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COUNTRY SNAPSHOTS:

BANGLADESH

BACKGROUND

Bangladesh is the fifth most populated country in Asia. With high poverty levels and population density, HIV-prevalence in the general population is low (less than 0.1 percent), with the epidemic concentrated among key populations, including MSM, female sex workers (FSW), PWID, TG and migrants. Bangladesh is one of only four countries in Asia-Pacific in which HIV prevalence has increased over 25 percent in the last decade.[1]

COUNTRY PRIORITIES

The National Strategic Plan (2011 - 2015) focuses on services to prevent new HIV infections ensuring universal access to services, provide universal access to treatment, care and support services for people infected and affected by HIV, strengthen the coordination mechanisms and management capacity at different levels to ensure an effective multi - sector HIV/ AIDS response and strengthen the strategic information systems and research for an evidence based response. A human rights approach will be adopted to maximise service access by marginalised populations and empower them to be involved in all aspects of the national response. Three major HIV programmes were/are implemented under the stewardship of NASP and the three key contributors that support major prevention programmes in the country are the World Bank, the Global Fund and USAID.[2]

In Bangladesh total 309 DICs, 61 voluntary counseling testing (VCT) centers and 98 blood transfusion centres for HIV screening in hospitals are in operation. These are operated in partnership with NGOs, media and civil society. The NGOs mainly concentrate on high-risk groups such as 119,869 men who have sex with men (MSM) and 8,533 TGs. The government acknowledges the fact that it needs more HIV Testing and Counseling (HTC) centers.[3]

DATA SUMMARY

Epidemiology	Estimate	Year
Estimated No. Of MSM[4]	119,869	2016
HIV prevalence per national estimates [5]	0.4%	2016
No. of times higher than among general population[6]	<1% (KP) 0.1% (GP)	2016
HIV prevalence among youth MSM[7]	NA 0 (According to one source)	2015
No. of MSM/TG on ART	NA	-
STI prevalence among MSM/TG[8]	32.7% (MSM) 32% (TG)	2016
Syphilis prevalence among MSM/TG[9, 10]	1.1% (MSM) 3% (TG)	2015
Estimated No. of TG/Hijra[11]	8,533	2016
HIV Prevalence as per national estimates[12]	1.4%	2015
No. of times higher than among general[13]	<1% (KP) 0.1% (GP)	2016
Behavioural (MSM)	**Estimate**	**Year**
Average number of partners	6-8 in a month	2016
Condom use during last encounter (anal sex)	46%	2016
HIV test in last six months	68.6%	2016
Prevention knowledge	30%	2015
Reported vaginal sex in last one month	30%	2016
Substance use	51%	2016
IDUse	NA	----
Behavioural (TG)	**Estimate**	**Year**
Average number of partners	5 clients a week	2016
Condom use during last encounter (anal sex)	58.4%	2016
HIV test in last six months	76.5%	2016
Prevention knowledge	35.8%	2014
Reported vaginal sex in last one month	7.9%	2016
Substance use	NA	----
IDUse	NA	----

DATA SUMMARY

Programmatic	Estimate	Year
HIV Prevention Coverage MSM/TG[25]	40% (MSM) 45% (TG)	2015
National level strategy for MSM/TG[26]	Bangladesh has several policies to implement Targeted intervention and care and support project with MARP and the same is applicable for MSM community.	2016
Legal	**Status**	**Year**
Male to male sex [27]	Country's criminal code prohibits "unnatural sex," contributing to the fear of disclosure for MSM	2016
Sex work in private [28]	Sex work is legal in Bangladesh	2015
Soliciting for sex [29]	Municipal ordinances against soliciting place them at high risk for police harassment and Police have been known to arrest members of many marginalised groups arbitrarily and without warrant	2016
Sections criminalising same sex activities [30]	Section 377 of the Penal Code 1860 criminalises same-sex relations in Bangladesh. Men who have sex with men are stigmatised and socially marginalised in Bangladesh.	2016
Third gender recognised [31]	Yes	2014
HIV Policy [32]	Mandatory testing and no comprehensive enforceable national laws against discrimination on the grounds of HIV status	2016
TG/H Policy or bill [33]	In 2014, Cabinet agreed to a proposal from the Ministry of Social Welfare to give legal recognition to Hijras as a third gender. This enables Hijras to access rights in relation to education, health and housing.	2016

FAST TRACK RESPONSE

HIV TESTING STATUS

HIV testing and counselling (HTC), which includes Voluntary counselling and Testing (VCT) and Provider Initiated Testing and counselling (PITC), is an essential component of HIV prevention, care and support. With the advent of treatment as prevention, HTC may act as the first entry point into the continuum of care, and at the same time provides an opportunity for education and counselling in a confidential environment. Monitoring of data from HTC sites can be used to effectively identify new populations at increased risk for HIV and to assess the impact of public health interventions.

Since the establishment of the first HTC centre in 2002 by the International Centre for Diarrheal Disease Research, Bangladesh, the number of HTC sites in Bangladesh has increased, and has also expanded across the country, through the efforts of various non-governmental organisations (NGOs). However, analysis characterising utilisation of HTC services in Bangladesh are lacking, and identifying the population groups testing positive for HIV at HTC sites could provide useful information for the optimisation of prevention programmes.[34]

HIV TREATMENT DELIVERY

Bangladesh is committed to universal access to HIV treatment, care and support for those in need. Because of limited capacity in the government sector and competing demands, HIV services is delivered across government, non- government and private sectors. The complexity of HIV medicine requires different levels of expertise for undertaking different tasks. For example, initiation and monitoring of ART is less complex than management of treatment failure. Services are provided through a team-based approach across different sites and functions (e.g. basic ART maintenance, provision of diagnostic services and management of related complications). Opportunistic infections are treated through prophylaxis through accredited doctors.

The provision of anti-retroviral therapy can reduce risk of HIV transmission after HIV exposure. PEP is available in health care settings. Awareness of the availability of PEP is promoted to health care workers as a method to reduce risk of post exposure transmission and thereby also reduce fear of providing treatment and care. A national referral centre will be identified where case management can be provided of PEP on a shared care basis with local service providers. Local service providers receives advice from the national centre on suitability of administering PEP, where and how to access PEP drugs and on-going support and monitoring while PEP is being administered.[35]

INTENSIFIED COMBINATION PREVENTION

To intensify prevention efforts, Bangladesh health ministry adopted following strategies. A basic service package will be available to the general population. This includes provision of basic HIV information, access to VCT and STI services and access to condoms/lubricant. Service provision will be less intensive and mainstreamed. Addressing changes in patterns of risk and vulnerability in the general population will occur through piloting and scaling up interventions based on regular vulnerability mapping and mobilising the private sector to provide workplace interventions.

FAST TRACK RESPONSE

Standardised service delivery packages based on evidence of best practice are described. Agencies will have flexibility to adapt implementation to local circumstances. Better coordination between service providers, use of strategic information and enhanced capacity development will improve quality of service delivery. Where evidence is lacking on which to scale up service provision, pilot interventions will be implemented and evaluated. Hidden population at higher risk and/or vulnerability will be reached through behaviour specific messages in communication targeted at the general population (e.g. inclusion of anal sex as a risk factor). [36]

Significant communication initiatives

- Currently Bangladesh has a vibrant electronic and print media. There are many satellite channels competing for the audience's attentions. There is increasing coverage of both land and satellite based channels. The print media circulation is increasing. There is significant scope for involvement of electronic and print media in promoting public education and information regarding HIV and AIDS prevention, care and reducing stigma to create an enabling environment.
- The specific role media plays are: creating awareness of everyone's risks of contracting HIV, developing understanding of the underlying causes and consequences of the epidemic, contributing to an enabling environment in which people with HIV and AIDS can live in dignity with full protection of their human rights.

OWNERSHIP

The Bangladesh National HIV Strategy is based on the principle of partnership between government and community sectors. [37]

INNOVATION

Not Available

BEST PRACTICE

Following best practices[38] have been identified in the period 2013-2016.

- Initiating MIS for interventions with Key Populations.
- Recognition of Transgender / Hijra as the third gender in Bangladesh. Hijras are now considered as a separate gender in Bangladesh and will get priority for education and other rights. Currently steps are being taken to fully legalise this recognition. Hijras are already enlisted as voters in Bangladesh.
- Community Access to HIV Treatment Care and Support Services Study: Bangladesh Report Asia Pacific Network of People Living with HIV/AIDS (APN+) under the support of the Global Fund Round-10 conducted a study on `Community Access to HIV Treatment Care and Support Services (CAT-S) in Seven Asian Countries'. The study sites were Bangladesh, Indonesia, Laos, Nepal, Pakistan, Philippines and Vietnam. In Bangladesh, Ashar Alo Society (AAS) conducted this study. It is hoped that this study has provided insights on working towards effective mainstreaming and scale-up of HIV programmes in Bangladesh. This cross-sectional study, conducted during November 2012 to April 2013, serves as a baseline study to measure longitudinal changes in access to HIV treatment-related issues in Bangladesh.

FAST TRACK RESPONSE

ZERO DISCRIMINATION

MSM

Section 377 of the Penal Code 1860 criminalises same-sex relations in Bangladesh. Men who have sex with men are stigmatised and socially marginalised in Bangladesh. As MSM face social discrimination and legal persecution in Bangladesh, this compromises their physical, mental and sexual health. The stigma surrounding homosexuality makes this a difficult-to-reach population subgroup. Islamic religious beliefs, hetero-normative pressures, and social norms demand that men be masculine and heterosexual. Deviations are unacceptable, and those who defy these norms face ridicule, physical and mental violence, and discrimination in educational, social and employment settings. Homosexuality is a criminal offence, which makes both MSM and health outreach staff that supports them prone to frequent harassments from police and local hoodlums. The resulting environment of fear prevents vulnerable MSM from seeking information and services, such as treatment for STIs and counseling on adopting safer behaviors to reduce their risk of HIV infection. Cases of some MSM committing suicide due to discrimination have been reported. Double stigmatisation occurs when MSM are diagnosed with HIV infection and have to cope with two ostracised identities.[39]

TG

Hijra, a traditional transgender identity, is formally recognised as a third gender, yet members of this community remain highly stigmatised and subject to abuse. Police have been known to arrest members of many marginalised groups arbitrarily and without warrant.[40]

MONITORING AND EVALUATION

To strengthen monitoring, evaluation and planning the monitoring/evaluation plan for the national strategy are used as a framework for developing a common curriculum and tools across implementing agencies. The HIV Management Information System (MIS) are in the process of getting integrated with the broader health information system (HIS). This integrated system will effectively combine prevention, treatment, pharmaceutical supply, laboratory support, supervision, and programme management at all levels. Strengthening community system monitoring, evaluation and planning capacity is necessary to facilitate improvement in service delivery. The development of shared systems/processes, service definitions and indicators across organisations implementing the HIV strategy will reduce duplication in services, and provide a basis to compare performance and share learning. A monitoring/evaluation technical working group will advise NASP on all aspects of strategic information. It will be composed of M&E experts from government, UN agencies, Development partners and Key HIV/AIDS NGOs, academic and research experts. All components of strategic information, will contribute to monitoring/evaluation. The monitoring/evaluation framework will inform specific needs to be addressed in other components of the strategy.

National guidelines and tools will be standardised to ensure quality of all data collected for monitoring/evaluation purposes. A management information system (MIS) database will be maintained containing all information collected to meet indicators of the M/E framework. IBBS and serological surveillance are conducted on a regular basis.[41]

PROGRAMMATIC ALLOCATIONS

Bangladesh will save USD 79.6 million with a cost benefit ratio of 7.2[42]

(Taka in lakh)	Total	GoB	PA (RPA)	Source of PA
Approved cost of the PIP (Development Budget)	22,17,666.21	8,60,350.12	13,57,316.00	Pooled, WHO, USAID, GFATM, UNAIDS, UNICEF, UNFPA.
Estimated cost of the OP	27,291.90	1300.00	2599.00	GFATM, UNAIDS, UN ICEF, UNFPA.
Cost of OP as % of PIP	1.23%	0.15%	0.19%	

Source: *Operational Plan NATIONAL AIDS/STD PROGRAMME (NASP) July 2011 - June 2016, www.dghs.gov.bd*

TREATMENT CASCADE

There are limited treatment facilities for PLHIV in Bangladesh. Less than 500 PLHIV are documented as currently receiving ARV. ARV is available through the government health system. Provision of diagnostic services for Opportunistic Illnesses and monitoring disease progression is very limited. Only Dhaka Infectious Diseases Hospital (IDH) provides in-patient services for the PLHIV among the public facilities and the number in private and non-government settings, is low. Capacity to provide more complex HIV treatment needs (e.g. failure of first line ARV therapy; Hepatitis C and TB confections; elevated risk of other morbidities such as cervical cancer, diabetes) is extremely limited. Mechanisms to ensure quality of treatment service provision are absent.

Enhancing laboratory capacity for measuring CD4 counts and better diagnosis of OIs is essential to initiate treatment cascade. It is not adequate to provide equipment only for these purposes, training (both at the time of installation as well as refresher), ensuring supply of reagents, capacity to store reagents appropriately, capacity to maintain equipment, etc. are all required. Quality Assurance of tests will be established. Care and support needs will be met through improved needs assessment of PLHIV, better linkages between services and strengthening of PLHIV organisations.

ADDITIONAL RESPONSE

UIC

Not Available

ADVOCACY AND CAPACITY BUILDING

Advocacy and capacity strengthening efforts are present in the country at various levels (community, state, national) that will aide and support fast track programme. Local level advocacy is included as a core function of service provision. Advocacy are provided to key gatekeepers such as police and law enforcement agencies on effective HIV prevention, and on working with and protecting the rights of members of vulnerable groups, including PWID, sex workers, Hijras and MSM. Bangladesh has started mobilising media with regular orientation and capacity building workshops.

The capacity building strategy categorises capacity development as follows:[44]

Cross sector human resource development

- Health system strengthening
- Community system strengthening

The capacity building partners are

- The Global Fund to Fight AIDS, Tuberculosis & Malaria
- Project DIVA Community Representative Steering Committee
- UNAIDS and Co-sponsors
- USAID, FHI
- Global Forum on MSM and HIV (MSMGF)
- APN+

GENDER BASED VIOLENCE

MSM, MSWs and TG people in Bangladesh face several different types of GBV, ranging from being teased by people on the street to being raped and murdered, from a large range of different groups of people, ranging from boys on the street to religious leaders, police, and sex partners. The most common type of GBV reported by MSM/MSW/TG participants and key informants in Bangladesh was what is being described as “other” gender-based violence - stigma, discrimination, exclusion, harassment, blackmail, clients refusing to pay after having sex, rejection or non- acceptance by family or community members, disrespect, police ignoring GBV complaints, healthcare staff refusing to provide care, and humiliation. Participants also reported instances of theft and blackmail linked to their sexual identity or behaviour.[45]

ADDITIONAL RESPONSE

NETWORKS

The consortium model of service delivery in Bangladesh has reduced duplication of efforts and/or conflicting messages being delivered to target populations. Furthermore, opportunities to share information, resources and knowledge have been enhanced. The model will continue to be used. Several NGO-based programmes in Bangladesh specifically exist to help prevent the spread of HIV in MSM. The Bandhu Social Welfare Society, a partner of the Naz Foundation International, addresses the needs and risks of MSM via a community-based and peer-led approach. This group also conducts outreach and prevention programmes in a number of locations throughout the country. They have created several community-based networks of MSM and TG in Bangladesh.[46]

PUBLIC PRIVATE PARTNERSHIP

Medical care and assistance provided to HIV/AIDS patients in private institutions are subject to the same regulations and considerations considered valid for the public sector. In particular, private institutions must preserve confidentiality, avoid discrimination and allow patients to live normal and productive lives.

The garment industry has been a pioneer in private sector development of workplace responses in Bangladesh. With technical support from the HIV sector, industry bodies and specific employers are (at varying levels of coverage and intensity) developing policies to protect employees from stigma and discrimination on the basis of HIV, providing HIV education, and integrating HIV and STI services into company provided health services (including condom distribution)

SOCIAL ENTITLEMENT SCHEMES

Bangladesh is addressing HIV and key populations in social protection policies. Reviews recommended that social protection policies address the social, housing, livelihood and welfare needs of people living with HIV, key populations, orphans and children made vulnerable by HIV. People living with HIV are included in the national social protection policies of the country. [47]

CHALLENGES

- A gender equality strategy for national HIV response is not in place to address the gender-specific barriers for FSW/MSM/TG in the prevention, treatment, care and support, and address key gender-specific issues including GBV.
- Legal and policy barriers remain in HIV response due to punitive and discriminatory legal environment. Amendment of laws and policies is necessary to ensure positive social and medico- legal environments.
- Though Hijras were recognised as the third gender, it still needs to translate into other policies and reflect at implementation level.
- Follow up of recommendations made in the gender assessment was inadequate due to resource constraint.
- Marginalisation, social exclusion and criminalisation of key populations with respect to HIV lead to wide-spread stigma and discrimination and the addressing interventions are inadequate.
- All key populations including sex workers and Hijras face high level of sexual and gender based violence.
- Existing programmes do not address overlap between sex work, drug use and MSM behavior, partners of key populations and gender norms and masculinity
- Understanding how to access the hidden populations of MSM who don't identify and are unlikely to be accessed by current interventions is a significant challenge.

RECOMMENDA-TIONS

- Improve government mechanisms to build capacity of CSOs
- Efficiently reach hidden population of MSM/TG
- Ensure the capacity and smooth operation of clinics and supply chains
- Ensure government leadership is empowered to effectively manage the HIV response and introduce newer approaches and policies related to UIC, PrEP and self-testing

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We are united in advocating for issues around HIV and those that advance the rights, health and well being of people of diverse sexual orientation, gender identity, gender expression and sex characteristics.

Equity. Dignity. Social Justice.

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