

# Bangladesh

## Country Review September 2011

### BANGLADESH AT A GLANCE

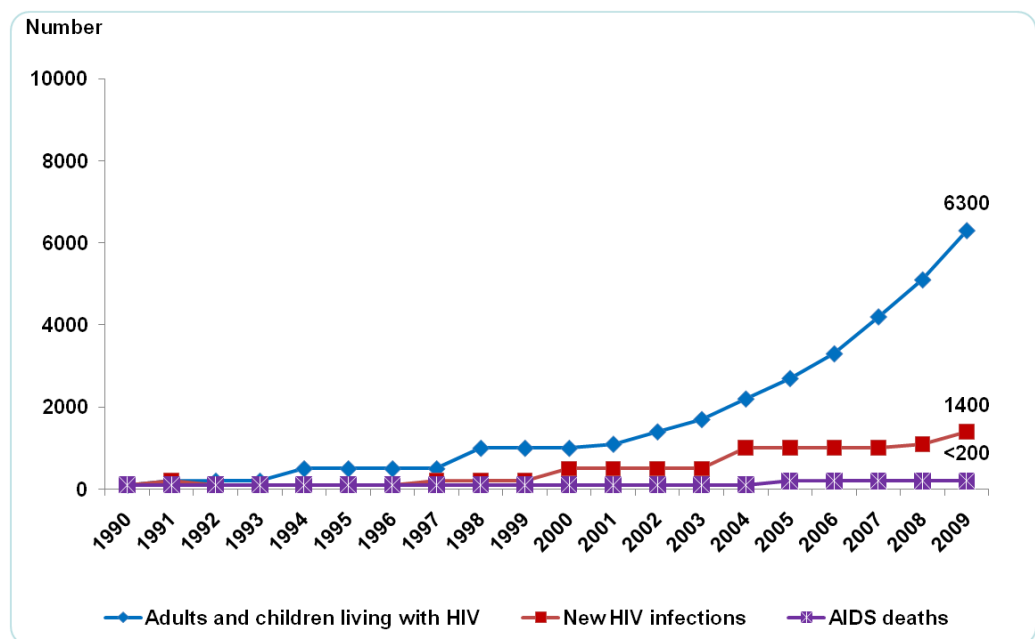
Total population (in thousands)	164,425 (2010) <sup>1</sup>
Annual population growth rate	1.3% (2010-2015) <sup>1</sup>
Population aged 15-49 (thousands)	654,884 (2010) <sup>2</sup>
Percentage of population in urban areas	28 % (2010) <sup>3</sup>
Crude birth rate (births per 1,000 population)	21.4 (2009) <sup>4</sup>
Under-5 mortality rate (per 1,000 live births)	54 (2008) <sup>5</sup>
Human development index (HDI) - Rank/Value	129/0.469 (2010) <sup>6</sup>
Life expectancy at birth (years)	66.9 (2010) <sup>6</sup>
Adult literacy rate	55% (2005-2008) <sup>6</sup>
Ratio of girls to boys in primary and secondary education (%)	106 (2007) <sup>4</sup>
GDP per capita (PPP, \$US)	1,416 (2009) <sup>4</sup>
Per capita total health expenditure (Int.\$)	42 (2007) <sup>5</sup>



## HIV EPIDEMIOLOGY AND TRENDS

The first case of HIV in Bangladesh was detected in 1989. Since then, the number of HIV cases has grown and by December 2009 an estimated 6,300 [5,200-8,300] adults and children were living with HIV (Fig. 1).<sup>7</sup> HIV prevalence has remained low, at less than 0.1% in the general population in 2009.<sup>7</sup>

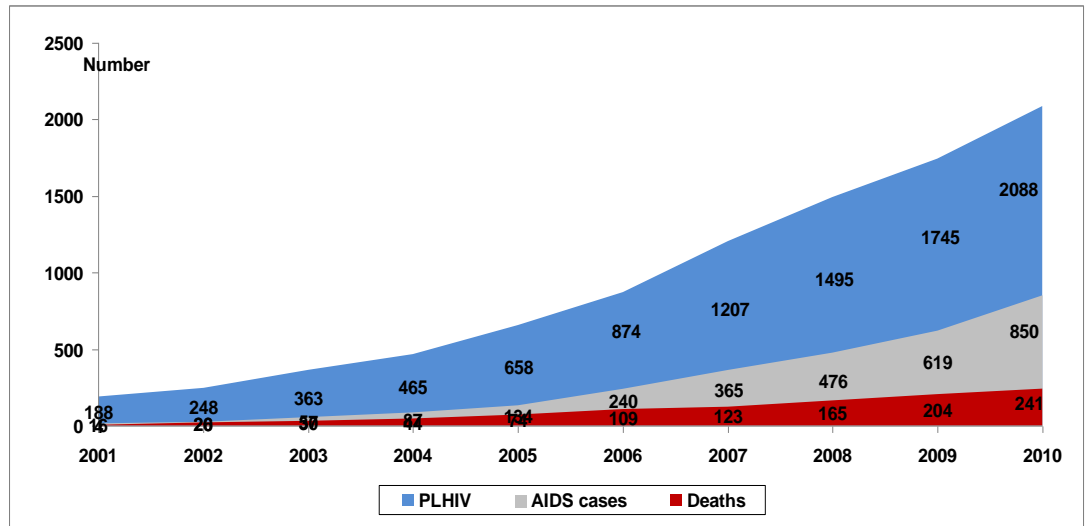
**Figure 1: Estimated number of adults and children living with HIV, new infections and AIDS deaths, 1990-2009**



Source: Prepared by [www.aidsdatahub.org](http://www.aidsdatahub.org) based on UNAIDS, Report on the Global AIDS Epidemic, 2010

The National AIDS/STD Program (NASP) has reported a cumulative total of 2,088 HIV cases in 2010 (Fig. 2). In 2010, a total of 343 new cases were identified, 231 individuals developed AIDS and 37 deaths were reported.<sup>8</sup>

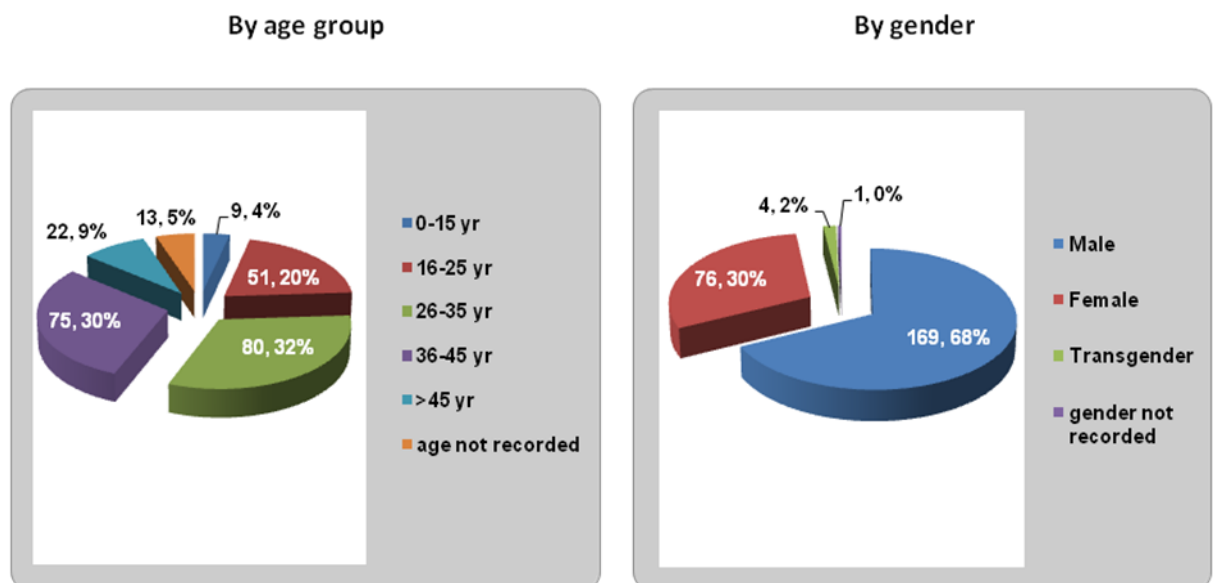
**Figure 2: Cumulative number of HIV and AIDS cases and deaths, 2001 – 2010**



Source: Prepared by [www.aidsdatahub.org](http://www.aidsdatahub.org) based on Bangladesh, Ministry of Health and Family Welfare, National AIDS/STD Programme (NASP) Report, 2010

Based on data from 2009, new HIV infections were most commonly reported among those aged 26-35 years (32%), while children (aged 0-15 years) and young people (aged 16-25 years) accounted for 4% and 20% of new cases, respectively. Sixty-eight percent of new cases were among males (Fig. 3).

**Figure 3: Percent distribution of new HIV infections by age group and gender, 2009**



Source: Prepared by [www.aidsdatahub.org](http://www.aidsdatahub.org) based on Bangladesh, Ministry of Health and Family Welfare, National AIDS/STD Programme (NASP) Report, 2009

The low prevalence of HIV found in Bangladesh could be due to: the epidemic having gained momentum later than in most countries; the epidemic still concentrated among key affected populations; and the common practice of circumcision among males in the predominantly Muslim population. In addition, numerous prevention efforts were implemented by the government four years before the first documented case in 1989, and services for key affected populations were initiated and expanded before the epidemic was established. Indeed, Bangladesh's sex worker programs and harm reduction programs have been cited as best practice.<sup>9: 10</sup> Also, modelling has shown that interventions among injecting drug users (IDUs) in Dhaka have been effective in delaying the epidemic.<sup>11</sup>

However, in 2006, Bangladesh has moved from being a low prevalence country for HIV to be a concentrated epidemic one with 7% HIV prevalence HIV among male IDU in Dhaka<sup>12</sup>. Early action is essential to prevent escalation and spread of the epidemic to other most-at-risk-population and subsequently to the general population.

#### **Surveillance Systems:**

- National HIV sentinel surveillance (HSS) system among key affected populations (since 1998)
- Behavioral surveillance surveys (BSS) among key affected populations (since 1998)
- Small-scale cohort studies on HIV prevalence among IDUs
- Numerous rapid situation and response assessments conducted by NGOs

#### **WHO IS AT RISK OF HIV IN BANGLADESH?**

HIV Sentinel Surveillance (HSS) in Bangladesh has focused on selected groups of individuals known to be most-at-risk of acquiring HIV infection, including sex workers, IDUs, MSM, and hijra<sup>a</sup>. In addition, specific population subgroups – such as regular partners of sex workers and mobile men, including truckers and rickshaw pullers – are also evaluated.

According to 2007 HSS (Round 8), HIV prevalence among female sex workers (FSWs) and transgenders (hijras) was 0.3%. Although HIV prevalence was below 1% in all FSW sites, in Hili (a small border town in the northwest part of Bangladesh), prevalence was as high as 2.7% among the casual sex workers, all of whom had crossed the border into India to sell sex. In the MSM community, prevalence was reported much lower – 0% for MSM in Dhaka and 0.3% in a combined MSM and MSW sample in Chittagong.<sup>13</sup>

Overall, HIV prevalence among IDUs was 1.2%, with low rates found in drug users from five cities. However, IDUs in Central Bangladesh have far exceeded the 1% threshold – with prevalence increasing from 4.9% in the 6th round to 7% in the 7th and 8th rounds. In particular, an increase was seen from 1.4% to 7% within six years in Dhaka, where the largest concentration of IDUs is found – 7,400 of the estimated 20,000-40,000 IDUs in Bangladesh.<sup>14</sup> In fact, in one locality, it has risen up to 10.5% in 2006 and further to 11% in 2007.<sup>12: 15</sup>

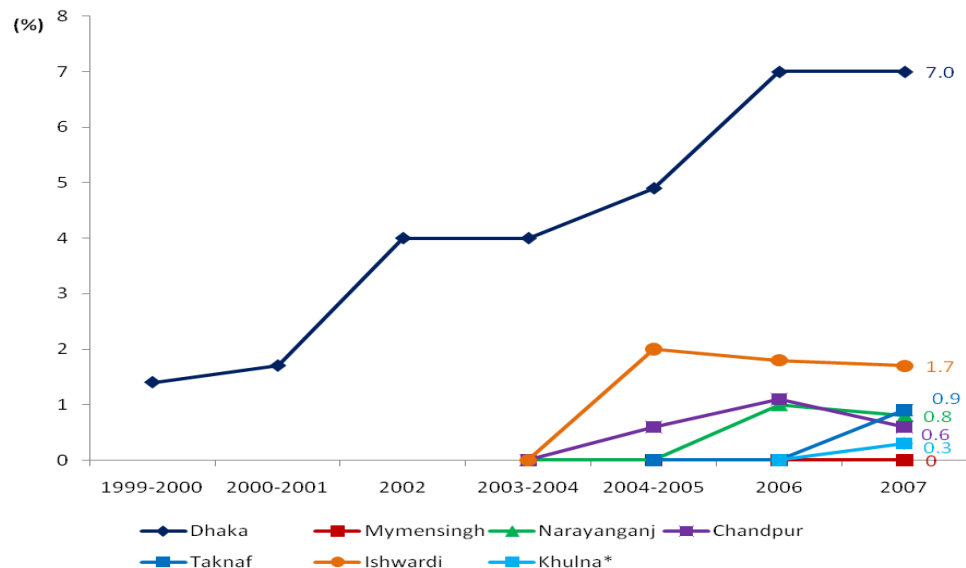
<sup>a</sup>Transgendered people, most of whom are mostly biologically male, but their gender and sexual orientation are feminine

## Injecting Drug Users

In the 2007 HSS, drug users (including IDUs and non-injecting heroin smokers, or a combination of the two) were sampled from 28 sites and HIV was detected in only 8 sites. The HIV epidemic is localized in Dhaka in a neighbourhood which could be considered as the epicentre of the epidemic.

Figure 4 reveals the trend of HIV prevalence among IDUs in Dhaka since 1999 and 7 other sentinel sites having HIV positive drug users. It is evident that HIV positive IDUs have become increasingly concentrated in Dhaka over the years.

**Figure 4: HIV prevalence among IDUs in selected cities (1999-2007)**



\*Males & females combined, IDUs and heroin users combined

Source: Prepared by [www.aidsdatahub.org](http://www.aidsdatahub.org) based on Bangladesh, National HIV Serological Surveillance, 8<sup>th</sup> round Technical Report, 2007

A cohort study among female IDUs (n=130) found that 63% were also sex workers.<sup>16</sup> HIV prevalence was found to be 0.8% and 1% in sero-surveillance rounds 7 and 8, respectively, among female drug users<sup>13</sup> and active syphilis rates were 9.9% and 14.6%, respectively.<sup>12; 15</sup> Beyond their vulnerability to HIV through unsafe injection and sexual risk behaviour, female injectors commonly reported being victims of some form of violence (rape or other physical violence - sex workers IDU 78% and non-sex worker IDU 27.1%).<sup>16</sup>

## *Female sex workers*

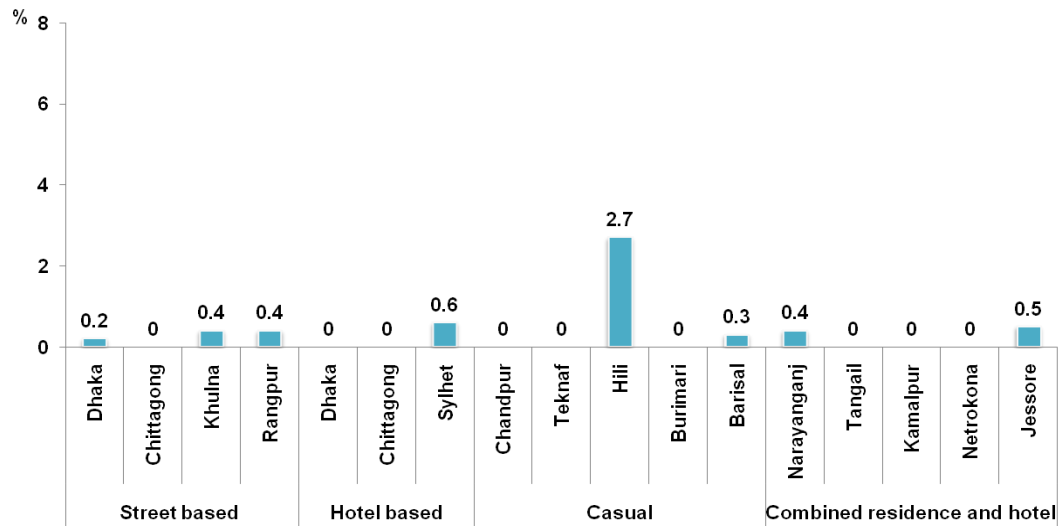
FSWs in Bangladesh are often classified into four categories: brothel-based, street-based, hotel/residence-based, and casual sex workers. It is important to note, however, that these categories are not rigid as sex workers may change venues.<sup>14</sup>

- Brothel-based – those who are contacted by clients in a brothel setting, with the sex act generally taking place in brothels.
- Street-based – those who are contacted by clients on the street, with the sex act taking place in public spaces or other venues.
- Hotel- or residence-based – those who are contacted by clients in a hotel setting, with the sex act taking place there. Residence-based sex workers also often sell sex from hotels. Some residence-based sex workers are managed by *sarder/sarderni* (males/females who run the sex trade through acquisition of females in various ways) and *dalal* (pimps who supply the women). On the other hand, some operate autonomously, with clients contacting them directly or through other sex workers.
- Casual sex workers – those who sell sex either in the street, residence or hotel. They often work part-time and have one or more alternative sources of income.

MSWs and *hijra* sex workers are two additional categories of sex workers in Bangladesh. MSWs usually sell sex at hotels and residences, whereas *hijra* usually sell sex in public places like parks and in residences.<sup>17</sup> Similar to the case of FSWs, the current estimation of the number of MSWs is thought to be an underestimate – particularly given the fact that MSM and MSWs are often hidden due to the stigma and discrimination associated with these groups as well as inconsistencies in the way these individuals self-identify their sexual orientation and/or involvement in sex work. As it stands, the estimated number of MSM and MSWs in Bangladesh was between 40,000 and 150,000 (as of 2004).<sup>18</sup> In addition, it was estimated that there were 10,000–15,000 *hijras* (as of 2004).<sup>18</sup> HIV prevalence remained very low among MSWs over the rounds of surveillance, yet was 0.7% in 2006<sup>12</sup> and 0.3% in 2007. HIV prevalence was also 0.3% among *hijras* in 2007.<sup>15</sup>

In the 2007 HSS, 4,797 FSWs were sampled from 15 cities from different venues (streets, hotels and a combination of residences and hotels).<sup>15</sup> HIV prevalence among FSWs was found to be 0.3%, overall. As shown in Figure 5, HIV prevalence among FSWs was variable across different settings, and was as high as 2.7% among casual FSWs in Hili. While brothel-based sex workers were not sampled in the 2007 HSS, the previous round in 2006 found HIV prevalence to be 0.2% among this group.<sup>15</sup>

**Figure 5: HIV prevalence among female sex workers by type of FSW and sentinel site, 2007**



Source: Prepared by [www.aidsdatahub.org](http://www.aidsdatahub.org) based on Bangladesh, National HIV Serological Surveillance, 8<sup>th</sup> round Technical Report, 2007

It was estimated that in 2004, there were up to 90,000 FSWs in Bangladesh.<sup>18</sup> This estimation is thought to be a gross underestimate, given that many FSWs are casual sex workers, working part-time.<sup>14</sup> The 2006-07 BSS estimated that there were 3,600 brothel-based sex workers working out of 14 brothels throughout the country.<sup>17</sup> This figure represents a decline from 6,584 in the 1998/99 BSS round and highlights the transition from brothels to more conspicuous venues that are less regulated.<sup>14</sup>

The average number of clients per FSWs in Bangladesh is generally very high, and reported as being among the highest anywhere in Asia.<sup>9</sup> In 2006-2007, the mean number of new or regular clients in the last week ranged widely from 8.1 among street-based sex workers in Khulna to 63.8 among hotel-base sex workers in the same city. Among MSWs and *hijras*, figures ranged from 3.9 among MSWs in Chittagong to 30 among *hijras* in Dhaka.<sup>17</sup> The BSS 2006-2007 also identified the usual partners of brothel-based sex workers as people in business, rickshaw pullers, truckers and students. Moreover almost one-third of sex workers reported anal sex with new or regular clients in the past week.<sup>19</sup>

Clients of sex workers are largely derived from the general population of men. The study "Assessment of Sexual Behaviour of Men in Bangladesh: a Methodological experiment" in 2006 reported non-marital sex by 27% of never married and 13% of ever married men in the previous year. Of these 10% were commercial sex interactions. This is a cause for concern as 40% of these were unprotected sexual encounters and around 20% of them had 3 partners or more.<sup>20</sup>

### ***Men who have sex with men***

The estimated number of MSM ranges widely – from 40,000 by the National AIDS Program to more than 1 million.<sup>21</sup> HIV prevalence among MSM in Dhaka in 2006 and 2007 was 0.2% and 0%, respectively.<sup>13</sup> Despite these relatively low levels of HIV prevalence, risk behaviours among this group are documented. Many MSM had female sex partners and/or were married due to societal pressure to marry and become fathers.<sup>21</sup> Also, large proportions of MSM reported STI symptoms, had multiple sex partners (including women), engaged in group sex (often associated with violence and without condoms) and reported very low condom use with all types of partners.<sup>13</sup>

### ***Mobile populations***

Mobile populations are well-represented in Bangladesh's surveillance system. Dock-workers, truckers, rickshaw-pullers, and launch-workers from different cities have been sampled in different rounds. HIV has not been detected in any of these groups with the exception of one rickshaw-puller (out of 401 sampled) in Dhaka during the 5th Round of the serological surveillance (2003-2004).<sup>22</sup>

In addition, findings from the HSS (Round 7) indicate high mobility of sex workers to neighbouring India and sometimes Myanmar. Approximately three quarters of sex workers surveyed in one border area crossed the border to India, of which 92.8% sold sex. In another border area, 23% crossed to Myanmar, with 65.2% of them selling sex. No data was available on the extent of condom use in this migration-related sexual contact.<sup>12</sup>

### ***Young people***

Many adolescents and young people in Bangladesh are sexually active and at risk of contracting STIs, including HIV. A 2005 National base-line survey conducted among adolescent and youth clients of FSWs (n=1,013) showed that half of the respondents had their first sexual encounter before the age of 18 years and some were as early as 11 to 14 years of age.<sup>23</sup> FSWs were the single most common sex partner in their first sexual experience. Around 18% of the youth had never used a condom and only 15% reported that they had used condoms for all sexual encounters. The 2008 National end-line survey among youth in Bangladesh found that 24.3% had their first sexual encounter before the age of 19 (males 11.8%, female 30.6%).<sup>24</sup>



## KNOWLEDGE, VULNERABILITY FACTORS & RISK BEHAVIOURS

### Vulnerability factors:

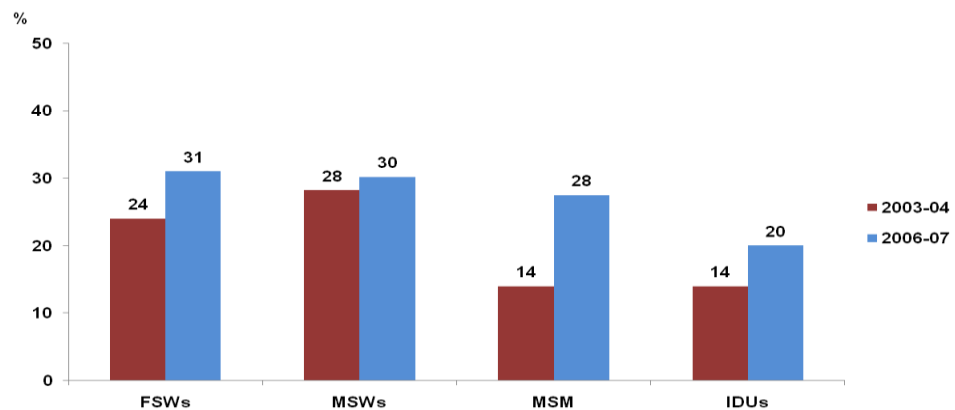
While Bangladesh continues to be a low-prevalence country, its population is highly vulnerable. Specifically, risk behaviours – including high levels of unprotected sex with commercial partners and unsafe injecting practices – are of concern. Condom use in Bangladesh is reportedly the lowest in Asia, although the figures have been rising due to interventions by non-governmental organizations.<sup>25</sup>

In addition to the risks posed by sexual and other behaviours among particular groups of people, a range of structural factors heighten the vulnerability of Bangladesh's general population to an HIV epidemic. Bangladesh is a poverty-stricken country with poor rankings for most of the global development indicators and about half of the population lives on less than one dollar a day.<sup>5</sup> Other structural factors include: a low adult literacy rate; low social status of women and the trafficking of women into the commercial sex industry; high population mobility within the country, including interstate and rural-urban as well as international labour migration, particularly across its porous borders with India and Myanmar, both of which are experiencing concentrated epidemics.<sup>25</sup>

### Knowledge about HIV

Misconceptions regarding HIV transmission persist among key affected populations. With the exception of hijras, less than half of all groups have comprehensive knowledge about HIV – that is, are able to both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission. From 2003-2004 to 2006-2007, the percentage of key affected populations who had comprehensive HIV knowledge rose from 24% to 31% among FSWs, from 28% to 30% among MSWs, from 14% to 28% among MSM and from 14% to 20% among IDUs (Fig. 6).<sup>26</sup> HIV knowledge rose significantly among hijras, from 4% to 55% during the same period.<sup>27</sup>

**Figure 6: Percentage of key affected populations who had comprehensive HIV knowledge, 2003-04 and 2006-07**



Among the general population of young people (aged 15-24), comprehensive knowledge increased from 10% in 2005 to 18% in 2008.<sup>24</sup> More young males had this knowledge as compared to their female counterparts (22% vs. 13%, respectively).<sup>24</sup> Among adults aged 15-49, only 6% of females and 14% of males had comprehensive knowledge in 2006-2007, while 67% of females and 87% of males had ever heard of HIV/AIDS.<sup>28</sup>

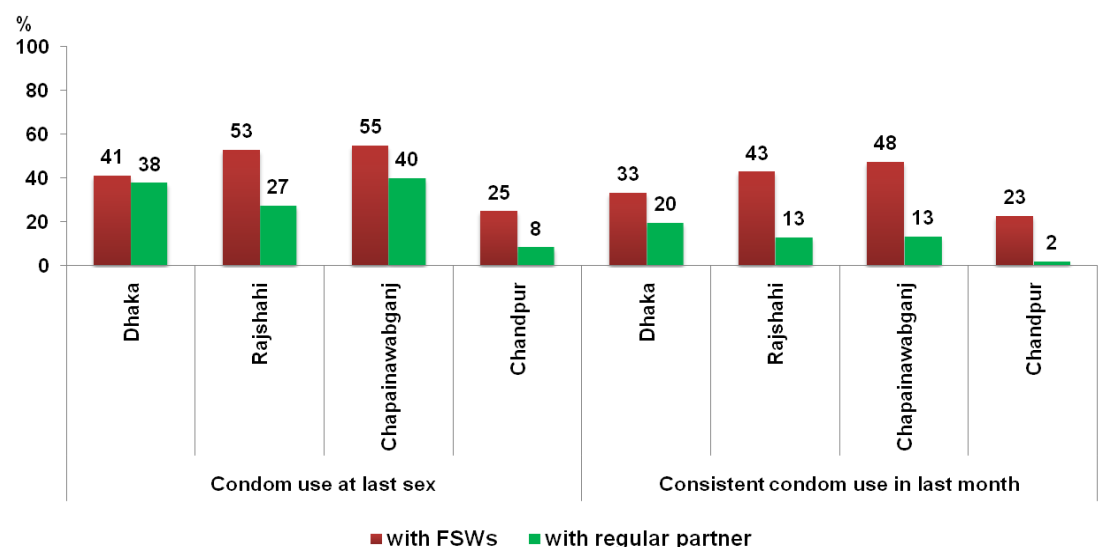
### Condom Use

Low condom use by men remains one of the largest barriers to prevention of HIV in Bangladesh. Qualitative studies among men revealed some deep-rooted issues that can act as barriers to condom use.<sup>29</sup> In particular, they revealed that direct penile-vaginal contact and ejaculation inside the vagina is the way men express their emotion and trust as they consider this to be a 'pure' and 'natural' sex act. By avoiding condoms, men sought to preserve an image of a 'good man', as condoms are equated with promiscuity.<sup>29</sup>

The percentages of male IDUs reporting the use of a condom at last sexual encounter in 2007 were 44% for commercial sex and 31% for non-commercial sex. On the other hand, among female IDUs, condom use at last sex was 55% and 42% for commercial and non-commercial partners, respectively.<sup>16</sup> In the cohort studies on male IDUs, 8% had bought sex from sex workers in the previous month, among whom 51% had used condoms all the time in the last month.<sup>30</sup>

The BSS 2006-2007 findings imply that a very high percentage of IDUs engage in commercial sex: on average 54% of IDU bought commercial sex last year.<sup>17</sup> The percentage of IDUs reporting having bought sex in the last year was as high as 66% in Dhaka, 57% in Chandpur, 47% in Rajshahi and 46% in Chapainawabganj in 2006-2007.<sup>17</sup> Figure 7 compares the percentages of IDUs who reported condom use at last sex and consistent condom use in the last month in 2007 with FSWs and with regular partners. Condom use is higher with FSWs than with regular partners in all sites, yet overall condom use is low (below 60%) across all sites, regardless of type of partner.<sup>17</sup>

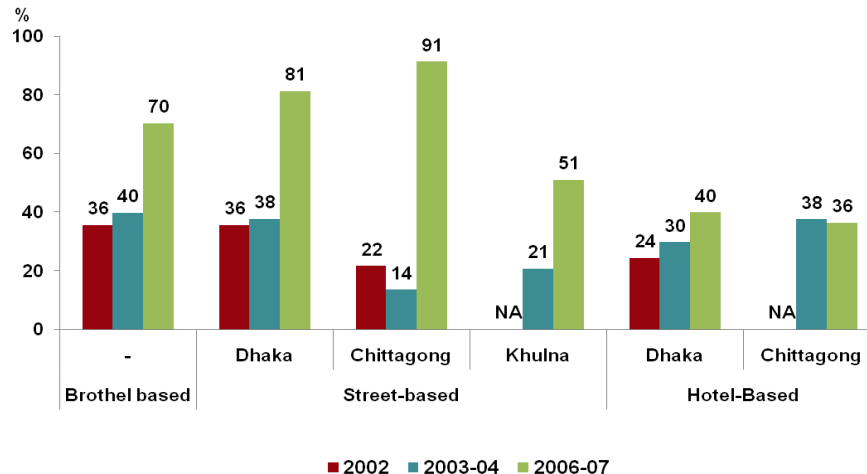
**Figure 7: Percentage of IDUs who reported condom use at last sex and consistent condom use in the last month by type of partner and surveyed city, 2006-07**



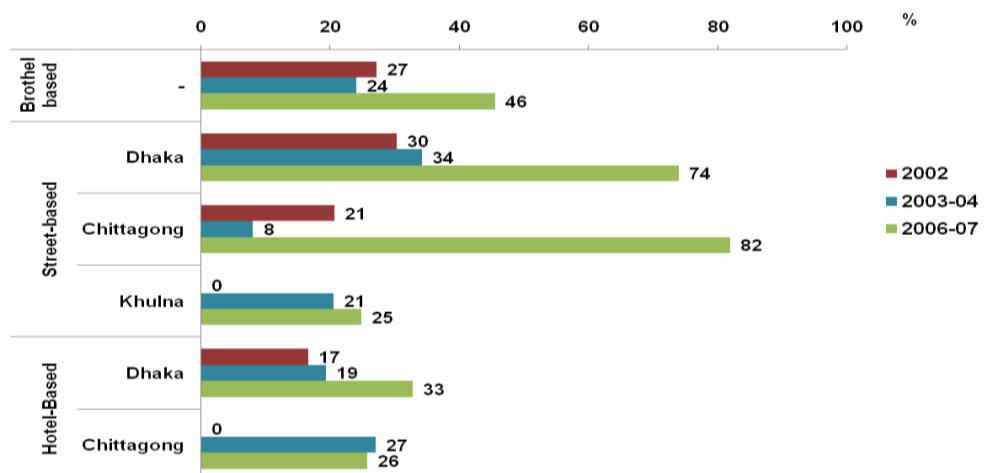
The BSS conducted in 2003-2004 and 2006-2007 showed a marked increase in the percentage of FSWs reporting condom use with their most recent client, from 31% in 2005 to 67% in 2007.<sup>26</sup> Figure 8 (a-b) compares the percentages of condom use at last sex among different types of sex workers with new and regular clients in three consecutive rounds of surveillance. A remarkable increase in condom use was observed among all types of sex workers in the last round (in 2007). Street-based sex workers in Chittagong showed the most significant increase with both new and regular clients – reaching 91% and 82%, respectively.<sup>17</sup> Still, reports of condom use at last sex remained low in numerous populations, particularly among hotel-based sex workers in Dhaka and Chittagong and among street-based sex workers in Khulna.

**Figure 8: Percentage of FSWs who used a condom at last vaginal sex, 2002 – 2007**

**a) with a new client**



**b) with a regular client**



Source: Prepared by [www.aidsdatahub.org](http://www.aidsdatahub.org) based on Bangladesh, National AIDS/SID Programme (NASP), and Behavioural Surveillance Surveys, 2002, 2003-04 and 2006-07



MSM in Bangladesh are at increased risk of HIV infection due to their risky sexual behaviour including high number of partners and low condom use.<sup>19</sup> The Behavioural Surveillance Surveys (BSS) conducted in 2003-2004 and 2006-2007 show a considerable decline in condom use at last sex with a male partner by MSM in Dhaka, from 49.2% to 31%.<sup>31</sup> Anecdotal evidence suggests a shortage of supply of condoms and lubricants for MSM as a reason for declining condom use.<sup>32</sup>

BSS data show that risk behaviours among both MSWs and hijras are very high. In 2006-2007, 44% of MSWs reported condom use at last sex with a client.<sup>27</sup> In addition, almost all Hijras (99.8%) were reported to have sold sex in the last week and 66.5% reported consistent condom use during that period.

### ***Sharing of injecting equipment***

The 2006-2007 BSS showed that 61.7% of IDUs from Dhaka either borrowed or lent needles/syringes at the time of their last injection (49% in Rajshahi, 55% in Dhaka, 63% in Chandpur and 74% in Chapainawabganj).<sup>19</sup> Roughly, over half of the IDUs shared needles and syringes in all three most recent rounds of surveillance in all of the sentinel sites except Rajshahi. Although there was a marked decline in the sharing of needles/syringes in Dhaka in 2006-2007 (down to 55% from 86% in 2003-2004), the HIV prevalence in Dhaka was consistently on the rise. Meanwhile, overall, only 32% of IDUs used sterile injecting equipment at last injection.<sup>27</sup>

## **NATIONAL RESPONSE**

### ***Governance***

The National AIDS committee (NAC) was founded in 1985, four years before the detection of first case of HIV in Bangladesh and it serves as the highest body of the government in making policy decisions related to HIV and STIs. In 1997, NAC worked with various stakeholders to develop the National Policy on HIV/AIDS and STD related issues. This was closely followed by the Strategic Plan for The National AIDS Programme of Bangladesh, 1997-2002.

NAC has been responsible for approving successive national HIV strategies, monitoring and evaluation frameworks, and operational plans developed under leadership of the National AIDS and STD Programme (NASP), formed within the Ministry of Health and Family Welfare as the functional body to facilitate and oversee the national response to AIDS.

### ***Legal issues and discrimination faced by key affected populations***

Discriminatory practices which have been counter-productive to HIV prevention program include denial of services to the key affected populations and PLHIV. Lack of knowledge plays a big role, though laws also criminalize activities like injecting drug use, sex work and sodomy and prevent individuals from disclosing their status and receiving treatment.

Male to male sexual activity is an offense under section 377 of the Bangladesh penal code and there is an absence of non-discrimination laws and regulations which specify protection for MSM. Due to legal issues and societal norms and pressure, MSM rarely disclose their status. Instead, they marry women to hide their true sexual identity and may eventually spread the infection to their wives.

The most important issue needing be addressed – as recommended by almost 75% PLHIV respondents of the PLHIV Stigma Index study in Bangladesh, 2009 – is that the organisations working with PLHIV work to remove stigma and prejudices which are deeply embedded in the society.

### ***National Strategic Plan***

In 2005, Bangladesh reviewed the 1st National Strategic Plan for HIV/AIDS (NSP I) and developed its 2nd NSP (2004-2010) with the active involvement of a wide body of stakeholders. The objectives, strategies and priorities of this plan are closely aligned with the National Policy for AIDS and the Millennium Development Goals, and are further guided by an analysis of the HIV situation and vulnerability factors in Bangladesh.<sup>22</sup> The main objectives of NSP II are to:

- provide support and services for priority groups
- prevent vulnerability to HIV infection in Bangladesh
- promote safe practices in the health care system
- provide care and treatment services to people living with HIV (PLHIV) and
- minimize the impact of the HIV/AIDS epidemic

In 2006, NASP produced the National HIV and AIDS Communication Strategy 2005-2010, again involving all relevant government ministries, NGOs, UN and other development agencies. In line with the NSP II, the Communication Strategy identified the high-risk populations – sex workers, drug users, MSM, and mobile populations (external migrants, border crossing people, transport workers, factory and other mobile workers, prisoners, uniformed forces and street children) – as priority groups for HIV prevention, and recognized the need to also involve these vulnerable groups in policy dialogue and formulation.<sup>33</sup> However, the three major HIV prevention projects operating now in Bangladesh focus only on young people, sex workers, IDUs, MSM and mobile populations like transport workers and rickshaw pullers – not all of the groups identified as being at risk.

In 2007, with the assistance of UNAIDS, NASP developed the 'National AIDS Monitoring and Evaluation Framework and Operational Plan' and drafted the 'Operational Plan for The National Strategic Plan for 2006-2010'. The operational plan included detailed assessments of the resources required for planned prevention, treatment and care activities.<sup>34</sup> Currently, the 3rd NSP for HIV/AIDS is being developed in line with the new Health, Nutrition and Population Sector Programme (HNPSPP, 2011-2016) commencing July 2011.

### **National policies/guidelines and strategies:**

- National AIDS Policy, 1996
- National Strategic Plan 2004-2010
- National Harm Reduction Strategy for Drug Use and HIV (2004-2010)
- National HIV and AIDS Communication Strategy (2005-2010)
- National AIDS Monitoring & Evaluation Framework and Operational Plan (2006)
- National ART Guidelines (2006)
- National STI Management Guidelines (2006)
- Training Modules for Health Managers on HIV/AIDS (2006)
- National Standards for Youth Friendly Health Services (2007)
- National Policy and Strategy on Blood Safety (2007)
- Training of Trainers Manual for School and College; Teacher and Facilitation Guide (2007)
- Training of Trainers Manual on Mainstreaming HIV/AIDS for NGOs and Five Key Ministries (2007)
- National Technical Support Plan for HIV and AIDS (2008-2015)
- Standard Operating Procedure for Services to People living with HIV and AIDS (2009)

### ***Programme implementation and coverage***

While there are policies and documents that provide the necessary policy building blocks for resource mobilization and programme development, implementation in practice has been limited in certain areas.

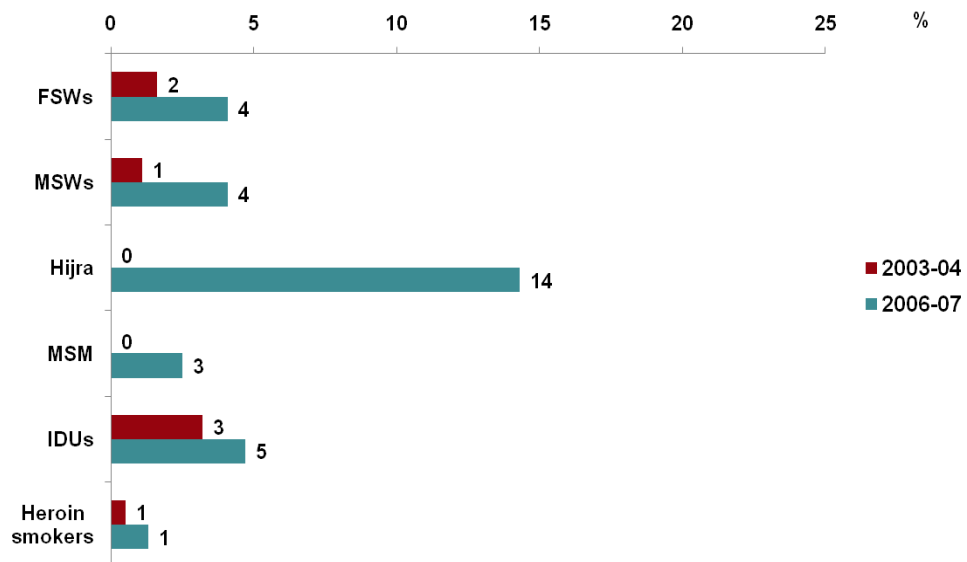
National HIV programmes have focused on targeted interventions for key affected populations, principally prevention activities, but increasingly they are working across the continuum of needs to treatment, care and support. A National Harm Reduction Strategy of Drug Use and HIV (2004-2010) was produced by the NASP<sup>35</sup> and endorsed by Government, but is not yet systematically implemented. Given that harm reduction interventions remain the main priority and that the HIV epidemic evidently remains concentrated within the small population of IDUs, implementing the Harm Reduction Strategy together with recently endorsed opioid substitution therapy (OST) will provide the country with an opportunity to reduce the number of new HIV infections among IDUs and mitigate the impact among HIV infected IDUs.

NGOs implement many of the activities; however community participation in the policy and advocacy environment remains somewhat limited. Legislative changes are required in order to enable universal access to injecting equipments for IDUs, condoms for sex work and MSM, and to create an enabling environment for universal access by the wider population. The technical and organisational capacity of project implementing agencies across Bangladesh needs to be expanded in order to facilitate the scaling-up of activities.

## Prevention

As of 2009, 105 out of a total of 5,161 health facilities were providing voluntary counselling and testing (VCCT) services (up from 83 in 2008).<sup>36; 37</sup> HIV testing is extremely low among all key affected populations in Bangladesh. Figure 9 depicts the percentages of key affected populations tested for HIV in the past year and who knew their result in 2006-2007 as compared to 2003-2004.<sup>26</sup> With the exception of hijras (14% of whom received testing and knew their results) in 2006-2007, HIV testing ranged from only 1% to 5% among FSWs, MSWs, MSM, IDUs and heroin smokers.

**Figure 9: Percentage of key affected populations tested for HIV in the last 12 months and received the results, 2003-04 and 2006-07**



Source: Prepared by [www.aidsdatahub.org](http://www.aidsdatahub.org) based on Bangladesh, National AIDS/SID Programme (NASP), Behavioural Surveillance Surveys, 2003-04 and 2006-07, cited in UNGASS Country Progress Report, 2010

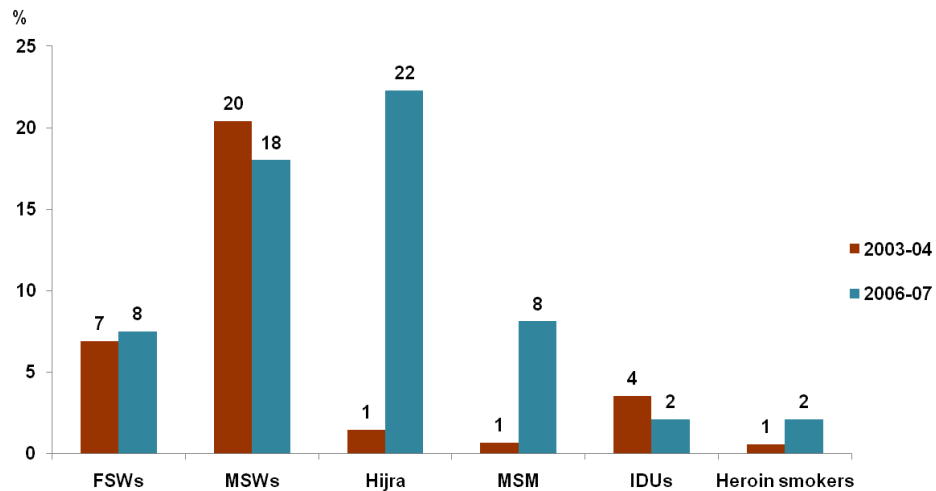
The percentage of key affected populations reached by prevention programmes was similarly low, with hijras again being most reached and vastly improved upon (at 22% in 2006-2007, up from 1% in 2003-2004) (Fig. 10).<sup>26</sup> Notably, IDUs – the population with highest HIV prevalence in the country – have the lowest levels of HIV testing uptake and prevention programme coverage among key affected populations.

Harm reduction interventions, including large-scale needle/syringe exchange programmes began in 1998 when HIV prevalence among IDUs was still below 1%, and modelling data suggest that this may have reduced HIV incidence in Dhaka by over 90%.<sup>38</sup> As of 2009, no opioid substitution therapy sites had been established, yet there were 2.7 needle and syringe programme sites per 1,000 IDUs, with an average of 161 needles/syringes distributed by such programmes per IDU per year.<sup>37</sup>

<sup>b</sup>One of only five countries worldwide to report more than 100 syringes per IDU per year (Viet Nam, Kazakhstan, Kyrgyzstan and Tajikistan being the others); however, still far below the internationally recommended target that is likely to have an effect on the HIV epidemic – of 200 syringes provided per IDU per year.



**Figure 10: Percentage of key affected populations reached with HIV prevention programmes, 2003-04 and 2006-07**



Source: Prepared by [www.aidsdatahub.org](http://www.aidsdatahub.org) based on Bangladesh, National AIDS/SID Programme (NASP), Behavioral Surveillance Surveys, 2003-04 and 2006-07, cited in UNGASS Country Progress Report, 2010

Although overall coverage of all the key affected populations reached with HIV prevention programmes had increased from 5.2% (BSS 2003-2004) to 7.2% (BSS 2006-07), it remained low. Coverage levels varied among different population groups during these same periods. For instance, an increase in coverage could be noted amongst FSWs (from 7% to 8%), hijras (from 1% to 22%) and heroin smokers (from 1% to 2%). On the other hand, there was a coverage reduction amongst MSWs (from 20% to 18%) and IDUs (from 4% to 2%).<sup>13</sup>

### ***Antiretroviral treatment, Prevention of Mother-to-Child Transmission***

In 2009, 6 out of 5,161 health facilities were providing antiretroviral therapy (ART), with 353 adults and children receiving ART (up from 283 in 2008)<sup>37</sup> and 48% of adults and children with advanced HIV infection receiving ART.<sup>13</sup> Six different types of ARV drugs are currently produced by two national pharmaceutical companies in Bangladesh. More preparations are required to allow administration in different combinations and paediatric formulations.<sup>19</sup> Antiretroviral formulations for pregnant mothers are made available and being implemented through a pilot intervention of UNICEF. Moreover, prevention of mother-to-child transmission (PMTCT) is challenged by the fact that voluntary confidential counselling and testing (VCCT) facilities in Bangladesh are very limited. Furthermore, a majority of women do not receive antenatal care and they prefer home deliveries – partly due to the cost and the hassle of transportation as well as to deep-rooted customs and beliefs.<sup>39</sup>

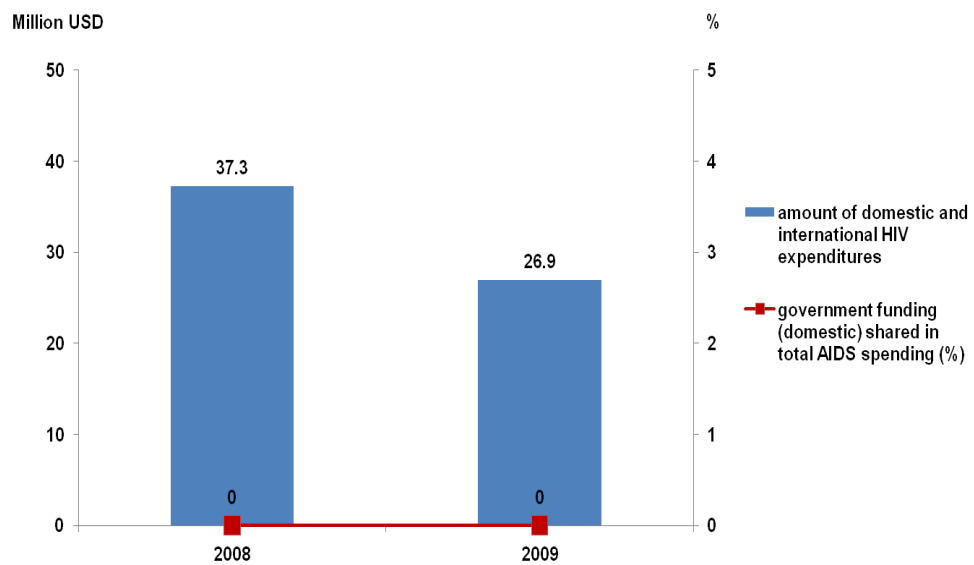
In terms of PMTCT, as of 2008, 551 health facilities were providing antenatal care services, with only one providing ANC and VCCT services and ARVs for PMTCT.<sup>37</sup> Also in 2008, an estimated 4%-13% of pregnant women living with HIV received ARVs for PMTCT, while an estimated 12% of infants born to HIV infected mothers received ARVs for PMTCT.<sup>37</sup>



## ECONOMICS OF AIDS

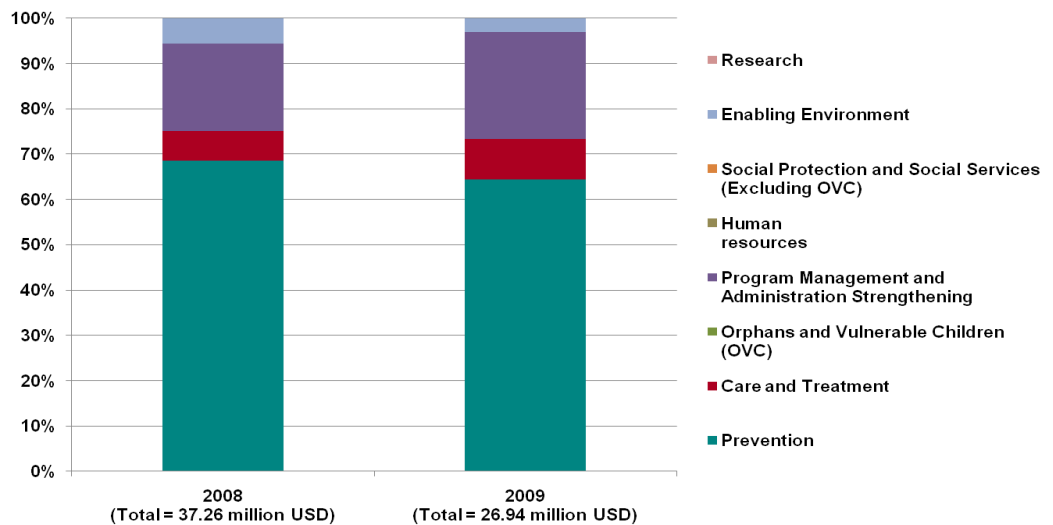
In 2009, a total of US\$ 27 million was spent on AIDS, down from US\$37 million the previous year (Fig. 11).<sup>13</sup> Figure 12 shows the percentage distribution of funding based on spending category in 2009. HIV prevention programmes had the largest expenditure share for both 2008 and 2009.

**Figure 11: Amount of domestic and international HIV expenditures and % shared by government, 2008 - 2009**



Source: Prepared by [www.aidsdatahub.org](http://www.aidsdatahub.org) based on UNAIDS, Report on the Global AIDS Epidemic, 2010

**Figure 12: Percent distribution of total HIV expenditures by major spending category, 2008-2009**



Source: Prepared by [www.aidsdatahub.org](http://www.aidsdatahub.org) based on UNAIDS, Report on the Global AIDS Epidemic, 2010

In recent years, the government has mobilized and secured credit funds through the World Bank, The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and other development partners. Since 2004, in partnership with NGOs and donor organizations, the government has implemented four national HIV Prevention Projects:

- The HIV Prevention Project (HAPP), jointly funded by the World Bank, DFID and the government and executed by UNICEF, UNFPA and WHO - US\$ 26 million was allocated for this project.
- Through a pool fund under the Health, Population and Nutrition Sector Program (HNPSP), the GoB – with primary contributions from the World Bank – allocated US\$ 22 million towards implementing HIV Targeted Interventions within 2009-2011.
- The Project of Prevention of HIV among Youths and Adolescents funded by the Global Fund and executed under Round 2 by Save the Children (USA). The first phase, 2004-2007, had a budget of USD 19 million. Under Round 6 of GFATM, USD 40 million will be provided over 2007-2012 for interventions targeted at a wider range of high risk populations. Bangladesh also has been awarded with the Rolling Continuation Channel for GFATM R2 - the value of this is 72 million for the period 2009-2015.
- The Bangladesh AIDS Programme 2005-2009, funded by USAID with about US\$14 million, and implemented through a team composed of FHI, Social Marketing Company, John Snow Inc. Bangladesh and Masjid Council for Community Advancement, with the support of 18 implementing agencies and numerous collaborating partners.<sup>13</sup>

It is important to note that the funding situation is constantly changing. New grants occasionally come in, while frequent interruptions between funding tranches have become a regular feature of certain current grants.

### **Issues and Challenges**

Since Bangladesh is one of the world's most densely populated countries, even if only 1% of the general population becomes infected with HIV, there will be 1.5 million people infected. Therefore, there is a pressing need to take steps to prevent this from occurring. However, there are both facilitatory and inhibitory factors currently at play.

#### ***Key facilitatory factors***

- Prevalence is still very low in Bangladesh, offering a good opportunity to make a large impact from targeted, cost-effective intervention measures.
- The coverage of HIV prevention activities was limited in the past few years. However, the quality and coverage of the national HIV programme progressively improved. The government mobilized loans and grants from development partners, including the World Bank, GFATM, UN agencies, and other multilateral and bilateral donors, to support interventions to prevent HIV and treat AIDS, particularly among vulnerable populations.

#### ***Key inhibitory factors***

- Indicators of risk behaviour show that risk levels are high.
- High vulnerability factors could hamper intervention efforts, particularly in behaviour change strategies.
- Poverty and social inequality are persistent.
- Cultural impediments against discussing or addressing sexual issues exist.

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