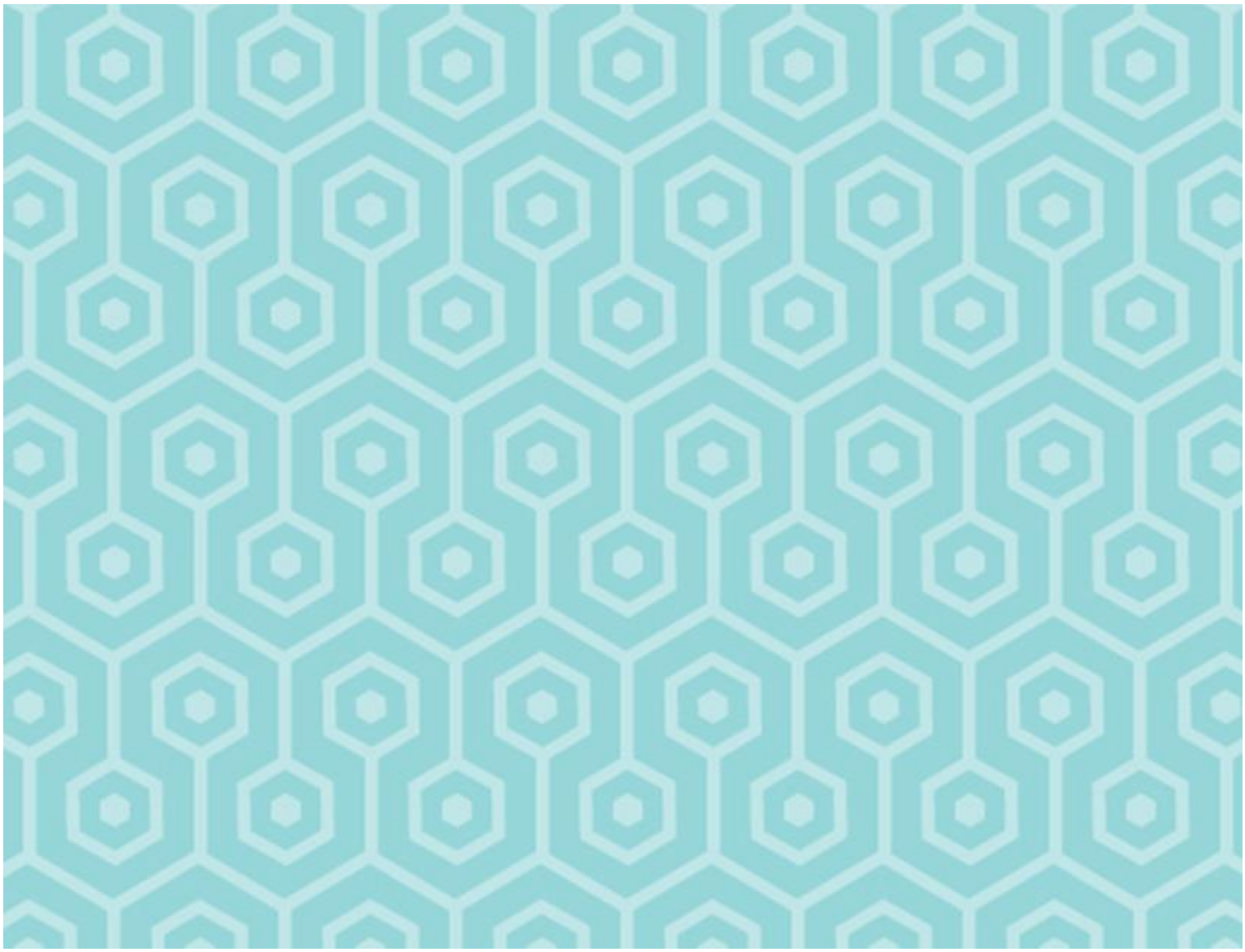
Country progress report - Bangladesh

Global AIDS Monitoring 2017



Contents

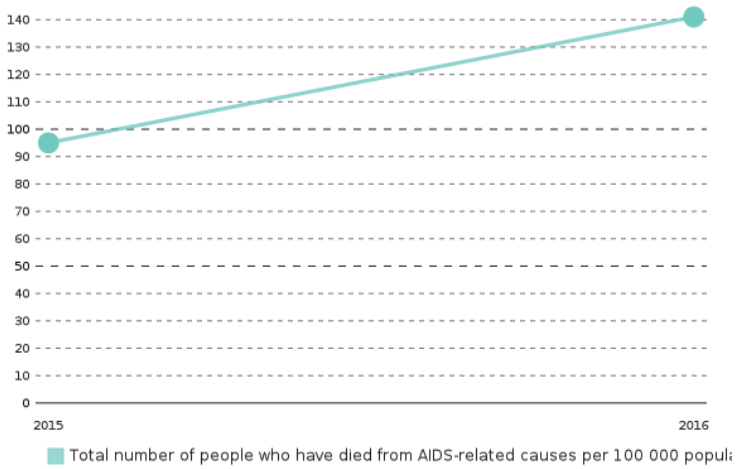
Overall

Fast-track targets

Progress summary

Till 1st December 2016, 4,721 HIV positive cases were detected in Bangladesh of whom 578 were new. Most of the newly identified people living with HIV (PLHIV) were concentrated in Dhaka (37.5%), Chittagong (23.5%), Khulna (17.0%) and Sylhet divisions (14.0%). The estimated number of PLHIV was 9,636 and the estimated sizes of the Key Populations (KPs) are 102,260 for female sex workers (FSWs), 33,067 for people who inject drugs (PWID), 101,695 for males having sex with males (MSM), 29,777 for male sex workers (MSWs), and 10,199 for transgender women (locally known as hijra).

3.1 AIDS mortality, Bangladesh (2015-2016)



Commitment 1

Ensure that 30 million people living with HIV have access to treatment through meeting the 90-90-90 targets by 2020

Progress summary

For treatment, care and support services for PLHIV, antiretroviral therapy (ART) and management of opportunistic infections (OIs) are provided through government support. Community based organizations (CBOs) and networks are engaged to complement this activity. Under the 4th health sector program of the Government of Bangladesh (GoB) from 2017-2022 activities are expected to encompass HTS, treatment, care and support for PLHIV. PLHIV will receive ART supported by the 4th health sector program of the GoB.

It is planned that CBOs will form community ART groups comprising of PLHIV within the community to bring PLHIV to the CST centres, link them to services, conduct counselling for adherence and identify and resolve bottlenecks, conduct home visits.

With Global Fund support, HTS coverage is 50% for MSM and hijra, 42% for PWID and FSWs. Referrals for ART are in place. However, outreach services for treatment adherence, bringing ART to the doorstep and measuring viral load are quite inadequate.

Policy questions

Is there a law, regulation or policy specifying that HIV testing:

a) Is solely performed based on voluntary and informed consent

No

b) Is mandatory before marriage

No

c) Is mandatory to obtain a work or residence permit

No

d) Is mandatory for certain groups

No

What is the recommended CD4 threshold for initiating antiretroviral therapy in adults and adolescents who are asymptomatic, as per MoH guidelines or directive, and what it the implementation status?

≤500 cells/mm3; Implemented in few (<50%) treatment sites

Does your country have a current national policy on routine viral load testing for monitoring antiretroviral therapy and to what extent is it implemented?

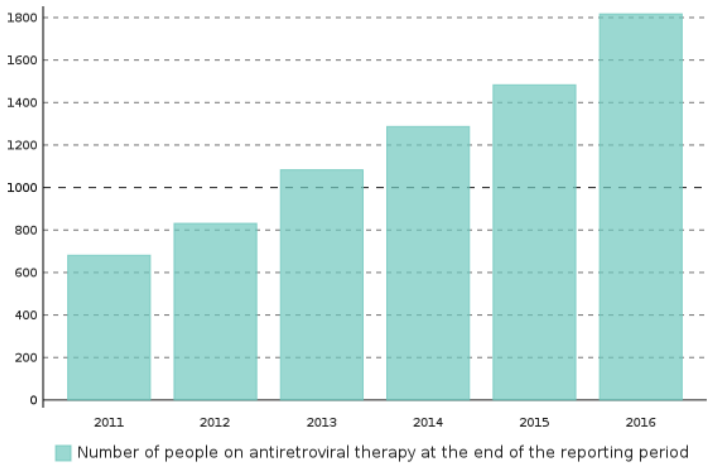
a) For adults and adolescents

Yes, fully implemented

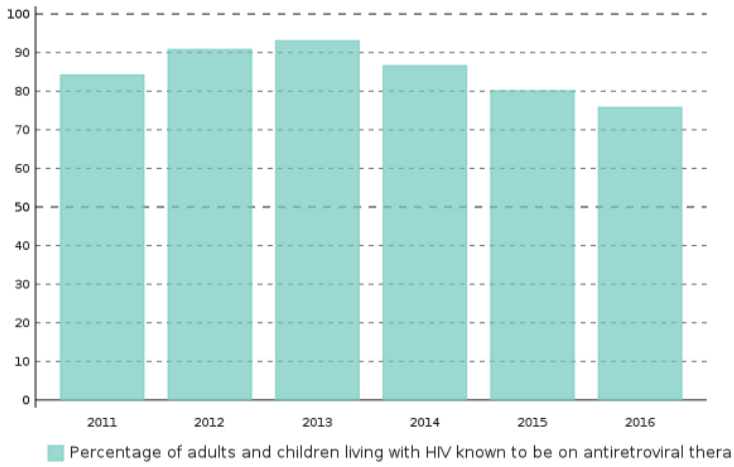
b) For children

Yes, fully implemented

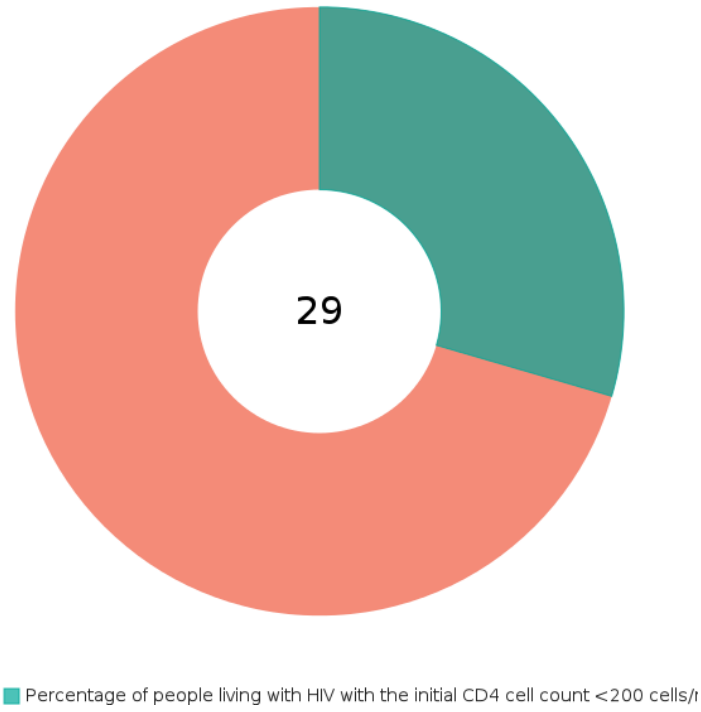
1.2 People living with HIV on antiretroviral therapy, Bangladesh (2011-2016)



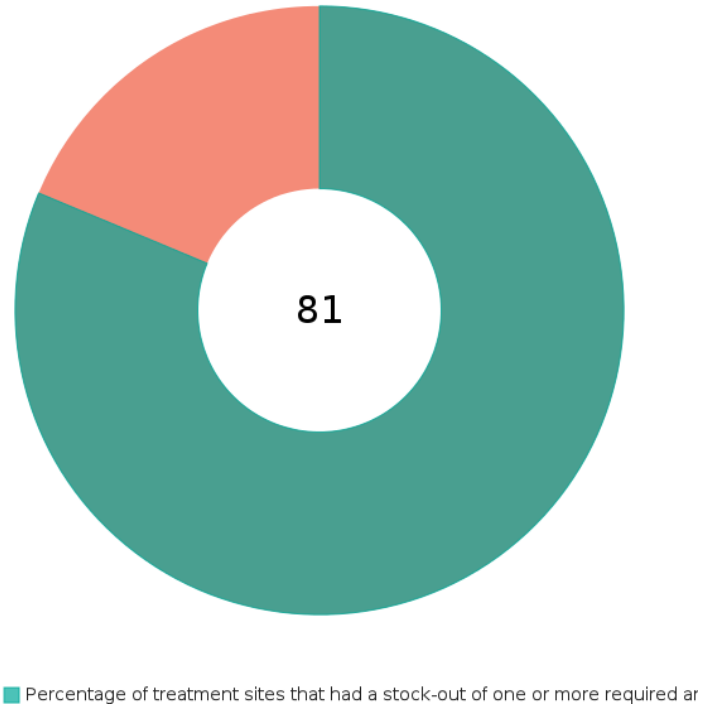
1.3 Retention on antiretroviral therapy at 12 months, Bangladesh (2011-2016)



1.5 Late HIV diagnosis, Bangladesh (2016)

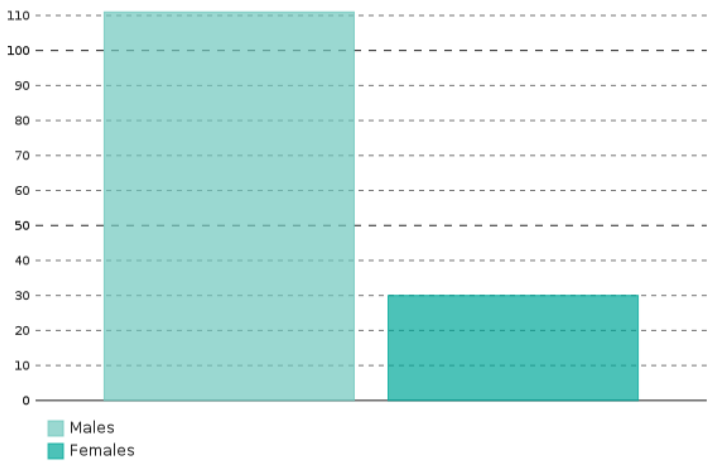


1.6 Antiretroviral medicine stock-outs, Bangladesh (2016)



1.7 AIDS mortality, Bangladesh (2016)

Number of people dying from AIDS-related causes in 2016



Commitment 2

Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018

Progress summary

For PMTCT, UNICEF enabled HIV counselling, testing and treatment services for pregnant women in three national medical university/college hospitals. The major challenge is sustainability of these initiatives.

Several guidelines were developed - National PMTCT guideline, National HIV Risk Reduction Strategy for Most At Risk Adolescent (MARA) and EVA, National HIV/AIDS Counselling Guidelines for Children and Adolescents, Size Estimation and Mapping of Children Infected and Affected by AIDS

Policy questions

Does your country have a national plan for the elimination of mother-to-child transmission of HIV?

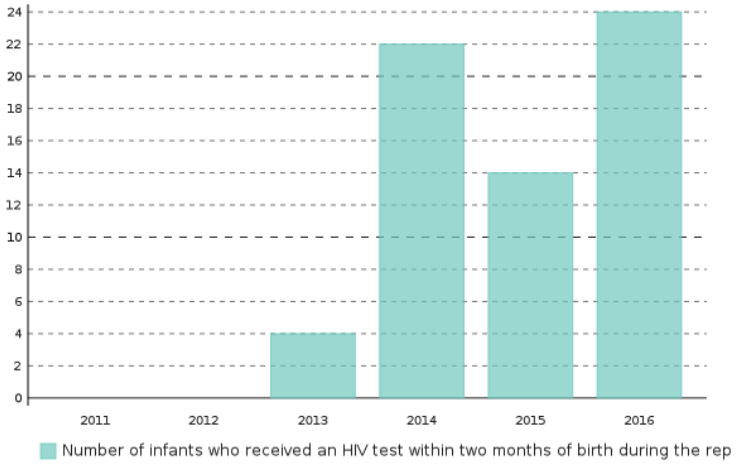
No

Do the national guidelines recommend treating all infants and children living with HIV irrespective of symptoms and if so, what is the implementation status of the cut-off?

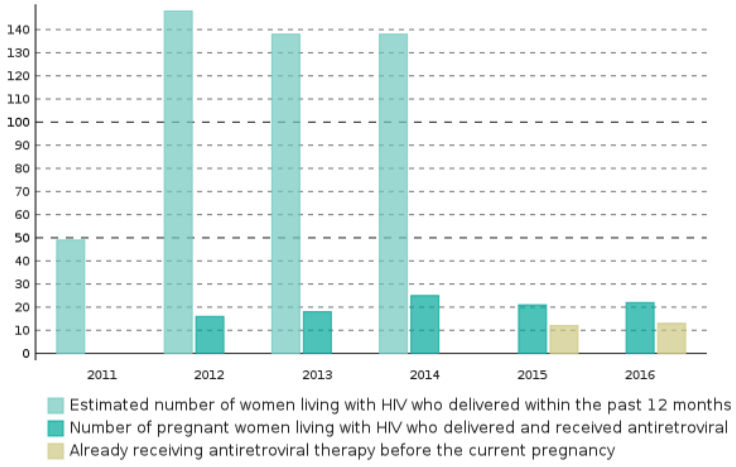
Yes, with an age cut-off to treat all of <5 years

Implemented in a few (<50%) treatment sites

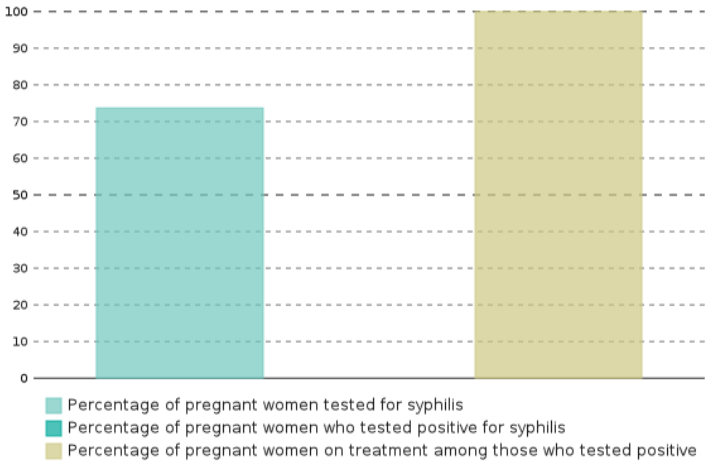
2.1 Early infant diagnosis, Bangladesh (2011-2016)



2.3 Preventing the mother-to-child transmission of HIV, Bangladesh (2011-2016)



2.4 Syphilis among pregnant women, Bangladesh (2016)



Commitment 3

Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners

Progress summary

The current national coverage of prevention interventions for PWID is at 35%, FSWs 25%, MSM (including MSWs) 23.6%, and hijra 39.8%. These interventions include harm reduction, condoms distribution and selling, and HTS mostly through community led approaches. Under the 4th health sector program of the Government of Bangladesh (GoB) from 2017-2022 activities are expected to encompass prevention interventions for KPs and migrants.

Consistent condom use among key populations remains low for diverse reasons. Hence, understanding the enablers and barriers to PrEP implementation in the context of Bangladesh is required. Thus, a PrEP demonstration project in Dhaka is planned for sexual minority people. Also, as a pilot, PrEP will be provided to 1,000 people who are in substantial risks for HIV (eg. adolescent FSW, sex partners of PWID and serodiscordant couple) under the proposed Global Fund funding request.

Policy questions: Key populations

Criminalization and/or prosecution of key populations

Transgender people

Neither criminalized nor prosecuted

Sex workers

Partial criminalization of sex work

Men who have sex with men

Yes, imprisonment (14 years - life)

Is drug use or possession for personal use an offence in your country?

Possession of drugs for personal use is specified as a criminal offence

Legal protections for key populations

Transgender people

Constitutional prohibition of discrimination based on gender diversity

Sex workers

Constitutional prohibition of discrimination based on occupation

Men who have sex with men

Constitutional prohibition of discrimination based on sexual orientation

People who inject drugs

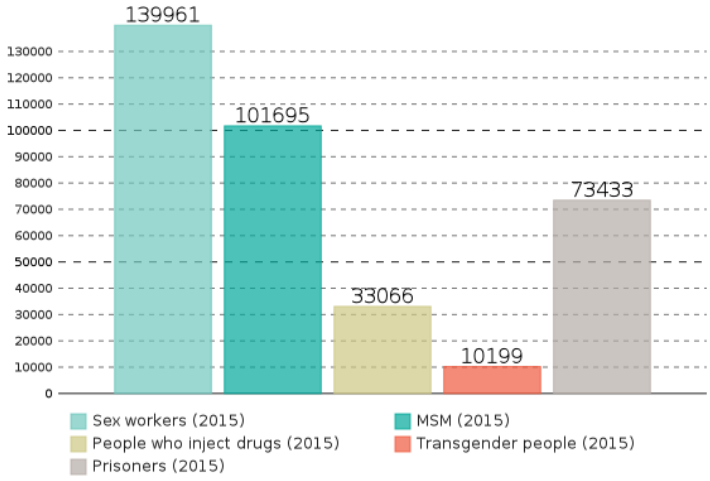
No

Policy questions: PrEP

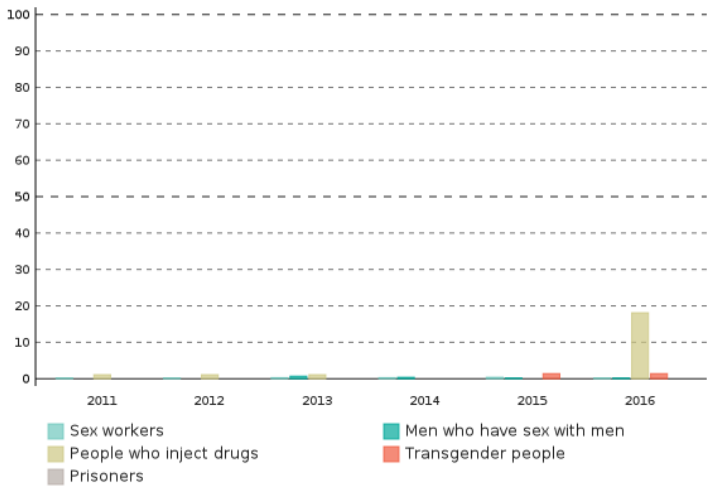
Is pre-exposure prophylaxis (PrEP) available in your country?

No

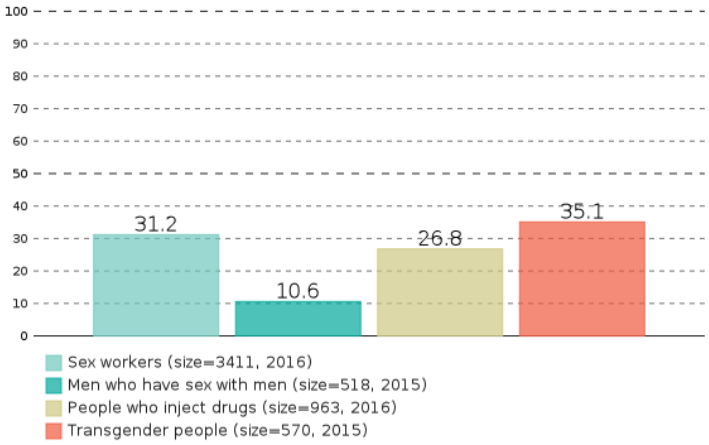
3.2 Estimates of the size of key populations, Bangladesh



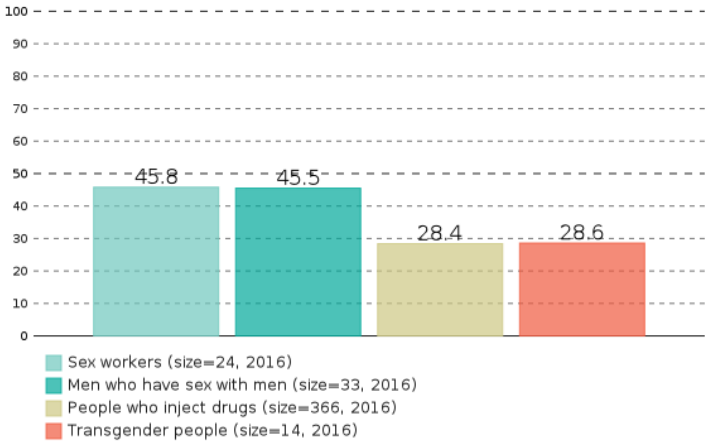
3.3 HIV prevalence among key populations, Bangladesh (2011-2016)



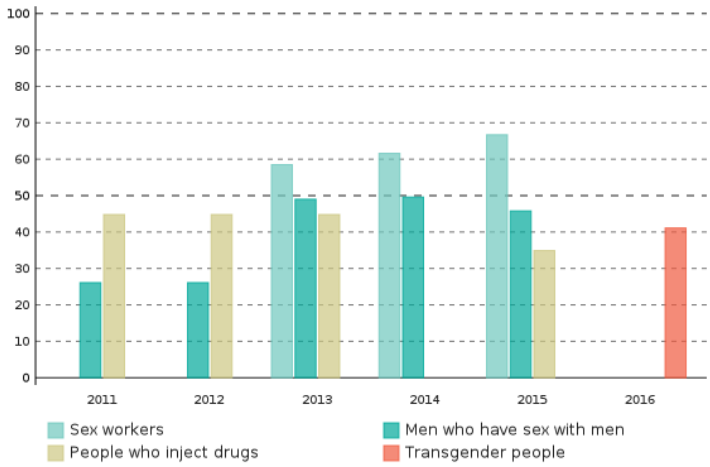
3.4 Knowledge of HIV status among key populations, Bangladesh



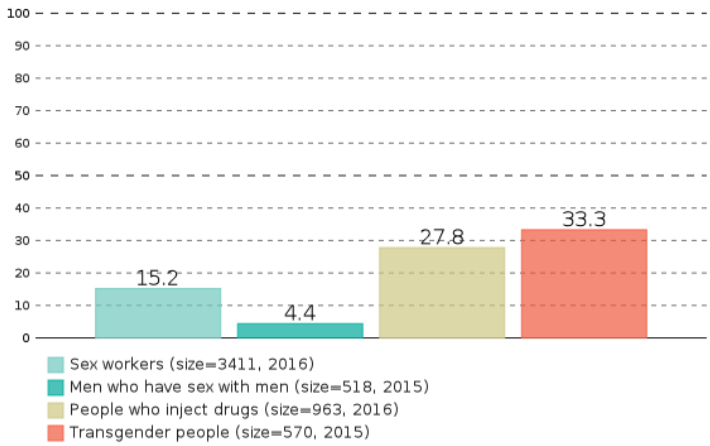
3.5 Antiretroviral therapy coverage among people living with HIV in key populations, Bangladesh



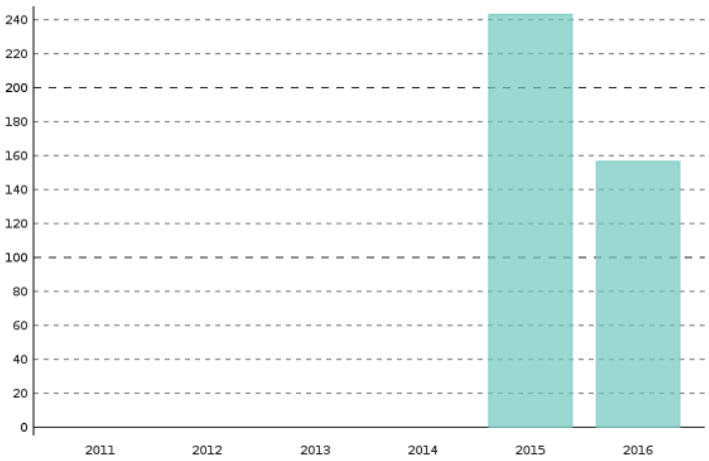
3.6 Condom use among key populations, Bangladesh (2011-2016)



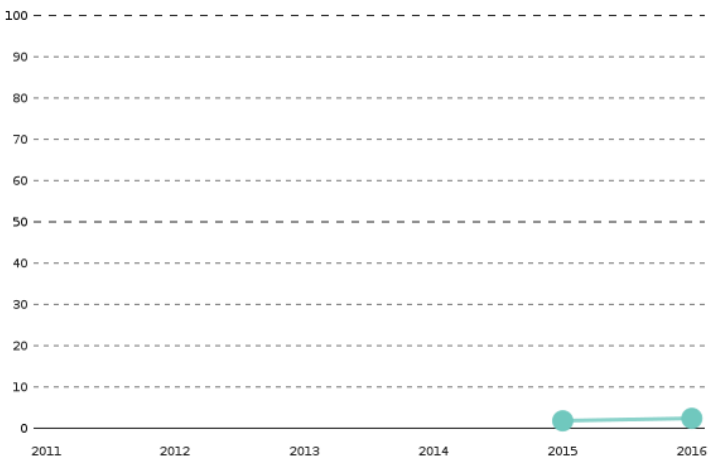
3.7 Coverage of HIV prevention programmes among key populations, Bangladesh (2016)



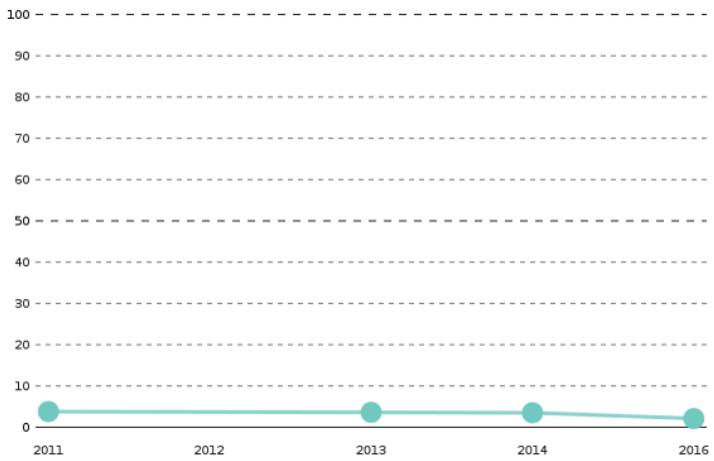
3.9 Needles and syringes distributed per person who injects drugs, Bangladesh (2011-2016)



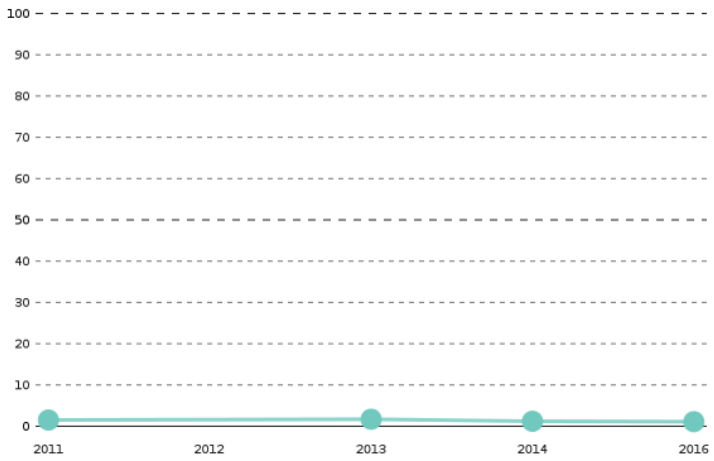
3.10 Coverage of opioid substitution therapy, Bangladesh (2011-2016)



3.11 Active syphilis among sex workers, Bangladesh (2011-2016)



3.12 Active syphilis among men who have sex with men, Bangladesh (2011-2016)



Commitment 4

Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020

Progress summary

Human rights and gender issues have been at the core of HIV prevention approaches in Bangladesh. The GoB has recognized hijra as a separate gender category beyond male-female dichotomy and recently, NASP developed a Gender Strategy (2017-2021) aimed at addressing gender based violence (GBV) among KPs, Emerging & Vulnerable Groups (EVA), PLHIV and affected family members.

Currently integration of HIV prevention services with other relevant platforms such as MNCH, adolescent health and other communicable diseases are being planned. FSWs and female PWID will be referred to health facilities for their SRH needs, such as abortion care and FP. To ensure PMTCT, pregnant FSWs, female PWID and female partners of male PWID will be initially screened for HIV at DICs and will be linked to tertiary hospitals for pregnancy care, ART, breast feeding counselling, early infant diagnosis, etc. Efforts to refer female partners of married MSM to SRH services will be made initially on a small scale and based on experience this will be scaled up in some priority districts. Opportunities will be explored to link young KPs with adolescent friendly health service of DG-FP available at their locality.

Prevention approaches are supported by community squads formed for FSW to respond to harassment through a 24/7 hotline which allowed 122 GBV cases to be addressed between July-December 2016. All cases were referred to public health facilities for treatment and linked for legal aid support. Through the Multi-Country South Asia GF Regional Program for MSM advocacy for policy change was conducted and networks maintained with different entities. An interim memo was issued by MOHFW instructing service providers to allow HIV testing, condom promotion, needle syringe program for MARA.

Policy questions

Does your country have a national plan or strategy to address gender-based violence* and violence against women that includes HIV

Yes

Does your country have legislation on domestic violence*?

No

Does your country have any of the following to protect key populations and people living with HIV from violence?

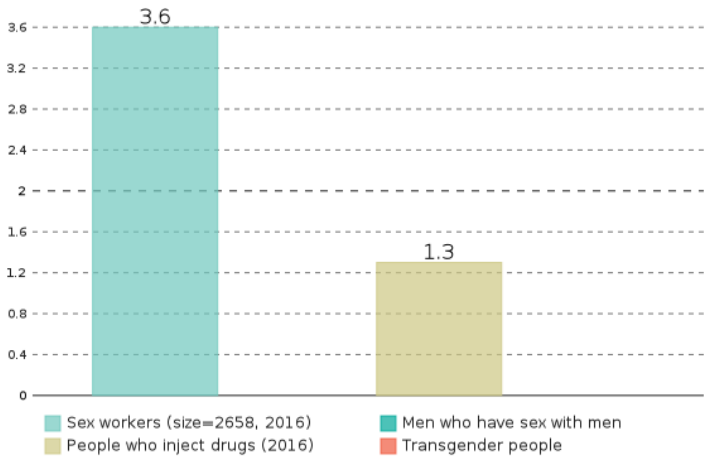
General criminal laws prohibiting violence

Programmes to address intimate partner violence*

Does your country have policies in place requiring healthcare settings to provide timely and quality health care regardless of gender, nationality, age, disability, ethnic origin, sexual orientation, religion, language, socio-economic status, HIV or other health status, or because of selling sex, using drugs, living in prison or any other grounds?

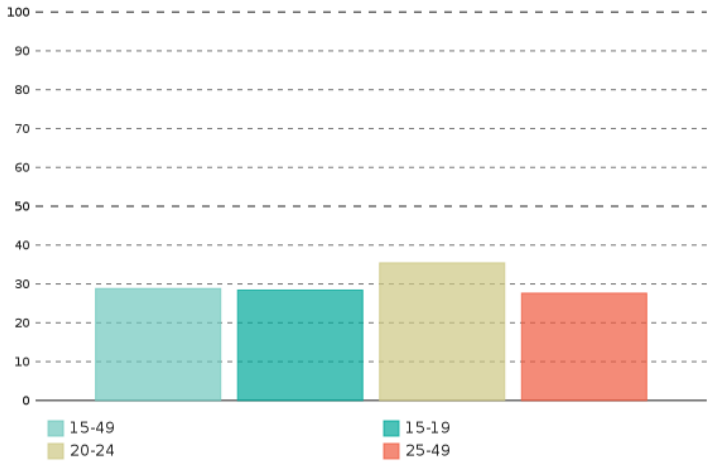
Yes, policies exist but are not consistently implemented

4.2 Avoidance of HIV services because of stigma and discrimination among key populations, Bangladesh

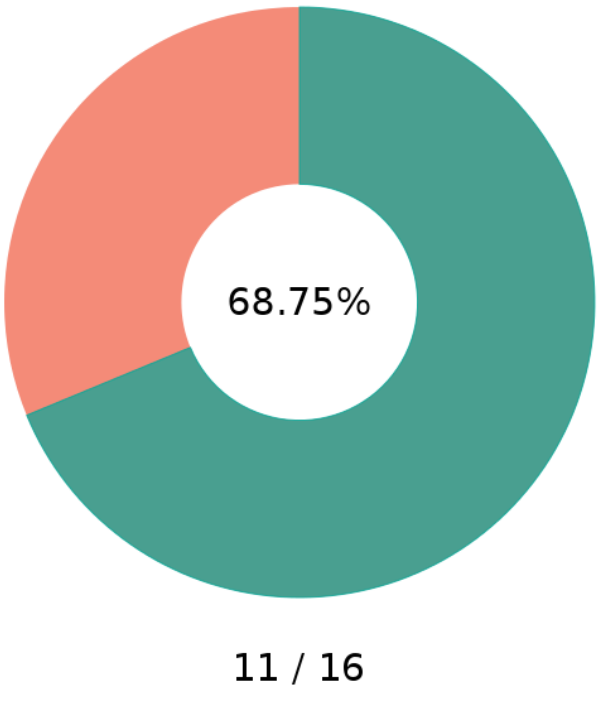


4.3 Prevalence of recent intimate partner violence, Bangladesh

Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months (n=21688; 2015)



Percentage of Global AIDS Monitoring indicators with data disaggregated by gender



Commitment 5

Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year

Progress summary

For MARA, UNICEF enhanced GoB capacity to design and implement high impact HIV prevention, treatment and care interventions for adolescent KPs, while sustaining general awareness/ knowledge levels on HIV through school-based Life Skills Education.

Under the Global Fund funding request, age appropriate Peers will be deployed to provide HIV prevention services to MARA who are MSM and hijra. Each month a separate day will be dedicated for STI services and HTS for MARA MSM/hijra. Age appropriate BCC materials will also be developed and distributed. This has already been implemented in case of MARA who are FSW and PWID. The estimated number of adolescent FSWs is 17,384 and the NSP target is 11300. In the Funding Request, customized services will be provided to 1850 adolescent FSWs which is 16% of the NSP target. Opportunities will be explored to link young KPs with adolescent friendly health service of DG-FP available at their locality.

Policy questions

Does your country have education policies that guide the delivery of life skills-based HIV and sexuality education*, according to international standards*, in:

a) Primary school

No

b) Secondary school

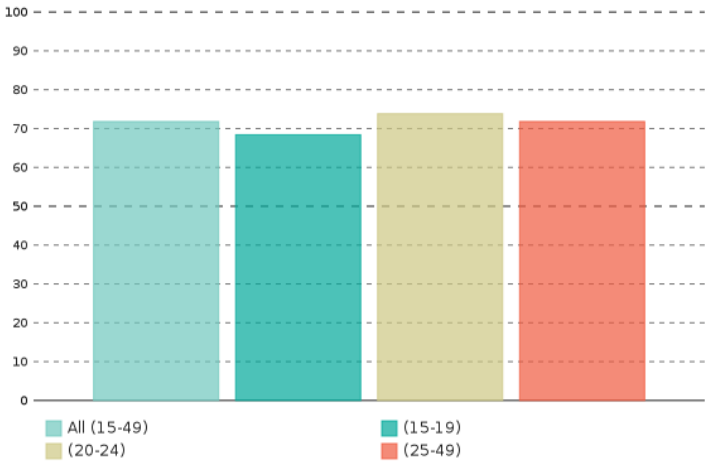
No

c) Teacher training

No

5.2 Demand for family planning satisfied by modern methods, Bangladesh (2016)

Percentage of women of reproductive age (15-49 years old) who have their demand for family planning satisfied with modern methods



Commitment 6

Ensure that 75% of people living with, at risk of and affected by HIV benefit from HIV-sensitive social protection by 2020

Progress summary

Under the Global Fund Funding Request, there are specific structural interventions proposed with MoHFW, Ministry of Social Welfare, Ministry of Women and Children Affairs for increasing availability and accessibility of government mainstreaming services including universal access to health coverage, government social safety-net program, access to legal support, etc. The updated National Social Security Strategy covers hijra and PLHIV.

Policy questions

Yes

a) Does it refer to HIV?

Yes

b) Does it recognize people living with HIV as key beneficiaries?

Yes

c) Does it recognize key populations (sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people, prisoners) as key beneficiaries?

Yes

d) Does it recognize adolescent girls and young women as key beneficiaries?

Yes

e) Does it recognize people affected by HIV (children and families) as key beneficiaries?

Yes

f) Does it address the issue of unpaid care work in the context of HIV?

Yes

Do any of the following barriers limit access to social protection* programmes in your country

Social protection programmes do not include people living with HIV, key populations and/or people affected by HIVLack of information available on the programmesComplicated proceduresFear of stigma and discriminationLack of documentation that confers eligibility, such as national identity cardsBiasness of local leader in selection process

Commitment 7

Ensure that at least 30% of all service delivery is community-led by 2020

Progress summary

For treatment, care and support services for PLHIV community based organizations (CBOs) and networks are engaged to reach PLHIV including HIV positive KPs. It is planned that CBOs will form community ART groups comprising of PLHIV within the community to bring PLHIV to the CST centres, link them to services, conduct counselling for adherence and identify and resolve bottlenecks, conduct home visits.

All current prevention programs are led by communities, however community based testing is planned under the funding request and in the next health sector program.

Under the funding request in case of FSWs, part time Peer Volunteers (PVs) selected from the cruising spots will be their primary contacts. PVs will be supervised by Community Organizers selected from the community. Community empowerment for sex workers: CBOs, self-help groups (SHGs) and network will be capacitated to mobilize the community for their rights, empowerment and will be engaged in participatory monitoring. Community squads' of FSWs respond to harassment cases through a 24hr hotline and link to one stop crisis centre (OCC) for medico-legal service. HIV positive FSWs will be linked to the ART centres at GoB health facilities and followed up by PVs and community organizers. Community organizers will be responsible for follow up of STI cases.

Under the PWID interventions, community engagement will be assured through selection of 'spot leaders' recruited directly from injecting spots, who will be the primary contact for PWID, and Community Organizers, will supervise spot leaders. CBOs, SHG and networks will carry out participatory monitoring, community based detoxification, follow up for ART adherence and OST retention efforts.

HTS for MSM and hijra will be provided at SDPs and in the community. ART will be provided to HIV positive MSM/hijra from GoB ART centres by working in close collaboration with SHGs and PLHIV networks. Adherence counselling will be provided by case workers recruited from

the community.

An operations research study will be undertaken among MSM/hijra to asses feasibility of community based TB screening with sputum collection and referral to DOTS centres by PE/PA which if successful, will be expanded to priority districts.

Policy questions

Does your country have a national policy promoting community delivery of antiretroviral therapy?

No

Are there any of the following safeguards in laws, regulations and policies that provide for the operation of CSOs/CBOs in your country?

Registration of HIV CSOs is possible

Registration of CSOs/CBOs working with key populations is possible

HIV services can be provided by CSOs/CBOs

Services to key populations can be provided by CSOs/CBOs

Number of condoms and lubricants distributed by NGOs in the previous year

a) Male condoms:

33260226

b) Female condoms:

0

c) Lubricants:

616956

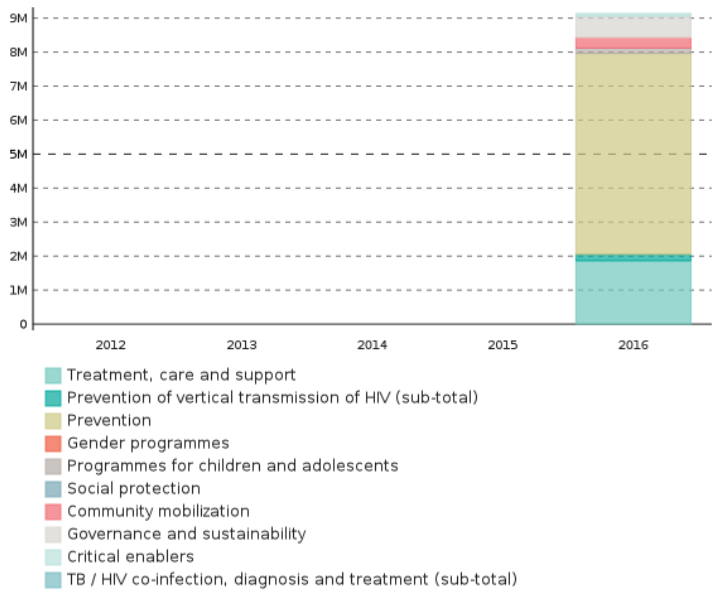
Commitment 8

Ensure that HIV investments increase to US$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers

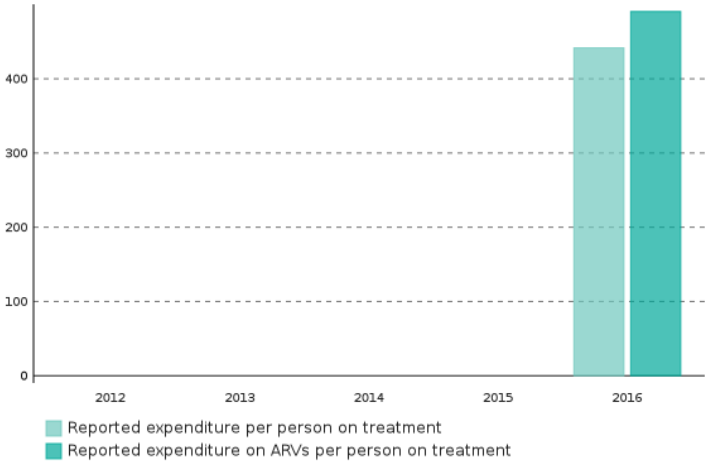
Progress summary

The GoB has increased investment for HIV Prevention. Data shows that in the 3rd health sector program, the OP for NASP allocated USD 24.4 million while in the 4th health sector program approximately USD 47 million has been allocated. Due to decreasing donor support, modalities in service provision are constantly changing. This is hampering prevention efforts.

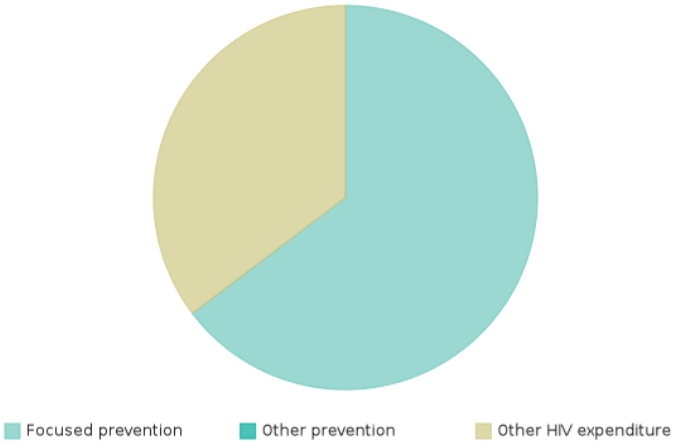
8.1 Domestic and international HIV expenditure by programme categories and financing sources, Bangladesh (2012-2016)



Expenditure per person on treatment, Bangladesh (2016)

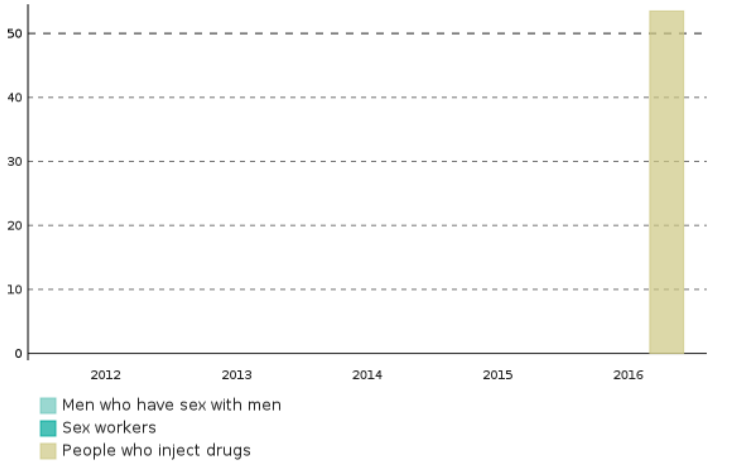


Share of effective prevention out of total, Bangladesh (2016)



Structure of investments on effective and other prevention programmes (%), Bangladesh (2016)

Expenditure per person reached by key population services, Bangladesh (2012-2016)



Commitment 9

Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights

Progress summary

CBOs, self-help groups (SHGs) and network will be capacitated to mobilize the community for their rights, empowerment and will be engaged in participatory monitoring. The stigma index will be conducted and the recommendations will be pursued. Existing 'Community squads' of FSWs will continue to respond to harassment cases through a 24hr hotline and link to one stop crisis centre (OCC) for medico-legal services. Similar referral linkages will be established with service providers for providing medico-legal and psychosocial support services for GBV and Human Rights violation and also a National Task Force (NTF) under NASP will be established to safeguard Human Rights of the hijra

CBOs, SHG and networks are mobilizing the community for their rights. Local, district and national advocacy and sensitization activities are ongoing with religious leaders, influential people, members of law enforcement agencies and journalists. Efforts will be given for drug policy reform in coordination with NASP.

Advocacy with key/relevant ministries including of Home, Education, Social Welfare, Women and Children Affairs, Labour and Overseas Employment, etc. are continuing by engaging HIV focal persons and addressing annual plans.

Policy questions

In the past two years have there been training and/or capacity building programmes for people living with HIV and key populations to educate them and raise their awareness concerning their rights (in the context of HIV) in your country?

Yes, at a small scale

Are there mechanisms in place to record and address cases of HIV-related discrimination (based on perceived HIV status and/or belonging to any key population)?

No

Does your country have any of the following accountability mechanisms in relation to discrimination and violations of human rights in healthcare settings?

-

Does your country have any of the following barriers to accessing accountability mechanisms present?

Mechanisms are not sensitive to HIV

Affordability constraints for people from marginalized and affected groups

Awareness or knowledge of how to use such mechanisms is limited

Commitment 10

Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C

Progress summary

Although the prevalence of HCV has significantly declined among male PWID in Dhaka from 66.5% in 1999 to 39.6%, still it remains as one of the gaps in providing comprehensive service package for PWID in Bangladesh. Neither the government nor the any program addressed hepatitis C issue adequately. In the Funding Request, IEC/BCC activity for prevention of HCV is planned among targeted PWID. Under this above allocation, a provision is proposed to provide screening and management of HCV among PWID. Considering the prevalence of HCV, in Dhaka, and Chapai Nawabganj PWID will be routinely screened for HCV and around 200 HCV positive PWID will be provided medicine support. Trained physicians will be responsible for screening, diagnosis and management of HCV from comprehensive DICs.

Policy questions

Is cervical cancer screening and treatment for women living with HIV recommended in:

a. The national strategy, policy, plan or guidelines for cancer, cervical cancer or the broader response to non-communicable diseases (NCDs)

Yes

b. The national strategic plan governing the AIDS response

Yes

c. National HIV-treatment guidelines

Yes

What coinfection policies are in place in the country for adults, adolescents and children?

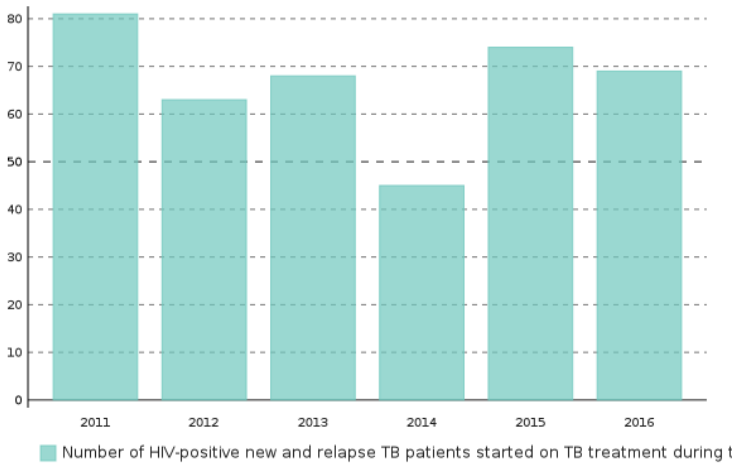
Isoniazid preventive therapy (IPT) or latent TB infection (LTBI) prophylaxis for people living with HIV

Intensified TB case finding among people living with HIV

TB infection control in HIV health-care settings

Co-trimoxazole prophylaxis

10.1 Co-managing TB and HIV treatment, Bangladesh (2011-2016)



10.2 Proportion of people living with HIV newly enrolled in HIV care with active TB disease, Bangladesh (2015-2016)