Factors Facilitating the Vulnerability of HIV/AIDS in Bangladesh and the National Responses

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Abstract:

In the global scenario of HIV/AIDS, Bangladesh is among those countries with a low prevalence of infection. Bangladesh initiated an early response to the HIV epidemic starting in the mid-1980s. This paper reviews available sources of data, including routine surveillance, general population surveys, and various research studies with the aim to understand the facilitating factors of HIV/AIDS in Bangladesh. This paper also focuses on the national responses to HIV/AIDS considering the leadership and strategic direction, key government structure of HIV/AIDS prevention programme, national policy on HIV/AIDS/STIs related issues. Available data show that the HIV epidemic is still at relatively low level; however, there are lots of factors which may contribute to the spread of HIV/AIDS in Bangladesh. This paper finds that continuing high risk behaviour among sex workers and their clients, transgender, having sex with men, injecting drug users, high rate of STIs, low condom use, extramarital and premarital sexual activity, illiteracy, low level of HIV/AIDS awareness, gender inequalities, gaps in the health care disparity all contribute to the threat of the spread of epidemic unless critical preventive efforts are initiated to avert it in the general population.

Key words: AIDS, HIV, STIs, *Hijra*, Injecting drug user, MSM; Risk behaviours, Sex workers, Bangladesh

Introduction

Asia Pacific region has the second highest number in the world of people living with HIV/AIDS. Bangladesh still has a relatively low prevalence of HIV with a rate of less than one per cent among most at risk population groups. It is estimated that there are 13,000 HIV-positive people in the country and that HIV prevalence in the adult population is less than 0.01 per cent (WHO, 2011). Through this exercise the range of the size of the vulnerable groups has been estimated, which shows that there are large number of people who could be most at risk of HIV. According to sixth round National HIV Sero-Surveillance 2004-2005, among IDUs in Central Bangladesh HIV infection rate has reached 4.9 per cent that point towards a concentrated epidemic in this population group. The rapid and consistent increase in the prevalence of HIV among IDUs from 1.4 per cent in 2000 to 1.7 per cent in 2001, 4 per cent in 2002 and 4.9 per cent in 2005 (MoHFW, 2003a).

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Sexual intercourse with prostitutes is the riskiest behaviour in Bangladesh for spreading HIV/AIDS especially where a higher percentage of prostitutes and general population are not aware of this pandemic (WHO, 1994). The behavioural data reported on HIV epidemics in Bangladesh identified brothel based sex workers as a group whose sexual behaviour make them at risk of infection (Azim et al., 2000). The floating sex workers constitute another core group for HIV transmission since they play a role as vectors for STIs/HIV transmission, linking male clients to the general population of women (Sarker et al., 1998). Further the risk behaviour of unprotected sex as evidenced by low condom use among sex workers and MSWs (male sex workers) is high. The behavioural surveillance survey (2003-2004) provides information on condom use among men who have sex with men (MSM) during anal sex whereby it indicates that in non-commercial sex the rate is 37 per cent, while in commercial sex it is 49 per cent. Additional data exists on condom use among MSM who reported anal sex with a female partner (for non-commercial sex 20.2 per cent vs. 44.2 per cent in commercial sex). Various studies suggest that extra- and pre-marital sex on the part of men and women is not uncommon (Caldwell et al., 1999; Caldwell and Pieris, 1999).

Gender violence and inequality exist in Bangladesh society that is largely male dominated and thereby putting women and girls at additional risk of HIV. Since sexual expression for females is typically more limited than males; the small population of sex workers has large number of clients and consequently high rates of STIs which enhance HIV transmission (Abdul-Quader, 1998). According to behavioural surveillance survey findings of 2003-2004 a large number of clients of sex workers were married men who could put their wives at risk of HIV even if they themselves remained faithful. According to the seventh round national serological surveillance data, the rate of active syphilis among street based sex workers in Southeast region of Bangladesh is 10.1 per cent (MoHFW, 2006b). In the 2004-05 HIV sentinel surveillance across the country, the active syphilis prevalence rate was 3.4 per cent among the high risk groups out of 11, 029 individuals who had been tested for STIs, 376 had been identified having an active syphilis (MoHFW, 2005c). On the other hand, brothel-based female sex workers in Bangladesh report the highest turnover of clients than anywhere in Asia (an average of 18.8 clients per week).

A bulk literature has shown that a large majority of adolescents in Bangladesh do not have information on sexuality, contraception, or STIs and HIV/AIDS (Khan et al., 2004; Barkat et al., 2000). Data on knowledge and behaviour indicates that only 17 per cent of most at risk population have correct knowledge about prevention and misconceptions on HIV/AIDS ranging from 3.7 per cent among transgender (*Hijra*) to 36.6 per cent among brothel based sex workers (MoHFW, 2004d). Surveys show that only about 65 per cent of young people, fewer than 20 per cent of married women, and just 33 per cent of married men have even heard of AIDS. To avoid the social consequences of unplanned pregnancy, transmission of STIs and HIV/AIDS, people need to be aware of their reproductive health.

In recognition of the threat of HIV/AIDS, the Government of Bangladesh developed and approved a comprehensive Policy on HIV/AIDS and STD Related Issues in 1997. The National AIDS Committee (NAC) was created in 1985 to ensure policy direction and promote multi-sectoral effort on HIV/AIDS. The President of the country is the Chief Patron of NAC and the Minister of Health and Family Welfare (MOHFW) is its Chairperson. The Technical Committee (TC) of NAC that comprises mainly of Health Experts supports it. The National AIDS/STD Program (NASP) that falls under the Directorate General of Health Services within MOHFW is charged with the responsibility to facilitate overall coordination and support for the national response to HIV/AIDS (NASP, 2004a). To complement Government effort, NGOs working on HIV/AIDS have set up the AIDS/STI Network that seeks to improve coordination among them and enhance their contribution to deal with the epidemic

1.1 Geographical Vulnerability

Geographically Bangladesh is located in such a place where the risk of being infected by the deadly disease in apprehended to be very high. Spanning northern Thailand, Myanmar (Burma), Laos, northeast India, and portions of southern China, this region has some of the highest HIV infection rates in Asia. In addition to sharing its land borders with India and Myanmar, a flourishing sex industry, increased injection drug use (IDU), large scale migration, illiteracy, and socio-economic disparity are all important factors present in Bangladesh as well as in the other countries in the region that facilitate the spread of HIV. As a result, there is increasing concern that marked epidemic spread of HIV in Bangladesh might occur in a manner similar to that witnessed in several neighboring countries (Bhuiya et al., 2004). On the other hand, Chittagong Sea port also facilitates the spread of HIV/AIDS in Bangladesh. Some studies suggest that busy, land border crossing and international fishing ports have higher incidences of HIV and STIs than other locations. Everyday thousands of transport dock or port laborers, of whom many carry HIV or AIDS virus, enter the country through port from neighboring countries. They go to different brothels and do not use safety methods during sexual intercourse (STEP, 2004).

Bangladesh is one of the Asian Nations from where cases of human trafficking are reported to be very high owing to poverty stricken socio-economic conditions. Moreover, sexual exploitation, forced prostitution of the trafficking women adds risks of more HIV infection. India is one of the highest risky countries in the world for AIDS and Myanmar already has AIDS epidemic. Because of these factors Bangladesh is a high-risk area despite lesser AIDS infections up to now. Particularly, the border regions are high-risk areas and women of those areas are more likely to be infected with HIV/AIDS.

1.2 Low Level of HIV/AIDS Awareness

Low levels of HIV and AIDS awareness still prevail in Bangladesh. The Bangladesh Demographic and Health Survey found that only 31 per cent of ever married women and

50 per cent of currently married men had heard of AIDS (BDHS, 1999-2000). A significant number of respondents from different groups in the third surveillance are not knowledgeable about the basic transmission of HIV/AIDS (Pisani et al., 2001). The National Assessment of Situation and Responses to Opioid/Opiate use in Bangladesh (NASROB) found that 68 per cent of the IDUs knew that needle sharing spreads HIV, a high proportion of drug users (90 per cent) were unaware of the risk from male-to-male sex or sex with *hijras*, although 10 per cent reported such activities combined with low condom use (MoHFW, 2005cb). On the other hand, the data indicates that HIV/AIDS awareness programs with sex workers in the central region and IDUs in the central and northwest regions have managed to increase their consciousness about the matter. Vulnerability is also high among young people. A number of research studies have indicated that young people in Bangladesh are vulnerable because they do not have clear ideas about the transmission and prevention of HIV/STIs, or the symptoms of common STIs (Amin et al., 2002; Bhuiya, 2002).

1.3 Poverty Linked Vulnerabilities

Poor people are less able to act on information they receive, partly because of powerlessness, but partly because survival needs may drive them to adopt risky survival strategies. Malnutrition and poor living conditions also increase the risk of exposure to other infections and health hazards. In a study on health inequalities in Bangladesh, an unacceptably high gap was found between the poor and the rich quintiles with respect to heath indicators (Sen, 2001). Rural people are often forced into migration within Bangladesh due to poverty or natural disasters. Many women and adolescent girls who migrate for employment are victimized or forced to resort to sex work to support them. They are vulnerable to STIs/HIV because of lack of awareness regarding safer sex and lack of negotiating power in this context.

Evidence suggests that extensive trafficking of women and children also occurs within Bangladesh, and to other Asian countries (Heissler, 2001). The victims are mainly sold as bonded labour or into prostitution. Several recent studies have found that children in general are at risk of sexual harassments, exploitation, and abuse, 'street children' are particularly vulnerable (MWCA, 2001; Kabir, 2001; Ahammed et al., 1998). These children have generally ended up on the streets due to poverty, migration and trafficking. Studies indicate that a significant proportion of both these boys and girls have had sexual experience through choice or force or occupation as sex workers, but their low levels of STIs/HIV awareness and lack of access to facilities make them particularly vulnerable (Saidel et al., 2003). Not only does poverty enhance HIV related vulnerability; AIDS widens the gap between the rich and poor, and hampers economic growth. The escalating incidence or HIV in developing countries highlights the role that poverty pays in fueling the epidemic.

1.4 Intravenous Drug Users (IDUs)

Bangladesh has an estimated 20,000-40,000 people who inject drugs (Reddy et al, 2008). HIV prevalence among people who inject drugs has been rising in Bangladesh. By 2007, HIV prevalence at 7.0 per cent had been reported in Dhaka and one neighbourhood of Dhaka, where 11.0 per cent of people who inject drugs tested HIV positive, is likely to be the epicentre of the epidemic (NASP, 2007a). By November 2008 there were 1,495 reported HIV cases in Bangladesh (Khan, 2008) and an estimated 7,500 persons are living with HIV (National AIDS Committee, 2005). There has been a three fold increase in the number of HIV cases reported since 2003. Of all reported HIV infections 11.1% (ICDDR,B, 2008) have been associated with injecting drug use. A significant proportion of men who inject drugs also buy sex (45.6% - 66.4%) and reported condom use in sex work encounters ranges from 24.9 to 54.7 % (NASP, 2007b).

The National Assessment of Situation and Response to Opioid/Opiate use in Bangladesh (NASROB) study looked at the connections through which HIV/STIs can potentially spread from IDUs based on sexual practices (Panda et al., 2002). The study found that 97 per cent IDUs were also sexually active and of them almost 50 per cent within the previous week, 70 per cent within the previous month. The majority of all drug users' respondents reported having sex with sex workers, but once again condom use was low about 50 per cent and 62 per cent of current IDUs and heroin smokers respectively had never used condoms. The study found that 10 per cent of male drug users have sex with another male or *hijra* (transgender).

Research studies on blood collection for the second and third sero-surveillance indicated a high rate of Hepatitis B, C and Syphilis among IDUs in needle exchange program (NEP) in the North West were 12 per cent, 59.69 per cent and 12.5 per cent, respectively (Azim et al., 2000). In the third surveillance, the prevalence of Hepatitis C and Syphilis detected among IDUs in programs in the Central and North West region were 18.2 per cent and 8.6 per cent, respectively (Pisani et al., 2001).

1.5 Prostitution

Bangladesh has a thriving sex industry. It is estimated that there are 60,000-100,000 sex workers in Bangladesh and approximately one million men buy sex. There are 15-17 major brothels operating throughout the country accommodating 25,000-35,000 sex workers. The existence of risky behavior and high levels of sexually transmitted infections (STIs) among the 'Core Groups' indicate the potential for a serious HIV/AIDS epidemic in the country. STIs are widespread amongst the prostitutes including syphilis gonorrhea, chlamydiosis, trichomoniasis, herpes and cancroids, which facilitate to be infected with HIV/AIDS (Choudhury et al., 1989). In the third round of behavioural surveillance, female sex workers in Bangladesh reported the highest turnovers of clients anywhere in Asia – brothel based sex workers averaged 18.8 clients per week, while hotel based sex workers averaged 44 clients per week (Pisani et al.,

2001). It was found that majority of the prostitutes were suffering from serious STIs (Bloem et al., 1995; Siddiqui et al., 1993). Choudhury et al. (1989) identified STIs were widespread among the prostitute that includes syphilis, gonorrhea, chlamydiosis, trichomoniasis, herpes and chancroids. Syphilis was denoted to occur with highest frequency (57.14%), other STIs were found in the following frequencies: chlamdiosis 20 per cent, herpes 20 per cent, and gonorrhea 14.3 per cent, and human papilloma virus (HPV) carries 5.7 per cent.

Low condom use by men remains one of the largest barriers to prevention of HIV in Bangladesh. The third behavioural surveillance found that condom use among men having sex with men (MSMs) is low, although the number of partners is high. Over 90 per cent of these men report they do not always use condoms (Pisani et al., 2001). It was also found that consistent condom use among female sex workers is lower in Bangladesh (2 to 4 per cent) than anywhere else in Asia (Saidel et al., 2003). The study indicates that about 61 per cent of the sex workers of different groups (brothel, hotel and street) reported that their clients used condom irregularly, about 34 per cent regularly and 5 per cent rare (Mahmud, 2006). Behavioural Surveillance Survey data have consistently shown that risk behaviours in both male sex workers and *Hijra* are very high. Consistent condom use in anal sex in the last week with new or regular clients was less than 25 per cent. Despite risky behaviours, HIV rates have remained <1 per cent for both *Hijra* and male sex workers. Active syphilis rates remained similar in male sex workers but declined in *Hijra* over the rounds although the rates in *Hijra* were higher.

The low levels of awareness and presence of risk factor among the sex workers makes the potential for rapid spread of HIV transmission (Habib, et al., 2000). Sex workers display high levels of knowledge about HIV/AIDS and apparently low frequencies of condom use, which clearly indicate that behaviour was not solely determined by knowledge (Hossain, et al., 2004). Among sex workers majority did not know about pandemic diseases, while the rest had poor knowledge on HIV/AIDS (Ullah and Rahman, 2000). The study conducted by a local NGO (Light House), explored other risk-generating behaviour of the community, which makes them more vulnerable to STI/HIV/AIDS. The sex workers were found to be quite unaware of the risks of STI/HIV/AIDS and safer sex practice (AIDS Conference, 2002).

1.6 Gender Inequalities

Gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS (UNAIDS, 1998; Sherr et al., 1997; Pyette and Warrr, 1997; Bruyn, 1992). The 21st Special Session of the UN General Assembly (ICPD+5) held in 1999 drew attention to the role of gender equality and equity as a key determinant of success in the struggle against AIDS. In most society's gender norms influence individual and societal risk and vulnerability to HIV/AIDS (Tallis, 2000). Gender roles determine how and what men and women are expected to know about sexual matters and sexual behavior. As a result, girls and

women are often poorly informed about reproduction and sex, while men are often expected to know much more.

The gender situation in Bangladesh can increase the vulnerability of women and girl children due to the lower social status accorded to them, low levels of literacy, and limited skills training and employment opportunities. Women are more at risk from violence, trafficking, and coercive sex that compromise their ability to negotiate protection or leave risky relationships (Khan et al., 2002). This leaves women in a position where they are often unaware of the dangers of HIV and AIDS, but yet are exposed to high risk behaviors of their partners/spouses. Very little attention has been paid to the issues of parent-to-child transmission of HIV, and preventing mothers and would be mothers from getting infected. There are few provisions for confidential testing or counseling of HIV positive pregnant women, or those contemplating pregnancy in Bangladesh. There is a paucity of programs for effective awareness generating for women. They have limited access to proper healthcare facilities. The challenge is that many women have home deliveries, and therefore clinic based programs leave them out. HIV positive mothers need counseling on their infant feeding options, and measures are needed to reduce the stigma associated with being unable to breastfeed.

Bringing men into the discourse on HIV prevention has been a focus of global HIV prevention efforts. To do this more effectively, understanding male sexuality and masculinity is necessary. Qualitative studies at ICDDR,B have shown that, for men in Bangladesh, 'manhood' is constructed by patriarchal norms, and relationships with women are within this construct so that men are men only when they can be 'providers' and 'protectors' of women. The sense of masculine responsibilities also creates sexual double standards and undermines sexual rights and equality of women in relationships.

1.7 Gaps in the Healthcare Delivery System

Despite considerable progress in terms of policy guidelines and new safe blood legislation, blood transfusion practices in the country remain complex and can be conducive to transmission of STIs/HIV infections. Blood is now screened at 97 hospitals across the country, but a proportion at other public and private facilities is still not screened. Biomedical safety issues and universal precautions are not observed at all in healthcare facilities in Bangladesh. Hospital hazardous wastes, including used syringes, and bloodstained materials, are routinely dumped in open public waste containers and not incinerated. Presently, 55,000 healthcare providers have been trained regarding HIV and AIDS, but still more capacity building is required. People living with HIV and AIDS are unable to avail of appropriate care and support because of attitudes of denial and discrimination towards them.

The healthcare system needs to be more geared up to deal with women. Many women and adolescent girls suffer from STIs, but they have less access to health facilities in

general, and STIs clinics in particular. There is also a lack of user friendly health services to reach special groups like youth and old people. The healthcare system has to integrate as a core function the need to increase levels of HIV and AIDS awareness. There has to be capacity building in training and materials for behaviour change communication. Experience has shown that men often do not consider the use of barrier contraceptives, nor do they inform their partners of their sexual history. On the other hand, for men who want to be responsible it is sometimes difficult to get information and/ or appropriate services.

1.8 Adolescents Sex

Increasing risk behavior trends are also noticed among adolescents who include engaging in sex, suffering from STIs, having sex with sex workers, in addition to having limited knowledge regarding HIV/AIDS and limited access to reproductive health services (Bhuiya, 2002). Furthermore, adolescents are involved in sex trade taking drugs (Panda et al., 2002), and migrating to other countries where they are exposed to risky situations. According to UNAIDS study, some 10 million youths from 15 to 24 years of age are HIV positive across the globe and every day 6,000 youths are infected with the virus. The majority lack access to effective prevention programme, while many cannot access condoms. In the fourth round HIV surveillance, more than 55 per cent of STIs patients sampled were below 24 years. According to Bangladesh Demographic Health Survey 1999-2000, more than half of the male adolescents working in the urban areas were rural migrants, and one of the main complaints these adolescents had was the various kinds of abuse they faced (MWCA, 2001).

Various studies demonstrate that the school based intervention led to a significant increase in knowledge about STIs among adolescents but not specific knowledge about HIV and AIDS. Overall, the data suggests that there exist other sources of information; especially mass media that are also helping improve knowledge regarding HIV and AIDS. These findings support the conclusion that it will be difficult to attribute changes in knowledge or behaviour to a single intervention. Adolescents are being exposed to multiple sources of information, which make the assessment of changes extremely complex.

1.9 Pre-Marital and Extra-Marital Sex

Pre-marital sex is traditionally taboo in Bangladesh for a variety of social, religious and cultural reasons. In the past, very little attention has been given to explore the sexual behavior of unmarried adolescents in Bangladesh but the paradigm shift towards HIV/AIDS arena make it important to explore any risk associated with their sexual behavior. Studies indicate that the incidence of premarital sex is quite widespread in Bangladesh. A study shows that 50 per cent of the youths had the experience of sex before marriage and the incidence of this practice was more in the lower socioeconomic

class than in the higher (Aziz and Maloney, 1985). Another study also shows that 29 per cent of the premarital sex partners use condom during intercourse (Folmar et al., 1992). A survey of long distance truck drivers revealed that 60 per cent of the respondents investigated had extra marital sex with prostitutes about twice a month and they did not know about HIV/AIDS.

1.10 Migration

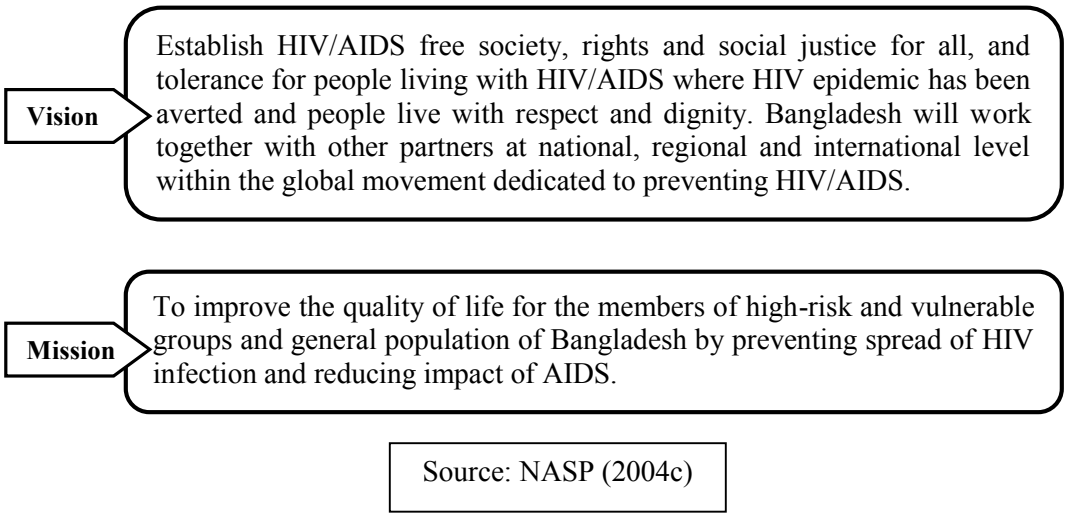
Bangladesh has a large number of overseas migrant workers who have gone in search of better job opportunities mainly to countries in the Middle East, followed by Malaysia and East Asian countries. Migration for work abroad is very common in Bangladesh and some special issues regarding migration are closely related to the HIV epidemic. Among the 363 HIV positive cases found in the country, most are returned migrant workers (Blancher, 2002). To date, 371 people attending the ICDDR,B's VCT Unit have been identified as infected with the virus; of them 54 per cent are returnee migrants, suggesting that migrants working away from their families may be particularly vulnerable to HIV (Zaidi et al., 2004). In two ICDDR,B surveillance areas in Mirsarai (Chittagong district) and Abhoynagar (Jessore district), 1,200 (10.8%) of married women of reproductive age have a husband living abroad. Return from working in a high-prevalence country is one of the ways HIV is introduced into low-prevalence countries. Similarly, a recent study in Nepal found that a high proportion of men working abroad had sex with a sex worker and had higher rates of HIV infection than those who had not left Nepal (New ERA/SACTS and FHI, 2002).

2. National Responses to HIV/AIDS

2.1 Leadership and Strategic Direction

Bangladesh was one of the first countries in the region to develop a policy document on HIV and AIDS and STIs related issues. The national response was initiated in Bangladesh in 1985 with the establishment at the central level of a National AIDS Committee (NAC) and Technical Committee (TC). In order to achieve the national objectives for HIV and AIDS prevention a coalition among the NAC, the Ministry of Health and Family Welfare (MoHFW), and the Director General of Health Services (DGHS) coordinates the National AIDS/STD Programme (NASP), which implements the activities. A well-established NGO network is involved in carrying out various HIV and AIDS prevention and care interventions.

Figure 1: Vision and Mission of HIV/AIDS Prevention in Bangladesh



Source: NASP (2004c)

2.2 Key Government Structure for HIV and AIDS Prevention

The NAC is the National Advisory Body that provides policy direction and advice on all matters related to HIV and AIDS. It is mainly a Government body, but also has NGO and civil society representatives. The President is the chief patron of the NAC, and the Honorable Health Minister chairs it. The members include Ministers and Secretaries from related ministries, three Honorable Members of Parliament, and leading experts from related fields. There are three sub-committees in NAC: Technical, Motivation and Publicity, and Monitoring and Evaluation. The TC is the key technical advisory panel comprised of leading experts from various relevant fields. The MoHFM acts as the Coordinating and Executive Body for AIDS/STIs activities and the DGHS are the Implementing Agency, which acts through the National AIDS/STIs Programme (NASP).

2.3 National Policy on HIV and AIDS and STIs Related Issues

The infection of HIV is, undoubtedly, a human problem having a myriad of sinister dimension that encompass the many faceted health issues inextricably linked with social, economic, ethical and legal elements (Choudhury et al., 1997). To address the complexity and gravity of the HIV and AIDS epidemic, in 1995 an 11 members 'Task Force' was appointed by the DGHS to initiate formulation of an HIV and AIDS policy, in collaboration with the NAC. The final policy draft was prepared after thorough review by a 'Core Group' of experts formed by DGHS, and evaluation at a Multi-sectoral Consensus Workshop. The Cabinet approved the 'National Policy on HIV and AIDS and STIs Related Issues' in 1997. Four crosscutting issues have been emphasized in the policy document.

First: Human Rights (HR): The UDHR offers public health a previously an available instrument and approach for analyzing and responding to the societal dimension of vulnerability to HIV/AIDS/STIs.

Second: Gender Equity (GE): one cannot proceed with a HIV/AIDS/STIs policy while continuing to decline women and men's reproductive and behavioural health from societal issues and roles.

Third: Information, Education and Communication (IEC): IEC is the first major strategy for HIV/AIDS/STIs prevention and care. Although, IEC alone cannot change behavior, knowledge of the means of transmission and most of prevention are necessary to facilitate a change.

Fourth: Empowerment and Organization of Vulnerable Communities (EOVC): communities at risk need to be empowered and given the ability to begin to address their own needs in a meaningful way.

The TC/NAC and the TF worked hard and drafted a policy document that can be divided into three parts-

Part 1: Policy Statement and Fundamental Principle: indicates the commitment of the GOB in the fight against the disease and the basic principles for dealing with HIV/AIDS in the country.

Part 2: Bangladesh AIDS Prevention and Control Program: outlines roles and functions of all partners in the fight against HIV/AIDS. In this the TF recommended a 'tripartite coalition' comprising of NAC – as the supreme advisory body; MOHFP – the line ministry as the executive body; and DGHS and the directories of other ministries – as the implementing bodies.

Part 3: Specific Guidelines: address the various healths and non-health related issues by the spread of the HIV virus in the country. In the final analysis, 24 issues have been included in this part.

Some specific Guidelines are elucidated in the National Policy regarding the main issues comprising the HIV and AIDS responses i.e. HIV and AIDS Epidemiological Surveillance, HIV Testing Policy, Management of AIDS and HIV infection, including associated TB, Counseling of HIV and AIDS patients and confidentially, National blood transfusion services, HIV and AIDS and women, HIV and AIDS/STIs and men, Children and HIV and AIDS, Adolescents and HIV and AIDS, HIV and AIDS in educational institutes, HIV and AIDS and the workplace, HIV and AIDS and Mobility, Commercial Sex, Information, Education and Communication, Condom promotion and distribution, HIV and AIDS in prisons, HIV and AIDS and the media, Policies on STIs, Drug users and HIV and AIDS, HIV and AIDS and minority communities, Social science and behavioural research, Clinical/Vaccine Trials for HIV and AIDS/STIs, Ethical aspects of HIV and AIDS research, Legal aspects of HIV and AIDS.

2.4 Non-Governmental Organizations Initiatives

More than 380 NGOs and AIDS Service Organizations have been implementing programs/projects in different parts of the country. These initiatives focused on prevention of sexual transmission among high-risk groups involving mostly female sex workers, MSM, IDUs, rickshaw pullers and truckers. NGOs are often in a better position than the public sector to reach high-risk groups, such as sex workers and their clients and injecting drug users. Building the capacity of NGOs, especially the small ones, and combining their reach with the resources and strategic programs of the government is an effective way to change behavior in high-risk groups and prevent the spread of the virus to the general public.

Conclusion

There is much good news in relation to HIV for Bangladesh. Although overall HIV prevalence remains under 0.1 percent among the general population in Bangladesh, there are risk factors that could fuel the spread of HIV among high-risk groups. There has been strong government support for surveillance both serological surveillance and behavioural surveillance, and need to initiate various programmes to mitigate the vulnerability factors of HIV/AIDS. The bad news relates to the highly risky behaviour of large groups of people who put themselves and others at risk of infection. There are many deeply held cultural norms regarding acceptable behaviours, reluctance to use condoms, and gender issues that are major constraints to reducing the risk of an epidemic. The epidemic among IDUs which is now starting—will be the focus of the impending, more general epidemic, and it would seem that much more successful strategies are needed to reduce sharing of needles, possibly including provision of clean oral drugs to these drug users. Mandatory testing for HIV infection is common in many countries before traveling and those returning from countries with high HIV/AIDS prevalence. Bangladesh should follow these norms.

Effective interventions are evidence based, and research is essential to better understand the factors driving the epidemic, and in some cases, there may even be 'protective factors' that need to be explored and tried as effective intervention strategies. To prevent a major epidemic, Bangladesh needs to address HIV/AIDS using a multi-pronged strategy including formulation of national HIV/AIDS communication strategy, concentration on groups most vulnerable to the infection, working with the general population (community mobilization and community supports) and care and support with voluntary counseling to those already infected and affected by HIV/AIDS. It is needed to change our society through public policy research, public awareness, increased funding, and community education. Above all Bangladesh should immediately translate its HIV/AIDS policies into action to benefit the people and for that reason strong and an effective leadership is required.

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