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# Gender Assessment of the National HIV Response in Bangladesh

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A country report 2014

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# Gender Assessment of the National HIV Response in Bangladesh

## National AIDS/STD Programme

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স্বাস্থ্য অধিদপ্তর, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়

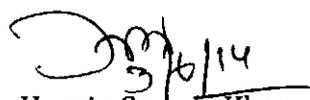


## Foreword

It is a great pleasure to disseminate the report of Gender Assessment of National HIV Response gaining a full understanding of the existing gender-related policy and programmatic gaps in Bangladesh. The report describes the status of the HIV epidemic through the lens of gender differences, deeper understanding of the factors affecting equitable access to needed HIV services by key populations at higher risk including women and girls and identifies critical gaps and opportunities to make HIV response more gender transformative.

This assessment is crucial in strengthening gender issues in the National Strategic Plan (NSP) through midterm review and a key opportunity to strengthen gender and reference including indicators and measurement to the HLM goal and Global Fund New Funding Model. It also supports to achieve UNDAF targets especially on gender equality and women's advancement in Bangladesh by providing (baseline) information against (globally) required indicators.

We believe that the report will provide critical insights into the gender transformative HIV response in Bangladesh. Under the leadership of the National AIDS/STD Programme, it will assist policy makers and experts to address identified gaps and recommendations to strengthen gender related policy and programmatic interventions.



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## Abbreviation

AIDS	Acquired Immune-Deficiency Syndrome
ARV	Anti-Retroviral
ART	Anti-Retroviral Treatment
BCC	Behavior Change Communication
BDHS	Bangladesh Demographic Health Survey
BSS	Behavioral Surveillance Survey
BSWS	Bandhu Social Welfare Society
CSO	Civil Society Organization
FSW	Female Sex Worker
GBV	Gender Based Violence
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with AIDS
GOB	Government of Bangladesh
HIV	Human Immunodeficiency Virus
icddr'b	International Centre for Diarrheal Diseases Research, Bangladesh
KP	Key Population
LGBT	Lesbian Gay Bisexual and Transgender
MARP	Most at Risk Population
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MOHFW	Ministry of Health & Family Welfare
MOWCA	Ministry of Women & Children Affairs
MSM	Men who have Sex with Men
MSW	Male Sex Worker

NASP	National AIDS/STD Programme
NGO	Non-Governmental Organization
NOP+	Network of PLHIV
NSP	National Strategic Plan
PPTCT	Prevention of Parent-to-Child Transmission
PLHIV	People Living with HIV
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
SGBV	Sexual and Gender Based Violence
SHG	Self Help Group
SRH	Sexual Reproductive Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SW	Sex Worker
TG	Transgender
UNFPA	United Nations Population Fund
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
VCT	Voluntary Counseling and Testing
YKAP	Young Key Affected Population

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## Introduction

Nearly 30 years into the HIV epidemic, persistent gender inequality and human rights violations continue to hamper progress and threaten the gains that have been made in HIV prevention and treatment response globally.<sup>1</sup> In Bangladesh, although HIV prevalence continues to be low (<0.1%) among general population, it is significant among key population groups such as people who use drugs (PWUD), sex workers (SW), transgender persons (TG) and Men who have sex with Men (MSM).<sup>2</sup> More than 37% of newly identified HIV cases in 2013 were among women and transgender.<sup>3</sup> 74% of the newly reported HIV cases were among general married population.<sup>4</sup> Persistent gender inequalities, widespread discrimination, injustice and other factors such as high levels of violence against women and girls and transgender populations not only undermine the efforts in curbing HIV epidemic but continue to impact on country's overall efforts in achieving Millennium Development Goals (MDGs).

Gender inequalities, gender-based violence (GBV) and harmful gender norms promote unsafe sex and reduce access to HIV and sexual and reproductive health services for women, men and transgender persons. In particular,

- GBV including the threat or fear of violence makes women and girls, sex workers, men who have sex with men and transgender people more vulnerable to HIV.<sup>5</sup>
- Norms of masculinity (including homophobia) can encourage high risk sexual behavior by men and make their partners more vulnerable.
- Norms of femininity can prevent women (especially young women) from accessing HIV information and services.<sup>6</sup>
- Lack of education, social norms and positioning, and economic insecurity limits decision-making power, mobility and access to information and services.
- Health seeking behavior is influenced by gender and, stigma and discrimination.

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<sup>1</sup>UNAIDS. 2009. *Operational Plan for UNAIDS Action Framework: Addressing Women, Girls, Gender Equality and HIV* (UNAIDS/PCB (25)/09.CRP.19). Geneva. Retrieved from:

[http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/informationnote/2009/20091124\\_25th\\_pcb\\_genderoperationalplan\\_crp19\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/informationnote/2009/20091124_25th_pcb_genderoperationalplan_crp19_en.pdf)

<sup>2</sup>IEDCR and icddr. 2011. *National HIV Serological Surveillance*. Bangladesh: National AIDS/STD Programme (NASP). Retrieved from: [http://www.aidsdatahub.org/sites/default/files/documents/HSS\\_9th\\_round\\_2011.pdf](http://www.aidsdatahub.org/sites/default/files/documents/HSS_9th_round_2011.pdf)

<sup>3</sup>National AIDS/STD Programme, Ministry of Health and Family Welfare. 2013. Annual Case Reporting. Govt of Bangladesh.

<sup>4</sup> Ibid.

<sup>5</sup>UNAIDS. 2013. *HIV in Asia and the Pacific* (UNAIDS / JC2558). Bangkok. Retrieved from:

<http://www.aidsdatahub.org/sites/default/files/publication/UNAIDS-2013-Asia-Pacific-report.pdf>

<sup>6</sup>World Health Organization. 2008. Gender Inequalities and HIV. Retrieved from:

[http://www.who.int/gender/hiv\\_aids/en/](http://www.who.int/gender/hiv_aids/en/)

Therefore, HIV services must be sensitive to sexual and reproductive health and gender needs and rights of women, men, transgender persons in all their diversity, in particular those living with HIV and key populations at higher risk of HIV.<sup>7</sup>

The UNAIDS Agenda for Women, Girls, Gender Equality and HIV<sup>8</sup> and strategy “Getting to Zero”<sup>9</sup> commits to advancing gender equality for an effective HIV response, calling for gender-transformative HIV responses in which gender equality and human rights are at the center of the AIDS response.

Building on achievements of a multi partner initiative (involving 11 Ministries and 9 UN agencies) towards achieving MDG 3, which is *Promote Gender Equality and Empower Women*, the National AIDS/STD Programme together with UNAIDS agreed to undertake a comprehensive Gender Assessment of the current HIV epidemic and the response. The assessment was strategically aligned with the ongoing Mid Term Review of the 3<sup>rd</sup> National Strategic Plan (NSP) on AIDS and was undertaken during the period of September to December 2013. The main objectives of the Gender Assessment were to:

- Assess the status of the HIV epidemic through the lens of gender, and gain a deeper understanding of the factors affecting equitable access to HIV services by key populations at higher risk including women and girls.
- Identify critical gaps and opportunities to make HIV response more gender transformative and ensure that the revision of NSP and costing of strategic and operational plans fully consider gender transformative interventions.
- Use assessment findings to strengthen multi-sectorial partnership and resource mobilization for formulating policies and implementing programs that address gender inequality, gender based abuse and harmful gender norms and practices that hinder effective response to HIV.

## Gender Assessment Tool

The Gender Assessment Tool is a structured set of guidelines and questions that can be used to guide and support the process of analyzing the extent to which national responses to HIV, in both generalized and concentrated epidemics, take into account the critical goal of gender

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<sup>7</sup>UNAIDS Global Report. 2013. Eliminate gender inequalities and gender-based abuse and violence. Geneva: UNAIDS. Retrieved from:

[http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS\\_Global\\_Report\\_2013\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf)

<sup>8</sup>UNAIDS. 2010. Action Framework: Addressing Women, Girls, Gender Equality and HIV (JC1794). Geneva.

<sup>9</sup>UNAIDS. 2011. UNAIDS Strategy 2011-2015, GETTING TO ZERO.

equality.<sup>10</sup>The development of the tool was facilitated by UNAIDS at the global level, by convening an international Expert Reference Group comprised of members from various governments, UN agencies and civil society organizations. The Expert Reference Group provided strategic guidance on the development of the tool.<sup>11</sup>

The Tool is a planned, systematic and deliberate set of steps and processes which examine and question the status of the HIV response (plans and actions undertaken by national governments to address HIV) with specific reference to its gender dimensions (the socially constructed roles, behaviors, activities and attributes that a given society considers appropriate for women and men, including key populations).<sup>12</sup>The tool enables a greater understanding on the extent to which a national response recognizes and then acts on recognition of gender inequality as a key determinant of HIV. It also helps to ensure that gender equality is a goal of the national response to HIV.

Gender Assessment process of an HIV response involves the following four stages:

- Preparing for the Gender Assessment of the National Response (STAGE 1)
- Knowing your HIV epidemic and country context from a gender perspective (STAGE 2)
- Knowing your country response from a gender perspective (STAGE 3)
- Using the findings of the Gender Assessment to strengthen the HIV response (STAGE 4)

The tool has been piloted in several countries and is flexible and adaptable to different contexts.

### **Process of Gender Assessment in Bangladesh**

Under the leadership of the National AIDS/STD Programme, UNAIDS Country office in Bangladesh along with UN Women, development partners and civil society undertook a gender assessment of the national HIV response process using UNAIDS Tool. An international consultant and a national consultant were hired by UNAIDS to provide technical support and manage the assessment process including writing of the assessment report.

The methodology for undertaking gender assessment was based on the principles of transparency and inclusivity, with particular care given to facilitate and ensure a meaningful participation of people living with HIV, women in all of their diversity, and key populations at all stages of the assessment process.

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<sup>10</sup>UNAIDS. 2012. Gender Assessment Tool for National HIV Responses. Geneva: United Nations Joint Programme on HIV/AIDS.

<sup>11</sup> Ibid.

<sup>12</sup> Ibid.

## Gender Assessment Core Team

The Gender Assessment Core Team was formed by the National AIDS/STD Programme and constituted representatives from National AIDS/STD Programme (NASP), Ministry of Women and Children Affairs (MoWCA), UN Women, UNFPA, icddr'b, CARE Bangladesh (CARE-B), Save The Children, Network of PLHIV (NOP+) and Bandhu Social Welfare Society (BSWS) respectively and secretariat support from the UNAIDS Country Office in Bangladesh (see ANNEX 1 for the ToRs of the core team members and ANNEX 2 for list of members). The main purpose of the core team was to ensure country ownership of the assessment process and provide overall guidance and direction. Under the overall leadership of the National AIDS/STD Programme in Bangladesh, the core team had a responsibility to plan and execute a participatory and transparent assessment process with the support from consultants. They were also responsible for technical oversight and finalization of the key findings and analysis including recommendations.

## Validation Workshop

A 3 day validation workshop was organized from 09-11 December, 2013 to bring together stakeholders from diverse sectors, including gender and HIV experts to systematically review and validate data pre-populated tool and develop key recommendations including priority interventions for gender transformative HIV response. A total of 44 participants from 23 organizations including from various government institutions, CSOs, NGOs, UN and other partners reviewed, provided feedback and formulated recommendations for future action at this workshop. The specific objectives of the workshop were to:

- Present, review and validate assessment data and analysis done by the consultants and the core team.
- Identify gaps and opportunities for making HIV response more gender transformative.
- Develop a set of recommendations including key interventions to be included in the currently being reviewed 3<sup>rd</sup> National Strategic Plan on HIV.
- Agree on next steps for implementation of the recommendations including for integrating into the Global Fund New Funding Model Concept Note, other sectorial plans and programs.

## The Status of the Current HIV Epidemic

The overall HIV prevalence in Bangladesh has remained <0.1% since 2000 as per serological surveillances. Since the beginning of the epidemic, the country has registered a total of 3241 cases of HIV infection.<sup>13</sup> However, the estimated number of PLHIV is around 8000. Although HIV

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<sup>13</sup>National AIDS/STD Programme, Ministry of Health and Family Welfare, 2013. Annual Case Reporting. Govt of Bangladesh.

prevalence has remained below 1% as per annual case reporting, the rate of new HIV infections are increasing gradually and the trend is rising significantly over the years among key populations.<sup>14</sup> In 2012, about 26% of new infections were among those who were 25 years or less.<sup>15</sup> In 2013, females accounted for 35.9% of new infections.<sup>16</sup> 74% of the newly reported HIV cases were among general population who are married.<sup>17</sup>

According to the latest Serological Surveillance (Round 9, 2011),<sup>18</sup> the HIV prevalence among PWUD was 1.1%, Female Sex Workers (0.3%), Hijra (0.7%), MSM and MSW (0%). Although HIV prevalence was below 1% in most groups of female sex workers, in casual sex workers (those who were selling had either one or more main sources of income) from Hilli (a small border town in the northwest part of Bangladesh), HIV prevalence was 1.6% and 3.2% among Hijra.

The Round 9 surveillance<sup>19</sup> tested 7,529 drug users (PWID, heroin smokers and the combined group of PWID and heroin smokers) from 30 different cities in 2011. HIV prevalence was detected in five groups with highest rate of 5.3% was reported in Dhaka among male PWID. The other four groups include male PWID from Narayanganj (1.5%) and Satkhira (0.4%); female combined PWID and heroin smokers from Dhaka, Narayanganj, Tongi (1.2%) and Benapole (1%). However, a 2009 study indicated that female PWUD may be at more risk as many sold sex to support their addiction, and depended on their male partners to buy their drugs and then shared injections with them. The study also stated that two-thirds of female drug users were sex workers.<sup>20</sup>

MSM and MSW were tested positive for HIV (0.2% and 0.7% respectively) in 7<sup>th</sup> surveillance round in 2006.<sup>21</sup> However, in 9<sup>th</sup> surveillance round, none of the MSM or MSW tested was positive for HIV. But in 2013, a Midline survey was conducted among Global Fund supported

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<sup>14</sup> National AIDS/STD Programme, Ministry of Health and Family Welfare, 2013. Annual Case Reporting. Govt of Bangladesh.

<sup>15</sup> National AIDS/STD Programme, Ministry of Health and Family Welfare, 2012. Annual Case Reporting. Govt of Bangladesh.

<sup>16</sup> National AIDS/STD Programme, Ministry of Health and Family Welfare, 2013. Annual Case Reporting. Govt of Bangladesh.

<sup>17</sup> Ibid.

<sup>18</sup> IEDCR and icddr'b. 2011. National HIV Serological Surveillance. Bangladesh: National AIDS/STD Programme (NASP). Retrieved from: [http://www.aidsdatahub.org/sites/default/files/documents/HSS\\_9th\\_round\\_2011.pdf](http://www.aidsdatahub.org/sites/default/files/documents/HSS_9th_round_2011.pdf)

<sup>19</sup> Ibid.

<sup>20</sup> Azim, T. et al., 2009. 20 Years of HIV in Bangladesh: Experiences and Way Forward. Dhaka: World Bank. Retrieved from: [http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2011/09/12/000356161\\_20110912075553/Rendered/PDF/643620WP0Bangl00Box0361535B0PUBLIC0.pdf](http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2011/09/12/000356161_20110912075553/Rendered/PDF/643620WP0Bangl00Box0361535B0PUBLIC0.pdf)

<sup>21</sup> IEDCR and icddr'b. 2006. National HIV Serological Surveillance. Bangladesh: National AIDS/STD Programme (NASP). Retrieved from: [http://www.aidsdatahub.org/sites/default/files/documents/MOHEFW\\_%282007%29\\_NHSS\\_2006\\_Bangladesh\\_7th\\_Round\\_Technical\\_Report.pdf](http://www.aidsdatahub.org/sites/default/files/documents/MOHEFW_%282007%29_NHSS_2006_Bangladesh_7th_Round_Technical_Report.pdf)

interventions in Dhaka where HIV prevalence was found to be 0.7%.<sup>22</sup> Among the transgender community (hijra) however, the HIV prevalence was 1% in two sites (Dhaka –the capital of Bangladesh and Manikganj-a peri-urban site adjacent to Dhaka.

HIV Prevalence Rate							
	Overall	Female	Male	<25 Years		> 25 Years	
				F	M	F	M
IDU*	1.1%	1.1%	1.2%	1.3%	0.9%	1.1%	1.3%
Sex Workers*		0.3%	0	0.2%	0	0.3%	0
Transgender*	1.1%			1.7%		0.8%	
MSM**	0.7%						

\*Source:9<sup>th</sup> Round National HIV Serological Surveillance, 2011.

\*\*HIV Midline Survey among MSM, MSW & TG, icddr'b, 2013 (Unpublished data from Dhaka only)

## Main Issues from Stage 2 in the Gender Assessment Tool

This section presents a summary of the main issues emerging from the review and analysis of existing literature including information included in the pre-populated GAT tool Stage 2.

### HIV Awareness and Condom Use

The review of existing data showed key populations, including SWs, PWID, TGs and Young key populations, generally lack understanding about HIV and engage in sexual practices which are not safe. Although many have heard of HIV, only 31% of FSWs, 30% of MSWs, 28% of MSMs and 20% of PWID have a comprehensive knowledge of HIV according to Behavioral Surveillance 2006-2007.<sup>23</sup> Only 13.8% of females and 22.9% of males in the age group of 15-19 years and 13% of females and 22% of males in the age group of 20-24 years correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions as reported in 2012.<sup>24</sup>

Another icddr'b study suggested that only 21.8% of hijra sex workers reported using condoms during last sex in the last week with regular clients.<sup>25</sup> Consistent use of condoms was reported to be even lower – 13.3% reported consistent use of condoms with new clients and 12% with

<sup>22</sup> icddr'b. 2013. HIV Midline Survey among MSM, MSW & TG (Unpublished data from Dhaka only).

<sup>23</sup> AIDS Datahub. (2011). Country Review: Bangladesh. Retrieved from:

[http://www.aidsdatahub.org/sites/default/files/country\\_profile/download\\_country\\_reviews/Bangladesh\\_Country\\_Review\\_2011\\_HIV\\_and\\_AIDS\\_Data\\_Hub\\_for\\_Asia-Pacific\\_%282011%29\\_0.pdf](http://www.aidsdatahub.org/sites/default/files/country_profile/download_country_reviews/Bangladesh_Country_Review_2011_HIV_and_AIDS_Data_Hub_for_Asia-Pacific_%282011%29_0.pdf)

<sup>24</sup> Ministry of Health and Family Welfare, Government of Bangladesh. 2012. Global AIDS Response Progress Report. National AIDS/STD Programme, Directorate General of Health Services. Retrieved from:

[http://www.unaids.org/en/dataanalysis/knownyourresponse/countryprogressreports/2012countries/ce\\_BD\\_Narrative\\_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/knownyourresponse/countryprogressreports/2012countries/ce_BD_Narrative_Report[1].pdf) (Data was extracted from National End line Survey among young people, NASP, Save The Children, icddr'b, 2008)

<sup>25</sup> icddr'b. 2011. Risk of and Vulnerability to HIV among Hijra in Dhaka, Bangladesh: A Behavioral Survey of Hijra in Dhaka. The Global Fund

regular clients in the last week.<sup>26</sup>In case of MSM, only 20.9% used condom with non-commercial male/hijra sex partners, 23.7% with commercial male sex partners and 22.6% with female sex workers according to a Behavioral Survey conducted in 2011.<sup>27</sup>In case of MSW, condom use in last anal sex act was reported at 39% with new clients and 24.9% with regular clients.<sup>28</sup>29% condom use in the last sex act was reported with non-commercial male/hijra sex partners.<sup>29</sup>For sex workers, condom use varies with settings and locations. Among street based sex workers: the use of condom during last sex act with new and regular clients was high in Chittagong (76.7%), in Dhaka 43.3%, in Khulna 23.7%.<sup>30</sup>

Another indicator of unsafe sexual practices is active syphilis. According to the Round 9 Serological Surveillance from 2011, over 5% of PWUD, FSW, and Hijra from 10 different cities have syphilis, which is unacceptably high. But a large majority of KPs do not know their HIV status. Only 9.3% of MSM received an HIV test in the past 12 months and know their results (10.8% under age 25, 8.4% over age 25).<sup>31</sup>Among male sex workers, 37.7% received an HIV test in the past 12 months and know their results in 2012.<sup>32</sup>

## High Risk Behavior and Early Sexual Debut

Approximately 10% of men in Bangladesh reported having ever bought sex from female sex workers.<sup>33</sup> In the national survey among youth in 2008, almost 20% of unmarried males reported having premarital sex and for 28% of these respondents, the last sex was with a sex worker.<sup>34</sup> The reporting of consistent condom use amongst this group with FSWs, however, has risen from 14% (2005) to 48% (2008).<sup>35</sup>Also, 58% decision made for condom use is by clients, 13%

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<sup>26</sup>icddr'b. 2011. Risk of and Vulnerability to HIV among Hijra in Dhaka, Bangladesh: A Behavioral Survey of Hijra in Dhaka. The Global Fund

<sup>27</sup>icddr'b. 2011. Risk of and Vulnerability to HIV among MSM in Dhaka, Bangladesh: A Behavioral Survey of MSM in Dhaka. The Global Fund.

<sup>28</sup>icddr'b. 2011. Risk of and Vulnerability to HIV among MSW in Dhaka, Bangladesh: A Behavioral Survey of MSW in Dhaka. The Global Fund.

<sup>29</sup> Ibid.

<sup>30</sup>Govt. of Bangladesh. 2009. Behavioral surveillance survey 2006-2007. *Technical Report*. Dhaka. National AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh. Retrieved from:

[http://www.aidsdatahub.org/sites/default/files/documents/BSS-6\\_edited\\_for\\_NASP\\_draft\\_2006-07.pdf](http://www.aidsdatahub.org/sites/default/files/documents/BSS-6_edited_for_NASP_draft_2006-07.pdf)

<sup>31</sup>Ministry of Health and Family Welfare, Government of Bangladesh. 2012. Global AIDS Response Progress Report. National AIDS/STD Program, Directorate General of Health Services. Retrieved from: [http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce\\_BD\\_Narrative\\_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_BD_Narrative_Report[1].pdf)

<sup>32</sup> Ibid.

<sup>33</sup>FHI360/icddr'b. 2006. Male Reproductive Health Survey.

<sup>34</sup>NASP, Save the Children and icddr'b. 2008. End line survey among young people

<sup>35</sup>. Ministry of Health and Family Welfare, Government of Bangladesh. 2012. Global AIDS Response Progress Report. National AIDS/STD Programme, Directorate General of Health Services. Retrieved from:

by sex workers and 28% by both.<sup>36</sup> However, the client turnover rate is high: mean number of clients per sex worker in a week ranged between 16-19 in the brothels, 42 in hotels and 15 among street based sex workers.<sup>37</sup>

According to a mapping survey conducted in 2012, TGs (hijras) reported to have had first sex at 12.9 years on average.<sup>38</sup> Majority of TGs had first sex unintentionally (84%) or unplanned while 45% of the TGs had the first sex in transaction of cash or kind.

Additionally, the average age for MSM/MSWs to have first sexual act was 13.3 years according to 2012 survey among MSM/MSWs.<sup>39</sup> While for 18% of the MSM/MSWs, the first sex was unplanned or unintentional; 26% reported that first sex was transactional or commercial.<sup>40</sup>

These data emphasizes the need for more concerted prevention efforts among general population as well as key populations including young KPs for knowledge increase and behavior change. These efforts may include life skills education in both formal and informal set up<sup>41</sup>, improved access to condoms through social marketing and general health seeking behavior, involving power structures to provide information to young clients of sex workers,<sup>42</sup> setting up community friendly and gender sensitive health services including for HIV testing.

## Status of Women and Girls

Although women and girls in Bangladesh have witnessed increased political empowerment, better job opportunities, greater movements and autonomy over the years, there continues to be persistent challenges with respect to realization of girls' and women's human rights and full potentials. The social, health and economic indicators indicate that women remain

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[http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce\\_BD\\_Narrative\\_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_BD_Narrative_Report[1].pdf) (Data was extracted from National End line Survey among young people, NASP, Save The Children, icddr'b, 2008)

<sup>36</sup> icddr'b, FHI and BWHC. 2009. Exploring Acceptable and Appropriate Interventions to Promote Correct and Consistent Condom Use among Young Male Clients of Hotel-based Female Sex Workers in Dhaka, Bangladesh. The Global Fund

<sup>37</sup> Govt. of Bangladesh, 2009. Behavioral surveillance survey 2006-2007. *Technical Report*. Dhaka. National AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh. Retrieved from:

[http://www.aidsdatahub.org/sites/default/files/documents/BSS-6\\_edited\\_for\\_NASP\\_draft\\_2006-07.pdf](http://www.aidsdatahub.org/sites/default/files/documents/BSS-6_edited_for_NASP_draft_2006-07.pdf)

<sup>38</sup> Nielsen Bangladesh. 2012. Mapping and Behavioral Study of Most At Risk Adolescents to HIV in Specific Urban/Semi Urban Locations in Bangladesh. UNICEF Bangladesh

<sup>39</sup> Nielsen Bangladesh. 2012. Mapping and Behavioral Study of Most At Risk Adolescents to HIV in Specific Urban/Semi Urban Locations in Bangladesh. UNICEF Bangladesh.

<sup>40</sup> Ibid.

<sup>41</sup> NASP, Save the Children, icddr'b, and Population Council. 2008-2009. Creating Conditions for Scaling Up Access to Life Skills Based Sexual and Reproductive Health Education and Condom Services.

<sup>42</sup> NASP, Save the Children and icddr'b. 2008-2009. Exploring acceptable and appropriate interventions to promote correct and consistent condom use among young male clients of hotel based female sex workers

subordinated to men in all aspects and their access to education, health and other services remain limited. For example, in education the gender gap is diminishing (34.1% women have no education compared to 30.7% men in 2007<sup>43</sup>; whereas 27.7% women have no education compare to 27.8% men in 2011<sup>44</sup>), but women are still lagging behind men in attaining education and dropout rates.

Furthermore, women and girls are often subjected to early marriage, sexual abuse and violence in intimate and marital relationships. Approximately, 11% of young girls (age group of 10-14 years) and around 46% (age group of 15-19 years) are married.<sup>45</sup> In rural areas, up to 85% of girls are married by the age 16.<sup>46</sup> The median age at first marriage among women age 25-49 is 15.5 years, and among men age group it is 24.2 years, indicating large differences in age between husbands and wives, which is one of the factors affecting women's ability to negotiate safe sexual behaviors including for family planning.<sup>47</sup> As a result, one-third of adolescent girls begin childbearing between the ages of 15-19 years.<sup>48</sup>

Moreover, women are subject to frequent domestic violence, trafficking, acid attacks and rape. 48.7% of currently married women have experienced physical violence in their current marriage

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<sup>43</sup> National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International. 2009. Bangladesh Demographic and Health Survey 2007. Dhaka, Bangladesh and Calverton, Maryland, USA: National Institute of Population Research and Training, Mitra and Associates, and Macro International. Retrieved from: [http://www.dghs.gov.bd/licts\\_file/images/BDHS/BDHS\\_2007.pdf](http://www.dghs.gov.bd/licts_file/images/BDHS/BDHS_2007.pdf)

<sup>44</sup> National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. 2013. Bangladesh Demographic and Health Survey 2011. Dhaka, Bangladesh and Calverton, Maryland, USA: NIPORT, Mitra and Associates, and ICF International. Retrieved from: <http://dhsprogram.com/pubs/pdf/FR265/FR265.pdf>

<sup>45</sup> Govt. of Bangladesh. 2006. Bangladesh Adolescent Reproductive Health Strategy, Ministry of Health and Family Welfare. Retrieved from: [http://dgfpbd.org/dgfp\\_documents/DGFP\\_Policy%20&%20Strategy/DGFP\\_National%20ARH%20Strategy,%20Bangladesh%20%282006%29.pdf](http://dgfpbd.org/dgfp_documents/DGFP_Policy%20&%20Strategy/DGFP_National%20ARH%20Strategy,%20Bangladesh%20%282006%29.pdf)

<sup>46</sup> Ibid.

<sup>47</sup> National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. 2013. Bangladesh Demographic and Health Survey 2011. Dhaka, Bangladesh and Calverton, Maryland, USA: NIPORT, Mitra and Associates, and ICF International. Retrieved from: <http://dhsprogram.com/pubs/pdf/FR265/FR265.pdf>

<sup>48</sup> Govt. of Bangladesh. 2006. Bangladesh Adolescent Reproductive Health Strategy, Ministry of Health and Family Welfare. Retrieved from: [http://dgfpbd.org/dgfp\\_documents/DGFP\\_Policy%20&%20Strategy/DGFP\\_National%20ARH%20Strategy,%20Bangladesh%20%282006%29.pdf](http://dgfpbd.org/dgfp_documents/DGFP_Policy%20&%20Strategy/DGFP_National%20ARH%20Strategy,%20Bangladesh%20%282006%29.pdf)

at some time.<sup>49</sup> Estimated 300,000 girls trafficked to work in brothels in India and 200,000 to Pakistan in the last 10 years which put them into higher risk of violence and exposure to HIV.<sup>50</sup>

Furthermore, stigma and discrimination against women living with HIV are severe. Married women, who have contracted HIV from having unprotected sex with their husbands, are often scorned, mistreated and even evicted from their in-laws home when their HIV status becomes known.<sup>51</sup>

Eliminating gender inequalities and harmful norms and practices requires investing in programs to empowering girls and women and addressing underlying economic, social and legal factors, such as lack of education, employment opportunities, decision-making power, that impede women and girls' ability to protect themselves from HIV and other adversities.

### **Sexual and Gender based Violence**

Violence against women and girls is persistent in Bangladesh. According to BDHS 2007, 53.3% of ever married women ever faced any form of physical and/or sexual violence (push; shake; throw something; slap; twist arm; pull hair; punch with his fist or with something that could hurt; kick; drag; beat up; try to choke or burn on purpose; threaten or attack with a knife, gun, or any other weapon; physically force to have sexual intercourse). On average, 250 cases of acid violence are reported annually.<sup>52</sup>

According to the Behavioral Surveillance 2006-2007, female sex workers also report high levels of violence. Almost one-half of the street-based sex workers in all locations reported being beaten particularly by members of law enforcement agencies and by local mastans (extortionists).<sup>53</sup> Among adolescent sex workers, forced sex ever was more experienced by street based FSWs (53%) than hotel based (40%), brothel based (38%) and home based FSWs

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<sup>49</sup> National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International. 2009. Bangladesh Demographic and Health Survey 2007. Dhaka, Bangladesh and Calverton, Maryland, USA: National Institute of Population Research and Training, Mitra and Associates, and Macro International. Retrieved from: [http://www.dghs.gov.bd/licts\\_file/images/BDHS/BDHS\\_2007.pdf](http://www.dghs.gov.bd/licts_file/images/BDHS/BDHS_2007.pdf)

<sup>50</sup> Govt. of Bangladesh. 2006. Bangladesh Adolescent Reproductive Health Strategy, Ministry of Health and Family Welfare. Retrieved from: [http://dgfpbd.org/dgfp\\_documents/DGFP\\_Policy%20&%20Strategy/DGFP\\_National%20ARH%20Strategy,%20Bangladesh%20%282006%29.pdf](http://dgfpbd.org/dgfp_documents/DGFP_Policy%20&%20Strategy/DGFP_National%20ARH%20Strategy,%20Bangladesh%20%282006%29.pdf)

<sup>51</sup> UNAIDS, FPAB, AAS, BRACU. 2009. People Living with HIV Stigma Index Study in Bangladesh.

<sup>52</sup> Govt. of Bangladesh, 2006. Bangladesh Adolescent Reproductive Health Strategy, Ministry of Health and Family Welfare. Retrieved from: [http://dgfpbd.org/dgfp\\_documents/DGFP\\_Policy%20&%20Strategy/DGFP\\_National%20ARH%20Strategy,%20Bangladesh%20%282006%29.pdf](http://dgfpbd.org/dgfp_documents/DGFP_Policy%20&%20Strategy/DGFP_National%20ARH%20Strategy,%20Bangladesh%20%282006%29.pdf)

<sup>53</sup> Govt. of Bangladesh. 2009. Behavioral surveillance survey 2006-2007, technical report. Dhaka: National AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh. Retrieved from: [http://www.aidsdatahub.org/sites/default/files/documents/BSS-6\\_edited\\_for\\_NASp\\_draft\\_2006-07.pdf](http://www.aidsdatahub.org/sites/default/files/documents/BSS-6_edited_for_NASp_draft_2006-07.pdf)

(39%).<sup>54</sup> A study in 2012 revealed, 44% of the FSWs, who ever had experience forced sex, admitted of having forced sex in last 12 months.<sup>55</sup>

Violence experienced by MSM, especially effeminate MSM and TG is also considerably high, especially intimate partner violence (IPV). For example, a study of male and transgender sex workers in Bangladesh found that 27.8% had been raped and of that 21.9% is by regular sex partners/clients.<sup>56</sup> Violence against MSM and transgender people may take numerous different forms, including intimate partner violence, rape and sexual coercion, and police abuse.<sup>57</sup> Similarly, more than 40% of Hijra respondents have been beaten in the last year (both physical and sexual), according to a 2011 study in Dhaka.<sup>58</sup>

Growing evidence in the region suggests that sexual and gender based violence makes women, girls, men who have sex with men and transgender people more vulnerable to sexually transmitted infections, including HIV and less likely to be able to negotiate safe sex.<sup>59</sup> While a strong multi-sectorial approach is needed to address the wide-spread SGBV in Bangladesh, the current HIV response must be readjusted to include interventions that empower communities and support building their social capital to develop partnership with the law enforcement agencies and other powerbrokers, set-up crisis response mechanism to ensure services for those who experience violence including access to justice for redress as well as raise awareness among young people, especially young boys on gender norms, debunk myths around gender roles and masculinity.

## Stigma and Discrimination

The Stigma Index Study conducted in 2010 showed people living with HIV faced high levels of stigma and discrimination.<sup>60</sup> Out of 238 PLHIV, 24.37% were verbally insulted, harassed and/or threatened by others. Among them, 58.62% because of their HIV status and 5.2% were because of both HIV and for other reasons. 12.18% of PLHIV were physically harassed and/or threatened by others and among them 48.27% because of their HIV status, 6.9% because of their HIV status

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<sup>54</sup>Nielsen Bangladesh. 2012. Mapping and Behavioral Study of Most At Risk Adolescents to HIV in Specific Urban/Semi Urban Locations in Bangladesh. UNICEF Bangladesh.

<sup>55</sup> Ibid.

<sup>56</sup>Icddr'b. 2011. Risk of and Vulnerability to HIV among Hijra in Dhaka, Bangladesh: A Behavioral Survey of Hijra in Dhaka. The Global Fund Secretariat.

<sup>57</sup>Interagency Gender Working Group. 2011. Case Study: Screening for GBV in Thailand. Retrieved from: [http://www.igwg.org/igwg\\_media/Training/CS\\_ScreeningForGBVThailand.doc](http://www.igwg.org/igwg_media/Training/CS_ScreeningForGBVThailand.doc)

<sup>58</sup>Icddr'b. 2011. Risk of and Vulnerability to HIV among Hijra in Dhaka, Bangladesh: A Behavioral Survey of Hijra in Dhaka. The Global Fund Secretariat.

<sup>59</sup>UNAIDS. 2013. *HIV in Asia and the Pacific* (UNAIDS / JC2558). Bangkok. Retrieved from: <http://www.aidsdatahub.org/sites/default/files/publication/UNAIDS-2013-Asia-Pacific-report.pdf>

<sup>60</sup>UNAIDS, FPAB, AAS and BRACU. 2009. People Living with HIV Stigma Index Study in Bangladesh.

and for other reasons. The study further showed that PLHIV not only face discrimination from various facets of society but most importantly from their own family members including exclusion from family and social activities.<sup>61</sup> Study by Hasan et al., 2012<sup>62</sup> also indicates high levels of self-stigma among PLHIV -- approximately 68% of the PLHIV felt ashamed, and 54% felt guilty because of their HIV status. Self-stigma served as a barrier to seek help and access services when needed.

Another study by Ullah, 2011 regarding health providers and stigma in Bangladesh showed that 80% of the nurses and 90% of the physicians' behavior with the HIV-positive individuals were discriminatory. They talk to their patients standing far from them. The interview revealed that the spouses of the physicians and nurses in charge of the HIV-positive individuals put pressure to stop serving the patient or even quit the job.<sup>63</sup>

The Stigma Index study also reported higher levels of stigma and discrimination faced by female PLHIV. They reported being thrown out of their in-laws houses, tortured and having their inherited properties and money taken away etc. even in cases where in-laws knew that the participant had become infected with HIV through her husband. Female participants also felt the added pressure from in-laws to become pregnant since they did not know of their son and daughter-in-law's positive status. Participants reported that family members verbally discriminated against them when they could not participate in family activities or perform their daily tasks and chores.<sup>64</sup>

In general, key populations, in particular FSW, TGSW and MSM face social exclusion, marginalization and violence in Bangladesh.<sup>65</sup> This not only affects their well-being and dignity but the ability to access services when they need them. Intensive efforts are required to design and implement targeted stigma reduction programs using community mobilization and empowerment approaches, working with faith based organizations, media/journalists and other community leaders as well as by changing laws and practices that fuel further stigmatization and discrimination towards all KPs including women and girls.

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<sup>61</sup> Ibid.

<sup>62</sup> Hasan, M. T. et al., 2012. Internalized HIV/AIDS-related Stigma in a Sample of HIV-positive People in Bangladesh. *J Health Popul Nutr.* 2012;30(1):22–30. Dhaka: icddr'b

<sup>63</sup> Ullah, A. K. 2011. HIV/AIDS-Related Stigma and Discrimination: A Study of Health Care Providers in Bangladesh. *Journal of the International Association of Providers of AIDS Care (JIAPAC)*. Vol. 10 no. 2 97-104

<sup>64</sup> UNAIDS, FPAB, AAS and BRACU. 2009. People Living with HIV Stigma Index Study in Bangladesh.

<sup>65</sup> Ministry of Health and Family Welfare, Government of Bangladesh. 2012. Global AIDS Response Progress Report. National AIDS/STD Programme, Directorate General of Health Services. Retrieved from: [http://www.unaids.org/en/dataanalysis/knownyourresponse/countryprogressreports/2012countries/ce\\_BD\\_Narrative\\_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/knownyourresponse/countryprogressreports/2012countries/ce_BD_Narrative_Report[1].pdf)

## **Main Discussion Points from Stage 3 Gender Assessment Tool**

This section discusses the status of HIV response in Bangladesh based on the analysis of pre-populated information included in the Gender Assessment Tool Stages 2 and 3 as well as the feedback collected from the main stakeholders at Gender Assessment Workshop. It highlights the key gender related issues, challenges and gaps in current response.

### **Policies, Strategies and Structures**

In Bangladesh, the national HIV/AIDS response, as guided by the National HIV Policy<sup>66</sup> and stipulated in the National Strategic Plan, 2011-2015<sup>67</sup> on HIV incorporates a human rights based approach to HIV response and builds on four cross cutting themes: human rights, gender, behavior and information, education and communication. It also recognizes diverse gender identity and sexual orientation, as they relate to MSM and Hijra populations. Furthermore, the need to address broader sexual and reproductive health and other gender based issues is stressed and specific references are made to acknowledge that gender inequality heightens vulnerability to HIV, particularly that of women and girls. The strategy further recognizes the need to improve legal environment related to key populations, strengthen an enabling environment to address stigma and discrimination as well as violence against key populations including women and girls.

However, the main challenge has been in translating these well-formulated policy and program strategies into implementation. It was noted during the consultative process that the operational plan on HIV does not adequately articulate the service delivery model and implementation arrangement of gender transformative intervention strategies, such as addressing violence against KPs. Furthermore, it was noted that even when operational plan includes gender transformative interventions, these are not adequately resourced; even when resourced, these are mostly for advocacy and campaigns but not for tangible program activities which improves access to legal services, prevents violence, and reduces stigma.

Furthermore, there are issues related to capacity for implementation of gender transformative HIV interventions. The stakeholders who participated in the assessment process noted that HIV actors -- both the policy makers, implementers and others -- have varying degree of awareness on gender issues. Although there is a strong political will, lack of awareness of gender issues results in capacity gaps for formulating and implementing HIV interventions that address gender differences and inequalities as relevant to the response.

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<sup>66</sup>Ministry of Health and Family Welfare, Government of Bangladesh. 1995. National Policy on HIV/AIDS and STD Related Issues. National AIDS Committee, Bangladesh and its Technical Committee, Directorate General of Health Services.

<sup>67</sup>Ministry of Health and Family Welfare, Government of Bangladesh. 2012. 3<sup>rd</sup> National Strategic Plan for HIV and AIDS Response 2011-2015. National AIDS/STD Program, Directorate General of Health Services.

The assessment revealed that national AIDS program has also well-established structures allowing greater participation of key populations, women and girls and other civil society organizations in planning and implementing HIV programs. Although the program has an established mechanism for coordination across different sectors, the linkages between different sectorial policies and plans are often unclear resulting in poor coordination and harmonization across sectorial programs. For example, there are not functional and established linkages between HIV and SRH programs although both the National Strategic Plan for HIV Response and the Bangladesh Adolescent Reproductive Health Strategy<sup>68</sup> refer to addressing SRH and HIV related issues respectively.<sup>69</sup> The SRH and HIV integrated service delivery model is not well-articulated unless the implementing agencies are already implementing SRH programs.<sup>70</sup> Similarly, although the National Policy for Advancement of Women<sup>71</sup> recognizes that violence increases the risk of HIV transmission, it only refers to eradicating violence against women and does not include transgender persons and effeminate MSMs. There are existing coordination mechanisms to harmonize these policy instruments but these are not always well-functioning as revealed during the assessment process. Therefore, concerted efforts are needed to improve multi-sectoral coordination mechanisms and effective program linkages.

Bangladesh also has a number of other policy instruments which have the potential to address broader social and economic conditions that increase vulnerabilities related to HIV. For example, the country has a National Social Protection Strategy<sup>72</sup> which has been designed to address the marginalization of vulnerable communities including of KPs. The National social protection strategy aims to integrate HIV-sensitive considerations, wherever necessary and feasible, into existing social protection schemes and policies. It envisages enhancing social protection of people living with HIV, key populations, especially women and girls, through increased support for livelihoods opportunity, food security, nutritional support, and access to

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<sup>68</sup> Govt. of Bangladesh. 2006. Bangladesh Adolescent Reproductive Health Strategy, Ministry of Health and Family Welfare. Retrieved from: [http://dgfpbd.org/dgfp\\_documents/DGFP\\_Policy%20&%20Strategy/DGFP\\_National%20ARH%20Strategy,%20Bangladesh%20%282006%29.pdf](http://dgfpbd.org/dgfp_documents/DGFP_Policy%20&%20Strategy/DGFP_National%20ARH%20Strategy,%20Bangladesh%20%282006%29.pdf)

<sup>69</sup> Ministry of Health and Family Welfare, Government of Bangladesh. 2012. 3<sup>rd</sup> National Strategic Plan for HIV and AIDS Response 2011-2015. National AIDS/STD Program, Directorate General of Health Services.

<sup>70</sup> This was reported by the stakeholders who are implementing HIV and SRH programs during the Gender Assessment Workshop held in December 2013.

<sup>71</sup> Govt. of Bangladesh. 2011. National Policy for Advancement of Women, Ministry of Women and Children Affairs

<sup>72</sup> Bangladesh is in the process of formulating a new Social Protection Strategy which will integrate HIV sensitive social protection schemes for marginalized and KPs. A 3<sup>rd</sup> draft of the strategy has been shared and inputs are being gathered to finalize it.

legal services. HIV-sensitive social protection is a prerequisite for strengthening impact mitigation, service delivery, and human rights.<sup>73</sup>

Similarly, Bangladesh also has a National Policy for Advancement of Women, 2011, which clearly articulates the actions to address inequalities facing Bangladeshi women, including ensuring women's equal access to all levels of quality education, employment, technical training, equal remuneration or wage, health and security while at work, social security and health care.<sup>74</sup> There are functioning decentralized mechanisms to ensure these programs at sub-national and grass root levels. However, as noted during the gender assessment workshop, the existing women's programs are poorly resourced and have not been able to adequately address the needs of marginalized women's groups such as female sex workers and women living with HIV.<sup>75</sup> As FSWs and women living with HIV tend to be socially excluded and marginalized, even women's empowerment programs do not tend to serve such marginalized women.<sup>76</sup> Yet, there are existing opportunities to strengthen collaboration with relevant stakeholders to ensure that women's empowerment programs, as stipulated by the National Policy for Advancement of Women, address issues facing women affected by HIV as well as safeguard their access to health, education and other social protection services.

### **HIV Response Focusing on Key Population**

While Bangladesh has made notable progress in reducing HIV prevalence among PWID and among sex workers in some selected sites, the current levels of prevention and treatment program coverage among KPs is far below the global standards. Also, reaching highly mobile and hidden groups of key populations for outreach and service is still challenging. As a result, a basic HIV awareness level among all key populations is low; so is consistent use of condoms among key population groups. However, client turnover rates are high among both FSW and TG sex workers. There are overlapping behavior between sex work, MSM and injecting drug use but programs are not addressing the issue and partners are not intervened.<sup>77</sup> In addition, there are no interventions for hard to reach MSM. A joint UNAIDS and World Bank study<sup>78</sup>

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<sup>73</sup> UNDP, UNAIDS, ILO and UNICEF. 2011. HIV Sensitive Social Protection for Impact Mitigation in Asia and the Pacific. Bangkok. Retrieved from:

<http://www.snap-undp.org/elibrary/Publications/SocialProtectionMeetingReport.pdf>

<sup>74</sup> Govt. of Bangladesh. 2011. National Policy for Advancement of Women. Ministry of Women and Children Affairs

<sup>75</sup> This was mentioned during the validation workshop by the stakeholders participating in the review and finalization of the prepopulated GAT tool.

<sup>76</sup> Ibid.

<sup>77</sup> Ministry of Health and Family Welfare, Government of Bangladesh. 2012. Global AIDS Response Progress Report. National AIDS/STD Program, Directorate General of Health Services. Retrieved from: [http://www.unaids.org/en/dataanalysis/knownyourresponse/countryprogressreports/2012countries/ce\\_BD\\_Narrative\\_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/knownyourresponse/countryprogressreports/2012countries/ce_BD_Narrative_Report[1].pdf)

<sup>78</sup> Azim, T. et al., 2009. 20 Years of HIV in Bangladesh: Experiences and Way Forward. Dhaka: World Bank. Retrieved from: <http://www->

has reported challenges facing FSWs to negotiate safe sexual practices with their clients. The same can be implied for women and girls who marry young and have multiple births well before their child rearing age. Only 5.5% couples use male condoms in family planning, indicates that they are not preferred by men.<sup>79</sup> Moreover, there are lack of social support mechanism and financial safety nets for aging FSW and their children.

Similarly, OST and harm reduction facilities are inadequate as revealed during the consultation process, female condoms are not available and HIV prevention programs are not targeting and reaching clients of sex workers and young key populations.<sup>80</sup> Sexual and gender based violence has been reported as one of the main issues facing women, girls and key population groups, particularly female sex workers, hijras, effeminate MSM and women living with HIV. However, there are fewer programs to prevent and address this. Also, the last national level size estimation of hijras and MSM was done in 2004. Therefore, new size estimation is needed for these KPs. Only married couples can access the sexual reproductive health services. The needs are further exacerbated by high rates of STIs; but, access to health services are hindered due to high levels of stigma and discrimination, proximity of health services and poor health seeking behavior of key populations.<sup>81</sup> Married women and migrant workers carry a bulk of new HIV infections and this trend is rising. However, there are fewer prevention programs addressing their needs.<sup>82</sup> Especially for HIV positive females, stigma and discrimination by the family and immediate social environment is high according to Stigma Index Study conducted in 2010. There is a need to urgently provide services for these population groups and their spouses including for impact mitigation and economic empowerment programs. Despite of a large number of Bangladeshi outbound migrants, the current health system does not adequately reach migrant workers with needed health services.

There is also need to focus more on promoting knowledge and awareness of sexual and reproductive health rights and life skills education to other vulnerable groups such as readymade garment (RMG) industry workers.

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[wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2011/09/12/000356161\\_20110912075553/Rendered/PDF/643620WPOBangl00Box0361535B0PUBLIC0.pdf](https://wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2011/09/12/000356161_20110912075553/Rendered/PDF/643620WPOBangl00Box0361535B0PUBLIC0.pdf)

<sup>79</sup> National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. 2013. Bangladesh Demographic and Health Survey 2011. Dhaka, Bangladesh and Calverton, Maryland, USA: NIPORT, Mitra and Associates, and ICF International. Retrieved from: <http://dhsprogram.com/pubs/pdf/FR265/FR265.pdf>

<sup>80</sup> These inputs were made by the program implementers who participated in the Gender Assessment Workshop.

<sup>81</sup> UNAIDS, FPAB, AAS and BRACU. 2009. People Living with HIV Stigma Index Study in Bangladesh.

<sup>82</sup> Ministry of Health and Family Welfare, Government of Bangladesh. 2012. Global AIDS Response Progress Report. National AIDS/STD Program, Directorate General of Health Services. Retrieved from: [http://www.unaids.org/en/dataanalysis/knownyourresponse/countryprogressreports/2012countries/ce\\_BD\\_Narrative\\_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/knownyourresponse/countryprogressreports/2012countries/ce_BD_Narrative_Report[1].pdf)

## Laws, policies and practices affecting HIV response

In Bangladesh, some aspects of sex work and MSM are criminalized.<sup>83</sup> There is death penalty for drug-related offences.<sup>84</sup> Due to existing punitive laws, policies and practices, communities of key populations face high levels of violence, frequent arrests and arbitrary harassment. These incidents not only discourage key populations from accessing needed services, but criminalization means that they cannot receive legal recourse even when their basic human rights are violated. Because of high levels of stigma and discrimination facing these marginalized communities and lack of protective laws, they further face difficulty in securing bail, long and protracted trials.<sup>85</sup>

Despite a punitive legal policy environment, there have been increased efforts in providing legal education and legal access to key populations in case of rights violation as evident by a newly established partnership with the National Human Rights Commission.<sup>86</sup> There is continued effort to sensitize policy makers, law enforcement officials and partner with media to create a positive image of the key populations.<sup>87</sup> However, according to the stakeholders at the Gender Assessment Workshop, these human rights programs including preventing and addressing gender based violence and stigma and discrimination are reported to be inadequate.<sup>88</sup> Furthermore, they are not sufficiently integrated into the existing sectorial programs and continue to be funded through external donor partners as stand-alone project activities, which pose challenges to both scaling-up and sustainability.<sup>89</sup>

Although both adolescent and young key populations among sub-population and in general are one of the most affected by HIV, existing HIV interventions are not adolescent and young people friendly and are not reaching YKAP with services as reported by different partners during this assessment process. Some programs have been initiated to address risk and vulnerabilities facing this population group, but existing legal and policy frameworks impede effective HIV prevention efforts among YKAP. For example, only family planning services include

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<sup>83</sup> National AIDS/STD Program, UNDP and UNAIDS. 2013. National Consultation on Punitive Laws hindering the AIDS Response in Bangladesh

<sup>84</sup> Ibid.

<sup>85</sup> National AIDS/STD Program, UNDP and UNAIDS. 2013. National Consultation on Punitive Laws hindering the AIDS Response in Bangladesh. These inputs were made by the program implementers who participated in the Gender Assessment Workshop. Poor legal and policy environment were identified as one of the main bottlenecks for effective HIV programming.

<sup>86</sup> Ministry of Health and Family Welfare, Government of Bangladesh. 2012. Global AIDS Response Progress Report. National AIDS/STD Program, Directorate General of Health Services. Retrieved from: [http://www.unaids.org/en/dataanalysis/knownyourresponse/countryprogressreports/2012countries/ce\\_BD\\_Narrative\\_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/knownyourresponse/countryprogressreports/2012countries/ce_BD_Narrative_Report[1].pdf)

<sup>87</sup> Ibid.

<sup>88</sup> These inputs were made by the program implementers who participated in the Gender Assessment Workshop.

<sup>89</sup> Ibid. Coordination among 16 ministries has been also highlighted as a challenge in 2012 Country Progress Report for Bangladesh.

condom supply which is only for married couples.<sup>90</sup>This hinders YKAP access to condoms; especially for young girls, buying condoms is more difficult due to broader societal perceptions and stigma related to condom purchase and perceived “promiscuity” of women and girls if they did so. Furthermore, for a young female sex worker, the stigma is double – that of being a girl and a sex worker.

Similarly, parental consent is required for young populations below the age of 18 years to take HIV testing.<sup>91</sup> This further discourages YKAP to undergo HIV testing. Additionally, given a high levels of violence against women and girls, low levels of awareness about HIV and SRH issues in general and challenges faced by women in negotiating safe sex (both for family planning and HIV/STI prevention), the formal and non-formal education programs should further consider providing life-skills based gender, sexual and SRH education for YKAP including young women and girls.

On a positive note, in November 2013, Bangladesh recognized Hijra as the third gender.<sup>92</sup>Those who identify as Hijra are now able to identify this way on government documents including national ID cards and passports. This legal provision is aimed at ending discrimination in education, health, housing and economic security facing Hijra community in Bangladesh. Although this is a positive step forward, there are lack of protective laws and policies which can safeguard their rights and ensure access to justice in case of discrimination.

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<sup>90</sup>Directorate General of Family Planning. 2012. Family Planning Manual. Ministry of Health and Family Welfare

<sup>91</sup>Govt. of Bangladesh. 1996. National Policy on HIV/AIDS and STD Related Issues. Directorate General of Health Services, Ministry of Health and Family Welfare

<sup>92</sup>Govt. of Bangladesh. 2014. Bangladesh Gazette. Ministry of Social Welfare.

## Summary of Key Issues, Gaps and Challenges for Gender Transformative HIV Response

This section summarizes the main issues, gaps and challenges identified by the assessment process based on the analysis of literature review and feedback from key stakeholders on the status of HIV epidemic and response in Bangladesh. It also presents the key interventions agreed at the Gender Assessment Workshop to achieve greater gender equality in HIV response below:

1. There is no specific linkage between National Women's Advancement Policy and HIV Policy; and Women's Policy does not focus on any specific group of marginalized women.
2. Lack of a national level standard size estimation of Hijras and MSM (last one was in 2004); and FSW and PWUD (last one was in 2009).
3. Low literacy rates; poor knowledge and health seeking behavior among key populations.
4. Condom services by govt. are only for married couple; lack of sex education among YKAP.
5. Condom negotiation is challenging for sex workers as HIV prevention programs are not targeting and reaching clients of sex workers. This also implies that more needs to be done in terms of financial empowerment of sex workers.
6. Poor uptake of HIV and other health services. Inadequate OST and harm-reduction facilities.
7. Though prevention programs have been running for over 20 years, reaching highly mobile and hidden groups of key populations for outreach and service referral is still challenging.
8. HIV prevention services are not reaching YKAP groups, e.g. no age and sex representative outreach & BCC. There is also lack of legal and policy support for SRH and HIV services among YKAP. There are no specific program activities targeting YKAP.
9. There is overlap between sex work, drug use and MSM behavior- and programs are not catering to this issue. Partners of key populations are not intervened and there is lack of programs targeting couples/partners of key population (i.e. lack of partner counseling and testing).
10. Social exclusion, marginalization and criminalization of all key populations lead to widespread stigma and discrimination. The interventions addressing stigma and

discrimination are inadequate and translating policy and program strategies into implementation is a challenge.

11. A high level of SGBV is faced by all key populations especially sex workers, hijras and women & girls.
12. Men lack understanding and awareness of gender norms and masculinity. There is poor realization of women's rights (e.g. marital rape not recognized, existing property and inheritance rights, etc.).
13. Lack of social protection mechanisms including addressing poverty, unemployment, family/children issues (especially for female sex workers, hijras and spouses of migrant workers), etc. of key populations.
14. Weak multi-sectorial coordination mechanisms and lack of effective program linkages.

## Recommended Policy and Program Interventions

1. Scale-up community based HIV prevention and treatment interventions with geographical coverage and by including most marginalized groups of key populations to provide comprehensive services, e.g. contact tracing, strengthen HTC for KP and general populations.
2. Advocacy for legal policy reform to:
  - a) Remove or harm minimization of laws that criminalize sex work, injecting drug use and MSM behavior, and also laws that are reportedly used to routinely discriminate, harass, detain or deny services to key populations as well as to female migrants/spouse of migrants.
  - b) Adopt protective laws to prevent violence, marginalization and discrimination, and facilitating provision of social and legal protection for key populations.
  - c) Establish functional linkage between National Women's Advancement Policy and HIV Policy and focus on specific needs of marginalized women.
  - d) Build the capacity of Law Enforcement agencies to understand the legal and human rights of key populations and PLHIV, and ensure non-discrimination and equitable access to the justice system. Advocacy, orientation, expanding in-service training courses, etc. may be initiated giving global examples of other countries where law enforcers take part in harm reduction programs.
  - e) Support scaling-up of OST and harm reduction programs.
  - f) Create enabling environment for accessing SRH services for YKAP through capacity building, central and local level advocacy and facility enhancement.
  - g) Strengthen work on National Social Protection Strategy to integrate HIV-sensitive considerations.
  - h) Reinforce strict implementation of laws for perpetrators of SGBV.
3. Provide life-skills based education for YKAP on SRH issues as well as on issues that propagates gender inequality (such as traditional gender norms for boys and girls, masculinity and male role, female roles, etc.) parallel to client interventions. Contact tracing need to be ensured within the existing program.
4. Expand social marketing of condoms towards clients of sex workers as well so that female and male sex workers, hijra, MSM and, men and women in general are better able to negotiate safe sex. Introduce female condoms to program interventions.

5. Capitalize on service delivery synergies between the provision of SRH and HIV services for groups who have unmet need of SRH services.
6. Conduct campaigns and community-based stigma reduction programs through print and electronic media.
7. Involve the gatekeepers and faith-based leaders into SRH initiative.
8. Address the power structures (such as police, husbands, mastans, hotel management, madams etc.) focusing issues of violence against women and gender based violence against sex workers, hijras, women and girls.
9. Create public health promotion campaigns to increase awareness around issues of GBV and IPV as well as the provision of the new GBV law.
10. Provide legal support to seek redress in case of violence, denial of care and treatment programs, work related discrimination.
11. Work with health service providers to reduce stigma and discrimination, and create provision for psychosocial/mental health, family counseling and support for female PLHIV.
12. Introduce economic empowerment programs for female migrant workers, spouses of migrants, sex workers and PLHIV including orphans.
13. Reach spouses of migrant workers and female migrant workers with HIV information, HIV testing and other support services.
14. Create social support and financial safety nets for aging FSW such as saving schemes, protection of children.
15. Take steps to reflect the recognition of Hijra into practical implementation.
16. Promote knowledge and awareness of sexual and reproductive health rights and life skills education to other vulnerable groups that may be at risk such as readymade garment (RMG) industry workers.

## Agreed Actions as Next Steps

The following actions were formulated and agreed upon by the national stakeholders who participated in the Gender Assessment Workshop to carry forward the implementation of findings from the gender assessment process.

- Use the assessment outcomes to reflect into the mid-term review of the NSP and ensure the revised 3<sup>rd</sup> NSP and the operational plan integrate the recommended gender-transformative interventions.
- Ensure that the concept note for the Global Fund under the new funding model is gender-sensitive.
- Ensure that HIV related ongoing and future resource mobilization and capacity development initiatives are guided by principles and program practice that can achieve gender equality in HIV response.
- Gender must be at the forefront of new policy initiatives such as the rolling out of the WHO's new treatment guidelines, Treatment 2.0 and the post-2015 agenda.
- Advocacy for gender-sensitive program indicators into National MIS and lay out a tracking mechanism for those.
- Activate the 'Revised National HIV/AIDS and SRH Communications Strategy 2014'.
- Develop a fund raising strategy to support the implementation of the gender assessment findings and priority interventions.
- Develop and implement a targeted advocacy plan to disseminate the key priorities emerging from the gender assessment and mobilize relevant stakeholders to achieve gender transformative policy reform and programs.
  - Advocacy and lobby to Ministry of Women and Children to develop an inclusive gender policy and a social protection scheme for PLHIV, key populations and other vulnerable groups.
  - Advocacy and lobby to Ministry of Home Affairs to address sexual and gender based violence against key populations within their sectorial policy and programs.
  - Advocacy and lobby to Ministry of Education for inclusion of Sexual and Reproductive health education and gender equality education into formal and non-formal education with especially emphasis on empowering girls and boys from key population community.
  - Advocacy and lobby to Ministry of Social Welfare to address the practical implementation of recognition of Hijra by Government.
  - Advocacy with Ministry of Overseas Employment and Expatriate Welfare to address the migrants' health across the migration cycle with special focus on female migrants & spouse of migrants.
- UN organizations should continue to facilitate mobilizing resources and provide technical support required to make HIV response more gender transformative.

## **Annex 1 TOR: THE CORE TEAM SUPPORTING THE UNDERTAKING OF GENDER ASSESSMENTS OF NATIONAL HIV RESPONSES IN BANGLADESH**

### **About the Gender Assessment Tool**

The Gender Assessment Tool for HIV Responses (hereinafter referred to as the Tool) is a structured set of guidelines and questions that can be used to guide and support the process of analyzing the extent to which national responses to HIV, in both generalized and concentrated epidemics, take into account the critical goal of gender equality. At the global level, the Tool has been developed by UNAIDS, which convened an expert Reference Group comprised of members from across the globe and from government, UN agencies and civil society organizations, to guide its development.

The Tool is a planned, systematic and deliberate set of steps and processes which examine and question the status of the HIV response (plans and actions undertaken by national governments to address HIV) with specific reference to its gender dimensions (the socially constructed roles, behaviors, activities and attributes that a given society considers appropriate for women and men, including key populations). In using the Tool, we are able to learn about the extent to which the national response recognizes and then acts on the recognition of gender inequality as a key determinant of HIV. It helps us ensure that gender equality is a goal of the national response to HIV.

The Gender Assessment process of an HIV response involves:

Knowing your HIV epidemic and country context from a gender perspective.

Knowing your country response from a gender perspective.

Using the Findings of the Gender Assessment to strengthen the HIV response.

The tool can be used by individuals and partners in government, civil society, the United Nations and other multilateral agencies, to support key national processes, such as the development or review of a National Strategic Plan on HIV, Global Fund proposal, or other opportunity as identified in country.

### **Scope of the Gender Assessment Core Team**

Under the overall leadership of the National AIDS Programme in Bangladesh, the Gender Assessment Core team will provide overall guidance on the gender assessment process of the national HIV response to ensure country ownership and leadership with a diversity of stakeholders engaged. Specifically, the core team will:

Support and work with the international and national consultants to plan and execute a participatory and transparent gender assessment process including for organizing gender assessment workshop and developing a final report along with recommendations for future actions

Provide technical inputs on the desk review, any background documents produced for undertaking the assessment including on workshop agenda, sessions, etc. This also includes providing timely review and feedback on the populated GAT tool.

Act as a resource person during the gender assessment workshop (tentatively confirmed for 8-10 December 2013) and co-facilitate and/or moderate group discussions

Facilitate and support the development of the key messages and recommendations to be included in the report as well as a road-map on how these will be implemented in the future

The core assessment team will be composed of government representatives, experts on HIV policies and services, experts on gender policies and services and stakeholders from both the fields of HIV and gender, including civil society. The stakeholders could include but not restricted to UN Agencies, government, and civil society partners from various sectors, such as health, gender, justice, human rights, and finance. In addition, particular care will be taken to ensure the meaningful involvement of people living with HIV and members of key population groups at all stages, including in the country assessment team. List of core team members are given in Annex.

#### **Selection of the Core Team Members**

The core assessment team is formed in consultation with and under the leadership of National AIDS/STD Programme (NASP). The criteria for selection of members in the core team are:

Knowledge, expertise, experience and leadership in HIV and/or Gender programming

The relevance and importance of their involvement (and of the organization they represent) and

Interest and availability to participate in the process

The core team includes 2 representatives from government, 1 each from NASP and Ministry of Women and Children Affairs (MoWCA). 2 UN Agencies, UN Women and UNFPA are considered to be part of the core team based on their critical work on HIV and Gender. icddr'b and CARE are considered vital as one is the lead research agency in Bangladesh and the other is the lead international NGO implementing HIV programs for almost 2 decades in Bangladesh respectively. Network of PLHIV and MSM Network are also on board to ensure meaningful participation of people living with HIV and members of key population groups.

#### **Roles and Responsibilities of the Core Team Members**

The role of the core team members is voluntary and non-remunerated. They will need to closely work with the national and international consultants to plan and implement the gender assessment. In order to achieve the purpose of this initiative, the core team will:

Need to closely familiarize itself with the Gender Assessment Tool and related materials.

Participate in the two WebEx sessions planned for 2nd and 4th week in November respectively

Provide timely communication, review and feedback on the documents produced by the consultants including the populated assessment tool and the workshop agenda

Co-facilitate and participate in the workshop including the formulation of the recommendations and the future roadmap for implementation of the recommendations

### **WebEx Sessions**

Two WebEx sessions will be organized and facilitated by the international consultant with the support from the national consultant.

1st WebEx: is tentatively planned for 12 November 2013. The objective of this WebEx is to brief and gain a common understanding among the core team members on the assessment, their roles and responsibilities in the assessment process and agree on the next steps. During this WebEx, the consultants will also present the adapted version of the tool to gain feedback and clarify any issues on the desk-review and data analysis.

2nd WebEx: is tentatively planned for 27 November 2013. The objective of this session is to mainly gather feedback on the background research, data analysis and preparation done by the consultants. It is expected that the national consultant will in advance distribute the populated gender assessment tool before 22nd November. This way, the core team members will have had a chance to systematically review the document before the session and provide their feedback during the WebEx. It is also proposed that the core-team members discuss the workshop preparation including the agenda during this WebEx, resolve any outstanding issues and finalize the plan for the workshop.

### **Gender Assessment Workshop**

The objective of the gender assessment workshop is to:

- Present, review and validate the assessment data and analysis done by the consultants with support from the core-team
- Identify the gaps and opportunities for making HIV response more gender transformative.
- Develop a set of recommendations including key interventions to be included in the currently-being reviewed national strategic plan on HIV
- Agree on the next steps for the implementation of these recommendations in the near future including inclusion in the GFATM proposals and other country mechanisms, plans and programs

It is envisioned that the workshop will bring together stakeholders from a diverse sectors, including gender and HIV experts. The participants of the workshop will be agreed up by the core team under the leadership of the National AIDS Programme. UNAIDS will provide technical and logistical support to organize the workshop. The tentative dates for the workshop are from 8-10 December 2013.

## Annex 2 List of Core Team Members Supporting the Undertaking of Gender Assessments of National HIV Response in Bangladesh

Sl	Name	Organization	Designation	Email
1	Mahbuba Begum	National AIDS/STD Programme	Deputy Program Manager, Program Management	dr.mahbubabegum@yahoo.com
2	Dr Abul Hossain	Ministry of Women and Children Affairs	Project Director, Multi Sectorial Program on Violence Against Women	Chossain2019@yahoo.com
3	Mahtabul Hakim	UN Women	Programme Coordinator	Mahtabul.hakim@unwomen.org
4	Gorkey Gourab	icddr'b	Manager, Monitoring & Evaluation	gorkey@icddr.org
5	Habiba Akther	Network of PLHIV	President	Habiba_aas@yahoo.com
6	Shamima Pervin	UNFPA	Senior Programme Officer- Gender	pervin@unfpa.org
7	Md Abu Taher	CARE- Bangladesh	Team Leader, Emphasis Project, HIV Program	taher@bd.care.org
8	Shale Ahmed	Bandhu Social Welfare Society, (MSM Network)	Executive Director	shale@bandhu-bd.org
9	Dr Lima Rahman	Save the Children	Program Director, HIV/AIDS Sector	lima.rahman@savethechildren.org

**Technical Support will be provided by:**

<b>Sl</b>	<b>Name</b>	<b>Designation</b>	<b>Email</b>
1	Smriti Aryal	International Consultant	aryal_smriti@yahoo.com
2	S.M Naheean	National Consultant	NaheeanS@un aids.org

## Annex 3 Validation Workshop of the Gender Assessment of National HIV Response in Bangladesh

**Dates: 9-11 December 2013**

**Venue: Lakeshore Hotel, Gulshan-2, Dhaka**

### Agenda

Day 1 : Tuesday 8 October	
9:00-9:30	Welcome and opening remarks Dr Md Abdul Waheed, Line Director, National AIDS/STD Programme- Chief Guest Ms Christine Hunter, UN Women Country Representative
9.30-9:45	Purpose and objective of the workshop Mr. Leo Kenny, UNAIDS Country Coordinator
9:45-10:15	Coffee/Tea break
10:15-10:35	Introduction of the participants Ground rules
10:35-11:05	Presentation “Why address gender issues in HIV response in context of Bangladesh?” followed by Q&A Mahtabul Hakim, UN Women
11:05-11:35	Presentation on overview of assessment process and introduction to the assessment tool followed by Q&A Dr. Mahbuba Begum, DPM Program Management, NASP
11:30-12:00	Group Work on Stage 2 Knowing the HIV epidemic and context in the country <ul style="list-style-type: none"> <li>• Review prepopulated summary of key findings and analysis</li> <li>• Identify any gaps and validate the data/information</li> </ul>
12:00-13:00	Lunch

13.00 – 14:00	Continuation of Group Work and preparation of the group summary on consolidate findings and analysis
14:00-15:00	Coffee/Tea break
15:00-15:45	Plenary presentation of the group work and discussion Finalize the main findings and analysis of Stage 2
15:45-16:30	Group Work on Stage 3 Knowing the HIV Response <ul style="list-style-type: none"> <li>• Review prepopulated summary of key findings and analysis</li> <li>• Identify any gaps and validate the data/information</li> </ul>
16.30	Closure of Day 1
Day 2 Wednesday 9th October	
9:00-9:15	Re-cap of Day 1
9.00-11:00 (including coffee break)	Continuation of Group work on stage 3 and preparation of group summary on consolidate findings and analysis
11:00-11:30	Plenary presentation of the group work and discussion Finalize the main findings and analysis of Stage3
11:30-12:30	Management, coordination and capacity needs for making HIV response gender transformative Discussion and agreement on key issues, gaps and opportunities Moderator: TBC
12:30-13:30	Lunch
13.30 – 16:30 (including tea break)	Group work on Stage 4: Using the findings and analysis for a gender transformative HIV Response <ul style="list-style-type: none"> <li>• Prioritizing activities and interventions</li> <li>• Identify opportunities and</li> <li>• A road-map for implementation</li> </ul>
Day 3 Thursday 10 October	
9:00-9:15	Re-cap of Day 2
9.15-10:15	A quick review and validation of the summary outcomes by the workshop participants Group work for final inputs

10:15-10:45	Tea break
10:45-11:30	Plenary presentation of the priority areas, interventions and road-map followed by question answers and discussions A word of endorsement by decision makers and participants and agreement on a way forward
11:30-12:00	Workshop closure and lunch AM Badrudduja, Additional Secretary, MOHFW-Chief Guest Argentina MatavelPiccin, UNFPA Country Representative-Special Guest