.3	To develop an educational curriculum on HIV/AIDS and drug use including harm reduction.		+	

Appendix 5

Action Plan of the National Harm Redution Strategy (NHRS):

Implementing Strategy and Planned Actions	Indicators - Time Period	Tentative Budget
Strategy 1: Strengthen understanding of drug using patterns and locations, and strengthen and expand research on drug use		
1.1 To develop a national research programme on drug use with systematic process for identifying research gaps and priorities on drug use and provision of relevant and emerging operational research (e.g costing, effectiveness and impact of intervention)		
a. Review all research on drug use in the past 6 years so as to identify issues that have not been examined previously and to re-examine areas that require more focus such as reasons for ongoing sharing and other risk behaviours		
b. Undertake independent assessments of current design and approaches of HIV and drug use prevention, treatment, outreach, peer education and drop-in-centres at 6-8 programs in different districts. Findings will be disseminated widely and at higher policy levels including Government of Bangladesh (MOHA, MOH, DNC, NASP, Prisons, and Police) and other key stakeholders to have greater impact.		
c. Establish an agreement among Government of Bangladesh (MOHA MOH, DNC, NASP, Prisons, Police) and other key stakeholders of what a minimum harm reduction package would look like (for example, needle and syringe distribution; bleach, sterile water (?) and condom distribution using peers and other outreach strategies; development and dissemination of IEC materials; primary health care located with the DIC and/or outreach; and a range of other ancillary services). This would be followed by undertaking a costing assessment of this package based upon capacity of programs and estimated demand for services by drug users.		
d. Foster cooperation between national and international research institutes that focus on broad based drug issues in order to learn, exchange insights, and ideas which will in turn develop quality and rigorous research.		
1.2 Strengthen research networks between the Department of Narcotics, Ministry of Health and Family Welfare, Law Enforcement, Ministry of Education and Centres for HIV and drug use, locally, nationally and internationally		
a. Form a research sub group with in the Harm Reduction Working Group (HRWG, Strategy 6) and develop linkage with international institutions		
Strategy 2: Strengthen and expand programmes to reduce and eliminate the harm caused by drug injecting practices throughout the country		
2.1 To increase local community understanding and acceptance of harm reduction, detoxification and rehabilitation programmes		
a. Seek a high profile respected figure within the community who is sensitive and understanding of the reasons for harm reduction to speak to the mass media at a specific public event. (ie., the launch of the NHRS)		

Implementing Strategy and Planned Actions		Indicators - Time Period	Tentative Budget
	b. Organize community level advocacy meeting and use local key people like school teacher, elected people, parents or police officer to advocate harm reduction issues		
2.2	To strengthen and expand the involvement of drug users, former drug users, and organizations of drug users in programme development, implementation and evaluation.		
	a. Encourage and include the opinions and views of current and ex-drug users during the planning process of program development to ensure wider impact		
	b. Recruit (minimum proportion……) peer educator, out reach worker, DIC personnel from current and ex-drug users		
2.3	To ensure access to harm reduction and elimination interventions including access to sterile equipment, abscess management, drug substitutes, health services, detoxification, rehabilitation programmes, and assist in the development of protective sharing practices		
	a. Government of Bangladesh (MOHA, MOH, DNC, NASP, Prisons) and other key stakeholders will advocate at all levels of governments and at a multi-agency level to support the implementation of the various components of harm reduction approaches that are based on science and research evidence		
	b. Ensure at least ??? 80% coverage of injecting drug users across the country		
2.4	To increase the coverage to optimum level by reaching out to more injecting drug users and other drug users		
	a. Employ more outreach workers who are current or ex-drug users and increase the recruitment of peer educators as they have better access to the drug using community		
2.5	To advocate for a public health approach towards illicit drug use		
	a. Long term strategically planned advocacy efforts by the Government of Bangladesh (MOH, MOH, DNC, NASP, Prisons) and all other key stakeholders of the need to shift attitudes and perception of drug users as criminals towards victims of drug dependency		
2.6	To explore and create innovative approaches to reach out beyond the street based drug user scene		
	a. Undertake a brief assessment of private detox clinics and rehabilitation centres by running focus groups with the more affluent clients. The aim is to get their views and perspectives as to what they believe are good communication channels to reaching out beyond the street based drug users		
2.7	To develop where necessary services specifically for female drug users		
	a. Set up DIC or arrange special times for female drug users to come to the DIC in which educational sessions are held		
	b. Create IEC materials taking into consideration women's health needs such as reproductive health.		
2.8	To ensure that there are mechanisms in place for systematic and periodical review of the approaches of outreach to respond to changes in the drug using environment		
	a. Every 6 - 12 months brief assessments can be done by the DIC to receive views of the drug users regarding the service.		

Implementing Strategy and Planned Actions	Indicators - Time Period	Tentative Budget
a. Every 6-12 months a brief assessment can be done by external agencies to randomly select group of drug users to assess knowledge, attitude and practices of specific drug use and HIV/AIDS issues in order to identify behavioural changes and effectiveness of the programme		
Needle and syringe distribution		
a. In collaboration with drug user networks assess the views and opinions of a range IDUs of the equipment on offer to determine suitability. If not appropriate seek a solution.		
2.9.1 To ensure that the drug injecting equipment available is varied, appropriate, at all time and accepted by the drug injecting community to prevent further risk behaviours		
a. Organize regular ongoing advocacy meetings involving multi-sectorial Ministerial participation to officially allow such programs to operate without potential closure or interruption.		
b. Advocacy efforts can involve seminars on specific components of harm reduction and/or of regional /international site visits to view successful implementation of such programs		
c. Organise meetings with local police commissioners at various sites to advocate for the need to improve the quality of the service by providing more options for drug users during unconventional hours		
2.9.2 To ensure intensive on-going advocacy efforts are undertaken by Government of Bangladesh (MOHA, MOH, DNC, NASP, Prisons, Police) and key stakeholders to support the implementation of such programs		
a. Drug users with the guidance of DIC and outreach workers and peer educators should revisit the cleaning techniques in order to avoid using contaminated equipment when new equipment is not accessible and/or available		
2.9.3 To ensure cleaning guidelines of injecting equipment is widely disseminated		
a. Develop a guideline on occupational health and safety issues especially about the disposal of used equipment		
b. Provide suitable disposable containers for all outreach workers and for DIC staff to ensure needle syringe injury are avoided		
c. Provide training to all staff of the need to avoid handling or touching ANY injecting equipment returned by the clients		
2.9.4 Develop clear policies and guidelines on occupational health and safety issues especially about the disposal of used equipment		
Outreach Work		
a. Develop a comprehensive training package with national and international inputs		
b. Training programs are to be conducted for all outreach workers with regular updates of skills		
2.10.1 To further develop the skills, knowledge capacity and diversity of outreach workers to ensure effective and efficient targeting of drug users from varied socio-economic backgrounds		

Implementing Strategy and Planned Actions	Indicators - Time Period	Tentative Budget
a. Female outreach workers will be encouraged to join the program in order to ensure gender sensitivity and suitability for female drug users		
2.10.2 To explore the ratio of outreach workers and number of drug users from both cost effectiveness and coverage.		
a. Undertake a cost analysis of improving the ratio between outreach worker and drug users.		
b. Document a baseline assessment of the effectiveness of the outreach work load both from the perspective of the workers and the drug users. If the ratio changes can be introduced undertake another assessment to identify the outcome and impact of the change with a focus on coverage and quality of service		
c. Program manager should have regular meetings and debriefings with outreach staff to identify problems and/or potential problems to attempt to find ways as to how the concerns could be addressed		
2.10.3 To ensure the operational hours of the outreach workers are appropriate and suited to the needs of drug users.		
a. Assess from the drug users perspective if the working hours of outreach suit their needs. Working hours should be revisited at least every 12 months to identify that the quality of the service is being achieved		
Peer Education		
2.11.1 To strengthen peer education programs		
a. Develop a evidence based peer training programme with national and international inputs		
b. Train and retrain peer educators based on developed training package		
Drop -in- Centre		
2.12.1 To strengthen the capacity of the DIC in order to provide a more holistic approach to dealing with the multiple needs of drug users including assisting those that wish to cease drug use		
a. Identify 1-3 'model' DIC that can be used as a site visit destination for staff from other programs to learn and replicate what is considered best practice		
b. Undertake training programs for DIC staff about the importance of service delivery and how it should be done.		
c. Develop linkage for DIC to refer drug users to detoxification and treatment centres in each district and where possible with appropriate skills, training and funds undertake detoxification camps		
2.12.2 To create demand for services among the drug users		
a. Inform population around the out reach regarding the services available at DICs		
b. Initiate awareness/motivation programme among the family/peers /police/ social organizations to refer DUs to programme for services		
2.12.3 To develop the capacity of counseling skills of staff working with drug users and their families and to strengthen the emotional capacity among staff to undertake the task effectively		

Implementing Strategy and Planned Actions	Indicators - Time Period	Tentative Budget
a. Organize training skill workshops on counseling that not only focus on theories of drug dependency but the psyco-social needs of drug users		
b. Training programs for counseling staff of techniques used to avoid 'burn out'		
2.12.4 To develop an official agreement between each DIC and local police commissioner and street level police personal to operate with minimal harassment		
a. Organize regular high level meetings/advocacy sessions on drug use and HIV with the police of the rational behind such a service for drug users and reach a formal understanding for effective functioning of DIC		
b. Invite the local police during non-operational hours of the DIC so they can see the type of service it offers and it also provides the opportunity to answer their questions and issues of concerns and reach a formal agreement of understanding		
c. Undertake a social marketing approach of DIC as a vehicle for public health promotion for the entire community when meeting with law enforcement personal of officials that		
2.12.5 To ensure the operational hours of the DIC are appropriate and suited to the needs of drug users.		
a. Assess the suitability of the operational hours by seeking the views of the drug users that come to the service and also those reached by outreach		
2.12.6 To ensure that each DIC has the mechanisms in place to facilitate a constructive relationship, partnership and involvement of the community and local leaders		
a. Develop a DIC working group that has representation by various sectors of the community proving an opportunity for discussions about service operations, problems and seeking solutions		
Drug treatment and rehabilitation		
2.13.1 To improve accessibility, availability, effectiveness and quality of drug dependence treatment and rehabilitation services		
a. Create quality guidelines for abstinent based rehabilitation approaches that are based on research evidence.		
b. Treatment centres will explore the option and financial feasibility of organizing more detoxification camps to meet the growing number of drug users.		
c. Create more drug treatment and rehabilitation services in public and private sector		
d. Support services post detoxification will be further utilized with increased linkages to already created narcotic anonymous groups		
2.13.2 To develop and build upon the educational capacity of the staff working in drug treatment services		
a. Organize training programs to raise staff awareness about the complexity of drug dependency and HIV/AIDS issues		

Implementing Strategy and Planned Actions	Indicators - Time Period	Tentative Budget
2.13.3 To ensure that the management approach of drug dependant patients involves a combination of medical, psycho-social, social and religious approaches following evidence based drug treatment principles and that they are culturally appropriate		
a. Assessment skills undertaken by staff will be further refined and expanded to take into consideration many aspects of the life of the individual drug user such as what does the patient want?; is the patient dependent ?; What is their level of tolerance ?; is the patient using/dependent on other drugs ?; and is their motivation for change ?		
b. Train and retrain staff on revised management approaches		
2.13.4 To ensure community acceptance of drug treatment services		
a. Organize social marketing approaches within the community to inform them of the services offered and importantly manage expectations of the outcomes		
2.13.5 To increase the involvement of mainstream health services		
a. Organize training sessions or forums targeting general medical practitioners of the current situation of drug use and HIV/AIDS and explore how they can contribute in early prevention and relapse prevention		
Relapse prevention programs		
2.14.1 To explore the introduction of pilot drug substitution programs as a part of the continuum of drug treatment, using evidence based guidelines involving medical supervision.		
a. Intensive long term advocacy efforts will be organized to highlight the evidence based success of drug substitution therapy from all regions of the world and that its implementation has further legitimacy as an emergency measure during a concentrated HIV/AIDS epidemic		
b. Organize international exposure visits where drug substitution programs are implemented such as Iran, India, China, Indonesia, and Malaysia to name some nations. Participants would represent Ministry of Home Affairs, Department of Narcotics, Ministry of Health, and NASP.		
c. Develop evidence based guidelines which do not exist for the substitution drug Naltrexone which is currently being administered in some drug treatment centres		
2.14.2 To develop the capacity of drug treatment staff to undertake evidence based drug user and family counseling and support		
a. Organize training sessions for staff on various aspects of addiction and relapse education theory		
b. Organize training sessions that focus on family counseling in order to understand their participation in treatment can contribute as part of the recovery process		
2.14.3 To encourage all drug treatment facilities and services to explore the feasibility of introducing employment training and employment opportunities for former and recovering drug users.		
a. To coordinate with local social service agencies and business community a series of meetings to explore the option of the creation of vocational skill building and potential employment opportunities for drug users to maintain healthier and productive lives		

Implementing Strategy and Planned Actions	Indicators - Time Period	Tentative Budget
2.14.4 To develop a Narcotic Anonymous network and the creation of operational guidelines		
a. Organize a 1 - 2 day forum/seminar of all known NA groups in the country to come together and exchange ideas about their operations in order to identify common themes for the creation of operational guidelines.		
2.14.5 Create a drug detoxification and rehabilitation network that could link all the agencies currently providing services to formulate and implement a uniform minimum standards of service		
a. Undertake a mapping exercise of all drug treatment services in operation in the county		
b. Organize a 1-2 day forum/seminar of all known drug treatment centres/facilities to come together and create what will be considered minimum standards of service. When created it will be widely disseminated to have greater impact		
Strategy 3: Better understand the ways in which drug use influences sexual behaviour and to ensure access to protection		
3.1 To monitor changing patterns of drugs in use and promote research on drug related factors influencing sexual behavior among drug users.		
a. Maintain the behavioral component of the annual sero surveillance which provides useful information about the interaction of drug use and sexual practices		
3.2 To ensure that drug users and their partners have access to the means of protection in their sexual behavior and are provided with STI treatment as available		
a. Condom distribution will be occur from various sites such as DIC, outreach, peer educators and other ancillary services or referral points that are linked with the harm reduction program. Provide quality STI services for drug users and their partners from DIC and /or refer to appropriate facility		
3.3 To raise the knowledge of individual risk perception in both IDUs, including non-injectors, and their sex partners of their vulnerability to HIV/AIDS.		
a. Organize a targeted information, education and communication campaigne through the DIC and the communication channels of outreach workers and peer educators about sex risk behaviours and issues of vulnerability		
b. Counseling sessions with drug users and partners will incorporate sexual health education into overall discussions. This can be done not just at the DIC but at all drug treatment services.		
3.4 To develop interventions that focus on individual risk appreciation and negotiation skill for safer sex practices through individual (for women or men as well and not just for IDUs) and couple-oriented sessions.		
a. Training sessions with drug user and their partners on sexual health overall and from a drug use perspective to be conduced in the DIC by health staff or where appropriate by trained outreach workers		

Implementing Strategy and Planned Actions	Indicators - Time Period	Tentative Budget
Strategy 4: Slow down entry into drug use		
4.1 To strengthen peer group norms and practices based on awareness of the potential harm of drug use.		
a. Trained outreach workers and peer educators will inform drug users of their potential risk, provide education messages in a manner that can be understood and provide the tools to preventing risk behaviours such as clean needles and syringes and condoms.		
4.2 To strengthen interpersonal communication and conflict resolution in the families		
a. Small workshops with participation of all staff linked to the DIC to explore various techniques for enhancing communication skills between the drug user and their family		
4.3 To develop school based drug education programs that are evidence based and designed to prevent harmful drug use.		
a. Collaborate between NASP, GFATM, Department of Narcotics, Ministry of Education and other appropriate departments to create a teacher friendly curriculum on drug use and harmful consequences. Feasibility of its implementation into overall school curriculum is crucial.		
4.4 Develop the capacity and encourage individuals, families and various community based organizations to take ownership and participate in efforts to reduce drug use and drug related harm.		
a. Appropriate sectors of the government and NGOs will assist communities to understand drug use and harmful consequences through community forums using various educational tools. The knowledge gained from these information sessions will inform community members of the means to inform others how to develop local		
b. To disseminate widely research evidence and data of a range of harm reduction strategies		
Strategy 5: Generate political, bureaucratic and legal support required for an effective programmatic response to drug use and HIV		
5.1 To strengthen understanding of the need for effective programming, in particular harm reduction strategies.		
a. Organize regular advocacy sessions with representatives of the Government of Bangladesh (MOHA, MOH, DNC, NASP, Prisons, and Police) and other key stakeholders to illustrate the scientific evidence supportive of harm reduction. This in turn will assist the Strategy to enter the operational plan of each Ministry.		
5.2 To strengthen the mechanisms currently in place to facilitate an ongoing dialogue among the health/law/narcotics control and police		
a. Government of Bangladesh (MOHA, MOH, DNC, NASP, Prisons, Police) and other key		
stakeholders will meet on a regular period as necessary to foster ongoing dialogue to improve intervention on drug use and HIV/AIDS		
b. Government of Bangladesh (MOHA, MOH, DNC, NASP, Prisons, and Police) and other key stakeholders will examine how multi-sectoral, coordinating committees have worked in other nations, their effectiveness and document the lessons learned.		

Implementing Strategy and Planned Actions	Indicators - Time Period	Tentative Budget
5.3 To work towards legislative and departmental policy change that currently hinder the effective implementation of HIV prevention strategies for drug users		
a. Government of Bangladesh (MOHA, MOH, DNC, NASP, Prisons, Police) and other key stakeholders will conduct regular advocacy sessions and personal interactions with political leaders and civil society		
b. Develop an educational package using scientific evidence and national research findings to be presented at forums, seminars etc that are specifically targeted towards educating politicians, community leaders, religious leaders, relevant ministries and other decision makers about the urgent need to respond to the identified problems of HIV among IDUs and of the spread to wider community		
5.4 To ensure that different wings of GoB (MOHA, MOH, DNC, NASP, Prisons, and Police) and other key stakeholders are in consensus to the endorsement of the National Harm Reduction Strategy and widely disseminated .		
a. Foci representatives of each appropriate Ministry and representatives of other key stakeholders advocate that the Strategy does not go off the National agenda and is raised at regular meetings and important gatherings until endorsement is sought.		
b. A support network should be sought if and when difficulties arise during the process of seeking endorsement and solutions to problems are explored and implemented.		
c. Study tours and site visits for key decision makers, and later for staff of programs to see the effectiveness of harm reduction and its benefits to the community. These study tours and site visits could be to Iran and India where comprehensive harm reduction programs are in place.		
d. If there is no endorsement with particular aspects of the strategy which may be considered more controversial such as officially sanctioning needle and syringe distribution and/or exploring the introduction of substitution therapy programs arise then further advocacy efforts and new strategic approaches will be necessary.		
Strategy 6: Develop multi-stakeholder coordination to harmonize and integrate HIV/AIDS and drug use prevention, care and treatment policies of government agencies, private sector community, NGOs and the community to achieve desired objectives effectively and efficiently		
6.1 Strengthen the existing coordination mechanism between the NASP, HIV/AIDS working groups, all NGOs servicing high risk groups, Self Help Groups comprised of current and ex-drug users and/or HIV/AIDS foci representatives within the different Ministries		
a. Organize regular meetings (every 1-3 months) with multi-stakeholders from the government, non government sector and community in order to be briefed on latest issues, problems and solutions.		
b. Minutes of each meeting are to be distributed among guests and various agencies to act as a resource of information.		
c. Strengthen and enhance the role of existing focal points of the different Ministries		
d. Provide educational support and create updated fact sheets/ briefing papers of unfolding events and issues on drug issues to improve advocacy skills. Possibly groups involved in research could ensure latest reports and papers get wide dissemination		

Implementing Strategy and Planned Actions	Indicators - Time Period	Tentative Budget
6.3 Create a multi-agency Harm Reduction Working Group (HRWG) to allow for more effective coordination of policy, planning, budgeting and improve implementation on drug use and HIV prevention approaches.		
a. Government of Bangladesh (MOHA, MOH, DNC, NASP, Prisons, and Police) and other key stakeholders including representative/s from affected community will meet every 1-2 months to share information about harm reduction issues from a national, regional and international perspective.		
b. Invited guests involved in the harm reduction area can be invited to briefly present on a topic for open discussion		
6.4 Ensure greater coordination and communication between all stakeholders through regular and ad hoc meetings of institutions from central to district level as well as through national meetings.		
Strategy 7: To develop a capacity for sustainable response to drug use and HIV at all levels of administration through high commitment and strong leadership with information and resources to support it		
7.1 To ensure that NASP secure a full time staff member to act as a foci resource person to lead the advocacy interventions at all levels of administration with regards to drug use and HIV/AIDS		
a. An official from NASP will be entrusted as focal person and ensure there is ongoing capacity building and provided with the educational tools/resources to undertake the role effectively and efficiently		
b. A small harm reduction unit will be created to meet the demand and multiple challenges linked with HIV/AIDS and drug use interventions around the country		
7.2 To ensure that advocacy efforts are intensified in order for the goals of drug use and HIV/AIDS prevention and care to be accomplished		
a. Government of Bangladesh (MOHA, MOH, DNC, NASP, Prisons, Police) and other key stakeholders will continue to target various sectors within each Ministry, mass media, community groups, religious leaders with evidence for action in response HIV/AIDS and drug		
7.3 To improve access to knowledge and skills development through professional education and training (Bangladesh adaptation of the Manual for Reducing Drug Related Harm in Asia into Bangla, University credited course in Bangladesh on harm reduction, Centre of Excellence focused on programmatic harm reduction delivery) .		
a. Targeted education and training programs focusing on drug use prevention, treatment and care appropriate to the needs of the Government of Bangladesh (MOH, MOH, DNC, NASP, Prisons, Police) and other key stakeholders will be implemented on a regular basis to meet the demand for professional development and knowledge		
b. A small working group within Bangladesh will be identified to undertake a community development approach of creating a country specific version addressing issues of cultural context and relevancy. International technical assistance will be sought to ensure quality assurance of the final product		

Implementing Strategy and Planned Actions	Indicators - Time Period	Tentative Budget
c. A partnership will be created between a University in Dhaka and an international technical agency to develop a harm reduction curriculum course		
d. An indigenous training team will be sought to implement the curriculum course		
e. Identify a suitable DIC and build up the capacity and foster an environment in which evidence based practices of harm reduction only are implemented		
7.4 To develop adequate funding mechanisms and resource mobilization to effectively implement and expand drug use related HIV/AIDS prevention and care programs.		
a. Government of Bangladesh (MOH, MOH, DNC, NASP, Prisons, Police) and other key stakeholders will seek funding sources national, regionally and internationally for effective and sustainable development of drug use and HIV prevention programs		
Strategy 8: Enhance monitoring and evaluation on impacts of drug use related HIV/AIDS prevention and care programs in the country		
8.1 To develop and formulate specific guidelines to ensure that activities of all programs focused on drug use and HIV/AIDS proceed effectively and efficiently		
a. Develop a generic guideline for programme development to have minimum quality standard		
8.2 To strengthen the capacity of DIC on the principles of monitoring and evaluation and how to improve effectiveness (including cost effectiveness. This will require a review and refinement of performance indicators		
a. Organize short training workshop for DIC staff as how to conduct monitoring and evaluation effectively and efficiently within a harm reduction context		
8.3 To communicate to all levels of appropriate Ministries, key stakeholders and the wider community the successes, problems and challenges of the National Harm Reduction Strategy		
a. Raise issues associated with the Strategy at the appropriate forums and/or meetings such as the Harm Reduction Working Group		
Strategy 9: Provide access to necessary HIV/AIDS treatment and care services to drug users, their families and partners living with HIV/AID		
9.1 To advocate for the increased availability of antiretroviral (ARV) medications as part of the prevention approach		
a. Government of Bangladesh (MOHA, MOH, DNC, NASP, Prisons, Police) and other key stakeholders will work towards identifying the funding sources and the mechanisms to access ARV medications		
9.2 To ensure HIV/AIDS treatment and care services to drug users their families and partners are available at appropriate, accessible settings		
a. HIV/AIDS treatment and care services		
9.3 To develop the capacity and reorientation of existing health services to improve access by drug users to access treatment and care services.		
a. Conduct training programs for all health staff to sensitize them to the complex needs of drug users to improve service delivery		
Strategy 10: Introduce harm reduction measures into prisons that can significantly bolster preventing the transmission of HIV/AIDS in the prison community and the wider community in the interests of public health		

Implementing Strategy and Planned Actions		Indicators - Time Period	Tentative Budget
10.1	To strengthen and/or create drug detoxification facilities inside prisons of a standard that is available to that in the wider community.		
	a. Create a minimum detox facility with in every prison with human resource		
	b. Provide training to prisons guards and medical professionals to be aware of the signs and symptoms of withdrawal and how to respond appropriately		
	c. Create self-groups based on the principles of narcotic anonymous		
10.2	To ensure that prison guards and all prisoners are provided with basic health promotion materials and knowledge related to HIV/AIDS, other blood borne viruses and STDs and how they spread.		
	a. Provide training programs for prison guards that instill educational health information that will also be appropriate for their working environment		
	b. Create peer education programs which involve prisoners in the development, design and delivery of health education materials		
10.3	To develop the educational capacity and resources of doctors and nurses to ensure the delivery of appropriate and an acceptable standard of care for prisoners		
	a. Provide training and a health educational package that exams issues of drug use and HIV/AIDS		
10.4	To develop a pre-release program for drug users to prepare them for re-entry into the general community		
	a. Develop an easy to understand brief training session covering 1-2 hours of issues about drug use, HIV/AIDS, STDS including sexual health and other associated risk behaviours.		
	b. Each prisoner will be provided with links to community health services, NA organizations, drug treatment services and voluntary counseling and testing facilities		
10.5	To explore and develop the means to introduce vocational training and educational programs to assist in prisoner reintegration to the wider community upon release		
	a. Government of Bangladesh (MOHA, MOH, DNC, NASP, Prisons, Police) and other key stakeholders will advocate for funding to establish vocational training and educational programs		
Strategy 11: To develop a partnership between law enforcement and the health sector to improve the effectiveness and efficiency HIV/AIDS prevention and control measures targeting drug users			
11.1	To ensure that all harm reduction programs have a consultative approach with law enforcement implementers from the outset		
	a. All written agreements with the authorities will be tabled at the initiation of any harm reduction program activities		
	b. Regular meetings, communications and community education is an ongoing process		

Implementing Strategy and Planned Actions	Indicators - Time Period	Tentative Budget
11.2 To ensure that law enforcement implementers at the street level are able to identify outreach workers and others linked with the DIC and that their role is clear as health workers and as public health educators		
a. Meet with the law enforcement officials at the local level providing a names and photographs of all DIC staff and of their duties.		
b. Encourage the law enforcement officials to provide either a letter of endorsement to support the work of those linked with the DIC or a type of police stamp on their identification card that acknowledges the type of work undertaken.		
11.3 To develop an educational curriculum on HIV/AIDS and drug use including harm reduction to be incorporated in to the professional training of law enforcing agencies		
a. Curriculum developed will be incorporated into police training involving the police and law enforcement academies, and using police as trainers		

Appendix 6: Core group members

1.	Md. Kamal Uddin Ahmed Director General, Department of Narcotics Control, Ministry of Home Affairs E-mail: dgdnc@bijoy.net
2.	Mr. SM Jahurul Islam Additional Secretary, Ministry of Home Affairs, Bangladesh Secretariat
3.	Prof. Dr. Md. Shahadat Hossain Director General, Directorate General of Health Services & Line Director, National AIDS/STD Programme & Safe Blood Transfusion Programme (SBTP)
4.	Maj. Gen. (Rtd.) Dr. ASM Matiur Rahman Chief HIV Adviser, Ministry of Health and Family Welfare
5.	Md. Nuruzzaman Miah Joint Secretary, Ministry of Law, Parliament Bhavan, Dhaka
6.	Col. Md. Shirajul Karim Additional DG, Directorate General of Prison, Dhaka
7.	Alamgir Hossain Sikder Director, Treatment and Rehabilitation, Department of Narcotics Control
8.	Prof. Dr. Md. Nazmul Ahsan Director, Drug Addiction Care Center
9.	Dr. Abdus Salim, Programme Manager National AIDS/STD Programme, stdaids@dekko.net.bd
10.	Dr. Mozammel Hoque Deputy Programme Manager, National AIDS/STD Programme, stdaids@dekko.net.bd
11.	Dr. Everisto Marowa UNAIDS Country Coordinator, E-mail: evaristo.marowa@undp.org
12.	Bina Valaydon Public Health Specialist, World Bank, E-mail: bvalaydon@worldbank.org
13.	Dr. Muhammad. Abdus Sabur Sector Manager, Health and Population, DFID, E-mail: ma-sabur@dfid.gov.uk
14.	Mukta Sharma, FHI, Bangladesh E-mail: msharma@fhidhaka.org
15.	Dr. Munir Ahmed, CARE-Bangladesh E-mail: munir@caredfo.dhaka.net
16.	Shamim Rabbani, Padakhep, E-mail: shamimrabbani@yahoo.com
17.	Dr. Tasnim Azim Head, Virology Department, ICDDR.B, E-mail: tasnim@icddrb.org
18.	Md. Siddiqur Rahman Senior Assistant Secretary, Ministry of Home Affairs, Bangladesh Secretariat
19.	A.Taufiq Ahmed, UNICEF E-mail: atahmed@unicef.org

20.	Dr. Rebeka Sultana, UNFPA E-mail: rebeka@unfpa-bangladesh.org
21.	Brother Ronald Drahozal Director, Apon punarbashan Nibash (APON), E-mail: apon@citechco.net
22.	Md. Zafor Ullah Nizam National UNV Project Officer, UNODC H13 Project E-mail: mzun_1973@yahoo.com
23.	Dr. Shamim Matin Chowdhury Independent Consultant, E-mail: allabj@dhaka.net
24.	Dr. M. Ziya Uddin Drug User Intervention Specialist, National AIDS/STD Programme E-mail: stdaids@dekko.net.bd