

SITUATION ANALYSIS OF RISK TAKING BEHAVIOUR OF IDUs AND HEROIN SMOKERS IN HILI LANDPORT



Md. Shafiqul Alam

Md. Saiful Islam

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**Concern for Environmental
Development And Research
(CEDAR)**

768 Satmasjid Road, Dhanmondi R/A

Dhaka- 1209, Bangladesh

Phone: 880-2-9121504

E-mail: contact@nocorruptionbd.org,
cedar@bdonline.com

Abstract

Injecting drug users and heroin addiction considered to be the potential risk peoples of HIV/AIDS. A concentrated epidemic of HIV/AIDS reported in Bangladesh. Considering this view, this cross sectional descriptive study was conducted in Hilli land port among the injecting drug users and heroin smokers. The main objective of the study was to assess the pattern and magnitude of the injecting drug and heroin smoking and also to determine the risk taking behaviour in relation to HIV/AIDS and STIs. Both quantitative and qualitative data were collected. For quantitative data analysis, a total of 100 injecting drugs addicted and heroin smokers were interviewed using semi-structured questionnaire. To supplement the quantitative analysis, qualitative data were collected by selected Key Informant Interviews (KIIs) and series of Focus Group Discussions (FGDs) using unstructured guidelines. Data analysis indicated that the majority of the drugs users were in the age group of 25-45 years. Among them, one third was illiterate and small traders were predominant drugs users. Though the respondents have ever heard the name AIDS. But they were not aware about the transmission and its consequences. The most frequent form of drug use was in the form of Intravenous and Puff (41%) followed by in mixed form such as oral, intravenous or snuffs (39.0%). Qualitative data analysis indicated that unemployment, unrest family and frustration appeared to be main reasons for drug abuse. It was also revealed that 65% of them seek treatment for drug abuse. But data showed that the most of the practitioners were not qualified and traditional healers having no sufficient knowledge on impact of drug abuse. However, one third (35.0%) did not seek treatment at all. Though the study was small one, forecasting burden of the disease is challenging to the country. So, an intervention programme with participation of government and non-government organization are advocated.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BDR	Bangladesh Rifles
BSS	Behavioral Surveillance Survey
CBZ	Cross Border Zone
CSW	Commercial Sex Workers
DHS	Demographic Health Survey
FGD	Focus Group Discussion
FHI	Family Health International
FSW	Female Sex Worker
GFATM	Global Fund to fight AIDS, TB and Malaria
GOB	Government of Bangladesh
HNPSP	Health Nutrition and Population Sector Programme
ICDDR,B	International Centre for Diarrhoeal Diseases Research, Bangladesh
IDUs	Injection Drug Users
IEDCR	Institute of Epidemiology Disease Control and Research
KI	Key Informant
HIV	Human Immunodeficiency Virus
MoHFW	Ministry of Health and Family Welfare
MSM	Men who have sex with men
MSW	Male Sex Worker
NAC	National AIDS Committee
NASP	National AIDS/STD Programme
PLHIV	People Living with HIV and AIDS
SAN	STI/AIDS Network
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
RMP	Rural Medical Practitioner
UNAIDS	Joint United Nations Program on HIV/AIDS

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1.1 Introduction

The initial case of HIV/AIDS in Bangladesh was detected in 1989. Bangladesh are one of the fortunate countries where the infection rate of HIV is still low in comparison to the neighbouring countries. However, there is certain reason for concern. The experts envisage that HIV approaching to the community as epidemic, if Bangladesh fail to prevent the virus. The number of HIV/AIDS cases in Bangladesh is still very few. Despite existence of high-risk groups in Bangladesh the HIV positive is still very low compared to India, Myanmar, Nepal, Pakistan and other countries in this region. The country had about 13,000 adults and children living with HIV infection, according to UNAIDS estimates. However, only 465 HIV cases have actually been reported. Significant under reporting of cases occurs because of the ignorance, illiteracy, very little knowledge about HIV, limited voluntary testing and counseling capacity, social stigma and humiliation, and fear of being identified and detected as HIV positive. Despite all of the above reality, Bangladesh is still low prevalence country. This low prevalence in spite of high-risk behaviour indicates the possibility of an impending epidemic among the general population if not tackled with right attitude and foresight. In the presence of a National Policy on HIV/AIDS and STI related issues and Government's commitment to ward off the virus, more comprehensive intervention program need to be launched and utilise the window of available opportunity to fight this deadly scourge.

Drug abuse has been present for thousands of years. Aside smoking of opium and cannabis, Bangladesh has been facing ever-increasing consumption of different abusive drugs. Poverty limited economic opportunities, unequal distribution of wealth, financial aspiration, increasing marginalization; conjugal disharmony and political unrest are among the reasons that feed Bangladesh's drug trafficking

situation. Studies have shown that addiction rates get higher in drug trafficking routes and Bangladesh has been using as an easy pray for trafficking as it is not far away from Golden Triangle and Golden Crescent.

Hili landport is likely an effective and significant route for trafficking drugs from India to Bangladesh and vice versa. Though there is no statistically significant data by which it can be estimated how many drugs are trafficking everyday or month or year through this cross border zone. However it is surely affirmed that there must happen drugs trafficking by a robust cycle of national and international traffickers. It is more than sure that huge numbers of drug abusers are also found there at Hili landport and its adjacent areas whose are using injecting drugs and smoking heroin with high-risk behavior prevailed. This types of facts are prevailing in the last 20 years in the selected areas of Bangladesh though the concerned government and non-government efforts are to be made to averting the situation especially among the risk population such as truckers, floating sex workers, hijrah (transgender), rickshaw and van pullers in different locations with government and non-government efforts for preventing HIV/AIDS in Bangladesh. In course of time, it is important to adopt to devise and to implement subsequently a comprehensive STI/HIV/AIDS prevention program for the IDUs and heroin smokers in the same venue. As a matter of fact this assessment survey has been conducted aiming at devising such program prior to incept the target implementation.

1.2 Description of Hili CBZ

Hili is the second largest land port of Bangladesh. It is situated at the northwestern part of the country along the India-Bangladesh borderline. This land port is under the administrative Upazila of Hakimpur of Dinajpur district. This is the

significant business point as huge numbers of goods are trafficked everyday from and to both India and Bangladesh. The port authority legally regulates these trafficking of goods. At the same time, another huge volume of illicit goods are also trafficked illegally through bypassing the eye of the port authority as well as sometimes with their vested interest. Besides, a large number of people always gather there who are used as vehicles of trafficking between Bangladesh and India. Of the illicit goods trafficked through the border, abusive drugs remain top of the lists. These people are mostly drug users, heroin smokers, truckers, sex workers, Hijrah (transgender), rickshaw and van pullers, stone crushing workers and so on.

Particularly it is almost a free zone to the drug users and heroin smokers for abusing drugs and smoking heroin respectively. It is revealed that such indiscriminate drug using and heroin smoking spread out due to the poor surveillance of local law enforcement forces and in many instances, the law enforcing agencies are also involved in these deals. Besides, the easy to avail of banned drugs and heroin expedites the magnitude of such problem.

It can be mentioned here that CEDAR has in-depth experience to work there at Hili for the prevention of transmitting HIV/STI for the last ten years. But the target communities of the program are truckers, sex workers, hijra and rickshaw pullers. ActionAid Bangladesh initially started to fund for this program during the period of July 1997 to March 2002 and subsequently CARE Bangladesh had been continuing to provide financial and technical assistance from April 2002 to March 2005 since ActionAid Bangladesh renounced their support for the project activities. At present, this program has still been continuing at a small scale by the own resource of CEDAR. Over the last few years, CEDAR has gained sufficient information and knowledge about the risk taking behaviors of the high-risk people and their potential

to spread the infection among the general population. It has been revealed over the years that the extent of transmitting HIV/STI at this cross border zone has deliberately been changing. Enormous numbers of local and settler population migrated from the other parts of the country accrue in quest of jobs and subsequently engage themselves in shooting injecting drugs and smoking heroin. Even these injection drug users and heroin smokers use to have sex with the sex workers and Hijra, and they also practice very poor sexual behavior. This has been experienced from the sex workers and Hijra targeted in the existing program as well as data revealed in the survey. At the same time, they perpetually share syringes and needles with each other, and also use cocktail drugs, which are seen from the data gathered in this study.

Considering the above facts and findings CEDAR decide to work on the prevention of HIV/AID and STI for the injection drug users and heroin smokers in the same venue. As a matter of fact, I have taken the opportunity to supplement the vision and thinking of CEDAR to conduct an assessment survey at Hili landport and adjacent areas to find out the needs, sexual behavior and practice, and the pattern and magnitude of using drugs and smoking heroin of the target communities prior to devise a project related to abridge those issues.

2. Literature Review

A literature review of existing data about the magnitude and problem posed by injecting drug use and heroin smoking, mode of drug used by IDUs and heroin smokers and their sexual behavior, and their existing knowledge level on HIV/STI. Massive drive has been given to collect the research and survey papers on the said issues of the same community. Unfortunately there was none to find regarding the same issues at this particular target location. Only the sixth round of national HIV serological surveillance is shown to cover the northwest part of the country. But it is not certainly known whether this surveillance was covered Hili land port and adjacent areas.

As with other South Asian nations Bangladesh has a long history of illicit drug use, particularly of opium and cannabis. Before 1948, Bangladesh was a part of an undivided India and therefore much of its history mirrors eastern India, particularly Bengal. From the time of British colonization until 1984 it was possible to purchase opium from government controlled vendors¹. Cannabis has been widely used in Bangladesh society for many years and was often not perceived as a drug of abuse². In the late 1970s consumption of opium was strictly restricted and the scheme of compulsory registration identified about 1,600 chronic opium addicts³. Since 1987 production of cannabis has been banned and most is now smuggled across the Indian border⁴. Until mid 1980s the drugs of use, among the young, were cannabis, local wine and prescribed tablets (*Mandrax* and *Prodrom*). Heroin, generally called ‘brown sugar’, did not appear until mid to late 1980s. It had low potency and became the drug of choice among the lower socio-economic sector and some students^{1,2}. In 1991, the majority of drug users in treatment indicated heroin as their drug of choice, followed by *Pathedine*. At this time the level of education and affluence tended to influence drug-taking practices; 15% of the poor injected compared to 42% of the more affluent⁵. At the same time as heroin addiction increased, a shortage in supplies

emerged as a result of law enforcement activities. As a result drug users turned to the pharmaceutical *buprenorphine* from India^{6,7}. The emerging popularity of *buprenorphine* (commonly known as Tdgesic) stems from its cheapness, availability, longevity of effect and as a result of some pharmacies promoting the drug as a way of treating heroin addiction². By the mid 1990s individuals dependent on *buprenorphine* started to appear in treatment centers¹.

Bangladesh is surrounded by one of the largest drug producing regions in the world. While it is not a significant producer of narcotics, opium cultivation near the Myanmar border, albeit small, has been detected in some districts. In 1999, 90 acres of poppy fields were destroyed by the army and 28 kilograms of heroin and 2.3 metric tons of cannabis were seized^{8,9}. The drug *Phensidyl* (cough syrup containing codeine) has become increasingly popular among drug users. In 1996, a Rapid Situation Assessment (RSA) of the drug use in three major cities (Dhaka, Rajshahi and Chittagong) was conducted; 1,750 participants were selected at random. The results of this survey reported the most commonly used drugs in descending order were cannabis, cough syrup (codeine based), sedatives and heroin. For those surveyed in treatment centers the most commonly used drugs in descending order were heroin, codeine, cough syrup, *buprenorphine*, cannabis and sedatives¹. Among all the participants the life time use of selected drugs show cannabis at 25.8%; cough syrup at 11.3% with heroin and *buprenorphine*, 2.9% and 0.5% respectively (Ray 1998). However, a recent study in Dhaka showed *buprenorphine* as the most commonly used drug among users (70%)¹⁰. It is widely agreed among experts that there is increasing evidence of the widespread use and availability of illicit drugs^{1,6,11-13}. In the northern part of the country, drug use, including injecting, has been reported in the cities of Cox's Bazar, Chittagong, Jessore, Khulna, Rajshahi and Chapainawabganj and drug

use is common in several areas of the capital, Dhaka¹⁴⁻¹⁶. While drug use is mainly confined to the urban centres it has also been reported in several rural areas and villages^{1,14}. In 1998, a study was undertaken to assess the vulnerability of an estimated 200,000 street children (aged between 5 – 14 years) living in the metropolitan area of Dhaka. While the study found many of the children were the victims of exploitation, harassment and abuse (including sexual) it also found that some were addicted to injectable drugs and other substances. Awareness on HIV/AIDS issues was reported to be poor among this group¹⁷.

While the most popular routes for taking drugs is reported as ingesting or inhalation, injecting does appear to be gaining popularity^{12,13}. The injecting of drugs is believed to have commenced in 1990 and data recorded in treatment centres reports an increase in the rate of injecting from 6% in 1993 to 17% in 1995^{1,7}. The time frame from using different types of drugs before switching over to injectables ranges from six to fifteen years^{10,14}. In 1996, a study in Rajshahi reported the injecting of sedatives as widespread (78%), followed by *buprenorphine* (21%)⁶. The behavioural surveillance study of 1998-99 showed that for those who injected, the drug of choice was *buprenorphine* which was frequently mixed in a cocktail of substances including *diazepam*, *promethazine hydrochloride* and *chlorpheniramine*. A recent study also reported that 29% of participants injected a cocktail of drugs^{7,10}. Heroin was used by only 2% of participants, and was usually dissolved in lemon juice before injecting². One study shows that 90% of all injectors had once smoked heroin¹⁶.

Reports of drawing up blood in the syringe in order to dilute the drug and front or back loading (moving the drug from one syringe to another) occurs, albeit in small numbers (<10%)^{10,18}. In 2000, a study in Dhaka reported the average number of injections per day was two and the sites of injecting varied; 26% injected into the

vein, 56% into muscle and the rest (18%) used both the vein and the muscle¹⁰. Another earlier study reported that 59% always injected into the vein¹⁹.

In the city of Rajshahi most IDUs used the services of a professional injector in an *adda*: an *adda* is a place where IDUs gather to inject and where the drugs and the professional injector can be found. While the same practice is likely to occur in Dhaka it is not as common^{7,15}. It has been suggested the professional injectors are able to maintain business through a good supply of drugs, connections to wholesalers and by providing the injecting services. In 1999, in Rajshahi an estimated 50 *adda* injectors operated and there were an estimated 94 *addas* in the city. These facilities are often located in disused buildings and lane ways but some also operate in hotel rooms⁷. For a small additional cost, people can ask to be injected at their homes. In one study it was reported up to 90 persons a day used a single *adda* injector, often for multiple injections. Being an *adda* injector was not exclusively the domain of men as several women had also become involved¹⁴.

Reports suggest an *adda* injector will use the same needle for 20-50 people and that it is not unusual for it to be used for 2-3 days²⁰. Studies in the late 1990s reported widespread sharing of needles among all IDUs (60%-90%) and that professional injectors did not sterilize their needles and syringes^{4,16,21}. The sharing of injecting equipment has also been documented among street children⁵. Among professional injectors it has been observed that a needle is only changed when it becomes blunt and glass syringes are rarely changed or discarded⁴. New needles add an expense that few poor IDUs can afford thus explaining the reasons for the widespread sharing and that's why some people have been known to use syringes rejected by hospitals^{14,20}. It costs an average of three Taka (US\$0.05) to buy a disposable syringe and needle. There are regulations in place requiring a prescription

to buy such equipment but this is often ignored. It is not difficult to find a needle and syringe in most parts of the country. Cleaning of needles by those who shared their needles is nearly always inadequate. Some methods included using cotton or paper to clean the needle or using distilled water¹⁰. Some IDUs used saliva to clean their needles believing this would destroy any poisons found in the blood²⁰. The establishment of needle and syringe programs (NSP) from May 1998 has shown some behavioral changes. Results from a recent study between two surveys show the overall sharing of needles in Dhaka appears to have been reduced from 93% to 75% of people ever sharing in the last week. In Rajshahi the reduction is from 96% to 55%²¹. The government recognizes that NSP clearly impacts on the proportion of injections shared²².

The number of drug users has been estimated to be between 100,000 to 1.7 million^{1,23-25}. In the early 1990s it was estimated that there were 100,000 heroin users in the country but this figure is likely to have lessened as *buprenorphine* has become the favored drug²⁶. It has been estimated there could be 20,000 to 25,000 IDUs in the country^{14,26,27}. In the capital Dhaka, reports suggest there are 7,650 injectors and at least 11,000 heroin users¹⁶. In northern Bangladesh there are an estimated 12,000 to 15,000 injectors, most of whom are found in the cities of Rajshahi and Chapainwabganj¹⁹. However, these figures are disputed by others: a Rapid Situation Assessment (RSA) in 2000 found there were no more than 2,000 IDUs in Rajshahi and 1,000 IDUs in Chapainawabgonj²⁸.

The majority of drug users, and those who inject, is reported to be male with less than 2.5% females^{7,15,22}. The number of female drug users could be greater but reaching out to this sector of the community is difficult when most are very hesitant to identify themselves as IDUs¹⁵. One outreach program in Dhaka has contacted with

about 40 female IDUs most of whom are also sex workers¹⁶. In one southern city a survey found 14% of street female sex workers injected drugs and in the brothels 6% stated they were IDUs. Among male IDUs a high proportion paid for sex. A survey in various cities has shown that half to three-quarters of male injectors paid for sex and close to one in ten bought sex from men or transvestites; less than 25% used a condom the last time they paid for sex²⁹.

According to available data from sixth round National HIV Sero-Surveillance³⁰. Bangladesh still has a relatively low prevalence of HIV with a rate of less than one percent among most-at-risk-population groups. However, among IDUs in Central Bangladesh that mainly includes Dhaka city HIV infection rate has reached 4.9 percent that points towards a concentrated epidemic in this population group. Of major concern is the rapid and consistent increase in the prevalence of HIV among IDUs from 1.4 percent in 2000 to 1.7% in 2001, 4% in 2002 and 4.9% in 2005. While the average HIV infection rate was 4.9% among IDUs in Central Bangladesh there was a pocket where the infection level was as high as 7.1%³⁰.

In 1986, HIV was first detected in a foreign drug trafficker and in 1989 the first case of HIV in a citizen of Bangladesh was recorded^{4,5}. While the HIV prevalence levels have remained relatively low there has been a sizeable increase since 1989⁵. As of December 2000 the total number of HIV/AIDS cases was 157 (127 males, 30 females). Between December 1999 and December 2000 the number of identified HIV infections was 31 cases, the highest number in a single year. A breakdown of the transmission route is not available but it is likely the majority are sexually acquired³¹. In 1999 an estimated 7,500 adults and children lived with HIV infection³², but in 2000 this increased to 13,000²⁵. It has been calculated that the annual number of AIDS cases was 1,100 in 2000 which will rise to 1,700 by 2005²⁵. The estimated number of people living with HIV and AIDS (PLHIV) is 7,500 as of end of 2004 (MoHFW/NASP) based on results using UNAIDS/WHO guidelines³³. Through this exercise the range of the size of the vulnerable groups has been estimated, which shows that there are large number of people who could be most-at-risk of HIV (approximately 2.2 million to 3.9

million). Only 14.7% of male IDUs are adopting safe practices as found from the BSS data. Information obtained from IDU Cohort study indicates that among female IDUs 21.1% are practicing safe behaviors. Furthermore, according to reports and anecdotal evidence there are other associated vulnerability and risk factors that could trigger an expansion of the epidemic beyond its current level. A sero-surveillance of 1998-1999 reported that among IDUs coming into detoxification centers, 2.5% were found to be HIV positive and among the 880 surveyed the rate of needle and syringe sharing was about 90%³⁴. A follow up survey for the second national expanded HIV surveillance in mid 2000 reported that of the 418 participants from a central NSP, 6 people (1.4%) were found to be HIV positive²². The low levels of HIV infection in the two rounds of surveillance have yet to be fully explained considering widespread sharing of needles was still occurring. Studies have shown that Hepatitis C can be found in 25% of IDUs: this was associated with the sharing of needles and the longer duration of drug injecting³⁵. Surveys conducted on IDUs have shown a wide age range (15 to 70 years) with the average age being 30 to 35 years^{7,10}. Many have poor education and unskilled occupations, a substantial number are married, and the majority had previously been to jail, mostly for drug offences^{6,7,15,19}. A study found most family members were aware of the user's drug using behavior⁶. Use of commercial sex workers, particularly among the unmarried, was fairly common and the use of condoms was generally very low; condoms are rarely a consideration and are seen as mainly for family planning^{10,13,19-21,26}. Many sex workers were aware of colleagues having sex with drug users without condoms⁵. A 1997 study showed 21% of IDUs donated their blood and many did so as a way to raise money¹⁴. This is clearly a problem when none of the blood banks test the blood for HIV¹⁵.

In the Narcotics Control Act, 1990, there is provision for the establishment of narcotic addiction treatment centers and when it is deemed treatment is necessary the person is directed to a competent physician or a treatment centre¹. However, detoxification and rehabilitation programs are scarce in the country and few drug users have the resources to attend them. As occurs in most countries of the world

recidivism is high for those receiving treatment. A 1998-99 study showed 90% of the participants who had made attempts to stop drug use had failed ⁷. It has been suggested that the drug prohibition laws enacted under the Narcotics Act of 1990 are not an effective strategy for harm reduction⁶. The government does not view drug addiction as a high priority issue and it is seen as a self-created problem¹².

If a person is found in possession of heroin, cocaine and coca derivatives, and the quantity does not exceed 25 grams, imprisonment will not be less than two years and not exceed 10 years. If the quantity exceeds 25 grams the penalty can be the death sentence or life imprisonment. For possession of pathedine, morphine or tetrahyrocannabinol, if the quantity does not exceed 10 grams, imprisonment will be no less than two years and no more than 10 years. If the quantity exceeds this amount the penalty is a death sentence or life imprisonment. There are various A class narcotics which is where buprenorphine is likely to be classified. Being in possession of this drug is also likely to incur a severe penalty. The penalty is an imprisonment of not less than two years and no more than 15 years: the possession amount is not specified ³⁶. There is usually no provision for arrested drug users to be sent to drug treatment centre. The only option appears to be prison.

The Department of Narcotics Control has recently initiated a community level of coordination to streamline the activities of the non-governmental organizations (NGOs) to strengthen existing and future drug prevention activities in the country³⁷. There are four government de-addiction centers in the country with a total of 55 beds¹.

The traditional approach to treating drug users is in the psychiatric units of hospitals. The shortage of beds results in few being able to receive treatment. Other problems include physicians being discouraged from offering their services to treatment centers because they

can lose their seniority if they are not properly released by the Ministry of Health and placed under the Department of Narcotic Control¹².

The two models of treatment are the ashram model, run by non-medical social activists, and the medical hospital model run by medical professionals. Most drug users are serviced by government health care facilities and at the Dhaka centre people stay for four weeks. There is only one program designed to cater for female drug users¹². Only one government-run-detoxification centre exists in Dhaka, which has 40 beds and charges a nominal fee¹⁵. Many drug users have tried various ways to stop their drug use and a study shows 68% had been in prison at least once. However, even here drug injecting occurs¹⁸.

The government is aware of the link between HIV/AIDS and drug use as has been shown in the two sero-surveillance surveys. It has been acknowledge NSP can play a role in reducing the amount of needle sharing and impact upon HIV transmission. However, there are reports of IDUs being arrested for carrying syringes and needles even though no 'paraphernalia laws' exist^{4,15}. Substitution therapy is currently not available. Information about HIV/AIDS which directly targets drug users is reported to be unavailable. The Ministry of Health and Family Welfare produced a National HIV/AIDS Policy which received approval by the cabinet in 1998. In the policy there is a special focus on IDU and approval of harm reduction as a useful strategy. However, the Ministry of Home Affairs, whose focus includes narcotic laws, does not approve of harm reduction believing such a policy cannot supersede the law of the land. As a result of these contradictions serious threats from the Narcotics Department and police have emerged with this policy. In recent times the Narcotics Department has indicated they acknowledge the existence of NSP and at this stage have tended to ignore the operations of such programs^{38,39}.

In 1999, the SHAKTI project CARE-Bangladesh (NGO) operated seven drop-in-center in Dhaka, which were open six hours per day, six days per week and offer needles and basic primary health care for drug users¹⁵. A NSP has been set up at a professional injector site in Rajshahi, reaching approximately 10-20% of the local IDUs. In 1999, SHAKTI was estimated to have access to 3,500 IDUs; peer educators distributed two new syringes and six needles every other day, per person at their drop-in-center (Jenkins 2001). About 90,000 needles and syringes per month are exchanged at the DIC with a reported high return (>80%)²⁷. As there is no incinerator in Bangladesh, there has been no other option for NGOs but to burn collected needles and syringes at the drop-in-center in the open air¹⁵. CARE-Bangladesh also has programs in Rajshahi and in early 2001 they set up a program in Chapai Nawabgonj which reaches 200 IDUs. In this latest project they have trained five *adda* educators who are current drug users. Their role is to educate other IDUs and professional drug injectors on STI/HIV issues and to exchange old needles and syringes for new ones⁴⁰. It has been reported there are nine NGOs focused on drug demand reduction with a total of 190 beds between them for in-patient treatment¹. With levels of HIV infection low both in the general population and still to a large extent in high-risk groups, but with levels of STIs high in high-risk groups, Bangladesh has a window of opportunity to saturate prevention program coverage, particularly among female SWs and also among MSM and IDUs, wherever the latter subpopulations are identified. Evidence from the Shakti project of CARE Bangladesh suggests that harm reduction can work. That project reaches an estimated 5,000 IDUs in Dhaka, providing them with a drop-in center, detoxification services, HIV prevention education and individual counseling, and safe injecting equipment. A recent evaluation showed that, among IDUs, HIV prevalence has remained relatively low and sexual risk practices have declined. However, needle sharing has fluctuated, climbing from 66 percent in 2002 to 86 percent in 2004. Fieldworkers attribute this increase during the two-year period to police action against those carrying injecting equipment, which underscores the importance of legal reform to support harm reduction.

Fact File of Drug Users in Bangladesh

Estimated number of drug users: 100,000-1.7 million

Estimated number of IDUs: 20,000-25,000

Drugs used: cannabis, cough syrup, buprenorphine, sedatives, heroin, codeine

Drugs injected: sedatives, buprenorphine, heroin, drug cocktails

Estimated number of HIV infection: 2.5% of IDUs in detoxification centers among IDUs are HIV +. In accordance with data on IDU is for Central A of Bangladesh that covers mainly Dhaka city, the percentage of IDUs infected with HIV is 4.9.

Source: Personal Communication with different relevant authorities

Only 14.7% of male IDUs are adopting safe practices as found from the BSS data. Information obtained from IDU Cohort study indicates that among female IDUs 21.1% are practicing safe behaviors. The actual number of PLHIV who are on ART is not known and there is no public programme providing anti-retroviral treatment. The only information from peer support groups shows that less than 50 people are currently on ART through private and NGO support for which long-term support is not ensured.

3. Methodology

3.1 Objectives

3.1.1 General objective

This survey was undertaken in order to gain baseline information about the injection drug users and heroin smokers pertaining to their risk taking behaviors and its relation to HIV/AIDS upon which a comprehensive program can be designed and developed for intervention at Hili CBZ.

3.1.2 Specific objectives

- to determine the pattern and magnitude of drug injecting and heroin smoking at Hili land port;
- to determine the risk taking behaviors of the IDUs and heroin smokers in relation to HIV/AIDS and STIs;
- to identify the health hazards and ultimate consequences of injecting drug and smoking heroin on the users;
- to identify the felt needs of the target people and existing health care seeking behavior;
- to identify the factors that may facilitate or constrain intervention program which would be devised on the basis of findings of the survey;

3.2 Operational Definition

Injection drug users: Those who are primarily injectors and had injected in the previous year.

Heroin Smokers: Those who are primarily smokers and had not injected more than twice in the previous six months.

3.2 Location of the study

Hili land port and adjacent areas i.e., Birampur and Panchbibi. This survey was held in the different spots of these locations. The spots of **Hili land port** are *South Basudebpur, Badarpotti, Atapara, Rajdhani More, Dakshinpara, Daronda, Fakirpara, Station Bosti, Kaliganj and Churipotti*. The spots of **Panchbibi** are *Gopalpur and Chechra*, the spot of

Birampur is *Birampur Bazar*. Hili is in the northwest part of Bangladesh which is under Hakimpur Upazila of Dinajpur district and it is the second largest land port at Indo-Bangladesh border. Being a land port, most of the businesses are linked to export and import business. Besides, illicit trafficking of women and children and other goods increase the local people's exposure to high-risk behaviors and as a result, their vulnerability to drug addiction, contacting STIs and thereby HIV increases by manifolds. There is continuous mobility of people to and from Bangladesh and India. So, that is why Hili has attracted our attention in regards to assess the magnitude of the problem posed by IDUs and heroin smokers.

3.3 Target Population: Injection drug users and heroin smokers were the target population

3.4 Time frame: The study was conducted for a period of 06 months started from November 2006 - April 2007

3.5 Survey Components

The study was conducted using three primary methodologies: Key Informant Interview, Focus Group Discussion and Individual Interview of the target community.

3.5.1 Key Informant Interviews: Primary data was collected through key informant interviews with the drug sellers or rural medical practitioners, border security force, illicit goods traffickers and brokers, reproductive health service providing NGO personnel, and sex workers and transgender. The aim at these key informant interviews was to assess the characteristics of the IUDs, source of drugs, types of drugs they use to have and information about their health care seeking behavior in that particular area. A team comprising of a Supervisor and two Interviewers were sent to collect information from the key informants. A guideline and questionnaires were provided to control the flaws of the information collected from the key informants. Participants were selected by random sampling. Below is a breakdown of the key informant interviews conducted:

- Two drug sellers or RMP
- Two reproductive health care providers (NGO personnel i. e.- paramedic)
- Three sex workers
- Four transgender i. e. hijra
- Two BDR members
- Seven lineman (negotiator between illicit goods traffickers and the members of border security force and others local government and non-government authority)

3.5.2 Focus Group Discussions: Four Focus Group Discussions (FGDS) were held comprising of 8-10 persons in each group. Focus Group Discussions were held among five groups and they are i) IDUs and Heroin Smokers, ii) Community Leaders, iii) Drug sellers and RMPs, iv) Sex workers and v) a mixed group comprising from all the above four. One Facilitator and one Rapporteur conducted those FGDs. A guideline was given for the facilitator and rapporteur to conduct the FGDs.

3.5.3 Individual Interviews: Two interviewers engaged to conduct the individual interviews through using a pre-structured questionnaire supervised by a supervisor following the given guidelines. Interview was conducted with prior consent of the interviewee, and they are assured that the information provided by them during the survey would be kept secret and used only for this survey. The interviewee had opportunity to exit the survey in case he didn't like to answer questions that appeared personal to them. A total of 7 interviewees exited from the survey halfway during interview. And these 7 were excluded from the analysis. Besides, 100 participants were interviewed those who have completed the pre-structured questionnaire, and they were taken into consideration for data analysis. Among them 96 respondents are injecting drug users and again 80 out of these 96 are also heroin smokers. The

remaining 4 respondents use to have either whisky (local wine) or heroin or cannabis or tablet.

3.6 Data Analysis

Data gathered from individual interview and key informant interview through using pre-tested structured questionnaire and subsequently inserted into a robust database through using software. Before entry into the computer, 5% of the collected data has been cross-checked at field level for validation. The insertion of data into the database is done through using the programmer designed user interface. SPSS, the user-friendly analytical software was used in this connection. Afterwards, the data stored into the database has been compiled and analyzed through using compiler and different tools and utilities of SPSS. Finally the report has been made for exploring relevant findings. In this connection, cross tabulation is also done for matrix report.

4. Results

This assessment survey has the provision to carry out one to one interviews among the target community and their key informants as well. Besides few focus group discussions were also held among the group of target community itself, and among the mixed groups of the target community and their key informants. Findings of the survey have been described in three different manners on the basis of survey strategy. These may be as i) findings of survey through one-to-one interview among the target community, ii) findings of the one-to-one interview among the key informants and iii) findings of the group discussions.

4.1. Findings of survey through one-to-one interview among the target community

Findings from this assessment survey held mainly among the IDUs and heroin smokers can be categorized into the following group considering the extent and nature of the response provided by the interviewees:

- Socio-economical and familial, and HIV/AIDS related issues;
- Magnitude of injecting drug use and heroin smoking; and
- Sexual and health care seeking behavior.

4.1.1. Socio-economic and familial and HIV/STI related issues

The respondents taken part into this survey are mainly IDUs and heroin smokers and have been randomly sampled and the gathered data has been collected from 13 different cohorts (*adda*) of the IDUs and heroin smokers at Hakimpur (Hili landport), Panchbibi and Birampur Upazila.

Major findings in relation to socio-economic and familial, and HIV/STI related issues explored from this group are as follows: More than two thirds (69%) of

the respondents are from the prime time of their age i.e., from 25-44 years, 13% are less than 25 years and 3% are beyond 55 years. Two thirds of the respondents (65%) are literate and their educational status ranges from primary level to postgraduate. Twenty six percent can only sign their names and 9% are illiterate. More the two fifths (46%) are from business, service, students and other occupational background. Fourteen percent are day laborers, 9% cultivators and 31% unemployed. Regarding their living status, 33% stay alone, 67% stay with family, spouse, kids and friends. Majority of the respondents were married (83%) while 13% single, 2% widower and 2% divorced.

Table 1. Distribution of respondents by socio-demographic characteristics
(n=100)

Variables	Frequency	Percent
<i>Age in years</i>		
15-24	13	13.0
25-34	41	41.0
35-44	28	28.0
45-54	15	15.0
>55	3	3.0
Educational status		
Illiterate	9	9.0
Can sign	26	26.0
Primary	31	31.0
High school	25	25.0
SSC	8	8.0
Graduate/postgraduate	1	1.0
<i>Occupation</i>		
Unemployed	31	31.0
Cultivator	9	9.0
Day Labourer	14	14.0
Business	37	37.0
Service	1	1.0
Student	1	1.0
Non-specific	7	7.0
Living status		
Alone	33	33.0
Spouse & kids	27	27.0
Family	39	39.0
Friends	1	1.0

<i>Marital status</i>		
Single	13	13.0
Married	83	83.0
Divorced	2	2.0
Widower	2	2.0

The interviewed respondents reportedly mentioned that 90.0% did not ever hear the name of the deadly disease AIDS. More than one fourth (28%) opined that AIDS could be cured while 42% said no and 30% don't know either.

Table 2. Distribution of respondents by ever heard the name AIDS and curability of AIDS (n=100)

<i>Variables</i>	<i>Frequency</i>	<i>Percent</i>
Ever heard the name of AIDS		
Yes	90	90.0
No	10	10.0
Curability of AIDS		
Yes	28	28.0
No	42	42.0
Don't know	30	30.0

Regarding contacting HIV infection, the interviewee has different opinions. Among them (28%) told that sex workers, 14% mentioned both sex workers and Hijras, 9% sex workers, Hijra and IDU, 8% sex workers and IDU and rest 3% mentioned about polygamous and 38% didn't know any. One percent of the interviewee knew all the modes of HIV transmission, 47% partially know and 33% don't know either whereas 19% had misconception regarding HIV transmission. More than one fourth (28%) mentioned that HIV/AIDS posed serious risk while 28% few risk and 4% no risk while 40% didn't know either. Regarding the different mode of

prevention of HIV/AIDS, 24% advised to refrain from having unprotected sex, 39% to use condom always while having sex and avoid contaminated syringe and needle while 4% advised not to smoke heroin. Besides, 33% didn't know any.

Table 3. Distribution of respondents by knowledge on risk peoples of AIDS, mode of transmission and prevention of AIDS (n=100)

<i>Variables</i>	<i>Frequency</i>	<i>Percent</i>
Knowledge on risk people of AIDS		
Sex workers	54	54.0
Transgender (Hijra)	27	27.0
IDU	16	16.0
Heroin smoker	6	6.0
Polygamy	5	5.0
Male to male sex (MSM)	2	2.0
Do not know	38	38.0
Knowledge on mode of transmission of AIDS		
Sex with sex worker	53	53.0
Sharing needle or syringe	20	20.0
Polygamous	20	20.0
Sex with AIDS patients	16	16.0
Sharing plate or bathroom	7	7.0
Sleep same bed	6	6.0
By mosquito	6	6.0
Sharing cloths	5	5.0
Infected mother to her baby	4	4.0
Play together	1	1.0
Unscreened blood	1	1.0
Do not know	33	33.0
Vulnerability to AIDS		
Serious risk	28	28.0
Few risk	28	28.0
No risk	4	4.0
Don't know	40	40.0
Knowledge on prevention of AIDS		
Using condom during sex	43	43.0
Avoid unprotected sex with sex worker	30	30.0
Unfaithful sex	17	17.0
Sharing un-sterilized syringe & needle	17	17.0
Taking heroin using needle & syringe	10	10.0
Use of unscreened blood & blood products	1	1.0
Don't know	33	33.0

In the Table 4, it is illustrated that 67 out of 100 respondents compelled to go under police custody due to use illicit drugs. They have usually been harassed by the police in the spots of having drugs and also while carrying drugs, which have been known as long as they were interviewed.

Table 4. Frequency of the interviewees ever been at police custody for illicit drug use

<i>Type of Response</i>	<i>Frequency</i>	<i>Percent</i>
Yes	67	67.0
No	33	33.0
<i>Total</i>	100	100.0

4.1.2. Magnitude of injecting drug use and heroin smoking

Total of 100 participants was taken part into this survey, 96 out of 100 interviewees are IDUs and again 80 out of these 96 are also smoking heroin as well. Findings from the survey regarding the magnitude and pattern of injecting drug use and smoking heroin are described hereinafter as tabular and graphical forms.

Table 5 describes that 96 out of 100 respondents are injecting drug users, and again 80 of them are also heroin smokers. That means, only 14 are absolutely injecting drug users and another 80 are altogether IDU and heroin smoker as well. The remaining 4 are either having cannabis or wine or tablet or heroin.

Table 5. Frequency showing types of drugs used by the interviewee

<i>Type of Drugs</i>	<i>Frequency</i>	<i>Percent</i>
Intravenous (Pathedine, Morphine, Phenargon, Sedil, and Tdjesic)	14	14.0
Puff (Heroin and Cannabis)	1	1.0
Oral (Wine and Tablet) and Intravenous	2	2.0
Intravenous and Puff	41	41.0
Oral (Wine and Tablet) and Puff	3	3.0
Oral (Wine and Tablet), Intravenous and Puff	39	39.0
Total	100	100.0

In this above-mentioned table (Table 6), it is shown that 92% of the respondents use to have drugs for more than one year, and only 1% is new user. The type of drugs taken by them whether it is injecting drugs or smoking heroin.

Table 6. Frequency of duration of any drug abuse

<i>Duration of Drug Use</i>	<i>Frequency</i>	<i>Percent</i>
>3 months	2	2.0
>6 months	6	6.0
>1 year	39	39.0
>2 years	53	53.0
Total	100	100.0

Figure 1 shows the percent of the respondents and it depicts that 97% of the interviewees are injecting drug users. Almost all of these IDUs use to have intravenous drugs for more than 1 year. Even they use to smoke heroin concurrently.

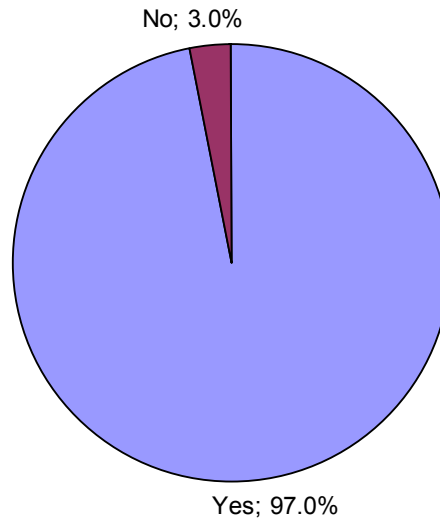


Figure 1. Frequency showing Intravenous drug use

In this table (Table 7), it is shown that 70 out 100 IDUs and heroin smokers are cocktail drug users, and only 30 don't use cocktail. Basically, these 30 use to have injecting drugs and to smoke heroin altogether.

Table 7. Frequency showing the combination of drugs used for cocktail by the interviewees

<i>Combination of drugs for cocktail</i>	<i>Frequency</i>	<i>Percent</i>
Diazepam and Phenargon	25	25.0
Tdjesic and Phenargon	22	22.0
Diazepam, Tdjesic and Phenargon	12	12.0
Diazepam and Tdjesic	5	5.0
Others	6	6.0
Didn't use cocktail	30	30.0
Total	100	100.0

Table 8. Frequency distribution of having abscess in hands or legs due to use of IV drugs by the interviewees

<i>Type of response</i>	<i>Frequency</i>	<i>Percent</i>
Yes	68	68.0
No	30	30.0
No response	2	2.0
Total	100	100.0

Two thirds(68%) of the interviewees are having abscess due to using of IV drugs, which is shown in the above mentioned frequency table (Table 8). Among these 68% all of the respondents use to have cocktail drugs and thereby getting abscess either in their hands or legs that can be seen in the below mentioned table (Table 9) where showing the comparative frequency between using of cocktail drugs and having abscess due to injecting.

Table 9. The comparative frequency on using of cocktail drugs and accordingly having abscess due to injecting

<i>Drugs used for cocktail</i>	<i>Having abscess due to injecting drugs</i>		<i>Total</i>
	Yes	No	
Diazepam, Tdjesic and Phenargon	10	2	12
Diazepam and Tdjesic	2	3	5
Tdjesic and Phenargon	20	2	22
Diazepam and Phenargon	22	3	25
Others	2	4	6
Total	56	14	70

Table 9 shows that 56 out of 70 IDUs using cocktail drugs have got abscess due to injecting drugs. Most of the cocktail drug users use the combination of Tdjesic and Phenargon and Diazepam and Phenargon for cocktail. Twelve out of 70 also use the combination of Diazepam, Tdjesic and Phenargon.

Table 10. Frequency distribution of sharing un-sterilized syringes and needles by interviewees

<i>Type of response</i>	<i>Frequency</i>	<i>Percent</i>
Sometimes	49	49.0
Rare	18	18.0
Never	27	27.0
No response	6	6.0
Total	100	100.0

Data collected through this survey revealed that 67 numbers of total respondents have been found to sharing un-sterilized needles and syringes during having injecting drugs, which is viewed in Table 10.

Table 11. The comparison rate of taking drugs by the interviewees and of using cocktail by them

<i>Interviewees ever taken drugs</i>	<i>Using of cocktail drugs</i>		<i>Total</i>
	Yes	No	
Yes	65	32	97
Never	2	-	2
No comments	-	1	1
Total	67	33	100

In this table (Table 11), it is seen that 97% of the respondents have taken injecting drugs or have smoked heroin. Out of these drug users, 65% have used cocktail drugs. Such drug-taking behavior of the interviewees certainly leads them to have abscess in their body where they use to push needle while having intravenous drug.

Table 12 shows that 56 out of 70 IDUs using cocktail drugs have got abscess due to injecting drugs. Most of the cocktail drug users have used the combination of Tdjesic and Phenargon and of Diazepam and Phenargon for cocktail.

Table 12. The linkage between the drugs used for cocktail and having abscess

<i>Drugs used for cocktail</i>	<i>Having abscess due to injecting drugs</i>		<i>Total</i>
	Yes	No	
Diazepam, Tdjesic and Phenargon	10	2	12
Diazepam and Tdjesic	2	3	5
Tdjesic and Phenargon	20	2	22
Diazepam and Phenargon	22	3	25
Others	2	4	6
Total	56	14	70

4.1.3. Sexual and health care seeking behavior

Figure 2 shows that 61 out of 100 respondents use to have extramarital sex with such sexual partners those who are also using injecting drugs or smoking heroin or any other drugs. Moreover, the interviewees carry risky sexual behavior, as the 86% of the respondents does not use condom while having extramarital sex. At the same time, 95% of respondents use to have extramarital sex.

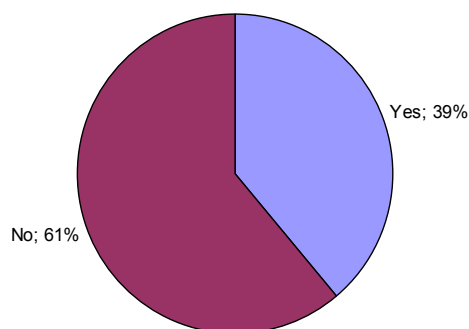


Figure 2. Frequency showing numbers of the interviewees' sex partners taken drugs

Table 13. Showing the percentage of using condom during extramarital sex

<i>Type of response</i>	<i>Percent</i>
Yes	9.0
No	86.0
No comments	2.0
No response	3.0
Total	100.0

In the above-mentioned table (Table 13), it is shown that 86% of the respondents does not use condom while having sex with other than their wives. As a matter of fact, sexual transmission of HIV/STI can be made easy as they are carrying high-risk sexual behavior. Even the chances of HIV/STI transmission through these respondents can be carried double risk.

Table 14. Percentage distribution of extramarital sex among the interviewees

<i>Type of response</i>	<i>Percent</i>
Yes	95.0
No	4.0
No comments	1.0
Total	100.0

The rate of having extramarital sex is absolutely very high among the interviewees, which is shown in the above-mentioned table (Table 14) that is also alarming for transmitting HIV/STI among the general population.

Below mentioned figure (Figure 3) shows that 67 out of 100 respondents admit to contacting STI at any span of time in their past life, and ample numbers of them are still carrying STD.

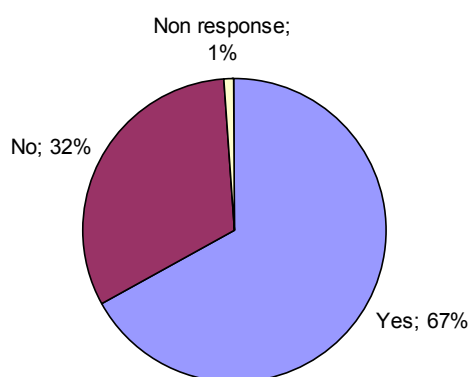


Figure 3. Frequency distribution of the respondents by STI ever been contacted by them

A very few number of the respondents, i.e. only 8 interviewees use to have sex only with their wives (Table 15). On the other hand, 91 interviewees use to have sex concurrently with their spouse as well as extramarital sexual partners. These sexual partners are also heterosexual and they don't have enough skill to negotiate with their male partners to use condom during sex. As a result, the sexual behavior of interviewees seems eventually very risky.

Table 15. Showing the types of sexual partners with whom the interviewees used to have sex

<i>Type of sexual partners</i>	<i>Frequency</i>
Spouse, MSM/Hijra and sex workers	50
MSM/Hijra and sex workers	15
Spouse and sex workers	12
Spouse only	8
Spouse and MSM/Hijra	8
Spouse, MSM/Hijra, sex workers and addict partners	4
Sex workers only	2
Don't have sex	1
Total	100

Table 16. Frequency distribution of different STI syndromes contacted by the interviewees

<i>Type of STI Syndromes</i>	<i>Frequency</i>
Discharge	24
Ulcer	34
Both Discharge and Ulcer	8
Others	1
No STI or didn't admit	33
Total	100

Two thirds (67%), out of 100 interviewees are contacted by STI (Table 16), which is known from their honest confession while the survey has been conducting. It was also assumed in the process of taking interview that some of the interviewees not contacted by STI shown in Table 16 didn't give honest confession about their having of STD. Among these STD patients, 24 have got discharge and 34 have ulcer, and 8 have both discharge and ulcer. 33 didn't contact by STI or didn't admit of having STI.

Table 17. Distribution of respondents by pattern of treatment seeking behaviour

<i>Type of response</i>	<i>Frequency</i>
Didn't seek treatment	35
Faith healer	21
MBBS	8
Rural Medical Practitioners (RMP) and Drug Sellers (Pharmacist)	10
STI specialist	2
Faith Healer and MBBS	14
RMP and MBBS	1
Faith healer and RMP	9
Total	100

Sixty seven out of 100 interviewees are found being contacted by STI (Table 17) and 65 of these STI contacted interviewees have gone to different health care service providers for getting treatment. But it is amazing that only 10 interviewees went foremost to MBBS or specialist, and another 15 went to MBBS followed by RMP or Faith Healer. Most of them have suffered from STD for a long time and gone to the local faith healer though they don't feel need to go to MBBS for treatment. Therefore, their health care seeking behavior is very poor, which is found from data gathered through this survey and observation as well.

Table 18. Comparative frequency on the extramarital sex and STI syndrome contacted by the respondents

<i>Respondents ever having sex except their spouse</i>	<i>Respondents contacted STI syndrome</i>					<i>Total</i>
	Discharge	Ulcer	Discharge and Ulcer	Others	None	
Yes	24	34	8	1	28	95
No	-	-	-	-	4	4
No comments	-	-	-	-	1	1
Total	24	34	8	1	33	100

Table 18 shows that 95 out of 100 respondents have been experiencing to have extramarital sex of which 67 contacted with STI that indicates very high rate of STI among the surveyed IDUs and heroin smokers.

Table 19. Comparative frequency between contacting of STI and sharing of un-sterilized syringes and needles

<i>Respondents ever having STI</i>	<i>Respondents shared un-sterilized syringe and needle</i>				<i>Total</i>
	Yes	Rare	Sometimes	Never	
Yes	1	9	33	21	64
No	-	8	15	6	29
Total	1	17	48	27	93

In the above mentioned table (Table 19), it is shown that 64 out of 93 IDUs have contacted with STI and 43 of these 64 respondents have shared un-sterilized

syringes and needles. On the other hand, 66 out of 93 have shared un-sterilized syringes and needles, but 23 out of these 66 didn't contact with STI.

Table 20. Comparative frequency of contacting of STI syndrome by the interviewees and the health care service providers they did seek for treatment

<i>Interviewees having STI syndrome</i>	<i>Interviewees seek STI treatment</i>								<i>Total</i>
	None	Faith and healer	MBBS	RMP and Pharmacist	Specialist	Faith healer and MBBS	RMP and MBBS	Faith Healer and RMP	
Discharge	2	8	4	5	1	2	-	2	24
Ulcer	-	11	4	5	1	6	1	6	34
Discharge and Ulcer	-	1	-	-	-	6	-	1	8
Others	-	1	-	-	-	-	-	-	1
None	33								33
Total	35	21	8	10	2	14	1	9	100

Table 20 shows the STI syndrome of the interviewees and their treatment-seeking behavior in this connection. Thirty three out of 100 respondents don't have any STI syndrome, and 77 have got either discharge or ulcer or both syndromes in accordance with their confession given in the questionnaire during survey period. Out of these 77, 24 have had discharge, 34 have ulcer and 8 have both syndromes. It is very unfortunate that only 8 and 2 respectively went to MBBS and specialist primarily for seeking STI treatment. Another 15 went to MBBS secondarily after going to either RMP or Faith healer. Forty out of 77 went to Faith Healer or RMP, which to some extent substantially shows their inaccessibility or unavailability of health care service providers in that particular areas.

4.2. Findings of the one-to-one interview among the key informants

This survey has also the provision to collect data from the key informants whose are well known about the behavior and practice of the IDUs and heroin smokers. Findings in relation to socio-economic and familial and AIDS related issues have been explored from the survey among the key informants can be described as tabular format in below.

Table 21. Percentage distribution of Key Informants by their profession

Profession of Key Informant	Frequency	Percent
Broker or Lineman	7	35.0
Hijra	4	20.0
Sex worker	3	15.0
Drug Seller	2	10.0
Paramedic	2	10.0
BDR	2	10.0
Total	20	100.0

In the above-mentioned table (Table 21) it is shown that a total of 20 Key Informants were conducted for taking interview in the survey. Among them 2 interviewees were drug sellers, 2 were paramedic, 3 were sex workers, 4 were hijra, 7 were broker or lineman and another 2 were the members of Bangladesh Rifles working as border security force.

Table 22. Percentage distribution of Key Informants by duration of living

Duration in years	Frequency	Percent
≤2	2	10.0

3 - 5	11	55.0
6 - 10	3	15.0
>10	4	20.0
Total	20	100.0

It is seen that 55% of the KIs have had 3 to 5 years long professional experience at Hili land port area. On the other hand, 20% have got more than 10 years and another 15% have 6 to 10 years experience in their respective profession at the same place. The professional duration containing more 3 years of 90% KIs may significantly be denoted their experience to tell about risk carrying behavior of the drug users particularly of IDU and heroin smokers (Table 22).

Table 23. Percentage distribution of Key Informants by their opinion about the availability of drug users at survey areas

<i>Quantity of drug users at survey area</i>	<i>Frequency</i>	<i>Percent</i>
Enormous user	20	100.0
Few user	0	0
No user	0	0
Total	20	100.0

All the Key Informants expressed their opinion that huge numbers of drug users have been seen in and around Hili landport (Table- 23). No one of the key informants replied ‘few user’ or ‘no user’ which was very much remarkable about the presence of enormous drug users prevailing at the survey areas as well.

Table 24. Percentage distribution of the key informants by their knowledge of known drug users

<i>Number of drug users known by the KI</i>	<i>Frequency</i>	<i>Percent</i>
15 – 50	8	40.0
51 – 150	10	50.0
151 – 250	1	5.0
>250	1	5.0
Total	20	100.0

In Table 24 it is shown that 50% of the key informants know 51 to 150 numbers of drug users, 5% of them know 151 to 250 and another 5% also know more than 250 which is shown in the above-mentioned table. Despite the less numbers of drug user (15 to 50) are known by 40% of the key informants, who may validate the presence of significant numbers of drug users at the survey.

Table 25. Percentage of the KIs telling the type of community people use to have drugs

<i>Community use to have drugs in accordance with the KI</i>	<i>Frequency</i>	<i>Percent</i>
Unemployed, problematic family member and frustrated people	12	60.0
Student, lineman, broker and unemployed	4	20.0
Lineman, broker and unemployed	3	15.0
Student, lineman, broker, unemployed and problematic family member	1	5.0
Total	20	100.0

The Table 25 shows that 60% of the key informants opined that the individuals of unemployed, problematic family and frustrated groups of the society have been using drugs at an augmenting rate. Another 40% also repeated about unemployed groups as the drug users. Besides the students, linemen, brokers and the

members of the problematic family have also been having drugs in accordance with the opinion of those 40% key informants.

Table 26. Percentage distribution of types of drug being used by the drug users

<i>Commonly used drugs in accordance with the KI</i>	<i>Frequency</i>	<i>Percent</i>
Cannabis, IV Drug, Heroin and Phensidyl	8	40.0
Cannabis, IV Drug and Heroin	7	35.0
IV Drug and Heroin	4	20.0
Heroin, Cannabis, Afim, Wine and Phensidyl	1	5.0
Total	20	100.0

In the above mentioned table (Table. 26) it is shown that 95% of the key informants commonly opined that drug users present at survey area use to have heroin and intravenous drugs, and there are few who use to have cannabis, phensidyl, afim and wine as well.

Table 27. Percentage of numbers of narcotics seller known by the key informants

<i>Numbers of narcotics sellers known by the KI</i>	<i>Frequency</i>	<i>Percent</i>
<10	6	30.0
10 – 25	11	55.0
26 – 40	3	15.0
Total	20	100.0

Table 27 shows that 55% of the key informants admit that they know 10 to 25 numbers of narcotic sellers resided in and around Hili landport whose use to sell IV drugs, heroin, cannabis and so on to the drug users. It is really amazing that no one of the key informants tell that they don't know narcotic seller. As a matter of fact the

presence of huge numbers of narcotic sellers ascertain the availability of huge numbers of drug users in the survey area.

Table 28. Percentage distribution of treatment seeking behaviour of the drug users

<i>Treatment seeking behaviour by drug users</i>	<i>Frequency</i>	<i>Percent</i>
Sometimes	8	40.0
Not usually	3	15.0
Satisfactorily	3	15.0
Don't know	6	30.0
Total	20	100.0

In the above mentioned table (Table 28) it is shown that drug users' practice for seeking treatment of STI being infected was found very poor as only 15% of the key informants opined about the satisfactory going of them for seeking STI treatment. This type of finding is, to some extent, very significant for the chance of infecting HIV by themselves and subsequently to the mass population. The drug users being infected with STI sometimes go for seeking treatment in accordance with opinion of another 40% of the interviewees, which may have little light of hope. But on the other hand, remaining 60% inform that the drug users don't want to go for seeking treatment of STI in spite of having the same by themselves, which can show the opportunity and need for intervention work regarding STI/AIDS prevention among them.

Table 29. Percentage distribution of drug users by their information seeking practice

<i>Drug users' practice of seeking information on HIV/ADS</i>	<i>Frequency</i>	<i>Percent</i>
Not usually	7	35.0

Sometimes	9	45.0
Don't know	4	20.0
Total	20	100.0

It is shown in the above-mentioned table (Table 29) that drug users sometimes go for seeking information on HIV/AIDS to the respective key informants, which is opined by 45% of them, and not usually go for same in accordance with the opinion of 35%, and another 20% does not know whether the drug users use to go for seeking information on the same. It is importantly come out that practice for seeking information on HIV/AIDS is frequent among the drug users as no one of the key informants opined while carrying out the survey among them.

Table 30. Percentage distribution of extra-marital sexual practice by the drug users

<i>Drug users having sex with sex worker</i>	<i>Frequency</i>	<i>Percent</i>
Frequently	12	60.0
Sometimes	3	15.0
Don't Know	1	5.0
May be	4	20.0
Total	20	100.0

The Table 30 shows that 95% of key informants involved with survey process opine that drug users use to have sex with sex workers, which is shown in the above-mentioned table. It is indeed significantly proven the risk of drug user for HIV infection as the drug users frequently do sex with sex workers, which is the opinion of 60% of the key informants. And another 35% interpret that the drug users sometimes or may be use to have sex with sex workers. Besides, only one of the key informants

gives his opinion that he does not know whether the drug users use to have sex with sex workers.

4.3. Findings of the focus group discussions

Focus group discussions were held among four different groups comprising of 8-10 persons in each, and a mixed group discussion were also held by taking individuals from all of the groups. The groups partaken in FGDs are IDUs and heroin smokers, community leaders, drug sellers and RMPs, sex workers. Findings explored from the discussions may be described separately.

4.3.1. Findings of group discussion among IDUs and heroin smokers

Most of the participants in this group are about to know the mode of HIV transmission. But they opined that most of the IDUs in and around Hili landport use to share syringes and needles while having injecting drugs. In addition, the IDUs and heroin smokers are carrying risky sexual behavior, as they don't want to use condom while having extramarital sex though most of them are known about that extramarital sex without condom is very risky to transmit HIV among them as well as to the general population. Some of the members of this group also opined that most of the IDUs use to use cocktail drugs and do have STIs and abscess. Most of the IDUs and heroin smokers inform that their health care seeking behavior is very poor, and even they don't usually want to go to the health care service providers while having STIs due to ignorance and lethargy. The IDUs and heroin smokers, those who sometimes want to go for STI treatment, usually go to faith healer, RMP, quack, drug seller but not to MBBS or STI specialist. As a matter of fact, they have been practicing very poor and at the same time, risky health care seeking behavior. At the end it is known

that they need mental and treatment support, and they want to come back from the dark life as they opine, if someone provide rehabilitation support for them.

4.3.2. Findings of group discussion among sex workers

Sex workers were found free-spoken while asking them to tell about sexual behavior of the IDUs and heroin smokers during focus group discussion conducted among them. In this connection, they inform that both the IDUs and heroin smokers don't want to use condom while they come to the sex workers for buying sex. The sex workers also inform that most of the time they could not able to negotiate with the IDUs and heroin smokers for using condom during sex. Heroin, phensidyl, cannabis, injection are the main narcotics using by the drug users at Hili areas which is known from the findings of group discussion held absolutely among the sex workers. The participants also let to know that unemployed, frustrated and members of the family got out of shape usually use to have injecting drugs and heroin. And if someone come forward to take responsibility to rehabilitate the IDUs and heroin smokers they might be come back from this societal curse.

4.3.3. Findings of group discussion among RMP and drug sellers

Discussion made among the group of rural medical practitioners and drug sellers was very animated. But their opinion about practice and behavior of the IDUs and heroin smokers was very amazing as they let to know that most of the IDUs and heroin smokers in and around Hili landport areas are getting STIs at an increased rate. They also let to know that the drug users' attitude towards life is negative. On the contrary they want to come back from this dark towards light containing meaningful life. The drug users come to them with STI and ask for treatment, but don't follow the line of treatment, as because of leading meaningless life. The participants also inform

that the drug users also go to the nearest Medical College and district level hospitals for selling blood to meet up the expenditure for buying drugs and heroin as well.

4.3.4. Findings of group discussion among the community leaders

Discussions among this group have significant findings about the social perception towards the IDUs and heroin smokers. The participants opined that the IDUs and heroin smokers are socially excluded and neglected. They also exist with social stigma and humiliation. Most of the drug users coerced to go for anti-social activities like stealing, illicit goods trafficking and so on for meeting up the expenditure of drug abusing. They also opine that there are huge numbers of drug users is seen in and around Hili landport. In accordance with the opinion of the participants in this group, the problem posed by the drug users in the survey areas can be reduced by creating awareness on the injurious issues of drug abuse, providing health care supports to the drug users, creating more employment for young class and improving law and order situation along the border areas.

4.3.5. Findings of group discussion among the mixed groups

Focus group discussion among the mixed groups containing IDUs and heroin smokers, sex workers, RMP and drug sellers and local community leaders were found to be participatory and very effective. The participants from all groups were seen cordial and communicative with each other. All of the participants have given honest confession that increasing trend of drug users in and around Hili landport is one of the noteworthy acute problems. They also spelled out that increasing trend of drug users in this area has been turned out as because of frustration, unemployment, financial problem, bad company, family distortion, failure in love affair, social discrimination

and carelessness being prevailed in the society. In accordance with the opinion of the participants, intervention program consisting of health care supports, awareness creation, employment generation, social acceptance of the drug users, rehabilitation activities, minimizing social stigma and so on may lead to dimensional change.

5. Discussion

Observation made during study revealed that frequency of injection drug users is found very high and the number of people sharing injecting instruments is still rather high in the survey area. Some are too poor to afford to “get high” alone, so they try to survive by sharing drugs with their peers. Other IDUs share injecting instruments as a result of insufficient knowledge. The first injection experience of many IDUs was with the “residues” of other IDUs by using shared reused equipment. Sharing injecting instruments may be unintentional during their first experience. The first injection might occur when many people cannot control themselves, e.g.-frustration due to long-term unemployment, sudden refusal from their lovers, creation of mental disturbance among the members of distorted family etc. Some others trust their peer IDUs and believe that they know each other well, for instance, there are IDUs who often inject together or friends or lovers. In addition, some interviewed IDUs had no hesitation in sharing injecting instruments when they had the craving for drugs. Some said that they would not be able to control themselves and the only thing their minds were set on was getting the drug, without thinking of the further consequences. Besides, after having the IV drugs ample number of the IDUs use to have unsafe sex with sex workers. This dangerous situation augments the risk of HIV/STIs transmission among themselves as well as to the general population. Some IDUs used drugs filled in a syringe without knowing if it was a new syringe or not, or if the drug had been moved from a used syringe. Such cases occurred amongst the IDUs groups who often injected together and who often shared drugs due to a shortage of money. This happens at an increasing rate among the IDUs present in the survey area, as awareness among them is not in a due level as a result of the absence of intervention program at the target area.

It is revealed in the result that 96% of the respondents are injection drug users, 84% of them are also heroin smokers. And again 80% of the participants are concurrently injection drug users and heroin smokers, which denotes most of the drug users in that particular location have been using injecting drugs as well as smoking heroin. Not only this but 70% of the IDUs also use cocktail drugs, and among them 68% are getting abscess either in their hands or legs due to using of intravenous drugs. On the other hand, 64.32% of the IDUs were found to have been sharing unsterilized needles and syringes with each other while having injecting drugs. Therefore, the risk of getting STI/HIV among the IDUs and heroin smokers in the survey areas is very high. It is found in the findings of survey that 64 out of 96 IDUs have contacted with STI and 43 of these 64 respondents shared unsterilized syringes and needles. On the other hand, 66 out of 96 shared unsterilized syringes and needles, but 23 out of these 66 didn't contact with STI.

As 91% of the interviewees use to have sex concurrently with their spouses as well as extramarital sexual partners. Moreover, these sexual partners are also heterosexual and they don't have enough skill to negotiate with their male partners to use condom during sex. As a result, sexual behavior of the interviewees seems eventually very risky and thereby it can potentially lead to spreading HIV among general population through these IDUs and heroin smokers. It is found in the result that 67% of the respondents admit to contacting STI at any span of time at the past life. Still ample numbers of them are carrying STD. Therefore, it exhibits real alarm and highest chance to spreading HIV among themselves as well as general population through their sexual partners. Among the respondents, 61% use to have extramarital sex with such sexual partners those who also use injecting drugs or smoke heroin or use any other drugs. On the other hand, 95% of the respondents experienced to have

extramarital sex of which 67 contacted with STI that indicates very high rate of STI among the surveyed IDUs and heroin smokers. Moreover, the interviewees carry risky sexual behavior, as 86% of the respondents does not use condom while having extramarital sex despite 95% of them use to have extramarital sex. As 86% of the respondents does not use condom while having sex with other than their wives, as a result, sexual transmission of HIV/STI can be made easy as they are carrying high-risk sexual behavior. Even the chances of HIV/STI transmission through these respondents can be carried double risk.

Findings of the survey also revealed that 67% of the interviewed drug users are contacted with STI, which is known from the interviewees' honest confession while the survey had been conducting. On the contrary, it may also be assumed during interview process that some of them not contacted with STI didn't give honest confession about having of STD. Among the respondents, 33% don't have any STI syndrome, and 77% have got either discharge or ulcer or both syndromes in accordance with their confession given in the questionnaire during survey period. Out of these 77, 24 have had discharge, 34 have ulcer and 8 have both syndromes. It is very unfortunate that only 8 and 2 respectively went primarily to MBBS and specialist for seeking STI treatment. Another 15 went to MBBS secondarily after going to either RMP or faith healer. 40 out of 77 went to faith healer or RMP, which to some extent substantially shows their inaccessibility or unavailability of health care service providers in that particular areas. Among the STD patients found in the survey findings, 24 have got discharge, 34 have ulcer, and 8 have both discharge and ulcer. Therefore, it can without hesitation be outlined that prevalence of STI among the IDUs and heroin smokers of survey areas are very high and thereby the risk and potential of spreading HIV among both the target community and general population

profoundly exists. The findings of the survey also revealed some 67 out of 100 interviewees are found being contacted with STI and 65 of these respondents have gone to different health care service providers for getting treatment. But it is amazing that only 10 interviewees went foremost to MBBS or specialist, and another 15 went to MBBS followed by RMP or Faith healer. Most of them have been suffering from STD for a long time and have gone to the local faith healer though they don't feel need or don't know whether to go to MBBS for treatment. Therefore, their health care seeking behavior in particular of STD is very poor, which can lead them to be infected with HIV.

The frequency of injecting drug users and heroin smokers among the young group have been increasing day by day which is found from observation made during key informants' interview. This situation may occur due to the lack of appropriate intervention program. At the same time, sharing of injecting instruments has also been increased as a result of unavailability of syringes and needles, and of inadequate knowledge and information. Findings of the key informants' interview revealed that 100% of them expressed their opinion that ample number of drug users has been seen in and around Hili landport. And even no one of the key informants replied 'few users' or 'no user' which was remarkable about the proven presence of enormous drug users at the survey areas as well. Besides each of the key informants know at least 15 drug users and even some of them also know more than 250 numbers. On the basis of the opinion of both individual interviewees and key informants' interview, the members of unemployed, problematic family and frustrated groups come for using drugs, and the community feel need to undertake some programs for those groups so that the opportunity to become drug users can be reduced. The key informants also opined that most of the drug users, in and around Hili landport, use to have heroin and

intravenous drugs and they know so many drug (narcotic) sellers in that particular area.

It is found in the findings of key informants' interview that drug users' practice for seeking treatment of STI being infected was found very poor, and it is, to some extent, very significant for the chance of infecting HIV by themselves and subsequently to the mass population. On the other hand, some of the drug users don't want to go for seeking treatment of STI in spite of having the same by themselves, which can show the opportunity and need for intervention work regarding STI/AIDS prevention among them. Drug users frequently use to have sex with sex workers without using condom, which can potentially be effective for spreading STI/HIV among general population. The findings of the key informants' interview also significantly show prove the risk of drug users for HIV infection, as the drug users do unsafe sex frequently with sex workers and moreover, share syringes and needles with each other while taking intravenous drugs.

The group discussions held particularly among the target community as well as their allied communities, and also among the mix group of them revealed that the drug users in and around Hili landport have been carrying high risks for spreading HIV/STI among themselves and the general population as well. Drug users don't want to use condom while having sex with sex workers and the sex workers can not able to negotiate with their partners using drugs in order to use condom, which has also been explored from the findings of group discussion held among the sex workers. Most of the drug users having STI are reluctant to seek treatment, but who have willingness to seek, they can not go to specialists as either result of lacking money or unavailability of specialist doctors at survey locations. The rural medical practitioners clearly expressed the same opinion while holding discussion among the group of them. It is

explored in the discussion among the drug users' group that they want to come out from the curse of illicit drug use if some body look onward with intention to rehabilitate them on to the mainstream of society. The number of drug users has gradually been increasing at Hili landport areas on the basis of the opinion come out from the discussion made among the community leaders group. This group also expresses their scare about deterioration of the societal basement due to increasing trend of drug users present in the survey locations. Above all, although IDUs and heroin smokers constitute a high-risk group because of their drug and equipment-sharing behaviors, they can also increase their HIV risk by practicing unsafe sex. And the efficiency of HIV transmission through injecting drug use and heroin smoking behaviors and networks can accelerate the growth of HIV epidemics among them and the general population as well.

6. Conclusions and Recommendations

The current study found a gloomy picture of drug users in a selected area land port Bangladesh. The drugs users are unaware about the consequences. Their perception about the disease, mode of transmission and prevention was very poor. On the basis of the survey findings, it can be recommended to devise and develop an appropriate and comprehensive intervention program for taking immediate steps to implement at Hili landport aiming at preventing STI/HIV transmission among the IDUs and heroin smokers, and general population at large. The recommended program could have provisions of awareness creation, syndromic treatment of STI, rehabilitate components of the heroin smokers and IDUs through ensuring withdrawal management, harm reduction and detoxification among the IDUs along with some support services. This program should include the IDU, heroin smoker, sex worker and hijra as the target community. And the target stakeholder would be the community leader, RMP or drug seller, social leader, religious leader (imam), school teacher, member of the law enforcing agencies, border security force (BDR) and elected representative of the local government authorities. This program can initially be implemented in the survey locations and subsequently it can be replicated at other vulnerable locations. Prior to replicating the program at other locations, baseline survey or catchment program should be undertaken at those locations where the experience gathered from the present survey could be possible to be utilized thereon. The national target fixed in relation to HIV/AIDS prevention on the basis of the millenium development goals has to be considered whenever go for designing and devising the recommended intervention program among the aforesaid target community and stakeholder as well.

This survey also recommends to looking for donors at both national and international arena for implementing intervention program in order to rescue the probable AIDS/STI epidemic among general population posed by such high-risk groups. Issues like poverty and basic human rights attached with the probable AIDS epidemic will also be brought under consideration while designing the intervention program for preventing STI/AIDS among the target population. The survey expect the findings being explored could be useful to design and devise a comprehensive intervention program to prevent the transmission of HIV among the IDUs and heroin smokers, and general population at large. At the same time, data collected through this survey can be the valid primary source for conducting another survey or holding research activities on the same issues to be done by any other individual or organization.

On the basis of data presented in this report, a number of recommendations are made for improving the quality and scope of HIV prevention programming and building the necessary capacity to do so. Expanding surveillance and research to better understand the socioeconomic factors contributing to the epidemic is also important in developing more effective responses. The recommendations draw attention to the importance of rural HIV epidemics and the need to better understand risk and vulnerability in rural contexts in order to effectively respond. Reducing stigma and discrimination directed against people engaging in high-risk behaviors will be critical to support scale up of HIV prevention programs across the vulnerable locations in the country.

The specific recommendations are:

- 1) Building non-governmental organization capacity to work with high-risk groups in particular of IDUs and to support and involve community-based organizations in the design and delivery of HIV prevention and care programs.
- 2) Building capacity at all levels to map vulnerable populations, conduct situation assessments, and analyze and use data generated from these activities.
- 3) Immediate prevention program has to be undertaken among IDUs, SWs and Hijras and their clients with including outreach, peer education, condom promotion, provision of sexually transmitted infection treatment and related services and comprehensive harm reduction and socio-economical rehabilitation for IDUs
- 4) Prevention programs among IDUs in this particular location need to give more attention and resources to comprehensive harm reduction approaches, including needle exchange and drug substitution, and to develop structural framework to rehab the IDUs.
- 5) Socioeconomic and behavioral studies to gain a better understanding of the structural dynamics of the community and how to intervene within them effectively are a priority; more knowledge and understanding of stigma and how to reduce it is also critical.
- 6) Expanded and more comprehensive mapping is required at cross-border-zone levels for high-risk groups, such as IDUs, female SWs and their clients, Hijra.

- 7) The importance of CBZ-based intervention and IDUs-driven programs needs to be better understood. Practical approaches to reducing risk and vulnerability and to undertake rehab programs among IDUs also need to be developed.
- 8) Stigma reduction through multi-sectoral approaches is essential to provide a supportive environment for risk reduction and to increase access and use of prevention and care services.
- 9) Coordinated efforts with India, with a focus on drugs trafficking to Bangladesh could enhance HIV prevention among IDUs. The cross-border drug trade and sexual networks between the highest prevalence districts in Bangladesh underscore the role of migration and call for trans-regional and inter-sectoral cooperation. Cooperation and coordination within countries, and across sectors are also important but not only for stigma reduction, but to increase access to prevention programs and care programs.

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Questionnaire for the Injection Drug Users and Heroin Smokers
in relation to HIV/AIDS & STI

Attention:

No Respondents can be questioned without prior consent

CEDAR (Concern for Environmental Development And Research)

768 Satmasjid Road, Dhanmondi R/A, Dhaka- 1209

Phone: 880-2-9121504, 8130585

E-mail: cedar@bdonline.com

Contents

Sl. No.	Types of Questions	Sl. No. of the Questions
01.	Personal and Family related	01 to 06
02.	HIV/AIDS related issues	07 to 18
03.	Drug abusing matters	19 to 28
04.	STD related issues	29 to 37

Proclamation: All rights of the questionnaire are reserved by the Executive Director, CEDAR

Rules of the Survey:

1. At first, the interviewers have to be explained his personal and organizational orientation.
2. Respondents are to be ensured about the aim of the survey.
3. Tick or round mark has to be given duly in the right place of each question.
4. Respondents can not be questioned in such way so that they can get hint about the probable right answer.
5. Thanks have to be given to the respondents for giving time in the interview process.
6. Answers to be given by the respondents have to be honored duly.
7. No respondents can be forced for giving answer.
8. Sign has to be given in the right place of the questionnaire after completing the interview process with each respondent.

Questionnaire for the Injection Drug Users and Heroin Smokers in relation to HIV/AIDS & STI:

Introduction: I am a development worker, I have come from a national level non-governmental development organization for collecting information for survey purpose. CEDAR has been working in Bangladesh for a long period for preventing HIV/AIDS. This organization has also been implementing intervention program on HIV/AIDS prevention at Hili landport since 1996. I want to ask some question about HIV/AIDS and related issues. Everything, which you would make reply, have to be kept secret, and information given by you would be used only for the study purpose. You shall have every right to stop giving answer in any stage of the interview process if you desire. If you express your intention to join with this interview process, then you need to be honest to provide information in the interest of the survey. Can we let to start?

Survey area: _____ Place of interview: _____ Date: _____

No.	Questions	Answers	Comments
Section- 01: Personal and Family related			
01	Sex of the respondent	1. Male 2. Female 3. Others (Specify) _____	
02	How old are you?	1. 15 to 24 years 2. 25 to 34 years 3. 35 to 44 years 4. 45 to 54 years 5. 55 years and above	
03	Educational status of the respondent	1. Illiterate 2. Can sign 3. Primary level 4. High School level 5. SSC/HSC 6. Graduation/Post-graduation	
04	Profession of the respondent	1. Unemployed 2. Cultivator 3. Day laborer 4. Businessman 5. Service holder 6. Student 7. Others (Specify) _____	
05	With whom do you live at present?	1. Alone 2. Spouse and children 3. Family (i.e. with parents or brothers)	

No.	Questions	Answers	Comments
		4. Friends or colleagues 5. Others (Specify) _____	
06	Marital status of the respondents	1. Unmarried 2. Married 3. Divorced 4. Widower 5. Widow	
<i>Section 2: HIV/AIDS related issues</i>			
07	Did you hear about HIV/AIDS?	1. Yes 2. No	
08	Can AIDS be cured?	1. Yes 2. No 3. Don't know	
09	Who does get AIDS?	1. Don't Know 2. Sex workers 3. Hijra 4. Polygamy 5. MSM 6. IDUs 7. Heroin Smokers 8. Others (Specify) _____	
10	How does get AIDS?	1. Don't know 2. Sharing cloths 3. Playing together 4. Sleeping in a same bed 5. Using same plate or bathroom 6. By mosquito or insect 7. Sharing syringe or needle 8. Using unscreened blood 9. Having unprotected sex with HIV infected or carrier 10. Having unprotected sex with sex worker 11. Polygamous 12. HIV infected or carrier mother to her baby	
11	How much AIDS is vulnerable to you, other and society at large?	1. Serious risk 2. No risk at all 3. Few risk 4. Don't know	
12	What to do to avoid AIDS?	1. Don't have unfaithful sex 2. Using condom during sex 3. Not to share syringe or needle	

No.	Questions	Answers	Comments
		4. Not to have unscreened blood 5. Not to have unprotected sex with sex worker 6. Not to smoke heroin indiscriminately 7. Don't know 8. Others (Specify) _____	
13	Do you support NGO activities for preventing HIV/AIDS?	1. Yes 2. No 3. No comments	
14	Do you want to know about AIDS?	1. Yes 2. No 3. No comments	
15	If yes, then which source do you prefer?	1. Radio/TV 2. Newspaper 3. NGO/Health workers 4. Others (Specify) _____	
16	Do you have any involvement in any of the AIDS related programs currently running in this location?	1. Yes 2. No	
17	Did you ever take drugs?	1. Yes 2. No	
18	If yes then, which type of drugs did you have?	1. Whisky or Brandy or Vodka or any other 2. Afim 3. Morphine 4. Heroin 5. Cannabis 6. Pathedine or Injecting drugs 7. Abusive tablet	
Section- 3: Drug abusing matters			
19	How many days have you been abusing drugs?	1. New abuser 2. More than 3 months 3. More than 6 months 4. More than a year 5. For 2 years or more	
20	Have you ever had drugs through injection	1. Yes 2. No	

No.	Questions	Answers	Comments
21	How many days have you been taking injecting drugs	1. For 3 months or less 2. >3 to <6 months 3. >6 months to <1 year 4. >=1 year	
22	Did you use cocktail drugs?	1. Yes 2. No	
23	If yes then, which drugs do you use for cocktail?	1. Sedil 2. Diazepam 3. Nitrazepam 4. Tdjesic 5. Phenargon 6. Others (Specify) _____	
24	Did you ever have abscess due to injecting drugs?	1. Yes 2. No	
25	Did you ever go to jail due to have drugs?	1. Yes 2. No	
26	Did you ever sell blood for having drugs?	1. Yes 2. No	
27	Did you ever share unsterilized syringe & needle?	1. Yes 2. Rare 3. Sometimes 4. Never	
28	Are any of your sex partners use to have drugs?	1. Yes 2. No	
Section- 4: STD related issues			
29	Did you ever have sex except your spouse	1. Yes 2. No	
30	How types of sex do you like to have?	1. Traditional 2. Oral sex 3. Homo sex 4. Annul sex 5. Group sex 6. Others (Specify) _____	
31	Who are your expected sexual partners?	1. Spouse 2. Other than spouse 3. Hijra 4. Sex worker 5. Homo sexual 6. Bisexual 7. Drug user colleague 8. Others (Specify) _____	
32	Did you ever hear about STI?	1. Yes	

No.	Questions	Answers	Comments
		2. No	
33	Did you ever have STI?	1. Yes 2. No	
34	What type of STI did you have?	1. Syphilis 2. Gonorrhea 3. Others (Specify) _____	
35	Whom did you go for STI Treatment?	1. Faith healer 2. Drug seller 3. MBBS doctor 4. STI Specialist 5. Nobody 6. Others (Specify) _____	
36	Do you use to use condom while having sex except spouse?	1. Yes 2. No 3. No comments	
37	Do you think blood should be screened while transmitting?	1. Yes 2. No	

Thank you very much for taking part into this interview process.

Signature of the Interviewer : _____ Date: _____

Signature of the Supervisor: _____ Date: _____

Questionnaire for the Key Informants in relation to
Injection Drug Users and Heroin Smokers

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Questionnaire for the Key Informants in relation to Injection Drug Users and Heroin Smokers:

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Survey area: _____ Place of interview: _____ Date: _____

[N. B.: All the questions are open-ended.]

No.	Questions	Answers	Comments
01	Sex of the respondent.		
02	How old are you?		
03	What are your present profession and how many days do you in this profession?		
04	How many days do you live in this locality?		
05	What do you know about the drug abusers in this locality?		
06	How many drug users do you know staying in this locality?		
07	What types of people do use to have drugs usually in accordance with your opinion?		
08	How types of drugs the drug users do use to have?		
09	Where do the drug users collect these drugs?		

No.	Questions	Answers	Comments
10	What types of people do usually sell these drugs?		
11	How many drug sellers do you know staying in this locality?		
12	Do the drug users come to you for STI treatment?		
13	Does anyone come to you for getting information on HIV/AIDS?		
14	Is there any tendency of the drug users to have sex with sex workers?		

Thank you very much for taking part into this interview process.

Signature of the Interviewer : _____ Date: _____

Signature of the Supervisor: _____ Date: _____