A Report on the Rapid Assessment of Human Rights-barriers to HIV and TB services in Bangladesh

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Disclaimer
Towards the operationalization of Strategic Objective 3(a) of the Global Fund Strategy, Investing to End Epidemics, 2017-2022, this paper was commissioned by the Global Fund to Fight AIDS, TB and Malaria. It is a working document for reflection and discussion with country stakeholders and technical partners and presents findings of research relevant to reducing human rights-related barriers to HIV and TB services and implementing a comprehensive programmatic response to such barriers. The views expressed in the paper. Do not necessarily reflect the views of the Global Fund.

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List of Acronyms

AAS	Ashar Alo Society
ACSM	Advocacy Communication and Social Mobilization
AIDS	Acquired Immune Deficiency Syndrome
APOSH	Ashokta Punarbashan Sangstha
ART	Antiretroviral Therapy
BCCM	Bangladesh Country Coordination Mechanism
BLAST	Bangladesh Legal Aid and Services Trust
BRAC	Bangladesh Rural Advancement Committee
BSWS	Bandhu Social Welfare Society
CBO	Community Based Organization
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CLM	Community Led Monitoring
CoC	Code of Conduct
CRG	Communities, Rights and Gender
DGHS	Directorate General of Health Services
DIC	Drop-In Centre
DLAC	District Legal Aid Office
DNC	Department of Narcotics
FGD	Focus Group Discussion
FJS	Foundation for a Just Society
FSW	Female Sex Workers
GBV	Gender Based Violence
GC-7	Grant Cycle -7
GF	Global Fund
GF-CCM	Global Fund Country Coordination Mechanism
HCV	Hepatitis C
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HTC	HIV Testing Centre
ICDDR'B	International Centre for Diarrheal Disease Research in Bangladesh
ICCPR	International Covenant on Civil and Political Rights
IPC	Infection Protection Control
KII	Key Informant Interview
KP	Key Population
KPI	Key Performance Indicator
LEA	Law Enforcement Agency
MBBS	Bachelor of Medicine and Bachelor of Surgery
MDF	Millennium Development Fund
MSM	Men who have Sex with Men
MSW	Male Sex Workers
NCA	Narcotics Control Act

NASP	National AIDS and STD Programme
NGO	Non-government organizations
NHRC	National Human Rights Commission
NID	National Identifications Card
NLASO	National Legal Aid Services Organization
NPUD	Network of People Who Use Drug
NSP	Needle Syringe Programs
NTF	National Task Force
NTP	National Tuberculosis Programme
OPD	Outpatients Department
OSCC	One Stop Crisis Centre
OST	Opioid substitution treatment
PE	Peer Educator
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	Peoples Living with HIV
PR	Principal Recipients
PrEP	Pre-exposure Prophylaxis
PWID	Peoples with Injectable Drugs
PWUD	Peoples Who Use Drugs
SEAH	Sexual Exploitation, Abuse and Harassment
SOGIEC	Sexual Orientation, Gender Identity, and Sexual Characteristics and Expression
SOP	Standard Operating Protocol
SR	Sub- recipients
SRHR	Sexual and Reproductive Health Rights
STD	Sexually Transmitted Disease
STI	Sexually transmitted Infections
SWIT	Sex Worker Implementation Tool
SWNB	Sex Workers Network of Bangladesh
TG	Transgender
TB	Tuberculosis
ToT	Training of Trainer
UHC	Universal Health Care
UN	United Nations
UNAIDS	United Nations AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Populations Activities
UNODC	United Nations Organizations for Drug Control
USD	United States Dollar
WHO	World Health Organization

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Executive Summary

Introduction

The Breaking Down Barriers Initiative aims to "*Reduce human rights barriers to services: # countries with comprehensive programs aimed at reducing human rights barriers to services in operation (Global Fund, 2016b)*." This KPI measures, "*the extent to which comprehensive programs are established to reduce human rights barriers to access*." These programs are considered "comprehensive" when the right programs are implemented for the right people in the right combination at the right level of investment to remove human rights-related barriers and increase access to HIV and TB services. The Global Fund has identified the following key areas where reducing human rights barriers will improve access to HIV and TB services:

- Stigma and discrimination reduction
- Training for health workers on human rights and medical ethics related to HIV and TB
- Sensitization of lawmakers and law enforcement agents
- Improved Legal literacy ("know your rights")
- Increased access to justice.
- Monitoring and reforming laws, regulations, and policies
- Reducing gender discrimination, harmful gender norms and violence against women & girls in all their diversity and
- Community mobilisation and advocacy for human rights

Additional program areas relevant to the removal of barriers in the context of TB include:

- Programs in prisons and other closed settings.

Based on criteria that included needs, opportunities, capacities and partnerships in the country, the Global Fund selected Bangladesh for intensive support to scale up programs to reduce barriers to services. This rapid assessment will provide critical; data to support the Government of Bangladesh to develop a national human rights strategy aimed at reducing barriers to HIV and TB services. Bangladesh will receive $1 million as a matching fund to reduce human rights-related barriers in HIV. This plan aims to support and complement efforts under the National Strategic Plan 2018-2023. The matching funds do not extend to the TB program.

Purpose, Scope and Methodology

The assessment serves to document and review the situation in relation to the current human rights and gender related programmatic responses being implemented across the country, aimed at reducing barriers to services for key populations. For the purpose of this assessment the main key populations in Bangladesh include female sex workers (FSW), people who use drugs and populations with diverse sexual orientation, gender identity, and sexual characteristics and expression (SOGIESC) such as men who have sex with men (MSM), male sex workers (MSW) and Transgender people/Hijra/Third Gender (TG). A baseline score to measure the increases in scale of programs to reduce human rights related barriers guided by KPIE1 has been established and will be reviewed annually to measure the progress. The assessment also recommends new, and/or scale up of existing human rights programming where gaps have been identified.

A national and international consultant were engaged to conduct the assessment. A thorough desk review was conducted as well as an in country field visit to speak to key stakeholders including government, non-government and community based organizations, key populations and other relevant stakeholders to understand the context, gaps, map existing programmatic interventions and provide recommendations for new programmatic opportunities and/or to scale up and strengthen existing programmes that could be used to scale up interventions and/or develop new human rights programs.

A ten day in country visit entailed visits to programmatic sites including community drop-in centres, government HIV Testing Centres and outreach activities. The consultants spoke with a total of 134 stakeholders including key Informant Interviews and Focus Group Discussions. A qualitative semi structured questionnaire was developed to capture the relevant information. Following data collection, the information received was reviewed, analysed and sorted for relevance and presented for discussion at a National Debrief meeting in Dhaka. A draft report was developed and circulated for review. Inputs, and comments which were incorporated into this final draft.

Limitations: There were a number of limitations to the assessment. Due to time constraints, it was not possible to speak to certain stakeholders including Departments of Narcotics Control, Police, and National Human Rights Commission. It was also not possible to speak with prison populations, clients of sex workers, migrants and those affected by TB. Further due to the rapid nature of this assessment, it is not a comprehensive report on the human rights situation for key population groups however it does capture a snapshot of the issues they face and provides some recommendations to address rights violations and areas to strengthen rights-based programming.

Overview

Since its first detection in 1989, Bangladesh has maintained a low prevalence of HIV in the general population. Prevalence among those aged between 15-49 is less than 0.1%. There were an estimated 14,513 people living with HIV in 2022[1]. One third of the 1,676 new case from 2021-2022 were identified in the general population, 18% in migrant workers and their partners and 13% found in populations forcibly displaced from Myanmar. The remainder were in MSM and PWID[2]. More men are HIV positive than women. Key population groups, MSM, TG, MSW, PWUD and FSW continue to experience comparatively higher rates of HIV transmission than the general population. These populations also share sexual and drug taking networks, exacerbating intra-population risk factors of HIV transmission[3].

In terms of achieving 95-95-95 cascade targets, according to data from 2022, the country has successfully diagnosed 67% of the estimated number of PLHIV, 77% of PLHIV diagnosed enrolled into ART treatment, and 90% of those enrolled on ART achieving an undetectable viral load. The implementation of solid HIV/AIDS and STI programming by the Government of Bangladesh since 1985 has substantially contributed to these results, with progressive expansion of the coverage of comprehensive HIV prevention, treatment and care packages to support those living with HIV/AIDs and those at risk over the last three decades. It should be noted that the National Strategic Plan on HIV/AIDs and STI includes a strong commitment to utilising human rights responses to the implementation of services in order to reduce vulnerabilities. It is also very reassuring to see that the Government of Bangladesh has recognised all KP groups in the National Strategic Plan to Address Gender Based Violence (GBV) for Bangladesh HIV and AIDS Response (2017-2021)[4]. The strategy acknowledges how gender inequalities and gender-based violence led to harmful practices that limit access to services, and opportunities and increase their vulnerability to HIV.

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[1] AIDS/STD Programme (ASP), *WORLD AIDS DAY 2022, HIV/AIDS Situation in Bangladesh.* 2022, Directorate General of Health Services (DGHS), Ministry of Health and Family Welfare, Govt. of the People's Republic of Bangladesh, December 01, 2022, http://asp.gov.bd/sites/default/files/files/asp.portal.gov.bd/page/c1685412_5b68_44dd_b68c_e1070527fb23/2022-12-05-04-03-971a19b963d88288f518ac2be5b720bd.pdf

[2] Ibid

[3] Gourab G, Khan MNM, Hasan AMR, Sarwar G, Irfan SD, Reza M.M, et al. (2019) The willingness to receive sexually transmitted infection services from public healthcare facilities among key populations at risk for human immune deficiency virus infection in Bangladesh: A qualitative study. PLoS ONE 14(9):e0221637.https://doi.org/10.1371/journal.pone.0221637

[4] National AIDS/STD Control Program (NASP) (2017). National Strategic Plan to Address Gender Based Violence. Ministry of Health and Family Welfare, Directorate General of Health Services, NASP.

NGOs and community-based organizations/self-help groups further provide essential HIV prevention services for key population groups. Principal Recipients (PR) of the Global Fund, International Centre for Diarrheal Disease Research in Bangladesh (ICDDR,B) and Save the Children (SCI) have been working with national NGOs, community based organisations and three National Key Population Networks representing PWUD, PLHIV and FSW (NPUD, PN+ and SWN respectively) to deliver a comprehensive package of HIV/AIDs and STI services through drop-in centres as well as integrated gender-based violence services, peer and outreach support, capacity building training on legal literacy, referrals to auxiliary services, advocacy and livelihood programs[5].

Yet despite this commitment, action to address rights violations is constrained by conservative religious beliefs and harmful gender norms that limit action to protect the rights of key populations who transgress the dominant societal heteronormative and patriarchal values that currently prevail across the country. These issues will be further explored in the next section on human rights barriers affecting each of the key population groups.

Findings: HIV and the Human Rights Context including Socio-Political and Legislative Barriers for Key Population

Female Sex Workers

In Bangladesh, there are currently no laws or statutes that regulate or prohibit sex work[6]. The Constitution of the People's Republic of Bangladesh, under section 18(2), provides that the State shall adopt effective measures to prevent prostitution and gambling. However, as long as the 'prostitute' is female and over the age of 18 it is permitted. Yet despite this ruling, sex workers face high levels of harassment and violence from police who often misuse and abuse laws on public order, public nuisance and trafficking to persecute sex workers. Sex workers participating in FGDs expressed having very limited **access to justice** including lack of free legal aid and complaints mechanisms or redress, hence even if they wanted to address rights violations, their means to do so are constrained.

Sex workers experience **stigma and discrimination** in many facets of their lives. Social exclusion, isolation, poverty and limited economic opportunities increase their vulnerability and limit their opportunities to progress socially and economically within society. Discussions during FGDs illustrated extensive societal and community-based discrimination; most sex workers stated they were unable to get their national ID cards, preventing them from accessing essential government services for example the CovidCovid-19 vaccine.

Within **health care** institutions FSW report high levels of stigma and discrimination including, refusal of services and poor-quality treatment. To mitigate this, sex workers do not readily disclose their identities. However, they are at times identified during medical history taking. At these times they state that they are spoken to badly or refused service. Most sex workers, join this profession due to extreme poverty. FSW experience high levels of **gender-based violence** with very limited access to justice, root causes are driven by gender inequalities, gender discrimination and patriarchal norms and traditions that promote and condone violence against those that do not conform to societal values and norms.

The Sex Workers Network of Bangladesh (SWNB) is a self-organised community-based organisation formed in 2000 to **mobilise their community and advocate** for greater rights protections and to

[5] This is not a comprehensive list of services provided by NGO's and CBO's but a snapshot to illustrate the diversity of support they provide to KP groups.

[6] Ibid

highlight the injustice, discrimination and rights violations experienced by Sex Workers in Bangladesh. During the FGD, SWNB stated they reach approximately 26,000 FSW and TG sex workers, through 29 CBOs representing local brothel and street-based sex workers.

People who use drugs

The use of illicit drugs is criminalised under the Narcotics Control Act (1990) which renders possession and use of illicit drugs punishable dependent on the type and quantity found. Penalties range from 6 months in jail, life imprisonment and the death penalty.[7] The Narcotics Control Act was revised again in 2018 alongside a Prime Ministerial declaration on the "*war on drugs"* promoting a punitive zero tolerance campaign further exacerbates the vulnerabilities of those who are using drugs. NSP and OST programs have, globally contributed to a reduction of the transmission of blood borne viruses.[8] However in countries where law enforcement agencies and public health agencies values are misaligned, PWUD are often detained on the basis of being in possession of injecting paraphernalia. During FGD discussion with PWUD, many stated that they were targets of harassment and arrested by police officers on the suspicion of holding injecting equipment, regardless of whether they also had drugs on their person. There are very limited resources that support **access to justice** when arrested with many PWUD have little knowledge of such services.

Given the nature of their 'undesirable' behaviour as per the dominant societal values, people who use drugs experience extensive **stigma and discrimination** from a wide variety of actors and institutions. During FGDs participants stated that they are reluctant to visit **health care** facilities, especially those that are Government based. This is largely due to a lack of quality care, denial of services and being ignored by hospital staff. Women are more likely than men to exchange or sell sex for drugs, they are less likely to attend NSP programs to access clean needles and syringes, they are more likely to share needles and the needles they use are less likely to be sterile which can lead to increases in abscess and staph infections[9]. There was very limited information on the sexual and reproductive needs or services for women who use drugs and a lack of capacity around **gender sensitive service provision** and an understanding of their programmatic needs by service providers both CBO and Government services.

The Network of People Who Use Drug (NPUD) in Bangladesh is the apex network providing a number of services and trainings to a wide variety of actors. Representing 17 CBOs across nine districts they have reached over 2,000 PWUD with skills development and livelihood training, advocacy with law enforcement agencies and peer based psychosocial support. Many of the current program implementation sites including DIC and OST sites are being operated collaboratively by **community-based organisations**.

Men who have sex with men

The current legal and policy environment for men who have sex with men is punitive and punishing. In Bangladesh, same sex activity is criminalised under Unnatural Offences; Section 377, Penal Code 1860 prohibiting "*carnal knowledge against the order of nature*". Rarely enforced, this law has been used to harass, extort and justify violence against men who have sex with men and other gender and sexual minorities. Men who have sex with men have limited **access to justice** when their rights are violated as they are unable to go to the police for fear of arrest and harassment.

Considered immoral, vectors of disease, and criminals, they experience **stigma and discrimination** from all facets of society, family, community and employers. Stigma and discrimination and potential legal repercussions lead this population to hide their identity and their behaviours, this can

[7] https://www.hri.global/files/2019/06/24/submission-committee-torture-bangladesh-drug-policy.pdf
[8] NASP 2016; National Harm Reduction Strategy 2017-2021
[9] Ibid

contribute to reduced access to appropriate health care interventions including access to condoms, lubricant, HTS and STI testing and management.[10] The overarching constraints imposed by the legal environment leaves many MSM in fear of attending and **accessing health services**, especially government services. During FGD's most participants stated they did not disclose their identities to health care workers if they did not have too. Further when attending for general health concerns, participants stated that when they did disclose their identities, they were treated with disgust and shamed for their behavior.

In Bangladesh there is a denial of same sex sexualities largely due to religious conservatism. These conservative beliefs also govern **sexual and gender norms** in society, and what is deemed appropriate behaviour for men and boys, women and girls to engage in. Due to norms of masculinity within Bangladeshi society, MSM are also often married or have female sexual partners. This can contribute to greater risks of HIV transmission for female sexual partners yet also has a fundamental impact on how societal expectations and norms curtail MSM's freedom of expression.

Bandhu Social Welfare Society is an example of an organisation leading peer-based **community advocacy** and programs for MSM and TG populations. Bandhu works across 50 districts with over 30 CBOs and partners with a reach of approximately 50,000 people. They implement programs with four key objectives: human rights, Health, Livelihood and Sustainability. Visibility is required for advocacy and social change, however both KIIs and the literature highlight that these organisations are frequently subjected to intimidation and death threats, online abuse and hate speech[11]. Despite this, they continue to organise and build their movement towards legal recognition and the right to live with dignity, free from violence and discrimination.

Hijra and Gender Diverse people (including transgender women, non-binary and intersex people) The Government of Bangladesh has accepted the Hijra Community as an accepted gender role in society. Given an almost mythological status in society, they are not considered as transgressors of gender norms but rather consider part of a holy caste with clearly defined roles and rituals performed during ceremonial events. Yet the definition of who fits within that category is obscure, and further continues to exclude people who identify beyond the hijra/third gender category. The lack of legal recognition and poorly defined legal frameworks designed to protect those with diverse gender identities leads to a lack of **access to justice** and redressal mechanisms when their rights are violated.

Hijra, third gender and transgender people experience high levels of **stigma and discrimination** from all facets of society, and due to exclusions from education and employment institutions, many work as sex workers to earn income. Hijra, Transgender people and those identifying in the third gender category, stated during FGDs that most doctors do not understand their biomedical needs as a gender diverse person. When they do go to Government **health centres** or MBBS doctors, they are examined as a curiosity, they are asked unnecessary and invasive questions about their gender identity, genitals and sexual history unrelated to the reason they attended. The lack of gender affirming health care services such as hormone therapy and gender affirming surgeries continues to drive this population towards self-medicating with hormones, which are often bought from the internet or pharmacies. During COVID those who did not have an NID, or who's NID photos did not match their gender and physical presentation were refused or denied the vaccine, leading to a great vulnerability to infection, poor health and outcomes.

[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10324373/

[11] https://static1.squarespace.com/static/5a84777f64b05fa9644483fe/t/60b5f55ce39ebd529578e968/1622538224862/Bangladesh+Country+Report_ILGA+Asia2021_opt2.pdf

The transgression of the gender norms and traditions in Bangladeshi society is the greatest driver of **gender based violence** towards this key population. Those who physically present in a way this does not match their gender prescribed at birth, are shunned from society, family and community.

It has only been a recent shift of the separation of trans and hijra issues with men who have sex with men. Transgender and hijra communities are starting to emerge from under the MSM **organising** space into their own, to advocate for their own distinct issues. Due to this, there is a need to improve the leadership and advocacy capacity of transgender/Hijra organisations to progress the movement forward.

PLHIV

In Bangladesh there are no HIV specific criminal laws and no general laws have been used to prosecute against the transmission of HIV. However similar to experiences of KP populations above there are also no specific laws that protect PLHIV from discrimination, which they face in education and employment institutions as well as from society in general. There is limited **access to justice** mechanisms and services including legal aid services and a reluctance to report violations as often there is a rightful perception that no one will be held accountable, and that the status quo will remain.

During FGDs and according to the last Stigma Index PLHIV face **stigma and discrimination** from all facets of society. This has a grave impact on their mental health and hinders access to health, disclosure of status and support services[12]. Self-stigma also impacts on their sense of worth in having a child (or additional children), they refrain from having an intimate relationship and for women it impacts on their desire to have sex[13].

In **health care institutions** during the FGDs PLHIV spoke about receiving inappropriate remarks and behaviour from health professionals. This was mostly the case outside of Anti-Retroviral Therapy (ART) and HTC centres. They stated that they usually speak to doctors at the ART centres for any health issues outside of HIV so as not to be exposed to negative and judgmental attitudes. A key issue for PLHIV is confidentiality and privacy. ART centres and HTC services especially in Government centres are clearly labelled as such and so when entering these facilities, they lose their privacy. For those living in rural areas, long distances to ART centres reduces the likelihood of follow up care.

While the country has progressed in terms of **gender equality** to some extent, pervasive conservative beliefs subjugating women in society deprive them of equality and equitable outcomes. Throughout the FGDs women participants bought up issues around a lack of attention to their sexual and reproductive health needs, family planning and adequate care, dignity and respect in the peri and post-natal period. The stigma Index highlights that women are more likely to have their HIV status disclosed by others without their consent.

The National PLHIV Network (NOP+), which recently got registration in the name of PN+, and Ashar Alo Society (AAS), are **community-based organizations** working at the national level to advocate for, empower and support those affected by HIV in Bangladesh. AAS provides essential training for PLHIV and health and policy stakeholders on a wider variety of issues including leadership and advocacy, carer support peer and policy-based ART training on treatment guidelines. They are essential actors in providing care, counselling, outreach and treatment support to people on ART, expanding

[12] 2017 Network of PLHIV (NOP+) Bangladesh: HIV/AIDS Related Stigma and Discrimination against PLHIV in Bangladesh: 2nd National Stigma Index, Bangladesh
[13] Ibid

treatment coverage, reducing loss to follow up, increasing adherence outcomes and providing psychosocial and mental health support to PLHIV.

Prison Populations

The Ministry of Home Affairs is responsible for the prison population in Bangladesh and management of prisons are governed by the Prisons Act of 1894. As of December 2022, there were 81,156 people reportedly in imprisoned across 68 prisons in the country, with 55 district prisons and 13 central prisons prison. The official capacity of the prisons in Bangladesh to hold 42,626 people – current occupancy level is 190.4%. Considered as centres of confinement, prisons are overcrowded, lack privacy and prisoners often experience inhuman and dehumanised treatment from prison officers. The National Legal Aid Services Organisation (NLASO) provides some legal aid support to prisoners who cannot afford private attorneys but access to these services is limited, burdened by extensive complex administrative requirements for eligibility. The extent to which the legal environment and **access to justice** impacts on those specifically living with or at risk of HIV is unknown as there is very limited data or research available that explores the experiences of KPs and PLHIV while they are imprisoned.

There is a dearth of information available on the experiences of **stigma and discrimination** within prison settings felt by KP and PLHIV in grey literature. It can be assumed that within such a closed setting and with limited access to information and knowledge on HIV and transmission those at risk or living with HIV may experience even higher levels of stigma and discrimination than those not imprisoned. With limited privacy and lack of appropriate accommodation the lack of privacy and confidentiality may also impact on the disclosure of their status.

Prison Directorate statistics does show that **health services** in prison settings are woefully underserviced and underfunded with up to 43 of 141 positions for prison doctors vacant across the country and only 5 doctors assigned to full time positions[14].There are currently HIV and STI testing services in 8 prisons in Bangladesh implemented in partnership with between MOHFW and Ministry of Home Affairs. This includes a medical technician to facilitate testing and a counsellor to provide information and consent. Since November 2022, 1879 prisoners have been tested for HIV with one positive result. HIV/Syphilis/TB/Hep C testing services have been initiated in seven prisons.

Through the work supported by organizations such as Dhaka Ahsania Mission (DAM), CARE Bangladesh and Khulna Mukti Seba Sangstha (KMSS) volunteer peer educators have been mobilized in prison settings to support with awareness raising activities on HIV and STI issues for prisoners. Volunteers mobilize their peers with symptoms to get tested, provide information on prevention, testing and treatment as well as psycho-social support[15]. However beyond this there are no formal networks of prisoners or ex-prisoners conducting **community mobilization or advocacy** activities.

Existing programs to address human rights-related barriers to HIV and New and Existing Opportunities to Scale Up

It was apparent that there are number of programs that currently exist to reduce human rights related barriers. It is also clear that over the decade's long implementation of HIV programming, these programs have made an impact in improving the human rights related environment. Existing programs were used to develop the baseline score tabulated below, required to measure to what extent existing programmes are reducing human rights and gender related barriers to accessing HIV services based on the eight key areas identified by the global fund.

[14] https://www.state.gov/reports/2022-country-reports-on-human-rights-practices/bangladesh/

[15] https://www.unodc.org/southasia/frontpage/2012/November/bangladesh_-promoting-hiv-prevention-in-prisons-a-critical-but-often-overlooked-initiative.html

Legal literacy ("know your rights"): All community-based networks had implemented some kind of know your rights training program. These programs are project based and dependant on continued funding. These programs inform individuals of their rights and educate them on how to exercise those rights – including how to claim their rights through the judicial system and what resources are available to them to do so. To what extent these trainings **Baseline Score: 2.3**

Ensuring rights-based law enforcement practices: A number of organizations convened law enforcement actors including police, department of narcotics control, prison officials, lawyers, judges and students to conduct sensitisation training on the experiences and needs of KPs. They also conducted advocacy from the local to the national level. For example from advocating to local police thana in-charge officers to uphold the rights of individuals in their Uppazilla's to advocating for the removal of punitive laws against drug use with the Department of Narcotics control. **Baseline Score: 2.6**

Improving laws, regulations and polices relating to HIV: At the national level the most comprehensive monitoring of laws, regulations and polices that occurs for Bangladesh at the national level is performed through the Country Progress Report periodically published by UNAIDS including for example, laws, regulations or policies specifying that HIV testing, viral load testing, criminalisation and/or persecution of KPs, what protections are in place for people living with or at risk of HIV to live free from violence. Other organisations have used international treaty and convention monitoring and reporting mechanisms such as CEDAW and the UPR to report on human rights violations. **Baseline Score: 2.6**

Eliminating Stigma and Discrimination in all Settings: There are a number of programs available on reducing stigma and discrimination that have had an overall impact on the reduction in harassment and abuse experienced by KP's as they themselves have acknowledged. They include, broad community sensitisation campaigns for example on Wordl AIDS day and/or International Day of Sex workers, they have also included programs to reduce self stigma and family stigma for PLHIV. Sensitization of Government Health Workers has also led to reduced discrimination at the health care setting. **Baseline Score: 2.6**

Community Mobilization and Advocacy for Human Rights: All the national and community-based networks are committed to capacitating their networks to build strong movements that are well governed, accountable to their beneficiaries and technically skilled. They are essential actors in empowering communities to build skills and knowledge to advocate for an enabling rights based environment. There are currently three National KP Networks, PLHIV, PWUD and SWN. MSM are represented by CBO's including Bandhu, Chinnamul Manab Kallyan Sanganstha and Badhon Hijra Shangha, Sustho Jibon to name a few. **Baseline Score: 2.6**

Overall Baseline Score for Human Rights Programming HIV	
Thematic Area	Score
Legal literacy ("know your rights")	2.3
Ensuring rights-based law enforcement practices	2.6
Improving laws, regulations and polices relating to HIV and HIV/TB	2.6
Eliminating stigma and discrimination in all settings	2.6
Ensuring non-discriminatory provision of health care	3
Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity	3
Community mobilization and advocacy for Human Rights	2.6
Overall Score	2.7

Suggested Recommendations:
The following list of suggested recommendations has been developed following stakeholder discussions and a review of the literature and where gaps have been identified beyond what has been programmed into GC7 proposal.

Suggested Recommendations			
Activity	**Purpose**	**Benefiting Stakeholder**	**Suggested Lead Implementer (supporting Implementer)**[16]
Overall Recommendations			
Develop an evidence based Human Rights Package of Services	There are a multitude of human rights programs being implemented across the country with little understanding of their efficacy or impact on the intended outcomes. This provides the opportunity to test a number of interventions across pilot and control sites to assess how effective human rights programs are in removing barriers. This will be either an RCT or quasi-experimental study design within the framework of implementation science. We propose to take a few districts to conduct this study. Findings of this study can support the formulation of a Human Rights Protocol Framework providing guidance on evidence-based effective and quality human rights-based programs to be scaled up across the country.	All	and All three PRs (Save the Children, icddr,b and ASP), DNC (MOHA)
Access to Justice			
Implement training for BCCM Members on Human Rights of KPs	To ensure that across the program cycle, at all levels, stakeholders are working from a human rights-based perspective.	BCCM	GF PR
Develop an updated assessment on HIV related policy frameworks	To enable better monitoring of laws and reforms	All	ASP
Implement community-led efforts to analyze, monitor, advocate against and reform harmful laws and policies	Empowering community networks to increase their role in monitoring human rights and advocating for reforming	KP and KP Networks	KP community networks
Develop a coordination mechanism to oversee efforts to improve the national legal environment to better support the national AIDS response	In order to coordinate efforts from reviewing laws, policies and reforms and work undertaken by community networks to monitor human rights violations, a coordination committee mechanism can facilitate the adoption of specific and critical areas of advocacy to undertake.	All	ASP, Community Networks, PRs
Eliminating stigma and discrimination in all settings			

[16] This section has been agreed to with consensus during the circulation of the report to all relevant stakeholders.

Engaging religious leaders through trainings and workshops to lead positive messaging for KPs	Training religious leaders in human rights can further enable them to mitigate negative perceptions of these groups and improve societal perceptions and reduce community related rights violations experienced by KPs	All KP and society	NASP (KP CBOs)
Implement human rights sensitisation and training on HIV education with employers and in workplaces to reform or instate policies that provide an enabling work place for people living with or at risk of HIV to work free from stigma and discrimination	Improve the employability of PLHIV as well as minimise negative experiences often faced by KPs. Encouraging workplaces to implement a no tolerance policy of discrimination to include KPs and PLHIV can create an enabling environment.	KPs and employees	NASP + Ministry of Labour
Provide training to workers on their rights within the workplace and tools and services for redress.	Improve the understanding of PLHIV workers to know their rights and facilitate access to legal aid services when rights are violated	workers	Unions and Ministry of Labour
Design a Social Media Campaign to reduce stigma and discrimination	Develop a social media campaign to increase coverage of stigma reduction messages and combat discriminatory attitudes	Society	GF PR's
Improve access to information on the stigma and discrimination of KPs and PLHIV in prison settings through an exploratory study	There is a dearth of information on the stigma and discrimination experiences of KPs and PLHIV within prison settings. A greater understanding of their needs may increase HIV and STI testing.	Prison populations	ASP, Ministry of Home Affairs, UNODC
Non-discriminatory Provision of Health care			
Develop a cadre of peer mental health counsellors to provide support and counselling to affected populations as wella s monitor the impact of stigma and discrimination impacting on KPs	As first responders this will improve their skills in providing much needed mental health support but also improve outcomes for KP's. Peer mental Health Counsellors to be employed at integration sites.	Peer outreach workers	ASP and relevant CBO's
Organize a national workshop on Gender, Human Rights and Drug use	To increase the understanding of how gender intersects with drug use and how gender related vulnerabilities exacerbate human rights violations.	PWUD, FSW	NPUD and SWN In collaboration with ASP and Save the Children
Monitoring of the implementation of confidentiality and privacy procedures across all hospital	Implement policies and procedures that improve confidentiality and privacy of services administered in government health centres; ambiguous name for HTC clinic, ensure names of patients remain confidential and not	Health Care Workers	NASP

settings	accessible, ensure results are delivered in private rooms, ensure no patients results are shared without their consent.		
Conduct regular attitudinal assessments on health care providers (both within HIV/ART settings and beyond)	To gain an understanding of the effectiveness of stigma and discrimination training and to use the results to adapt training as required.	Health Care Workers	KP Networks and ASP
Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity			
Scale up the Ain Alap hotline implemented by BSWS and program for all KP groups	Expand the number and coverage of panel lawyers to support all KPs experiencing GBV access to recourse.	All KP	Bandhu (KP Networks)
Expand the GBV data base implemented by ICDDR, B	To capture all KP related GBV cases and actions to improve data collection on the experiences of GBV (frequency, type), design of appropriate needs-based programs and impactful implementation.	All KP	ICDDR, B
Improve on sensitisation and training programs for law enforcement actors that reduce GBV against sex workers	Implement awareness campaigns and training for police, lawyers and other law enforcement actors to raise awareness on this issue and mechanism to support them in holding perpetrators accountable would benefit their well-being and safety.	Sex workers	SWN
Undertake a gender assessment related to the needs of women drug users	To better understand how services can improve access to services and health seeking behaviour of women who use drugs.	Women PWUD	NPUD and SWN in collaboration with Save the Children and ASP
Sensitisation and training on stigma and discrimination reduction for obstetrics and gynaecological specialists and health care workers in Maternity Unit wards	To improve pre and post ante natal care and delivery services for pregnant women and their partners	Women KPs	ASP (STC)
Exploratory study on the experiences of women KPs and gender diverse people in prison settings	Policymakers and prison authorities should understand the needs of women and transgender people and incorporate the proposed evidence- and human rights-based interventions and international standards into their prison policies and strategies, applying them to all people in prison.		
Implement training to increase the understanding of prison officials and employees on gender related barriers and gender related vulnerabilities	There is a dearth of information available on the needs of women and gender diverse prisoners and the gender related vulnerabilities both within the prison system and once released. Prisoners and prison officials should be capacitated to implement gender sensitive programming for this population.	Women and gender diverse prisoner; program developers	ASP, Bandhu, Save the Children, ICDDRB
Establish a crisis	Particularly in government health care services	Victims of	ASP and

response mechanisms to prevent and respond to abuse, including gender-based violence.	to establish a mechanism to address and respond to GBV incidents for KP's through strengthened collaboration with the Department of Women's Affairs to strengthen linkages with OSCC on site.	GBV	Department of Women's Affairs
Community mobilisation and advocacy for human rights			
Providing core support to community-led organizations for recruitment, training, management and monitoring and evaluation activities relating to human rights goals	In order for community based organisations to exist and operate effectively it is essential they are adequately financially supported with staff and resources to undertake activities	CBO's	Donors
Implement a small grants program for nascent and grass roots organisations to mobilise KP constituents and implement human rights programming. This program should also include organisational development and governance training.	Building the capacity of nascent and grass roots organisations is essential to sustain and grow the movement. Often unregistered organisations due to their lack of capacity, means and opportunity to apply for government registration and funding, small grants provide a stepping stone towards 'legitimisation' to access further funding	Nascent and grass roots CBOs	Donor and PRs

Overview of the context for the Tuberculosis epidemic and key affected populations

Implemented under the auspice of the National Tuberculosis Program (NTP), an Essential Package of Services is delivered across each level of government infrastructure, from National level to the ward level. Committed to the End TB Strategy the Government of Bangladesh's National Strategic Plan for TB Control 2021 -2025 will continue its successful strategy to maintain sustained treatment success rates over 90% since 2005 and reaching 95% in 2018. Yet while treatment rates are high, case detection rates require further efforts with only 75% detected in 2018[17]. With Bangladesh having the 7th highest burden of TB cases globally, the country is committed to investing in and scaling up programmes to End TB.

Under the Global Fund program NTP partnering with BRAC have increased efforts to expand reach. This has improved though screening across prisons, slums, areas with high migratory populations, and other high-risk groups workplace- areas with high concentrations of informal sector workers. National data shows that 11% of registered TB patients in the country are coinfected with HIV[18]. There are currently limited programming efforts for systematic screening for TB in HIV related Key Populations, with the Government of Bangladesh keen to scale up efforts[19]. NTP and BRAC are working with the Global Fund Community Rights and Gender team to develop an action plan to scale-up community-based and community-led monitoring, additional human rights education, and advocacy activities.

[17] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7509970/
[18] https://www.ntp.gov.bd/wp-content/uploads/2021/07/21-TB-HIVGuidelines-2nd-edition.pdf
[19] Ibid

Findings: TB and the Human Rights Context including Socio Political and Legislative Barriers for Key Population

Legal Environment and Access to Justice

Despite constitutional protections available for all Bangladeshi citizens against discrimination, those living with TB have few resources available in terms of **access to justice**, including lack of financial means, access to lawyers or legal aid nor the time to deal with long delays due to administrative and bureaucratic complexities of the Bangladeshi court systems. In 2018 a legal environment assessment was conducted jointly with UNOPS, BRAC and Stop TB partnership with a comprehensive overview of the various policies and laws relevant to TB affected populations and how they are or are not applied to the TB context. What it found was that while policies exist, there is a lack of awareness and systematic documentation on the violations experienced by people affected by TB.

KII's with stakeholders highlighted a significant reduction in **stigma and discrimination** faced by people living in TB largely due to systematic mass awareness campaigns conducted by government and non-government actors. Examples of stigma experienced by TB positive patients include isolation from community functions, gossip by neighbours, families were separating utensils, bedding, and clothing of the affected person from others in the household, divorce and separation of married couples, and the eligibility of unmarried women was impacted.

With the expansion of the DOTS community health worker model, health active case finding and referral for diagnostic confirmation has improved awareness and reduced barriers to services, yet for those 20% missing cases, it is reported both in KII's and through the literature that they may see a 'local' (non MBBS) doctor or self-medicate; procuring (ineffective) medicine from pharmacies. The hesitation to attend **health care facilities** is largely centred around the fear of a positive result and the ensuing stigma and discrimination they anticipate experiencing. There is also fear that their privacy and confidentiality will be breached. This results in people travelling further afield for their treatment rather than in locations closer to them, increasing the time and cost of treatment as well as adherence[20].

There is a high burden of risk on women, including their predominance in being employed in garment factories- often migrating to urban settings from rural areas, as health care workers in hospital settings treating TB positive patients, lack of adequate women friendly service points in many of the areas where TB is of concern and victims of conservative and traditional **gender** norms that limit their independent access to places outside of the home.

Unlike in the HIV space, there are no structured **community-based networks** for TB populations. On an ad hoc basis there are people who participate in the local courtyard meetings held to raise awareness and reduce stigma and others who participate in the multi stakeholder ward meetings however this does not occur systematically.

Existing programs to address human rights-related barriers to TB

There are very limited know your rights programming for TB populations. The most notable would be around educating employers and employees on their rights in relation to unfair dismissal, health insurance, access to sick leave. This has led to promising work with garment factory unions with a reach of 80,000 garment workers and factory owners who have supported TB positive staff to take 14 days paid sick leave and job protections following treatment[21]. BRAC is planning to scale up this

[20] https://assets.publishing.service.gov.uk/media/57a08b69ed915d3cfd000cd8/60425_TB-related_stigma_in_Asia_Bangladesh_1_.pdf

[21] https://stoptb.org/assets/documents/communities/CRG/TB%20CRG%20Assessment%20Bangladesh.pdf

initiative amongst other employer groups and unions such as transport, and brickfield employees. **Baseline Score: 2.6.**

Ensuring rights-based law enforcement practices: There are currently no TB specific programs being implemented to ensure law enforcement practices as identified during the rapid assessment process. This may be due to a lack of information and understanding of the issues people living with TB may face when they interact with law enforcement agencies. **Baseline Score: - 0**

Improving laws, regulations and polices relating to HIV and HIV/TB: In 2018 UNOPS, BRAC and the Stop TB Partnership undertook a Community Rights and Gender Assessment in Bangladesh[22]. As part of this assessment, a Legal Environment Assessment (LEA) was conducted to evaluate the government response and commitment to enforce and/or increase legal and policy protections that foster an enabling environment aimed at reducing the vulnerability of TB affected populations and their families. **Baseline Score**: **1.0**

Eliminating stigma and discrimination in all settings: As stated by those by KII participants, mass awareness programs over the years have overall reduced stigma and discrimination towards TB affected populations. Courtyard meetings held by community health workers to raise awareness and sensitise communities has also contributed to reduced harassment and gossip at the community level.
Community health workers involved in active case finding further conduct their activities in a manner that reduces self-stigma and creates a supportive environment that propels people to access TB treatment and care services. **Baseline Score: 3.**

Ensuring non-discriminatory provision of health care: At the National level, NTP implements training for health workers on clinical management of TB including treatment and adherence and communication skills on information on TB and transmission, yet these trainings do not explicitly address human rights. Due to time constraints additional information was not available. **Baseline Score: 1.0**

Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity: No formal standalone programs were identified during the discussion with stakeholders, however efforts are made during the courtyard meetings and by community health workers to ensure sensitisation and outreach activities are convenient for women. Some efforts have been made to create 'women friendly spaces' by ensuring more female health workers[23] however how this has supported an increase in women seeking health services is unclear. **Baseline Score**: **2.0**

Existing programs on Community mobilization and advocacy for Human Rights
There are currently no programs that facilitate the community mobilisation and movement building for advocacy for TB affected populations. **Baseline Score: 0**

Overall Baseline Score for Human Rights Programming TB	
Thematic Area	**Score**
Legal literacy ("know your rights")	2.6
Ensuring rights-based law enforcement practices	0
Improving laws, regulations and polices relating to HIV and HIV/TB	1.0

[22] https://stoptb.org/assets/documents/communities/CRG/TB%20CRG%20Assessment%20Bangladesh.pdf
[23] https://www.stoptb.org/sites/default/files/bangladesh_3.pdf

Eliminating stigma and discrimination in all settings	3.3
Ensuring non-discriminatory provision of health care	1.0
Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity	2
Community mobilization and advocacy for Human Rights	0
Overall Score	**1.4**

Suggested recommendations

These suggested recommendations go beyond the CRG Action Plan. Again similar to the Action Plan, there is currently no allocation of funds for these activities. It will be essential for program implementers to mobilize funds in order to improve huma rights programming under the TB program.

Suggested Recommendations			
Activity	**Purpose**	**Benefiting Stakeholder**	**Suggested Lead Implementer (supporting Implementer)**[24]
Access to Justice			
Implementation of a hotline and other rapid response mechanisms in cases of TB-related rights violations.	This will increase TB affected peoples access to justice when their rights are violated, including access to information on how to proceed and where to seek support	TB affected people	NTP, Brac, NLAOS
Advocacy for non-custodial alternatives for non-violent offenses and pretrial periods to reduce overcrowding.	Given that most prisoners are in jail on remand awaiting trial, consideration of non-violent offenders who are TB positive to be released home until trial to reduce the transmission of TB within prison settings and to enable better treatment outcomes.	TB affected populations, prison populations	NTP, Ministry of Home Affairs
A review of policies including employment, insurance, education, prisons, refugee and social security that impact access to TB services amongst people who are affected by TB will be undertake with a specific analysis on each of the focus key populations.	Undertake an annual review of laws, policies and reforms impacting on people affected by TB to track progress or lack thereof	All	NTP, Brac
Eliminating stigma and discrimination in all settings			
Establish, strengthen and support health committees led by members of the community and health facility leadership	Improve coordination between affected people and health care facilities by establishing health committees to ensure service delivery is accessible, cost effective and of quality.	Health facility leadership, TB affected populations	NTP and Brac

[24] This section has been agreed to with consensus during the circulation of the report to all relevant stakeholders.

Teachers of educational institutions will be oriented on TB services as well as human rights and gender principles, which will eventually reduce the stigma and increase the case detection including child TB.	Improve understanding of TB and transmission for teachers and officials in education institutions to facilitate greater awareness amongst young people as well as case detection amongst children and to do so without fuelling stigma and discrimination	Teachers, students, young people affected by TB	NTP, Teachers associations, Ministry of Education
Non-discriminatory Provision of Health care			
Existing recommendations under the CRG Action Plan are adequate			
Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity			
Community consultations to identify specific gender-related barriers to accessing TB. services.	There is limited evidence of the gender related experiences of women, girls and gender diverse populations affected by TB, this can impact on the level of gender sensitive activities implemented across the program. Engaging women, girls and gender diverse people in community consultations can improve access to TB programs	Women, girls, gender diverse people	NTP, Brac, Bandhu
Empowering women's groups to raise awareness of TB-related rights and monitor violations.	Working closely with women's organisations to improve coverage of awareness of TB amongst women and related rights violations. This can also support monitoring of rights violations against women to gain a better understanding of *what* rights are violated and what level of access to justice they have.	Women	Brac and women's organsistions
Community mobilisation and advocacy for human rights			
Support CBOs and TB affected communities to advocate and mobilize resources or provide small grants to support financial, nutritional, psychological and mental health support for people with TB and their families, particularly through government social protection schemes and corporate social responsibility programs where possible.	Empowering CBOs with the skills to mobilize resources or providing small grants ensures the needs as defined by the community can be met. Further improving their knowledge of social protection schemes and the mechanisms in which to access can also ensure the TB affected populations are able to avail themselves of government benefits.	TB CBO's	Brac
Engagement of prisoner leadership on peer-led TB activities and stigma and violence reduction efforts, including building capacity of peer educators.	Developing a prison-based leadership group of TB affected prisons can support the implementation of awareness raising opportunities, mobilization and psycho-social support	Prisoners	Brac

Background – Overview of Breaking down Barriers.

Since the adoption of the Strategy 2017-2022: Investing to End Epidemics, the Global Fund has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programmes to remove such barriers in national responses to HIV, TB and malaria (Global Fund, 2016a). This effort is grounded in Strategic Objective 3 which commits the Global Fund to: "introduce and scale up programs that remove human rights barriers to accessing HIV, TB and malaria services"; and, to "scale-up programs to support women and girls, including programs to advance sexual and reproductive health and rights and investing to reduce health inequities, including gender-related disparities."

The Global Fund has recognized that programmes to remove human rights and gender-related barriers are an essential means by which to increase the effectiveness of Global Fund grants as they help to ensure that health services reach those most affected by the three diseases. The Global Fund is working closely with countries, UNAIDS, WHO, UNDP, Stop TB, PEPFAR and other bilateral agencies and donors to operationalize this Strategic Objective.

Though the Global Fund will support all countries to scale up programs to remove barriers to health services, it is providing intensive support in 20 countries in the context of its corporate Key Performance Indicator (KPI) 9: "*Reduce human rights barriers to services: # countries with comprehensive programs aimed at reducing human rights barriers to services in operation (Global Fund, 2016b)*." This KPI measures, "*the extent to which comprehensive programs are established to reduce human rights barriers to access*." These programs are considered "comprehensive" when the right programs are implemented for the right people in the right combination at the right level of investment to remove human rights-related barriers and increase access to HIV and TB services. The Global Fund has identified the following key areas where reducing human rights barriers will improve access to HIV and TB services:

- Stigma and discrimination reduction
- Training for health workers on human rights and medical ethics related to HIV and TB
- Sensitization of lawmakers and law enforcement agents
- Improved Legal literacy ("know your rights")
- Increased access to justice.
- Monitoring and reforming laws, regulations, and policies
- Reducing gender discrimination, harmful gender norms and violence against women & girls in all their diversity and
- Community mobilisation and advocacy for human rights

Additional program areas relevant to the removal of barriers in the context of TB include:

- Programs in prisons and other closed settings.

Based on criteria that included needs, opportunities, capacities and partnerships in the country, the Global Fund has selected Bangladesh for intensive support to scale up programs to reduce barriers to services. This rapid assessment will provide critical; data to support the Government of Bangladesh to develop a national human rights strategy aimed at reducing barriers to HIV and TB services. Bangladesh will receive $1 million as a matching fund to reduce human rights-related barriers in HIV. This plan aims to support and complement efforts under the National Strategic Plan 2018-2023. The matching funds do not extend to the TB program.

Purpose, scope of work, and expected outcomes of the Baseline Assessment

The assessment serves to document and review the current situation in relation to the current human rights and gender related programmatic responses being implemented across the country, aimed at reducing barriers to services for key populations. For the purpose of this assessment the main key populations in Bangladesh include female sex workers (FSW), people who use drugs and populations with diverse sexual orientation, gender identity, and sexual characteristics and expression (SOGIESC) such as men who have sex with men (MSM), male sex workers (MSW) and Transgender people/Hijra/Third Gender (TG). A baseline score to measure the increases in scale of programs to reduce human rights related barriers guided by KPIE1 has been established and will be reviewed annually to measure the progress. The assessment also recommends new, and/or scale up of existing human rights programming where gaps have been identified. These recommendations will be used subsequently to develop a key population's human rights strategy and costed implementation plan. As part of the assessment, a team comprised of an international and national consultant were tasked to:

1. Conduct a thorough desk review of relevant grant documents and previous assessments/studies conducted that review and assess the current human rights landscape impacting on people living with HIV and TB
2. Map existing programmatic responses implemented to reduce barriers to services for people living with HIV and TB, including key implementers, target populations, geographic reach, implementation modalities, funders, and delivery modalities (integrated or stand-alone); this should also include a cross cutting gender analysis- including programmatic responses.
3. Rapidly assess current performance and progress in removing human rights and gender related barriers to services for people living with HIV and TB and capacity needs of implementers (e.g., Principal Recipient(s) and Sub-recipients (SRs) who are expected to implement human rights responses.
4. Use the data to populate the baseline component of the KPI E1 Scale up to address Human Rights related barriers Scorecard that will be used annually to measure progress on the increase in scale up of programs.
5. Provide recommendations for new programmatic opportunities and/or to scale up and strengthen existing programmes and support relevant stakeholders in removing bottlenecks, in order to increase synergies, results and impacts over the strategy period.

Methodology

The methodology undertaken to achieve this includes a mixed methods approach.

Desk Review: A thorough desk-based literature review was undertaken to develop a detailed understanding of the socio-legal and political context for HIV and TB related human rights situation and programming aimed at removing human rights related barriers. This was done though internet-based research as well as request for relevant documents from stakeholders involved in implementing programming HIV and TB services in Bangladesh. Documents reviewed are included in the Reference list in Annex 1.

Development and finalisations of Data Collection Tools: Data collection tools were developed based on available standardised qualitative questionnaire sets with the inclusion of questions relevant for the local context. The tools were circulated for review, comments and suggestions, validated and finalised for use. A stakeholder list was developed by in-country partners including primary recipients (PR), sub recipients (SR), implementing organisations Community Based Organisations (CBO), Key Population Networks, Development Partners and Government Administrators and Public Health Officers. These can be found in Annex 2.

Field data collection: Data collection in the field began in last week of July by the national consultant and from the 31st of July to the 9th of August 2023 with both national consultant and international consultant. A stakeholder list was provided by NASP and the national consultant, with NASP staff, developed a schedule of interviews including field visits to Rajshahi, Jashore and Chattogram as well as data collection in Dhaka. During this time the team spoke with 134 stakeholders: 32 KII and FGDs with 102 people. This helped to develop an understanding of the current human rights context, barriers and enabling factors experienced by people living with or at risk of HIV and TB, current programmatic responses, gaps and opportunities for scale up. List of Stakeholders can be found in Annex 3.

Data Analysis: Following data collection, the information received was reviewed, analysed and sorted for relevance. The data established the key human rights issues impacting on PWUD, FSW, MSM and TG populations, programs that were effective in mitigating violations, persistent systemic and programmatic challenges for these groups and a plan for a progressive future focussed outlook.

Finalisation of Report: On the 9th of August, an in-country meeting was held to present preliminary findings from the extensive interviews and focus group discussions. Key stakeholders from NASP, NTP, CBOs, NGOs and Development partners, UNAIDS, UNFPA and WHO were present, providing additional suggestions and information. Following this a draft report was developed and circulated for review. Inputs, and comments which were incorporated into this final draft.

Limitations: There were a number of limitations to the assessment. Due to time constraints, it was not possible to speak to certain stakeholders including Departments of Narcotics Control, Police, and National Human Rights Commission. It was also not possible to speak with prison populations, clients of sex workers, migrants and those affected by TB. Time limitations impacted on the extent of stakeholder interviews and geographical reach. For example, the need for the assessment to be completed in time for the scheduled final review and approval of the Grant Cycle (GC) 7 proposal, impacted on the opportunity to reach broader stakeholders and geographical areas.

Due to the rapid nature of this assessment, it is not a comprehensive report on the human rights situation for key population groups however it does capture a snapshot of the issues they face and provides some recommendations to address rights violations and areas to strengthen rights-based programming. The matching funding does not cover TB programming, the TB programme will be required to mobilise funding in order to implement the CRG Action plan and any recommendations listed.

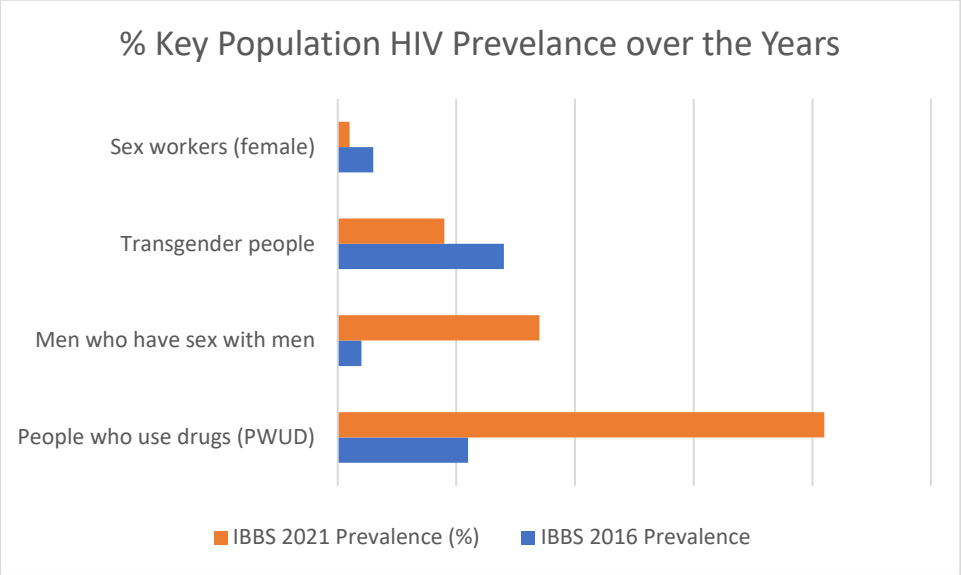
Overview of the context for the HIV/AIDS epidemic and key affected populations

Bangladesh shares a border with India to the northeast and northwest and Myanmar to the southeast. The southern part of Bangladesh opens to the Bay of Bengal. Bangladesh has a population of 169.8 million people[25], women represent 50.43% and men comprise 49.51% of the population with the majority residing in rural areas (66%)[26]. Since its first detection in 1989, Bangladesh has maintained a low prevalence of HIV in the general population. Prevalence among those aged

[25] https://bangladesh.unfpa.org/en/news/2023-state-world-population-report-8-billion-question-too-many-or-too-few%E2%80%9D
[26] https://www.aidsdatahub.org/resource/bangladesh-country-slides

between 15-49 is less than 0.1%. There were an estimated 14,513 people living with HIV in 2022[27]. One third of the 1,676 new case from 2021-2022 were identified in the general population, 18% in migrant workers and their partners and 13% found in populations forcibly displaced from Myanmar. The remainder were in MSM and PWID[28]. More men are HIV positive than women. Key population groups, MSM, TG, MSW, PWUD and FSW continue to experience comparatively higher rates of HIV transmission than the general population. These populations also share sexual and drug taking networks, exacerbating intra-population risk factors of HIV transmission[29].

Positively, since the previous IBBS study conducted in 2016, there has been relatively little change in prevalence in FSW and TG populations, however the prevalence rate for MSM and PWUD populations has increased. It should be noted however that a different method of surveillance was used from the previous study[30] and may impact on comparing results.



Engaging in high-risk behaviours such as unprotected sex and sharing needles by key populations continues to drive transmission of HIV. Factors impacting access to healthcare such as high costs, lack of transport, stigma and discrimination further hamper health seeking behaviour and access to information on prevention and treatment efforts.

In terms of the Government response, the National AIDS/STD Control Programme (NASP) is responsible for leading the implementation of the 4th National Strategic Plan for HIV and AIDS Response 2018-2023. NASP is a wing of the Directorate General of Health Services (DGHS) under the Ministry of Health & Family Welfare (MOHFW). The main goal of the strategic plan is to reduce the transmission of HIV with a focus on the global commitment to "*Ending AIDS by 2030".* In terms of achieving 95-95-95 cascade targets, according to data from 2022, the country has successfully

[27] AIDS/STD Programme (ASP), *WORLD AIDS DAY 2022, HIV/AIDS Situation in Bangladesh.* 2022, Directorate General of Health Services (DGHS), Ministry of Health and Family Welfare, Govt. of the People's Republic of Bangladesh, December 01, 2022, http://asp.gov.bd/sites/default/files/files/asp.portal.gov.bd/page/c1685412_5b68_44dd_b68c_e1070527fb23/2022-12-05-04-03-971a19b963d88288f518ac2be5b720bd.pdf

[28] Ibid

[29] Gourab G, Khan MNM, Hasan AMR, Sarwar G, Irfan SD, Reza M.M, et al. (2019) The willingness to receive sexually transmitted infection services from public healthcare facilities among key populations at risk for human immune deficiency virus infection in Bangladesh: A qualitative study. PLoS ONE 14(9):e0221637.https://doi.org/10.1371/journal.pone.0221637

[30] https://asp.portal.gov.bd/sites/default/files/files/asp.portal.gov.bd/page/4129b6d9_3565_48d5_8f89_ef37abb51732/2020-04-28-14-55-957a925c30c246e938a35336c26e29ca.pdf

diagnosed 67% of the estimated number of PLHIV, 77% of PLHIV diagnosed enrolled into ART treatment, and 90% of those enrolled on ART achieving an undetectable viral load.

The implementation of solid HIV/AIDS and STI programming by the Government of Bangladesh since 1985 has substantially contributed to these results, with progressive expansion of the coverage of comprehensive HIV prevention, treatment and care packages to support those living with HIV/AIDs and those at risk over the last three decades. It should be noted that the National Strategic Plan on HIV/AIDs and STI includes a strong commitment to utilising human rights responses to the implementation of services in order to reduce vulnerabilities. The plan highlights a commitment to upholding 'various rights such as access to health care, information, confidentiality and privacy, legal rights and gender equity' and to empower communities to mobilise to address barriers, improve self-esteem and reduce self-stigma to increase access to services.[31]

The Government of Bangladesh implements a comprehensive package of HIV services for KPs. The following are the programmatic aims of the HIV program referred to in the 2024-2026 Global Fund Funding Request form:

Programme Essentials

- HIV Primary Prevention: availability of condoms and lubricants, including focused interventions for FSW (including young and street based FSW), pre-exposure prophylaxis (PrEP) for MSM and TGW and harm reduction services including Opioid Substitution Therapy for PWID.
- Differentiated HIV Testing and Diagnosis: facility-based, community-based, HIV self-testing, as well as safe, ethical partner (index) and social network-based testing, following a three-test algorithm.
- HIV/TB: PLHIV with active tuberculosis (TB) are started on ART early, TB preventive therapy is available for all eligible people living with HIV.
- Differentiated Service Delivery (DSD): prevention, testing and treatment are available in health facilities, testing is available outside health facilities, including through community, outreach and digital platforms; multi-month ART dispensing is available.
- Human Rights: HIV programmes for key and vulnerable populations integrate interventions to reduce human rights- and gender-related barriers; stigma and discrimination reduction activities for KP are undertaken in health care and other settings; legal literacy and access to justice activities are accessible to KP; support is provided to reform criminal and other harmful laws, policies and practices that hinder effective HIV responses.
- Safety and security of HIV health service providers, including outreach team, by introducing health insurance, hepatitis C vaccination, PEP, necessary supporting letter from the government.

With the introduction of Global Fund Grant Cycle six (NFM3), a process of relocation of KP service centre to government hospital has commenced and it is planned that as part of the GC7 proposal a considerable number of service delivery points (SDP) including DIC/Community DIC and Outlet will be shifted into government health systems, and in this way a full integration will be done gradually. Since the time of writing this report, there have been eight SDPs relocated and five (three PWID and two FSW) are under process. Two SDPs for MSM and TG have also relocated to government services,

[31] https://gh.bmj.com/content/4/6/e002155.full

but the model of integration is not same as PWID and FSW. Relocation of these SDPs have occurred with mixed results. There are concerns by community-based service providers and service users regarding the reduction of access, availability and quality of care that will be provided at government health centres, this will be elaborated on in the findings section below.

It is very reassuring to see that the Government of Bangladesh has recognised all KP groups in the National Strategic Plan to Address Gender Based Violence (GBV) for Bangladesh HIV and AIDS Response (2017-2021)[32]. The strategy acknowledges how gender inequalities and gender-based violence led to harmful practices that limit access to services, and opportunities and increase their vulnerability to HIV. The strategy further acknowledges there is limited information and understanding of experiences of GBV among KP groups and has proposed greater research and assessment in the area to develop an evidence-based approach to reducing vulnerabilities and providing services for prevention and support. However, there is very limited information available on the progress of implementation of the recommendations within the strategy and how these have impacted on the outcomes for KPs.

NGOs and community-based organizations/self-help groups further provide essential HIV prevention services for key population groups. Principal Recipients (PR) of the Global Fund, ICDDR,B and Save the Children have been working with national NGOs and community based organisations to deliver a comprehensive package of HIV/AIDs and STI services through drop-in centres as well as integrated gender-based violence services, peer and outreach support, capacity building training on legal literacy, referrals to auxiliary services, advocacy and livelihood programs[33]. There are three National Key Population Networks representing PWUD, PLHIV and FSW (NPUD, PN+ and SWN respectively. These networks are work in partnership with Save the Children in NFM3 Grant, community led advocacy and monitoring, and quality program delivery to ensure optimum community participation. At the same time, they are strengthening governance and management practice with support from PR and SR, UNAIDS and other relevant stakeholders. Their representatives are now in BCCM and play critical role in raising community voices wherever needed.

Bandhu Social Welfare Society (Bandhu) is a national community-based organisation representing the needs of MSM, MSW, TG groups and sexual and gender diverse persons. These peer-based networks are essential in mobilising and empowering communities around key advocacy issues such as criminalisation of behaviour, access to quality health, education and employment support, building capacity on legal literacy, access to justice and further are vital in providing peer counselling and support. Non-government actors are also essential in providing a monitoring and accountability role of the governments operational and implementation progress. They are pivotal in supporting these communities to raise their voices and be empowered to advocate for greater change and better outcomes.

This support is particularly pertinent given the legal, political and religious environment that impacts on the safety, freedom of movement and criminalization of behaviours that KP groups engage in. These issues often exacerbate stigma and discrimination, limit access to justice, drive risk behaviours underground increasing risk of poor health and impact on access to employment, education and basic services including access to National Identification Cards (NID). This is despite the Constitutional guarantee of fundamental rights of all citizens without any discrimination and including legal, social and economic protections and human dignity. Additionally, Bangladesh is a

[32] National AIDS/STD Control Program (NASP) (2017). National Strategic Plan to Address Gender Based Violence. Ministry of Health and Family Welfare, Directorate General of Health Services, NASP.

[33] This is not a comprehensive list of services provided by NGO's and CBO's but a snapshot to illustrate the diversity of support they provide to KP groups.

signatory to a number of International Treaties and Covenants including the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights (ICCPR), International Covenant of Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and is committed to achieving the Sustainable Development Goals in support of Agenda 2030. Yet despite this commitment, action to address rights violations is constrained by conservative religious beliefs and harmful gender norms that limit action to protect the rights of key populations who transgress the dominant societal heteronormative and patriarchal values that currently prevail across the country. These issues will be further explored in the next section on human rights barriers affecting each of the key population groups.

Findings: HIV and the Human Rights Context including Socio-Political and Legislative Barriers for Key Population

Female Sex Workers

Legal Environment and Access to Justice

UNAIDS Guidance Note on HIV and Sex Work[34], that defines sex workers to include female, male and transgender adults, who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not self-identify as sex workers. Sex work is consensual sex between adults, which takes many forms, and varies between countries and communities[35]. This report does not cover issues pertaining to trafficking of persons however laws concerning the trafficking, namely the Human Trafficking Deterrence and Suppression Act, 2012 and Oppression of Women and Children (Special Enactment) Act 1995 are used to detain women who sell sex[36].

In Bangladesh, there are currently no laws or statutes that regulate or prohibit sex work[37]. The Constitution of the People's Republic of Bangladesh, under section 18(2), provides that the State shall adopt effective measures to prevent prostitution and gambling. However, as long as the 'prostitute' is female and over the age of 18 it is permitted. In addition, a decision of the Bangladeshi High Court in 2000 upheld that, provided the sex worker sign a sworn affidavit outlining their consent in selling sex and submitted this to the local administration, they may work in one of the few licensed brothels or red-light areas that exist across the country and receive protection from local authorities. This decision was further used to provide protections on the right to shelter and safe working conditions. Yet despite this ruling, sex workers face high levels of harassment and violence from police who often misuse and abuse laws on public order, public nuisance and trafficking to persecute sex workers. For example, Section 290 of the penal code (offence affecting the public health, safety, convenience, decency and morals) is used to arrest and fine sex workers as committing public nuisance which is considered by the Dhaka Metropolitan Police Ordinance 1976 as an attempt by anyone to attract attention in any public place or soliciting or molesting anyone for the purpose of prostitution. Sex workers participating in FGDs expressed having very limited access to free legal aid and complaints mechanisms or redress, hence even if they wanted to address rights violations, their means to do so are constrained.

Stigma and Discrimination

Sex workers experience stigma and discrimination in many facets of their lives, including their community, family members, health services, education and employment. Social exclusion, isolation,

[34] www.unaids.org/sites/.../JC2306_UNAIDS-guidance-note-HIV-sex-work_en.pdf

[35] http://www.nswp.org/sites/nswp.org/files/Refugees%20Engaged%20in%20Sex%20Work%2C%20Women%E2%80%99s%20Refugee%20Commission%20-%202016.pdfissues

[36] https://www.carebangladesh.org/publication/Publication_5820760.pdf

[37] Ibid

poverty and limited economic opportunities increase their vulnerability and limit their opportunities to progress socially and economically within society. Discussions during FGDs illustrated extensive societal and community-based discrimination; most sex workers stated they were unable to get their national ID cards, preventing them from accessing essential government services for example the CovidCovid-19 vaccine. They also stated that their children were refused birth registration by ward councillors due to their status as sex workers. Children of sex workers were viewed as the result of sin leading refusal of enrolment in school and for those who did go to school, their children were often isolated and socially excluded from other children.

Experiences with Health Care Institutions

Within health institutions FSW report high levels of stigma and discrimination including, refusal of services and poor-quality treatment. To mitigate this, sex workers do not readily disclose their identities. However, they are at times identified during medical history taking. At these times they state that they are spoken to badly or refused service. They also mentioned that while services have improved over time and there has been some reduction in poor and negative attitudes from some service providers especially in HTS, STI management and ART clinical settings. Overall, they report Government health service providers require much greater training and competency in providing non-discriminatory and compassionate clinical care services.

Gender Based Violence and Gender related Discrimination.

Most sex workers, join this profession due to extreme poverty. FSW experience high levels of gender-based violence with very limited access to justice, root causes are driven by gender inequalities, gender discrimination and patriarchal norms and traditions that promote and condone violence against those that do not conform to societal values and norms. Sex workers under the age of 34 experience greater levels of violence than those older than them[38].

Sex workers are arrested under laws pertaining to public nuisance, vagrancy and obscene conduct.[39] While detained, sex workers are frequently extorted for money, raped and physically assaulted. Further, FSW stated during FGDs that when they do experience violence from perpetrators including local power structures (gangs) clients or *Mustaans*[40] they do not report to the police, stating that they are disbelieved, disregarded and/or blamed for the cause of the violence, with police refusing to file their cases.

FSW have limited negotiation capacity to use condoms with clients. If a client refuses, due to male/female power relations and elements of criminal behaviour, women are unlikely to insist for fear of losing a client, physical violence and rape.[41]

Community Mobilisation and Organising

The Sex Workers Network of Bangladesh (SWNB) is a self-organised community-based organisation formed in 2000 to advocate for greater rights protections and to highlight the injustice, discrimination and rights violations experienced by Sex Workers in Bangladesh. During the FGD, SWNB stated they reach approximately 26,000 FSW and TG sex workers, through 29 CBOs representing local brothel and street-based sex workers. With support from Save the Children their members have access to legal aid support, income generating programs, community monitoring, and referral for One Stop Crisis Centre (OSCC) for victims of GBV. The National Network has mobilised

[38] https://asp.portal.gov.bd/sites/default/files/files/asp.portal.gov.bd/page/4129b6d9_3565_48d5_8f89_ef37abb51732/2020-04-28-14-55-957a925c30c246e938a35336c26e29ca.pdf

[39] ibid

[40] Local muscle men who control gang related activities including sex work

[41] https://asp.portal.gov.bd/sites/default/files/files/asp.portal.gov.bd/page/4129b6d9_3565_48d5_8f89_ef37abb51732/2020-04-28-14-55-957a925c30c246e938a35336c26e29ca.pdf

sex workers in GBV awareness, peer outreach for HIV prevention and treatment services and advocacy on the plight of sex workers in Bangladesh. This includes submitting a report on the status of rights of sex workers in Bangladesh to the CEDAW Committee, and organising conferences to build capacity on organising, leadership and rights. They testified at a public hearing with the Chairman of the National Human Rights Commission on the status of sex workers in Bangladesh, who subsequently made recommendations to abolish laws related to the criminalisation of prostitution, increase legal protections and access to justice through legal aid services, further train law enforcement agents. Sex workers to file complaints of human rights violations to the NHRC[42].

People who use drugs

Legal Environment and Access to Justice

The use of illicit drugs is criminalised under the Narcotics Control Act (1990) which renders possession and use of illicit drugs punishable dependent on the type and quantity found. Penalties range from 6 months in jail, life imprisonment and the death penalty.[43] The Narcotics Control Act was revised again in 2018 alongside a Prime Ministerial declaration on the "*war on drugs"* promoting a punitive zero tolerance campaign further exacerbates the vulnerabilities of those who are using drugs. For example, instead of targeting those responsible for importing and distributing drugs around the country, raids have been conducted in slum areas, with poor and under privileged targets. It is further reported that those with means have been bribing law enforcement actors to not target certain individuals[44] . The *war on drugs* has been likened to that in the Philippines, where extrajudicial killings, violence and abuse without cause or recourse.[45] One of the reasons for this was also to curb the use and sale of 'Yaba' – methamphetamine pills – which has in recent years become a popular drug used by KP groups especially young people. The use of 'Yaba' and how it may impact on risk of HIV transmission is currently unexplored and will require further assessment.

Despite such punitive laws a harm reduction program in the form of needle syringes program (NSP) was started by CARE Bangladesh in 1998 with funding support from DFID, under national HIV response. In 2004, the government health sector program under the Ministry of Health formally engaged in implementing a harm reduction program for PWID. In 2010, Opioid Substitution Therapy started as a pilot in a government owned treatment centre with scale up to community setting (DIC) occurring in 2012. Global Fund started to support harm reduction program for PWID in 2009.

NSP and OST programs have, globally contributed to a reduction of the transmission of blood borne viruses.[46] However in countries where law enforcement agencies and public health agencies values are misaligned, PWUD are often detained on the basis of being in possession of injecting paraphernalia. During FGD discussion with PWUD, many stated that they were targets of harassment and arrested by police officers on the suspicion of holding injecting equipment, regardless of whether they also had drugs on their person. When arrested only a few people were aware of legal aid services available to support them. In Rajshahi, two PWUD referred to the Bangladesh Legal Aid Service Trust (BLAST) as a source of free legal support, the remainder said they often rely on their families to seek support.

Further while the National Harm Reduction Strategy (2017-2021) developed by the NASP outlines a pragmatic, rights based public health response aimed at reducing harm for PWUD and their families it is currently unable to address the punitive legal and policy environment that criminalizes this

[42] https://www.nswp.org/sites/default/files/cedaw_report_bangladesh_swasa_-_2016.pdf
[43] https://www.hri.global/files/2019/06/24/submission-committee-torture-bangladesh-drug-policy.pdf
[44] Ibid.
[45] https://idpc.net/news/2018/06/ngos-call-on-the-united-nations-to-condemn-bangladesh-drug-war
[46] NASP 2016; National Harm Reduction Strategy 2017-2021

population largely due to deeply held conservative and religious belief systems that see drug use and users as sinful.

Stigma and Discrimination

Given the nature of their 'undesirable' behaviour as per the dominant societal values, people who use drugs experience extensive stigma and discrimination from a wide variety of actors and institutions. During FGDs with this group, many stated that given their low standing in society because of their drug use, they and their families are isolated and are not able to find employment, relegating them to low class jobs such as rickshaw drivers, tokai work and for most women using drugs, sex work, further lowering their standing in society. For many families affected by drug use, with children of marriageable age, eligibility is affected.

Experiences with Health Care Institutions

During FGDs participants stated that they are reluctant to visit health care facilities, especially those that are Government based. This is largely due to a lack of quality care, denial of services and being ignored by hospital staff. This was not as much the case for OST, HTS and STI related services but rather for auxiliary services for example abscess treatment and management. These findings complement the latest End Line Survey (Behaviour) on Continuation of the Prioritized HIV Prevention Services among Key Populations in Bangladesh funded by the Global Fund[47] The report further highlighted that both men and women are likely to self-medicate before going to health facilities, however when they do seek care, men are more likely to visit doctors for treatment whereas women are more likely to go to NGO-run clinics. These findings will be relevant to guide the upcoming integration process (discussed in more detail below). Additionally, there is a lack of coordination between NASP and the Department of Communicable Diseases to ensure HCV screening for all PWID and subsequent education on prevention, treatment and care. This is partially due to a lack of adequate laboratory facilities available to conduct screening[48]. With National Guidelines being developed as of October 2022, this should accelerate the process.

Further in terms of confidentiality and privacy, during a field visit to the OST Centre located at a DNC run treatment centre, the billboard outside clearly stated the purpose of the centre. Inside the treatment centre, in a well-meaning gesture, the names of clients who had achieved prolonged success with OST were clearly visible and posted on the wall. Further, the dosing sign in sheet also displayed names of clients. There should have a caution in maintaining record to ensure there are no breaches in the confidentiality of clients.

Gender Based Violence and Gender related Discrimination.

Due to logistical and time challenges, no FGDs were conducted with women, however during a brief conversation with a female peer outreach worker in Rajshahi it was highlighted that though fewer women use drugs, they are often more marginalised, and their vulnerabilities exacerbated. Women are more likely than men to exchange or sell sex for drugs, they are less likely to attend NSP programs to access clean needles and syringes, they are more likely to share needles and the needles they use are less likely to be sterile which can lead to increases in abscess and staph infections[49]. They are also less likely to be on OST due to lack of access to transport and family

[47] https://asp.portal.gov.bd/sites/default/files/files/asp.portal.gov.bd/page/4129b6d9_3565_48d5_8f89_ef37abb51732/2020-04-28-14-55-957a925c30c246e938a35336c26e29ca.pdf

[48] https://www.globalhep.org/sites/default/files/content/country-profiles/files/2022-12/National%20Hepatitis%20Elimination%20Profile_Bangladesh-final-12-2_0.pdf

[49] Ibid

support, distance to OST clinic and cost of transport. The peer educator in Rajshahi explained that women drug users experience high levels of violence and harassment from police, they experience rape and sexual assault from clients, drug sellers and police. There was very limited information on the sexual and reproductive needs or services for women who use drugs and a lack of capacity around gender sensitive service provision and an understanding of their programmatic needs by service providers both CBO and Government services.

Community Mobilisation and Organising

The Network of People Who Use Drug (NPUD) in Bangladesh is the apex network providing a number of services and trainings to a wide variety of actors. Representing 17 CBOs across nine districts they have reached over 2,000 PWUD with skills development and livelihood training, advocacy with law enforcement agencies and peer based psychosocial support. This includes advocacy with police on the rights of drug users, reducing stigma and discrimination and reducing arrests. As part of this program, they have also provided community level stigma reduction sessions to reduce negative attitudes towards PWID in their local communities. They have implemented this in 13 districts across Bangladesh. Many of the current program implementation sites including DIC and OST sites are being operated collaboratively by community-based organisations. One was visited during the in-country field trip. Run by APOSH, a self-reliant and peer organised organisation working under the consortium of CARE Bangladesh, operates a drop-in Centre and OST centres closely with the Department of Narcotics control (DNC). Not only providing comprehensive HIV services, but they also play a big role in peer outreach, community advocacy with community members, ward councillors, police officers and are a bridge to Government health services. This was a unique and effective model of service provision not found in other parts of the country with DNC providing space for a DIC within the OST clinic. This was possible due to extensive advocacy with DNC, indicating the importance of advocacy to shift service delivery and create enabling environments for KPs even with the most conservative of government institutions.

Men who have sex with men

Legal Environment and Access to Justice

The current legal and policy environment for men who have sex with men is punitive and punishing. In Bangladesh, same sex activity is criminalised under Unnatural Offences; Section 377, Penal Code 1860 prohibiting "*carnal knowledge against the order of nature*"[50]. Introduced by the British during colonisation, the Government of Bangladesh retained these laws following independence. Rarely enforced, this law has been used to harass, extort and justify violence against men who have sex with men and other gender and sexual minorities. Further, those who work in institutions that support this key population group are also the targets of threats to themselves and their families, largely perpetrated by religious extremists, fanatics and conservative groups in society. Men who have sex with men have limited access to justice when their rights are violated as they are unable to go to the police for fear of arrest and harassment. They are also unable to report rape as the laws in Bangladesh fail to recognise the rape of an adult male. Existing laws are limited to penile-vaginal rape, and Section 377 does not adequately cover the nature of force and lack consent used to commit sexual assault and rape of a man. These cases were received from across the country.

With the widespread use of dating apps, emerging findings from the FGDs highlighted frequent experiences of blackmail and violence perpetrated by people who were seeking sex from men who have sex with men. These were some of the experiences reflected in the human rights violations data base for sexual and gender diverse populations led by ICDDRB and Bandhu Social Welfare Society (Bandhu). In 2022, 51% of rights violations and 44% of gender-based violence cases were

[50] https://www.humandignitytrust.org/country-profile/bangladesh/

followed up by lawyers[51]. Most of these cases came from Sylhet followed by Khulna and then Chattogram; cases were also received from Dhaka, Barisal and Rajshahi.

Participants from FGDs stated that the state was not ready to accept their sexualities and despite having constitutional protections. Yet of all the KP groups who participated in FGDs men who have sex with men were most aware of their rights and were most likely to have had some kind of legal literacy/know your rights training. This is in large part to the well organised and better funded community-based groups, compared to other key population groups (this will be discussed further below).

Stigma and Discrimination

Men who have sex with men are a diverse group of people, they include gay men, men married to women who have sex with men, bisexual men, men who sell sex and non-binary people with male sexual characteristics. FGD discussions highlighted that those who present effeminately are persecuted more than those who are able to 'pass'[52]. These people report experiencing physical abuse and sexual harassment from education and employment institutions, they are blackmailed, beaten up, gang raped, and experience daily harassment being called a girl or 'half lady'. When MSM sell sex, use drugs, are living with HIV or all of the above they vulnerabilities are layered and multiplied. For example, gay men who test positive can be isolated and rejected from the MSM community and also not accepted in the PLHIV community due to discriminatory attitudes regarding their sexuality.

Considered immoral, vectors of disease, and criminals, they experience stigma and discrimination from all facets of society, family, community and employers. During FGDs in Chattogram, one young gay man spoke about how he felt forced to drop out of school at 5th grade due to severe bullying. For this population there is also high levels of internalised stigma leading to poor mental health and experiences of feeling hopelessness, suicide ideation and self-harm[53]. Stigma and discrimination and potential legal repercussions lead this population to hide their identity and their behaviours, this can contribute to reduced access to appropriate health care interventions including access to condoms, lubricant, HTS and STI testing and management.[54]

Experiences with Health Care Institutions

With extensive training and sensitization provided to government clinicals working specifically in ART and HIV prevention services, this client group stated that the quality of care and stigma and discrimination has reduced. However, the overarching constraints imposed by the legal environment leaves many MSM in fear of attending and accessing health services, especially government services. During FGD's most participants stated they did not disclose their identities to health care workers if they did not have too. Further when attending for general health concerns, participants stated that when they did disclose their identities, they were treated with disgust and shamed for their behavior. They also mentioned that many physicians in the Government hospital setting were not appropriately or adequately trained to diagnose and treat STIs in the anus and rectum. There are very limited mental health services for this key population (and more broadly for any KP), with many

[51] https://www.BSWS-bd.org/wp-content/uploads/2023/06/Rights-Violation-report-2022-of-Gender-Diverse-population.pdf

[52] A predominately western term used for people who may be LGBTI and are able to pass for straight, heterosexual and/or cisgender.

[53] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0289597

[54] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10324373/

psychiatrists and psychologists continue to see homosexuality and same sex behavior as abnormal with 'curative' and 'conversion' therapies as the solution to mental anguish[55].

Gender Based Violence and Gender related Discrimination.

In Bangladesh there is a denial of same sex sexualities largely due to religious conservatism. These conservative beliefs also govern sexual and gender norms in society, and what is deemed appropriate behaviour for men and boys, women and girls to engage in. There is no recognition of broader SOGIESC aspects of a person's identity. During one FGD, a person who identified as non-binary spoke about their experiences being born intersex. They stated that as their parents wanted a boy at birth non-consensual 'corrective' surgery was performed which now as a 20-year-old continues to impact on their physical and mental health.

Due to norms of masculinity within Bangladeshi society, MSM are also often married or have female sexual partners. This can contribute to greater risks of HIV transmission for female sexual partners yet also has a fundamental impact on how societal expectations and norms curtail MSM's freedom of expression.

Community Mobilisation and Organising

Bandhu Social Welfare Society is an example of an organisation leading peer-based community advocacy and programs for MSM and TG populations. Bandhu works across 50 districts with over 30 CBOs and partners with a reach of approximately 50,000 people. They implement programs with four key objectives: human rights, Health, Livelihood and Sustainability. BANDHU conduct legal literacy trainings, sensitization workshops with law enforcement actors including police, judges and lawyers. They have legal hotline called Ain Alap which provides legal advice to MSM and TG people across Bangladesh's 64 districts and have trained panel lawyers in the key human rights issues impacting on this key population and using the law for redress and justice. They further provide HTS and STI support services through drop-in centres including peer outreach, psychosocial support and mental health counselling. Bandhu conduct a range of community sensitisation programs including Gender identity art and film festivals and alongside ICDDR, B they contribute to a human rights violation database capturing rights violations experienced by MSM and TG populations through the Aian Alap hotline. In 2022, they received 680 phone calls, and documented 179 cases.

Visibility is required for advocacy and social change, however both KIIs and the literature highlight that these organisations are frequently subjected to intimidation and death threats, online abuse and hate speech[56]. Despite this, they continue to organise and build their movement towards legal recognition and the right to live with dignity, free from violence and discrimination.

Hijra and Gender Diverse people (including transgender women, non-binary and intersex people)

Legal Environment and Access to Justice

In 2014, Hijras were recognised under a separate gender category by the Bangladesh Cabinet. Hailed as a landmark decision this law only recognises people who identify as hijra. Indigenous to South Asia, Hijras are a group of people who consider themselves neither male nor female. Given an almost mythological status in society, they are not considered as transgressors of gender norms but rather consider part of a holy caste with clearly defined roles and rituals performed during

[55] https://www.ohchr.org/sites/default/files/lib-docs/HRBodies/UPR/Documents/Session4/BD/SRI_BGD_UPR_S4_2009_SexualRightsInitiative_JOINT_upr.pdf

[56] https://static1.squarespace.com/static/5a84777f64b05fa9644483fe/t/60b5f55ce39ebd529578e968/1622538224862/Bangladesh+Country+Report_ILGA+Asia2021_opt2.pdf

ceremonial events[57]. The Government of Bangladesh has accepted the Hijra Community as an accepted gender role in society. They are commonly considered to be missing or have ambiguous genitalia,[58]. This common misconception has led to a number of concerning outcomes for this group, that is not addressed by the recognition laws, as many hijra are born male with intact male genitalia and consider themselves to have a feminine spirit.

Following recognition, the Ministry of Social Welfare created 14 low-ranking officer positions for hijras. The 12 that were selected were required to undergo a physical medical examination which required proof of their 'authenticity' as a hijra, and all but one of the selected candidates had male genitalia. Causing a media frenzy, these people were claimed to be fake and masquerading as hijras[59]. This highlights that while the recognition of third gender category can be a positive outcome, the definition of who fits within that category is obscure, and further continues to exclude people who identify beyond the hijra/third gender category.

During FGDs in Chattogram, a young transwoman stated she did not identify as a hijra but as a trans woman, she stated law enforcement do not recognise her as a trans woman nor a hijra, but as a man. She described an incident where she went out with her friends and was attacked and sexually assaulted by a group of men because of her appearance. She reported to the police found that as she was a 'man' and men could not be sexually assaulted (or raped) by men therefore no criminal activity had occurred. This was a common theme amongst FGD participants who identified as trans and hijra. They spoke of experiencing daily violence, taunts, bad words, beatings, sexual assault and rape.

The lack of clarity around third gender category recognition also has an impact on their ability to change their National Identity Cards (NIC). There are currently no clear procedures in carrying out identification processes[60]. For some this means undignified and disrespectful physical examinations as described above. This means that authorities can implement procedures as they choose. For example, one participant during the Dhaka National workshop stated that she had begun the process of changing her NIC and passport in 2014 after recognition, to only a decade later finally has all documents updated to a third gender category. This was not an easy process but one full of administrative bureaucracy difficult to navigate and hence not possible for most of the participants we spoke to during the FGDs. Further to this, with only the recognition of those who identify within the third gender category it is impossible for a transwoman to change her gender to female, thus those with SOGIESC beyond hijra (trans women and trans men) remain without legal recognition.

Gender affirmation is a pivotal component of self-expression, self-confidence and dignity. In Bangladesh there is no law that governs gender affirmation surgery as legal or illegal, however according to participants in the FGDs, in early 2023, the Directorate of Public Health issued a gazette stating that gender affirmation surgery was illegal. The lack of an enabling legal environment for trans people to affirm their gender often leads to poorer physical and mental health outcomes. It is commonplace for those in punitive legal environments including in Bangladesh to purchase and self-medicate hormone replacement therapies as well as go to disreputable medical professionals for body modification procedures[61].

[57] https://www.hrw.org/report/2016/12/23/i-want-live-my-head-held-high/abuses-bangladeshs-legal-recognition-hijras
[58] https://www.tandfonline.com/doi/full/10.1080/13691058.2017.1317831
[59] Ibid
[60] https://www.blast.org.bd/content/publications/Policy-Brief-Hijra-and-GDC-Rights.pdf
[61] https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-023-15085-0

The lack of legal recognition and poorly defined legal frameworks designed to protect those with diverse gender identities leads to a lack of access to justice and redressal mechanisms when their rights are violated. While there are some legal services through BLAST and Ain Alap that cater to supporting this group to hold perpetrators to account for violations, most go unreported with the general consensus, as stated during FGDs, that those charged to protect them (police) are the main perpetrators of violence towards them.

Stigma and Discrimination

Hijra, third gender and transgender people experience high levels of stigma and discrimination from all facets of society, and due to exclusions from education and employment institutions, many work as sex workers to earn income[62]. Their average age of entry into sex work for this group is 13.7 years old[63]. Stigma and discrimination fuels violence towards this group. Police and sex partners are the greatest perpetrators of violence[64] During FGDs, participants stated they are often in insecure housing as landlords do not rent to them and they dropped out of school due to taunting and abuse from peers. Without protective support systems in place (friends, safe home, livelihoods) there is little protection from harassment and emotional and physical abuse, including denial of services, denial of access and isolation from family and community.

Experiences with Health Care Institutions

Hijra, Transgender people and those identifying in the third gender category, stated during FGDs that most doctors do not have an understanding of their biomedical needs as a gender diverse person. When they do go to Government health centres or MBBS doctors, they are examined as a curiosity, they are asked unnecessary and invasive questions about their gender identity, genitals and sexual history unrelated to the reason they attended. They also claimed they are given the wrong tests and treatment due to a lack of understanding of their physiology. Some stated they are denied services or due to ridicule and humiliation do not feel comfortable attending.

The literature also illustrates that most do not go to doctors for treatment of STI symptoms and rather self-medicated, getting medicine from a 'local doctor' (not MBBS qualified) pharmacy or friends. Government clinics and MBBS doctors are the last place they choose to seek treatment from.[65] Further, attending Government health clinics, they are faced with scrutiny, undesirable interest and fear-based responses from the public attending hospitals[66]. When arriving at the hospital they are often misgendered, yet the paperwork required by the hospital does not include third gender category. Currently at public hospitals, men and women line up separately for administrative purposes (ticket counter) and to receive services, yet there is currently no provision for those identifying as third gender.[67] When choosing either line they are yelled at and abused. If admitted into hospital, there are no processes indicating if they should be admitted to the women's or the men's ward and they themselves are not asked where they would like to be admitted.[68]

The lack of gender affirming health care services such as hormone therapy and gender affirming surgeries continues to drive this population towards self-medicating with hormones, which are often

[62] https://asp.portal.gov.bd/sites/default/files/files/asp.portal.gov.bd/page/4129b6d9_3565_48d5_8f89_ef37abb51732/2020-04-28-14-55-957a925c30c246e938a35336c26e29ca.pdf
[63] Ibid
[64] Ibid
[65] https://asp.portal.gov.bd/sites/default/files/files/asp.portal.gov.bd/page/4129b6d9_3565_48d5_8f89_ef37abb51732/2020-04-28-14-55-957a925c30c246e938a35336c26e29ca.pdf
[66] https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-020-09284-2
[67] Ibid
[68] https://www.researchgate.net/publication/344261891_Discrimination_against_Hijra_Transgender_in_Accessing_Bangladesh_Public_Healthcare_Services

bought from the internet or pharmacies. Similarly, undergoing body modification surgeries by unregistered and untrained doctors and so-called experts, both within the country and internationally[69] leads to a greater burden on their mental and physical health as well as the public health system when medical interventions go wrong.

Finally, during COVID those who did not have an NID, or who's NID photos did not match their gender and physical presentation were refused or denied the vaccine, leading to a great vulnerability to infection, poor health and outcomes.

Gender Based Violence and Gender related Discrimination.

The transgression of the gender norms and traditions in Bangladeshi society is the greatest driver of violence towards this key population. Those who physically present in a way this does not match their gender prescribed at birth, are shunned from society, family and community. Discrimination and stigma limit their entry into secure and dignified employment opportunities. The function of a hijra person is very fixed in society, and beyond their role in ceremonial events, births, marriages etc, they are relegated to the fringes of society. Despite the guarantee in Article 28 to the *right to equality and non-discrimination for every citizen of the country*, there are no enabling laws in Bangladesh to protect this community against discrimination on the basis of gender identity or characteristics in all or any facet of society, including education, employment and access to services[70]. This means there are no mechanisms or pathways to hold perpetrators of gender-based discrimination accountable for their actions.

Community Mobilisation and Organising

Gender diverse people are represented by a number of local CBOs across Bangladesh. Bandhu and Chinnamul Manab Kallyan Sangansthа who attended the National Workshop on the 8th of August work closely with largely men who have sex with men and gender diverse people. Badhon Hijra Shangha, Sustho Jibon work specifically with gender diverse people. There are many more CBOs at the local level. It was unfortunate these organisations did not attend the workshop. Chinnamul Manab Kallyan Sangansthа works in four districts, supporting six local CBOs with counselling and community awareness on the plight of their community and the need for social acceptance. ICDDR,B has further been a major stakeholder in research interventions, capacity building and training in the field of MSM/TG in Bangladesh since 1996.

It has only been a recent shift of the separation of trans and hijra issues with men who have sex with men. Transgender and hijra communities are starting to emerge from under the MSM organising space into their own, to advocate for their own distinct issues. Due to this, there is a need to improve the leadership and advocacy capacity of transgender/Hijra organisations to progress the movement forward.

PLHIV

Legal Environment and Access to Justice

In Bangladesh there are no HIV specific criminal laws and no general laws have been used to prosecute against the transmission of HIV. However similar to experiences of KP populations above there are also no specific laws that protect PLHIV from discrimination, which they face in education and employment institutions as well as from society in general. HTS is voluntary and there are no laws or policies that dictate testing is required during marriage, or to obtain a work[71].Again there is limited access to legal aid services and a reluctance to report violations as often there is a rightful

[69] Ibid

[70] https://www.BSWS-bd.org/wp-content/uploads/2021/11/Policy-Brief_GBV-2021.pdf

[71] https://www.unaids.org/sites/default/files/country/documents/BGD_2018_countryreport.pdf

perception that no one will be held accountable, and that the status quo will remain. Lack of financial capital, fear of consequences and a lengthy bureaucratic burden further prevents them from seeking justice.

Stigma and Discrimination

During FGDs and according to the last Stigma Index PLHIV face stigma and discrimination from all facets of society. This has a grave impact on their mental health and hinders access to health, disclosure of status and support services[72]. Within the community they are a source of gossip, they are prevented from attending gatherings with their family or in public. Those diagnosed within the first year of their diagnosis experience greater amounts of stigma from the public yet also self-stigma that impacts on their confidence and self-esteem. Self-stigma also impacts on their sense of worth in having a child (or additional children), they refrain from having an intimate relationship and for women it impacts on their desire to have sex[73].

Experiences with Health Care Institutions

In Health Care institutions during the FGDs PLHIV spoke about receiving inappropriate remarks and behaviour from health professionals. This was mostly the case outside of Anti-Retroviral Therapy (ART) and HTC centres. They stated that they usually speak to doctors at the ART centres for any health issues outside of HIV so as not to be exposed to negative and judgmental attitudes. These attitudes impact on PLHIV's willingness to disclose their status to health care workers, and while the use of universal procedures can mitigate any transmission to health care workers, additional concern lies in the contraindicators of treatment if the PLHIV is on ART. A key issue for PLHIV is confidentiality and privacy. ART centres and HTC services especially in Government centres are clearly labelled as such and so when entering these facilities, they lose their privacy.

PLHIV also state that they lack confidence in doctors within the health setting, as they have a limited understanding of their needs as HIV patients, auxiliary services to manage HIV and treatment of opportunistic infections are expensive and unaffordable. For those living in rural areas, long distances to ART centres reduces the likelihood of follow up care. Participants also noted a reduction in peer outreach workers, contributing to a decrease in much needed counselling and support.

Gender Based Violence and Gender related Discrimination.

Throughout the FGDs women participants bought up issues around a lack of attention to their sexual and reproductive health needs, family planning and adequate care, dignity and respect in the peri and post-natal period. One woman spoke of being rejected from the hospital when she presented to give birth due to HIV status. The stigma Index highlights that women are more likely to have their HIV status disclosed by others without their consent.

While the country has progressed in terms of gender equality to some extent, pervasive conservative beliefs subjugating women in society deprive them of equality and equitable outcomes. For example, Bangladeshi women earn less than men, are discriminated against in inheritance and property laws, are less likely to complete tertiary education and have lesser access to health which can be impacted by their home-based care duties.

Community Mobilisation and Organising

The National PLHIV Network (NOP+), which recently got registration in the name of PN+, and Ashar Alo Society (AAS), work at the national level to advocate for, empower and support those affected by

[72] 2017 Network of PLHIV (NOP+) Bangladesh: HIV/AIDS Related Stigma and Discrimination against PLHIV in Bangladesh: 2nd National Stigma Index, Bangladesh

[73] Ibid

HIV in Bangladesh. They have a total of 1,840 members working largely across Dhaka, Sylhet and Chattogram. AAS provides essential training for PLHIV and health and policy stakeholders on a wider variety of issues including leadership and advocacy, carer support peer and policy-based ART training on treatment guidelines. AAS and NOP+ is now partner of Save the Children in NFM3 global fund grant.

They are essential actors in providing care, counselling, outreach and treatment support to people on ART, expanding treatment coverage, reducing loss to follow up, increasing adherence outcomes and providing psychosocial and mental health support to PLHIV. Since October 2017, government started operating ART centre directly and currently there are 13 centres across the country. The network of PLHIV (through AAS) complements and supplements the national program as community partners.

Prison Populations

Legal Environment and Access to Justice

The Ministry of Home Affairs is responsible for the prison population in Bangladesh and management of prisons are governed by the Prisons Act of 1894. As of December 2022, there were 81,156 people reportedly in prison, despite the official capacity of the prisons in Bangladesh to hold 42,626 people – current occupancy level is 190.4%. The majority of these people are men 96.1%, and 75.6% were pretrial detainees or in remand – many awaiting years for a trial[74], highlighting the slow and delayed nature of the judicial proceedings. There are 68 prisons in total with 55 district prisons and 13 central prisons.

Considered as centers of confinement, prisons are overcrowded, lack privacy and prisoners often experience inhuman and dehumanised treatment from prison officers[75]. In 2002 a Ministerial Committee or Jail Reforms, headed by the then State Minister for Home Affairs made several recommendations to improve human rights and conditions impacting on prison populations. Some of these included, installing a social welfare officer, providing hygiene supplies for prisoners, reducing sentencing periods by one third, not imposing hard labour on male prisoners and providing women with vocational skills. Yet after four years of meetings, the draft recommendations were not approved[76].

There are a number of laws and policies under the Prison Act 1894 that aim to create a more enabling environment for prisoners which include, sufficient accommodation (Section 4), juveniles should be separated from the general population (section 29), solitary confinement should only occur in a cell for no more than 24 hours and that medical professional shall visit the prisoner at least once per day and Section 37 assures the right to health[77]. Yet again these laws are not enforced scarcity of food, accommodation and health care is widespread, bribery is commonplace, those who can pay prison officials are favoured with extra rations, bedding and access to health[78].

Local Human Rights organisation such as Ain o Salish Kendra (ASK) monitor the conditions in prisons and also provide extensive research and policy advocacy including preparing recommendations for reform, amendment or repeal of harmful laws including those affecting prisoners[79]. The National Legal Aid Services Organisation (NLASO) provides some legal aid support to prisoners who cannot

[74] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8554923/
[75] https://www.askbd.org/ask/rights-prisoners/
[76] Ibid
[77] http://lawyersclubbangladesh.com/en/2020/10/15/prisoners-rights-and-the-reality-in-bangladesh/
[78] Ibid
[79] https://www.askbd.org/ask/legal-advocacy-policy-reform-unit/

afford private attorneys but access to these services is limited, burdened by extensive complex administrative requirements for eligibility[80]. The government has also permitted inspections of prisons by government inspectors and non-government organisations however no documentation or reporting on conditions has been forthcoming following visits[81].

Yet the extent to which the legal environment and access to justice impacts on those specifically living with or at risk of HIV is unknown as there is very limited data or research available that explores the experiences of KPs and PLHIV while they are imprisoned.

Stigma and Discrimination

There is a dearth of information available on the experiences of stigma and discrimination within prison settings felt by KP and PLHIV in grey literature. It can be assumed that within such a closed setting and with limited access to information and knowledge on HIV and transmission those at risk or living with HIV may experience even higher levels of stigma and discrimination than those not imprisoned. With limited privacy and lack of appropriate accommodation the lack of privacy and confidentiality may also impact on the disclosure of their status. HIV and STI testing programs are currently being implement in 8 prisons in Bangladesh as part of GC7 these programs will be scaled up to include an additional 11 prisons and 8 satellite services. These initiatives provide an important opportunity to undertake further research on the experiences of stigma and discrimination for KP's and PLHIV.

Experiences with Health Care Institutions

There is currently no available data on the prevalence rate of people living with HIV in prison settings. Further the desk review highlights that overcrowding and poor access to health services and commodities to reducing HIV transmission as well as low knowledge of HIV may have an impact on increased transmission[82]. There are currently HIV and STI testing services in 8 prisons in Bangladesh implemented in partnership with between MOHFW and Ministry of Home Affairs. This includes a medical technician to facilitate testing and a counsellor to provide information and consent. Since November 2022, 1879 prisoners have been tested for HIV with one positive result. HIV/Syphilis/TB/Hep C testing services have been initiated in seven prisons. Positive patients are linked into local government services for treatment. There was no published information available on the progress of this program, to what extent consent is garnered, confidentiality and privacy are maintained nor linkages to treatment.

Prison Directorate statistics does show that health services in prison settings are woefully underserviced and underfunded with up to 43 of 141 positions for prison doctors vacant across the country and only 5 doctors assigned to full time positions[83].

Gender Based Violence and Gender related Discrimination.

There are currently approximately 2981 women in prison. Some reside there with their children. A lack of access to justice, poverty and limited work opportunities are some reasons why women end up in prison. Many law enforcement actors are not sensitised to the needs of women[84]. When released from prison, they face stigma and discrimination and rejection from their families and

[80] https://www.state.gov/reports/2022-country-reports-on-human-rights-practices/bangladesh/
[81] Ibid
[82] https://www.unodc.org/southasia/frontpage/2012/November/bangladesh_-promoting-hiv-prevention-in-prisons-a-critical-but-often-overlooked-initiative.html
[83] https://www.state.gov/reports/2022-country-reports-on-human-rights-practices/bangladesh/
[84] https://gender-works.giz.de/wp-content/uploads/filebase/49_Bangladesh.pdf

society more broadly. There is no information available on the prevalence rate of HIV in women in the prison population nor is there information available on their access to and quality of health care.

Beyond cis-gender women there is further no information available on the experiences of gender diverse people who are imprisoned.

Community Mobilisation and Organising

Through the work supported by organizations such as Dhaka Ahsania Mission (DAM), CARE Bangladesh and Khulna Mukti Seba Sangstha (KMSS) volunteer peer educators have been mobilized in prison settings to support with awareness raising activities on HIV and STI issues for prisoners. Volunteers mobilse their peers with symptoms to get tested, provide information on prevention, testing and treatment as well as psyhco-social support[85]. However beyond this there are no formal networks of prisoners or ex prisoners.

Improvements in the Human Rights Environment for Key Populations Affected by HIV

It is reassuring to note that with almost three decades of investment in the HIV/AIDS program space there have been improvements in the human rights environment that were noted by key populations and key population groups. During the national workshop held on the 9th of August and as expressed during the FGDs, all KP groups noted a noticeable reduction in societal stigma, they attributed it to mass awareness and education programs, this included seeing a reduction in harassment and gossiping, and greater acceptance of them within the community. They further remarked on reduction in stigma and discrimination by Government health workers, contributing it to greater awareness, education and sensitisation programs conducted by NASP and community-based organisations. This was particularly the sentiment in ART and HTC centres, unfortunately within the broader health system stigma and discrimination continues to persist, with specific mention to maternity services.

Sensitization with law enforcement agents has also improved some understanding of issues impacting on -particularly PWUD. In Rajshahi and Dhaka, extensive formal and informal sensitisation and training led by CBOs has reduced harassment by police officers. Reports included a decrease in harassment, abuse and petty arrests. In Bangladesh there are approximately 3200 people nationally on OST through 15 centres (12 under SCI Grant and 3 in icddr,b). SCI and ASP also will start OST in prison in Dhaka Central Jail and Narayanganj jail respectively in current grant. Those in the FGDs on OST reported significant improvements in the quality of their life and their standing within their family and society. Two men reported improved relations with their families, being able to gain secure and dignified employment. They stated that, since commencing OST, police harassment had ceased, and one man spoke of his standing improving in society so much so that his daughter was able to find an eligible match for marriage.

Many spoke of their own experiences of a decrease in self and internalised stigma due to the vital support of peer outreach staff. Psychosocial counselling, mental health support and peers to support the navigation through complex and bureaucratic health systems have led to greater confidence, self-empowerment and self-esteem.

[85] https://www.unodc.org/southasia/frontpage/2012/November/bangladesh_-promoting-hiv-prevention-in-prisons-a-critical-but-often-overlooked-initiative.html

A key area in which all KP Networks hailed as a progressive and positive outcome was the opportunity to advocate at all levels of community and Government. This advocacy has led to greater collaboration between key Government actors; health centre, police, ward councillors, civil surgeon and it also led to building greater allies within and between networks.

For Hijra and TG groups, legal recognition of their identities remains flawed, both in terms of legal reform to facilitate recognition of gender identities that exist in reality, and in the administrative complexity of navigating legal gender recognition. However, they do see it as a positive first step towards exercising their right to be recognised and their freedom of expression.

Additional Human Rights Barriers to HIV Prevention, Treatment and Care Services

Lack of nuanced approach to service delivery: Under the Protocol of HIV Services for Key Populations[86] developed by the Government of Bangladesh, one of the essential guiding principles to achieve Sustainable Development Goal 3 and corresponding target 3.3: "End epidemics of AIDS, TB, malaria, and neglected tropical diseases by 2030, and combat hepatitis, water-borne infections, and other communicable diseases.", commits to decentralising service provision to KP community-led programs and shifting tasks to KP peers as health workers. Yet under the new Global Fund grant cycle it appears that HIV services are being centralised and led by Government actors; while this is not in itself a negative outcome – as the Government should be providing comprehensive health services to key populations –it does reduce user choice and removes communities as implementers.

The ASP has developed a comprehensive package of essential HIV services for KPs as outlined above, and the literature review highlights that all KPs used some aspect of the comprehensive package of services. However, there remain vulnerabilities for some subsets of the broader KP groups. For example, sex workers limit their use of condoms when their clients refuse them, condoms further reduce pleasure for clients and extend the time of ejaculation meaning women have to spend longer with one client, impacting on their earnings for the day. For MSM and Hijra groups, similarly their desire for pleasure as well as the fear of being found with condoms on their person impacts on their access and use.[87]

These examples highlight a need to take a nuanced approach to providing these services, not only across each of the KPs but also within the KP groups where there is much diversity. For example, among sex workers there are those who are: street based, brothel based, male sex workers, female sex workers, transgender sex workers, and men who have sex with men who comprise of gay men, men who are married and have sex with men, bisexual men. Each of these subcategories have different motivations and their demand for services are unique. A one size fits all model is inadequate especially as we see the rate of HIV rising in certain populations namely MSM and PWUD. Differentiated service delivery model are an effective pathway to addressing the evolving needs of KPs.

While this has been occurring through the implementation of services by non-government actors, with the move to integration of all non-government operated DICs into Government sites over the next funding period, there will be period of teething out challenges associated with providing a nuanced approach to serving each of these KPs. It will be pivotal for Government health clinics to

[86] 2023 NASP: Protocol of HIV Services for Key Populations in Bangladesh
[87] End Line Survey (Behaviour) on Continuation of the Prioritized HIV Prevention Services among key Population in Bangladesh

work closely with district level CBOs implementing DICs to develop operational guidelines that will promote access, availability, quality and cost effective services to a population who will be concerned about the timeliness in taking services, appropriateness of health care workers, the confidentiality and privacy in attending and the public scrutiny that may come while they are waiting to be seen by a health care worker. For example, for sex workers, long wait times may take them away from earnings. They may also not be able to attend clinics during daytime hours due to the timings of their trade.

Additionally non-government DICs provide a wide range of auxiliary services to KPs including mental health, counselling and psychosocial support as well as referrals to access to justice programs and gender-based violence support. How these will be integrated into the Government clinics remains unclear.

In the hospitals visited in Chattogram and Rajshahi, a One Stop Crisis Centre (OSCC) was located onsite, operated under the Department of Women's Affairs to provide support to victims/survivors of gender-based violence. However, the was no information available on how KPs could be referred to the OSCC nor if they were sensitised to the GBV related issues experienced by KPs.

During a visit to Rajshahi, a site visit to the HTS clinic in the hospital that has already begun to serve PWUD was conducted. Served by a compassionate and skilled medical officer, the local KP community networks were very pleased with the services received. During the KII, further information was sought on how integration would operate at a practical level, to consider the unique needs of each population. For example, staff were questioned about what would be required to seek a urine sample for Hijra/Transgender patients, with the question, "Which bathroom would they go to, male or female?". Staff found it challenging to come up with a response.

Finally, programs are often hampered or set back when medical staff turn over so frequently often due to a reposting, this impacts on trust and relationship building with client groups as well as a loss of institutional knowledge. In Rajshahi, participants of the FGDs were highly satisfied and pleased with the quality of care received from the Medical Officer currently employed. Their greatest fear and concern to impediments to sustainable service access was if she were to be reposted to another facility. Furthermore, currently with the integration of PWUD and FSW clinics, the medical officer sees approximately 15-20 people per day. Time management and quality of care concerns may arise once all four KP groups are integrated.

Lack of focus on structural interventions: While the scope of the NASP is to implement the program essentials, it is heavily focused on a biomedical model of test and treat. This model fails to effectively address the root causes that place key populations at risk of HIV transmission. Ultimately, these programs will remain insufficient in eliminating HIV unless structural interventions address root causes; education, poverty, employment and – across the board education, poverty and a punitive legal environment was a significant factor in higher levels of violence, lower levels of health care access and higher levels of stigma and discrimination. During the FGDs one of the most common issues raised by all KP's was not HIV but the need for safe accommodation, access to NIC, their children attending school and dignity in work.

Exclusion from services due to lack of national identity cards: The issue of NID Cards was a particular concern for all KPs. The lack of identification limited their access to essential services, for example banking. Without a NID they cannot apply for a bank account. This forces them to only exist within the cash economy, limiting their access to services that are not cash based. This in particular marginalises women further, who are at risk of having their money stolen from them by intimate partners, *Mustaans,* or their clients when they do not have a bank account to deposit their savings

in. Additionally, without an NID, people were not eligible to get a Covid Vaccine. An already vulnerable population further excluded from accessing health services.

Lack of knowledge on SOGIESC issues: During the in-country field trip, it was apparent beyond organisations working with gender diverse populations, there is a lack of understanding of SOGIESC in general as well as how the lack of recognition of peoples diverse SOGIESC can limit their access to health and HIV services. Within the umbrella of gender identity lies hijra's, kothi's, transgender women, transgender men, non-binary people and those who identify as intersex. Each of these groups has unique identity, expression, community and social outlook that governs their behaviour and impacts on their risk factors. These risk factors also relate to and impact on their biomedical needs, which through FGDs and KIIs illustrated that health care workers have very little understanding on. It will be pertinent that education is provided to relevant actors on these concepts and ways in which it impacts on an individual's health and wellbeing.

Unsustainable funding environment: The lack of secure and sustainable funding impacts on the quality of interventions. When project-based funding stops, the projects themselves also cease with limited opportunities for organisations to continue. Tightly timebound projects without sustainable funding further mean that interventions do not often target structural changes which take time. Additionally target based interventions can reduce the quality of the intervention or pressurise organisations to fabricate numbers in order to meet funding requirements.

Existing programs to address human rights-related barriers to HIV and New and Existing Opportunities to Scale Up

It was apparent that there are number of programs that currently exist to reduce human rights related barriers. It is also clear that over the decade's long implementation of HIV programming, these programs have made an impact in improving the human rights related environment. Furthermore, it must be noted that the under Global Fund Grant Cycle 7 proposal a comprehensive list of activities aimed at reducing human rights barriers for each KP has been included. With approximately USD$ 3 million (over ten percent of the total grant) the commitment by key stakeholders (both government and non-government) in the country to improve the human rights environment for KPs is well demonstrated. Due to this being a rapid assessment, this is not a comprehensive list however it provides a snapshot of the existing work that is ongoing and how new or scaled up programs can further decrease rights violations and improve health and HIV outcomes for KPs.

As part of this rapid assessment a baseline score is required to measure to what extent existing programmes are reducing human rights and gender related barriers to accessing HIV services based on the eight key areas identified by the global fund:

- Legal literacy ("know your rights")
- Ensuring rights-based law enforcement practices
- Improving laws, regulations and polices relating to HIV and HIV/TB
- Eliminating stigma and discrimination in all settings
- Ensuring non-discriminatory provision of health care
- Reducing HIV-related gender discrimination, harmful gender norms and
- violence against women and girls in all their diversity
- Community mobilization and advocacy for Human Rights
- Prison Populations

The rating scale is based on the reach of the programs of the target populations. The rating provided in this report captures the reach of the program within the area for all KPs (MSM, TG, PWUD and FSW) combined.

Rating scale for assessing program areas

Rating	Definition
0	No formal programs or activities identified.
1.0	One-off activities that are time-limited, pilot initiative.
2.0	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching <35% of targeted population.
2.3	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching 35-65% of targeted population.
2.6	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching >65% of targeted population.
3.0	Operating at subnational level (btw 20% to 50% national scale) and reaching <35% of targeted population
3.3	Operating at subnational level (btw 20% to 50% national scale) and reaching 35-65% of targeted population
3.6	Operating at subnational level (btw 20% to 50% national scale) and reaching >65% of targeted population
4.0	Operating at national level (>50% of national scale) and reaching <35% of targeted population
4.3	Operating at national level (>50% of national scale) and reaching 35-65% of targeted population
4.6	Operating at national level (>50% of national scale) and reaching >65% of targeted population
5	At scale is defined as more than 90% of national scale, where relevant, and more than 90% of the population

The most recent size estimation study done in 2023 will provide the target population. The value of the point estimate will be used as the basis of the target population.

KP National Estimates 2023		
KPS	Min Size	Point Estimate
FSW Street	24400	37629
FSW Brothel/Hotel	7488	24167
FSW Residence	16198	47828
MSM	39784	116498
MSW	27957	48694
PWID	25751	34370
TG		12629
Overall	**141578**	**321815**

This section will outline the examples of existing program activities being implemented by diverse actors under each thematic area and the baseline score for that area. This will be followed by what is planned in the GC7 proposal funding request. These activities are structured in a table that begins with activities devised for Module 9: Reducing Human Rights related Barriers to HIV/TB Services followed by the KP specific activities for Human Rights and Community Mobilization and Advocacy devised under the Prevention Modules. The proposal for the upcoming grant cycle has taken into account the necessary actions needed to reduce stigma and discrimination, harmful laws and policies and to strengthen community empowerment. next proposal and finally opportunities for scale up, beyond the GC7 proposal framework. Following this a section on opportunities for new and/or scale up of programs has been outlined.

Existing Programs on Access to Justice

Legal literacy ("know your rights"). All community-based networks had implemented some kind of know your rights training program. These programs are project based and dependant on continued funding. These programs inform individuals of their rights and educate them on how to exercise those rights – including how to claim their rights through the judicial system and what resources are

available to them to do so. To what extent these trainings have an impact on these communities to exercise their rights and utilise the judicial system is limited. During FGDs with sex workers, men who have sex with men and transgender and hijra populations some were able to list a number of rights they were entitled to and some resources that could assist in seeking justice but for the most part they stated that even when they try to seek justice, it often does not benefit them nor lead to desired results, recourse or remedy. Some examples of 'know your rights programs' are listed below.

Sex Workers: Ashar Alo has recently completed implementing the project *Strengthening Capacity of Sex workers leaders to address harmful policy and practice within sex work and build solidarity.* Funded by Women's Fund Asia, this project aims to equip sex workers with the skills to advocate on harmful policies impacting on their right to work and live free from violence. SWAN has been rolling out the Sex Worker Implementation Tool (SWIT) roll-out and capacity building. The SWIT provides evidence for the necessity of decriminalisation of sex work, the involvement of sex workers in developing policy, and the empowerment and self-determination of sex work communities as a fundamental part of the fight against HIV.

Men who have sex with men: Bandhu has an extensive portfolio of programs on access to justice. They have advocated to the National Legal Aid Services Organization (NLASO) to include trans gender issues in its policies and extend support to gender diverse population. BSWS has also lobbied for a separate box for 3rd gender on the Legal support application form of NLSAO, to which they complied. BSWS also have a legal hotline called Ain Alap which serves to provides legal advice to MSM and TG people across Bangladesh's 64 districts and link them with para legals and local legal aid services to remedy human rights violations.

Transgender and Hijra Bandhu in their function in serving gender diverse population further has developed a flagship course on Sexuality and Gender in 2022[88] run by gender-diverse women for women, girls, trans, and intersex communities. This course provided skills development and training to gender diverse communities to live a dignified life in Bangladesh, including a safe environment, counselling, capacity building, SRHR, human rights, and awareness on gender and sexuality. This is funded by Mama Cash & Foundation for a Just Society (FJS),

Scoring the Baseline: Know your rights – Score 2.3

Rating scale for assessing program areas

Rating	Definition
0	No formal programs or activities identified.
1.0	One-off activities that are time-limited, pilot initiative.
2.0	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching <35% of targeted population.
2.3	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching 35-65% of targeted population.
2.6	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching >65% of targeted population.
3.0	Operating at subnational level (btw 20% to 50% national scale) and reaching <35% of targeted population
3.3	Operating at subnational level (btw 20% to 50% national scale) and reaching 35-65% of targeted population
3.6	Operating at subnational level (btw 20% to 50% national scale) and reaching >65% of targeted population
4.0	Operating at national level (>50% of national scale) and reaching <35% of targeted population
4.3	Operating at national level (>50% of national scale) and reaching 35-65% of targeted population
4.6	Operating at national level (>50% of national scale) and reaching >65% of targeted population
5	At scale is defined as more than 90% of national scale, where relevant, and more than 90% of the population

Ensuring rights-based law enforcement practices: At a community level CBO's report to conduct informal sensitisation of law enforcement actors, for example, both APOSH in Rajshahi and Bonchita, a sex work CBO in Jessore work closely with the local police thana and their respective In Charge's,

[88] https://www.BSWS-bd.org/flagship-course-on-sexuality-and-gender-2022/

to advocate for and address individual rights violations impacting on their KP beneficiaries. A few more examples are listed below.

PWUD: The National Network of PWUD (NPUD) in Dhaka and APOSH in Rajshahi both spoke about providing sensitization training to police, these programs were both formal and informal in nature. For APOSH they provided continued advocacy at district committee meetings at the local level. Both organisations stated these programs had led to a reduction in harassment for PWUD. They also stated that UNODC has been working closely with the Department of Narcotics to advocate for less punitive punishments for petty drug users and to decriminalise certain kinds of drug use in order to reduce harassment and the burden on law enforcement agencies and the prison system. Save the Children along with its harm reduction program partner CARE Bangladesh organized several workshops/meeting with DNC central, divisional and district office and also with police as part of regular advocacy. As informed by Save the Children representatives, in a recent meeting with DNC central office the Director General (DG), DNC agreed to form a committee to discuss and review relevant issues under the narcotics control act, that negatively impact on harm reduction approaches. It illustrates the DNC positive commitment in addressing human rights violations.

In 2022, UNODC conducted the first ever five-day training on "Drugs, Crime and HIV/AIDS", in collaboration with the Bangladesh Police Staff College. I was attended by 25 inspectors from the Dhaka Metropolitan Police, the training was based on a manual, '*Police Training Module on Drugs, Crime and HIV/AIDS*,' jointly developed by UNODC and Bangladesh Police[89].

Men who have sex with men: Bandhu Social Welfare Society has built a trained cadre of 206 "Bandhu Lawyers Panel" enlisted from various districts in Bangladesh to enhance and ensure doorstep legal support to the victims. This is volunteer services by the lawyers and Bandhu provides all kind of cost related to the cases. Bandhu arranges regular training for them. These Panel Lawyers also support the Ain Alap hotline. This service reaches MSM, Transgender and Hijra populations across all 64 districts Bandhu will also be embarking on a training to sensitise judges on MSM, transgender and hijra issues this year.

Scoring the Baseline: Sensitisation of Law Enforcement Actors – Score 2.6

Rating scale for assessing program areas

Rating	Definition
0	No formal programs or activities identified.
1.0	One-off activities that are time-limited, pilot initiative.
2.0	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching <35% of targeted population.
2.3	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching 35-65% of targeted population.
2.6	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching >65% of targeted population.
3.0	Operating at subnational level (btw 20% to 50% national scale) and reaching <35% of targeted population
3.3	Operating at subnational level (btw 20% to 50% national scale) and reaching 35-65% of targeted population
3.6	Operating at subnational level (btw 20% to 50% national scale) and reaching >65% of targeted population
4.0	Operating at national level (>50% of national scale) and reaching <35% of targeted population
4.3	Operating at national level (>50% of national scale) and reaching 35-65% of targeted population
4.6	Operating at national level (>50% of national scale) and reaching >65% of targeted population
5	At scale is defined as more than 90% of national scale, where relevant, and more than 90% of the population

Improving laws, regulations and polices relating to HIV At the national level the most comprehensive monitoring of laws, regulations and polices that occurs for Bangladesh at the national level is performed through the Country Progress Report periodically published by UNAIDS

[89] https://www.unodc.org/southasia/en/frontpage/2023/February/bangladesh_-unodc-builds-law-enforcement-capacities-on-open-source-intelligence-to-counter-trafficking-in-persons-and-smuggling-of-migrants.html

including for example, laws, regulations or policies specifying that HIV testing, viral load testing, criminalisation and/or persecution of KPs, what protections are in place for people living with or at risk of HIV to live free from violence. Organisations such as Bandhu further monitor the legal environment through the development of policy briefs for example in 2021 they produced the Gaps in Legal Protections Against Gender-based Violence for Transgender Persons in Bangladesh[90]. There is limited information available on how local laws and policies are being monitored at district level and below.

In addition, some organisations such as SWN, Bandhu and civil society groups[91] have also submitted reports to the Universal Periodic Review and CEDAW Committee Concluding Observations on monitoring issues relating to violence against sex workers, impact of punitive and invasive colonial laws (Section 377) and the lack of accountability and justice of the torture and extrajudicial killings of people who use drugs by law enforcement actors during the 'war on drugs' strategy.

ICDDR, B in collaboration with Bandhu monitor the impact of gender-based violence committed against MSM and Transgender and Hijra people through the Gender Based Violence Database. This database records the number of people who have sought support through Ain Alap hotline, what information they seek, and how the violation is resolved.

Furthermore, there have been efforts to reform laws by UNODC and the National Network of Drugs users, Bandhu, SWN and other activists in Bangladesh through advocacy meetings, protests, and sensitization on decriminalising drugs, sex work and removing punitive penalties for same sex behaviour however as of yet no progress has been made other than the legal recognition of third gender people.

Scoring the Baseline: Monitoring and reforming laws, regulations, and policies – 2.6

Rating scale for assessing program areas

Rating	Definition
0	No formal programs or activities identified.
1.0	One-off activities that are time-limited, pilot initiative.
2.0	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching <35% of targeted population.
2.3	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching 35-65% of targeted population.
2.6	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching >65% of targeted population.
3.0	Operating at subnational level (btw 20% to 50% national scale) and reaching <35% of targeted population
3.3	Operating at subnational level (btw 20% to 50% national scale) and reaching 35-65% of targeted population
3.6	Operating at subnational level (btw 20% to 50% national scale) and reaching >65% of targeted population
4.0	Operating at national level (>50% of national scale) and reaching <35% of targeted population
4.3	Operating at national level (>50% of national scale) and reaching 35-65% of targeted population
4.6	Operating at national level (>50% of national scale) and reaching >65% of targeted population
5	At scale is defined as more than 90% of national scale, where relevant, and more than 90% of the population

Proposed Interventions Under the GC7 Proposal on Access to Justice

Overall Interventions to Improve Access to Justice
Divisional-level legal support and crisis management groups will be formed in 8 divisions of Bangladesh to which critical and complex cases are referred. The divisional level groups will be supported by a central legal and human rights advisory group, formed among human rights activists, journalists, UN partners, researchers, and policy stakeholders who will lead the activity from the national level.

[90] https://www.BSWS-bd.org/wp-content/uploads/2021/11/Policy-Brief_GBV-2021.pdf
[91] https://www.fidh.org/IMG/pdf/solidarity_group_for_bangladesh_fourth_cycle_upr_report_joint_submission.pdf

Provide gender, sexuality and HIV training to community paralegals
Provide training/orientation on harm reduction, gender, sexuality, and dynamics of different KP to law enforcers, paralegals, lawyers, and human rights activists.
Good practices in accessing pro bono services will be expanded so all KP and PLHIV can access legal support. Law enforcers (including through the LEAHN: Law Enforcement and HIV Network), and pro bono lawyers will be engaged through the District Legal Aid Office (DLAC).
Provide orientation/training to PMO staff of SR and SSR on Sexual exploitation, abuse and harassment (SEAH), Code of Conduct (CoC), safety and security and gender-based violence (GBV)
Set up a hotline to address health/human rights violations/GBV of KP.
Legal support for the victim of GBV and human rights violation
Consultation meeting with the National Task Force (NTF) and other stakeholders on legal issues of KP to support NTF in developing medium- and long-term action plans based on the HR strategy and recommendations from the Human Rights Assessment and the 3rd National Stigma Index.
Consultative workshop with prominent lawyers and human rights experts to review punitive laws for KP. Policy-level advocacy meeting with parliamentarians to pass and enact anti-discriminatory law for KP.
Arrange policy dialogues, media events, round table discussions, workshops, etc., through the leadership of departments and commissions under the Ministries of Home Affairs and Law, Justice and Parliamentary Affairs to enhance understanding of barriers that KP and PLHIV face and carry forward ways to overcome these barriers, including advocacy for the rapid endorsement of the Anti-discriminatory Act and further review of punitive laws.
Regular meetings with human rights advisory group members.
Workshop with different govt and other stakeholders to assess and review the human rights situation of KPs and develop an action plan
Conduct annual review of the human rights situation
Establish working committees/ groups with KP communities and local police focal persons to improve policing practices. DIC Advisory Committee will ensure more engagement of local people with interventions to address human rights-related barriers. Law enforcers from 27 districts will be sensitized in a continuous manner.
MSM Specific Interventions
Legal and rights literacy services will be provided for the legal empowerment of MSM/MSW.
Human rights and legal literacy issues will be integrated into the peer educator training manual.
Community paralegals cum peer human rights educators will be deployed to look after the legal issues of MSM and hijra at the field level. A legal coordinator will be recruited to support the community paralegals and link victims of abuse to district-level lawyers' groups.
FSW Specific Interventions
Advocacy for legal protections and social integration by the SW network and CBOs.
Annual workshops will be held with the District Legal Aid Committees.
Training sessions will be held on human rights and stigma discrimination for the Law Enforcement Agency (LEA) and healthcare providers.
Training on human rights and gender issues for CBOs will be held under the Sex Workers Network (SWN).
FSW in need of legal support will be referred to legal aid organizations.

Host advocacy and sensitization meetings with LEA and policy makers on human rights, HIV, and gender to mitigate human rights violations.
Transgender and Hijra Specific Interventions
Legal and rights literacy services will be provided for the legal empowerment of transgender people.
Human rights and legal literacy issues will be integrated into the peer educator training manual, including community paralegal cum peer human rights educators.
PWUD Specific Interventions
Advocacy with DNC and other LEA as per the framework developed recently, in NFM3 (including an overseas tour to best practice sites by LEA/Govt officials, workshop, orientation meeting with stakeholders).
Training/Orientation of CBOs under Network of People Who Use Drugs (NPUD) on the issues of human rights and gender, especially those involved in participatory monitoring and reporting of abuses.
Contracting a law firm to provide legal support to KP and aware them about their rights who are often harassed or arrested due to drug use and carrying paraphernalia.
Orientation and training sessions on human rights, stigma, and discrimination will be conducted for law enforcement agencies and health service providers incl. with the district legal aid committee.
Organize TOT for police through the leadership of ASP and the Police Staff College/Institute based on the training manual on harm reduction and other HIV prevention interventions developed for the police. The manual will be updated to include GBV. Trained Police will then support orientation and training for district-level police. The training will be across all divisional cities
Activities to adequately engage the Department of Narcotics Control (DNC) and the Police to support harm reduction from a public health viewpoint will be conducted from the central to the district level. These activities will include continued advocacy, especially for the Decriminalization of the Drug Dependency (Triple D) Framework (developed in the previous grant) and to reform the NCA.

Opportunities to Strengthen programs on Access to Justice

It is clear that in the next proposal the NASP, Save the Children and ICDDR, B and its partners have strived to develop a very comprehensive human rights plan of activities for the GC7 which includes Human Rights Matching Funds and which aim to address the many gaps highlighted in the findings. The prioritisation on Know your rights programs for key populations, alongside increasing access to legal aid services and programme and policy advocacy work planned with national and district decision makers to sensitise them to the rights of KPs as well as work towards reducing violations are structural interventions that could, if sustainable applied remove human rights related barriers to HIV services.

Beyond these, interventions, it is recommended at the project level, the BCCM also receive human rights and gender sensitivity training to ensure that across the program cycle, at all levels, stakeholders are working from a human rights-based perspective.

One of the key barriers to accessing justice mechanisms is the lack of National Identity Card. Across the program the provision should be made that all KP's without an NID are supported to apply for one. Without which, fundamental rights to freedom of movement and access to services continue to be limited.

Existing Programs Eliminating Stigma and Discrimination in all Settings.

There are a number of programs available on reducing stigma and discrimination that have had an overall impact on the reduction in harassment and abuse experienced by KP's as they themselves have acknowledged. During the Covid 19 pandemic, Save the Children ran stigma and discrimination training for all health care workers around caring for KPs with dignity and respect. As part of their HIV training package for medical officers, the NASP has a component on reducing stigma and discrimination, which includes a session with leaders from key affected populations.

The Stigma Index[92] report, due to be updated as part of the GC7 proposal is a vital source of information on the experiences of stigma by PLHIV and at risk KPs and it provides essential data to guide programming. Across the country networks and CBO's bring mass awareness to society on HIV/AIDs, these programs are pivotal in reducing societal stigma.

Informally the work that CBOs do at the community level is aimed at reducing stigma and discrimination across all facets of society, through participation in local and district level committees, they are able to sensitise decision makers to take a stand against discrimination. For example, Bonchita a local sex worker organisation in Jessore has developed a relationship with the civil surgeon at the government hospital, providing education and sensitisation on issues experienced by sex workers within the health setting, the impact of this led to sex workers in Jessore without NID cards receiving a Covid vaccine. In Bangladesh, producing an NID was essential in receiving a Covid vaccine. Similarly, through the district level drop-in centres, peer outreach workers and clinical staff play an important role in reducing self-stigma of KP's which lead to improved health outcomes, treatment adherence, confidence and self-esteem. Some other programs of note include.

PLHIV: Ashar Alo Society is currently implementing a program funded by Women's Fund Asia on "Reducing Sigma & Discrimination and Increasing Awareness on HIV among the Family Members of the Woman PLHIV". Aimed at reducing self-stigma, this year long project includes sensitisation of KPs with the health system, providing skills development training to secure a livelihood and outreach home visits to provided psychosocial and treatment adherence support[93].

FSW: For the last 15 years, sex worker groups have been using International Sex Workers Day on the 2nd of June every year to give sex workers a platform to raise their voices against the violence, discrimination, exploitation and stigmatisation that have consistently persecuted them for decades[94].

MSM and TG: In 2016, Bandhu organized three days training for the Government Health Service Providers to reduce stigma and discrimination in providing health care services to MSM/TG population following the module developed by WHO and UNDP and approved by ASP. The objective of the training was to sensitize the participants on sexuality and health needs of MSM/TGs addressing stigma and discrimination and to provide better management of STIs and other common health problems for this stigmatized group. Twenty-seven participants attended[95].

[92] 2017 Network of PLHIV (NOP+) Bangladesh: HIV/AIDS Related Stigma and Discrimination against PLHIV in Bangladesh: 2nd National Stigma Index, Bangladesh

[93] https://asharalo.org.bd/projects/

[94] https://www.newagebd.net/article/157530/sex-workers-in-bangladesh-are-honoring-the-international-day-to-end-violence-against-sex-workers?fbclid=IwAR1knbdnF7XZLwqkQ8PrxWS1PMnWNik721bRHkmZum-LRTzF5TtW5cginz0

[95] https://www.BSWS-bd.org/training-program-on-stigma-and-discrimination-related-to-hiv-and-sti-syndromic-management-for-government-health-service-providers-june-2016/

As a result of the successful policy advocacy of Bandhu, the National Curriculum and Textbook Board of Bangladesh has agreed to incorporate Transgender issues in the Supplementary Reading Material for the students of class IX and above[96]

Scoring the Baseline: Eliminating Stigma and Discrimination in all Settings – 2.6

Rating scale for assessing program areas

Rating	Definition
0	No formal programs or activities identified.
1.0	One-off activities that are time-limited, pilot initiative.
2.0	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching <35% of targeted population.
2.3	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching 35-65% of targeted population.
2.6	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching >65% of targeted population.
3.0	Operating at subnational level (btw 20% to 50% national scale) and reaching <35% of targeted population
3.3	Operating at subnational level (btw 20% to 50% national scale) and reaching 35-65% of targeted population
3.6	Operating at subnational level (btw 20% to 50% national scale) and reaching >65% of targeted population
4.0	Operating at national level (>50% of national scale) and reaching <35% of targeted population
4.3	Operating at national level (>50% of national scale) and reaching 35-65% of targeted population
4.6	Operating at national level (>50% of national scale) and reaching >65% of targeted population
5	At scale is defined as more than 90% of national scale, where relevant, and more than 90% of the population

Proposed Interventions to Eliminate Stigma and Discrimination Under the GC7 Proposal

Overall Interventions to Eliminate Stigma and Discrimination
Conduct the 3rd National Stigma Index (PLHIV, including all KP).
Develop and disseminate a national strategy for stigma reduction and an accountability mechanism based on evidence generated from the human rights assessment, consultations, the 3rd National Stigma Index.
Develop and update IEC and advocacy materials on human rights and harm reduction including policies, briefs and training manuals to be used by policy makers, journalists, law enforcers, KP themselves, etc., on the rights of KP, people who have diseases, including communicable and infectious diseases, etc. and ensure GBV, 80-60-30, sexuality, gender power relations, access to health, UHC, and human rights including health equity and equality and other issues are included.
Conduct training/orientation for journalists and social media personalities to develop a critical mass of expertise for positive journalism and media messaging to decrease discriminatory views linked to workshops, media events, “Day” celebrations, etc.
Innovations such as arranging for Human Rights Fairs and social media events will also contribute to advocacy efforts.
Higher level advocacy meeting/workshop with the Ministry of Education (General and Medical Education), Ministry of Health and Family Welfare to incorporate a section on gender diversity, sexuality and human rights.
MSM Specific Interventions
The frequency of individual-level counselling will be increased to mitigate internalised stigma and increase self-esteem.
Contract with a theatre group to conduct participatory theatre intervention to eliminate stigma and discrimination faced by MSM and TGW
Conduct meetings for peer mobilisation and support groups to counter internalised stigma among MSM and TGW.

[96] https://www.apcom.org/BSWSs-service-models-recognized-as-the-best-practice/

Transgender and Hijra Specific **Interventions**
The frequency of counselling sessions with TGW will be increased to mitigate internalised stigma and increase self-esteem.
FSW Specific Interventions
Bolster community participation through local advocacy efforts, ensuring human rights and mitigating stigma.
Refer sex workers to certified Vocational Training Institutes for better economic opportunities and assist them to obtain a national ID card and opening a bank account. This action can build confidence and options for an alternative livelihood.
PWUD Specific Interventions
Organizing TV talk shows and roundtable discussions to create mass awareness and a favourable situation among policy makers regarding human rights issues related to HIV and harm reduction.

Opportunities for Strengthening Programs that Eliminate Stigma and Discrimination in all Settings.
The upcoming proposal identifies a significant commitment to reducing stigma and discrimination for KP's across diverse facets of society. However due to a lack of resources they have been implemented inconsistently with limited scale and coverage.

Additional areas to consider would be to engage with religious leaders, who have significant power within society to reduce stigma and discrimination of KPs by speaking about them in positive manner in public address and sermons. Training them in human rights can further enable them to mitigate negative perceptions of these groups and improve societal perceptions and reduce community related rights violations experienced by KPs.

HIV education with employers and in workplaces can also improve the employability of PLHIV as well as minimise negative experiences often faced by KPs and PLHIV who do not disclose their status due to fear of harassment, gossip and unfair dismissal. Encouraging workplaces to implement a no tolerance policy of discrimination to include KPs and PLHIV can create an enabling environment.

Social media can be used as a vehicle to dispel misconceptions and myths. With the widespread use of smart phones and access to the internet, a social media campaign and strategy could be developed collaboratively with key HIV stakeholders to increase coverage of stigma reduction messages and combat discriminatory attitudes. Using respected public figures and/or well-liked celebrities can further propel messaging.

Existing Programs to Ensuring Non-discriminatory Provision of Health Care
Under the HIV program, there have been many programs aimed at sensitising health care workers to improve their capacity in providing quality and compassionate health care provision to KPs. For example, NASP has a national orientation program on health and HIV that runs every quarter, capacitating health care providers on HIV and STI management. This program is pivotal in improving access and quality care for KPs in government hospitals. Further to this they provide regular training and monitoring visits to clinicians in HTC and ART centres to ensure they are up to date in clinical areas as well as mitigating any barriers to access. Other programs include:

MSM: A WHO and UNDP training package on the STI and HIV/AIDs management of prevention, treatment and care of sexual and gender diverse people. Bandhu is currently implementing a project in collaboration with Dhaka Medical College to capacitate interns on common health and HIV concerns experienced by sexual and gender diverse groups.

FSW: During the Covid 19 Pandemic, UNFPA, UNAIDS and the World Food Programme conducted a needs assessment and vulnerability mapping initiative of FSW which was used to inform programming for livelihood support, food security, improved access to antiretroviral therapy, sexual and reproductive health services and gender-based violence prevention and response services. It was also used to advocate for expanding the reach of social protection and humanitarian response services to be inclusive of sex workers, but could also inform the scale-up of community-led programming[97]

PWUD: At the district level, community-based groups like APOSH who are working with DNC controlled OST centres have been able to sensitise clinicians and administrators of the service to provide improved access to harm minimisation programs, this includes referrals to medical services for treatment of HCV and abscess. Across the 13 districts where harm reduction programs are being implemented, close contact is maintained with DNC and other Law Enforcement Agencies to ensure programs run smoothly Under the leadership of the DNC, events marking the 'International day against drug abuse and illicit trafficking' are held to create partnerships between ham reduction program implementers and the drug control authority.

Prison Populations: UN agencies such as UNODC with their national partners Care, Dhaka Ahsania Mission (DAM), and Khulna Mukti Seba Sangstha (KMSS) to monitor rights violations in prisons and conduct advocacy with Ministry of Home Affairs. Alongside ASP they initiated the integration of HIV/AIDS testing programs within the prison setting in 2021[98].

Supported by UNODC, Dhaka Ahsania Mission developed an online HIV awareness training for prison officials and employees in 13 Central Jails and 47 District Jails across the country[99].

As mentioned previously, Dhaka Ahsania Mission (DAM), CARE Bangladesh and Khulna Mukti Seba Sangstha (KMSS) had carried out - a series of awareness initiatives in prison sites across Bangladesh. Plays and quiz competitions were used as intervention techniques, as these are proven tools that can help in raising awareness on critical health issues, especially among populations where literacy levels are low. They have also trained peer educators supporting at risk prisoners by facilitate access to information on HIV and STI as well as testing services where available[100].

Scoring the Baseline: Ensuring Non-discriminatory Provision of Health care - 3.0

Rating scale for assessing program areas

Rating	Definition
0	No formal programs or activities identified.
1.0	One-off activities that are time-limited, pilot initiative.
2.0	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching <35% of targeted population.
2.3	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching 35-65% of targeted population.
2.6	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching >65% of targeted population.
3.0	Operating at subnational level (btw 20% to 50% national scale) and reaching <35% of targeted population
3.3	Operating at subnational level (btw 20% to 50% national scale) and reaching 35-65% of targeted population
3.6	Operating at subnational level (btw 20% to 50% national scale) and reaching >65% of targeted population
4.0	Operating at national level (>50% of national scale) and reaching <35% of targeted population
4.3	Operating at national level (>50% of national scale) and reaching 35-65% of targeted population
4.6	Operating at national level (>50% of national scale) and reaching >65% of targeted population
5	At scale is defined as more than 90% of national scale, where relevant, and more than 90% of the population

[97] https://www.miragenews.com/vulnerability-mapping-to-help-sex-workers-in-bangladesh-and-myanmar/#google_vignette

[98] https://www.carebangladesh.org/media-center-view-details.php?type=MediaUpdates&id=120

[99] https://www.tbsnews.net/bangladesh/human-rights-high-risk-groups-prisons-need-be-ensured-hiv-prevention-ig-prisons-331513

[100] https://www.unodc.org/southasia/frontpage/2012/November/bangladesh_-promoting-hiv-prevention-in-prisons-a-critical-but-often-overlooked-initiative.html

Proposed Interventions under GC7 to Ensuring Non-discriminatory Provision of Health Care

Overall Interventions to Ensuring Non-discriminatory Provision of Health Care
Orient health service providers and conduct pre-and in-service training on patient rights and human rights for health care providers (i.e., doctors, nurses, paramedics, support staff) and authorities of DICs; including on universal precautions for infection prevention and mental health.
Conduct view exchange meetings between hospital authorities and KP and coordination meetings between hospital authorities and comprehensive HIV care centres.
Development of a Training Module for Mental Health.
Orient health service providers and conduct pre-and in-service training on patient rights and human rights for health care providers (i.e., doctors, nurses, paramedics, support staff) and authorities of DICs; including on universal precautions for infection prevention and mental health.
Conduct view exchange meetings between hospital authorities and KP and coordination meetings between hospital authorities and comprehensive HIV care centres.
Development of a Training Module for Mental Health.
Joint monitoring visits will be conducted to implementation sites with stakeholders (BCCM members, ASP, NTP, PRs, and UN agencies) to understand human rights related to TB/HIV and suggest actions.
Develop a section on gender diversity, sexuality and human rights of MSM and TGW to incorporate it into the higher secondary and medical academic curriculum
Orientation on sexual diversity among health care services provides
Establish collaboration between public health care facilities and CBOs/NGSDP for patient support through periodic meeting
Orientation of health care providers in public and private health facilities (i.e., doctors, nurses, paramedics, support staff) and members of law enforcement agencies at priority districts.
Training of trainers (staff of PR, SR, and SSR) on addressing human rights violations and gender-based violence to ensure equity in accessing healthcare
MSM Specific Interventions
Engagement/employment of capacitated MSM and MSM CBOs in programme implementation.
Provide sensitisation meetings with SRH service providers.
Institute a system for reporting healthcare complaints.
Transgender and Hijra Specific Interventions
Sensitization meetings with SRH service providers will be held.
FSW Specific Interventions
Engage PE in outreach activities, including social mapping, spot analysis, and community-led HTS.
PWUD Specific Interventions
Organizing TV talk shows and roundtable discussions to create mass awareness and a favourable situation among policy makers regarding human rights issues related to HIV and harm reduction.

Prison Populations
Capacity-building of prison management and policy-level staff will be conducted, emphasising HIV, HTS, and human rights issues related to prisoners, thereby ensuring equitable access to HIV services (including access to HIV prevention services/condoms).
A policy dialogue will be facilitated with the prison steering committee (senior staff of the Home Ministry, Health Ministry, Prison Directorate, and HIV programme stakeholders) about the human right to HIV prevention, treatment and care at prisons, including the availability and accessibility of condoms, clean needles and HTS services for prisoners.

Opportunities for Strengthening Programs on Ensuring Non-discriminatory Provision of Health care.

With the expected integration of all NGO operated clinical services into government hospitals, it would be useful to develop a systematic framework, that has guiding Standard Operating Procedures (SOP) for each KP. This will enable a better understanding of the burden on the health system, what needs of KPs will need to be met to ensure access and ensure health workers are capacitated to the issues of each KP. Save the Children has already begun, and their process can be scaled up across other KP groups.

While in the next program, mental health training has been slated, there is further a need to build a cadre of peer based mental health professionals with training in providing counselling and psychological first aid. As first responders this will improve their skills in providing much needed mental health support but also improve outcomes for KP's. Additionally, the establishment of mental health corners in newly operated government HTC clinics will also provide a more wholistic approach to health care for KPs.

With the changing nature of drug use, following the increasing use of Yaba, it will be important to understand if and how the risk factors of HIV and STI transmission may change. It is reported that the accessibility of Yaba and ease of use has reduced injecting drug use however the implications for the HIV program are as of yet not fully known.

A greater integration between HIV and Viral Hepatitis services are required given the increasing rates of HIV and Hepatitis C infections. Community education, prevention and linkages to treatment are required to stem transmission.

There is a high turnover of medical staff in government facilities that impacts on the quality of services. It is recommended that for the duration of the next Global Fund Grant, project-based positions are given to clinicians at government integration sites to promote sustainability of the centres, strengthen engagement of KPs, improve access and build trust.

Confidentiality and Privacy are major concerns for KPs attending government health services. It will be essential that clear policies and procedures on confidentiality be implemented, and services are located in an area where privacy is not breached. Further it would be pertinent to give the government HTC clinic an ambiguous name, so that those who enter are not identified as KP groups or requiring HIV and STI services.

Existing Programs on Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity.

There was only a limited number of programs aimed at reducing gender-based violence mentioned during the rapid assessment. Some examples, follow; peer educators at DIC and outreach, provide

essential counselling to victims of violence, they support beneficiaries to attend health clinics and provide psychosocial support.

At each tertiary level Government Hospital there are One Stop Shop Centres providing survivors of GBV with essential support and counselling. It is unclear however how effective they are in supporting the needs of KP groups.

MSM: One of the most innovative and promising for scale up is the previously mentioned ICDDR, B GBV database that collects data on the frequency and types of violence experienced by sexual and gender diverse populations through the BSWS implemented Ain Alap hotline. This information is used to design and implement programs that aim to reduce violence and support victims to seek recourse.

Scoring the Baseline: Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity - 3.0

Rating scale for assessing program areas

Rating	Definition
0	No formal programs or activities identified.
1.0	One-off activities that are time-limited, pilot initiative.
2.0	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching <35% of targeted population.
2.3	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching 35-65% of targeted population.
2.6	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching >65% of targeted population.
3.0	Operating at subnational level (btw 20% to 50% national scale) and reaching <35% of targeted population
3.3	Operating at subnational level (btw 20% to 50% national scale) and reaching 35-65% of targeted population
3.6	Operating at subnational level (btw 20% to 50% national scale) and reaching >65% of targeted population
4.0	Operating at national level (>50% of national scale) and reaching <35% of targeted population
4.3	Operating at national level (>50% of national scale) and reaching 35-65% of targeted population
4.6	Operating at national level (>50% of national scale) and reaching >65% of targeted population
5	At scale is defined as more than 90% of national scale, where relevant, and more than 90% of the population

Proposed Interventions to Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity under GC7 Proposal

Overall Interventions to Reduce Gender Based Violence and Gender Related Discrimination (Module 9- Human Rights
Recording and reporting systems to record and link human rights violations/GBV cases to legal authorities will be developed, linked to efforts to strengthen CLM.
Continue the current practices of appointing focal persons at service delivery points to record, report and mitigate GBV, harassment and other human rights violations. Focal persons' capacity shall be enhanced through continued training.

Participatory assessment of the gender responsiveness of programmes and human rights of KP with a particular focus on MSM and hijra across intervention districts in Bangladesh to understand intersectionality to make interventions more acceptable and friendly.
Higher level advocacy workshop with Ministry of Law, Justice and Parliamentary Affairs; Ministry of Social Welfare and other stakeholders to review and reform family and property and inheritance law for TGW
Hold regular meetings of NTF.
MSM Specific Interventions
Strengthen national information systems of GBV among KP.
Transgender and Hijra Specific Interventions
Strengthening of national information systems on GBV among KP and instituting a system for reporting healthcare complaints. To document and report gender-based violence and human rights violations related data, relevant information will be collected from hijra that will be utilized to strengthen the national information system.

Opportunities for Strengthening programs that Reduce HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity.

There is a great opportunity to scale up the Ain Alap program for all KP groups and to expand the number and coverage of panel lawyers to support all KPs experiencing GBV access to recourse. Further expanding the ICDDR, B data base to also capture all KP related GBV cases and actions, can provide opportunities for much needed data on the experiences of GBV (frequency, type), design of appropriate needs-based programs and impactful implementation.

The National Strategic Plan to Address Gender Based Violence for Bangladesh HIV/AIDS Response 2017-2021 outlines a comprehensive plan, with a number of relevant activities. These include reducing the experiences of GBV through implementing assessments, conducting baseline studies, increasing education and awareness and facilitating access to prevention services and medico-legal support for survivors. However, no evaluations or reports on the quality, efficacy or impact of the framework was available. A timebound monitoring and evaluation plan is required for the outcome of the implementation Strategy, with results disseminated to facilitate better program design.

While there is data available on the extensive violence that sex workers face by numerous perpetrators, GC7 does not provide for any GBV programs addressing violence against sex workers. For example, awareness campaigns for police, lawyers and other law enforcement actors to raise awareness on this issue and mechanism to support them in holding perpetrators accountable would benefit their well-being and safety.

There is very little information available on the experiences of women who use drugs or how gender sensitive current programs are in meeting the needs of this population. A gender assessment related to the needs of women drug users should be undertaken to better understand how services can improve access to services and health seeking behaviour of women who use drugs.

Specific education and awareness sessions need to be held for staff in maternity wards and with obstetrics and gynaecological specialists to reduce stigma and discrimination faced by women from KP groups when they present to hospitals for pre and post ante natal care and during delivery.

Greater collaboration with the Department of Women's Affairs and NASP is required to ensure that OSSC services located at government hospital sites are functional, capacitated and are meeting the needs of KP groups who experience GBV. In order for integration to be successful addressing GBV

will be essential and KP groups should feel empowered and comfortable to utilise government OSSC to address their concerns.

Existing Programs on Community Mobilization and Advocacy for Human Rights

All the national and community-based networks are committed to capacitating their networks to build strong movements that are well governed, accountable to their beneficiaries and technically skilled.

MSM: In 2019 Bandhu and Millenium Development Fund (MDF) collaboratively designed a project to build the capacity of the BSWS's employees, this included leadership and People Management Coaching, Proposal Writing, Programme Management and technical content on sexual and reproductive health rights. Under this capacity building project, a total of 160 staff members enhanced their knowledge on particular issues.

Transgender and Hijra: Ashar Alo, with funding from Women's Fund Asia is implementing a yearlong project aimed at "Strengthening Feminist Movements Grant Making Program 2022 for The Hijra Community". This program involves building stronger movements through workshops, community meetings and awareness raising events.

Sex workers SWN: Uses regular reporting, sharing and communication to maintaining accountability to members. They build leadership skills among their members, represent Bangladeshi sex worker issues at regional and international meetings and use communication tools such as social media and news articles to increasing visibility about the needs and achievements of SWN and its members.

PWUD: In response to recommendations from UNODC-Global fund joint mission (2020) the program has increased the number of female outreach workers. A joint plan with FSW DIC has been made to enhance the enrolment of women drug users in the program as some women who sell sex also use drugs. Among the FSW, drug use behaviour is found in all the behaviour surveillance, thus addressing their needs is also important from the place (either PWUD or FSW DIC or both) where they feel comfortable. A national workshop on Women and Drugs has been planned to organize to increase understanding of their issues and address their needs.

PLHIV: In 2018 Ashar Alo also implemented a project funded by the Global Fund aimed at increasing the technical knowledge of communities on intellectual property right and access to medicines, conduct advocacy meetings with relevant stakeholders to support an increase in HIV and related medicines.

The Importance of NGO run Drop in Centres

On a special note, it should be remarked that a vital service that addresses a gamut of human rights related issues and facilitates community organising and advocacy are the non-government operated Drop-in Centres (DIC). Drop-in Centres not only provide clinical program essentials but often what KPs identify as more important than HTC; psychosocial support including mental health counselling, support to victims of GBV, a safe place to find refuge, a place to sleep or shower and training and skill development programs aimed at improving knowledge on their rights, confidence and alternative livelihood programs. Operating hours meet the needs of the community and services are often delivered in a timely manner. The are less concerns around privacy, and confidentiality than in government facilities. Additionally, they do not have the same fear around disclosing criminalised behaviour (sex work, same sex behaviour, drug use) as they do in government operated clinics. These DIC are essential community and movement building spaces that facilitate advocacy and organising on issues of key concern.

Scoring the Baseline: Community Mobilization and Advocacy for Human Rights – 2.6

Rating scale for assessing program areas

Rating	Definition
0	No formal programs or activities identified.
1.0	One-off activities that are time-limited, pilot initiative.
2.0	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching <35% of targeted population.
2.3	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching 35-65% of targeted population.
2.6	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching >65% of targeted population.
3.0	Operating at subnational level (btw 20% to 50% national scale) and reaching <35% of targeted population
3.3	Operating at subnational level (btw 20% to 50% national scale) and reaching 35-65% of targeted population
3.6	Operating at subnational level (btw 20% to 50% national scale) and reaching >65% of targeted population
4.0	Operating at national level (>50% of national scale) and reaching <35% of targeted population
4.3	Operating at national level (>50% of national scale) and reaching 35-65% of targeted population
4.6	Operating at national level (>50% of national scale) and reaching >65% of targeted population
5	At scale is defined as more than 90% of national scale, where relevant, and more than 90% of the population

Proposed Interventions to Increase Community Mobilisation and Organising under GC7 Proposal

Overall Interventions to Increase Community Mobilisation and Advocacy for Human Rights
Capacity building for KP communities under three networks (NPUD, SWN and NOP+) following existing good practices so they understand their rights and know mechanisms of how to access health and legal support, including training of peer human rights educators.
Life-skills training among KP who experienced human rights violations
Media campaign through development and broadcast of audio-visuals, documentaries, talk shows, round table discussions, and short ads.
Continued meetings of DIC management/Advisory Committee for creating/maintaining an enabling environment and community-level sensitisation meetings with relevant stakeholders for collaboration (including on FSW rights), which is vital for continuation of interventions with sex workers (and other KPs), as societal norms would usually direct the neighbouring communities of DICs or other service provision facilities towards harassment against sex workers. With integration of prevention services into government facilities, this activity is even more important as the support of the wider community will be needed while accessing the mainstream services of the hospitals
MSM Specific Interventions
Formation of community coalitions, roundtables and meetings to mobilise MSM/MSW communities.
CBO representatives will be trained in leadership, public speaking, and negotiation skills to build self-confidence.
Engagement/employment of capacitated MSM and MSM CBOs in programme implementation.
Safe spaces will be continued in 64 rented locations for NGO-operated areas in 23 districts,

while three government health facilities will be used for this intervention where services will be rendered by the government. These spaces will be used for providing 'know-your rights' and stigma reduction counselling to MSM/MSW, including clinical services (STIs and HTS) and storage of health/non-health products as well as training, BCC sessions etc.
Transgender and Hijra Specific Interventions
Safe spaces will be continued in 64 rented locations for NGO-operated areas in 23 districts while three government health facilities will be used for this intervention where services will be rendered by the government. These spaces will be used for providing 'know-your rights' and stigma reduction counselling, clinical services i.e., STIs and HTS and storage for health/non-health products as well as training, BCC sessions etc.
Formation of community coalitions, roundtables and meetings to mobilize TGW communities. Community members will be deployed as field staff.
Engagement of more capacitated TGW CBOs in programme implementation.
FSW Specific Interventions
Empower sex worker-led organizations by providing training on participatory monitoring, human rights, and leadership.
Refer sex workers to certified Vocational Training Institutes (VTIs) for better economic opportunities and assist them to obtain a national ID card and opening a bank account. This action can build confidence and options for an alternative livelihood.
The current 25 DICs (providing safe spaces for rest, showers, and self-care) will be reduced to 10 centres, with the shortfall supplemented by government hospitals and some of the community led DICs and CBOs, ensuring no FSW is left behind. Six districts plan to close, whereas in 3 district PWID programme is already integrated with Govt facilities, FSW is planning to integrate service there. It is also planned for 10,000 additional FSW to be reached with PAAR resources, if available.
Engage PE in outreach activities, including social mapping, spot analysis, and community-led HTS.
PWUD Specific Interventions
The teams responsible for managing the service centres will collaborate with the PUD community network, and its member organisations to ensure effective monitoring, guidance, and supervision of the programme.
Effective collaboration and coordination will be maintained with other interventions (e.g., FSW) to identify participants who use drugs including women to bring them under harm reduction programme.
PWID and their communities will experience improved access to essential services, including shelter, healthcare, and livelihood opportunities.
DIC Advisory Committee (DAC) at the service centre level will undergo reforms to ensure meaningful community representation and engagement, and job opportunities will be created.
The PWID network and its member organizations will be supported for capacity development, including issue-based advocacy to reduce stigma and discrimination, how to address human rights issues with regional and national policymakers, leadership, public speaking, and negotiation skills.
Skilled network and network member organizations will be contacted for programme activities, e.g., issue-based advocacy, participatory monitoring, etc. using performance-based funding.

Opportunities to Strengthen Community Mobilisation and Advocacy for Human Rights

At this time, there are no additional opportunities identified under this thematic area as long as the GC7 activities are effectively implemented.

Overall Baseline Score for Human Rights Programming HIV	
Thematic Area	Score
Legal literacy ("know your rights")	2.3
Ensuring rights-based law enforcement practices	2.6
Improving laws, regulations and polices relating to HIV and HIV/TB	2.6
Eliminating stigma and discrimination in all settings	2.6
Ensuring non-discriminatory provision of health care	3
Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity	3
Community mobilization and advocacy for Human Rights	2.6
Overall Score	2.7

Suggested Recommendations:

The interventions developed in the GC7 proposal reflect a comprehensive, collaborative and committed approach to addressing the human rights violations impacting on access to health and HIV programs for KP groups. The following list of suggested recommendations has been developed following stakeholder discussions and a review of the literature and where gaps have been identified beyond what has been programmed into GC7 proposal.

Suggested Recommendations			
Activity	**Purpose**	**Benefiting Stakeholder**	**Suggested Lead Implementer (supporting Implementer)[101]**
Overall Recommendations			
Develop an evidence based Human Rights Package of Services	There are a multitude of human rights programs being implemented across the country with little understanding of their efficacy or impact on the intended outcomes. This provides the opportunity to test a number of interventions across pilot and control sites to assess how effective human rights programs are in removing barriers. This will be either an RCT or quasi-experimental study design within the framework of implementation science. We propose to take a few districts to conduct this study. Findings of this study can support the formulation of a Human Rights Protocol Framework providing guidance on evidence-based effective and quality human rights-based programs to be scaled up across the country.	All	and All three PRs (Save the Children, icddr,b and ASP), DNC (MOHA)
Access to Justice			
Implement training for BCCM Members on Human Rights of KPs	To ensure that across the program cycle, at all levels, stakeholders are working from a human rights-based perspective.	BCCM	GF PR
Develop an updated assessment on HIV related policy frameworks	To enable better monitoring of laws and reforms	All	ASP
Implement community-led efforts to analyze, monitor, advocate against and reform harmful laws and policies	Empowering community networks to increase their role in monitoring human rights and advocating for reforming	KP and KP Networks	KP community networks
Develop a coordination mechanism to oversee efforts to improve the national legal environment to	In order to coordinate efforts from reviewing laws, policies and reforms and work undertaken by community networks to monitor human rights violations, a coordination committee mechanism can facilitate the adoption of specific and critical areas of advocacy to	All	ASP, Community Networks, PRs

[101] This section has been agreed to with consensus during the circulation of the report to all relevant stakeholders.

better support the national AIDS response	undertake.		
Eliminating stigma and discrimination in all settings			
Engaging religious leaders through trainings and workshops to lead positive messaging for KPs	Training religious leaders in human rights can further enable them to mitigate negative perceptions of these groups and improve societal perceptions and reduce community related rights violations experienced by KPs	All KP and society	NASP (KP CBOs)
Implement human rights sensitisation and training on HIV education with employers and in workplaces to reform or instate policies that provide an enabling work place for people living with or at risk of HIV to work free from stigma and discrimination	Improve the employability of PLHIV as well as minimise negative experiences often faced by KPs. Encouraging workplaces to implement a no tolerance policy of discrimination to include KPs and PLHIV can create an enabling environment.	KPs and employees	NASP + Ministry of Labour
Provide training to workers on their rights within the workplace and tools and services for redress.	Improve the understanding of PLHIV workers to know their rights and facilitate access to legal aid services when rights are violated	workers	Unions and Ministry of Labour
Design a Social Media Campaign to reduce stigma and discrimination	Develop a social media campaign to increase coverage of stigma reduction messages and combat discriminatory attitudes	Society	GF PR's
Improve access to information on the stigma and discrimination of KPs and PLHIV in prison settings through an exploratory study	There is a dearth of information on the stigma and discrimination experiences of KPs and PLHIV within prison settings. A greater understanding of their needs may increase HIV and STI testing.	Prison populations	ASP, Ministry of Home Affairs, UNODC
Non-discriminatory Provision of Health care			
Develop a cadre of peer mental health counsellors to provide support and counselling to affected populations as wella s monitor the impact of stigma and discrimination impacting on KPs	As first responders this will improve their skills in providing much needed mental health support but also improve outcomes for KP's. Peer mental Health Counsellors to be employed at integration sites.	Peer outreach workers	ASP and relevant CBO's

Organize a national workshop on Gender, Human Rights and Drug use	To increase the understanding of how gender intersects with drug use and how gender related vulnerabilities exacerbate human rights violations.	PWUD, FSW	NPUD and SWN In collaboration with ASP and Save the Children
Monitoring of the implementation of confidentiality and privacy procedures across all hospital settings	Implement policies and procedures that improve confidentiality and privacy of services administered in government health centres; ambiguous name for HTC clinic, ensure names of patients remain confidential and not accessible, ensure results are delivered in private rooms, ensure no patients results are shared without their consent.	Health Care Workers	NASP
Conduct regular attitudinal assessments on health care providers (both within HIV/ART settings and beyond)	To gain an understanding of the effectiveness of stigma and discrimination training and to use the results to adapt training as required.	Health Care Workers	KP Networks and ASP
Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity			
Scale up the Ain Alap hotline implemented by BSWS and program for all KP groups	Expand the number and coverage of panel lawyers to support all KPs experiencing GBV access to recourse.	All KP	Bandhu (KP Networks)
Expand the GBV data base implemented by ICDDR, B	To capture all KP related GBV cases and actions to improve data collection on the experiences of GBV (frequency, type), design of appropriate needs-based programs and impactful implementation.	All KP	ICDDR, B
Improve on sensitisation and training programs for law enforcement actors that reduce GBV against sex workers	Implement awareness campaigns and training for police, lawyers and other law enforcement actors to raise awareness on this issue and mechanism to support them in holding perpetrators accountable would benefit their well-being and safety.	Sex workers	SWN
Undertake a gender assessment related to the needs of women drug users	To better understand how services can improve access to services and health seeking behaviour of women who use drugs.	Women PWUD	NPUD and SWN in collaboration with Save the Children and ASP
Sensitisation and training on stigma and discrimination reduction for obstetrics and gynaecological specialists and health care workers in Maternity Unit wards	To improve pre and post ante natal care and delivery services for pregnant women and their partners	Women KPs	ASP (STC)

Exploratory study on the experiences of women KPs and gender diverse people in prison settings	Policymakers and prison authorities should understand the needs of women and transgender people and incorporate the proposed evidence- and human rights-based interventions and international standards into their prison policies and strategies, applying them to all people in prison.		
Implement training to increase the understanding of prison officials and employees on gender related barriers and gender related vulnerabilities	There is a dearth of information available on the needs of women and gender diverse prisoners and the gender related vulnerabilities both within the prison system and once released. Prisoners and prison officials should be capacitated to implement gender sensitive programming for this population.	Women and gender diverse prisoner; program developers	ASP, Bandhu, Save the Children, ICDDRB
Establish a crisis response mechanisms to prevent and respond to abuse, including gender-based violence.	Particularly in government health care services to establish a mechanism to address and respond to GBV incidents for KP's through strengthened collaboration with the Department of Women's Affairs to strengthen linkages with OSCC on site.	Victims of GBV	ASP and Department of Women's Affairs
Community mobilisation and advocacy for human rights			
Providing core support to community-led organizations for recruitment, training, management and monitoring and evaluation activities relating to human rights goals	In order for community based organisations to exist and operate effectively it is essential they are adequately financially supported with staff and resources to undertake activities	CBO's	Donors
Implement a small grants program for nascent and grass roots organisations to mobilise KP constituents and implement human rights programming. This program should also include organisational development and governance training.	Building the capacity of nascent and grass roots organisations is essential to sustain and grow the movement. Often unregistered organisations due to their lack of capacity, means and opportunity to apply for government registration and funding, small grants provide a stepping stone towards 'legitimisation' to access further funding	Nascent and grass roots CBOs	Donor and PRs

Overview of the context for the Tuberculosis epidemic and key affected populations

Implemented under the auspice of the National Tuberculosis Program (NTP), an Essential Package of Services is delivered across each level of government infrastructure, from National level to the ward level. Services provided range from the public health level to facilitate control of the epidemic, to specialised medical interventions for complex cases, as well as the essential and pivotal work of community health works who facilitate the screening, referral, registration, and provision of treatment support to people with TB. TB Key Populations in Bangladesh include garment workers, urban poor, elderly, children, rural poor, diabetics, refugees (including Rohingya), prisoners, and hospital/health care workers.

Committed to the End TB Strategy the Government of Bangladesh's National Strategic Plan for TB Control 2021 -2025 will continue its successful strategy to maintain sustained treatment success rates over 90% since 2005 and reaching 95% in 2018. Yet while treatment rates are high, case detection rates require further efforts with only 75% detected in 2018[102]. The Strategy further aligns with the country's participation in the Strategic Initiative to Find the Missing People with Tuberculosis (SI). It is estimated that approximately 64000 TB patients are missed annually. This initiative provides targeted technical support to the country to accelerate case finding, reduce gaps in care, identify and overcome barriers to access in TB key populations and vulnerable groups, and to implement a rights-based people centred community and innovative approach to eliminating TB. With Bangladesh having the 7th highest burden of TB cases globally, the country is committed to investing in and scaling up programmes to End TB.

Under the Global Fund program NTP partnering with BRAC have increased efforts to expand reach. This has improved though screening across prisons, slums, areas with high migratory populations, and other high-risk groups workplace- areas with high concentrations of informal sector workers. Most effective results were found in areas where community health workers were employed to undertake active case finding exercises to implement activities on prevention, diagnosis, treatment, and the dissemination of awareness information.

National data shows that 11% of registered TB patients in the country are coinfected with HIV[103]. There are currently limited programming efforts for systematic screening for TB in HIV related Key Populations, with the Government of Bangladesh keen to scale up efforts[104]. This has begun with the screening of TB for all people living with HIV through the National Guidelines on TB/HIV Management and Program Collaboration and Implementation Manual 2016. Further efforts for at risk populations could improve outcomes to reduce coinfection through prevention strategies and ensure that cases are detected, and treatment commenced.

NTP and BRAC are working with the Global Fund Community Rights and Gender team to develop an action plan to scale-up community-based and community-led monitoring, additional human rights education, and advocacy activities. The plan will be used to compliment and extend the current Strategic Plan 2021-2023 to reduce risk factors, address the social determinants and eliminate other human rights and gender barriers that contribute to health vulnerabilities in the TB response.

[102] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7509970/
[103] https://www.ntp.gov.bd/wp-content/uploads/2021/07/21-TB-HIVGuidelines-2nd-edition.pdf
[104] Ibid

Findings: TB and the Human Rights Context including Socio Political and Legislative Barriers for Key Population

Legal Environment and Access to Justice

There are no specific laws that impact on the legal status of people with TB. However, they do face stigma and discrimination and rights violations associated with this with little or no access to justice or recourse. Given that many of the risk factors in the transmission of TB occur in workplaces where people work and reside in small, airless quarters such as garment factories and through transport routes transmitted by transport worker, unfair termination of employment contracts for positive TB cases. Fear of termination is a significant factor in nondisclosure and health seeking behaviour.

Other occupational safety issues concern health workers may be at risk of TB infection despite infection protection control (IPC) measures. Despite all efforts to maintain IPC a lack of resources to ensure and facilitate universal precautions to mitigate transmission may jeopardise safety. There is very limited policy governing the compensation and legal protection for those who are exposed and there is further limited information to what extent workplaces have incorporated protections for their staff[105].

Until recently treatment under the 'Bangladesh Regime' spanned a total of 9 months. Given the physically taxing nature of treatment, those suffering cannot work, further inhibiting health seeking behaviour to protect their livelihoods and financial security. With a new treatment regime to be implemented under the next strategy, treatment seeking, and adherence may improve.

Similarly, despite constitutional protections available for all Bangladeshi citizens against discrimination, those living with TB have few resources available in terms of access to justice, including lack of financial means, access to lawyers or legal aid nor the time to deal with long delays due to administrative and bureaucratic complexities of the Bangladeshi court systems.

In 2018 a legal environment assessment was conducted jointly with UNOPS, BRAC and Stop TB partnership with a comprehensive overview of the various policies and laws relevant to TB affected populations and how they are or are not applied to the TB context. What it found was that while policies exist, there is a lack of awareness and systematic documentation on the violations experienced by people affected by TB. As mentioned above, workplace policies remain limited and the lack of access to legal aid hinders the protection of those whose rights have been violated[106].

Stigma and Discrimination

KII's with stakeholders highlighted a significant reduction in stigma and discrimination faced by people living in TB largely due to systematic mass awareness campaigns conducted by government and non-government actors. Yet issues remain, these issues are also associated with the social determinants of those who are most at risk of TB for example, poverty, class disparities, low education levels and gender. This is particularly the case in rural and remote areas, where two thirds of Bangladesh's populations reside- where poverty is 8-10% higher than in urban areas[107].

As reported in KIIs and from the literature, examples of stigma experienced by TB positive patients include isolation from community functions, gossip by neighbours, families were separating utensils, bedding, and clothing of the affected person from others in the household, divorce and separation of

[105] https://stoptb.org/assets/documents/communities/CRG/TB%20CRG%20Assessment%20Bangladesh.pdf
[106] Ibid
[107] https://thefinancialexpress.com.bd/views/economic-liberalisation-and-rural-poverty-in-bangladesh-1556980997. Economic liberalisation and rural poverty in Bangladesh, The Financial Express, May 06, 2019

married couples, and the eligibility of unmarried women was impacted. In generally other than family members disclosure of their positive status is limited for fear of judgement and negative treatment.

Experiences with Health Care Institutions

While diagnostic (cough test) and TB treatment is free, there are many other direct and indirect costs that pose a significant economic burden on people affected by TB and their families. One study shows that patients on DS-TB treatment exhaust 50% of their family's annual income on treatment, with the amount rising to 66% for those on MDR-TB treatment[108]. This study also illustrated that early diagnosis could reduce the economic burden considerably, however high costs of TB treatment and care are a significant barrier to services. Through their programs, BRAC provides some social support for poor and ultra poor households including, transport costs, nutritional support and costs for additional tests for example, X-rays, CT scans however the criterion for inclusion needs to be more clearly emphasised.

With the expansion of the DOTS community health worker model, health active case finding and referral for diagnostic confirmation has improved awareness and reduced barriers to services, yet for those 20% missing cases, it is reported both in KII's and through the literature that they may see a 'local' (non MBBS) doctor or self-medicate; procuring (ineffective) medicine from pharmacies. The hesitation to attend health care facilities is largely centred around the fear of a positive result and the ensuing stigma and discrimination they anticipate experiencing. There is also fear that their privacy and confidentiality will be breached. This results in people travelling further afield for their treatment rather than in locations closer to them, increasing the time and cost of treatment as well as adherence[109].

In rural and remote areas, in which much of the population resides, access to TB treatment services is difficult. Time and cost are the greatest barriers to overcome. For women with working husbands, who are unable to travel by themselves, due to conservative religious norms, access is hampered.

Gender Based Violence and Gender related Discrimination.

The degree to which married women face issues in marrying following a TB diagnosis is unclear, however it is a pervasive perception that contributes to internalised stigma for unmarried women. Issues around marriage prospects are more concerning for women rather than men, largely due to gender inequalities and the normative roles of women in society. With women responsible for home-based care duties including cooking, caring for the children and subsistence farming, those who cannot perform are deemed unworthy spouses[110].

The CRG Action Plan[111] also highlights a high burden of risk on women, including their predominance in being employed in garment factories- often migrating to urban settings from rural areas, as health care workers in hospital settings treating TB positive patients, lack of adequate women friendly service points in many of the areas where TB is of concern and victims of conservative and traditional norms that limit their independent access to places outside of the home.

Community Mobilisation and Organising

[108] https://scholarcommons.sc.edu/etd/4409/

[109] https://assets.publishing.service.gov.uk/media/57a08b69ed915d3cfd000cd8/60425_TB-related_stigma_in_Asia_Bangladesh_1_.pdf

[110] Ibid

[111] Internal Document: Ministry of Heath and Family Welfare and Stop TB Partnership (2020): Costed Tuberculosis Community, Rights, and Gender (CRG) Action Plan 2021-2023 People's Republic of Bangladesh

Unlike in the HIV space, there are no structured community-based networks for TB populations. On an ad hoc basis there are people who participate in the local courtyard meetings held to raise awareness and reduce stigma and others who participate in the multi stakeholder ward meetings however this does not occur systematically. Community groups are vital in ensuring institutions understand actual needs and barriers. They are important stakeholders in the design and implementation phase of program development. This will be a key piece in the next CRG Action Plan.

Prison Populations

Due to a lack of ventilation, overcrowding, poor nutrition and a lack of access to health care, puts people at higher risk of TB transmission in prison settings. In one study conducted in 2010 in Bangladesh's most populated jail; Dhaka Central jail, the prevalence rate was 2,227 per 100,000 which is over 20-fold higher than the rate in the general population[112]. Positively drug resistance was not common amongst prisoners which proves to be a good marker for treatment outcomes both while imprisoned and on release. The study further found that 37% were TB positive prior to their incarnation but that those who were incarcerated with a person who was TB positive were three times more likely to contract the disease then those who were not suggesting that transmission while in prison also contributed to the high prevalence[113]. This data presents compelling evidence to scale up TB interventions in prison settings.

Overall there is very limited information regarding the experiences of people affected by TB inb prison settings including their access to justice, experiences of stigma and discrimination, their access to health care, the impact of gender related barriers or their ability to mobilze and advocate within the prison setting. Much more work needs to be done on understanding their experiences in order to effectively program for this population.

Existing programs to address human rights-related barriers to TB and New and Existing Opportunities to Scale Up

Outside of clinical services BRAC is the Principal Recipient under Global Fund to implement a community-based approach active case finding, screen, diagnosis, treatment and care services. Under the program, BRAC covers 297 sub-districts from 42 out of 64 districts, 7 city corporations with a population of 92.9 million people. This includes 31 academic institutes, 41 prisons, 405 peripheral laboratories and 26 external quality assessment centres. BRAC is supported by a group of 42 local NGOs who are the sub -recipients (SRs) implementing programs on the ground. BRAC provides supervision and monitoring of their work.[114] A costed CRG Action Plan (2021-2023) has been developed in partnership with the NTP, BRAC and the Stop TB Partnership. Reaching the tail end of the plan there is very little information on if these programs have been resourced, implemented and evaluated for impact.

This section outlines the existing programs being implemented to reduce human rights violations; the relevant activities planned under the CRG Action Plan as well as opportunities for scale up beyond those listed in the Action Plan. It should be noted that as of yet while the CRG Action Plan is costed, there is no secured budget or available funds for implementation of the activities listed below as of the time writing this report. It is also to be noted that the Matching Funds under the HIV

[112] https://www.researchgate.net/publication/44633483_Pulmonary_Tuberculosis_and_Drug_Resistance_in_Dhaka_Central_Jail_the_Largest_Prison_in_Bangladesh

[113] Ibid

[114] https://www.BRAC.net/program/health/tuberculosis-and-malaria-control/

program also do not cover TB related human rights programming. Relevant stakeholders will be required to mobilize resources in order to fund the implementation of any suggested activities (as well as the CRG Action plan as stated above)

Existing program on Legal literacy ("know your rights")

In discussions with BRAC, they stated there are very limited know your rights programming for TB populations. The most notable would be around educating employers and employees on their rights in relation to unfair dismissal, health insurance, access to sick leave. This has led to promising work with garment factory unions with a reach of 80,000 garment workers and factory owners who have supported TB positive staff to take 14 days paid sick leave and job protections following treatment[115]. BRAC is planning to scale up this initiative amongst other employer groups and unions such as transport, and brickfield employees.

Scoring the Baseline: Legal literacy ("know your rights")– 2.6.

Rating scale for assessing program areas

Rating	Definition
0	No formal programs or activities identified.
1.0	One-off activities that are time-limited, pilot initiative.
2.0	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching <35% of targeted population.
2.3	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching 35-65% of targeted population.
2.6	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching >65% of targeted population.
3.0	Operating at subnational level (btw 20% to 50% national scale) and reaching <35% of targeted population
3.3	Operating at subnational level (btw 20% to 50% national scale) and reaching 35-65% of targeted population
3.6	Operating at subnational level (btw 20% to 50% national scale) and reaching >65% of targeted population
4.0	Operating at national level (>50% of national scale) and reaching <35% of targeted population
4.3	Operating at national level (>50% of national scale) and reaching 35-65% of targeted population
4.6	Operating at national level (>50% of national scale) and reaching >65% of targeted population
5	At scale is defined as more than 90% of national scale, where relevant, and more than 90% of the population

Activities planned for implementation in the CRG Action Plan on Legal literacy ("know your rights")

Activity 1.5. Implement a mass media campaigns on removing human right and gender barriers to TB services.

Activity 1.11. Integrated 'know-your rights' trainings (based on Declaration of the rights of people affected by TB) for peer supporters, TB Champions, TB key populations.

Activity 1.12. Human Rights Capacity Building Workshop for Persons Living with and Experienced TB/TB Peer Support Groups/Clubs Using the HR Training Manual for TB affected communities- Asia & Pacific

Activity 1.13. Capacity building programme focusing on TB, human rights and gender for people affected by TB.

Activity 1.16. Develop Communication materials on TB, human rights and legal literacy.

Opportunities for scale up.

Historically there has been limited and inconsistent interventions and programs for people affected by TB and their families to reduce human rights violations. A focus on resourcing and implementing activities identified in the CRG Action plan would be a starting point to increase the capacity of those affected by TB. In addition, some suggestions are reflected below:

[115] https://stoptb.org/assets/documents/communities/CRG/TB%20CRG%20Assessment%20Bangladesh.pdf

Scale up work with worker trade unions and employer groups and strengthen collaboration with the Ministry of Labour to ensure workplace protections and compensations across all sectors where TB transmission is a risk factor, including in health care settings.

Improve linkages to legal aid services through referral points at TB screening, diagnosis and treatment sites.

Existing programs on Ensuring rights-based law enforcement practices.
There are currently no TB specific programs being implemented to ensure law enforcement practices as identified during the rapid assessment process. This may be due to a lack of information and understanding of the issues people living with TB may face when they interact with law enforcement agencies.

Scoring the Baseline: Ensuring rights-based law enforcement practices - 0

Rating scale for assessing program areas

Rating	Definition
0	No formal programs or activities identified.
1.0	One-off activities that are time-limited, pilot initiative.
2.0	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching <35% of targeted population.
2.3	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching 35-65% of targeted population.
2.6	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching >65% of targeted population.
3.0	Operating at subnational level (btw 20% to 50% national scale) and reaching <35% of targeted population
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4.6	Operating at national level (>50% of national scale) and reaching >65% of targeted population
5	At scale is defined as more than 90% of national scale, where relevant, and more than 90% of the population

Activities planned for implementation in the CRG Action Plan to ensure rights-based law enforcement practices.

Activity 1.9. Develop a network of paralegals and lawyers who can support access to justice initiatives for people affected by TB who are unable to realise their legal rights.
Activity 1.10. Conduct TB, rights and the law sensitization training with law society, magistrates, judges and prison wardens.
Activity 1.14. Engagement of peer para-legals, and linkage to pro bono legal services

Opportunities to strengthen programs to ensure rights-based law enforcement practices.
There is currently a lack of understanding of how people living with TB are impacted by law enforcement actors and how these experiences can impact on their capacities to exercise their rights. An up dated assessment to increase understanding on the impact of the current legal environment on the rights of people affected by TB, their knowledge of services available and barriers to access as well as their experiences with law enforcement actors. This review can further establish a baseline of the knowledge, perceptions and attitudes of law enforcement agencies and facilities the design of adequate and appropriate programs.

Existing programs on improving laws, regulations and polices relating to HIV and HIV/TB
In 2018 UNOPS, BRAC and the Stop TB Partnership undertook a Community Rights and Gender Assessment in Bangladesh[116]. As part of this assessment, a Legal Environment Assessment (LEA) was conducted to evaluate the government response and commitment to enforce and/or increase legal and policy protections that foster an enabling environment aimed at reducing the vulnerability of TB affected populations and their families.

[116] https://stoptb.org/assets/documents/communities/CRG/TB%20CRG%20Assessment%20Bangladesh.pdf

Scoring the Baseline: I**mproving laws, regulations and polices relating to HIV and HIV/TB – 1.0**

Rating scale for assessing program areas

Rating	Definition
0	No formal programs or activities identified.
1.0	One-off activities that are time-limited, pilot initiative.
2.0	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching <35% of targeted population.
2.3	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching 35-65% of targeted population.
2.6	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching >65% of targeted population.
3.0	Operating at subnational level (btw 20% to 50% national scale) and reaching <35% of targeted population
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4.3	Operating at national level (>50% of national scale) and reaching 35-65% of targeted population
4.6	Operating at national level (>50% of national scale) and reaching >65% of targeted population
5	At scale is defined as more than 90% of national scale, where relevant, and more than 90% of the population

Activities planned for implementation in the CRG Action Plan to improve laws, regulations and polices relating to HIV and HIV/TB

Activity 2.1. Conduct review of national and sub-national laws and policies including employment, insurance, education, prisons, refugees and social security that impact access to TB services amongst people who affected by TB with a specific analysis on each of the focus key populations.

Activity 2.2. Conduct a country dialogue to identify opportunities to increase social protection among vulnerable, such as urban poor, garment workers and Rohingya refugees, and TB affected communities.

Activity 2.3. Develop policy brief on CRG specific legal, social, and economic barriers to access that must be identified, monitored and overcome to end TB in Bangladesh

Opportunities to Strengthen laws, regulations and polices relating to HIV and HIV/TB

The CRG Action provides for a good baseline of activities to strengthen laws, regulations and polices relating to HIV and HIV/TB. In addition to those listed above, there is scope to work closely with HIV and TB actors to advocate for the inclusion of anti-discrimination protection laws and policies to ensure people living with HIV, TB and/or both are protected from human rights violations experienced due to their positive status.

Existing programs on Eliminating stigma and discrimination in all settings.

As stated by those by KII participants, mass awareness programs over the years have overall reduced stigma and discrimination towards TB affected populations. Courtyard meetings held by community health workers to raise awareness and sensitise communities has also contributed to reduced harassment and gossip at the community level.

Community health workers involved in active case finding further conduct their activities in a manner that reduces self-stigma and creates a supportive environment that propels people to access TB treatment and care services. Community health workers also work with family members,

educating them on TB, and recruiting them in monitoring patient treatment adherence. Community health workers are essential in reducing stigma and discrimination at the community setting.

Scoring the Baseline: Eliminating stigma and discrimination in all settings: 3.3

Rating scale for assessing program areas

Rating	Definition
0	No formal programs or activities identified.
1.0	One-off activities that are time-limited, pilot initiative.
2.0	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching <35% of targeted population.
2.3	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching 35-65% of targeted population.
2.6	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching >65% of targeted population.
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4.3	Operating at national level (>50% of national scale) and reaching 35-65% of targeted population
4.6	Operating at national level (>50% of national scale) and reaching >65% of targeted population
5	At scale is defined as more than 90% of national scale, where relevant, and more than 90% of the population

Activities planned for implementation in the CRG Action Plan to Eliminating stigma and discrimination in all setting.

Activity 1.3. Implement workplace programs-stigma and discrimination reduction activities.
Activity 1.8. Community sensitization - engagement with the community, opinion leaders.
Activity 4.4. Round table with journalists to discuss human rights and gender related barriers to accessing TB services that must be overcome to end TB.
Activity 6.6. TB Stigma Assessment Completed and indicators measured – comparing year one and three.

Opportunities to Strengthen programs that Eliminating stigma and discrimination in all settings.
No further opportunities have been identified at this time.

Existing programs on Ensuring non-discriminatory provision of health care.
At the National level, NTP implements training for health workers on clinical management of TB including treatment and adherence and communication skills on information on TB and transmission, yet these trainings do not explicitly address human rights. Due to time constraints additional information was not available.

Scoring the Baseline: Ensuring non-discriminatory provision of health care - 1.0

Rating scale for assessing program areas

Rating	Definition
0	No formal programs or activities identified.
1.0	One-off activities that are time-limited, pilot initiative.
2.0	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching <35% of targeted population.
2.3	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching 35-65% of targeted population.
2.6	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching >65% of targeted population.
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5	At scale is defined as more than 90% of national scale, where relevant, and more than 90% of the population

Activities planned for implementation in the CRG Action Plan to Ensure non-discriminatory provision of health care.

Activity 1.4. Integrated medical ethics and gender-responsive trainings for health care workers.
Activity 5.1. Develop/adopt/implement SOP for TB programming among hard to reach key and vulnerable populations.
Activity 5.2. Assess barriers and facilitators of implementing collaborative TB activities at different settings: Diabetes, Outpatient Department (OPD) and in-patient departments.
Activity 5.3. Strengthen TB Champions among key populations (interventions in hard-to-reach areas including prisons, refugee camps, garment factories and slums)
Activity 5.4. Scale up implementation of SOPs for TB programming among hard to reach key and vulnerable populations in order to increase case findings.
Activity 5.5. Update in-service training for HCWs to incorporate human rights, TB key population sensitivities, medical ethics, and legal literacy module in the context of TB.
Activity 5.6. Recruit and train persons living with and experienced by TB, including from TB key populations, to become Peer Counsellors and involve in the implementation of Snowball Approaches for supporting TB case detection amongst hard-to-reach populations.

Opportunities to Strengthen programs that non-discriminatory provision of health care.
The list of planned activities under the CRG are comprehensive. Stakeholders will need to mobilise resources for their implementation. No further opportunities have been identified.

Existing programs on Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity.
No formal standalone programs were identified during the discussion with stakeholders, however efforts are made during the courtyard meetings and by community health workers to ensure sensitisation and outreach activities are convenient for women, for example, holding courtyard meetings after to lunch to ensure women can attend. Some efforts have been made to create 'women friendly spaces' by ensuring more female health workers[117] however how this has supported an increase in women seeking health services is unclear.

Scoring the Baseline: **Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity – 2.0**

Rating scale for assessing program areas

Rating	Definition
0	No formal programs or activities identified.
1.0	One-off activities that are time-limited, pilot initiative.
2.0	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching <35% of targeted population.
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4.6	Operating at national level (>50% of national scale) and reaching >65% of targeted population
5	At scale is defined as more than 90% of national scale, where relevant, and more than 90% of the population

[117] https://www.stopt

Activities planned for implementation in the CRG Action Plan to Reduce HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity.

Activity 1.1. Conduct qualitative assessment on the range of TB related stigma and GBV experienced by women in different economic strata using the TB Stigma Assessment Implementation Handbook (do it twice - at Y1 and at Y3)

Activity 1.2. Disseminate respective findings of the TB related stigma and GBV.

Opportunities to Strengthen programs that Reduce HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity.

Following findings of the stigma assessment it will be important to design and resource relevant programs to address the findings. It will further be important to ensure that gender considerations should go beyond the binary of men and women but to also include considerations of sexual and gender diverse populations.

Existing programs on Community mobilization and advocacy for Human Rights

There are currently no programs that facilitate the community mobilisation and movement building for advocacy for TB affected populations.

Scoring the Baseline: **Community mobilization and advocacy for Human Rights - 0**

Rating scale for assessing program areas

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0	No formal programs or activities identified.
1.0	One-off activities that are time-limited, pilot initiative.
2.0	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching <35% of targeted population.
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4.3	Operating at national level (>50% of national scale) and reaching 35-65% of targeted population
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Activities planned for implementation in the CRG Action Plan to Community mobilization and advocacy for Human Rights

Activity 1.15. Raise awareness on human rights and legal literacy in the communities through the TB Champions, Peer supporters, and community outreach workers.

Activity 3.1. Establish, coordinate, and support a national network of TB champions that includes Patient Clubs and representatives of TB key populations.

Activity 3.2. Develop TB survivor and TB affected community communication materials based on TB responses and access to services.

Activity 3.3. Support community representatives to participate in country's strategic and resource mobilization meetings including the GF-CCM and other forums.

Activity 3.4. Facilitate meeting to strengthen existing community-based monitoring framework for CRG related TB interventions and include focus on availability, accessibility, acceptability and quality of TB services.
Activity 3.5. Building TB survivor community network for meaningful engagement in TB response
Activity 3.6 Review and implement Advocacy Community Social Mobilisation (ACSM) strategy to include meaningful community engagement, gender, stigma, discrimination, and human rights issues related to TB.
Activity 3.7. Conduct extensive capacity building trainings with TB survivors, Tb affected communities and TB key populations on TB literacy, TB treatment literacy, TB rights, community-led monitoring of the service delivery, quality and rights-violations, including drug stock-outs, drug side effects, stigma, discrimination and other rights-violations.
Activity 4. 3. Support TB survivors and TB affected community representatives to participate in country's strategic and resource mobilization and accountability meetings
Activity 4. 6. Scale-up community-based monitoring using existing structures such as volunteers and TB champions by providing capacity-building training and technical assistance and digital tools for community-based monitoring of availability, accessibility, acceptability, and quality of TB services.

Opportunities to Strengthen programs that Increase Community mobilization and advocacy for Human Rights
The CRG Action Plan provides a comprehensive strategy in strengthening programs to increase community organising.

Overall Baseline Score for Human Rights Programming TB	
Thematic Area	Score
Legal literacy ("know your rights")	2.6
Ensuring rights-based law enforcement practices	0
Improving laws, regulations and polices relating to HIV and HIV/TB	1.0
Eliminating stigma and discrimination in all settings	3.3
Ensuring non-discriminatory provision of health care	1.0
Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity	2
Community mobilization and advocacy for Human Rights	0
Overall Score	**1.4**

Suggested Recommendations			
Activity	**Purpose**	**Benefiting Stakeholder**	**Suggested Lead Implementer (supporting Implementer)**[118]
Access to Justice			
Implementation of a hotline and other rapid response mechanisms in cases of TB-related rights violations.	This will increase TB affected peoples access to justice when their rights are violated, including access to information on how to proceed and where to seek support	TB affected people	NTP, Brac, NLAOS
Advocacy for non-custodial alternatives for non-violent offenses and pretrial periods to reduce overcrowding.	Given that most prisoners are in jail on remand awaiting trial, consideration of non-violent offenders who are TB positive to be released home until trial to reduce the transmission of TB within prison settings and to enable better treatment outcomes.	TB affected populations, prison populations	NTP, Ministry of Home Affairs
A review of policies including employment, insurance, education, prisons, refugee and social security that impact access to TB services amongst people who are affected by TB will be undertake with a specific analysis on each of the focus key populations.	Undertake an annual review of laws, policies and reforms impacting on people affected by TB to track progress or lack thereof	All	NTP, Brac
Eliminating stigma and discrimination in all settings			
Establish, strengthen and support health committees led by members of the community and health facility leadership	Improve coordination between affected people and health care facilities by establishing health committees to ensure service delivery is accessible, cost effective and of quality.	Health facility leadership, TB affected populations	NTP and Brac

[118] This section has been agreed to with consensus during the circulation of the report to all relevant stakeholders.

Teachers of educational institutions will be oriented on TB services as well as human rights and gender principles, which will eventually reduce the stigma and increase the case detection including child TB.	Improve understanding of TB and transmission for teachers and officials in education institutions to facilitate greater awareness amongst young people as well as case detection amongst children and to do so without fuelling stigma and discrimination	Teachers, students, young people affected by TB	NTP, Teachers associations, Ministry of Education
Non-discriminatory Provision of Health care			
Existing recommendations under the CRG Action Plan are adequate			
Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity			
Community consultations to identify specific gender-related barriers to accessing TB. services.	There is limited evidence of the gender related experiences of women, girls and gender diverse populations affected by TB, this can impact on the level of gender sensitive activities implemented across the program. Engaging women, girls and gender diverse people in community consultations can improve access to TB programs	Women, girls, gender diverse people	NTP, Brac, Bandhu
Empowering women's groups to raise awareness of TB-related rights and monitor violations.	Working closely with women's organisations to improve coverage of awareness of TB amongst women and related rights violations. This can also support monitoring of rights violations against women to gain a better understanding of *what* rights are violated and what level of access to justice they have.	Women	Brac and women's organsistions
Community mobilisation and advocacy for human rights			
Support CBOs and TB affected communities to advocate and mobilize resources or provide small grants to support financial, nutritional, psychological and mental health support for people with TB and their families, particularly through government social protection schemes and corporate social responsibility programs where possible.	Empowering CBOs with the skills to mobilize resources or providing small grants ensures the needs as defined by the community can be met. Further improving their knowledge of social protection schemes and the mechanisms in which to access can also ensure the TB affected populations are able to avail themselves of government benefits.	TB CBO's	Brac
Engagement of prisoner leadership on peer-	Developing a prison-based leadership group of TB	Prisoners	Brac

led TB activities and stigma and violence reduction efforts, including building capacity of peer educators.	affected prisons can support the implementation of awareness raising opportunities, mobilization and psycho-social support		

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Annex 2: Data Collection Tools

Suggested Questionnaire Tools:

Implementers, Govt, Development Partners	
Focus Area	Question
Human Rights	Who (which communities) are most affected by human rights violations
	What are the main human rights-related barriers that community faces in accessing HIV (or TB or malaria) services?
	Are there currently any target groups whose needs are not being met or are excluded from programs?
	What programs are you aware of that are meant to address specific human rights-related barriers? If so, which ones? (both GF and non GF)
	How do communities access or benefit from these services? How are they made aware of their existence?
	What are the challenges in implementing these programs (reaching beneficiaries, distance, cost, health worker capacity)
	To what extent does the community participate in or lead, in the delivery of programs to reduce human rights-related barriers?
	What is your perception of these programs?
	Do you receive specific funding to carry out program activities? Is it sufficient?
	What gaps remain in the HIV (TB) response in terms of addressing barriers to access and reaching hard to reach groups? How can we address these gaps.
Gender (cross cutting)	What are the gender-based barriers that community members may face in accessing this intervention?
	How do programs take into account specific access challenges faced by women and girls, as well as LGBTIQ individuals? For TB programs – what barriers do men specifically face
	Does your program include activities to address gender-based violence? If so, how?
	Are monitoring and evaluation targets and indicators disaggregated by age and sex?
	Are there referral mechanisms to other services that may be critical for addressing harmful gender norms and practices? (For example, referrals to paralegals or legal aid for survivors of gender-based violence, links to shelters or psychosocial support services, etc.).
	Have HIV and TB gender assessments been conducted within the country and if so, has there been any follow-up on recommendations?
Program	Do your programs address any of the following human rights barriers- if so which ones, who do they target and where are they implemented (use the rating scale to determine the reach of the activity): • Stigma and discrimination reduction • Training for health workers on human rights and medical ethics related to HIV and TB • Sensitization of lawmakers and law enforcement agents • Improved Legal literacy (“know your rights”) • Increased access to justice. • Monitoring and reforming laws, regulations, and policies • Reducing gender discrimination, harmful gender norms and violence against women & girls in all their diversity and • Community mobilisation and advocacy for human rights

	Additional program areas relevant to the removal of barriers in the context of TB include: • Programs in prisons and other closed settings.
	What would improve the program (ie, improve quality, effectiveness, scope, scale, etc.) to make it more effective?
	Does this program aim to address and contribute towards changing gender norms? If so, how?
	How have gender transformative approaches been reflected in the program's design and implementation?
	What have been the biggest challenges and successes in implementing gender transformative programming?
	Who is funding your program?
	Have you ever received domestic funding? How secure is that funding? What are the prospects for increased domestic funding?
	Are programs to reduce human rights-related barriers integrated into the National Strategic Plans for HIV and TB and related Action Plans?
Quality	What project activities worked well and why? What did not work well and why?
	What is the evidence that interventions are effective in reducing or eliminating barriers?
	What is the most significant change you have seen after implementing your program
	Where are the opportunities to strengthen and scale-up interventions to reduce human rights-related barriers to services, including through integration within broader health programs addressing key and vulnerable populations, for example?
	Do you have a complaints or feedback mechanism where patients can report any issues or provide suggestions to improve the service?
	Do you have any skills building or training requests related to improving gender and human rights related programming? If so what are they?
	Would integration of HIV with UHC and SRHR impact service access for PLHIV and KPs?

KP and Beneficiaries	
No.	Question
1.	What are the main human rights-related barriers that your community faces in accessing HIV (or TB or malaria) services? • Stigma and discrimination • Poor quality health care and ethics of health workers related to HIV and TB • Harassment by state-based actors, lack of access to justice programs, awareness of access to justice programs • Legal literacy ("know your rights") • Criminalisation of behaviour • Gender discrimination, harmful gender norms and violence against women & girls in all their diversity and • The right to mobilise and movement building
2.	Are there any programs you need that you currently don't have?
3.	What programs are you aware of that are meant to address specific human rights-related barriers? If so, which ones? (both GF and non GF) • Stigma and discrimination reduction

	• Training for health workers on human rights and medical ethics related to HIV and TB • Sensitization of lawmakers and law enforcement agents • Improved Legal literacy ("know your rights") • Increased access to justice. • Monitoring and reforming laws, regulations, and policies • Reducing gender discrimination, harmful gender norms and violence against women & girls in all their diversity and • Community mobilisation and advocacy for human rights Additional program areas relevant to the removal of barriers in the context of TB include: Programs in prisons and other closed settings.
4.	How do you as communities' access or benefit from these services? How did you know they existed?
5.	Do you have any challenges in accessing these programs, (distance, cost of travel, awareness)
6.	Have you ever been asked what you would like to be included in the service you receive.
7.	What do you think are the three most important programs (from the list above) that you would like to see more of?
8.	What gaps remain in the HIV (TB) response in terms of addressing barriers to access and reaching hard to reach groups? How can we address these gaps.
9.	Have you ever needed a referral for a service such as GBV, access to justice etc? If yes? Ask- Did you receive a referral for that service?

Annexe 3: List of Stakeholders Key Informant Interviews and Focus Group Discussions

List of the Key informant Interviewees for Rapid Assessment on Human Rights related barrier to HIV/AID and TB in Bangladesh

SL	Name	Role and Organization
1.	Mr. Monoj Kumer Biswas	BCCM Country Coordinator, Global Fund , Ministry of Health
2.	Dr. Md. Mahafuzer Rahman Sarker	Line Director TB-L ASP, Directorate General of Health Services
3.	Dr. Mohammad Mahbubur Rahman	Deputy Director and Program Manager, NASC/ ASP, Directorate General of Health Services
4.	Md. Akhtaruzzaman	Senior Manager, ASP, , Directorate General of Health Services
5.	Dr. Rupali Shishir Banu	National Program Coordinator, NTP, , Directorate General of Health Services
6.	Md. Hafiz Uddin Munna	BCCM Member and Secretary, PLHIV network
7.	Dr. Sharful Isalm Khan	Head of HIV/ AIDS Program, Icddr,b
8.	Dr. Rounak Khan	Chief of Party, HIV/ AIDS , Save the Children
9.	Dr. Ikhtiar Ahmed	Director, Health, Care Bangladesh
10.	Md. Shale Ahmed	Executive Director, Bandhu Social Welfare Society
11.	Dr. Saima Khan	Country Director , UNAIDS Bangladesh
12.	Prof. Saif Ullah Munshi	Professor of Virology, BSMMU
13.	S.M.Abdullah-Al-Reza	Program Manager, Ashokta Punarbashan Sangstha (APOSH) Rajshahi
14.	Md. Abul Bashar	Executive Director, Asokta Punarbashon Songstha (APOSH), Rajshahi
15.	Md Shahid Alom	Counselor, Terokhadia OST Center, APOSH, Rajshahi
16.	Dr. Shaikh Robul Akther	Consultant, Divisional Drug Treatment Center, Rajshahi
17.	Md. Pintu Ahammad	PWID survivor, Rajshahi
18.	Dr. Shayla Akter	Associate Director, TB Program, BRAC
19.	Dr. Ferdous Wahid	Program Manager, CRG activities, TB program , BRAC
20.	Brig. General Md. Shamim Ahsan	Director, Chattogram Medical College Hospital
21.	Dr. Aung Sui Pro Marma	Deputy Director, Chattogram Medical College Hospital
22.	Dr. Harun-Ur-Rashid	Superintendent, Jashore 250 Bedded Hospital
23.	Dr. Nowmy Afrin	Medical Officer Cum center Manager KP Intervention Center, 250 Bedded General Hospital Jashore
24.	Md. Rahan Ali	Outreach Supervisor KP intervention Center, 250 Bedded General Hospital Jashore
25.	Md. Sudeb Kumar	Counselor HTC center ,250 Bedded General Hospital Jashore
26.	Bhorot Dash	Peer Educator PWID KP intervention, 250 Bedded General Hospital Jashore
27.	Ranu Akter	President , Banchita, Jashore (A sex worker based CBO)
28.	Dr. Nehal Uddin	Medical Officer, ART Center, Chattogram Medical College Hospital

Participants Attending National Level Debriefing: Rapid Assessment on Human Rights Related Barrier to HIV/AIDS and TB
09 August 2023 - IEDCR Conference Room, DGHS, Mohakhali, Dhaka.

SL #	Name	Role and organization
1.	Akhtar Jahan Shilpy	Team Leader, PWID, Care Bangladesh
2.	Md.Abu Taher	NPC,UNODC
3.	Reza Hasan Sabbir	Coordinator, NPUD
4.	Sabira Ferdousi	Project Officer OKUP
5.	Salma Sultana	Senior Program Manager, Save the Children
6.	Abu Yusuf Chowdhury	President, SANB
7.	Md. Kamruzzaman	Team Leader-FSW Interventions
8.	Md. Salah Uddin	Team Leader, MSM intervention Dhaka Ahsania Mission,
9.	Sangita Singh	International Consultant, Global Fund
10.	Narayan Chandra Sarkar	Team Leader, Bandhu
11.	Dr. Md. Hasan Ali	National Consultant, DF-ASP
12.	Dr. Rokhsana Yasmin	Technical Officer, UNFPA
13.	Dr. Tanvir Ahmed	DPM,ASP, DGHS
14.	Israt Jahan Muna	Member, BMSS
15.	Ezazul Chowdhury	Technical Adviser, Save the Children
16.	Dr.Fatema Khatun	Technical Specialist (HIV), ASP, DGHS
17.	Iftekhar Ahmed Sakib	VPEA,BMSS
18.	Md.Mushfiqur Rahman	EALO,BMSS
19.	Saima Khan	Country Director ,UNAIDS
20.	Dr. Rawnak Jahan	Consultant, UNAIDS
21.	Dr.Rupali Shishir	NPC,NTP, DGHS
22.	Dr.AKM Masud Rana	Project Coordinator, ICDDR,B
23.	Dr. Sadia Sultana	Manager- KP ,ASP, DGHS
24.	Shale Ahmed	Executive Director, Bandhu Social Welfare Foundation
25.	Dr.Md.Abdul Nahid	PM,ASP,DGHS

SL #	Name	Role and organization
26.	Shahjalal Hossain Sium	BMSS
27.	Md.Akhtaruzzaman	Senior Manager, ASP,DGHS
28.	Nafisa Tasnim Binte Khalil	BMSS
29.	Farhana Zaman Raisa	BMSS
30.	Dr. Nusrat Momen	MSE Expert, ASP, DGHS
31.	Dr. Md.Shajjad Hossain	Asst.Manager, ASP, DGHS
32.	Md. Shahinul Islam Chowdhury	Asst Manager, ASP, DGHS
33.	Dr. Subhashree Monigram	PSM Officer, ASP, DGHS
34.	Jannatul Ferdous	Data Assistant, ASP, DGHS
35.	Fouzia Easmin	HIV Counseling Coordinator, ASP, DGHS
36.	Md.Akhlak Miah	Accountant, ASP, DGHS
37.	Md. Alauddin Chowdhury	Manager, Data & IT

Participants National KP Workshop on the Rapid Assessment on Human Rights Related Barrier to HIV/AIDS and TB in Bangladesh
08 August 2023 -NASP Conference Room, Mohakhali, Dhaka.

No.	Name	Occupation
1.	Rina Begum	President, Welfare of Women
2.	Baby Yeasmin	POW, Dhaka Ahsania Mission
3.	Shahnaj Begum	POW, Care Bangladesh
4.	Tanisha Yeasmin Chaity	Bandhu Social Welfare Society, Liaison Officer
5.	Munni Begum	Peer Educator, Badhon Hijra Shongho
6.	Haripada Das	Community Peer Counselor, IDH
7.	Mili	Bandhu Social Welfare Society
8.	Md. Shahin Sheikh	POW, Care Chankharpul, DIC
9.	Amena	POW (BSMMU)
10.	Reza Hasan Sabbir	Coordinator, NPUD
11.	Sabira Ferdousi	Project Officer, OKUP
12.	Md.Shahidul Islam	Program Coordinator,CMKS
13.	Pinky Shikder	Executive Director, Badhon Hijra Shongho
14.	Joya Shikder	President, Shomporker Noya Shetu
15.	Dr.Nusrat Momen	MSE Expert, ASP, DGHS
16.	Dr.Fatema Khatun	Technical Specialist (HIV), ASP, DGHS
17.	Dr.Sadia Sultana	Manager, KP-I, ASP, DGHS
18.	Dr.Subhashree Monigram	PSM Officer, ASP, DGHS
19.	Md.Hafizuddin Munna	Gen. Secretary, PLHIV Network

List of FGD Participants by KP	
Transgender Date: 25/07/2023 Place: Badda, DIC, Gulshan, Dhaka.	11
MSM/MSW Date: 25/07/2023 Place: Badda, DIC, Gulshan, Dhaka	11
MSM Date: 05August 2023 Place: Chattogram Medical College, ART center	8
Transgender and MSM Date: 05August 2023 Place: Chattogram Medical College , ART center	5
Female Sex Worker Date: 26/07/2023 Place: Mirpur-10, DIC, Dhaka	12
Female Sex Worker Date: 03 August 2023 Place: Bonchita Jashore Office	5
Peoples Who Use Drug (PWUD) Date: 29/07/2023 Place: Chankarpul, DIC, Dhaka	12
Peoples With Drug Use (PWUD) Date:02 /07/2023 Place: Mohishbatan Outlet, Aaposh Rajshahi	11
PLHIV Date: 05August 2023 Place: Chattogram Medical College , ART center	7
Total	**82**