

**NATIONAL HARM REDUCTION STRATEGY**

**FOR DRUG USE AND HIV**

**2017-2021**



**National AIDS/STD Programme (NASP)**

**DGHS, MOHFW**

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**Foreword**

Bangladesh is still considered to be a low prevalence country for HIV, but it remains extremely vulnerable given its dire poverty, overpopulation, and needle syringe sharing, drug use pattern, and gender inequality, high mobility of the population in country and having sex without condom. Migration to other countries for employment is also very common, particularly amongst younger people.

Bangladesh remains a low HIV prevalence country with less than 0.1% overall prevalence in general population over the years[[1]](#footnote-1). The HIV prevalence the highest rate among the PWID in Dhaka but the prevalence declined to 5.3% from 7%[[2]](#footnote-2). However, the decline is not statistically significant. Moreover, HIV was also detected among male and female PWUD. Active syphilis was detected among six groups of PWUD, and prevalence rate is around six percent. Antibodies to Hepatitis C virus (HCV) were measured in all PWID which is extremely high, in Rajshahi Division with Kanshat having the highest prevalence (95.7%).

Bangladesh has a strong political history and commitment to the HIV response. The country

has a unique possibility to succeed where several other developing countries have not, to keep the HIV epidemic from expanding beyond its current level through comprehensive and strategically viable prevention measures, avoiding a gradual spread of HIV from key populations to the general population.

To a significant extent, this is probably attributable to the willingness by government to acknowledge the existence of high risk groups and risk behaviors’ and a willingness to initiate effective interventions earlier rather than later, high quality interventions by NGOs, strong technical support from international agencies as well as local agencies and a clear strategic focus by donor agencies.

The Government of Bangladesh responded to HIV and AIDS from the first case detected in

1989, by forming the National AIDS Committee (NAC) and developing the first AIDS policy. Subsequently, several policy documents heve been developed to guide the national HIV and AIDS Program interventions. The goal of the National Harm Reduction Strategy 2017-2021 is to prevent initiation of drug related HIV epidemic in Bangladesh, control use of drug and improve the quality of life of drug users through comprehensive package of intervention generating sustainable commitment and support among multi-sectoral stakeholders. The National AIDS/STD Programme (NASP) is one of the wings of Directorate General of Health Services (DGHS) under the Ministry of Health & Family Welfare (MOHFW) responsible for coordinating with all stakeholders and development partners involved in HIV/AIDS programme activities throughout the country.

The National Harm Reduction Strategy was developed based on the synthesis of evidence and a thorough assessment with several consultations with government departments, civil society, public and private sector partners, NGOs, PLHIV networks and community based organizations. The entire process was based on local knowledge but also having consideration to neighboring countries’ programs and the overall trends of drug use and HIV in this region. The core team members worked closely together and were involved throughout these processes. The National Harm Reduction Strategy development was 20 days excluding two consultation meeting and DIC visit.

Based on the principles of the National Harm Reduction Strategy, the various interventions will continue to provide NSPs, ART, OST and other evidence-based drug dependence treatment, HTC, STIs management, distribution of condom, BCC/IEC activities including sexual partners, prevention, vaccination, diagnosis, and treatment for viral hepatitis and prevention, diagnosis and treatment of TB for PWUDs. The NHRS is adopting an inclusive, participatory and widely consultative approach to ensure quality and coverage, policy and advocacy and to eliminate stigma and discrimination.

I would like to acknowledge the cooperation of the PWUDs, Peer educators, and DIC In-charge who help the consultant for data collection regarding harm related to drug use.

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**Abbreviations**

AIDS Acquired Immune Deficiency Syndrome

ART Antiretroviral Treatment

BCC Behavioural Change Communication

CBO Community Based Organization

DGHS Directorate General of Health Services

DIC Drop in Center

FSW Female Sex Worker

GF Global Fund

HIV Human Immunodeficiency Virus

HTC HIV Testing and Counselling

HVC Hepatitis Virus C

IEC Information Education and Communication

IP Implementation Plan (of the 3rd National Strategic Plan)

KP Key Populations

MARA Most at Risk Adolescents

M&E Monitoring and Evaluation

MOHFW Ministry of Health and Family Welfare

MOHA Ministry of Home Affairs

MOWCA Ministry of Women and Children Affairs

MOE Ministry of Education

MOYS Ministry of Youth and Sports

MSM Men Who have Sex with Men

NASP National AIDS/STD Programme

NAC National AIDS Committee

NGO Non-governmental Organization

NSEP Needle-syringe Exchange Program

NSP National Strategic Plan

OW Outreach Worker

PEP Post-exposure Prophylaxis

PE Peer Educator

PLHIV People Living with HIV

PWID People who Inject Drugs

PWUD People who use drugs

STI Sexually Transmitted Infection

TC-NAC Technical Committee of National AIDS Committee

**Contents Page**

Forward

Abbreviation

Executive summery 9

Introduction 11

What is harm reduction? 13

Comprehensive package for PWID 13

Core principles of harm reduction 15

Common concern about harm reduction 16

Human rights and harm reduction 18

Cost effectiveness of harm reduction program 20

Ending the criminalization of PWID 22

Present scenario of harm reduction 23

National response 28

Methodology 29

The role of National Harm Reduction Strategy 31

Scope of National Harm Reduction Strategy 32

Rationale for National Harm Reduction Strategy 33

Goal of the National Harm Reduction Strategy 34

Appendix - 1 : Prioritization of the National Harm Reduction Strategy 42

Appendix - 2 : Action plan of the National Harm Reduction Strategy 46

(NHRS)

Appendix - 3 : Core group members

**EXECUTIVE SUMMARY**

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

Bangladesh is a low prevalence country, but HIV prevalence the highest rate of HIV continues to be PWID in Dhaka but the prevalence declined to 5.3% from 7%[[3]](#footnote-3). However, the decline is not statistically significant. Fortunately, the localization of the PWID epidemic to one neighborhood of Dhaka observed in previous years has also remained. HIV was also detected in another four groups of people who use drugs (PWUD) - male PWID from Narayanganj (1.5%) and Satkhira (0.4); female combined PWID and heroin smokers from Dhaka, Narayanganj, Tongi (1.2%) and Benapole (1%). Active syphilis rates at >5% was detected among six groups of PWUD and the highest proportion was found in male PWID in Norsingdi (7.9%), followed by PWID in Chandpur (6.1%) and female PWUD in Dhaka, Tongi and Narayanganj (5.9%). High active syphilis rates suggest practice of unsafe sex.

Antibodies to Hepatitis C virus (HCV) were measured in all PWID and groups of combined PWID and heroin smokers but not in the groups consisting of only heroin smokers. The rates varied in the different cities and in six cities >50% were HCV positive. The higher prevalence for HCV was found among PWID from several cities of Rajshahi Division with Kanshat having the highest prevalence (95.7%). In Dhaka HCV rates have declined significantly (P<0.05) over the rounds of surveillance.

The revised 3rd National Strategic Plan for HIV and AIDS response 2011–2017, has the overarching goal of minimizing HIV transmission and the impact of AIDS at all levels of the Bangladeshi society through the four pillars of prevention; treatment, care and support; management and coordination and strategic information. These areas are reflected in the four objectives and their strategies, as well as in the programmatic targets of the implementation plan.

It is felt that based on the strategies, a comprehensive harm reduction strategy is needed to address the situation. The National AIDS/STD Programme (NASP), DGHS, MoHFW, Bangladesh took initiative to updated National Harm Reduction Strategy (NHRS) with technical assistance from new funding model of global fund. A core of different key stakeholders have experience in harm reduction activities facilitated the strategy development.

While there are differences among/between the approaches of supply demand and harm reduction, international research evidence shows they should have complement each other - resulting in an enabling environment in which it is possible to contain illicit drug use and address public health problems such as HIV/AIDS, STI and hepatitis-C among PWUDs.

The aim of harm reduction is to keep drug users alive, well, and productive until treatment works or they grow out of their drug use[[4]](#footnote-4). There is always an emphasis on the dignity and human rights of all members of a society, including PWIDs. Harm reduction aims to protect the community by engaging with drug users - rather than excluding them from the wider community - by making targeted efforts to address their often multiple needs. The wider community is also protected from the sexual/vertical transmission of HIV as harm reduction is focused also on the sexual partners of PWUDs and to reduce the risk of mother to child transmission of HIV, STI and HCV.

Based on analysis of the drug and HIV/AIDS situation and vulnerability factors to the drug induced HIV epidemic and ongoing responses, **"National Harm Reduction Strategy For Drug Use and HIV 2017-2021"** prioritized following strategies with specific implementing strategies;

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

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

**Strategy 3:** Prevententry into drug use. This strategy addresses how to delay or prevent entry of potential users in to drug use. Special focus has been given to children, adolescent and youths, focusing intervention in to early part of the cycle.

**Strategy 4:** Develop the capacity for sustainable response to drug use and HIV at all levels of administration through high commitment and strong leadership with information and resources to support it

**Strategy 5:** Enhance monitoring and evaluation on impacts of drug use related HIV/AIDS prevention and care programs in the country

**Strategy 6:** Develop a partnership among the Ministry of Health and Family Welfare, Ministry of Home Affairs, Ministry of Education, Ministry of Social Welfare, Ministry of Youth and Sports and Ministry of Women and Children Affairs to improve the effectiveness and efficiency in HIV/AIDS prevention and control measures targeting drug users

**INTRODUCTION**

Bangladesh is not basically a drug producing and drug consuming country. But it’s historically perspective, geographic proximity, ethnicity, traditional and heritage made it vulnerable to illicit drug trafficking and abuse. Drugs had been used in the sub-continent for memorable period of time. Opium, cannabis and alcohol existed all through Mughal and pre-British period. The British colonial rules introduced the consumption and commercial operations of drugs to earn revenue which continued even after liberation. Virtually, drug as a problems emerged mainly during mid-eighties which lead to various high risk behaviors. Particular concerns are injecting drug use and adverse health consequences such as blood borne viruses specifically HIV/AIDS, STI and Hepatitis C. Research evidence show that there is wide spread sharing of contaminated needles and syringes and with regards to sexual behaviors the majority of drug users visit sex workers and condoms are rarely used. Drug users are not an isolated community and their ability to transmit HIV/AIDS to the wider community is not in doubt.

HIV among PWID is a major public health concern in Bangladesh.[[5]](#footnote-5),[[6]](#footnote-6) The PWUD in the country are posing a serious risk to the country's healthcare system. There is an increased shift towards injecting drug use among drug users in the country. The problems associated with heroin use in Bangladesh are aggravated due to the country's widespread porous border with India, one of largest synthetic heroin producers[[7]](#footnote-7). However, fluctuations in heroin availability, purity and price have led many heroin users to change over to injecting drug use. Previous studies have also identified factors that have been associated with injecting synthetic drugs. In Dhaka, factors such as using drugs in groups or sharing needles/syringes were associated with recent onset of injections. Findings from the last Behavioral Surveillance Survey (BSS) conducted in 2006-07 reveal that 60 to 80 percent of PWID shared needles and syringes for their injection[[8]](#footnote-8).

There are few studies that explicitly address the impact of NEP services in Bangladesh[[9]](#footnote-9),[[10]](#footnote-10),[[11]](#footnote-11) Although there is no evidence to date that NEP causes increases in drug use, it is important to understand the relationships between trends of HIV transmission and the use of NEP programs. Information on such relationships is needed to address the potential spread of HIV among PWID and the many other health and social problems associated with drug use.

The revised 3rd National Strategic Plan for HIV and AIDS response 2011–2017, has the overarching goal of minimizing HIV transmission and the impact of AIDS at all levels of the Bangladeshi society through the four pillars of prevention; treatment, care and support; management and coordination and strategic information. These areas are reflected in the four objectives and their strategies, as well as in the programmatic targets of the implementation plan. Moreover, SDG Goal-3 and indicator 3.3 by 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis is also considered in the implementation plan. It was felt that based on the strategies, a comprehensive harm reduction strategy is needed to address the situation. The National AIDS/STD Programme (NASP), DGHS, MoHFW, Bangladesh took initiative to updated National Harm Reduction Strategy (NHRS). A core of different key stakeholders have experience in harm reduction activities facilitated the strategy development. The completed updated NHRS will provide the impetus and guidance to seek solutions to address the rapidly rising prevalence of HIV/AIDS among drug users and in turn will attempt to prevent the virus from spreading outwards to the wider community.

**WHAT IS HARM REDUCTION**

Harm reduction refers to policies, program and practices that aims to reduce the health, social and economic harms associated with the use of psychoactive drugs in people unable or unwilling to stop, without requiring people to stop using drugs[[12]](#footnote-12). Harm reduction is a pragmatic, non-judgmental set of strategies to reduce individual and community harm caused by drug use. The focus is on taking incremental steps to reduce harm rather than on eliminating drug use[[13]](#footnote-13).

For people who use drugs, harm reduction aims to prevent the spread of HIV/AIDS, hepatitis C and other blood-borne infections; reduce the risk of overdose and other drug-related fatalities; and decrease the negative effects drug use may have on individuals and communities[[14]](#footnote-14).

Harm reduction is a pragmatic response that focuses on keeping people safe and minimizing death, disease and injury associated with higher risk behavior, while recognizing that the behavior may continue despite the risks. At the conceptual level, harm reduction maintains a value neutral and humanistic view of drug use and the drug user. It focuses on the harms from drug use rather than on the use itself. It does not insist on or object to abstinence and acknowledges the active role of the drug user in harm reduction programs.

Harm reduction is not simply the provision of medical services. It has both public health and human rights at its core and as such, it requires that the elevated levels of stigma, discrimination and human rights abuses faced by people who inject drugs around the world be addressed. Evidence suggests that vulnerability and barriers to service access are heightened for particular groups who inject drugs, such as women, children and adolescents and sex workers[[15]](#footnote-15).

**COMPREHENSIVE PACKAGE OF SERVICES FOR PWID**

Harm reduction advocates often argue for the implementation of a wider range of interventions including for example, drug consumption rooms and peer naloxone distribution, for which there are growing evidence bases, as well as structural changes such as drug policy reform[[16]](#footnote-16). The WHO, UNODC, and UNAIDS have outlined a Comprehensive Package of Services[[17]](#footnote-17) to assist PWID who have HIV or are at risk of infection[[18]](#footnote-18). The package has been endorsed by both PEPFAR and the Global Fund. The WHO emphasized that the interventions were recommended based upon scientific evidence of their efficacy in preventing HIV infection and reducing other drug-related harms. The WHO has also noted that the interventions were most effective when deployed in combination.

**The Comprehensive Package includes:**

1. Needle and syringe programs (NSPs)

2. Opioid substitution therapy (OST) and other evidence-based drug dependence treatment

3. Antiretroviral therapy (ART)

4. HIV testing and counseling (HTC)

5. Prevention and treatment of sexually transmitted infections (STIs)

6. Condom distribution for people who inject drugs and their sexual partners

7. Targeted information, education, and communication (IEC) for people who inject drugs

and their sexual partners

8. Prevention, vaccination, diagnosis, and treatment for viral hepatitis

9. Prevention, diagnosis, and treatment of tuberculosis (TB)

**CORE PRINCIPLES OF HARM REDUCTION**

Harm reduction recognizes that drug use is a complex and multifaceted phenomenon that encompasses a continuum of behavior from abstinence to chronic dependence, and produces varying degrees of personal and social harm.

* **PRAGMATISM:** Harm reduction accepts that the non-medical use of psychoactive or mood altering substances is a near-universal human cultural phenomenon. It acknowledges that, while carrying risks, drug use also provides the user and society with benefits that must be taken into account. Harm reduction recognizes that drug use is a complex and multifaceted phenomenon that encompasses a continuum of behaviors from abstinence to chronic dependence, and produces varying degrees of personal and social harm.
* **HUMAN RIGHTS:** Harm reduction respects the basic human dignity and rights of people who use drugs. It accepts the drug user’s decision to use drugs as fact and no judgment is made either to condemn or support the use of drugs. Harm reduction acknowledges the individual drug user’s right to self-determination and supports informed decision making in the context of active drug use. Emphasis is placed on personal choice, responsibility and self-management.
* **FOCUS ON HARMS:** The fact or extent of an individual’s drug use is secondary to the harms from drug use. The priority is to decrease the negative consequences of drug use to the user and others, rather than decrease drug use itself. While harm reduction emphasizes a change to safer practices and patterns of drug use, it does not rule out the longer-term goal of abstinence. In this way, harm reduction is complementary to the abstinence model of addiction treatment.
* **MAXIMIZE INTERVENTION OPTIONS:** Harm reduction recognizes that people with drug use problems benefit from a variety of different approaches. There is no one prevention or treatment approach that works reliably for everyone. It is choice and prompt access to a broad range of interventions that helps keep people alive and safe. Individuals and communities affected by drug use need to be involved in the co-creation of effective harm reduction strategies.
* **PRIORITY OF IMMEDIATE GOALS:** Harm reduction establishes a hierarchy of achievable steps that taken one at a time can lead to a fuller, healthier life for drug users and a safer, healthier community. It starts with “where the person is” in their drug use, with the immediate focus on the most pressing needs. Harm reduction is based on the importance of incremental gains that can be built on over time.
* **DRUG USER INVOLVEMENT:** The active participation of drug users is at the heart of harm reduction. Drug users are seen as the best source of information about their own drug use, and are empowered to join with service providers to determine the best interventions to reduce harm from drug use. Harm reduction recognizes the competency of drug users to make choices and change their lives.

**COMMON CONCERNS ABOUT HARM REDUCTION**

* **Harm reduction enables drug use and entrenches addictive behavior:** This is rooted in the belief that drug users have to hit “rock bottom” before they are able to escape from a pattern of addiction and that harm reduction protects them from this experience. For those who do not want to quit, cannot quit, or relapse into drug use, harm reduction can effectively prevent HIV, hepatitis C and other drug-related harms. Harm reduction is often the first or only link that drug users have to the health and social service system and, as such, it is a gateway to addiction treatment. Harm reduction services increase the possibility that drug users will re-engage in broader society, lead productive lives and quit using drugs, instead of contracting and transmitting infectious diseases and/or succumbing to drug overdose death[[19]](#footnote-19).
* **Harm reduction encourages drug use among non-drug users:** This is based on the notion that harm reduction “sends out the wrong signal” and undermines primary prevention efforts. Some feel that helping drug users stay alive, reduce their exposure to risk and become healthier may encourage non-users to regard drug use as safe and to want to start using drugs. This view underestimates the complexity of factors that shape people’s decisions whether to use drugs. It also ignores numerous scientific studies that have found no evidence that the introduction of needle exchange or other harm reduction programs increases drug use[[20]](#footnote-20).
* **Harm reduction drains resources from treatment services:** Harm reduction interventions are relatively inexpensive and cost effective. They increase social and financial efficiency by interrupting the transmission of infectious disease at a lower cost, rather than waiting to treat complications of advanced illness at a much higher cost[[21]](#footnote-21).
* **Harm reduction is a *Trojan horse* for decriminalization & legalization:** Harm reduction attempts to deal with the harms from drug use as it occurs within the current global regulatory regime. Some advocates of harm reduction want to see changes in the way governments have been attempting to control the trade and use of currently illegal drugs; others do not. Harm reduction itself is neutral regarding the question of legalization[[22]](#footnote-22). The philosophy of harm reduction applies equally to alcohol and tobacco use, which is legal in most countries.
* **Harm reduction increases disorder & threatens public safety & health:** Often referred to as the “honey pot effect”, this concern assumes that harm reduction programs will attract drug dealers and compromise the safety and well-being of the surrounding community. Evidence has conclusively demonstrated that harm reduction programs do the opposite[[23]](#footnote-23). They have a positive impact on public health by reducing the prevalence of blood borne viruses such as HIV and hepatitis C. Needle exchange programs often recover more needles than they distribute, which means fewer used needles discarded publicly in the community. Supervised injection facilities reduce the number of public injections by providing a safe, indoor alternative to open drug use. Protocols between police and harm reduction service providers ensure drug trafficking laws are enforced – open drug dealing is discouraged, while drug users are encouraged to access needed services.

**HUMAN RIGHTS AND HARM REDUCTION**

Over the last decade, international endorsement for harm reduction has grown significantly, with an emerging consensus among multilateral agencies that harm reduction must be central to national responses to HIV, hepatitis C and drug use[[24]](#footnote-24). Today multiple UN human rights bodies have called on governments to implement harm reduction program as part of fulfilling the right to the highest attainable standard of physical and mental health, the right to benefit from scientific progress and its applications, and, in places of detention, to freedom from cruel, inhuman or degrading treatment or punishment. These include every holder of the mandate of the UN Special Rapporteur on the Right to Health, the current and former Special Rapporteurs on Torture, the UN Committee on Economic, Social and Cultural Rights and the UN Committee on the Rights of the Child[[25]](#footnote-25).

In 2009, the then UN High Commissioner for Human Rights recognized ‘the longstanding evidence that a harm reduction approach is the most effective way of protecting rights, limiting personal suffering, and reducing the incidence of HIV’, stressing that ‘this is particularly the case for those in detention, who are already vulnerable to many forms of human rights violations’[[26]](#footnote-26).

In 2013, the UN Committee on the Rights of the Child included harm reduction within its General Comment on the Child’s right to health (article 24 of the Convention on the Rights of the Child). General Comments are authoritative statements of the human rights treaty monitoring bodies providing normative guidance on the content of specific internationally protected rights. It is the clearest statement to date that appropriate harm reduction services must be considered a component of the right to health for children and young people under the age of eighteen who use drugs[[27]](#footnote-27).

Complementing this, the UN Committee on Economic, Social and Cultural rights continued to strengthen its positions on harm reduction, raising concerns with Ukraine in 2014 about “the punitive approach taken in the state party towards PWID, which results in high numbers of such persons being imprisoned”. The Committee also raised concerns about “existing regulations which restrict access to opioid substitution therapy (OST) and needle and syringe exchange (NSE)” and recommended, alongside efforts to address discrimination against people who use drugs “Allocating financial resources for the proper operation of opioid substitution therapy (OST) and needle and syringe exchange (NSE) program and increasing their coverage, as well as ensuring better access to such program in prisons program”[[28]](#footnote-28).

In 2015, the current High Commissioner supported this view, stating that ‘Criminalization of possession and use of drugs causes significant obstacles to the right to health’ and that ‘virtually all States urgently need far greater availability [*of harm reduction services*] in prisons’[[29]](#footnote-29). Both the Special Rapporteur on Torture and, more recently, the UN Human Rights Committee have deemed that the denial of harm reduction services can amount to cruel and degrading treatment, while the former UN Special Rapporteur on the Right to Health, Anand Grover, has stressed that States must ‘ensure that all harm reduction measures and drug dependence treatment services, particularly opioid substitution therapy, are available to people who use drugs, in particular those among incarcerated populations’[[30]](#footnote-30).

Most recently, UN Special Rapporteur on the Right to Health, Dainius Pūras, has called on States to commit the maximum available resources to scale up investment for harm reduction. He emphasized the need for ‘proactive and results-oriented discussion of harm reduction at the UNGASS and targets to be set on harm reduction scale up, both within and outside prisons and including access to naloxone to prevent opioid overdose’[[31]](#footnote-31).

**THE COST-EFFECTIVENESS OF IMPLEMENTING HARM REDUCTION**

HIV prevalence worldwide among people who inject drugs (PWID) is around 19%. Harm reduction for PWID includes needle-syringe programs (NSPs) and opioid substitution therapy (OST) but often coupled with antiretroviral therapy (ART) for people living with HIV. Numerous studies have examined the effectiveness of each harm reduction strategy. This commentary discusses the evidence of effectiveness of the packages of harm reduction services and their cost-effectiveness with respect to HIV-related outcomes as well as estimate resources required to meet global and regional coverage targets. NSPs have been shown to be safe and very effective in reducing HIV transmission in diverse settings; there are many historical and very recent examples in diverse settings where the absence of, or reduction in, NSPs have resulted in exploding HIV epidemics compared to controlled epidemics with NSP implementation. NSPs are relatively inexpensive to implement and highly cost-effective according to commonly used willingness-to-pay thresholds[[32]](#footnote-32).

There is a well-established evidence base for the effectiveness and cost-effectiveness of harm reduction interventions in preventing HIV infection among people who inject drugs. As a result, harm reduction has been endorsed by UN agencies, scientific research bodies and many governments around the world[[33]](#footnote-33). International guidance states that implementing priority harm reduction interventions to sufficient coverage levels would have substantial positive impact upon HIV epidemics among people who inject drugs.

Over the past decade the body of research into the cost-effectiveness of harm reduction has also grown. It is now indisputable that harm reduction works, is cost-effective and can be implemented successfully in a variety of settings. In Australia, for example, it was estimated that every dollar invested in NSPs returned four dollars in healthcare savings[[34]](#footnote-34). In eight countries in Eastern Europe and Central Asia, NSPs were found to be extremely cost-effective when considering prevention of both hepatitis C and HIV infections, with a return on investment of between 1.6 and 2.7 times the original investment[[35]](#footnote-35). The National Institute on Drug Abuse in the United States concluded that methadone treatment is ‘among the most cost-effective treatments, yielding savings of $3 to $4 for every dollar spent’[[36]](#footnote-36). Similarly, studies from China concluded that investment in OST provision would yield substantial savings for the government through averted HIV infections and decreased HIV treatment costs[[37]](#footnote-37). Research suggests that the combined implementation of harm reduction interventions and HIV anti-retroviral therapy for people who inject drugs offers the highest return on investment. This has been demonstrated by modelling the potential impact of scaled-up NSPs, OST and HIV testing and treatment in Kenya, Pakistan, Thailand and Ukraine from 2011 to 2015[[38]](#footnote-38). Researchers have also found that the peer distribution of naloxone to people who inject drugs is among the most cost-effective of all lifesaving interventions[[39]](#footnote-39).

As a result, they averted HIV epidemics PWID and maintained HIV prevalence rates of less than 1% among people who inject drugs. Where harm reduction approaches have not been adopted, or have limited coverage, much higher HIV prevalence among people who inject drugs can be seen, such as 16% in the US, 37% in Russia and 36% in Indonesia[[40]](#footnote-40).

***Economic analysis also reinforces the mathematical modeling results: the benefit-cost ratio for the harm reduction program that has been implemented in Dhaka during the last 15-year period was 1.37 and, hence, the program satisfied the standard criterion of return on investment (ratio above 1 indicates return on investment)*** – the amount of return generated by the program is higher than the cost of investment[[41]](#footnote-41).

The cost per HIV infection prevented over the first 3 years was US$110.4 (33.1–182.3). The incremental cost-effectiveness of continuing the intervention for a further year, relative to stopping at the end of year 3, is US$97 if behavior returns to pre-intervention patterns. When baseline PWID HIV prevalence is increased to 40%, the number of HIV infections averted is halved for the 3-year period and the cost per HIV infection prevented doubles to US$228[[42]](#footnote-42).

**ENDING THE CRIMINALIZATION OF PWID**

Punitive approaches to drug use have also resulted in criminal law forming the lead strategy for addressing drug use in our societies. This has produced enormous health, social and economic harms. Criminal records are handed down in almost every country for possession offences. Although often seen as a minor penalty, a criminal record damages not only one person’s life chances but often their children’s too. They limit the ability of people to enter the workforce and contribute to society.

Many countries impose custodial sentences for possession. The resulting mass incarceration of people who use drugs is both a human rights and public health crisis. People who inject drugs make up one third to one half of prison populations, and levels of injecting drug use in prisons are high[[43]](#footnote-43). Yet as of 2015, only seven countries or territories implement NSPs, and just 44 implement OST in prison[[44]](#footnote-44). As needles and syringes are scarce in prison, people who inject drugs are often forced to make or share injecting equipment, and sometimes up to 20 individuals inject with the same equipment,(39) fuelling HIV and hepatitis C infection[[45]](#footnote-45).

HIV, hepatitis C and tuberculosis (TB) have emerged as especially severe problems in prison systems worldwide. TB is one of the leading causes of mortality in prisons in many countries[[46]](#footnote-46), with rates up to 81 times higher in prisons that in the broader community[[47]](#footnote-47). Global HIV prevalence, for example, is up to 50 times higher among the prison population than in the general public[[48]](#footnote-48), while one in four detainees worldwide is living with hepatitis C[[49]](#footnote-49), in comparison to, for example, one in 50 people in the broader community in Europe[[50]](#footnote-50). These figures reflect the urgent need for a rethink of the current global approach to drugs, orienting goals and investments away from prohibition and towards health and human rights.

The harm reduction approach does not include the criminalization and imprisonment of people who use drugs, some of whom are in need of health or social support. Decriminalizing personal possession of drugs and ending the mass incarceration of people who use drugs are a priority for a Harm Reduction Decade. Supportive legal and policy environments are necessary for the full potential of harm reduction to be realized.

**PRESENT SCENARIO OF HARM REDUCTION**

The present scenario of harm reduction program in global, regional and country are given below:

**GLOBAL SCENARIO**

Drug use is a worldwide phenomenon, and drug use occurs in almost every country. The specific drug or drugs used varies from country to country and from region to region. The United Nations World Drug Report estimates that cannabis, or marijuana, is the most widely abused substance in all parts of the world[[51]](#footnote-51). Injecting drug use has been documented in at least 158 countries and territories worldwide[[52]](#footnote-52). The United Nations Office on Drugs and Crime (UNODC), Joint United Nations Program on AIDS (UNAIDS), World Health Organization (WHO) and the World Bank estimate that there are 12.7 million (range: 8.9–22.4 million) people who inject drugs (PWID), globally [[53]](#footnote-53). Among them, 13.1 per cent or 1.7 million people (range: 0.9–4.8 million) are living with HIV[[54]](#footnote-54) and more than 60% live with the hepatitis C virus with wide variations between regions and countries large regional variation[[55]](#footnote-55).

Of the 158 countries reporting injecting drug use 91 of these adopting harm reduction in national policy and practices, while needle and syringe exchange program (NSPs) and opioid substitution therapy (OST) are available in 90 and 80 countries or territories respectively[[56]](#footnote-56). However, in most of the countries where these programs are implemented, coverage remains extremely low. For example, only an estimated 10% of people who inject drugs access NSPs in Eastern Europe[[57]](#footnote-57). Similarly for OST, recent estimates suggest that 6–12% of people who inject drugs receive OST globally[[58]](#footnote-58). Globally eight countries providing harm reduction intervention at prison settings[[59]](#footnote-59).

UN agencies (UNODC, UNAIDS and WHO) recommend a package of nine core harm reduction interventions for HIV prevention, treatment and care among people who inject drugs. Among these, NSP and the provision of OST such as methadone and buprenorphine are prioritized[[60]](#footnote-60).

Relapse following drug treatment is common. It has been reported globally even in countries with high rates of completion of inpatient treatment: 33% in Nepal[[61]](#footnote-61), 55.8% in China[[62]](#footnote-62) and 60% in Switzerland[[63]](#footnote-63) relapsed into drug use between 1 month and 1 year after discharge from treatment programme. Multiple factors, such as post-treatment incarceration, mental or other comorbid disorders, craving for drugs and withdrawal symptoms, are reportedly associated with relapse[[64]](#footnote-64) [[65]](#footnote-65).

Opioids are potent respiratory depressants, and overdose is a leading cause of death among people who use it. Worldwide, an estimated 69 000 people die from opioid overdose each year[[66]](#footnote-66). Among people who inject drugs, opioid overdose is the second most common cause of mortality after HIV/AIDS[[67]](#footnote-67). A recent rise in opioid-overdose deaths in a number of countries is associated with an increase in the prescribing of opioids for chronic pain[[68]](#footnote-68) [[69]](#footnote-69). In 2010, an estimated 16 651 people died from an overdose of prescription opioids in the United States of America alone[[70]](#footnote-70).

**REGIONAL SCENARIO**

An estimated 3–5 million people who inject drugs live in Asia[[71]](#footnote-71), with an estimated 1.3 million opioid users residing in China[[72]](#footnote-72). Since 2012, new population size estimates are available for people who inject drugs from Cambodia, China, Indonesia, Nepal, Philippines and Vietnam[[73]](#footnote-73). Unsafe injecting drug use is a major driver of the HIV epidemic in many Asian countries, including Indonesia, Pakistan and the Philippines, where HIV prevalence among people who inject drugs continues to grow rather than stabilize[[74]](#footnote-74).

Although harm reduction is becoming increasingly accepted across the region, a largely punitive policy and legal environment remains firmly in place, undermining access to life-saving harm reduction programs, and directly blocking progress towards United Nations 2011 Political Declaration on HIV/AIDS targets to reduce the transmission of HIV among people inject drugs by 50% by 2015[[75]](#footnote-75). There are 11 countries that still have compulsory centers for people who use drugs, and 15 that still have the death penalty for drug-related offences[[76]](#footnote-76).

In certain countries, the early implementation of harm reduction services in the form of needle and syringe programs (NSPs) and opioid substitution therapy (OST) contributed to a significant drop in HIV prevalence among people who inject drugs. Nepal, for example, saw rates of HIV prevalence decline drastically from 68% in 2002 to 6.3% in 2011[[77]](#footnote-77). However, examples such as this are few, and although harm reduction coverage has been increased in Bangladesh, China, India, Indonesia, Malaysia Myanmar, Taiwan and Vietnam, the pace and scale up has been too slow to have a significant impact on reducing HIV transmission among people who unsafely inject drugs[[78]](#footnote-78).

Stimulant use across the region has also greatly expanded[[79]](#footnote-79), and several countries have already seen a trend for amphetamine-type stimulants (ATS) far exceed use of opiates. Few countries, however, report the existence of harm reduction services in response to the growing use of ATS[[80]](#footnote-80). In a study undertaken as far back as 1999 of 32 survey respondents in a treatment center in Japan, 53.8% used methamphetamine as their drug of choice, of whom 82.1% reported needle sharing[[81]](#footnote-81).

**BANGLADESH SCENARIO**

Bangladesh has a long history and tradition of illicit drug use, particularly of opium and cannabis. From the British period until 1984 registered opium users were provided with opium through government regulated licensed vendors. Following the prohibition of particular drugs such as opium and cannabis other illicit substances appeared on the market. The chronological flow chart of drug reveals that there had been emergence heroin during early eights, phensidyl (codeine preparation) during early nineties, injecting drug at the beginning of the present century, yaba (containing a mixture of methamphetamine and caffeine) (ATS) during 2005, and glue sniffing during 2008[[82]](#footnote-82). Currently other drug also use as buprenorphine in a synthetics form, pethadine and various tranquilizers drug. At the same time PWID was emerging but it was not until the mid-1990s that such practices became common place mainly in the cities of Dhaka and Rajshahi. According to intelligence sources at the Department of Narcotics Control (DNC), heroin is the deadliest of drugs in Bangladesh. In recent times, Yaba has gained popularity and has become a "fashionable" drug.

The mostly porous borders that Bangladesh shares with India are well suited to the smuggling of drugs and various trafficking routes have been identified. Various social and economic factors have likely contributed to conditions favorable to the spread and rise of drug use. The estimates of total drug users in the country vary with figures ranging from 500,000 to 4.6 million. A recent study was conducted in 21 districts on Mapping study and size estimation of the key population in Bangladesh for HIV/AIDS Programs 2015-2016, found that the estimated PWID ranging (26186 to 33067)[[83]](#footnote-83).

Bangladesh has so far contained the spread of HIV and consistently maintained a national HIV prevalence below 0.1 percent in the general population[[84]](#footnote-84) and below 1 percent among key populations (KPs) [[85]](#footnote-85). The only KPs where a concentrated epidemic has been recorded in male PWID in Dhaka, the prevalence was 5.3% in 2011, down from 7% in 2007. HIV prevalence at, or just above 1% was found among male PWID in Narayanganj (1.5%); females who use drugs in Dhaka/Tongi/Narayanganj and Benapole (1.2% and 1% respectively)[[86]](#footnote-86).

Surrogate markers of risk - hepatitis C (HCV) rates for unsafe injection and active syphilis for unsafe sex were measured. HCV rates among PWID varied in different geographical areas: HCV prevalence ≥30% was detected in 10 cities including Dhaka where the rate declined significantly over the years from 66.5% in 2000 to 39.6% in 2011 (p<0.01)[[87]](#footnote-87).

The first case of HIV in Bangladesh was detected in 1989 and up until December 2015 the total number of detected cases was 4,143 of whom 658 have died, leaving 3,485 known people living with HIV[[88]](#footnote-88). About one third of detected PLHIV are women and about 40% of cases are migrant-related (migrants and their spouses)[[89]](#footnote-89). However, the majority of infections are likely to remain undetected, and the total national estimate is about 9,000 PLHIV[[90]](#footnote-90).

Analysis of information from the HTC centers showed that between 2007 and 2013, HIV was detected in 60 out of 64 districts. However, 74% were concentrated in 12 districts: Dhaka, Sylhet, Chittagong, Comilla, Khulna, Moulavibazar, Cox’s Bazar, Munshiganj, Noakhali, Narayanganj, Chandpur and Gazipur. The heaviest affected districts were Sylhet, Munshiganj, Moulavibazar, Dhaka, Khulna and Cox’s Bazar. [[91]](#footnote-91)

Migrants constituted between 33.3%-46.3% of annual cases, with no clear trend over time[[92]](#footnote-92). However an increase was seen among spouses of migrants, who constituted around 10% of detected cases since 2011. In two Divisions-Sylhet and Chittagong -more than 50% of all cases were migrant-related. Although the number of infections is still low, Bangladesh is one of the four countries in the region where the epidemic continues to increase[[93]](#footnote-93). The geographical distribution of all HIV cases detected either through surveillance or through case detection for each KP and migrants are depicted in maps[[94]](#footnote-94) which clearly show HIV positive KPs are mostly located in Dhaka, while migrants are scattered all over Bangladesh.

The pattern of behaviors that boost the spread of the HIV infection is well established in the Bangladesh society[[95]](#footnote-95). A recent study undertaken in 2015-2016 among PWIDs indicated that nearly 28.4 percent male and 31.5% female PWID shared needles and syringes in the last week. The percent of PWID-Male who visit female sex workers was estimated to 40 percent. Although a significant portion of the male PWIDs reported to use condom during their last sex with sex workers; condom use with their regular partners or spouses was reported to 45.4 percent[[96]](#footnote-96). Moreover, selling sex to procure drugs is quite common in many parts of Bangladesh. Evidence shows that some female drug users in Bangladesh turn to sex work out of financial necessity to support their addiction[[97]](#footnote-97). The overlap between sex work and PWID is considered to be among the most dangerous conditions for rapid spread of HIV and other Sexually Transmitted Infections (STIs) and more opportunities for transmission to the general population[[98]](#footnote-98). Women who are involved in commercial sex are very often largely dependent on their partners for the procurement and use of drugs.

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

The number of drug treatment beds is considered completely inadequate for the number of drug users seeking help. The expansion of increasing drug treatment beds is currently a major challenge which is not just related to the cost involved but also the lack of capacity among drug treatment workers to service the number of drug users in the country. Drug treatment programs are mainly limited to the process of detoxification over a period of two weeks and the overall follow up aftercare is regarded as erratic to poor. The relapse rate for those completing drug treatment in Bangladesh is on average more than 60-90%[[99]](#footnote-99).

**NATIONAL RESPONSE**

The Government of Bangladesh (GOB) has a strong political history of commitment to the HIV response. Bangladesh responded to HIV and AIDS before the first case was detected in 1989.The early response helped keep the HIV epidemic from expanding beyond its current level. Comprehensive and strategically viable prevention measures helped in avoiding a gradual spread of HIV from key populations to the general population.

HIV prevention programs for KPs were initiated in Bangladesh in the mid-1990s and since then the services have been massively scaled up[[100]](#footnote-100). From the start, emphasis was given to surveillance, which would provide evidence, on which to base program decisions. The National AIDS Committee (NAC) was formed in 1985, four years before the first case of HIV detected in the country. The Chief Patron of NAC is the President of Bangladesh, and the MOHFW is the Chair. The NAC is the highest decision making body on issues related to AIDS and STIs and act as an advisory body responsible for formulating major policies and strategies on HIV/AIDS in Bangladesh. NAC also supervises program implementation and is responsible for mobilizing resources. The National AIDS/STD Program (NASP) is the body established by the Ministry to manage the NASP in the country.

Bangladesh was the first country in the region to adopt a comprehensive national policy on HIV/AIDS and STIs in 1997[[101]](#footnote-101), and then also developed the first National Strategic Plan for HIV/AIDS, 1997-2002. This was reviewed in 2005 and the second National Strategic Plan for HIV/AIDS 2004-2010 was adopted. The third National Strategic Plan was developed by NASP in 2011 to provide a framework for the national response to HIV and AIDS up until 2015, building upon the two previous NSPs, as well as the National Policy on HIV/AIDS and STD Related Issues. This revised and extended version of the 3rd NSP incorporates commendations and changes from the mid-term review process undertaken in the first half of 2014.

**PROGRAMATIC RESPONSE**

# CARE Bangladesh established SHAKTI Project 1995 with funding from the DFID. Primarily, the SHAKTI project has been promoting safer injecting practices among PWIDs and safer sex practices among CSWs and partners’ of CSWs[[102]](#footnote-102).

HIV/AIDS Prevention Project (HAPP) was the first major projects under NASP which was supported by World Bank and DFID. More than 100 NGOs were involved in the implementation of HAPP during 2004-2007. HIV/AIDS Targeted Intervention (HATI) was supported by the World Bank financed Health, Nutrition and Population Sector Program at 2008-2009. HIV/AIDS Intervention Services (HAIS) program was supported by World Bank financed Health, Nutrition and Population Sector Program (HNPSP) during 2009-2011 and intervention packages for (i) brothel based sex workers, (ii) street based sex workers, (iii) hotel and residence based sex workers, (iv) clients of sex workers, MSM, MSW and hijra (v) PWIDs. In 2011-2016, the HIV/AIDS Prevention Services (HAPS) program is supported by the HPNSDP). It implements intervention packages for FSWs, MSW, hijra and PWIDs. The HAPS will also be rolling out interventions among PLHIV and migrants as well by 2014. Funds are channeled through NASP.

Bangladesh AIDS Programme (BAP) was funded by USAID and implemented during 2000-2009. Modhumita was launched as the follow on to BAP and implemented through FHI, SMC and BCCP during 2009-2014.

In 2009-2014, Enhancing Mobile Populations’ Access to HIV & AIDS Services, Information and Support (EMPHASIS) aims to reduce the HIV vulnerability of mobile populations across the border areas of Bangladesh, India and Nepal.

The Link Up programme, funded by the Dutch Ministry of Foreign Affairs, aims to improve sexual and reproductive health of young people most affected by HIV and to promote the realization of young people’s sexual and reproductive rights at 2013-2015.

GF Round 2: Prevention of HIV/AIDS among Young People in Bangladesh. Save the Children USA worked as management agency and 16 NGOs implemented the activities across the country during 2004-2009. In 2007-2009, GF Round 6: HIV Prevention and control among High-Risk populations and vulnerable Young People in Bangladesh. A total of 45 NGOs/CBOs and academic organizations through 13 consortiums implemented the activities. GF Rolling Continuation Channel (RCC) R2: Expanding HIV prevention in Bangladesh during 1009-2016[[103]](#footnote-103).

**METHODOLOGY**

A core group comprised of different key stakeholders was formed to facilitate the National Harm Reduction Strategy (NHRS) development. The core group develop the guideline and process of strategy development and decided to appoint a national consultant with significant experience to facilitate the process. The national consultant (NC) was recruited by new funding model of global fund on behalf of the National HIV/STD Programme (NASP) to develop a National Harm Reduction Strategy over a period of 20 days. The first task by the consultant was to collect documents from nation and international organization including UN Agencies and review the collected documents. Two workshops were conducted with core group stakeholders. The first workshop held on September 26, 2016. A presentation of a global, Asia and Bangladesh overview of drug use and HIV/AIDS was conducted by the NC. The National Strategic Plan for HIV/AIDS 2011 – 2017 has as an objective of the need to the Priority Groups of People. PWUD. A subcomponent of this objective states the need to Provide Support and Services to Drug Users. This subcomponent was briefly reviewed and followed by a discussion among the stakeholders of strengths and weaknesses of the multiple harm reduction strategies implemented as prevention measures against HIV/AIDS, HVC and TB among drug users.

A series of individual and group interviews with all stakeholders was conducted by the consultant in association with representative of Global Fund and NASP. All interviews/discussions focused on the current constraints of implementing the multiple harm reduction strategies, suggested solutions to these constraints and to enquire as to what areas should be the covered in the update National Harm Reduction Strategy (NHRS). Each discussion also incorporated a high degree of advocacy on various issues of harm reduction. Two field visits were undertaken to the drop-in-center in Dhaka, organized and conducted group and individual sessions with PWUD, Peer Educators and DIC in-charge.

All information collected was reviewed and incorporated in the drafting the NHRS. A draft version of National Harm Reduction Strategy (NHRS) was sent out to stakeholders prior to the second workshop on October 30, 2016. Discussion and comments on the draft NHRS was documented and suggestions for improvement was incorporated during the refinement of the draft document. Discussion of the draft NHRS was documented and stakeholders were encouraged to email the NC for any further comments. Suggestions for improvement were incorporated during the refinement of the draft document.

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

**THE ROLE OF HR IN HIV/AIDS PREVENTION AND CONTROL**

While there are differences among the approaches of supply, demand and harm reduction, international research evidence shows they can also complement each other - resulting in a favorable environment in which it is possible to contain illicit drug use and address public health problems such as HIV/AIDS and Hepatitis C among PWIDs. Harm reduction gives priority to the more urgent and practical goals of reducing harm for drug users who do not have the capacity and/or resources to stop/off from using drugs at the present time. The approach acknowledges that no method to totally eliminate drug use has been demonstrated in any part of the world and that HIV/AIDS presents a more serious global threat than the drug itself. In many parts of the world HIV/AIDS is considered a public health emergency impacting upon drug using communities. It is under these circumstances that harm reduction can be viewed as a short term measure to achieve the long term goals of reducing the level of HIV/AIDS in the community and working towards keeping drug users alive and free of drug use. Harm reduction approaches have demonstrated to be both effective and cost effective in reducing the spread of HIV among and from PWIDs[[104]](#footnote-104)[[105]](#footnote-105). Harm reduction interventions have been shown to be safe, and international research evidence has shown that it does not lead to an increase in number of drug users, or the frequency of drug use.

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

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

Harm reduction approaches are increasingly adopted and adapted to the needs of different countries or communities providing an alternative approach and framework to deal with drug using problems. An increasing number of Muslim nations - Iran, Indonesia, Malaysia, Pakistan, Tajikistan, and Kyrgyzstan - have also implemented various harm reduction interventions including either or both substitution therapy programs and needle and syringe distribution. Controversy is often in the shadow of harm reduction yet it has a long history of producing meaningful benefits for individuals and communities. Harm reduction principles are shown to be pragmatic, humane, effective and holistic and as a result have provided many opportunities for further interventions to reduce adverse health, social and economic consequences.

**SCOPE OF THE NATIONAL HARM REDUCTION STRATEGY**

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

The multiple strategies of harm reduction approaches that are implemented in various environments and cultures are based on scientific evidence. The various harm reduction strategies for Bangladesh will include advocacy and policy adjustment; NSPs, Antiretroviral Therapy (ART), Opioid Substitution Therapy (OST) and other evidence-based drug dependence treatment, HIV Testing and Counseling (HTC), prevention and treatment of Sexually Transmitted Infections (STIs), distribution of condom, BCC/IEC including their sexual partners, prevention, vaccination, diagnosis, and treatment for viral hepatitis and prevention, diagnosis and treatment of tuberculosis (TB). Despite this, relapse prevention management and overdose management, capacity building of the service providers and government health system.

Taking the National Strategic Plan for HIV/AIDS 2017-2021 as the basis and considering the current situation of drug use and HIV in Bangladesh and ongoing programme initiatives following strategies are formulated.

**RATIONALE FOR THE NATIONAL HARM REDUCTION STRATEGY**

All the successive sero-surveillance data show that Bangladesh is still a low HIV prevalence country, <1% prevalence in all the high risk behavior population groups except the injecting drug using population. Drug users are as a result of their risk behaviors increasingly vulnerable to life threatening blood borne viruses such a HIV/AIDS and Hepatitis C. The 9th surveillance data shows that HIV prevalence the highest rate of HIV continues to be PWID in Dhaka but the prevalence declined to 5.3% from 7%[[106]](#footnote-106) (in the 8th round). However, the decline is not statistically significant. Fortunately, the localization of the PWID epidemic to one neighborhood of Dhaka observed in previous years has also remained. HIV was also detected in another four groups of people who use drugs (PWUD) - male PWID from Narayanganj (1.5%) and Satkhira (0.4); female combined PWID and heroin smokers from Dhaka, Narayanganj, Tongi (1.2%) and Benapole (1%). Active syphilis rates at >5% was detected among six groups of PWUD and the highest proportion was found in male PWID in Norsingdi (7.9%), followed by PWID in Chandpur (6.1%) and female PWUD in Dhaka, Tongi and Narayanganj (5.9%). High active syphilis rates suggest practice of unsafe sex.

Antibodies to Hepatitis C virus (HCV) were measured in all PWID and groups of combined PWID and heroin smokers but not in the groups consisting of only heroin smokers. The rates varied in the different cities and in six cities >50% were HCV positive. The higher prevalence for HCV was found among PWID from several cities of Rajshahi Division with Kanshat having the highest prevalence (95.7%). In Dhaka HCV rates have declined significantly (P<0.05) over the rounds of surveillance.

The revised 3rd National Strategic Plan for HIV and AIDS response 2011 – 2017, has the overarching goal of minimizing HIV transmission and the impact of AIDS at all levels of the Bangladeshi society through the four pillars of prevention; treatment, care and support; management and coordination and strategic information. These areas are reflected in the four objectives and their strategies, as well as in the programmatic targets of the implementation plan.

Considering the cost, effectiveness, human rights, public health and epidemiology of the HIV infection, the National Strategic Plan for HIV/AIDS, 2017-2021, has an emphasis on drug use related interventions and articulated the issues as sub component of objective one. With that background, there has been a growing consensus that IDU intervention needs a comprehensive package of intervention beyond NSEP. Injecting drug users are currently the most vulnerable group in the country and as part of a national response concerted targeted efforts to avert a potential explosive HIV epidemic have been deemed necessary. A core national expert group has suggested the need for an updated national harm reduction strategy as a first step to guide to create enabling environment and development of comprehensive service package for PWID intervention.

**GOAL OF THE NATIONAL HARM REDUCTION STRATEGY**

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

**Strategy 1: Strengthen understanding of drug using patterns, locations, and**

**strengthen research on drug use.**

***Implementing strategy:***

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

1.2 Strengthen research networks among the Department of Narcotics Control and Law enforcement, Ministry of Home Affairs, Ministry of Health and Family Welfare, Ministry of Education, NASP, National and International research organizations.

**Strategy 2: Strengthen and expand program to reduce and eliminate the harm**

**caused by drug injecting practices all over the country**

***Implementing strategies:***

2.1 To ensure access to harm reduction and prevention interventions i.e. NSPs, ART, OST and other evidence-based drug dependence treatment, HTC, STIs management, distribution of condom, BCC/IEC activities including sexual partners, prevention, vaccination, diagnosis, and treatment for viral hepatitis and prevention, diagnosis and treatment of TB;

2.2 To increase local community understanding and acceptance of harm reduction, drug detoxification, and treatment and rehabilitation program;

2.3 To strengthen and expand the involvement of CBO/SHG consisting of current and

ex-drug users in program planning, implementation, monitoring and evaluation;

***Needle Syringe Exchange Program:***

2.4.1 To ensure the availability, accessibility and affordability of new needle syringe, appropriate, at all-time and accepted by the PWID to prevent further risk behaviors;

2.4.2 Develop clear policies and guidelines on occupational health and safety issues i.e. timely and appropriate disposal (incinerators) of used equipment/materials either on the premises or a hospital.

2.4.3 Suitable disposable containers must be provided at DIC for the use of staff and peer educators. Collection should be undertaken by outreach workers, peer educators and/or DIC staff from outreach;

***Antiretroviral Therapy (ART):***

2.5.1 To advocate for the availability, affordability and accessibility of antiretroviral (ARV) medications as part of the prevention approach to the HIV+ PWID in a friendly environment following 90-90-90 model[[107]](#footnote-107), agreed and signed by government. Ensuring integrated intervention i.e. Oral drug substitution therapy (OST), ARV and NEP for HIV+ PWID;

2.5.2 To develop and strengthen the government health system to ensure for effective comprehensive intervention i.e. OST, ARV and NEP through government health system;

***OST Services:***

2.6.1 To ensure availability, accessibility and affordability of Opioid Substitution Therapy (OST) for the PWID, special prefer/attention will be given to the children and women;

2.6.2 An evidence based guidelines will be developed for training of the medical practitioners for prescribing substitution therapy;

2.6.3 To develop and expand opioid substitution therapy program outside of Dhaka to cover the more PWID. To involve more organizations to implement OST services for sustainability and cost effectiveness;

2.6.4 To ensure OST service from any service center and reduce the drop-out rate a uniform ID card will be issued among the OST users;

***Drug detoxification, treatment and rehabilitation:***

2.7.1 To improve and expand the drug detoxification, treatment and rehabilitation (institutional, potential home based and community based camps) following the eight domains: intake and screening, assessment, treatment planning, documentation, case management, discharge and continuing care, referral and ethics[[108]](#footnote-108). Children and adolescents will be given preference at the time of selecting drug users for drug treatment and rehabilitation;

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

***HIV Testing and Counseling (HTC):***

2.8.1 Develop a guideline to maintain the quality of the HTC services and ensure privacy throughout the process;

2.8.2 To develop a mechanism for ensuring 90 percent of PWUD through HIV testing and counseling at DIC or government health system.

***STI Syndomic Management:***

2.9 To ensure prevention and treatment of Sexually Transmitted Infections (STIs) management guideline in place and offer treatment following guideline. Identified STI case management will be completed at DIC and management of complicated cases through referral services to the government health system or NGO clinics;

***Distribution of condom:***

2.10 To develop a guideline for distribution of condom among the PWUD and their sexual partners considering their need. To ensure correct and consistent use of condom outreach workers and peer educators organize and conduct condom demonstration session at outreach and DIC and distribution of condom considering their requirement;

***BCC/IEC:***

2.11.1 To develop a process for increasing knowledge on harms associated with drug use, STI, HIV/AIDS, safer sex, hepatitis B & C and TB to the drug user including their sexual partners.

2.11.2 BCC/IEC material to be developed in the said issues and distribute among drug users, community people and civil society;

***Hepatitis B and C:***

2.13 To develop a protocol on diagnosis, treatment and vaccination of viral hepatitis B and C to the PWUD including outreach worker and peer educator to prevent hepatitis B and C. To ensure the quality and appropriateness, a renowned medicine company to be hired through bidding process for providing hepatitis B and C vaccine;

***Tuberculosis (TB):***

2.14.1 To ensure the diagnosis and treatment of tuberculosis among the PWUD a

guideline will be in place.

2.14.2 Diagnosis and treatment will be ensured at DIC or government hospital or NGO

clinic through referral system. Follow-up mechanism to be developed to ensure

the complete treatment of the TB patient;

***Relapse Management:***

2.15.1 To increase the knowledge regarding relapse management a guideline will be in place.

2.15.2 To reduce relapse rates after drug detoxification, treatment and rehabilitation involvement of the family members and public health service providers in early intervention and relapse prevention management;

***Overdose Prevention Management:***

2.16.1 To develop a mechanism regarding overdose management a guideline will be in place.

2.16.2To increase the knowledge on overdose management through IEC/BCC activities to the PWID, outreach workers and peer educators. Enhance capacity to the service providers regarding the handle of overdose management.

***Prison setting intervention:***

2.17.1 To strengthen and/or create drug detoxification facilities inside prisons of a standard that is available and following the narcotics control act 1990 that “The government may declare any government hospital or health centre including a jail hospital as a narcotics addiction treatment centre by notification in the official gazette”[[109]](#footnote-109);

2.17.2 Developing a peer education program inside the prison would be an efficient and effective means of disseminating information and knowledge on basic health to the inmates and guards following IEC/BCC activities. To involve inmates in the design, develop and distribute health education materials in order to increase their appropriateness and range of reaching;

2.17.3 To develop a pre-release program to reintegrate PWUD into the general community and linkage to drug treatment and HTC facilities;

**Population:**

2.18.1 To ensure harm reduction services for drug users including children, adolescent, women and prison inmates. Moreover, street based drug users those from more affluent backgrounds that often remain hidden and fear exposure to be covered.

***Children and adolescent***

2.18.2 To develop services to the children, adolescent and female drug users considering their context and need, where necessary. Children, adolescent and female drug users often present with various other needs e.g. reproductive health, supports services to reduce discrimination and stigma of the female drug users in relation to seeking health services etc. Despite this, to ensure services to the women particularly drug users and HIV+ during pregnancy and after delivery.

**Modalities:**

***Drop -in- Centre:***

2.19.1 To ensure standard and quality harm reduction services considering the needs of PWUD, a safe and secure place where PWUD enjoy required services with non-judgmental attitude and uphold human rights and dignity for all drug users. Harm reduction service should be operated following standard operation guideline. Moreover, to determine the operational hours of the DIC the PWUD will be consulted;

2.19.2 To ensure that each DIC has the mechanisms in place to facilitate a enabling relationship, partnership and involvement of the community leaders, religious leader, medical person, civil society and family members of PWUD. This will require the development of a DIC working group that has participation of DIC representation, the local police officials in any situation;

2.19.3 To develop a local level official agreement between each DIC and local police station with the objective to minimize harassment. Develop a mechanism to provide uniform ID card to the PWUD issued by local police officials, DNC and NASP subject to reduce harassment. Despite this, an official document/letter from policy level officials and DNC, MoHA to reduce potential harassment of DIC staff and PWUDs;

***Outreach Based Services:***

2.20 To ensure coverage through HR package outreach service to be provided by the outreach workers and refer PWUD to DIC if faces any complication. For ensuring quality service and coverage, outreach workers vs. drug users’ ratio should be determined;

***Peer Education:***

2.21 To strengthen peer education programs capacity building training, appropriate supervision, mentoring and coaching to be provided to the peer educator. Although, peer educators are mostly recruited on voluntary basis a criteria for selecting a peer educator should be in place;

***Capacity building initiatives****:*

2.22.1 To ensure and develop the capacity of the DIC staff including outreach workers and peer educators through different training i.e. harm reduction, counseling, outreach services, overdose management, relapse education & management, drug detoxification, treatment and rehabilitation, sexual health education, and exposure visit, coaching and mentoring. For providing the quality and effective training, national and international resource persons will be hired for facilitation of the training;

2.22.2 To develop a mechanism to continue capacity building training to the government health system including prison health service providers and officials. This is for ensuring health service and drug detoxification, treatment and rehabilitation program to be started at government hospital and prison setting without any stigma and discrimination. To ensure quality and effective training, national and international resource persons will be hired for facilitation of the training. Moreover, evidence based program should visit the government officials and health service providers;

***Advocacy and networking:***

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

2.23.2 To ensure that there is a mechanism in place for systematic sensitization of the government health system, and to improve capacity for ensuring health services of the drug users at public health facilities. Since a public health facility is a permanent setup, it would be a sustainable option for continuation of health services which is called “Margin to mainstreaming of health service”;

***Network among the treatment centers***

2.24.1 To utilize the resources for drug detoxification and rehabilitation a network to be established consisting of the agencies presently providing services to maintain a uniform minimum standard of service following standard guideline.

2.24.2 Despite this, they will be provided training to deliver efficient and quality services. There is a need to review the guidelines used by the various treatment centers and to ensure that what is offered to the clients is evidence based.

2.24.3 To develop a mechanism and link with the department of youth and sports to ensure employment of training and some financial support which facilitate to be a small entrepreneur. Moreover, after completion the training ex-drug users to be connected with microfinance institute for micro finance without any mortgage.

2.24.3 To develop a network with the service providers especially RMG sector or other private sector for job placement after completion the vocational training.

**Strategy 3: Prevent entry into drug use. This strategy addresses how to delay or prevent entry of potential users in to drug use. Special focus has been given to children, adolescent and youths, focusing intervention in to early part of the cycle.**

**[**

***Implementing strategies:***

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

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

3.3 To develop school based drug education programs that are evidence based and designed to prevent harmful drug use. This should be a multi-sectorial effort involving the NASP, MoHFW, Department of Narcotics, Ministry of Education, MoWCA and Department of Youth Affairs and sports;

3.4 Develop the capacity and encourage individuals, families and various community based organizations to take ownership and participate in efforts to reduce drug use and drug related harm;

**Strategy 4: Develop the capacity for sustainable response to drug use and HIV at all levels of administration through high commitment and strong leadership with information and resources to support it**

***Implementing strategies***

4.1 To ensure that NASP secure a full time staff member to act as a foci resource person to lead the advocacy interventions at all levels of administration with regards to drug use and HIV/AIDS. Gradually a harm reduction unit within the NASP will need to be created to address the multiple challenges associated with HIV/AIDS and drug use intervention activities;

4.2 To ensure that continued advocacy to target the different media i.e. print media and electronics media, community groups, religious leaders and Ministry of Home Affairs, Department of Narcotics and Police, Ministry of education and Ministry of youth and sports for review and amendment of drug policy considering the public health, HIV prevention and human rights;

7.3 To improve access to knowledge and skills development through professional education and training (Bangladesh may adapt the “Manual for Reducing Drug Related Harm in Asia” as a study course in universities with special focus on harm reduction). There is a need to conduct targeted education and training programs which focus on aspects of drug use and HIV/AIDS prevention, care and treatment appropriate to the needs of the stakeholders;

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

4.5 To develop and strengthen the capacity of the public health service providers who will be offered health care services to the PWUD without any discrimination and violation of dignity and disclosing their privacy and confidentiality. Showing the ID card by the PWUD, the service providers will ensure all necessary health services with dignity;

**Strategy 5: Enhance monitoring and evaluation on impacts of drug use related**

**HIV/AIDS prevention and care programs in the country**

***Implementing strategies:***

5.1 To develop national monitoring and evaluation frame work following national OP and PIP, which would be used to measure the progress, outcome and impact of national harm reduction program;

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

5.3 To strengthen the capacity of staff who are engaging in monitoring and evaluation and to improve its effectiveness based on the M&E findings (including cost effectiveness);

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

**Strategy 6: Develop a partnership among the Ministry of Health and Family Welfare, Ministry of Home Affairs, Ministry of Education, Ministry of Social Welfare, Ministry of Youth and Sports and Ministry of Women and Children Affairs to improve the effectiveness and efficiency in HIV/AIDS prevention and control measures targeting drug users**

***Implementing strategies:***

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

6.2 To ensure concerted advocacy efforts are undertaken by 16 key Ministries, directorates and departments and develop a advocacy forum to do advocacy with MoHA, Police officials, DNC for reviewing DNC laws, policy and legislative shift to create an enabling environment that officially allow crucial HIV prevention programs to operate and target efforts towards PWUDs, harassment issue and intervention at prison settings, initiative drug education program at school level;

6.3 Advocacy Forum will review the progress periodically and take further initiative for way forward. Any consensus reached by the ministries should be disseminated to the various sectors and levels of each Ministry such as street level law enforcement personal;

6.4 Advocacy efforts can include exposure visit to similar international sites where needles and syringe distribution is successfully implemented such as Iran, India and Malaysia;

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

6.6 To develop a curriculum on HIV/AIDS and drug use including harm reduction to be incorporated in to the professional training of law enforcing agencies. The process needs to have consultation with senior stakeholders representing both health and law enforcement sector as this will lead to acceptance of the proposition to conduct training at a senior level. The strength in training within police academies is the potential to influence law enforcement practice from the institutional core. This builds a strategic base within these institutions, where training on supply and harm reduction can take place. Seeking regional/international assistance to undertake this strategy will be required;

**Appendix 1: Prioritizing of the National Harm Reduction Strategy (based on 5 Year Plan )**

|  |  |  |  |
| --- | --- | --- | --- |
| **STRATEGY** | **Short Term**  **0-12** | **Medium Term**  **12-36** | **Long Term**  **36-60** |
| **Strategy 1: Strengthen understanding of drug using patterns, locations, and strengthen research on drug use.** | | | |
| **Implementing Strategy** |  |  |  |
| * 1. To develop a national research program on drug use with systematic process for identifying research gaps and priorities on drug use   and provision of relevant and emerging operational research (e.g. costing, effectiveness and impact of intervention) | **x** |  |  |
| * 1. Strengthen research networks among the Department of Narcotics Control and Law enforcement, Ministry of Home Affairs, Ministry   of Health and Family Welfare, Ministry of Education, NASP, National and International research organizations. |  | **x** |  |
| **Strategy 2: Strengthen and expand program to reduce and eliminate the harm caused by drug injecting practices all over the country** | | | |
| **Implementing Strategy** |  |  |  |
| 2.1 To ensure access to harm reduction and prevention interventions i.e. NSPs, ART, OST and other evidence-based drug dependence  treatment, HTC, prevention and treatment of STIs, distribution of condom, BCC/IEC including their sexual partners, prevention,  vaccination, diagnosis, and treatment for viral hepatitis and prevention, diagnosis and treatment of TB; | **x** |  |  |
| 2.2 To increase local community understanding and acceptance of HR, drug detoxification, treatment and rehabilitation program; |  | **x** |  |
| 2.3 To strengthen and expand the involvement of SHG consisting of current and ex-drug users in program planning, implementation,  monitoring and evaluation; | **x** |  |  |
| 2.4 To develop a mechanism for providing harm reduction services through DIC, outreach and prison settings interventions; |  | **x** |  |
| ***Needle Syringe Exchange Program*** |  |  |  |
| 2.5.1 To ensure the availability, accessibility and affordability of new needle syringe, appropriate, at all-time and accepted by the PWID  to prevent further risk behaviors; |  | **x** |  |
| 2.5.2 Develop clear policies and guidelines on occupational health and safety issues | **x** |  |  |
| 2.5.3 Suitable disposable containers must be provided at DIC for the use of used need syringe and medical equipment | **x** |  |  |
| ***Antiretroviral Therapy (ART)*** |  |  |  |
| 2.6.1 To advocate for the availability, affordability and accessibility of antiretroviral (ARV) medications as part of the prevention approach  to the HIV+ PWID in a friendly environment following 90-90-90 model | **x** |  |  |
| 2.6.2 To develop and strengthen the government health system to ensure for effective comprehensive intervention i.e. OST, ARV and NEP  through government health system |  | **x** |  |
| ***Oral substitution Therapy (ART) Services*** |  |  |  |
| 2.7.1 To ensure availability, accessibility and affordability of Opioid Substitution Therapy (OST) for the PWID |  | x |  |
| 2.7.2 To develop and expand opioid substitution therapy program outside of Dhaka to cover the more PWID. |  | x |  |
| 2.7.3 An evidence based guidelines will be developed for training | x |  |  |
| 2.7.4 To ensure OST service from any service center and reduce the drop-out rate ID card will be issued | x |  |  |
| ***Drug detoxification, treatment and rehabilitation*** |  |  |  |
| 2.8.1 To improve and expand the drug detoxification, treatment and rehabilitation (institutional, potential home based and community  based camps) |  |  | x |
| 2.8.2 To ensure that the management approach of drug dependent patients involves a combination of medical, psycho-social, social and  religious approaches |  | x |  |
| ***HIV Testing and Counseling (HTC)*** |  |  |  |
| 2.9.1 To develop a mechanism for ensuring 90 percent of PWUD through HTC at DIC or government health system. |  |  | x |
| 2.9.2 Develop a guideline to maintain the quality of the HTC services and ensure privacy throughout the process; | x |  |  |
| ***STI Syndomic Management*** |  |  |  |
| 2.10.1 To ensure prevention and treatment of Sexually Transmitted Infections (STIs) management guideline | x |  |  |
| 2.10.2 Identified STI case management will be completed at DIC and management of complicated cases through referral services to the  government health system or NGO clinics |  | x |  |
| ***Condom Distribution*** |  |  |  |
| 2.11.1 To develop a guideline for distribution of condom among the PWID and their sexual partners considering their need. | x |  |  |
| 2.11.2 Demonstration and distribution of condom following guideline |  | x |  |
| ***BCC/IEC activities*** |  |  |  |
| 2.12.1 To develop a process for increasing knowledge on harms associated with injecting drug use, STI, HIV/AIDS, safer sex, hepatitis B  & C and TB to the drug user including their sexual partners. | x |  |  |
| 2.11.2 Distribute of IEC materials among drug users, community people and civil society; |  | x |  |
| ***Hepatitis B and C*** |  |  |  |
| 2.13 To develop a protocol on diagnosis, treatment and vaccination of viral hepatitis B and C to the PWUD including outreach worker  and peer educator to prevent hepatitis B and C. |  |  | x |
| ***Tuberculosis (TB)*** |  |  |  |
| 2.14 To ensure the diagnosis and treatment of tuberculosis among the PWUD a guideline and treatment will be ensured |  |  | x |
| ***Relapse Management*** |  |  |  |
| 2.15.1 To increase the knowledge regarding relapse management a guideline | x |  |  |
| 2.15.2 To reduce relapse rates after drug detoxification, treatment and rehabilitation involvement of the family members and public health  service providers |  | x |  |
| ***Overdose Prevention Management*** |  |  |  |
| 2.16.1 To develop a mechanism regarding overdose management a guideline will be in place. | x |  |  |
| 2.16.2 To increase the knowledge on overdose management through IEC/BCC activities to the PWUD, outreach workers and peer  educators |  | x |  |
| ***Prison setting intervention*** |  |  |  |
| 2.17.1 To strengthen and/or create drug detoxification facilities inside prisons |  | x |  |
| 2.17.2 Developing a peer education program inside the prison would be an efficient and effective means of disseminating information  and knowledge on basic health to the inmates and guards following IEC/BCC activities. |  | x |  |
| 2.17.3 To develop a pre-release program to reintegrate PWUD into the general community and linkage to drug treatment and HTC  facilities |  | x |  |
| ***POPULATION*** |  |  |  |
| 2.18.1 To ensure harm reduction services for drug users; heroin smokers; children; adolescent; women; and prison inmates; street based  drug users those from more affluent backgrounds that often remain hidden and fear exposure; |  | x |  |
| ***Children and adolescent*** |  |  |  |
| 2.18.2 To develop services to the children, adolescent and female drug users considering their context and need, where necessary |  | x |  |
| ***Drop-in-Center*** |  |  |  |
| 2.19.1 To ensure standard and quality harm reduction services considering the needs of PWUD, a safe and secure place | x |  |  |
| 2.19.2 To ensure that each DIC has the mechanisms in place | x |  |  |
| 2.19.3 To develop a local level official agreement between each DIC and local police station, DNC and community leaders |  | x |  |
| ***Outreach Based Services*** |  |  |  |
| 2.20 To ensure coverage through HR package outreach service to be provided by the outreach workers and refer PWUD to DIC |  | x |  |
| ***Peer Education*** |  |  |  |
| 2.21 To strengthen peer education programs | x |  |  |
| ***Capacity building initiatives*** |  |  |  |
| 2.22.1 To ensure and develop the capacity of the DIC staff including outreach workers and peer educators | x |  |  |
| 2.22.2 To develop a mechanism to continue capacity building training to the government health system including prison health service  providers and officials. | x |  |  |
| ***Advocacy and networking*** |  |  |  |
| 2.23.1 To ensure that harm reduction can form a legitimate and balanced partnership with supply and demand approaches. |  |  | x |
| 2.23.2 To sensitization of the government health system, and to improve capacity for ensuring health services of the drug users at public  health facilities |  |  | x |
| ***Network among the treatment centers*** |  |  |  |
| 2.24.1 To provide training to the drug treatment institution/NGOs and develop a guidelines used by the various treatment centers | x |  |  |
| 2.24.2 To develop a mechanism and link with the department of youth and sports to ensure training and link with some financial support  organizations |  | x |  |
| 2.24.3 To develop a network with the service providers especially RMG sector or other private sector for job placement | x |  |  |
| **Strategy 3: Prevent entry into drug use.** |  |  |  |
| ***Implementing strategies*** |  |  |  |
| 3.1 To strengthen peer group norms and practices based on awareness of the potential harm of drug use; | x |  |  |
| 3.2 To strengthen interpersonal communication and conflict resolution in the families |  | x |  |
| 3.3 To develop school based drug education programs that are evidence based and designed to prevent harmful drug use. |  |  | x |
| 3.4 Develop the capacity and encourage individuals, families and various community based organizations to take ownership and  participate in efforts to reduce drug use and drug related harm |  |  | x |
| **Strategy 4: Develop the capacity for sustainable response to drug use and HIV at all levels of administration through high commitment and strong leadership with information and resources to support it** | | | |
| ***Implementing Strategy*** |  |  |  |
| 4.1 To ensure that NASP secure a full time staff member to act as a foci resource person to lead the advocacy interventions at all levels  of administration with regards to drug use and HIV/AIDS | x |  |  |
| 4.2 To ensure that advocacy efforts are intensified in order for the goals of drug use and HIV/AIDS prevention with different media | x |  |  |
| 4.3 To improve access to knowledge and skills development through professional education and training |  | x |  |
| 4.4 To develop adequate funding mechanisms and resource mobilization to effectively implement and expand drug use related HIV/AIDS  prevention and care programs. | x |  |  |
| 4.5 To develop and strengthen the capacity of the public health service providers who will be offered health care services to the PWUD  without any discrimination and violation of dignity and disclosing their privacy and confidentiality | x |  |  |
| **Strategy 5: Enhance monitoring and evaluation on impacts of drug use related HIV/AIDS prevention and care programs in the country** | | | |
| ***Implementing Strategy*** |  |  |  |
| 5.1 To develop national monitoring and evaluation frame work following national OP and PIP | x |  |  |
| 5.2 To develop and formulate specific guidelines to ensure that activities of all programs focused on drug use and HIV/AIDS | x |  |  |
| 5.3 To strengthen the capacity of staff who are engaging in monitoring and evaluation and to improve its effectiveness based on the M&E | x |  |  |
| 5.4 To communicate to all levels of appropriate Ministries, key stakeholders and the wider community the successes, problems and  challenges of the National Harm Reduction Strategy |  | x |  |
| **Strategy 6: Develop a partnership among the MOHFW, MOHA, MOE, MOSW, MOYS, MOWCA to improve the effectiveness and efficiency in HIV/AIDS prevention and control measures targeting drug users** | | | |
| ***Implementing Strategy*** |  |  |  |
| 6.1 To ensure that all harm reduction programs have a consultative approach with law enforcement implementers from the outset. | x |  |  |
| 6.2 To ensure concerted advocacy efforts are undertaken by 16 key Ministries, directorates and departments and develop a advocacy  forum to do advocacy |  | x |  |
| 6.3 Advocacy Forum will review the progress periodically and take further initiative for way forward. | x |  |  |
| 6.4 To ensure exposure visit to similar international sites where needles and syringe distribution is successfully implemented such as Iran,  India and Malaysia; | x |  |  |
| 6.5 To ensure that law enforcement implementers at the street level are able to identify outreach workers and others linked with the DIC  and that their role is clear as health workers and as public health educators | x |  |  |
| 6.6 To develop a curriculum on HIV/AIDS and drug use including harm reduction to be incorporated in to the professional training of  law enforcing agencies. |  | x |  |

**Appendix 2 : ACTION PLAN OF THE NATIONAL HARM REDUTION STRATEGY (NHRS)**

| **Implementing Strategy and Planned Actions** | **Indicators – Time Period** | **Tentative Budget** |
| --- | --- | --- |
| **Strategy 1: Strengthen understanding of drug using patterns and locations, and strengthen and expand research on drug use** | | |
| * 1. To develop a national research program on drug use with systematic process for identifying research gaps and priorities on drug use   and provision of relevant and emerging operational research (e.g. costing, effectiveness and impact of intervention) |  |  |
| 1. Review all research on drug use in the past 6 years so as to identify issues that have not been examined previously and to re-examine areas that require more focus such as reasons for ongoing sharing and other risk behaviors |  |  |
| 1. Undertake independent assessments of current design and approaches of HIV and drug use prevention, treatment, outreach, peer education and drop-in-centres at 6-8 programs in different districts. Findings will be disseminated widely and at higher policy levels including Government of Bangladesh (MOHA, MOH, DNC, NASP, Prisons, and Police) and other key stakeholders to have greater impact. |  |  |
| 1. Establish an agreement among Government of Bangladesh (MOHA MOH, DNC, NASP, Prisons, Police) and other key stakeholders of what a minimum harm reduction package would look like (for example, needle and syringe distribution; bleach, sterile water (?) and condom distribution using peers and other outreach strategies; development and dissemination of IEC materials; primary health care located with the DIC and/or outreach; and a range of other ancillary services). This would be followed by undertaking a costing assessment of this package based upon capacity of programs and estimated demand for services by drug users. |  |  |
| 1. Foster cooperation between national and international research institutes that focus on broad based drug issues in order to learn, exchange insights, and ideas which will in turn develop quality and rigorous research. |  |  |
| 1.2 Strengthen research networks among the Department of Narcotics Control and Law enforcement, Ministry of Home Affairs, Ministry  of Health and Family Welfare, Ministry of Education, NASP, National and International research organizations. |  |  |
| 1. Form a research sub group with in the Harm Reduction Working Group (HRWG, Strategy 6) and develop linkage with international institutions |  |  |
| **Strategy 2:Strengthen and expand program to reduce and eliminate the harm caused by drug injecting practices all over the country** | | |
| 2.1 To ensure access to harm reduction and prevention interventions i.e. NSPs, ART, OST and other evidence-based drug dependence  treatment, HTC, prevention and treatment of STIs, distribution of condom, BCC/IEC including their sexual partners, prevention,  vaccination, diagnosis, and treatment for viral hepatitis and prevention, diagnosis and treatment of TB; |  |  |
| 1. Government of Bangladesh (MOHA, MOH, DNC, NASP, Prisons) and other key stakeholders will advocate at all levels of governments and at a multi-agency level to support the implementation of the various components of harm reduction approaches that are based on science and research evidence |  |  |
| 1. Ensure at least ??? 80% coverage of injecting drug users/ drug users across the country |  |  |
| 2.2 To increase local community understanding and acceptance of HR, drug detoxification, treatment and rehabilitation program |  |  |
| 1. Seek a high profile respected figure within the community who is sensitive and understanding of the reasons for harm reduction to speak to the mass media at a specific public event. (ie., the launch of the NHRS) |  |  |
| 1. Organize community level advocacy meeting and use local key people like school teacher, elected people, parents or police officer to advocate harm reduction issues |  |  |
| 2.3 To strengthen and expand the involvement of SHG consisting of current and ex-drug users in program planning, implementation,  monitoring and evaluation; |  |  |
| 1. Encourage and include the opinions and views of current and ex-drug users during the planning process of program development to ensure wider impact |  |  |
| 1. Recruit (minimum proportion……) peer educator, out reach worker, DIC personnel from current and ex-drug users |  |  |
| 2.4 To develop a mechanism for providing harm reduction services through DIC, outreach and prison settings interventions; |  |  |
| 1. Contract with different level of NGOs/CBOs/SHGs and different organization for providing harm reduction services through DIC and outreach and prison |  |  |
| ***Needle Syringe Exchange Program*** |  |  |
| 2.5.1 To ensure the availability, accessibility and affordability of new needle syringe, appropriate, at all-time and accepted by the PWID  to prevent further risk behaviors; |  |  |
| 1. In collaboration with drug user networks assess the views and opinions of a range PWUDs of the equipment on offer to determine suitability. If not appropriate seek a solution. |  |  |
| 2.5.2 Develop clear policies and guidelines on occupational health and safety issues |  |  |
| 1. Develop a guideline on occupational health and safety issues especially about the disposal of used equipment |  |  |
| 1. Provide training to all staff of the need to avoid handling or touching ANY injecting equipment returned by the clients |  |  |
| 2.5.3 Suitable disposable containers must be provided at DIC for the use of used need syringe and medical equipment |  |  |
| 1. Provide suitable disposable containers for all outreach workers and for DIC staff to ensure needle syringe injury are avoided |  |  |
| ***Antiretroviral Therapy (ART)*** |  |  |
| 2.6.1 To advocate for the availability, affordability and accessibility of antiretroviral (ARV) medications as part of the prevention approach  to the HIV+ PWID in a friendly environment following 90-90-90 model |  |  |
| 1. Government of Bangladesh (MOHA, MOH, DNC, NASP, Prisons, Police) and other key stakeholders will work towards identifying the funding sources and the mechanisms to access ARV medications |  |  |
| 2.6.2 To develop and strengthen the government health system to ensure for effective comprehensive intervention i.e. OST, ARV and NEP  through government health system |  |  |
| 1. Conduct training programs for all health staff to sensitize them to the complex needs of drug users to improve service delivery |  |  |
| ***Oral substitution Therapy (ART) Services*** |  |  |
| 2.7.1 To ensure availability, accessibility and affordability of Opioid Substitution Therapy (OST) for the PWUD |  |  |
| 1. Government of Bangladesh (MOHA, MOH, DNC, NASP, Prisons, Police) and other key stakeholders will work towards identifying the funding sources and the mechanisms to access OST |  |  |
| 2.7.2 To develop and expand opioid substitution therapy program outside of Dhaka to cover the more PWID. |  |  |
| 1. Recruited experience organization to expand OST program outside of Dhaka and government ensure available of fund |  |  |
| 2.7.3 An evidence based guidelines will be developed for training |  |  |
| 1. Develop a guideline on OST |  |  |
| 2.7.4 To ensure OST service from any service center and reduce the drop-out rate ID card will be issued |  |  |
| 1. Government of Bangladesh (MOHA, MOH, DNC, NASP, Prisons, Police) will ensure ID card to the PWUD |  |  |
| ***Drug detoxification, treatment and rehabilitation*** |  |  |
| 2.8.1To improve and expand the drug detoxification, treatment and rehabilitation (institutional, potential home based and community based camps) |  |  |
| 1. Create quality guidelines for abstinent based rehabilitation approaches that are based on research evidence. |  |  |
| 1. Treatment centres will explore the option and financial feasibility of organizing more detoxification camps to meet the growing number of drug users. |  |  |
| 1. Create more drug treatment and rehabilitation services in public and private sector |  |  |
| 1. Support services post detoxification will be further utilized with increased linkages to already created narcotic anonymous groups |  |  |
| 2.8.2 To ensure that the management approach of drug dependent patients involves a combination of medical, psycho-social, social and religious approaches |  |  |
| 1. Assessment skills undertaken by staff will be further refined and expanded to take into consideration many aspects of the life of the individual drug user such as what does the patient want?; is the patient dependent ?; What is their level of tolerance ?; is the patient using/dependent on other drugs ?; and is their motivation for change ? |  |  |
| 1. Train and retrain staff on revised management approaches |  |  |
| ***HIV Testing and Counseling (HTC)*** |  |  |
| 2.9.1 To develop a mechanism for ensuring 90 percent of PWUD through HTC at DIC or government health system. |  |  |
| 1. Government of Bangladesh ensure the fund and conduct HTC service through DIC or government health system |  |  |
| 2.9.2 Develop a guideline to maintain the quality of the HTC services and ensure privacy throughout the process; |  |  |
| 1. Develop a HTC guideline through national consultant for maintain quality and provide unique services |  |  |
| ***STI Syndomic Management*** |  |  |
| 2.10.1 To ensure prevention and treatment of Sexually Transmitted Infections (STIs) management guideline |  |  |
| 1. Develop a STI syndromic management guideline following WHO through national consultant |  |  |
| 2.10.2 Identified STI case management will be completed at DIC and management of complicated cases through referral services to the  government health system or NGO clinics |  |  |
| 1. Trained medical professional to be recruited for identifying STI and provide treatment, any complicated case will be refer following guideline |  |  |
| ***Condom Distribution*** |  |  |
| 2.11.1 To develop a guideline for distribution of condom among the PWID and their sexual partners considering their need. |  |  |
| 1. Develop a condom demonstration, distribution and incineration guideline |  |  |
| 2.11.2 Demonstration and distribution of condom following guideline |  |  |
| 1. Peer educator and outreach workers will distribute condom following guideline or as pre requirement of the PWUD |  |  |
| ***BCC/IEC activities*** |  |  |
| 2.12.1 To develop a process for increasing knowledge on harms associated with injecting drug use, STI, HIV/AIDS, safer sex, hepatitis B & C and TB to the drug user including their sexual partners. |  |  |
| 1. Conduct advocacy meeting with the stakeholders for increasing knowledge on harms associated with injecting drug use, STI, HIV/AIDS, safer sex, hepatitis B & C and TB to the drug user including their sexual partners |  |  |
| 2.11.2 Distribute of IEC materials among drug users, community people and civil society; |  |  |
| 1. Develop IEC/BCC materials on STI, HIV/AIDS, safer sex, hepatitis B & C and TB to the drug user including their sexual partners. |  |  |
| 1. Distribute IEC/BCC materials among the PWUD, stakeholders and community |  |  |
| ***Hepatitis B and C*** |  |  |
| 2.13 To develop a protocol on diagnosis, treatment and vaccination of viral hepatitis B and C to the PWUD including outreach worker and peer educator to prevent hepatitis B and C. |  |  |
| 1. Government of Bangladesh (MOHA, MOH and NASP) will develop a protocol regarding diagnosis and treatment of hepatitis B & C |  |  |
| ***Tuberculosis (TB)*** |  |  |
| 2.14 To ensure the diagnosis and treatment of tuberculosis among the PWUD a guideline and treatment will be ensured |  |  |
| 1. Government of Bangladesh (MOHA, MOH and NASP) will develop a guideline regarding diagnosis and treatment of TB |  |  |
| ***Relapse Management*** |  |  |
| 2.15.1 To increase the knowledge regarding relapse management a guideline |  |  |
| 1. Government of Bangladesh (MOHA, MOH and NASP) will develop a guideline regarding relapse management |  |  |
| 1. Provide training to the drug treatment center on relapse prevention management |  |  |
| 2.15.2 To reduce relapse rates after drug detoxification, treatment and rehabilitation involvement of the family members and public health service providers |  |  |
| 1. Provide training to the public health service providers regarding the relapse after drug detoxification, treatment and rehabilitation |  |  |
| 1. Provide counseling to the family members during and after drug treatment of their family member and reason for relapse |  |  |
| ***Overdose Prevention Management*** |  |  |
| * + 1. To develop a mechanism regarding overdose management a guideline will be in place. |  |  |
| 1. Government of Bangladesh (MOHA, MOH and NASP) will develop a guideline regarding overdose management |  |  |
| 1. Provide training to the DIC staff on overdose management |  |  |
| 2.16.2 To increase the knowledge on overdose management through IEC/BCC activities to the PWUD, outreach workers and peer  educators |  |  |
| 1. Develop IEC/BCC materials on overdose management |  |  |
| 1. Distribution of IEC/BCC materials and provide information to the PWUD on overdose management through group education session |  |  |
| ***Prison setting intervention*** |  |  |
| 2.17.1 To strengthen and/or create drug detoxification facilities inside prisons |  |  |
| 1. Create a minimum detox facility with in every prison with human resource |  |  |
| 1. Provide training to prisons guards and medical professionals to be aware of the signs and symptoms of withdrawal and how to respond appropriately |  |  |
| 1. Create self-groups based on the principles of narcotic anonymous |  |  |
| 2.17.2 Developing a peer education program inside the prison would be an efficient and effective means of disseminating information and knowledge on basic health to the inmates and guards following IEC/BCC activities. |  |  |
| 1. Provide training and a health educational package to the inmates and guards on drug use, withdrawal period and HIV/AIDS |  |  |
| 2.17.3 To develop a pre-release program to reintegrate PWUD into the general community and linkage to drug treatment and HTC facilities |  |  |
| 1. Develop an easy to understand brief training session covering 1-2 hours of issues about drug use, HIV/AIDS, STDS including sexual health and other associated risk behaviours. |  |  |
| 1. Each prisoner will be provided with links to community health services, NA organizations, drug treatment services and voluntary counseling and testing facilities |  |  |
| ***POPULATION*** |  |  |
| 2.18.1 To ensure harm reduction services for drug users; heroin smokers; children; adolescent; women; and prison inmates; street based drug users those from more affluent backgrounds that often remain hidden and fear exposure; |  |  |
| 1. The heroin smokers; children; adolescent; women; and prison inmates; street based drug users those from more affluent backgrounds that often remain hidden and fear exposure will be considered for harm reduction intervention |  |  |
| ***Children and adolescent*** |  |  |
| 2.18.2 To develop services to the children, adolescent and female drug users considering their context and need, where necessary |  |  |
| 1. The preference will be given to the children, adolescent and female drug users considering their context and needs |  |  |
| ***Drop-in-Center*** |  |  |
| 2.19.1 To ensure standard and quality harm reduction services considering the needs of PWUD, a safe and secure place |  |  |
| 1. Implementing organization will select the DIC in consultation with PWUD |  |  |
| 2.19.2 To ensure that each DIC has the mechanisms in place |  |  |
| 1. Government of Bangladesh (MOHA, MOH and NASP) will develop a DIC standard operational guideline |  |  |
| 1. Develop a DIC working group that has representation by various sectors of the community proving an opportunity for discussions about service operations, problems and seeking solutions |  |  |
| 2.19.3 To develop a local level official agreement between each DIC and local police station, DNC and community leaders |  |  |
| 1. Organize regular high level meetings/advocacy sessions on drug use and HIV with the police of the rationale behind such a service for drug users and reach a formal understanding for effective functioning of DIC |  |  |
| 1. Invite the local police during non-operational hours of the DIC so they can see the type of service it offers and it also provides the opportunity to answer their questions and issues of concerns and reach a formal agreement of understanding |  |  |
| 1. Undertake a social marketing approach of DIC as a vehicle for public health promotion for the entire community when meeting with law enforcement personal of officials that |  |  |
| ***Outreach Based Services*** |  |  |
| 2.20 To ensure coverage through HR package outreach service to be provided by the outreach workers and refer PWUD to DIC |  |  |
| 1. Peer educator and outreach workers offer HR package to the PWUD at outreach |  |  |
| 1. Female outreach workers will be encouraged to join the program in order to ensure gender sensitivity and suitability for FDU |  |  |
| 1. Undertake a cost analysis of improving the ratio between outreach worker and drug users. |  |  |
| 1. Document a baseline assessment of the effectiveness of the outreach work load both from the perspective of the workers and the drug users. If the ratio changes can be introduced undertake another assessment to identify the outcome and impact of the change with a focus on coverage and quality of service |  |  |
| 1. Program manager should have regular meetings and debriefings with outreach staff to identify problems and/or potential problems to attempt to find ways as to how the concerns could be addressed |  |  |
| 1. Assess from the drug users perspective if the working hours of outreach suit their needs. Working hours should be revisited at least every 12 months to identify that the quality of the service is being achieved |  |  |
| ***Peer Education*** |  |  |
| 2.21 To strengthen peer education programs |  |  |
| 1. Develop a evidence based peer training programme with national and international inputs |  |  |
| 1. Train and retrain peer educators based on developed training package |  |  |
| ***Capacity building initiatives*** |  |  |
| 2.22.1 To ensure and develop the capacity of the DIC staff including outreach workers and peer educators |  |  |
| 1. Develop a comprehensive training package with national and international resource person |  |  |
| 1. Training programs are to be conducted for all outreach workers and staff with regular updates of skills |  |  |
| 1. Female outreach workers will be encouraged to join the program in order to ensure gender sensitivity and suitability for female drug users |  |  |
| 2.22.2 To develop a mechanism to continue capacity building training to the government health system including prison health service  providers and officials. |  |  |
| 1. Develop a comprehensive training package with national and international resource person |  |  |
| 1. Training programs are to be conducted for government health service providers including prisons officials |  |  |
| 1. Organize international exposure visits where drug substitution programs are implemented such as Iran, India, China, Indonesia, and Malaysia to name some nations. Participants would represent Ministry of Home Affairs, Department of Narcotics, Ministry of Health, and NASP. |  |  |
| ***Advocacy and networking*** |  |  |
| 2.23.1 To ensure that harm reduction can form a legitimate and balanced partnership with supply and demand approaches. |  |  |
| 1. Government of Bangladesh (MOHA, MOH, DNC, NASP, Prisons, Police) and other key stakeholders will conduct regular advocacy sessions and personal interactions with political leaders and civil society |  |  |
| 1. Develop an educational package using scientific evidence and national research findings to be presented at forums, seminars etc that are specifically targeted towards educating politicians, community leaders, religious leaders, relevant ministries and other decision makers about the urgent need to respond to the identified problems of HIV among PWUDs and of the spread to wider community |  |  |
| 1. Organize regular meetings (every 1-3 months) with multi-stakeholders from the government, non-government sector and community in order to be briefed on latest issues, problems and solutions. |  |  |
| 1. Minutes of each meeting are to be distributed among guests and various agencies to act as a resource of information. |  |  |
| 1. Strengthen and enhance the role of existing focal points of the different Ministries |  |  |
| ***Network among the treatment centers*** |  |  |
| * + 1. To provide training to the drug treatment institution/NGOs and develop a guidelines used by the various treatment centers |  |  |
| 1. Government of Bangladesh (MOHA, MOH, DNC and NASP) and treatment center will conduct regular meeting |  |  |
| 1. Provide training on drug detoxification, treatment and rehabilitation to the private treatment |  |  |
| 1. Organize regular meetings (every 1-3 months) with multi-stakeholders from the government, non-government sector and community in order to be briefed on latest issues, problems and solutions. |  |  |
| 1. Minutes of each meeting are to be distributed among network members |  |  |
| * + 1. To develop a mechanism and link with the department of youth and sports to ensure training and link with some financial support   organizations |  |  |
| 1. Government of Bangladesh (MOHA, MOH, NASP) and other key stakeholders will conduct regular advocacy sessions and personal interactions with youth and sports ministry and department |  |  |
| 1. To develop personal interactions with the department of youth and sports for ensuring training and financial support |  |  |
| 2.24.3 To develop a network with the service providers especially RMG sector or other private sector for job placement |  |  |
| 1. Government of Bangladesh (MOHA, MOH, NASP) and BGMEA and BKMEA will conduct regular advocacy sessions and personal interactions including RMG sector personnel |  |  |
| 1. To develop personal interactions with the department of RMG |  |  |
| **Strategy 3: Prevent entry into drug use** | | |
| 3.1 To strengthen peer group norms and practices based on awareness of the potential harm of drug use; |  |  |
| 1. Trained outreach workers and peer educators will inform drug users of their potential risk, provide education messages in a manner that can be understood and provide the tools to preventing risk behaviours such as clean needles and syringes and condoms. |  |  |
| 3.2 To strengthen interpersonal communication and conflict resolution in the families |  |  |
| 1. Small workshops with participation of all staff linked to the DIC to explore various techniques for enhancing communication skills between the drug user and their family |  |  |
| 3.3 To develop school based drug education programs that are evidence based and designed to prevent harmful drug use. |  |  |
| 1. Collaborate between NASP, GFATM, Department of Narcotics, Ministry of Education and other appropriate departments to create a teacher friendly curriculum on drug use and harmful consequences. Feasibility of its implementation into overall school curriculum is crucial. |  |  |
| * 1. Develop the capacity and encourage individuals, families and various community based organizations to take ownership and participate in efforts to reduce drug use and drug related harm |  |  |
| 1. Appropriate sectors of the government and NGOs will assist communities to understand drug use and harmful consequences through community forums using various educational tools. The knowledge gained from these information sessions will inform community members of the means to inform others how to develop local |  |  |
| 1. To disseminate widely research evidence and data of a range of harm reduction strategies |  |  |
| **Strategy 4: Develop the capacity for sustainable response to drug use and HIV at all levels of administration through high commitment**  **and strong leadership with information and resources to support it** | | |
| * 1. To ensure that NASP secure a full time staff member to act as a foci resource person to lead the advocacy interventions at all levels of administration with regards to drug use and HIV/AIDS |  |  |
| 1. An official from NASP will be entrusted as focal person and ensure there is ongoing capacity building and provided with the educational tools/resources to undertake the role effectively and efficiently |  |  |
| 1. A small harm reduction unit will be created to meet the demand and multiple challenges linked with HIV/AIDS and drug use interventions around the country |  |  |
| 4.2 To ensure that advocacy efforts are intensified in order for the goals of drug use and HIV/AIDS prevention with different media |  |  |
| 1. Government of Bangladesh (MOHA, MOH, DNC, NASP, Prisons, Police) and other key stakeholders will continue to target various sectors within each Ministry, mass media, community groups, religious leaders with evidence for action in response HIV/AIDS and drug use |  |  |
| 4.3 To improve access to knowledge and skills development through professional education and training |  |  |
| 1. Targeted education and training programs focusing on drug use prevention, treatment and care appropriate to the needs of the Government of Bangladesh (MOH, MOH, DNC, NASP, Prisons, Police) and other key stakeholders will be implemented on a regular basis to meet the demand for professional development and knowledge |  |  |
| 1. A small working group within Bangladesh will be identified to undertake a community development approach of creating a country specific version addressing issues of cultural context and relevancy. International technical assistance will be sought to ensure quality assurance of the final product |  |  |
| 1. A partnership will be created between a University in Dhaka and an international technical agency to develop a harm reduction curriculum course |  |  |
| 1. An indigenous training team will be sought to implement the curriculum course |  |  |
| 1. Identify a suitable DIC and build up the capacity and foster an environment in which evidence based practices of harm reduction only are implemented |  |  |
| * 1. To develop adequate funding mechanisms and resource mobilization to effectively implement and expand drug use related HIV/AIDS   prevention and care programs. |  |  |
| 1. Government of Bangladesh (MOH, MOH, DNC, NASP, Prisons, Police) and other key stakeholders will seek funding sources national, regionally and internationally for effective and sustainable development of drug use and HIV prevention programs |  |  |
| * 1. To develop and strengthen the capacity of the public health service providers who will be offered health care services to the PWUD   without any discrimination and violation of dignity and disclosing their privacy and confidentiality |  |  |
| 1. Develop a comprehensive training package with national and international resource person |  |  |
| 1. Training programs are to be conducted for government health service providers including prisons officials |  |  |
| **Strategy 5: Enhance monitoring and evaluation on impacts of drug use related HIV/AIDS prevention and care programs in the**  **country** | | |
| 5.1 To develop national monitoring and evaluation frame work following national OP and PIP |  |  |
| 1. Develop a comprehensive national monitoring and evaluation frame work with national and international resource person |  |  |
| 5.2 To develop and formulate specific guidelines to ensure that activities of all programs focused on drug use and HIV/AIDS |  |  |
| 1. Develop a generic guideline for programme development to have minimum quality standard |  |  |
| 5.3 To strengthen the capacity of staff who are engaging in monitoring and evaluation and to improve its effectiveness based on the M&E |  |  |
| 1. Organize short training workshop for DIC staff as how to conduct monitoring and evaluation effectively and efficiently within a harm reduction context |  |  |
| * 1. To communicate to all levels of appropriate Ministries, key stakeholders and the wider community the successes, problems and challenges of the National Harm Reduction Strategy |  |  |
| 1. Raise issues associated with the Strategy at the appropriate forums and/or meetings such as the Harm Reduction Working Group |  |  |
| **Strategy 6: Develop a partnership among the MOHFW, MOHA, MOE, MOSW, MOYS, MOWCA to improve the effectiveness and**  **efficiency in HIV/AIDS prevention and control measures targeting drug users** | | |
| 6.1 To ensure that all harm reduction programs have a consultative approach with law enforcement implementers from the outset. |  |  |
| 1. All written agreements with the authorities will be tabled at the initiation of any harm reduction program activities |  |  |
| 1. Regular meetings, communications and community education is an ongoing process |  |  |
| 11.2 To ensure that law enforcement implementers at the street level are able to identify outreach workers and others linked with the DIC and  that their role is clear as health workers and as public health educators |  |  |
| 1. Meet with the law enforcement officials at the local level providing a names and photographs of all DIC staff and of their duties. |  |  |
| 1. Encourage the law enforcement officials to provide either a letter of endorsement to support the work of those linked with the DIC or a type of police stamp on their identification card that acknowledges the type of work undertaken. |  |  |
| * 1. Advocacy Forum will review the progress periodically and take further initiative for way forward. |  |  |
| 1. Advocacy forum will conduct regular advocacy sessions and personal interactions with MoHA, MOWCA, youth and sports ministry and department |  |  |
| 1. To develop personal interactions with the concern ministry |  |  |
| 6.4 To ensure exposure visit to similar international sites where needles and syringe distribution is successfully implemented such as Iran, India and Malaysia; |  |  |
| 1. Organize international exposure visits where drug substitution programs are implemented such as Iran, India, China, Indonesia, and Malaysia to name some nations. Participants would represent Ministry of Home Affairs, Department of Narcotics, Ministry of Health, and NASP. |  |  |
| 6.5 To ensure that law enforcement implementers at the street level are able to identify outreach workers and others linked with the DIC and that their role is clear as health workers and as public health educators |  |  |
| 1. Meet with the law enforcement officials at the local level providing a names and photographs of all DIC staff and of their duties. |  |  |
| 1. Encourage the law enforcement officials to provide either a letter of endorsement to support the work of those linked with the DIC or a type of police stamp on their identification card that acknowledges the type of work undertaken. |  |  |
| 6.6 To develop a curriculum on HIV/AIDS and drug use including harm reduction to be incorporated in to the professional training of law enforcing agencies. |  |  |
| 1. Curriculum developed will be incorporated into police training involving the police and law enforcement academies, and using police as trainers |  |  |

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