I. THE CURRENT SITUATION

Epidemiology

- No estimates of MSM and/or TG completed since 2004. (Reference: 28)

- In 2008, serological surveillance found that the HIV prevalence rate for male sex workers was 0.7%; 0.6% for hijras (TG) and 0.2% for MSM. For MSM, this was unchanged from the year before. In 2010, the prevalence rate for male sex workers was 0.3%; 0.3 for hijras and 0.0% for MSM. (22,28,34)

- The HIV prevalence among male sex workers was 7 times higher than the general prevalence rate of 0.1% in 2008 and 3 times higher in 2010; 6 times higher for hijras in 2008 and 3 times higher in 2010; and 2 times higher for MSM in 2008, with 2010 being recorded as 0.0%. (26,28,34)

- A study reported in 2008 found active syphilis among hijras to be 10.4%. (14,24)

Behaviour, Knowledge and Social Research relating to HIV

- In 2004, 78% of 200 MSM had had more than 10 male partners in the last month. 21% had had more than 51 male partners. (27)

- Anal sex is common among MSM in Bangladesh. Consecutive rounds of behavioural surveillance indicated 99% of male sex workers reported anal sex in the last week. BSS round 2 found that 99% was receptive, and 32% also insertive. In MSM, 41% had engaged in receptive anal sex and 72% in insertive anal sex in the past week. (3)

- The BSS round 2 found unprotected anal sex was reported by 81.6% of male sex workers in the last week. It also found that of all the anal sex acts in the past week among male sex workers, 44% were protected and 56% unprotected. 2.2% of hijra sex workers used condoms regularly with clients. (3,8)

- Condom use at last anal sex with a non-commercial male partner was 37% in 2005 and 24.3% in 2007. (25,33)

- Condom use at last anal sex with a commercial male partner was 49.2% in 2005 and 29.5% in 2007. (25,33)

- In 2008 and 2010, the government reported to UNGASS that 6.4% of MSM had been tested for HIV and knew the result in the last twelve months. (26,34)

- Also in the 2008 and 2010 UNGASS reports, 27% of MSM could correctly identify ways of preventing sexual transmission of HIV and rejected major misconceptions. (26,34)

- In 2008, 99% of hijra sex workers sold sex in the past week, but only 17% used condoms. Hijra sex workers also reported a high average number of clients – 30 in the last week. (14,30)

- Sexual relations and marriage to women are common among MSM and male sex workers in Bangladesh. (8,19)

Legal Situation and Law Enforcement Authorities

- Sex between males is illegal under Penal Code 1860 Section 377. This law is generally not enforced. (32)

- Sex work is illegal for males, but legal for females. (12)

- Harassment of both MSM and HIV outreach workers by law enforcement authorities has been documented. MSM report a history of police harassment, assault, rape and extortion. (5,32)

- The legal system has been classified as “prohibitive in high intensity” and “highly repressive” for MSM/TG in two UN legal reviews. (6,32)

MSM Community, other Social Research and Stigma/Discrimination

- There is very little published information about the MSM and TG community in Bangladesh.

- The societal pressure to marry, and the stigma and discrimination toward male-male sex is intense. (19,28)

- Very few MSM in Bangladesh use the Western “gay” identity. They more commonly identify as hijra (transgender), kothi (feminine and sometimes cross-dressing MSM), or as straight men. The kothi call the “straight” men who have sex with men panthi. (19)
II. THE RESPONSE TO HIV

Government Response

- There is no specific program line or budget line for MSM in the national strategic plan (NSP 2006-2010). (5,28)
- MSM are not listed as a “priority group”, although male-male sex is listed as a key risk factor for HIV transmission. (28)
- The current NSP ends in 2010. (28)
- Bangladesh has not yet received funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria in support of MSM and TG. (11,28)
- Bangladesh is part of the successful Naz Foundation International multi-country Round 9 proposal, focusing on South Asian countries. The focus in Bangladesh will be on strengthening the key MSM CBO, the Bandhu Social Welfare Society. (28)
- In 2008 and 2010, the government reported on all 5 of the UNGASS indicators directly relevant to MSM, however some data was carried over between reports. (1,34)
- In 2006, it was reported that there was no MSM-related leadership or spokespeople in Bangladesh. (5)

Community-based Response

- MSM are formally and informally organised, with CBOs and social networks. (5)
- Examples of MSM CBOs include the Bandhu Social Welfare Society has been working with MSM since 1997, and the gay-identified Associated for Health and Social Development. (19,31)
- Services conducted by MSM CBOs include: drop-in centres, counseling, education, training, outreach, community mobilization, condom and lubricant distribution, referrals, health services and VCT. (33)

Strategic Information

- In 2006, it was reported that there is ongoing research on MSM in Bangladesh. (5)
- The surveillance system includes MSM and male sex workers, and also includes behavioural surveillance. (5,16)

Health System

- Bandhu Social Welfare Society has twice-weekly STI clinics for MSM in its nine drop-in centres. (33)

National and International Networks

- Bangladesh is included in the South Asian MSM and AIDS Network. (28)

III. THE RESULTS

Coverage of HIV services

- In 2008 and 2010, the government reported to UNGASS that 8.1% of MSM were reached with HIV/AIDS prevention services, up from 0.66% in 2004. (34)
- In 2007, it was reported that there was 13% coverage. In 2002, the coverage rate in Dhaka was estimated to be 62%, which fell to 58% in 2004. In Sylhet, the estimated coverage rate increased from 90% in 2002 to 97% in 2004. (12,26,33)

Resource Estimation and Gaps

- In 2006, it was estimated that USD $23 million would be needed to achieve 60% coverage with peer education, outreach, VCT, and condom/lubricant distribution. (21)

Effectiveness of prevention efforts

- HIV interventions have been effective in Bangladesh. One study found 6% condom use at baseline, followed by 40-50% six months later. Another intervention with male sex workers increased condom use with new clients from 8.1% without exposure to the intervention to 61.7% if exposed to the intervention. There were also increases among MSM, although not as significant as with male sex workers. (8,33)
IV. RECOMMENDED RESPONSES

List of recommended actions

- Remove laws impeding effective HIV prevention, including laws prohibiting male-male sex and those affecting sex workers.

- The to-be developed National strategic plan 2011-2015 should include a costed comprehensive response for MSM and TG.

- More systematic and regular surveillance of HIV rates, risk behaviors and MSM communities.

- Fully fund prevention programs, including condom and lubricant provision, peer education and outreach, community development, mass media, and individual counseling.

- Develop the capacity of MSM community-based organizations to provide advocacy and peer-based programs.

- Scale up MSM-friendly VCT and sexual health screening centers.

- Expand care, treatment and support facilities for HIV-positive MSM and TG.

- Address stigma and discrimination toward PLHIV in MSM communities.

- Specific prevention activities should focus on transgender people.

V. REFERENCES

All references are available at:

www.apcom.org/snapshots2010.html

Contact details of UNAIDS office in Bangladesh are available at
