Health care systems in transition III. Bangladesh, Part II. Bangladesh’s response to HIV–AIDS
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Introduction
This paper sets out to explore the current HIV epidemic in Bangladesh. After a description of the known epidemiology of HIV infection in this country, an outline will be presented of possible future trends within a societal, cultural and economic context. The response of various agencies, both governmental and non-governmental, is addressed in the final part of the paper.

At the end of December 1998, within a country of approximately 120 million people, only 102 HIV positive persons had been diagnosed and reported, and 10 people had been diagnosed with AIDS, of whom seven have died (N. Islam, personal communication, 1999). Many of the HIV-positive people fall into a few well-defined ‘risk categories’, including emigrant workers, long-distance truckers and commercial sex workers. The male:female ratio of HIV-infected persons currently stands at 4:1. The epidemiological picture, however, is incomplete, partly due to a lack of published comprehensive surveillance data.

Sentinel surveillance for HIV and syphilis was started in 1998 among suspected high-risk population groups. These included brothel-based and street-based ‘floating’ sex workers, men with symptoms or signs of sexually transmitted diseases (STDs) recruited in STD clinics, truck drivers and their co-drivers, men who have sex with men (MSM) and injecting drug users (IDUs). Of a total 3871 blood samples collected and tested, 17 (0.4 per cent) were HIV-1 seropositive, with 10 out of 402 injecting drug users having the highest recorded seroprevalence at 2.5 per cent. In contrast to the relatively low rates of HIV infection, syphilis was more prevalent. Out of a total of 3886 individuals tested, 877 (22.6 per cent) tested positive for syphilis; this included 227 (56.8 per cent) of the 400 ‘floating’ sex workers included in the survey.

Previous ad hoc surveys carried out among suspected high-risk groups and random population samples confirm the currently low HIV-prevalence status of the country. Nationwide surveillance, based on opportunistic sampling from 1989 to 1996 found a prevalence of 0.1 per cent HIV seropositives among more than 70 000 individuals tested. Results from a 1997 seroprevalence survey among commercial sex workers in Dhaka found no infected women among 296 who were tested.

In the same year, two population-based surveys – one urban and one rural (S. Hawkes, L. Morison, J. Chakraborty, D. Brown, A. de Francisco and D. Mabey, unpublished data) – also did not identify any HIV-infected persons among 2500 individuals screened.

None the less, Bangladesh is considered to be at risk from a large-scale HIV epidemic as a result of the existence of a variety of risk factors known from other countries to promote the spread of HIV. Whether the current low prevalence is a consequence of a failure to detect a more widespread epidemic or lack of spread of the virus is currently uncertain.

Populations at risk
Inasmuch as HIV is increasingly seen as a disease associated with poverty, the population at risk in Bangladesh is potentially huge. Bangladesh ranks among the poorest of the world’s low-income countries. With a high population density and low GNP per capita (US$260), Bangladesh is near the bottom of most league tables ranking global development indicators such as income levels, literacy, status of women, nutritional levels and health indices such as infant or maternal mortality. The scale of challenges faced by health planners, service providers and those who promote behaviour change cannot be underestimated.

Factors that put the population at particular risk of a large-scale HIV epidemic include the following.

1. A mobile population. Bangladesh, like many low-income
countries, has a highly mobile population. Migration is internal, from rural areas to the cities, or external, to work in the countries of south-east Asia or the Gulf states, predominantly as manual labourers. It is estimated that more than 165 000 men leave Bangladesh each year to work abroad.9 Such migration patterns can lead to sex ratio imbalances in both cities and rural areas.10 This arises predominantly as a result of differential paid employment opportunities for men and women, and may be encouraged by restrictive employment practices, high urban rents and lack of social support for women living without their families.

2. Proximity to areas of higher HIV prevalence. Bangladesh is bordered by the north-east states of India and by Burma. Both neighbouring countries have higher reported levels of HIV infection, especially associated with injecting drug use.11

3. Drug use. Through its major sea port of Chittagong, which is geographically close to Burma, Bangladesh serves as a transit point for drug trafficking from the ‘Golden Triangle’ area of opium or heroin production. A rapid assessment conducted in six cities of Bangladesh by CARE, Bangladesh, estimated a current population of 25 000 IDUs (C. Jenkins, unpublished data). Needle exchange programmes are in their infancy and currently operate only in Dhaka.

4. Commercial sex. For many of the reasons highlighted above, Bangladesh supports a large commercial sex industry. It has been estimated that between 100 000 and 1 million women, men and children sell sex either in brothels or as ‘floating’ prostitutes.2,12,13 A survey of sexual behaviour among men in a rural population found that one-fifth of all men and one-third of unmarried men, reported paying for commercial sex at least once in their lifetime.14 Protection against infection is low, with only 6 per cent of female sex workers reporting condom use during their last commercial sexual encounter.12 None the less, the few surveys and serosurveillance undertaken among sex workers have found infection to be at very low levels or absent.2–4

5. Changing social norms. Increasing urbanization and the pervasive process of ‘globalization’ are leading to a relaxation of previously strongly held social and cultural taboos and restraints that may have contributed significantly to controlling sexual behaviour patterns in the past.

6. Status of women. Bangladesh is a predominantly Muslim, relatively conservative society with a predominance of male-dominated socio-cultural traditions and practices. Such structures and attitudes can result in an inequality in marital relationships, leaving many women without power to either challenge their husbands or partners on the issue of multiple sexual relationships or insist on the use of safer sexual practices.

7. Barriers to treatment of sexually transmitted diseases. The link between HIV and other STDs is exacerbated in Bangladesh because of the paucity of effective and affordable treatment options. This is compounded by a situation in which the symptoms of reproductive tract infections and STDs are associated with a sense of shame and embarrassment, especially among women. Care from a qualified practitioner is not sought for a number of reasons: fear of stigmatization; a lack of privacy or confidentiality; prohibitive opportunity costs in terms of travel, lost work time or treatment costs, including consultation fees, laboratory fees or drug charges. Furthermore, there is a documented problem with drug resistant strains of some sexually transmitted pathogens, which make the costs of effective treatment even higher.15,16

Given the large number of known risk factors and at-risk situations, and the high levels of reported risky behaviours, it is surprising that Bangladesh has not to date experienced a major HIV epidemic. Perhaps some of the credit for this can be taken jointly by all those involved in HIV–AIDS prevention and management.

The government’s response

The response of the Government of Bangladesh (GOB) to the potential HIV epidemic pre-empted the first documented detection of HIV infection in the country by at least 5 years. The National AIDS Committee (NAC) was established in 1984, and the first recorded HIV positive case was not until 1989. In the interim, the Government set out its plans to curb the potential spread of the anticipated epidemic with short- and medium-term plans.

The most recent government initiatives are outlined in the National Policy on HIV and STDs, published in 1996.17 This document represents the work of an inclusive process of consultation and discussion among a variety of interested parties. During 1996, the NAC convened a series of consultative meetings and workshops with stakeholders from non-government organizations (NGOs), donor organizations, research institutions and service providers. The policies developed are very much in line with agreed international norms and standards for the prevention and management of HIV. For example, the Government declared its support for the protection of human rights of people with HIV–AIDS, including anti-discrimination issues, legislation to protect the blood supply and removal of any restrictions on the dissemination of full and accurate information about prevention. Such declarations of working principles for HIV policy enactment carry far-reaching implications in a society that is generally conservative and defers to the norms and values of prevailing religious groups. The declared policies also carry obvious financial implications for a public sector that currently spends less than US$4 per capita per annum on health care.18

Prevention efforts in the Government sector have concentrated predominantly on the development of a Behavioural Change Communication Strategy and ensuring the safety of the
blood supply. Seventy-nine centres have been identified and their infrastructure is being developed in terms of both equipment and training of staff. Blood for transfusion is obtained from both commercial and voluntary sources, although the exact contribution from each is currently unknown. Although blood and blood products in theory should be screened for a variety of infectious disease agents, the extent to which this has been implemented at a local level is currently unknown. Given the synergistic relationship between HIV and other STDs, the Government is committed to improving the standard of STD management as a tool for reducing HIV transmission. However, the exact methods for doing this are unclear – the widely recommended tool of syndromic management for management of symptomatic women is effective in treating STDs, but its low specificity generates relatively high costs. As such it has been unfavourably evaluated in a number of different situations in Bangladesh.19–21

A major Government success in the 1980s and 1990s has been the family planning programme. This is recognized worldwide as achieving total fertility reduction through the provision of acceptable choices for contraception. In terms of preventing infection, however, the family planning programme may be a victim of its own contraceptive success. The most common contraceptive methods in use are hormonal methods and intrauterine devices (IUDs); only 3.9 per cent of couples choose condoms as their prime method of birth control.22 Persuading people to use dual methods is notoriously difficult, but condoms are still marketed as contraceptives rather than as a method of protection against HIV infection. Some success may be achieved through current campaigns to promote condom use among commercial sex workers.

The Government recognizes that care of HIV-infected people is likely to become a major burden on the health system if numbers rise. Along with the epidemic of HIV, there is recognition that the country faces a serious risk of a large increase in the already high incidence and prevalence of TB.17 A parallel strengthening of the TB control programme is currently under way in the country, but, apart from a recent ad hoc HIV survey among 1000 TB patients, there is no formal HIV component within the expanded TB programme. The exact impact of the Government’s response to the HIV–AIDS epidemic has been difficult to quantify. Whereas a number of interventions are currently in place and process measures are quantifiable, the outcome measures are more difficult to assess as comprehensive surveillance systems have only recently been put into place. Furthermore, the impact of one part of the health sector alone is difficult to measure, as there are many other key stakeholders involved in health care provision in Bangladesh.

The role of NGOs

There are more than 13 000 NGOs operating in Bangladesh. Many of them are small-scale and geographically localized, but the country also boasts some of the world’s most renowned NGOs, such as Grameen Bank and the Bangladesh Rural Advancement Committee (BRAC). The NGOs provide more than 6 per cent of health and population services,23 and in urban areas, are among the most innovative service providers in the field of reproductive health care. NGOs have traditionally worked with groups who are at greater risk of HIV or other STDs. There are excellent examples of interventions and services provided by organizations such as CARE, Bangladesh and Marie Stopes Clinic Society, for commercial sex workers, seamen, truck drivers and injecting drug users, all groups that may be considered ‘hard to reach’ as far as Government services are concerned.

Thus, any policies which deal with HIV prevention and care cannot overlook the central role of these service providers. The relationships between GOB and NGOs are generally good, with NGO representation on the NAC and GOB officials sitting on the NGO STD–AIDS network. None the less, NGOs and GOB cannot overlook the central role of these service providers. The Government is involved in creating an inventory of NGOs working on HIV.

The role of the private sector

For-profit health care provision exists in a variety of forms in Bangladesh, ranging from indigenous systems of medicine practitioners at village level, through untrained allopathic drug-sellers, to large-scale sophisticated private enterprises of allopathic medicine with access to a full range of diagnostic services and treatments. The last are, by their very nature, limited to all but the wealthy few. The former, especially the village practitioners, are in many cases the first site of health care for many people with reproductive health conditions – including STDs.14 The small number of HIV-positive people identified means that there is no information about sources of health care used by people with this condition. It can be reasonably assumed, however, that if HIV is similar to many other diseases, the private sector will be the first site of health care for most people. Anti-retroviral drugs can only be obtained with a prescription in Bangladesh. Given their high cost, they are prohibitively expensive for all but the wealthy few and payment for these drugs is usually determined on a case-by-case basis with donors being asked to contribute for those unable to afford this therapy.

The challenges for implementing Government policies on HIV–STD prevention and care in the private sector are clearly manifold. The NAC includes one member from the private sector, the President of the Bangladesh Private Practitioners Association, but the majority of for-profit practitioners are not represented and the ability of the Government to regulate this sector and enforce national policies currently is limited.

External agencies and their response to HIV–AIDS

No review of the HIV–AIDS situation in Bangladesh would be
complete without consideration of the role of external funding agencies – both multilateral and bilateral donors. These agencies finance approximately one-half of the budget in the health and population control sector, which includes HIV–AIDS activities. Given such financial leverage, these agencies can exert a large amount of influence on many of the Government’s activities in the sector. It is therefore surprising to realize that the total value of the UN agencies’ activities on HIV–AIDS in Bangladesh in 1997 amounted to no more than US$1.6 million. When compared with the funds disbursed by the major donors in the health sector of over US$140 million per annum, HIV–AIDS receives only a relatively small amount of funding given the potential impact of a spreading epidemic. This reflects the fact that HIV–AIDS has to compete in a funding environment with a myriad of other, more immediate threats to health.

Conclusions

Bangladesh is unique among the countries in South Asia in that it has most of the known risk factors for a large-scale HIV epidemic, but no evidence that such an epidemic is evolving. Policy endorsement for interventions against HIV has not been directly translated into a full programme of appropriate activities. Moreover, the ability of programmes to have a significant impact may be compromised by a number of socio-cultural and economic factors that underlie the structure of Bangladeshi society. True intersectoral intervention, which recognizes and tackles some of the economic, gender, educational and other inequalities that put so many people at risk of HIV in Bangladesh, and which provides adequate safeguards for their care through a multifaceted, regulated and adequately funded health care system, will further enhance the measures taken to date and could prevent a full-scale HIV epidemic in this country. To implement such profound changes will be a challenge.

References

22. Demographic and Health Survey of Bangladesh, 1996–1997. [reference to be completed by author at proof stage].

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