PANOS

UNGASS Monitoring
Civil Society Perspectives
Bangladesh

The Declaration of Commitment on HIV/AIDS was adopted by 189 member states at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) in June 2001. The Declaration of Commitment outlines the requirements for a comprehensive response to HIV/AIDS.

As part of a consortium of partners, the Panos Global AIDS Programme is monitoring the implementation of the UNGASS Declaration of Commitment from a civil society perspective in selected countries, aiming to feed into the official review assessing progress in the implementation of the UNGASS Declaration five years after its adoption.

The Panos Global AIDS Programme commissioned studies in Bangladesh, Ethiopia, Haiti, Latvia, Malawi, Pakistan and Sri Lanka to identify achievements and challenges faced by these countries in relation to the Declaration of Commitment. This briefing note presents a summary of findings from Bangladesh.

Above
A peer educator provides information about HIV/AIDS and Sexually Transmitted Infections (STIs). Although demand for condoms is gradually increasing among vulnerable populations, supplies are unavailable or irregular.

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HIV/AIDS in Bangladesh

Bangladesh ranks the lowest of all South Asian countries on the United Nations Development Programme (UNDP) Human Development Index. Almost 36 per cent of the population of 140 million live on less than a dollar a day. Around 37 per cent of the population is aged under 15. This presents various challenges, including early marriage and pregnancy, high fertility and low levels of secondary and tertiary education. Adult literacy is around 41 per cent; health expenditure in the public sector is 0.8 per cent of gross domestic product (GDP); and there are just 23 physicians per 100,000 people.

The political scene in Bangladesh is volatile. Poor governance, corruption, nepotism, severe political tension and a lack of accountability contribute to a climate where human rights abuses against journalists, non-governmental organisations (NGOs) and other human rights defenders are common.

The Government of Bangladesh estimates that there are 7,500 people living with HIV/AIDS (PLWHA) in Bangladesh. According to the Joint UN Programme on HIV/AIDS (UNAIDS), this figure is approximately 13,000 people, or less than 0.2 per cent of the adult population (2003). National sero-surveillance in 2005 found a low HIV prevalence (less than 1 per cent) among groups such as female and male sex workers, men who have sex with men, *hijras* (transgenders), heroin smokers, and some groups of internal migrants. Nevertheless, HIV prevalence among male injecting drug users (IDUs) in central Bangladesh is rising steadily: at 4.9 per cent, it is close to a concentrated epidemic. Available data indicates that IDUs are well connected to the surrounding community, both sexually and through selling blood, putting the wider population at risk. Young people are also emerging as a key group vulnerable to HIV infection.

The national response to HIV/AIDS

Implementing UNGASS commitments

Bangladesh formed the National AIDS Committee (NAC) in 1985, with the president as chief patron. The cabinet approved a comprehensive AIDS policy, covering prevention, human rights, and reducing vulnerabilities, in May 1997, long before the UNGASS Declaration. A national strategic plan, based on the policy, was developed for a five-year period from 1997 to 2002. Following the UNGASS Declaration, a parliamentary caucus was formed in 2002, with 17 representatives from both government and opposition parties, including two women. This committee is currently working to pass a law on workplace policy interventions on HIV/AIDS.

From 1996 to 2003, the national HIV/AIDS response was largely supported by UNDP, the World Health Organization (WHO) and CARE, through the UK's Department for International Development (DFID). The World Bank-supported HIV/AIDS Prevention Project (HAPP) was approved in December 2000, but was not implemented until 2003 due to considerable problems identified by the World Bank team.

In order to be fully compliant with the UNGASS commitment, the government revised its strategic plan in February 2005. The National Strategic Plan for HIV/AIDS 2004–2010 identifies the following objectives:

- provide support and services for priority groups such as sex workers, drug users and migrants
- reduce the vulnerability of the general population to HIV
- promote safe practices in the healthcare system
- provide care and support services for people living with HIV/AIDS
- minimise the impact of HIV/AIDS

Currently, the National AIDS Sexually Transmitted Disease (STD) Programme (NASP) co-ordinates HAPP with support from the World Bank and DFID. Its four major components are intervention in high-risk groups; advocacy and behaviour change communication; blood safety; and institutional strengthening and capacity building.

Bangladesh recently received support from the Global Fund to Fight AIDS, Tuberculosis and Malaria to implement a project with young people. Most programmes under HAPP and the Global Fund are implemented through NGOs. NASP, UNAIDS Bangladesh, other UN bodies and international donors are facilitating a process to set up a national monitoring and evaluation framework using the 'three ones' principles.

Limitations in programme implementation

Although the national strategic frameworks, policies and guidelines cover almost all aspects of AIDS prevention and control, implementation has been slow and incomplete. One explanation might be NASP's inadequate capacity in planning and implementation.

Access to, and availability of, condoms

Although condoms remain the main HIV prevention tool, there is no systematic condom programming strategy. The Directorate of Family Planning distributes condoms as a contraceptive only, and not for the prevention of sexually transmitted infections (STIs), including HIV. As a result, condoms are still regarded primarily as a birth control device. Although demand for condoms is gradually increasing among vulnerable populations, supplies are unavailable or irregular.

Testing, counselling, care and treatment services

Facilities for diagnosing and treating opportunistic infections are limited. Counselling and testing services are only available in a few major cities and, although medicines to treat STIs should be available in government hospitals, this is rarely the case. The National Strategic Plan does not specify whether these should be free, and most donors are unwilling to provide them. If they can afford to, patients buy their medication from the private sector, where an average dose costs up to 500 taka – beyond the means of the average person. The national AIDS policy also addresses prevention of parent-to-child transmission (PPTCT), but this is rarely available in either the public or private sector.

Antiretroviral treatment (ART)

The government has made provision whereby PLWHA can buy subsidised antiretrovirals (ARVs) from specified pharmacies. But this is only for a period of one year, after which PLWHA do not know where they will get their medication. Laboratory and clinical services necessary to initiate and monitor ART have not yet been developed, and programmes to train health professionals on providing care, support and treatment are very limited, even in the capital city.

Planning is not participatory

The policies and documents do not reflect the concerns of, and are not owned by, marginalised sections of society. A representative from a donor community who requested anonymity said: "The very weakness of these policy documents is that they are not owned by the people of this country. Consultants from other countries come and prepare these documents." Language is also a major barrier in community participation – for example, a representative from the Sex Workers Networking Forum said: "I was once invited to a sharing meeting, but I could not understand anything as all the documents and sessions were in English."

Legislative measures to protect vulnerable groups

Groups targeted by NASP are susceptible to police excesses, because criminal laws are in direct conflict with HIV policies. So far, no legislative measures have been adopted to repeal these laws and protect the interests of the vulnerable population.

Stigma, discrimination and denial

Stigma continues to be a major barrier to working with HIV-positive people. A major cause of stigma is the association of HIV with sexual promiscuity and immoral behaviour. Awareness-raising programmes tend to focus on how HIV is spread; there is very limited discussion on human rights and AIDS, discrimination and stigma issues. There are very few education programmes among the medical community. As a result, public perceptions of PLWHA and members of vulnerable populations are very negative. Incidences of stigma and discrimination against PLWHA by the medical community are also common, which prevents a large section of PLWHA from accessing public or private health services.

The role of the media

The media has not been involved in implementing the national communication and advocacy plan. A national media sub-committee on HIV/AIDS prevention formed in 2002 to sensitise journalists and enable them to report responsibly on the subject has yet to undertake any activity.

A vertical programme

Although a number of other factors, such as widespread poverty, low levels of education and literacy, and gender inequalities make people vulnerable to HIV/AIDS, it is still seen mainly as a health problem and is housed in the Ministry of Health. No linkages have been established with poverty and gender to deal with the root causes of HIV/AIDS and strengthen the national response to the epidemic.

Co-ordination among donors

Funding for NASP currently comes mainly through the World Bank, DFID and the Global Fund, and is used mainly on prevention activities. However, a number of NGOs also receive funds directly from other donor agencies and, in the absence of a co-ordinating body to monitor funds and the implementation of HIV/AIDS programmes, there are many overlapping activities.

Recommendations

- Assertive political leadership is needed to ensure that new resources and the growing political commitment to HIV/AIDS are effectively translated into actions.
- Capacity building is needed within NASP, so it can offer effective implementation, guidance and monitoring to the different agencies (both public and private) working in this field.
- Continuous funding support is vital: donors need to come forward with co-ordinated, long-term funding plans.
- Current laws, policies and practices must be reviewed to reduce the vulnerability of the population to HIV/AIDS, and to ensure an enabling environment for implementing HIV prevention programmes.
- The government must formulate and implement programmes to reduce stigma and discrimination.
- The most marginalised sections of society must participate in the planning of policy and strategic plans, so that the programme is owned by the communities and is effective at the local level. Efforts should be made to translate documents into the local language.
- The media must play a stronger role in disseminating HIV/AIDS information and reducing negative perceptions towards PLWHA.
- There is a need to strengthen prevention, care, support and treatment programmes, as well as counselling and testing services. Vulnerable populations must have easy access to services.
- Infrastructure for the smooth delivery of ARVs must be put in place, and ARVs must be made continually available to PLWHA

Contact us

To find out more about the Global AIDS Programme and the HIV/AIDS activities of individual Panos offices, visit our website: **www.panosaids.org**

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