Commitment for Action:

Assessing Leadership for Confronting the HIV/AIDS Epidemic Across Asia

Focus on Bangladesh

January 2005

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*Assessing Leadership for Confronting
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By

Halida Hanum Akhter

January 2005

● Contents

● ACKNOWLEDGMENTS

ABBREVIATIONS

ABC	Abstinence, Be Faithful, Use Condoms
AIDS	acquired immune deficiency syndrome
ANE	Asia and the Near East
API	AIDS Program Effort Index
ARV	antiretroviral
CCM	country coordinating mechanism
DGHS	Director General for Health Services
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with HIV/AIDS
HAART	highly active antiretroviral treatment
HIV	human immunodeficiency virus
IDU	injection drug user
MSM	men who have sex with men
NAC	national AIDS committee
NACP	national AIDS control program
NGO	nongovernmental organization
NSP	national strategic plan
PLHA	person living with HIV or AIDS
PMTCT	prevention of mother-to-child transmission
STD	sexually transmitted disease
STI	sexually transmitted infection
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	voluntary counseling and testing
WHO	World Health Organization

EXECUTIVE SUMMARY

To prevent the further spread of HIV among vulnerable groups and the general population as well as to provide care, support, and treatment for those already affected, Bangladesh must enact a comprehensive response to the epidemic. Many of the most important features of a strong response—including multisectoral engagement, protection of human rights, civil society participation, meaningful involvement of people living with HIV or AIDS (PLHAs), well-financed programs and well-trained staff, and monitoring and evaluation systems that allow for developing lessons learned—are directly and indirectly influenced by an enabling policy environment and strong national political commitment. However, few attempts have been made to identify key characteristics of or ways to measure strong political commitment for addressing HIV/AIDS, particularly in the context of low HIV prevalence countries. Against such a backdrop, this assessment of national political commitment and leadership for confronting the HIV/AIDS epidemic in Bangladesh not only provides a mechanism for improving in-country responses but also contributes to the international community's understanding of political commitment and leadership and their impact on strategies to address HIV/AIDS worldwide.

The study involved a literature review of relevant materials and in-depth interviews with 17 key stakeholders representing various sectors of Bangladeshi society, including government, nongovernmental organizations (NGOs), PLHA groups, international donor organizations, international NGOs, faith-based groups, academia, human rights organizations, and the media. The interviews were structured around a qualitative assessment guide developed by the POLICY Project that covers 13 aspects of national political commitment and leadership, including policy environment, resources, organizational structure, and stigma and discrimination.

In terms of defining national political commitment, respondents noted several important characteristics and activities, including expression of support at all levels of government and society; creation of an enabling policy environment; multisectoral engagement, including NGO participation; meeting the needs of target populations; strategic use of existing resources; and increased human and financial resources. On the positive side, respondents reported that Bangladesh had established a National AIDS Committee (NAC) and a Technical Committee of the NAC that seek to improve multiministry involvement. The government has also adopted a national policy on HIV/AIDS and has updated its strategic plan. In addition, many respondents felt that Bangladesh, primarily through external donors, has sufficient financial resources to tackle HIV/AIDS.

Overall, however, most respondents concluded that national political commitment for combating HIV/AIDS remains low in Bangladesh. Many challenges hamper the country's response to the epidemic. For example, respondents identified lack of human resources and absorptive capacity as significant barriers to effective use of existing financial resources. High staff turnover, lack of training and staffing, a hierarchical and inefficient program structure, and lack of meaningful multisectoral participation were critical concerns. Respondents also noted that stigma and discrimination are prevalent in Bangladeshi society—and top political leaders often remain silent on the issue or exacerbate the situation by misinterpreting surveillance data or adding to the perception that certain groups are "guilty" for the spread of HIV. Respondents identified several instances where policies, in their view, are lacking or misguided, particularly those related to the most vulnerable populations, such as sex workers and injection drug users (IDUs). Another common concern pertained to the need to adopt a balanced program approach that considers emerging needs, such as care and treatment, as opposed to an approach focused on prevention

only. While NGOs and civil society groups were seen as playing a leading role in the country's response, many felt that the government needs to do more to build NGO capacity and identify program gaps and avoid duplication of effort.

In terms of strengthening political commitment and thereby improving Bangladesh's national response, stakeholders from across the government and society should work to:

- Sensitize national and local leaders to the importance of addressing HIV/AIDS now and conduct advocacy to help leaders from all sectors understand their role as opinion leaders who can help confront stigma and discrimination;

- Address several national policy gaps, particularly those that relate to vulnerable groups and affected communities;

- Establish mechanisms that will help translate policies and public statements into action, with special attention to effectively allocating resources and strengthening human capacity development within government and civil society;

- Strengthen multisectoral collaboration within government institutions and encourage meaningful involvement of civil society groups and members of affected communities; and

- Facilitate the collection, analysis, and dissemination of high-quality, accurate information regarding the epidemic, including HIV sentinel surveillance and behavioral studies, information about affected groups, and data highlighting the social and economic impacts of the epidemic.

INTRODUCTION

● INTRODUCTION

● Background

Bangladesh currently has a low national adult (15–49) HIV prevalence level, estimated at less than 0.2 percent at the end of 2003 (UNAIDS, 2004). Bangladesh counts an estimated 15,000 people living with HIV or AIDS (PLHAs). Despite the low prevalence level, several conditions could contribute to a rise in new HIV infections, including high-risk behaviors (e.g., injection drug use, low condom use), high prevalence of sexually transmitted infections (STIs), a large sex industry, porous borders with countries and regions experiencing concentrated HIV/AIDS epidemics, gender inequality, and other socioeconomic factors (e.g., high poverty, mobile populations). Prevalence is higher among vulnerable populations—for example, estimated at 4 percent among injection drug users in Bangladesh (IDUs) (USAID, 2004).

Unlike other countries where HIV/AIDS has taken hold, Bangladesh has a rare opportunity to contain the further spread of HIV. The effort will require specific and concerted actions to prevent new infections, to provide treatment and care to those already affected, and to mitigate the epidemic's harmful social and economic effects. A crucial element needed for these actions is strong leadership and national political commitment.

● Purpose and Methodology

This case study of Bangladesh is part of a multicountry assessment designed to analyze national political commitment and leadership for confronting HIV/AIDS in low HIV prevalence countries in Asia as well as to develop indicators to measure national political commitment. It is based on the assumption that while experience shows that political commitment can help catalyze a strong response before an epidemic spreads to the general population, political commitment is a term that is often used without a clear sense of what it means, how it affects programs, and how it can be strengthened by advocates and policymakers.

The study was conducted in four countries with low seroprevalence in Asia during the summer of 2003 by the POLICY Project for the Asia and the Near East (ANE) Bureau of the U.S. Agency for International Development (USAID).[1] The study expands and builds on POLICY's past efforts in the development of methodologies to measure political commitment for confronting the HIV/AIDS epidemic.[2] The study's methodology involved two phases:

- ▪ **Literature review and assessment guide development.** POLICY Project researchers conducted a review of the literature on political commitment for addressing HIV/AIDS and other relevant health issues, such as reproductive health. The review, coupled with the project's own experience in assessing and building political commitment, informed the development of a qualitative

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[1] The four countries in the study are Bangladesh, India, Nepal, and Viet Nam.
[2] See *HIV/AIDS Toolkit: Building Political Commitment for Effective HIV/AIDS Policies and Programs* (POLICY Project, 2000), available at http://www.policyproject.com/pubs/toolkit.cfm. See also "Measuring the Level of Effort in the National and International Response to HIV/AIDS: The AIDS Programme Effort Index (API)" (UNAIDS, USAID, and POLICY Project, 2001), available at http://www.policyproject.com/pubs/Monographs/APIreport.pdf.

assessment guide for measuring 13 aspects of national political commitment (see Appendix A). Local consultants and counterparts also reviewed relevant country-specific materials relating to the country's national response and political commitment. The materials included national HIV/AIDS plans; UNAIDS reports; applications to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM); and other relevant documents.

- **Identification of key stakeholders and in-depth interviews.** Key HIV/AIDS stakeholders were identified as interview subjects to gather their views on current levels of political commitment in Bangladesh. In-depth interviews with 17 persons were carried out. The respondents represent various sectors of Bangladeshi society, including government, nongovernmental organizations (NGOs), PLHAs, and PLHA groups, international donor organizations, international NGOs, faith-based groups, academia, human rights organizations, and the media.

● Characteristics of Political Commitment

Strong political commitment for confronting the epidemic is an essential component of a comprehensive and effective strategy for addressing HIV/AIDS at the local, national, regional, and international levels (UNAIDS, 2000; USAID, 2000). The POLICY Project defines political commitment as

> *[T]he decision of leaders to use their power, influence, and personal involvement to ensure that HIV/AIDS programs receive the visibility, leadership, resources, and ongoing political support that is required to support effective action to limit the spread of HIV and mitigate the impacts of the epidemic* (POLICY Project, 2000).

A sizeable body of literature addresses political commitment in general and political commitment for HIV/AIDS in particular (e.g., Patterson, 2000; POLICY Project, 2000). The review of the literature suggests several concrete actions and events that characterize political commitment. Examples include:

- *Formulating a national HIV/AIDS plan.* The Declaration of Commitment (2001) of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), for example, sets forth a goal that all countries should have had national strategic plans in place by 2003.

- *Strengthening the public health infrastructure.* Scaling up an HIV/AIDS response requires the development of and investment in necessary infrastructure, including health facilities, related systems, and human capacity. For example, the ability of a country, such as Thailand, to conduct vaccine trials is an important indicator of political commitment because clinical trials cannot be conducted without first developing basic utilities and laboratory facilities, training staff, ensuring supply lines and transportation, and so on.

- *Passing public health legislation.* Legislation can take many forms. One example is legislation that identifies HIV/AIDS as a communicable disease and outlines the role of the state in prevention, care, and mitigation. Another example is legislation that makes HIV/AIDS a national priority, such as the Philippines AIDS Law of 1998, which mandated education about HIV-related risks and safer practices and behaviors as well as screening, counseling, and the provision of health services (Stephenson, 2001). A third example is laws that prohibit discrimination against PLHAs.

- *Mobilizing and allocating resources.* Sufficient and cost-effective budget allocations are necessary for the successful implementation of prevention, treatment, and care programs.

- ***Encouraging civil society participation.*** NGOs should be encouraged to act locally to reduce risk behaviors and slow the spread of the epidemic and to participate broadly in the planning and policymaking processes of the country (Parkhurst, 2000).

- ***Promoting human rights.*** Commitment to international conventions and compliance with international standards, such as the "International Guidelines on HIV/AIDS and Human Rights" (Watchirs, 2000), is essential for creating an enabling policy environment for HIV/AIDS programs and for reducing stigma and discrimination.

- ***Serving as an "AIDS policy champion."*** Some top-level political leaders have used their status and personal dedication to keep HIV/AIDS high on the agenda in their own countries. Examples include President Yoweri Museveni of Uganda, former President Kenneth Kaunda of Zambia, former President Nelson Mandela of South Africa, and Senator Mechai Viravaidya of Thailand.

> *Political commitment is the decision of leaders to use their power, influence, and personal involvement to ensure that HIV/AIDS programs receive the visibility, leadership, resources, and ongoing political support that is required to support effective action to limit the spread of HIV and mitigate the impacts of the epidemic (POLICY Project, 2000).*

Patterson (2000) identifies a number of indicators of political commitment drawn from successful national programs, including:

- Key ministries with their own HIV/AIDS plans and budgets, as in the case of Thailand (Sittitrai, 2001);

- Provincial governors playing a lead role in the HIV/AIDS program of their respective provinces, as in the case of Thailand (Sittitrai, 2001);

- Encouraging multisectoral engagement and including businesses, PLHAs, faith-based organizations, and other community leaders in policy dialogue and resource mobilization, as in the case of Thailand (Sittitrai, 2001);

- Government publicly acknowledging the HIV/AIDS epidemic as a national priority and creating a highly placed national HIV/AIDS commission early on, as in the case of Uganda;

- Enabling and promoting NGO involvement in HIV/AIDS activities, as in the case of Senegal;

- Including HIV/AIDS-related topics in health and sex education for school-aged children, as in the case of Senegal;

- Integrating detection of and treatment for STIs into primary health services, as in the case of Senegal; and

- Providing antiretroviral (ARV) drugs and/or adopting a government policy of universal access, as in the case of Brazil.

The next chapter explores the extent to which Bangladesh's national response to HIV/AIDS has demonstrated strong political commitment for confronting the epidemic.

SALIENT FINDINGS

This section presents key findings from the in-depth interviews regarding respondents' attitudes and opinions toward several aspects of national political commitment. The major topics covered are:

- *Understanding of Political Commitment*
- *Top Leadership*
- *Government Response*
- *Role of NGOs and Civil Society*
- *Research, Monitoring, and Evaluation*
- *Stigma and Discrimination*

Where appropriate and primarily for providing additional background information, respondents' views are supplemented with information from the literature review of relevant policies, budgets, and strategic plans.

UNDERSTANDING OF POLITICAL COMMITMENT

Respondents were first asked for their views regarding what constitutes strong political commitment in the context of HIV/AIDS. A hallmark of political commitment, according to a political leader, is a clear understanding of the people's needs; of goals and priorities as articulated by Bangladesh's Constitution and international resolutions; and of the relationships among critical issues, such as poverty alleviation, education, and health. The respondent spoke of the need for good governance and said that each ministry should employ representatives who are responsive to the needs of the people. A respondent from the government HIV/AIDS program stated that political commitment involves talking openly about HIV/AIDS in various forums. According to the same respondent, some areas where the government could be seen as demonstrating commitment were youth health needs, safe blood transfusions, and behavioral change communication. It could also be seen, to some extent, in recognizing the need to address affected populations, such as sex workers and IDUs.

The respondents from other sectors shared similar views about the nature of political commitment to addressing HIV/AIDS.

- To the journalist, political commitment means that top leaders understand the issue, develop supportive attitudes, and understand their mandate.

- According to one PLHA representative, political commitment means that higher-level policymakers demonstrate their involvement through advocacy and by speaking in meetings, in Parliament, or in their own constituency. Such policymakers should be involved in HIV/AIDS policy formulation. For this respondent, political commitment means support from political groups and strong commitment to a multisectoral approach. Commitment should acknowledge the problem, create an enabling environment for program implementers, and enhance access for target populations. Funding and resource commitment are also needed.

- A respondent from an international donor agency stated that political commitment requires action according to policies and that the activities must go beyond lip service. It means that top leaders must demonstrate honesty and openness in both recognizing the problem and facilitating and supporting the implementation of activities.

- According to a faith-based leader, strong political commitment means that all political leaders, whether or not in power, must express interest in HIV/AIDS issues, engage in advocacy, and involve themselves in policy formulation and implementation. Advocacy means speaking publicly in meetings and congregations, enhancing government initiatives, and encouraging and involving NGOs in the implementation of projects.

- For a representative of a human rights group, political commitment involves addressing specific issues (e.g., violence against women) through policymaking, raising the issues in Parliament in order to adopt relevant legislation, and translating policy into action.

- A respondent from academia involved in program implementation felt that playing a proactive role in HIV/AIDS area is an essential aspect of commitment. Expressing responsibility and taking

action to promote prevention, control, and treatment of HIV/AIDS demonstrates true commitment.

Many respondents, both from government and civil society, noted a gap between political commitment as expressed in the public statements of top leaders and political commitment as demonstrated in the implementation of plans and programs. According to a government representative, translation of commitment into action was often deficient. A member of a PLHA group lamented that most planning occurs on an ad hoc basis and pointed to the need for increased (and better use of) resources. One respondent noted that top leaders' sensitivity in dealing with subjects such as HIV/AIDS hinders dissemination of information and that government officials rarely use scientific data or the latest information in their speeches. A respondent from an international organization stated that Bangladesh's top leaders expressed political commitment but that they had not gone far enough. Areas in need of greater commitment, according to this respondent, are issues surrounding stigma as well as women's vulnerability and the "4 Ds"—disempowerment, discrimination, denial, and destigmatization.

KEY POINTS: UNDERSTANDING OF POLITICAL COMMITMENT IN BANGLADESH

- Some characteristics of strong political commitment to addressing HIV/AIDS include expression of support at all levels of government and society, including top leaders; creation of an enabling policy environment; multisectoral engagement; encouragement of NGO participation; meeting the needs of target populations; strategic use of resources; and increased allocation of human and financial resources for HIV/AIDS programs.

- National leaders can demonstrate their political commitment by talking openly about HIV/AIDS and delivering speeches based on accurate information; directly involving themselves in public education campaigns and addressing stigma; and formulating and adopting policies, strategic plans, and legislation.

- A key concern is to ensure that political commitment goes beyond mere statements of support and is translated into support for the implementation of policies and programs.

● Top Leadership

Respondents were next asked to evaluate political commitment as expressed by the country's top leaders. A few respondents declined to comment. Of those who did respond, all stated that political commitment for HIV/AIDS programs is low among Bangladesh's top leaders. Respondents noted the following common concerns:

- Top leaders have failed to make HIV/AIDS a priority;

- High staff turnover rates in relevant ministries and departments hinder program implementation;

- Staff in charge of the HIV/AIDS program lack the appropriate training, knowledge, and skills;

- The HIV/AIDS program is hierarchical and inefficient; and

- The program lacks meaningful inclusion of and participation from stakeholders outside the government.

Specifically, one respondent involved in the implementation of programs stated that unequivocal support for implementation is lacking at the highest levels of the government of Bangladesh. While the Director General for Health Services (DGHS) was characterized as dynamic, open, and supportive, respondents felt that other key personnel seemed to lack training or commitment. A respondent from academia suggested that program leadership is weak and recommended the development of a cadre of trained professionals to manage and assume accountability for the program. Furthermore, according to respondents, the government's lack of implementation efforts and absorptive capacity undermine the prospects for major donor support, which is crucial to sustainability of the HIV/AIDS program. For example, one respondent stated that the World Bank has committed $40 million over five years for the HIV/AIDS program but that, in two and a half years, the nation has disbursed less than 2 percent of the funds.

A few other civil society participants expressed the need for top leaders to take an active role in breaking the silence surrounding HIV/AIDS in Bangladesh. A respondent from a PLHA organization reported that the Prime Minister does not mention HIV/AIDS in public speeches and that top leaders are reluctant to discuss HIV/AIDS openly. A member of an international NGO stated that Bangladesh's top leaders do not feel comfortable dealing with HIV/AIDS because of social stigma and because, to date, the disease has primarily affected stigmatized groups, such as sex workers.

Respondents expressed a general feeling that the government's top leadership lacks interest, involvement, and initiative. Even though personnel in top leadership positions participate in various meetings and forums when invited, they do not exhibit proactive leadership and self-motivation.

KEY POINTS: TOP LEADERSHIP IN BANGLADESH

- A few respondents did not feel comfortable assessing the political commitment of Bangladesh's top government leaders.

- Of those who did respond, all stated that the highest levels of government have not demonstrated political commitment to addressing HIV/AIDS. The respondents felt that government leaders, to date, had failed to make HIV/AIDS a priority.

- High turnover rates, lack of training and staffing, a hierarchical and inefficient program structure, and lack of multisectoral participation were among respondents' primary concerns.

- Top leaders, according to respondents, do not openly talk about or address issues surrounding HIV/AIDS and fail to discuss the needs of the stigmatized groups most affected by the epidemic.

● GOVERNMENT RESPONSE

This section explores respondents' assessment of specific aspects of the government's response, including policy formulation, national legislature, and regulatory environment; resources; organizational structure; multiministry involvement; program components; foreign technical assistance and foreign experience; and public information and education.

● Policy Formulation, National Legislature, and Regulatory Environment

Policy formulation. Bangladesh's National Policy on HIV/AIDS and STD-related Issues was drafted in 1996 and adopted in 1997. According to some respondents, the policy underwent development through a participatory approach that considered the viewpoints of multisectoral stakeholders. However, given that the first draft of the policy was conceived in part by international consultants, some respondents stated that the national policy is mostly donor-driven. In fact, a task force appointed by the DGHS drafted the national policy for review by a core group and discussion at a multisectoral workshop that brought together 10 stakeholder groups.

At the time of the study, the national policy was undergoing an update that, respondents noted, should incorporate emerging issues such as care and support, roles of other sectors, trafficking, safe blood transfusion as a government project, and the role of industries. Given that the last strategic plan (for the period 2000–2005) is nearing an end and that program needs are changing in view of the increasing number of HIV cases, the National Strategic Plan is being revisited and updated for 2004–2010 under a United Nations initiative. One respondent observed that the plan does not include behavioral surveillance and that monitoring of implementation still remains particularly weak.

In terms of vulnerable groups, the existing policy's commitment to women focuses on the "4 Ds"— disempowerment of women, discrimination, denial, and destigmatization. One major issue, a respondent noted, is the lack of evidence-based decisionmaking and policy development. For example, political leaders rarely use scientific data or data on women's vulnerability during their public advocacy. World Bank funds for scaling up program efforts have been allocated to blood screening of vulnerable groups.

National legislature and regulatory environment. Safe blood transfusion is one area for which Bangladesh has developed a regulatory framework, though one respondent noted that the regulations are not adequately enforced. The government respondent reported that the country has adopted safe blood transfusion legislation that mandates five screening tests, including HIV, hepatitis B and C, malaria, and syphilis, before a transfusion is permitted. According to the same respondent, safe blood transfusions are available at nearly 100 blood transfusion centers across Bangladesh.

In general, however, respondents noted important areas where laws and guidelines are lacking, unclear, or—in the view of respondents—misguided. A number of respondents identified the sex industry as a "gray area," stating that there is no clear law on the status or legality of sex workers and they are,

therefore, often the victims of abuse and violence.[3] A representative from an international NGO noted that sex workers do not have civil rights and that their children cannot enter government schools. Sex workers are denied healthcare and access to education. At the time of this study, a law addressing the repatriation of victims of trafficking had been drafted but not approved. Sex workers and victims of trafficking are vulnerable to HIV and STIs.

With regard to other vulnerable populations in Bangladesh, respondents noted that men who have sex with men (MSM) are criminalized and that it is illegal to provide clean injection equipment to IDUs as part of harm-reduction programs.[4] A law that prohibits unnatural sexual behavior is the basis for discrimination against MSM, who are beaten and arrested by police officers. A representative from the media suggested that laws should support the care of HIV/AIDS patients, IDUs, sex workers, *hijras*,[5] and other vulnerable groups.

In terms of other programmatic areas, legislation guaranteeing confidentiality for voluntary counseling and testing (VCT) had not yet been ratified at the time of this study. The essential drug list for Bangladesh did not list ARV drugs. HIV/AIDS information and awareness campaigns are not available in the native languages of migrant workers. In addition, the provision of condoms is largely limited to family planning purposes, and HIV/AIDS service providers must be registered in order to provide condoms to their clients.

● Resources

Almost all respondents mentioned that financial resources for the national HIV/AIDS program are adequate but that program utilization and absorptive capacity are very low. At the time of the study, respondents noted that, for a four-year period, $50 million had been allocated, primarily from the GFATM, World Bank credit, and the United Kingdom's Department for International Development (DFID). However, during the first half of the implementation period, funds were neither released nor used, leaving only $24 million available for the remaining two years of the plan period. Programs such as the HIV/AIDS Prevention Project, supported by DFID and the World Bank, have been scaled back in response to a number of logistical constraints. In addition, a respondent from a PLHA group stated that, while Bangladesh has received adequate funding from international donor groups, the government has allocated little of its own budget to HIV/AIDS programs.

Respondents noted the lack of human resources and absorptive capacity as the primary barriers to effective use of available financial resources. Human resources are inadequate at both an individual level and the government level. Due to lack of a proper fund release mechanism, the program cannot spend the money. A respondent from a faith-based organization pointed to the lack of vision, thus leaving much unplanned and unstructured in terms of needs projected by 2010. In particular, the government has undertaken neither a long-term projection of logistical needs nor an assessment of human resources needed for HIV/AIDS; as a result, the government is not developing appropriate training programs. A respondent from academia cautioned that an influx of funding without the capacity to use funds appropriately can lead to corruption.

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[3] USAID does not support the legalization of prostitution. It is, however, committed to supporting effective strategies to prevent the spread of the HIV/AIDS epidemic and to mitigate its impacts.
[4] USAID does not condone or promote the use of illegal drugs and U.S. government policy prohibits the use of federal funds for the purchase or distribution of needles and syringes for the purpose of injecting illegal drugs.
[5] *Hijra* is a term used to refer to transgender individuals, including hermaphrodites and eunuchs.

In terms of consideration about where funds should be allocated, some respondents said that HIV/AIDS awareness-building activities do not need much more funding but that implementation needs direction and leadership. One respondent from an international donor organization noted the importance of offering incentives to improve human resources while a researcher and program implementer stressed the need to allocate resources to programs that tackle issues related to injection drug use.

● Organizational Structure

The National AIDS Committee (NAC), established in 1985, is the highest-level decision-making body with regard to the HIV/AIDS program. The Health Minister heads the committee, and the President of Bangladesh is its Chief Patron. A representative from academia stated that the structure of the National AIDS Control Program (NACP) is acceptable but noted that political appointees hold most posts; therefore, the program lacks a stable, experienced cadre of civil servants with expertise in HIV/AIDS. At the time of this study, the NAC had met only once a year over the previous two years. The Technical Committee of the NAC met more often than the NAC, but respondents felt that it needs to meet more frequently.

The DGHS is the Line Director for the HIV/AIDS program. As a few respondents noted, given that the DGHS must deal with several important issues—not just HIV/AIDS—the NACP makes only limited progress as the higher-level approval process meets with delays, adversely affecting the timely implementation of HIV/AIDS activities. Furthermore, respondents noted, the HIV/AIDS Program Manager's low rank compromises his ability to pursue activities at the ministry level and, as such, results in delayed approvals. In addition, because the DGHS is the Line Director for the HIV/AIDS program, he himself cannot monitor the program or evaluate it objectively.

● Multiministry Involvement

Headed by the Health Minister as already noted, Bangladesh's NAC is multisectoral in its composition, bringing together representatives from 17 ministries. Each ministry has charged a senior official with serving as both the focal point for HIV/AIDS and a member of the NAC responsible for expediting implementation of the HIV/AIDS program. Some of the ministries represented on the NAC include Education, Law, Women's and Children's Affairs, Health, Finance, Youth and Sports, Labor, Agriculture, and Information. Most respondents suggested that multiministerial involvement needs to be improved. They noted, for example, that the committee meets only once a year; that greater responsibility should be given to each ministry's focal person; and that both lower- and upper-level collaborative linkages across ministries are lacking.

A senior government officer closely involved with the HIV/AIDS program reported that activities are becoming more multiministerial in nature. At the time of the study, eight ministries were actively involved in HIV prevention activities, including the Ministry of Health as the line ministry along with the ministries of Women's and Children's Affairs, Youth and Sports, Labor, Expatriates, Home, and Education. Some efforts sponsored by UNICEF provide orientation and training of the individuals designated as focal points for the ministries of Information, Education, and Women's and Children's Affairs. NGOs, the Narcotics Department, and the Home Ministry are also involved in the program. A respondent from an international donor organization noted that the Minister of Women and Children's Affairs is highly motivated. As an example, she chaired a roundtable meeting involving the ministries of Health, Women's and Children's Affairs, and Youth and Sports as a follow-up to a roundtable held in Nepal.

Despite some progress, respondents generally called for stronger linkages between ministries. They stressed that many issues should be addressed as intergovernmental matters, that political commitment is extremely important, and that more top-level involvement is needed. They noted that the ministries of Education and Youth and Sports have the need and potential to become more meaningfully involved in HIV/AIDS issues. A member of the faith-based community stated that NGO collaboration should be encouraged through supportive policies and mechanisms. NGOs, according to respondents, are better able than government to reach vulnerable groups such as IDUs and sex workers.

● Program Components

The NACP is characterized by a national HIV/AIDS policy, a national strategic plan, and specific interventions and facilities, including the establishment of nearly 100 blood transfusion centers. According to a respondent from an international NGO, the strategic plan calls for the involvement of community and district leaders, an aspect of the plan not yet achieved. A researcher believed that selected political leaders recognize the special burden of HIV/AIDS on women and that the country is collecting sufficient data on the disease, its nature, and the course of its spread. A government respondent reported that the HIV prevention program has been linked with a hepatitis B prevention program because 4.5 to 7 percent of the population is hepatitis B positive. The government also planned to establish liver units in 13 medical colleges and a liver transplant unit in one medical college. In addition, Bangladesh has received GFATM funding for an HIV/AIDS intervention targeting youth.

With regard to affected communities and vulnerable populations, respondents noted that trafficking of women and children must be addressed and that VCT, including protection of confidentiality, needs to be improved, especially for the migrant population. A respondent from academia stated that program and training needs should be assessed and that program implementation must occur methodically, making necessary adjustments in response to increasing demand for care and support services and other emerging aspects of the epidemic.

● Foreign Technical Assistance and Foreign Experience

One aspect of political commitment is the willingness of countries to learn from the successful programs and experience of other countries. A senior government respondent noted the importance of capacity building and the recipient country's ownership of the program. Bangladesh must be proactive if it is to maintain support at a sustainable level and build on lessons learned. Respondents felt that both the government and NGOs could benefit from technical assistance. According to a respondent from a human rights group, technical assistance is needed with respect to ensuring blood safety through proper testing, strengthened referral mechanisms, and working with brothel victims and sex workers. A respondent from an international NGO suggested that technical assistance is needed in the areas of counseling, dealing with drug users, undertaking preventive activities, providing substitution therapy, and so forth. In addition, the government needs technical assistance for creating help lines. According to a local NGO, technical assistance is greatly needed in the areas of counseling techniques, communication skills, opportunistic infection care and support, and universal hospital-level precautions. A respondent from an international donor organization emphasized the need to develop documentation processes to help assess whether policy changes are needed at the national level.

It is reported that, at the government level, consultants hired for the short term help improve the national program's human capacity while, at the NGO level, organizations seek technical assistance per their various needs. A respondent from an international donor organization suggested that technical assistance could be delivered at three levels: at the donor level, at the international NGO level, and at the national organization level. According to the same respondent, assistance could be provided at different stages or layers. For example, large donors would not provide technical assistance directly to smaller NGOs; instead, international NGOs would provide the needed assistance to small NGOs. A respondent from the media noted one effective model of providing assistance: the United Nations Development Program (UNDP) provides technical assistance on program implementation and monitoring every two months to minimize gaps and help develop country programs.

● Public Information and Education

In general, respondents felt that HIV/AIDS-related public information and education in Bangladesh are inadequate. The information is not properly connected to prevention issues and is often skewed. A few respondents stated that public information about HIV/AIDS is inaccurate and influenced by superstitions, transmits incorrect perceptions, and helps generate fear. According to respondents, messages do not explain that HIV cannot be transmitted through casual contact or demonstrate the user-friendliness of prevention methods, such as condoms. A respondent from academia believed that behavior change communication messages are not produced responsibly while a member of an international NGO noted that the existing political climate does not discourage messages based on superstitions about the disease.

With the increase in the number of HIV-positive cases, respondents felt that information and messages must go beyond a "prevention only" focus. According to respondents, the NACP should recognize the changing needs for information, content, and quality of messages and make necessary adjustments based on the need for care and support and other emerging aspects of HIV/AIDS.

An international NGO representative stated that the Chair of the Technical Committee of the NAC speaks out effectively about HIV/AIDS, as do the Health Minister and Home Minister. A respondent from the media lamented that government information officers do not release information and that most information sources are NGOs and development partners. A respondent from a large donor organization underscored that advocacy is important for tackling HIV/AIDS and commented that Parliamentarians should be more involved in meetings that increase exposure to and orientation on the issues. Members of Parliament should implement projects within their constituencies.

A few respondents emphasized the role of faith-based communities in the dissemination of HIV/AIDS information. A government respondent suggested that information on sensitive cultural issues may be more acceptable and more easily delivered if it builds on religious values and institutions. A respondent from a faith-based organization said that mosques need to communicate the idea that HIV/AIDS is not a disease of the sinner and should promote services and support. One respondent mentioned that a program was initiated with support from religious groups, especially imams, who agreed to discuss HIV/AIDS during Friday prayers.

As HIV/AIDS education has not yet been integrated into the general education system, respondents stated that adolescents have limited access to pertinent information. However, at the time of this study, some donors in collaboration with the Ministry of Education were producing a booklet for young people. Information on HIV/AIDS also needs to be broadcast on television during prime-time hours. One respondent noted, however, that, although the public media are strong, HIV/AIDS awareness-raising activities are limited and those in the media are still reluctant to address the issue.

KEY POINTS: GOVERNMENT RESPONSE IN BANGLADESH

- Bangladesh has adopted a national policy for HIV/AIDS as well as a revised strategic plan for program implementation. However, respondents reported that the policy is lacking, unclear, or in need of reform in several key areas—for example, needle and syringe exchange programs for IDUs, protection of confidentiality in VCT services, and the status of sex workers and MSM.

- Most respondents agreed on the need to strengthen absorptive capacity and the ability to use HIV/AIDS funding effectively. Bangladesh also relies heavily on external donor funding, and a few respondents warned of donor-driven policies and programs.

- As more Bangladeshis become HIV positive and eventually develop AIDS-related illnesses, respondents identified the need to move from strategies that focus solely on prevention to those that recognize the need for treatment, care, and support. Respondents raised this point in regard to the appropriate balance among program components and to messages in public education and information campaigns.

- Bangladesh established a National AIDS Committee in 1985. It is headed by the Health Minister and brings together members from 17 ministries, with the President of Bangladesh as Chief Patron. Along with the NAC's Technical Committee, it seeks to promote multisectoral engagement. Respondents, however, felt that both bodies need to meet more frequently, improve collaborative links across ministries, and encourage greater NGO participation, as NGOs are well suited to reach out to vulnerable populations.

- Public education and information campaigns, according to respondents, need to be improved as they often are based on inaccurate information or tend to generate fear instead of understanding. Several respondents mentioned faith-based organizations as a possible avenue for raising sensitive issues. They stated that religious leaders can help show that HIV/AIDS is not a punishment for sin and that people should instead focus on care and support for those affected by the disease. In some places, imams are already discussing HIV/AIDS during Friday prayer sessions.

● ROLE OF NGOS AND CIVIL SOCIETY

In an enabling environment supported by strong political commitment from a country's top leaders, NGOs and other civil society groups that are addressing HIV/AIDS might reasonably be expected to flourish and to be involved in helping plan and implement the country's HIV/AIDS efforts. At the same time, NGOs and civil society must demonstrate leadership and commitment and can play a role in encouraging greater commitment from government leaders at all levels.

Respondents agreed that NGOs have played a leading role in Bangladesh's HIV/AIDS response. A representative from the government AIDS program noted that NGO collaboration and involvement are essential to the HIV/AIDS program. The activities taken on by NGOs include advocacy and awareness raising, care giving, social mobilization, information-sharing forums, drop-in and clinical services, referrals, counseling, prevention activities, surveillance, and formation of support and self-help groups. Respondents also noted that NGOs have led the way in providing services to affected communities, including the delivery of care for PLHAs and working to meet the needs of *hijras* and brothel-based sex workers. NGOs have also been working to increase collaboration among various groups. Initiated in 1997, the National HIV/AIDS and STD Network consists of more than 160 member organizations across Bangladesh. A respondent from the media reported that, at the time of this study, an international organization was mapping the NGOs involved in HIV/AIDS in Bangladesh.

Some NGO representatives in the field noted a large gap between the government and NGO leadership. A few respondents argued that NGOs have had to compensate for a "nonexistent response" from the government. A respondent from an international NGO believed that NGOs do not have the support of the highest level of government to carry out their activities. According to respondents, the government needs to improve the coordination of NGO activities in order to avoid duplication and to identify program gaps. Through collaboration with NGOs, respondents believe that government can strengthen the national AIDS program and, through monthly task force meetings, enhance program monitoring activities. The government, according to respondents, also needs to play a role in building the capacity of NGOs. In addition, a few respondents suggested that some sectors of civil society need to become more involved in HIV/AIDS issues, including the media, academia, human rights groups, women's rights organizations, lawyers, teachers, and others.

In terms of challenges faced by NGOs working in the HIV/AIDS field, respondents pointed to the need to strengthen NGOs so that they can provide leadership and play facilitative roles in the country's national HIV/AIDS response. However, NGOs need a proper environment if they are to function effectively. A representative from academia lamented that, due to lack of capacity, some small NGOs may lose funding or may not survive. A member of a human rights groups observed that, due to stigma and the sensitive nature of HIV/AIDS work, many NGOs do not deal with HIV/AIDS. Hence, government leaders need to help coordinate NGO activities (to avoid duplication and identify gaps in the program, as already noted), build NGOs' organizational capacity, and help break the silence surrounding HIV/AIDS so that more groups will participate in the national response.

KEY POINTS: NGO AND CIVIL SOCIETY INVOLVEMENT IN BANGLADESH

- All respondents agreed that NGOs are critical to the success of the HIV/AIDS program and that, in many respects, NGOs have been leading the way. Activities undertaken by NGOs include advocacy and awareness raising, care giving, drop-in and clinical services, referrals, counseling, prevention activities, support and self-help groups, and meeting the needs of PLHAs and affected communities.

- According to respondents, some of the sectors that have not yet demonstrated a commitment to addressing HIV/AIDS in Bangladesh are the media, academia, human rights groups, women's rights organizations, lawyers, teachers, and others.

- Many respondents believed that government needs to do more to encourage, strengthen, and coordinate NGO activities. In particular, government needs to help build NGO capacity, identify program gaps and avoid duplication, and confront the stigma surrounding HIV/AIDS, which hinders NGO work and prevents other NGOs from taking up HIV/AIDS issues.

RESEARCH, MONITORING, AND EVALUATION

Research and monitoring and evaluation systems are essential so that countries develop a clear understanding of the nature of the epidemic and the impact of program efforts on the course of the disease. Sentinel surveillance began in Bangladesh in 1998. Many respondents noted that Bangladesh is collecting sufficient data in terms of monitoring national prevalence trends and behavior surveillance; in fact, the data reflect the nature and epidemiology of the disease in Bangladesh. According to a representative from an international NGO, the national sentinel surveillance is an "internationally commended system." Bangladesh undertakes both serosurveillance and behavioral surveillance, and Family Health International has completed and released the findings from the fourth round of the second-generation surveillance of HIV/AIDS.

A few respondents felt that the sentinel surveillance data are adequate but that in-depth analysis and details of the surveillance data are needed to develop a better understanding of certain aspects of the program and issues. One respondent remarked on the need for better information on vulnerable populations and affected communities, such as sex workers and their clients.

Others involved in program implementation did not think that an evaluation is planned to measure policy and program impact and believed that monitoring of activities does not occur. The draft version of the National Strategic Plan for HIV/AIDS for 2004–2010 recognizes the lack of a strong monitoring and evaluation system and calls for remedying this gap. A respondent from an international donor organization reported the absence of standardized formats for reporting on program activities and the failure to develop any program indicators. A senior government respondent mentioned that monitoring and evaluation is an important component in the document prepared for GFATM funding. Another expert suggested that any monitoring and evaluation must be performed independently.

KEY POINTS: RESEARCH, MONITORING, AND EVALUATION IN BANGLADESH

- In general, respondents felt that Bangladesh's solid HIV sentinel surveillance and behavioral studies provide accurate data on the state of the epidemic. Family Health International has completed and released the findings of the fourth round of second-generation surveillance.

- Respondents noted a need for better information regarding topics such as vulnerable populations. An additional area in need of improvement, according to respondents, is monitoring and evaluation to measure program impact and provide direction for future strategies.

● STIGMA AND DISCRIMINATION

Both the fear and experience of stigma and discrimination are critical barriers to the success of programs designed to prevent HIV transmission and meet the needs of people affected by the disease. Owing to stigmatization and the prospect of rejection by families and community members, individuals fear testing, deny their level of risk, or refuse to seek treatment. Given their position in society, national leaders from all sectors can play a significant role in efforts to reduce stigma and change attitudes toward PLHAs.

Most respondents reported that stigma surrounding HIV/AIDS in Bangladesh is widespread and pervasive. PLHAs face barriers when seeking care and thus fear disclosuring their status. Stigma translates into lack of medical care and social support for AIDS patients. In an extreme example of stigma and discrimination, an HIV-positive pregnant woman was denied hospitalization for childbirth. Similarly, respondents reported that the religious practice of bathing the dead was withheld from a deceased AIDS patient while the widow was denied access to her own house.

In considering the role of and response from Bangladesh's national leadership, some respondents stated that senior political leaders rarely talk about HIV/AIDS issues and have yet to address stigma as part of the national agenda. When leaders do talk about HIV/AIDS, they often increase stigmatization or misinterpret surveillance data. They also tend to avoid the "real issues," such as the vulnerability of women, and instead unfairly identify certain groups (e.g., sex workers) as "guilty parties." A PLHA representative reported that top leaders have yet to recognize the need to confront stigma and discrimination, though the representative noted that some imams are receiving sensitization training on HIV/AIDS. Respondents saw NGOs as uniquely positioned to help others understand and reduce stigma.

Vulnerable populations and affected communities, including sex workers, MSM, and IDUs, often face a double stigma—that associated with HIV/AIDS and that associated with membership in a marginalized group. A recent report by Human Rights Watch found, for example, that sex workers and MSM often face abuse and extortion from police and gangs and that failure to prosecute perpetrators of such abuse "reflects broader social attitudes which stigmatize both sex workers and men who have sex with men" (Human Rights Watch, 2003, p. 5). While the country's national policy recognizes the important role of affected communities in HIV prevention efforts, Human Rights Watch also found that sex workers and MSM delivering HIV/AIDS peer education and outreach are among those who have been beaten and arrested by police.

Respondents recommended empowering those affected by the disease, providing greater social support and protection from discrimination (e.g., in the workplace), and sensitizing communities and leaders to help remove the stigma surrounding HIV/AIDS.

KEY POINTS: STIGMA AND DISCRIMINATION IN BANGLADESH

- Most respondents believed that HIV/AIDS-related stigma and discrimination are pervasive in Bangladesh. PLHAs have been denied treatment in hospitals as well as social support and therefore are fearful about disclosing their status, thus preventing people from seeking testing and treatment. Stigma can persist even after death; the custom of ritual bathing of the dead may be withheld from those who die from AIDS-related illnesses while their immediate survivors are denied family property.

- Top leaders, according to respondents, tend to be silent on HIV/AIDS issues or have added to stigmatization by, for example, misinterpreting surveillance data. They have also been said to ignore key issues, such as women's vulnerability, while contributing to the perception that certain groups are "guilty" for the spread of the epidemic.

- Respondents recommended empowering those affected by the disease, providing greater social support and protection from discrimination (e.g., in the workplace), and sensitizing communities and leaders to help remove the stigma surrounding HIV/AIDS.

RECOMMENDATIONS AND CONCLUSIONS

RECOMMENDATIONS AND CONCLUSIONS

In its 2000 update on the global HIV/AIDS epidemic, UNAIDS identified nine common features of effective national responses (see box). "Political will and leadership" was the first item on the list. What attests to the importance of national political commitment is the fact that it plays a critical role in promoting all of the other eight common features of effective responses. For example, strong political commitment from a country's top leaders can help mobilize resources, facilitate buy-in across sectors, encourage community-based involvement, ensure the wherewithal to support a sustained response, and promote openness in terms of addressing HIV/AIDS and caring for those affected by the disease. Understanding and strengthening national political commitment is therefore essential for confronting the HIV/AIDS epidemic—particularly in low prevalence countries where there is still time to act before the epidemic spreads. These are the countries where political commitment early on can really make a difference—but the time to act is now.

> ## UNAIDS: Common Features of Effective National Responses
>
> 1. Political will and leadership
> 2. Societal openness and determination to fight against stigma
> 3. A strategic response
> 4. Multisectoral and multilevel action
> 5. Community-based responses
> 6. Social policy reform to reduce vulnerability
> 7. Longer-term and sustained response
> 8. Learning from experience
> 9. Adequate resources
>
> *Source: UNAIDS (2000)*

This study considered various aspects of national political commitment and leadership in Bangladesh. Respondents' general impression was that national political commitment to addressing HIV/AIDS is low. On the positive side, respondents noted that Bangladesh had established a National AIDS Committee and Technical Committee of the NAC that seek to improve multiministry involvement. The government has also adopted a national policy on HIV/AIDS and has updated its strategic plan. In addition, many respondents felt that Bangladesh, primarily through external donors, has sufficient financial resources to tackle HIV/AIDS.

Nonetheless, Bangladesh's national leaders could demonstrate greater political commitment in a number of areas. Respondents identified lack of human and absorptive capacity as significant barriers to effective use of existing financial resources. Chief concerns extended to high staff turnover, lack of training and staffing, a hierarchical and inefficient program structure, and lack of meaningful multisectoral participation. Respondents also noted that stigma and discrimination are prevalent in Bangladeshi society—and top political leaders often remain silent on the issue or exacerbate the situation by misinterpreting surveillance data or adding to the perception that certain groups are "guilty" of spreading HIV. Respondents also identified several instances where policies, in their view, are lacking or misguided, particularly those related to the most vulnerable populations, such as sex workers, MSM, and IDUs. A common concern was the need to adopt a balanced program approach that considers emerging needs, such as care and treatment as opposed to prevention only. While NGOs and civil society groups play a leading role in the country's response, many felt that government needs to build NGO capacity as well as identify program gaps and avoid duplication of effort.

In light of the findings of the study and the views of the respondents, the following sector-wise recommendations are proposed for strengthening the country's political commitment and national response to HIV/AIDS.

Top Leadership

- Unlike in some developing countries, women have attained top political leadership positions in Bangladesh. As a woman, the current Prime Minister should speak openly about family planning and HIV/AIDS in public forums and should break the silence on these issues. The opposition leader, also a woman, should do likewise.

- A cadre of trained personnel should be responsible and accountable for the entire HIV/AIDS program.

- International NGOs suggested that, even though resources are adequate and NGOs and civil society participate in the HIV/AIDS response, greater government support and facilitation are crucial for accomplishing planned activities.

- Top leadership needs to be sensitized to the realities of the nationwide health, economic, and social consequences of HIV/AIDS so that they will understand the importance of the issue to the future of Bangladesh.

- To make the NAC more efficient, its composition should be modified to meet needs for policymaking, program guidance, and facilitation of implementation at all levels and among all partners.

Government Response

- *Policy formulation.* The update of the national HIV/AIDS policy should address emerging issues such as care and support, the role of various sectors in responding to the epidemic, trafficking, safe blood transfusion, and the role of industries. Because the policy pertains exclusively to the health sector, it must be extended to other sectors through the preparation of specific plans. For example, issues faced by garment industry workers include vulnerability, lack of negotiation power, and generalized lack of empowerment. National policies need to account for and address the unique needs of groups vulnerable to HIV infection.

- *National legislature and regulatory framework*. Laws should ensure the support and care of HIV/AIDS patients, IDUs, sex workers, *hijras*, and other vulnerable groups. In the case of prevention of trafficking and repatriation, a law has been drafted but not yet approved. For migrant workers, information and awareness literature or brochures must be made available.

- *Resources*. Program implementers participating in this study recommended the reallocation of funds to ensure that the changing needs of the program are properly addressed. To meet the need for skilled technical staff, a systematic training needs assessment is in order along with training plans. To facilitate program implementation, capable leadership among senior staff is also needed. For public employees, improved incentives are needed to reciprocate for extra days and additional hours of work. A respondent from an international donor organization suggested the

use of UNDP funds and expertise to enhance the capacity and functioning of the subcommittee of the country coordinating mechanism for GFATM.

- *Organizational structure*. The NAC and its Technical Committee should meet more frequently to provide the program with continuing guidance, support, and national emphasis. The Health Ministry should meet monthly to coordinate activities. Planned activities should be supported by guidelines, legal sanctions, or protocols, and gaps in legal protection or procedures should be addressed. Some respondents recommended that the government should not be the conduit for donor funds; the government inadequately disburses fund and might become dependent on major donors. In addition, one official should have exclusive responsibility for HIV/AIDS issues at each ministry.

- *Multiministry involvement*. The most common recommendation is that political leaders—both those in power and members of the opposition—should take part in awareness-building activities. The NAC and its Technical Committee should convene more frequently, leading to better policymaking, program implementation, and monitoring. To reach out to young people, the Ministry of Education should incorporate pertinent information into the syllabus for high school students (in the textbook on health science) as well as into the medical and nonmedical curriculum. A senior government official recommended that imams of mosques should take part in the program, as their viewpoints are respected. People at the local government level should be involved, including in rural communities. Multiministry coordination and collaboration is crucial for reaching all segments of the population for awareness building and conducting prevention activities in order to protect vulnerable populations from HIV/AIDS.

- *Program components.* Policies and programs should be adjusted to address emerging needs and to fill any program gaps, including the need for prevention, treatment, and care and support among affected populations. In addition, a few respondents commented on prevention of mother-to-child transmission (PMTCT), suggesting that PMTCT is an emerging program area requiring attention.

- *Technical assistance.* Given that the HIV/AIDS program is in its infancy, technical assistance to the government is needed to maintain linkages between government and NGOs and between donors and the government. Respondents pointed to a need for more technical assistance from donors, international NGOs, and the recipient country government. Technical assistance could be provided at different stages or in layers; for example, donors could provide technical assistance to larger NGOs, and international NGOs could provide technical assistance to smaller NGOs. Technical assistance at the community level is also needed.

- *Public information and education.* National policies should be revised to accommodate the various types of needed information and to facilitate accessibility to that information. To reduce the population's lack of awareness about HIV/AIDS issues, appropriate mechanisms and appropriate messages should be developed. News media should inform and sensitize the public, and more specific efforts should involve media groups. Political leaders, such as Parliamentarians, should be more involved (e.g., by implementing projects in their constituencies). Adolescents in Bangladesh must be adequately informed, with separate strategic planning for reaching adolescent and high-risk groups. Limitations on condom provision for vulnerable populations at high risk for HIV infection should be relaxed.[6] Currently, for example, HIV/AIDS service providers must be registered before they are permitted to provide condoms to their clients.

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[6] Correct and consistent condom use is an important aspect of HIV prevention.

● Role of NGOs and Civil Society

- It is promising that the senior government officials think that NGO collaboration is essential. Improved coordination between and among NGOs and the NACP, the Technical Committee, and UNAIDS is needed.

- NGOs need to be strengthened so that they can provide leadership and play a facilitative role; however, NGOs need the proper environment in which to function. Because NGOs play specialized roles, they need to expand their capacity to undertake various activities.

- In sensitive types of activities associated with stigma, only small NGOs are at work; large NGOs do not play a role. More health-focused NGOs need to be encouraged to become involved.

- To avoid duplication of NGO activities, coordination should be the responsibility of the government program. The government should identify program issues and other gaps and take appropriate actions to address those gaps. NGOs and government should play complementary roles—for example, government should be responsible for providing treatment to complicated cases in hospital settings while NGOs may be better suited to reaching vulnerable populations with HIV prevention messages.

● Research, Monitoring, and Evaluation

- A senior government respondent mentioned that monitoring and evaluation is important. In fact, the data and statistics in the latest Bangladesh country profile need to be updated to include the most recent findings of the fourth-round surveillance of HIV. Both UNAIDS and UNICEF are helping to update the profile.

- Respondents noted the absence of standardized reporting and monitoring systems. Thus, formats for reporting and indicators for evaluation and reporting should be developed.

● Stigma and Discrimination

- Bangladesh has yet to understand fully the issues related to stigma and the need for destigmatization. Adequate information sharing and improved public education campaigns about the disease in all populations will be helpful.

- Discussions about religious roles may empower people with a greater sense of responsibility, for their own actions and for how they treat others. HIV/AIDS sensitization training with imams is underway and should be further encouraged for faith-based groups.

- Social support for continuing the employment of PLHAs is needed. Industries should not discriminate against PLHAs and should protect such employees from loss of jobs, benefits, and wages.

● Conclusions

From the overall information and impressions gathered from interviews, the following conclusions can be drawn:

1. With political commitment for combating HIV/AIDS weak in Bangladesh and top leaders reluctant to recognize the problem, attention to the epidemic remains inadequate. Visits to countries where the disease is highly prevalent and health and social consequences widely visible can help draw attention to the epidemic. Some exchange of dialogue with the leaders of other countries will help Bangladesh's leaders understand the gravity of the situation if HIV/AIDS does not receive adequate priority now.

2. The program should be adequately staffed with competent professionals capable of program implementation. Financial resources are available, but human resources are lacking. Technical assistance should be properly assessed and should follow a system to develop capacity.

3. Policies and strategic plans exist, but guidelines, rules, regulations, and national laws are inadequate to support government or NGO implementation of the program. Review of the program is needed to identify gaps and specify the appropriate steps to be taken to address emerging needs.

4. Resources are available, UN agencies are willing to help, and donors and international NGOs are able to provide technical assistance. Lack of emphasis on the program and lack of priority hinder proper utilization of existing resources dedicated to the program.

5. The multisectoral nature of the NAC is not strong enough to draw on interministerial involvement; focal points from each ministry should be oriented to and made responsible for the implementation of activities.

6. Adequate information sharing about the disease in all populations is essential for reducing stigma and increasingly important as the number of HIV-positive and AIDS cases grows. Adolescents and youth should be a priority target group for sharing information.

7. NGOs are playing an important role and should be increasingly involved in providing services, sensitization, and program evaluation. NGO capacity should be further developed according to emerging needs.

8. Political commitment is essential for successfully implementing the program, keeping HIV and STI prevalence in check, and making people aware of the facts and preventive skills.

Appendices

APPENDIX A: QUESTIONNAIRE

1. **What Do You Understand Political Commitment to Mean?**

   - How would you measure it?
   - How would you know it when you see it?

2. **Top Leadership**

   - Does the president or prime minister regularly make strong statements in support of HIV/AIDS programs?
   - Is the president or prime minister seen as leading the effort against HIV/AIDS? Why or why not?
   - In what ways, if any, does the president or prime minister indicate concern or commitment?
   - How has this changed over time, if at all?
   - Are there any personal connections to the HIV/AIDS epidemic by top leadership? E.g., a family member is affected by the disease. If so, is this openly disclosed or discussed?
   - Does the top leadership contribute toward reduction of stigma? If so, in what ways?
   - What has been the biggest success in the battle against HIV/AIDS? Who would you credit for this success?
   - What has been a failure or shortcoming in the leadership's actions (now or before)?
   - Is there broad-based leadership for political commitment or is it largely driven by one or two individuals?

3. **Policy Formulation**

   - Is there a national HIV/AIDS policy? Please describe. What are its strengths/weaknesses? Was it developed in a participatory manner? If so, how? Who participated?
   - Is there a national HIV/AIDS law? Please describe. What are its strengths/weaknesses? Was it developed in a participatory manner? If so, how? Who participated?
   - Is there a national HIV/AIDS strategic plan (NSP)? What are its strengths/weaknesses? Was it developed in a participatory manner? If so how? Who participated?
   - Is there commitment to the GIPA (greater involvement of people living with HIV/AIDS) principle? E.g., People living with HIV or AIDS (PLHAs) are included in a meaningful way in the policy formulation processes of the country.   Has this commitment been codified into national policies or law?
   - Has the NSP been fully implemented?
   - Has the NSP been costed?
   - Are there policies/laws that focus upon human rights? Of PLHAs? Are these HIV specific or included in other laws/policies?
   - Are there specific policies to address stigma and discrimination related to HIV/AIDS?

4. **Resources**

   - Does the country commit a significant amount of its own budget to the national HIV/AIDS program? How about ministries other than the Ministry of Health? If so, which?
   - Is the national HIV/AIDS budget transparent? Is it published and/or available for public review?

- If budget process is centralized, are funds allocated to the provincial budgets for HIV/AIDS?
- If budget process is decentralized, do provincial budgets allocate funds for HIV/AIDS activities?
- Do resources get from the national to the local level?
- Has there been a recent increase in government funding for HIV/AIDS?
- Has the country submitted an application to the Global Fund for AIDS, Tuberculosis and Malaria (GFATM)?
- Is the Country Coordinating Mechanism (CCM) multisectoral in nature? Does it include PLHAs and other affected populations?
- How do you think international donors view the adequacy of funding by the government for the HIV/AIDS program?
- Is the country pursuing donor support for HIV/AIDS? To what extent?
- Is the available funding actually spent?
- Is available funding used efficiently?
- Is AIDS a priority for debt relief funds?
- How would you characterize resource availability? Lots? Not enough? Okay?
- Is funding targeted to vulnerable groups most affected by the epidemic or to general population and/or low-risk populations?
- How are resources allocated according to prevention, treatment and care, and mitigation—is the allocation level balanced?

5. Organizational Structure/National AIDS Control Program

- Is there a central command structure or Steering Committee for the National AIDS Control Program (NACP)? If so:
  o How significant is it? Strengths? Weaknesses? Actions needed?
  o Is the head of the NACP highly placed within the government structure? Is he/she seen as having access to the top leadership of the country?
  o Are there sufficient personnel resources in the NACP?
  o Is the NACP multisectoral in focus? In its planning/prioritizing function or in program implementation?
  o Who are its members?
  o Are the members adequately trained and knowledgeable of the issues?
  o Does the HIV/AIDS program have a set of specific goals and targets?
  o Is there a specific mechanism to monitor the implementation of the NACP?

6. Multi-Ministry Involvement

- Which ministries, besides health, are significantly involved in the HIV/AIDS program? In what ways?
- Are implementation activities strongly supported by these ministries?
- Do ministries have their own dedicated HIV/AIDS budgets? Personnel?

7. Role of NGOs and Civil Society in Implementation

- To what extent are local NGOs involved in addressing the HIV/AIDS epidemic?
- Name the major NGOs that have HIV/AIDS programs.
- How are NGOs involved in the planning and implementation of the NACP?
- Do any organizations actively pursue issues related to stigma and discrimination? If so, which? How are they doing this?
- How supportive is each political party in addressing HIV/AIDS issues? What specific actions have they taken?

- Comment on the commitment of the following:
  - o Faith-based groups?
  - o PLHA groups?
  - o Academia?
  - o Health care professionals?
  - o Women's groups and other human rights groups?
  - o Business?
- Are there advocacy organizations made up of individuals from target groups? E.g., sex workers? Men who have sex with men (MSM)? Injection drug users (IDUs)?
- Are local celebrities and/or sports figures involved in open support of AIDS programs? Does the government encourage this?
- Has there been an increase in the number, size, and quality of roles played by civil society?

8. Foreign Technical Assistance and Foreign Experience

- Does the government analyze and study the experience of neighboring countries? E.g., Mekong region drawing on the experience of Thailand.
- Does the government send delegations to visit countries with effective HIV/AIDS programs?
- What specific programs/populations are of concern requiring increased technical assistance?

Programs	Populations
Voluntary counseling and testing (VCT)	IDUs
Prevention of mother-to-child transmission (PMTCT)	Sex workers
Access to highly active antiretroviral treatment (HAART)	MSM
	Youth
Public information and education	Women
Monitoring and evaluation	Heterosexual men
Condom distribution	Other
Other	

- Is available foreign technical assistance used to its maximum capacity?

9. Public Information/Education/Use of Media

- Does the government use the media to address the HIV/AIDS problem? In what ways? If not, what other mechanisms are used to address the HIV/AIDS problem and reach the public with information?
- Does the government give accurate information to the public about:
  - o Preventing HIV?
  - o ABC (Abstinence, Be Faithful, Use Condoms) campaign? Correct and consistent use of condoms?
  - o VCT?
- How is this information distributed/disseminated? Is there a national social marketing campaign addressing these issues?
- Is life skills education incorporated into the school curricula? What does it include? At what school levels?

10. Legal/Regulatory Environment

- Is there a special HIV/AIDS committee in the legislature?

- Is anti-discrimination legislation in place and enforced? Describe (e.g., employment testing, access to insurance).
- Has there been an effort to improve laws pertaining to HIV? If so, how? If not, why not?
- Have any HIV/AIDS-related constitutional amendments been passed or considered?
- Are the country's HIV/AIDS laws in accordance with international human rights guidelines?
- Are there laws safeguarding the human rights of vulnerable populations?
- Do businesses have clear and mandatory requirements regarding their policies and services for employees living with HIV/AIDS?

11. Monitoring and Evaluation

- Is there an effective HIV surveillance system? Describe.
- Does information reach local-level policymakers or remain only among the highest-level policymakers?
- Are priorities established systematically and based on the best available information?
- Are there specific benchmarks/goals for each of the main components of the NACP?

12. Program Components as Indicators of Political Commitment

- Does the NACP program implementation include components on:
  o VCT
  o PMTCT
  o HAART
- If not, is the program working to include each one?
- Are there specific prevention and care programs focused on vulnerable populations (e.g., sex workers, truck drivers, migrant workers, MSM, IDUs, orphans)? Describe.
- Are these programs reviewed and evaluated regularly by independent experts?

13. Stigma and Discrimination

- Is there a high level of stigma? For example, are people afraid to get tested? Are people afraid to disclose their HIV status because of violence, job loss, and ostracism?
- In your opinion, what are the root causes of stigma in this country?
- Are policymakers doing anything to address stigma? If yes, please describe what specific actions are being taken.

APPENDIX B: REFERENCES

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For more information, please contact:

Director, POLICY Project
Futures Group
One Thomas Circle, NW
Suite 200
Washington, DC 20005
Tel: (202) 775-9680
Fax: (202) 775-9694
Email: policyinfo@futuresgroup.com
Website: www.policyproject.com