


Transport Workers at Risk to HIV

Documenting our Experience
2000-2004



HIV Program
CARE Bangladesh



Managing Editor
Diane Lindsey

Editor
Virginia Curtain Knight

Published by
CARE Bangladesh
Progoti RPR Centre (8th-13th Floor)
20-21, Kawran Bazar, Dhaka-1215
Tel: 880-2-8114183
E-mail: carebang@bangla.net
Website: www.carebd.org

Photography by
Saiful Islam Kallol- freelance photographer,
Staff- CARE Bangladesh HIV Program

Cover Design and Computer Graphics
Syed Imtiaz Ahmed
Sk. Jahangir Hossain

Printed by
Presidency Press
June 2006

Copyright
CARE Bangladesh

ISBN: 984-32-3276-3

The Transport Workers at Risk document grew out of CARE Bangladesh's experience during the four year implementation of RASTTA BONDOR, an HIV prevention project focusing on truckers and their helpers, rickshaw pullers and dock workers. This paper was produced and coordinated by the HIV program office in Dhaka. Many people provided invaluable support and input during implementation of the program and development of the documentation. The publishers would specifically like to express appreciation to those listed below:

Government of Bangladesh
Director General Health and National AIDS/STD Program

Donor
Department for International Development (DFID)

Participants in the Transport Workers HIV Prevention Program
Dr. Asif Altaf Chowdhury, Sk. Jahangir Hossain and A.S.M. Enamul Hoque, many other staff, stakeholders, union leaders, partner NGOs, and CBOs

Thanks to Stefi Barna, consultant, who compiled the first draft of this document in 2004.

Communities
A special thanks to all community members who participated in the program and provided valuable insight on how best to work and educate others on prevention of HIV.

CARE Bangladesh

AIDS	Acquired Immune Deficiency Syndrome
BSS	Behavioral Surveillance Survey
CARE B	CARE Bangladesh
CBO	Community Based Organization
DFID	Department for International Development
DIC	Drop-in-Center
FHI	Family Health International
GoB	Government of Bangladesh
HIV	Human Immunodeficiency Virus
ICDDR,B	Centre for Health and Population Research (International Centre for Diarrhoeal Disease Research, Bangladesh)
IDU	Injecting Drug User
NGO	Non Government Organization
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
USAID	United States Agency for International Development

TABLE OF CONTENTS

Executive Summary	7
Chapter 1	
Background	9
1.1 HIV in Bangladesh	9
1.2 Transport Routes in Bangladesh	10
Chapter 2	
Introduction	13
2.1 The Beginning of CARE's HIV Program : SHAKTI	13
2.2 HIV in Sex Workers	14
2.3 Client Profile Survey	14
Chapter 3	
Target Groups	17
3.1 Transport Workers' Target Groups	17
3.2 Truckers and their Helpers	17
3.3 Rickshaw Pullers	18
3.4 Port, Dock, and Ghat Labor	20
3.5 Ferry Workers	21
3.6 Quarry Workers	21
Chapter 4	
Key Intervention Strategies for Transport Workers	23
4.1 Strategy One: Partnerships	23
4.1.1 Partnerships with workers' unions	23
4.1.2 Union leaders	24
4.1.3 Lessons learned	24
4.2 Strategy Two: Peer Educators and Peer Outreach Workers	25
4.2.1 Training	26
4.2.2 Outreach activities	26
4.2.3 Lessons learned	27
4.3 Strategy Three: Drop-in-Centers	27
4.3.1 Services at the DIC	28
4.3.2 Condom access	29
4.3.3 Lessons learned	29
Chapter 5	
Conclusions	31
References	32
Tables	
Table 1 CARE Annual Monitoring Surveys Consistent Condom Use with Clients in Vaginal Sex Acts during the Last 24 Hours	14
Table 2 Initiation of Transport-worker Intervention Groups	17

In 1995, CARE Bangladesh (CARE B) initiated an HIV/AIDS intervention program called Stopping HIV/AIDS through Knowledge and Training Initiatives (SHAKTI), which was funded by the United Kingdom's Department for International Development (DFID), to improve HIV and AIDS programming in Bangladesh. Although the project originally targeted rickshaw pullers, after several strategy meetings it was decided to begin the HIV/AIDS prevention program with female sex workers. SHAKTI eventually expanded to include some of their (female sex workers) clients as an intervention target group. The sex workers identified rickshaw pullers and truckers, along with dockworkers, as their main clients. This formed the beginning of the Rastta Bondor project.

Transport workers such as rickshaw pullers, dockworkers and truckers are not necessarily regarded as a vulnerable group in terms of national surveillance. They are, however, considered as possible "bridges" to the general population, potentially transmitting HIV and sexually transmitted infections (STIs) to their wives and to the population in general. Since many transport workers are drug users and clients of sex workers, CARE B decided to collect surveillance data on them. Transport worker surveillance began in 2000, serving several types of transport workers at local, national or cross-border levels.

A baseline survey, conducted by CARE B in May 2000, determined that more than 33% of transport workers in a given area had sex with sex workers within the six months preceding the survey. In the week preceding the survey, 37% of married truckers had sex with sex workers. Of those who had sex with a sex worker, only 11% used a condom.

In establishing transport-worker interventions, CARE B applied the same implementation model used previously with sex workers. CARE prioritized development of partnerships with transport unions, particularly truckers, as they greatly facilitated the reach that CARE B was looking for at a national level. The results of this partnership were mixed.

Outreach workers conducted regular HIV education activities as well as partner tracing for those transport workers who tested positive for STIs. Outreach workers referred transport workers (and their partners) to the drop-in-centers (DIC) for syndromic management of STIs. By 2004, the transport-worker intervention was selling up to 400,000 condoms per month across the country through its outreach worker system. Additionally, CARE B developed low-literacy materials for transport workers.

This document discusses CARE B sex worker intervention as a backdrop to the transport worker program. Over the course of the project, CARE learned some lessons about its approach to project activities, including use of DICs, peer outreach and partnerships. The purpose of this document is to describe CARE B experience with regard to HIV prevention among transport workers in Bangladesh.

Bangladesh is one of the most densely populated countries in the world with almost 140 million people. The population growth rate, however, has slowed considerably due to the country's family planning program. The total fertility rate (average number of children per woman) fell from 6.3 in 1975 to 3.0 in 2004.¹ Even with the decrease in the total fertility rate, the population is expected to double by 2040.

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

1.1 HIV in Bangladesh

Against this backdrop of overpopulation and poverty, Bangladesh has carried out serological surveillance annually since 1998. Surveys suggest HIV-prevalence rates of less than 0.1% in the general population and less than 1% among people practicing high-risk behaviors. From the inception of the surveillance surveys, HIV rates have continued to rise within the injecting- drug user (IDU) population. Although HIV prevalence remains low, less than 1% among vulnerable populations,³ active syphilis remains high, indicating risky sexual behaviors.

Data from South East Asia and Australia suggest that if the prevalence of HIV amongst high-risk behavior groups remains below 5%, it would not exceed 1% in the general population. Unfortunately, the 2003 National HIV and Behavioral Surveillance Report⁴ documented a prevalence rate of 4% amongst IDUs in Dhaka, the highest level of any given population in the country. By 2004, one part of neighborhood of IDUs in Dhaka reported a rate of 8.9%,⁵ confirming the start of a concentrated epidemic.

Transport workers such as rickshaw pullers, dockworkers and truckers are not necessarily regarded as a vulnerable group in terms of national surveillance; they are, however, considered as possible "bridges" to the general population. Since many transport workers are drug users and clients of sex workers, it was decided to collect surveillance data on transport workers. Transport-worker surveillance began in 2000.

During the sixth round of surveillance (August 2004-April 2005) mobile men - rickshaw pullers, truckers and dockworkers - were included in the national sample. Results from the national surveillance survey did not find any HIV - positive cases among the truckers, rickshaw pullers or dockworkers. Active syphilis rates were also low, with only 1.7% among dockworkers. HIV and active syphilis among truckers, rickshaw pullers and dockworkers have been sampled in at least three rounds of surveillance. For those surveillance sites where sampling was conducted for more than one round, changes in rates for HIV and active syphilis were not significant.

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

1.2 Transport Routes in Bangladesh

As a riverine country, Bangladesh maintains an extensive network of freight and passenger boat services. Sea routes link the entire Bay of Bengal, including the ports of Yangoon and Mumbai. Tens of thousands of workers are employed at sea and river docks and on passenger ferries along inland waterways. Over that past 10 years, development of the road transportation infrastructure has included construction of new highways and bridges, including the five-kilometer Jamuna Bridge in Tangail and Shirajgonj districts.

Bangladesh shares three-quarters of its border with India's northeastern states, and 2200 kilometers of this is with the state of West Bengal, with which it shares cultural and linguistic bonds. Population increases, environmental crises and structural adjustments in Bangladesh have encouraged migration to India. Many Indian border villages contain small colonies of undocumented Bangladeshi immigrants, some of whom have settled there with their families for more than 10 years.

Officially, the border between Bangladesh and India is monitored: passports and visas are required for entry. However, there is a constant flow of migrants by road, river, and sea routes. An estimated 2000 Bangladeshis cross the border every day, including laborers, smugglers and trafficked women and girls.

An estimated 180,000 truckers, and an equal number of truckers' assistants, convey goods by road. Regional truck routes that link India, Nepal and Bangladesh have truckers from all these countries moving from high-prevalence areas such as Manipur, India, to Benapole, Bangladesh. At the six land-port borders approximately 15,000 land-port workers unload goods arriving from India. At these sites, workers and truckers are away from their families and many engage in high-risk behavior with local sex workers. Road and sea transport workers act as a bridge population, transmitting HIV and sexually transmitted infections (STIs) to their wives and sex workers. In Bangladesh, transport workers' risks of acquiring or transmitting HIV are exacerbated by the following factors:

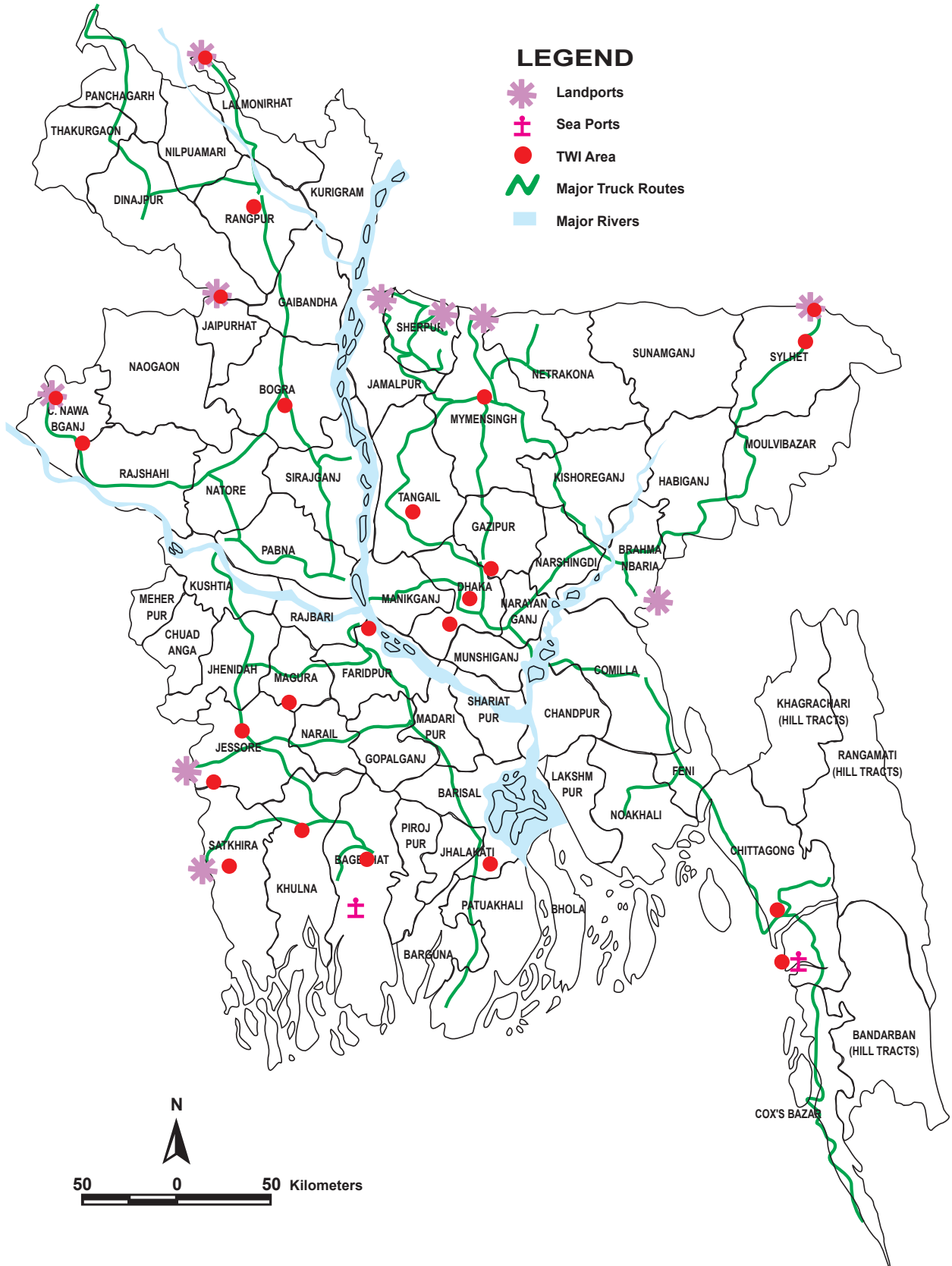
- | Extensive external and internal (rural-urban) mobility, most transport workers spend long periods away from home:
 - o As part of their work (truck drivers, launch laborers)
 - o To find work (rickshaw pullers, dockworkers and land-port laborers)
- | Findings from the 2002 monitoring survey conducted by CARE indicate that more than half the truckers were married and have extramarital sex (with commercial sex workers or with their male helpers)
- | High numbers of HIV infections in neighboring countries - India: 5 million, Myanmar: 350,000 (UNAIDS, 2004)
- | Presence of STIs among truckers (GoB, 2004)
- | Access to STI treatment is intermittent or delayed due to mobility or shame/taboo (CARE B, 2001)
- | Low knowledge of HIV (e.g., in 2000, 33% could not name a single method of HIV prevention⁶)

Despite the litany of problems, Bangladesh could be considered unique in its opportunity to prevent an HIV epidemic. While most other countries have entered a control phase in managing the HIV epidemic, Bangladesh seems to have the lowest prevalence in Asia⁷ (less than 0.1% in the general population and between 1% and 4% amongst those with high-risk behaviors, GoB, 2004). Although the country is relatively small, it has a good transportation infrastructure. Furthermore, the presence of a plethora of NGOs as well as generous international funding for HIV prevention bodes well for the future of prevention interventions.

6. Baseline survey 2000, CARE Bangladesh

7. With the exception of the Maldives, UNAIDS report 2004 on the global AIDS epidemic.

Location of HIV Program intervention areas with transport workers



2.1 The Beginning of CARE's HIV Program : SHAKTI

Launched in 1995, the SHAKTI⁸ project (Stopping HIV/ AIDS through Knowledge and Training Initiatives), a CARE Bangladesh (CARE B) initiative funded by DFID (United Kingdom's Department for International Development), to improve HIV and AIDS programming in Bangladesh. The project was initially funded to work with clients of sex workers, specifically rickshaw pullers. After a few months of information collection and strategy meetings amongst staff, however, SHAKTI shifted its focus from rickshaw pullers to brothel-based sex workers in a town called Tangail, a two-hour drive (90km) from Dhaka. Peer educators (volunteers) and outreach workers (sex workers who are paid by the project) played a crucial role in this project by providing information on sexually transmitted diseases (STD) and on condom use and distribution.

CARE B established health clinics inside the brothel and provided clinical services directly to sex workers. Tangail brothel-based sex workers planned clinic activities and provided limited clinical services. Within 18 months of the initial implementation phase, clinic management was handed over to the sex workers. Sex workers consulting the clinic for services paid between Tk.3 to 5 per visit. Initially CARE collected the money and gave it to the brothel samaj⁹, which decided how to spend the money. For instance, the money could be spent for a sex worker's funeral or for upkeep of the brothel after a heavy rain. After almost two years when the sex workers formed a self-help group, the money from the clinic that originally went to the samaj went to the self-help group.

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

The base-line study of street-based sex workers conducted in 1997 indicated that sex workers negotiated with clients in a large number of locations throughout the city, including parks, railway stations, movie halls, street corners, areas around office buildings and in many residential areas. Sex workers also used some of these locations to have sex with clients. The times sex workers conducted their business varied, depending on the locations and the characteristics of the women. For some, pimps and brokers arranged clients for sex workers, took their money and exerted a certain amount of influence over them.

In February 1998, SHAKTI supported sex workers to form self-help groups in the hopes that these groups would mobilize sex workers nationally to fight various forms of injustice and

8. In Bengali, Shakti means "power" or "strength"

9. A samaj represents an exclusive society governed by rules and regulations that are enforced by the group under the leadership

discrimination. Street-based sex workers in Dhaka formed Durjoy Nari Sangha, or Invincible Women's Organization, and brothel-based sex workers in Tangail formed Nari Mukti Sangha. The SHAKTI project worked only with female sex workers, as the initial project started in a brothel in which only female sex workers lived and worked.

2.2 HIV in Sex Workers

Sex workers in Bangladesh are thought to total around 100,000 (TvT Associates, 2001:1). HIV prevalence in Bangladesh remains under 1%, however, sex workers have been classified as one of the population groups 'most at risk' (ICDDR, B, 2004).

Data from Bangladesh National Surveillance in mid-1998 show that active syphilis was present in 57% and HIV in 3 per 1000 sex workers on the streets of Dhaka City, but this also included non-CARE areas (personal communication).

Table 1
CARE Annual Monitoring Surveys
Consistent Condom Use with Clients in Vaginal Sex Acts during the Last 24 Hours

Indicators	Baseline		2002		2004	
	N = 296		N= 240		N= 234	
		Total # of respondents had clients		Total # of respondents had clients		Total # of respondents had clients
Brothel-based sex workers	3.4% (8/227)	227	72.1% (129/179)	179	64.2% (113/176)	176
	Baseline		2002		2004	
	N = 230		N = 310		N = 322	
Street-based sex workers	13.5% (15/111)	111	59.4% (130/219)	223	74.7% (198/265)	269

The fifth round of the BSS in Bangladesh sampled 101 brothel-based sex workers and identified an HIV-positive rate of 2% and a decline in active syphilis cases in three of five locations. Street-based sex workers experienced a decline in syphilis rates overall (GoB, 2004). Sex workers not reached by a program reported condom use of 14% among brothel-based sex workers and 22% among those based in the street (FHI, 2004). Among clients, rickshaw pullers not reached by a program reported condom use of 11% (FHI, 2004). Brothel-based (38.5%) and street-based (28.9%) sex workers reported having anal sex with a client in the week before being interviewed (FHI, 2001). While these rates of condom use need to be improved, they represent significant improvements over rates of condom use in the first round of the survey (GoB, 2000).

2.3 Client Profile Survey

Despite the relative success of interventions like SHAKTI in Bangladesh, many issues related to female sex workers and their vulnerability to HIV have not been addressed. Underlying many interventions is the view that sex workers are a potential hazard to society as they contribute to HIV transmission by their frequent

change of sex partners. Interventions often do not sufficiently reflect the needs and interests of these women and do not appropriately address their clients. To this end, feedback from sex workers with regard to project interventions led CARE to conduct rapid surveys on clients of sex workers. These surveys identified five major occupation groups in 23 selected locations. These are: rickshaw pullers (17.7%); service employees including government staff, private staff, non-government organization staff, private car drivers, salesmen, hotel staff and cinema hall staff (15.3%); students (15.1%); police (13.4%); and businessmen (10.9%).¹⁰

Based on this information, an intervention was initiated to work with transport workers in an effort to increase effectiveness of project activities.

10. Bloem et al. 'HIV/AIDS and female street-based sex workers in Dhaka city: what about their clients?' In Resistances to behavioral change to reduce HIV/AIDS infection, Eds. Caldwell et al. 1999, 211-222

3.1 Transport Workers' Target Groups

The transport-worker intervention was launched in 2000, serving several types of transport workers at local, national or cross-border levels. Table 2 describes the type of transport worker and the year the intervention started. This phased approach allowed CARE to expand services and increase geographical reach during implementation.

In mid-2002 in collaboration with its Indian partner organization Bhoruka Public Welfare Trust, CARE B conducted a rapid situational assessment on HIV risk at major land-port sites along the Indo-Bangladesh border.¹¹ The focus was on mobile populations (illegal migrants and truckers) and border residents (road cleaners, hawkers, day laborers, money exchangers, dalas (illegal migration middlemen), smugglers, drug dealers, sex workers, ghat malick (traffickers) and customs and security personnel.¹²

3.2 Truckers and their Helpers

On both sides of the border, most truckers were between 20 and 30 years of age, with 12% being adolescents helpers. Half are educated up to the 10th standard, with a few being illiterate. Most of the Indian truckers could read and write both Hindi and Bangla. Over 33% reported having sex with sex workers within the past six months.

Having sex with other men (usually their helpers) was reported by 8% of Indian truck drivers and 17% of Bangladeshi drivers. These sexual experiences took place in parking lots, dhabas, or in the cabin of the truck. Condoms were rarely used with men during anal sex; the use of oil-based lubricants was common (Cross-border study CARE B, 2000).

DIC services were initiated on Bangladesh side of the border and were made available to both Indian and Bangladeshi truckers.

Year	Table 2 Initiation of Transport-Worker Intervention Groups
2000	1. Truckers (8 sites) 2. Rickshaw pullers (2 sites) 3. Dock workers (3 sites)
2001	1. Truckers (17 sites) 2. Ghat labor (1 site) 3. Rickshaw pullers (12 sites) 4. Quarry workers (1 site) 5. Dock workers (2 sites) 6. Land-port workers (1 site)
2002	1. Truckers (7 sites) 2. Launch labor (2 sites) 3. Launch labor (2 sites) 4. Rickshaw pullers (2 sites)

11. At Petrapole-Benapole and Bhomra -Ghojadanga

12. Benapole (Bangladesh): 100 truckers, 50 casual sex workers, 50 community members, 35 smuggling women; Petrapole (India) 50 truckers, 25 community people and 15 smuggling women. Total Sample size 325

Between 2000-2004, an estimated 418,390 transport workers were reached with services (more than half were rickshaw pullers and truckers).

In late 2000, CARE conducted a behavioral survey among long-distance drivers and their helpers. In the week preceding the survey, 37% of married truckers had sex with sex workers. Of those who had sex with a sex worker, 11% used a condom. About 64% of unmarried truckers had sex with sex workers in the week preceding the survey. Most truckers stated that they did not use condoms. Almost 30% of respondents stated that they believed they had a current STI symptom. Of those with a self-perceived STI symptom, 60% were truckers' helpers and 40% truck drivers. Almost 22% reported the use of some kind of substance, mostly alcohol, cannabis or codeine-containing cough syrups. Union leaders reported that up to 80% of drivers drink alcohol.

The high mobility of truck drivers posed the challenge of providing consistent standardized health care to a mobile population. To meet this challenge, CARE partnered with unions, who have an established nationwide network of services, thus giving truckers access to basic health services while travelling.

The Helper's Risk
When a truck arrives in a town after a night of driving, the driver goes off to rest in a cheap hotel room nearby while his truck is being unloaded. The helper cannot afford this - he works for as little as Tk.50 per day, plus food - and will sleep in the truck instead. To make extra money, the long-distance driver may rent the truck to a local driver to run errands during the day. About 10% of helpers in Chittagong Port reported that local drivers requested anal sex with them in exchange for money or goods, or through coercion. At the next town, both driver and helper may visit a brothel.

In 2000, an extensive mapping exercise was conducted along the national highways and major truck depots to find strategic points for intervention sites. Project sites were then chosen based on the number of truckers and their mobility in the area, the commercial importance of the area and whether it was river, sea or land port.

A land port, or dry port, is a border crossing point where trucks unload their goods rather than carry them to their final destination. These land ports are hubs of great activity: truckers are sidelined for periods of up to a week while their vehicles are unloaded and goods are checked. At all crossings along Indo-Bangladeshi borders, trucks of both nationalities are unloaded on the Bangladesh side. Most land-port workers, like dockworkers, migrated to the site from far-away villages. There are six major land ports with India, three of which are very large, involving hundreds of trucks per day.



Peer educator discussing HIV infection with transport workers in Dhaka

The truck-drivers intervention was a nationwide HIV prevention and clinical service project. It established 45 drop-in-centers and outreach services in 22 of the 64 districts of Bangladesh. The services also included follow-up with sex partners outside of family members.

3.3 Rickshaw Pullers

Cycle-rickshaws are large tricycles of wood and iron used to convey one or two people across short distances. It is the most popular form of transport in Bangladesh, used by most members of the middle and lower classes to get around in towns and cities. Pulling or cycling a rickshaw is hard physical work. The design of the rickshaw, its weight load and the poor condition of the roads make a rickshaw that much harder to pull.

There are an estimated one million rickshaw pullers in the country, half of them in greater Dhaka city. In the larger cities, up to 90% of rickshaw pullers are landless poor who have migrated from villages in search of

urban employment in hopes of a better future. Rickshaw pullers differ from other groups of transport workers: they earn much less than truck drivers, are less educated and are mistreated socially.

Rickshaw pullers are at high risk of contracting HIV. They are connected to the world of commercial sex, either as clients of sex workers, as the main form of transportation for sex workers in search of clients, or as brokers for clients in search of a sex worker. Additional exposure to HIV occurs through the use of injected drugs. This is particularly true of Dhaka, where an estimated 27% of IDUs are rickshaw pullers (although in other cities the proportion is far lower).¹³

In 1995, awareness-raising activities were conducted by CARE Bangladesh with rickshaw pullers, although the focus shifted to behavior change of sex workers and away from awareness raising. During the intervention with street-based sex workers, in late 1997, sex workers identified rickshaw pullers as a majority of their clients. With this information, CARE conducted focus group discussions with rickshaw pullers in Dhaka in 1998. Once information was collected CARE reconsidered potential interventions beyond awareness raising with transport workers in general.

Hoping to work more effectively with rickshaw pullers, CARE asked the rickshaw owners' associations in 2000 for their assistance in developing a collaborative intervention on HIV prevention. At least a dozen organizations in Bangladesh claim to represent rickshaw pullers, but most of them are affiliated to a political party. Only a few of them have any real following. Surveys conducted throughout the past 20 years have recorded no more than a 6% membership amongst rickshaw pullers.



Rickshaw pullers' garage were often site for DICs

Rickshaw owners (maliks) control fleets of between half a dozen and a hundred rickshaws. The cost of a new rickshaw is about Tk.5000. In addition to the capital investment, the owner must also buy or rent space to park the rickshaws overnight. All rickshaw maliks belong to one of several trade associations that represent their business interests. The activities of these associations include fighting against political decisions to eliminate rickshaws from city streets, recovering stolen rickshaws and bribing mastaans and local commissioners.

In all areas of the transport-workers' intervention, CARE tried to persuade owners' associations to support or sponsor part of the project. For example, in Chittagong, the Rickshaw Garage Owners' Union wrote to its members about the HIV intervention, and all 60 agreed to work as partners in the project. With their support, DICs were established in the rickshaw owners' garages. Most rickshaw pullers live in the garages when they are not working.

How much a rickshaw puller earns depends on his age, fitness, the season and motivation. In Dhaka, a rickshaw puller may earn between Tk.150 and 200 per day. However, after the rental of the rickshaw is paid (about Tk.40-50) and incidental minor repairs are made, this amount is reduced by half. In rural areas, gross daily earnings are less than half of those in Dhaka, although net earnings may not differ so much. Working five or six days a week, a puller's average income is equal to that of other unskilled workers (e.g. waiters, labourers, truck helpers).¹⁴

13. HIV in Bangladesh: The present scenario. A summary of key findings from the fifth round of serological and behavioral surveillance in Bangladesh (2003-2004). Ministry of Health and Family Welfare

14. The Rickshaws of Bangladesh, Rick Gallagher, University Press Limited, 1992

In large cities, rickshaw pullers live in rented accommodation in slums. Married pullers living with their families may pay Tk.1200-1500 per month for lodging. Slum life is precarious for all its residents; without legal rights to their housing, residents are subject to extortion or slum clearance. Those who cannot afford to house their families in the city spend months away from their wives, returning home a few times a year for festivals or the paddy harvest. Approximately, 60-80% of rickshaw pullers are effectively 'single'. They live in crowded bachelor dormitories, generally rented from the rickshaw owner. They may net between Tk.1500-2000 per month.

3.4 Port, Dock, and Ghat Laborers

Initiated in 2001, the dockworkers' intervention provided services to a range of laborers at sea and river ports, including those who work on ships in the harbor or on land at the jetty, dry docks, and warehouses.

The two major seaports in Bangladesh are government managed, but the trade unions control the labor. Usually the number of workers enlisted with the unions is greater than the number of jobs, so many of them do not receive daily assignments. Nonetheless, their salary and working conditions are better than for men working at locally managed docks.

There were five DICs for dockworkers at the seaports of Chittagong and Khulna. At these sites, with union office space not available or non-existent, the DIC rented its premises. This was expensive because real estate is at a premium within the dock areas.

Dockworkers are considered to be at risk of HIV because they are single and frequently visit sex workers. In addition, many foreign sailors come into the port area and use the same sex workers as local dockworkers.

Dockworkers' salaries depend on their level of skill and whether they are able to obtain government work (at Tk.300 per day) at the port authority or private work (earning around half that amount). Employee numbers, necessary for government assignments, are frequently rented out for one day at a time.

Skilled dock laborers earn salaries similar to truck drivers. Unskilled labor income corresponds to that of rickshaw pullers. Clinic fees for STI treatment are higher at trucker DICs and lower at rickshaw pullers DICs. At dockworker DICs, a higher rate was charged, which was difficult for some unskilled laborers to pay.

Most dockworkers' hours are fixed by daylight. For this reason, clinic services were under-utilized in some areas. Ideally, the dock DICs should be open in the evenings, when workers are idle, but it was difficult to find doctors willing to work at that time.

A ghat is a small jetty on the riverbank where goods are loaded, unloaded and stored. Workers come from villages around the country to work at the ghats and they live in nearby slums. Half of the ghat workers are married and some are women. Ghats are locally managed and the workers are generally defenseless against exploitation. Ghat workers often buy sex from either street-based sex workers or their female co-workers at the ghats. In some cases, female workers are manipulated by ghat bosses to have sex with them.¹⁵

The area around the docks and loading ghats is a vast expanse of corrugated iron warehouses (go-downs) and narrow lanes leading to the wide, slow river. Long jetties stretch out to cargo ships so that they can be unloaded. Dockworkers stream back and forth with their head loads or gunnysacks. Workers load, unload, and transport 50-kilo gunnysacks between boats, warehouses and trucks. Once a boat has docked, it can take a group of 50 men, working about 24 hours over two days, to empty it. They are paid between Tk.1-2 per gunnysack, and will move 100 or more a day.

15. Personal communication with key stakeholders of ghat workers

A worker can expect to earn Tk.100-120 per day. A strong, healthy, experienced worker can earn up to Tk.4000 per month, but most earn much less. Similar work at government-owned ports pays significantly more. Most dockworkers begin working at 12 or 13 years of age and have little or no schooling.

3.5 Ferry Workers

Bangladesh is a riverine country, where the passenger ferry or launch is an important means of transportation. They ply the river routes between major cities at night and are the cheapest mode of transportation in Bangladesh. An average launch carries up to 1500 passengers and 35 staff. Many launches are poorly equipped and maintained and indifferently navigated. These factors, combined with overcrowding and stormy weather, result in these launches often capsizing

Unskilled staff earns Tk.1000 per month, plus up to Tk.100 per day in tips. Passengers sleep on the open decks (third class), on padded benches or in private cabins (first class). Unskilled staff sleeps on the open deck but senior launch staff are assigned cabins. To earn extra money, they may rent their cabin out to a male passenger and his 'wife'. Rental rates may be reduced if staff members know the woman to be a sex worker and they are allowed to partake of her services as well.

CARE B's ferry-workers intervention began in Dhaka and Barishal, the two most important ferry terminals in the country. For both terminals, the ferry workers union is the intervention partner. Initially, clinic activities were held twice a week on one of the docked ferries. Outreach workers would hoist a CARE flag on the ship to indicate that the doctor was visiting, as the workers preferred to stay on the ferry during their free time, taking a rest or cleaning the ferry.

CARE's medical partners wanted to introduce a fixed base for clinic activities. They felt this would allow for a more sustainable project as people living in the neighborhood would also begin to access services; should funding for HIV outreach work eventually end, the clinic would continue to offer primary care and STI treatment.

In mid-2004, some rooms were rented in a dockside hotel to house a DIC. Now, the flag is hoisted there when the doctor is present. The goals are to build awareness of the availability of health services, to support health-seeking behavior and to ensure that the local population knows how to use condoms and medication properly.

3.6 Quarry Workers

A pilot project for quarry workers was added to the transport-worker intervention. As a largely migratory community, quarry workers are at risk of HIV in the same way that ferry workers are. In addition, many of the female workers are occasional commercial sex partners of truck drivers who transport the stone to the rest of the country.

Stone quarries in the country are located in the hills in the northeastern part of the country. For hundreds of years, workers have been quarrying at a hilly, rocky site on the border of Bangladesh near Assam, India.



An example of a quarry site in Dhaka

Jaflong is the largest stone crusher community in Bangladesh. The settlement consists of five slums of

temporary shelters (tents or small shacks), spread over an area of three-square kilometers. Drinking water is collected from the river. The land is hard to cultivate so food and other essential goods are expensive. Due to unhygienic living conditions and malnutrition, health problems are common. Slum owners and other local businessmen run the community.

Almost all of the 9500 people living there are employed in various quarrying tasks: breaking, collecting, or carrying rock. Most are young (60% are aged between 21 and 30) and have migrated from elsewhere in Bangladesh. Some work seasonally and return home for the rice harvest. About 40% of the quarry workers are female. They are primarily employed in breaking up the quarried rock, and are called stone crushers. They work an eight-hour shift, either during the day or at night, in addition to their regular household duties. Women involved in breaking or carrying rock earn Tk.50-100 per day, although some male quarry workers earn more. Half the labor force earns between Tk.1500 and 3500 per month. There are two "unions" for quarry workers. Membership is required to obtain a job, but does not entail representation of workers' rights. The labor force is primarily Muslim; a few are Hindu or Khashia tribals. As workers migrate from elsewhere, their social bonds are weak.

Although 66% of workers are married, most women are divorced, separated or single. All are of reproductive age, with the exception of a few child labor. There is no access to family planning services and family sizes are large. To obtain a job or to supplement their income, many women exchange sex for money. In 2002, 50% of women reported having had a sexually transmitted infection (STI).¹⁶

Every six months, CARE assessed changes in knowledge and behavior at outreach sites. Peer outreach workers, from a variety of districts where they have been trained to collect monitoring data, administered the questionnaires. To reduce staff bias, outreach workers did not collect information from their own area. Field trainers in each area supervised and monitored activities. In the truckers intervention, union leaders monitored activities, going into the field to observe outreach workers' performance and giving feedback. The monitoring instrument took 15-30 minutes to administer.

16. CARE Baseline Behavioral Survey, April 2002

KEY INTERVENTION STRATEGIES FOR TRANSPORT WORKERS

Although each transport-worker population differs in its needs and infrastructure, all the interventions share several strategies:

- | Partnership with existing labor-related organizations and NGOs
- | Participation of transport workers in outreach and other intervention activities
- | Fixed-sited DICs with standardized STI treatment protocols

4.1 Strategy One: Partnerships

Stakeholders in the transport industry were active in HIV-intervention activities through partnerships with transport workers' unions, transport owners' associations, governmental authorities, NGOs, and local community members. These partnerships focused on establishing clinical services and networking. Transport workers' unions provided an opportunity to broaden the reach and scope of the intervention through their national networks.

4.1.1 Partnerships with workers' unions

Truck driving is one of the few unionized professions in Bangladesh. Unions act as collective bargaining agents for drivers and, in some places, for the helpers. They offer training, advice, negotiation with owners and police and, at times, help with emergency health care costs. Members' dues fund operations; each union branch has an annual budget of between Tk.3000 and Tk.500,000 depending on the size of its membership.

There are two main unions for truck drivers. The Bangladesh Truck Drivers' Federation, an affiliate of the International Transport Federation, consists of 125 independent branches located in and around all the major truck depots. It claims a membership of 83,000 drivers (25,000 in one Dhaka branch alone), although membership figures are cumulative and it is unclear how many are currently active. The Anta Zila Truck Chalok Union has 258 branch offices; it represents a variety of large-vehicle drivers and is currently not affiliated with any international federation.



Union leaders planning HIV sensitizing program with both unions.

Most of the members of these unions are affiliated with one of the two main political parties of the country, although after a change of power many switch their political affiliation. For political reasons, CARE B staff maintains good relations

CARE prioritised development of partnerships with transport unions because they represent various worker groups. Unions offer an ideal environment for HIV-prevention activities with offices wherever there are truck stops. In addition, their ongoing programs made it easy for CARE B to dovetail HIV-prevention activities during regular union meetings. CARE B focused on building the capacity of the union leadership to carry out HIV-prevention activities under the union umbrella. These activities included conducting awareness-raising sessions, STI management and condom promotion through various outlets in and around the transport stops.

For HIV-prevention activities to continue after the project ends, the union, which normally collects Tk.10 per month from its membership, now collects Tk.12 a month to cover STI management activities. In three union offices, STD management services are continuing. In addition to these clinic services, health education sessions and discussions are ongoing.

Another way to ensure sustainability is to charge fees to recover 50% of medical expenses and 40% of the doctors' cost. In this way, clinic services will not collapse when funding ends. Additionally, patients may value services more when they have to pay for them, even if only contributing a nominal amount. Fees of between Tk.10 and 40 are affordable for an income earner.

4.1.2 Union leaders

Union leadership is an elected position. Most union leaders earn a living through business related to the transport industry, renting out trucks or brokering accident claims of union members. Although election to the union board does not provide a salary, it does bring with it increased prestige and influence, two important forms of currency in Bangladesh.

The union initially had reservations about collaborating with CARE due to bad experiences with other NGOs in the past. They resented the implication that truckers were responsible for HIV transmission; indeed, they even resisted the insinuation that truckers were sexually active outside of marriage. Open discussions about sexual activity and public displays of condom use, demonstrated on a plaster model of a penis, were regarded as novel, but suspicious.

Trusting relationships were established with union leaders through discussion, reputation-building, advocacy, and information dissemination. CARE provided relevant information during education sessions, held to its commitments and hired truck drivers and their helpers as peer outreach workers. Eventually, the often-tense relationship between CARE and the unions became friendly, with each acting as collaborators and equal partners.

To mitigate any potential corruption on the part of union leaders, CARE developed an extensive monitoring system (everything is transacted through the bank, bank statements are reviewed etc.). CARE did experience some small-scale misuse of funds, but the monitoring system picked it up and the situation was quickly rectified.

In addition to providing office space for the DICs, union leaders have contributed to the intervention in other ways:

- | Contributing time for the day-to-day management of the DIC
- | Participating in clinic governing committees
- | Monitoring outreach worker activities
- | Bearing the maintenance costs of the DIC
- | Sharing union office staff with the DIC
- | Motivating transport owners and agencies to support the intervention
- | Social marketing of condoms through union offices
- | Attending peer training graduation ceremonies

4.1.3 Lessons learned

The transport intervention took place from 2000-2005. During the first four years, CARE B was directly implementing the activities. In the final year of implementation, CARE B worked through partners to run the clinics/DICs. Although CARE B had been working with 29 unions during the first four years, only seven unions (deemed to have adequate capacity) were selected to continue implementing HIV activities in the fifth year. The other 22 sites were handed over to local NGOs. Due to the rather abrupt shift of activities from direct implementation to partnership, issues around sustainability, quality and monitoring were not adequately addressed. Once project staff reflected on the activities, they came up with the following lessons:

Partnering. CARE B designed the project to be implemented through partners from year one but delayed selecting partners until year four. As it started late, the process had to be rushed. Then without a cohesive partnership plan/selection criterion in place, the best choice of partners was not always made.

- u Partnerships with unions provide outreach. Collaboration with unions initially assisted in providing the necessary services and activities to a broad range of transport workers. In addition, working with and through union leadership led to immediate credibility with transport workers.
- u Address issues of sustainability from the beginning of the project. During the five years of project implementation, 45 DICs were established and rent was paid on all of these buildings. In general, rickshaw owners or union leaders provided the buildings. In addition, project funds paid for all DIC staffing. Given the amount of money required to run one DIC for a month, it is clear that issues around sustainability were never really addressed. To date, only three of 45 DICs are currently functional.
- u Establish CARE as a collaborator and not a political tool. As union leaders are elected officials, CARE must not be perceived as a political instrument of the leaders during election campaigns or during regular activities. An example of this might be if a union leader selected peer educators in the absence of transparent selection criteria. As incentives are usually given to peer educators, selection of peer educators by union leaders could be interpreted as favoritism.¹⁸

4.2 Strategy Two: Peer Educators and Peer Outreach Workers

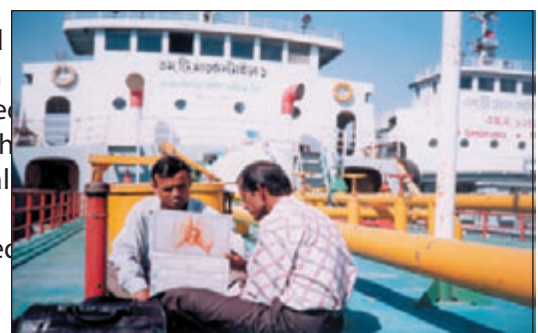
Peer education typically involves training and supporting members of a given group to effect change among



Peer outreach worker conduct an HIV information session with a group of truck drivers at a truck stand in Dhaka

members of the same group (Parker and Aggleton, 2002). CARE B used this approach to develop several aspects of its transport-worker intervention, primarily with regard to the use of peers (men currently working in the transport industry) as outreach workers. The peer outreach workers-cum-peer educators also identified areas for their activities and ensured the cultural appropriateness of prevention messages. Peer educators volunteered their services as and when they liked; outreach workers however were paid and were required to develop a work-plan, had a job description and targets to meet with regard to activities and conducted one-on-one sessions and group sessions. Finally, if outreach workers showed skills in data collecting, they were included in survey-related activities.

Because of their work, peer outreach workers also benefited beyond the primary aim of educating others. Working in a structured environment, they were supervised and encouraged to emphasize behavior appropriate to their role as health representatives. For example, maintaining good personal hygiene (despite their living conditions), trying to dress well and using condoms were all behaviors that were demonstrated as well as talked about.



Peer outreach worker conduct one-on-one session with a port worker at Chittagong port

18. Although peer educators are unpaid volunteers, they receive incentives that include small gifts and souvenirs

Both peer educators and peer outreach workers were recruited from trucker target groups. Peer educators participated in two-day training sessions about HIV and STI prevention. After training, they received a certificate of completion and were asked to provide information to their friends, family, and fellow peers, informally, over the course of their daily activities. The criteria for selection of peer educators (volunteer) included:

- | Interest in receiving training
- | Extroverted personality - outgoing, sociable among community members
- | Accepted by others in the community (through observation)
- | Able to explain clearly ideas and concepts to others

Peer outreach workers (paid) criteria included all of the above plus:

- | The same age as their peers
- | From the same geographical location where they will be working
- | An active participant in training peer educators

4.2.1 Training

Training for peer outreach workers included proper use of educational materials, condom demonstrations, identifying problems and skills in resolving them, and referral and follow up of STI patients. Those who showed an aptitude for data collection were asked to participate in the bi-annual monitoring survey.



Peer educator training with truck helpers in Dhaka

They received additional training on how to administer monitoring instruments. Field trainers monitor the quality of outreach workers' work and correct technical information or counseling approaches as necessary.

4.2.2 Outreach activities

Outreach is conducted on the streets surrounding each DIC between 8 a.m. and 4 p.m. Outreach workers' activities were to initiate contact with transport workers and increase their knowledge about HIV on a one-to-one basis and in small group sessions. To generate demand for condoms, outreach workers ensure their availability and demonstrate correct condom use. They also refer workers to DIC services, offer counseling on STI symptoms and follow up on treatment compliance. The credibility of outreach workers is founded on their membership in the community and as role models. During one-to-one or group education sessions, they use illustrated flipcharts and an album of STI photos to identify possible STI patients for referral to treatment at the center. Outreach workers also did partner tracing for those transport workers who tested positive for STIs. They distribute condoms and discuss individuals' barriers to consistent use. They follow-up STI patients, discuss individual health problems, and monitor users' self-reported activities and behavior change.



Peer outreach worker conducting one-to-one session in Dhaka

To assist outreach activities, CARE B developed low-literacy materials for transport workers. These included a peer outreach worker manual in Bangla, a booklet about common STIs and leaflets and posters.

4.2.3 Lessons learned

In establishing the intervention for transport workers, CARE applied the model used with the sex workers. There were, however, some major differences between these target groups, particularly with regard to marginalization and income. Only upon reflection after the project ended were staff able to articulate some of the lessons learned:

- | Truckers and helpers should be monitored separately. Truckers have a steady income and a hierarchal relationship with their helpers. With this in mind outreach and peer related activities should reflect the differences that exist between these two different target groups. Helpers are clearly more
- | marginalized in terms of socio-economic status.

- | Programmatically, approaches should recognize differences between transport workers' sexual networking. These differences can be looked at in terms of risks and peer related activities and should
- | address the specific risks of each target group.

- | Rickshaw pullers are more mobile and make small amounts of money, but dock laborers are not very
- | mobile and have frequent interactions with foreigners.

- | Different models should have been developed and piloted. The program was growing rapidly, but without consistent leadership or management. Thus greater attention should have gone to learning, as opposed to expansion. This would have laid a foundation for increasing the effectiveness across different target groups within the transport sector.

4.3 Strategy Three: Drop-in-Centers

The DIC model evolved from focus group discussions that took place as part of the baseline survey with street-based sex workers. During group discussions, participants indicated that they did not have a safe place to rest. As a result of these discussions, DICs were created to provide services for this high-risk group and to provide support for the street-based outreach activities. Across the country, 45 DICs for transport workers were established, 12 of them in Dhaka.

DICs provide treatment for people with STIs and other illnesses, HIV prevention education and counseling, and social and recreational facilities. Most centers are open between 8 a.m. and 4 p.m. Location, opening hours, and user-friendliness are the three most important considerations.

Each group of outreach workers is based at a DIC. A staff member, called the DIC-in-charge, manages the activities. The DIC-in-charge and all outreach workers are supervised by a field trainer, who usually oversees the work of four to 10 outreach workers, or is responsible for more than one DIC.

The DIC-in-charge is selected for his leadership and literacy skills. He / she is responsible for opening the clinic in the morning, maintaining attendance and service registers, making referrals to the doctor and scheduling return visits, providing one-to-one and group education sessions, helping prepare reports on counseling and STI treatments, preparing patient lists, handling day-to-day activities such as cleaning, ensuring stocks of condoms and interacting with clinic partners and visitors.



In addition to staff from CARE B and clinical partner NGOs, the DIC Management Committee includes other stakeholders such as union representatives, neighborhood homeowners, local business people, the ward

administrations and the health department. The committee is responsible for general troubleshooting and raising awareness.

The DIC is essential to the stability of the project's services. For those who live in slums, hygiene facilities are limited and access to a toilet and bathroom is a high priority. The DIC also offers recreational activities to help develop a feeling of camaraderie with staff and to help create an environment in which discussions about HIV and STIs become comfortable.

4.3.1 Services at the DIC

In Bangladesh, clinical consultation and treatment are not free and are not easily available to itinerant workers. The three greatest barriers to STI treatment¹⁹ are cost, embarrassment and accessibility. Typically, health clinics offer little privacy (i.e. a relatively sound proof space). Staff members are often judgemental and insulting. Few doctors have specific training in STIs and may prescribe inadequately, leaving the patient uncured and unconvinced. One-dose treatment is generally unavailable. Anal STIs are completely ignored, in both women and men, and are not mentioned in syndromic management guidelines.



Medical check up of a trucker in a drop-in-center in Dhaka

As truckers and rickshaw pullers often find it difficult to leave their vehicles, DICs are located within truck stands, port areas and rickshaw garages. The chief clinician in a DIC is the physician, provided by a partner NGO. Doctors are available according to patient load, from two half-days per week to six days a week.

All DICs for transport workers have a separate clinic room with an examination table. Clinic doctors provide STI care, but can also offer a few essential drugs for common symptoms (e.g. fever, back pain, anemia).

STI treatment meets one of the immediate needs of transport workers and serves as a key strategy in reducing HIV transmission. Outreach workers refer transport workers (and their partners) to the DIC for syndromic management of STIs. Transport workers visit the DIC clinic for any illness and bring their sex partners for STI treatment as well.

All patients receive a card that entitles them and their families to co-ordinated treatment. A small fee is charged for services to help ensure project sustainability. Truck drivers, the most affluent of the transport workers, are charged Tk.20 for the first visit and Tk.15 afterwards. Rickshaw pullers are charged Tk.5 per visit, and local residents (mostly slum dwellers) are charged Tk.10. There was a 50% discount on the cost of the prescription (up to Tk.100) for transport workers.

The DIC clinic treats local residents for primary care, so it is not stigmatised as an STI clinic.

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

4.3.2 Condom access

Outreach staff offers condoms for sale, rather than distributing them for free. Experience has shown that



Outreach staff delivers condom to a truck driver at Tejgaon truck stand in Dhaka

this reinforces the perceived value of the condoms among consumers. The price of condoms in Bangladesh is relatively low as they are subsidized by government (30 paisa to Tk. 3) so that they remain within anyone's reach. In addition, by selling condoms outreach workers do not compete with local merchants. Rather, they work hand-in-hand with those in the community who will carry on promoting and selling condoms once the intervention has ended. By 2004, the transport-worker intervention was selling up to 400,000 condoms per month across the country through its outreach worker system.

4.3.3 Lessons learned

In establishing transport-worker interventions, CARE B applied the same implementation model used previously with sex workers. However, there were some differences between these target groups, particularly with regard to marginalization and income. Most HIV-prevention projects focus on a particular risk group and devise activities based on their specific characteristics, as each sub-population is distinct in many ways. For example: truckers have a steady income and a hierarchical relationship with their helpers; rickshaw pullers are more mobile and make small amounts of money; and dock laborers are not very mobile but have frequent interactions with foreigners. It is therefore necessary to alter the intervention model from sex workers to the needs of other distinct target groups.



Tea stalls in and around truck stands keep condoms to distribute in absence of outreach workers

Several reasons explain why the program did not adapt/evolve as it moved forward. First, the program was expanding rapidly during this period and diversifying the intervention (i.e. the number of groups) became a priority. Second, the project did not have consistent leadership or management at this time - so it moved ahead without adequate guidance. Only upon reflection after the project ended were staff able to articulate some of the lessons learned. These lessons are listed below.

u

Monitor social and clinical indicators. An opportunity was missed to learn about who attends DICs for any given transport-worker intervention. For instance, why were some transport workers able to bring in their sexual partners and others not? Even though the focus of DIC activities was on providing clinical services, monitoring information on social indicators could have provided extremely useful information for outreach and for refining DIC activities. Not having developed indicators or collected regular information on issues related to power relationships, rights and social equity now limits our ability to articulate (with evidence) the impact of these issues on this HIV program.

u

treatment protocols and training for partners. This was effective in terms of quality control and working with partner staff on attitudes towards high-risk groups. However this clinical approach did not adapt for different groups (e.g. truckers' helpers) and at times did not properly diagnose illnesses (e.g. anal STIs) or lead to proper counseling.

- u Address issues around sustainability in the beginning of project activities. Increasing access to services and treatment was one of the key objectives of the intervention. However, in establishing and subsidizing DICs rather than using (and building the capacity of) existing services, no support structure remained after the life of the project. This created unrealistic demands on CARE B to continue this service.
- u Include female clinical assistants. To encourage transport workers to bring in their partners or spouses, female clinical assistants were recruited to work in the DICs. This proved to be an effective approach, as female partners were more comfortable discussing their sexual history with other females.

The lessons learned from this intervention with transport workers should inform future CARE B HIV prevention programs, particularly with regard to strategic approaches. The three strategic approaches designed for working with transport workers of all types were fostering partnerships, developing peer education and peer outreach and establishing DICs.

The first strategic approach, partnership, is more an approach of choice for program implementation across sectors, although it needs careful planning and consideration. To increase the outreach and provide national scope for intervention activities, CARE B partnered with truckers' labor unions and others. The project fell short of reaching its long-term sustainability goals, however, because the unions lacked both technical and organizational capacity. When working with or through partners, provision should be made well in advance for providing technical and organizational assistance (administration, finance etc.). By focusing solely on the technical aspects of HIV prevention, partners do not develop sufficient capacity to continue the program once funding subsides.

The second intervention strategy, peer education, drew several lessons for future HIV-prevention programs. The power relationships between the target group members, be it the helper and the driver or the sex workers and the madams, need to be clearly understood to ensure an intervention will be effective. For example since a trucker sees his helper as subservient, it is unlikely that the truckers would listen to their helper regarding health education and testing for STI. The situation would be the same for the sex worker and the madam.

Although peer education is a globally recognized approach to HIV prevention, its effectiveness across varying target groups can have mixed results. For example, an AIDS intervention in Tanzania by Mwizarubi et al.²⁰ found that although awareness and condom distribution increased, the women at the truck stops still needed greater skills for negotiating with their male clients to use condoms. A consultation report²¹ of 45 experts realized that to help reduce HIV transmission, structural interventions needed to be made. These interventions included raising salaries and limiting overtime and providing nursery care so that wives could travel with their husbands, and providing truckers with better contact with their families by increasing telephone access. Some of these interventions may be out of reach for general HIV prevention programs, but other programs with a focus on poverty reduction, gender equity and empowerment could consider them.

The third major strategic approach with the transport workers' intervention was establishment of DICs. During the intervention, the DICs were considered a success, as they provided a base for peer educators and outreach workers and a gathering point for clinical services and health education activities. However well intended, the DIC model did not prove to be sustainable. For instance, the clinic services at the DICs were sub-contracted to a service provider outside the government system, which also provides STI treatment. The sub-contracting created a parallel health service delivery system to that of the government. All staff salaries at the DICs were from project funds, which were unsustainable, once the project ended.

The purpose of this document is to share CARE B's experience in HIV/AIDS prevention with a broader audience. During documentation, the staff had an opportunity to reflect on the intervention outputs and processes. Through this reflection many of the lessons learned surfaced. In the future, reflective learning will become an integral part of each intervention, in an effort to adjust approaches to newly acquired knowledge and experience.

20. Mwizarubi, et al. 'Preventing HIV infection through peer education and condom promotion among truck drivers and their sexual partners in Tanzania, 1990-1993'. *AIDS Care*, Vol. 12, No. 1, 2000, 27 - 40

21. Peer Education and HIV/AIDS: Past experience and future directions, Horizon project, Population Council, 1999

REFERENCES

- Bloem, M.; Hoque, E.; Khanam, L.; Mahbub, T.S.; Salehin, M. and Begum, S. (1999) 'HIV/AIDS and female street-based sex workers in Dhaka city: what about their clients?' In *Resistances to behavioral change to reduce HIV/AIDS infection*, Eds. Caldwell et al. 211-222pp. Available at <http://htc.anu.edu.au/pdfs/resistances_ch17.pdf> accessed May 31, 2006.
- CARE B (2000) Baseline survey, HIV Program (unpublished).
- CARE B (2000) Cross-border study, HIV Program (unpublished).
- CARE B (2001) Annual monitoring report, HIV Program (unpublished).
- CARE B (2002) Annual monitoring report, HIV Program (unpublished).
- CARE B (2004) Annual monitoring report, HIV Program (unpublished).
- Gallahar, R. (1992) *The Rickshaws of Bangladesh*, University Press Limited, Dhaka.
- GoB (2000, June) Report on the Sero-Surveillance and Behavioral Surveillance on STD and AIDS in Bangladesh 1998-1999. National AIDS/STD program, Directorate General of Health Services, Ministry of Health and Family Welfare, Dhaka.
- GoB (2003, June) HIV in Bangladesh: Is Time Running Out? Background document for the dissemination of the fourth round (2002) of national HIV behavioral surveillance. National AIDS/STD program, Directorate General of Health Services, Ministry of Health and Family Welfare, Dhaka.
- GoB (2004, November) HIV in Bangladesh: The present scenario. A summary of key findings from the fifth round of serological and behavioral surveillance in Bangladesh (2003-2004). National AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Dhaka.
- GoB (2005, September) National HIV Serological Surveillance, 2004-2005 Bangladesh, Sixth Round Technical Report, National AIDS/STD program, Directorate General of Health Services, Ministry of Health and Family Welfare, Dhaka.
- FHI (2001) What Drives HIV in Asia? A Summary of Trends in Sexual and Drug-Taking Behaviors. Available at <http://www.fhi.org/en/hivaids/pub/survreports/hiv_asia_sexdrugs_summary.htm> accessed May 31, 2006.
- FHI (2004, July) Bangladesh Country Profile, FHI Asia Pacific Division, Bangkok.
- ICDDR, B (2004) HIV in Bangladesh: the present scenario. Centre for Health and Population Research Available at <<http://202.136.7.26/activity/index.jsp?activityObjectID=1185>> accessed June 4, 2006.
- Mwizarubi B. K.; Laukamm-Josten U.; Outwater A.; Mwaijonga C. L.; Valadez J. J.; Nyamwaya D.; Swai R.; Saidel T.; Nyamuryekung'e K. (2000) 'Preventing HIV infection through peer education and condom promotion among truck drivers and their sexual partners in Tanzania', 1990-1993. *AIDS Care*, Vol 12, No 1 / February 1, 27- 40pp.
- Parker, R.; Aggleton, P.; with K. Attawell, J. Pulerwitz, & L. Brown (2002, May) 'HIV/AIDS Stigma and Discrimination: Conceptual Framework and an Agenda for Action'. In *Findings from the Field, A Compilation to Date of Publications on HIV/AIDS from Horizons and Partner Organizations*, (CD-ROM). Population Council, New York.
- Population Council (1999) Peer Education and HIV/AIDS: Past experience and future directions, Horizon project, Population Council. Available at <http://www.popcouncil.org/pdfs/peer_ed.pdf> accessed June 5, 2006.
- TvT Associates (2001) HIV/AIDS in Bangladesh and USAID Involvement. Available at <http://www.usaid.gov/our_work/global_health/aids/Countries/ane/bangladeshbrief.pdf.2001> accessed February 26, 2005.
- UNAIDS (2004) UNAIDS report 2004 on the global AIDS epidemic, available at <http://www.unaids.org/bangkok2004/report_pdf.html> accessed May 25, 2006.

The *Transport Workers at Risk* document grew out of CARE Bangladesh's experience during the four year implementation of RASTTA BONDOR, an HIV prevention project focusing on truckers and their helpers, rickshaw pullers and dock workers. This paper was produced and coordinated by the HIV program office in Dhaka. Many people provided invaluable support and input during implementation of the program and development of the documentation. The project was funded by the United Kingdom's Department for International Development (DFID).

