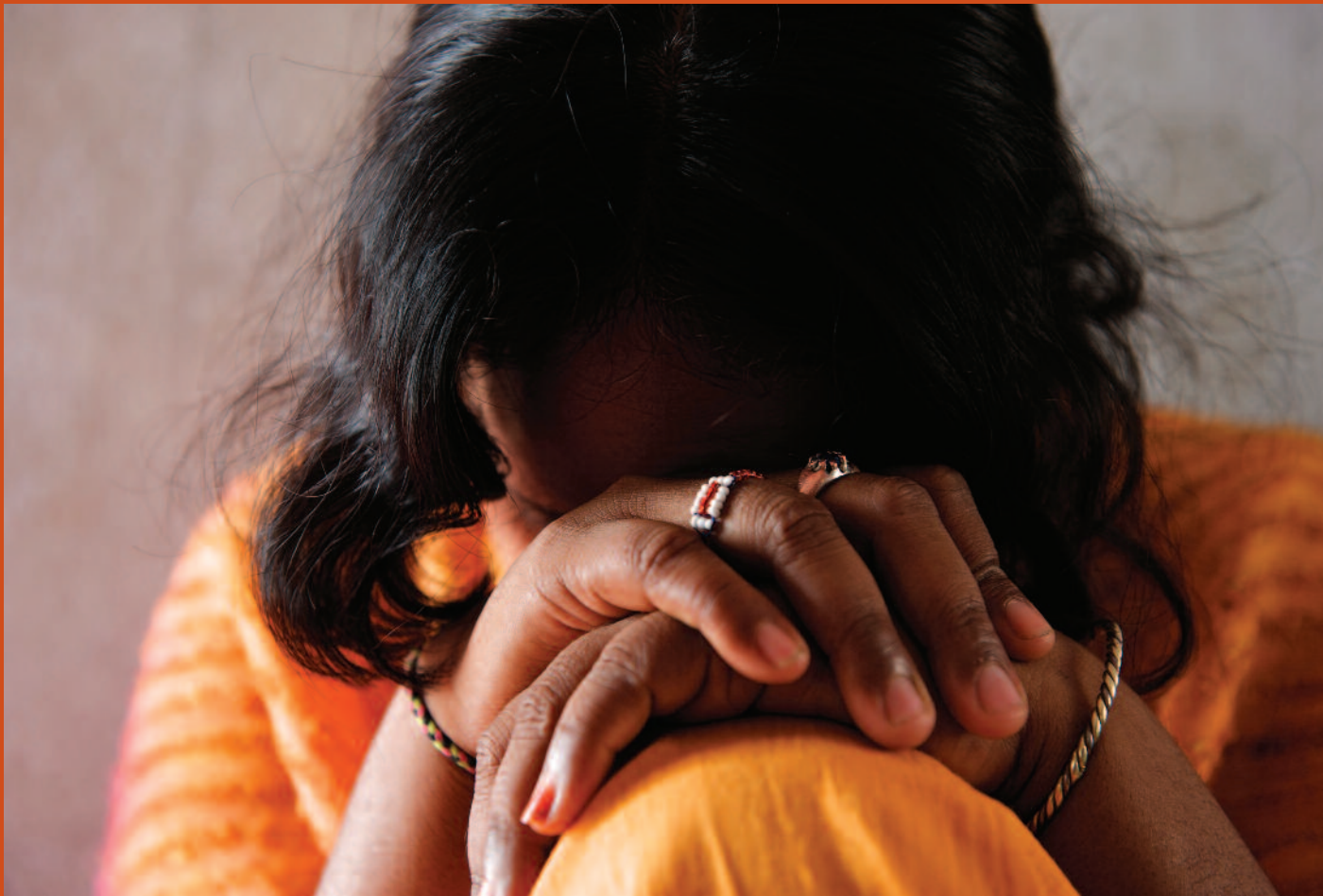




# National HIV Risk Reduction Strategy for Most At Risk & Especially Vulnerable Adolescents to HIV & AIDS in Bangladesh (2013 – 2015)



**National AIDS/STD Programme (NASP)**  
Ministry of Health & Family Welfare



**National HIV Risk Reduction Strategy  
for Most At Risk & Especially  
Vulnerable Adolescents to HIV & AIDS  
in Bangladesh (2013–2015)**

**National AIDS/STD Programme (NASP)**

**Directorate General of Health Services**

**Ministry of Health and Family Welfare**

**Dhaka, Bangladesh**

December 2013

Cover Photo: © UNICEF/NYHQ2009-2579/Noorani

Design & Layout: Dhruvadi

# Foreword

Bangladesh continues to have a low but concentrated AIDS epidemic with national HIV prevalence less than 0.1%. While the level of HIV infection remains generally low in the country, there are considerable vulnerabilities and risk that put children and adolescent at risk of infection. This has become important as the country has a large cohort of children and adolescent population under 18 years of age estimated at 45% of the total population.

According to UNAIDS, Most At Risk Adolescent (MARA) are adolescent (aged 10 – 19 years) who engage in behaviours such as injecting drug use, male who have sex with males, male sex work and female sex work. The Bangladesh National HIV and AIDS Strategic Plan 2011-15 prioritizes and requires the provision of age and gender appropriate services for Most at Risk Adolescents (MARA). Other than MARA, there Especially Vulnerable Adolescents (EVA) who are extremely vulnerable to HIV and AIDS (and STI) due to situations that limit their ability and utilization of support to protect themselves from exploitation, violence and abuse.

The National HIV Risk Reduction Strategy for Most At Risk & Especially Vulnerable Adolescents to HIV & AIDS in Bangladesh (2013 – 2015) was informed by the result of the Mapping and Size Estimation of Most At Risk Adolescents in Bangladesh conducted in 2011 with support from UNICEF. This strategy emphasizes key actions to improve legislation, policy and programmes to reduce risk and protect MARA/EVA in Bangladesh from HIV and AIDS. The strategy seeks to facilitate the generation and use of evidence to inform programmes for MARA/EVA, facilitate the participation and civic engagement of adolescents as part of social development and empowerment, and promote effective coverage of HIV and AIDS prevention treatment and care services for MARA/EVA.

The development of National HIV Risk Reduction Strategy for MARA/EVA in Bangladesh was led by a National MARA Strategy Working Group comprised of HIV programme managers, national and international NGOs, HIV positive network and UN Joint Team members under the leadership of the National AIDS/STD Programme (NASP). My sincere gratitude goes to the members of working groups as well as national and international expert who contributed to the development of this strategy for Bangladesh.

Finally, sincere thanks go to UNICEF Bangladesh for the technical and financial support for the development of the strategy.

**Dr. Md. Abdul Waheed**

Line Director

National AIDS/STD Programme (NASP)

Directorate General of Health Services

Ministry of Health and Family Welfare

Government of the People's Republic of Bangladesh

# Acknowledgment

The establishment of national strategic guidance to guide programme planning and monitoring is one of the key focus of National AIDS/STD Programme in Bangladesh, and development of National HIV Risk Reduction Strategy for Most At Risk & Especially Vulnerable Adolescents to HIV & AIDS in Bangladesh (2013–2015) is a further demonstration of the commitment of the Government toward comprehensive HIV and AIDS response in Bangladesh.

The National AIDS/STD Programme of Bangladesh wishes that all partners working on HIV/AIDS prevention in the country will utilize the strategic guidance to develop effective programme to address Most At Risk and Especially Vulnerable Adolescent of Bangladesh.

The strategy was developed under guidance of MARA Strategy Development Working Group, comprised of representative from Government, UN Agencies, FHI, Save the Children members, icddr, Action Aid Bangladesh, Dhaka Ahsania Mission, PMUK, APON, PIACT, BWHC, HASAB and PSTC. We like to express our sincere thanks to the organizations and participants of the working group to provide valuable inputs.

Aside the in-country team facilitated by Neilsen Bangladesh (via a contract with UNICEF), this document benefitted from external review from Prof. Radhika Balakrishnan (Center for Womens Global Leadership, USA), Mr. Scott McGill and Ms. Vanessa Veronese (Save the Children International Regional Office, Bangkok), Dr. Susan Kasedde (UNICEF Head quarters, New York USA) Dr. Paula Bulancea and Dr. Annefrida Kisesa (UNICEF Regional Office for South Asia, Nepal) and Mr. Gary Svenson (UNICEF International Consultant on MARA). The National AIDS/STD Programme appreciate the contribution of everyone towards the development of the strategy.

Finally we like to acknowledge the technical leadership and financial support provided by UNICEF Bangladesh which resulted in the development of the strategy.

## **Dr. Md. Anisur Rahman**

Focal person

MARA Strategy Development Working Group

Deputy Program Manager

National AIDS/STD Programme (NASP)

## Members of the MARA Strategy Working Group

Dr. Md. Abdul Waheed	Line Director, NASP
Dr. Sydur Rahman	Programme Manager, NASP
Dr. Anisur Rahman	Deputy Programme Manager, NASP
Dr. Mahbuba Begum	Deputy Programme Manager, NASP
Dr. Tajudeen Oyewale	Chief, HIV/AIDS UNICEF Bangladesh
Dr. M. Ziya Uddin	HIV/AIDS Specialist, UNICEF Bangladesh
Ms. Gloria Kibera	Youth & Adolescent Dev. Officer, Child Protection Section, UNICEF Bangladesh
Ms. Mira Mitra	Communication Manager, UNICEF Bangladesh
Mr. Leo Kenny	Country Coordinator, UNAIDS
Mr. ABM Kamrul Ahsan	HIV/AIDS Specialist, UNODC Bangladesh
Dr. Khandaker Ezazul Haque	HIV/AIDS Officer, UNFPA Bangladesh
Ms. Akhter Jahan	Technical Specialist, NASP
Ms. Komol	Deputy Secretary, Ministry of Women and Child Affairs
Ms. Kathrin Tengenfeldt	Country Coordinator, FHI360
Mr. Anup Kumar Bosu	Sr. Proj. Manager, IDU Intervention, Save the Children
Ms. Mousumi Amin	Sr. Proj. Manager, FSW Intervention, Save the Children
Ms. Jiniya Afroze	Manager, Child Protection, Save the Children
Mr. Gorkey Gourab	HIV/AIDS Programme, ICDDRDB
Mr. Helal Uddin	Deputy Managers, Women's Right & Gender, Action aid Bangladesh
Ms. Zinnat Afroz	Advisor, Protection, Plan International
Ms. Wahida Banu	Executive Directors, Aparajeyo Bangladesh
Mr. Shafique Islam	Director– Program, Dhaka Ahsania Mission (DAM)

Ms. Farhana Islam	Manager, Child Dev. PMUK Bangladesh
Bro. Ronald Drahozal	Executive Director, APON
Mr. Abu Yusuf Chowdhury	Executive Director, PIACT
Dr. Rounak Khan	Team Leader, BWHC



# Table of Contents

<b>FORWARD</b>	iii
<b>ACKNOWLEDGEMENT</b>	iv
<b>MEMBERS OF MARA STRATEGY WORKING GROUP</b>	v
<b>TABLE OF CONTENTS</b>	vii
<b>ABBREVIATIONS</b>	ix
<b>GLOSSARY OF TERMS</b>	xiii
<b>INTRODUCTION</b>	1
Context	3
Focusing on Adolescents	4
Development process of National HIV Risk Reduction Strategy for MARA and EVA	6
<b>SITUATION OF MARA AND EVA IN BANGLADESH</b>	7
Mapping and Behavioral Study of MARA and EVA	9
Findings from Mapping and Behavioral Study	10
Female Sex Workers (FSWs)	10
People who inject drugs (PWID)	11
Non-Injecting Drug Users (NIDUs)	11
Males Who Sex with Males (MSM) and Male Sex Workers (MSW)	12
Transgender (TG)	13
Children on the street and living in brothels (EVA)	14
Young people who use 'Yaba' (EVA)	14

<b>STRATEGIC FRAMEWORK</b>	15
Purpose of the Strategy	17
Guiding Principles	17
Strategic Objectives	18
Strategic Approaches	18
Strategic Approach 1: Protective Legislation and Policy Programmes	19
Strategic Approach 2: Knowledge-based programming and policy	20
Strategic Approach 3: Youth Participation and Networking	21
Strategic Approach 4: Comprehensive HIV and AIDS Related Services	22
<b>RESULTS FRAMEWORK</b>	25
<b>LOGICAL FRAMEWORK</b>	29
<b>THE WAY FORWARD</b>	37
<b>CONCLUSION</b>	41
<b>ANNEXES</b>	44
Annex 1: Mapping and Size Estimation of Young Female Sex Workers (10–24 years) in Bangladesh	44
Annex 2: Mapping and Size Estimation of Young Injecting Drug Users (10–24 years) in Bangladesh	45
Annex 3: Mapping and Size Estimation of Young Males who have Sex with Males/Male Sex Workers (10–24 years) in Bangladesh	46
Annex 4: Mapping and Size Estimation of Young Transgender (10–24 years) Bangladesh	47
<b>REFERENCES</b>	48

# Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BB	Brothel Based
BBS	Bangladesh Bureau of Statistics
BCC	Behavior Change Communication
BDHS	Bangladesh Demographic and Health Survey
BSS	Behavior Surveillance Survey
CBO	Community-based Organisation
DGHS	Directorate General of Health Services
DIC	Drop-in-Center
DSS	Department of Social Service
DYD	Department of Youth Development
EVA	Especially Vulnerable Adolescents
EVA/YP	Especially Vulnerable Young People
FSW	Female Sex Worker
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOB	Government of Bangladesh
HASAB	HIV/AIDS and STD Alliance Bangladesh
HmB	Home Based
HBSWs	Hotel Based Sex Workers
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
ICDDR, B	International Centre for Diarrheal Disease Research, Bangladesh
ICT	Information-Communication Technologies
INGO	International Non-Governmental Organization
HAPP	HIV/AIDS Prevention Project
HS	Heroin Smoker
HSC	Higher Secondary Certificate

LSE	Life Skills Education
MARA	Most at Risk Adolescents
MARP	Most at Risk Population
MAR/YP	Most at Risk Young People
MOHFW	Ministry of Health & Family Welfare
MOYS	Ministry of Youth and Sports
MSM	Men who have Sex with Men
MSW	Male Sex Worker
NAC	National AIDS Committee
NASP	National AIDS/STD Programme
NSP	National Strategic Plan
NGO	Non Government Organization
NIDA	National Institute on Drug Abuse
NIDU	Non Injecting Drug User
PEP	Post Exposure Prophylaxis (HIV)
PLHA	People Living with HIV/AIDS
PREP	Pre Exposure Prophylaxis (HIV)
PWID	People Who Inject Drugs
RDS	Respondent- Driven- Sampling
RH	Reproductive Health
SB	Street Based
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
SSC	Secondary School Certificate
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TG	Transgender
TLS	Time-Location-Sampling
UN	United Nations

TOR	Terms of Reference
UNAIDS	United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
WB	World Bank
WHO	World Health Organization
YP	Young People



# Glossary of Terms

## Terms for age groups

United Nation terms for various age groups are listed below. These age groups have different characteristics in terms of biological, psychological and social maturation as well as degree of dependency upon adults and social protective services. Overlap of age groups should be noted.

This typology can serve as a valuable guide for adapting and targeting responsive HIV and AIDS programming. **The focus of this strategy is on adolescents aged 10-19 yrs.** though the interventions and data presented may overlap into adjacent age groups.

Term	Age range
Children	Aged 0 to 18 yrs.
Adolescents	Aged 10 to 19 yrs.
Youth	Aged 15 to 24 yrs.
Young people	Aged 10 to 24 yrs.

## Definition of key population groups at higher risk of HIV exposure

The term 'key populations at higher risk of HIV exposure' refers to those most likely to be exposed to HIV or to transmit it. In all countries, key populations include people living with HIV and AIDS (PLWHA). In most settings, it includes men who have sex with men (MSM), transgender persons (TG), people who inject drugs (PWID), sex workers (SW) and their clients, and seronegative partners in sero-discordant couples. Each country defines the specific populations that are key to their epidemic and response based on epidemiological data and social contexts.

It is important to note that key population groups are not mutually exclusive and definitive but interrelated. Individuals can move between groups or out of groups and the groups themselves are constantly changing and evolving.

## EVA – Especially vulnerable adolescents

Some adolescents are 'especially vulnerable' to HIV risky behaviours due to factors such as social exclusion, gender, migration, poverty and drug use. These factors do not automatically lead to risky behaviour due to protective factors (e.g. education, supportive family and peer networks). EVA include the following:

- children of parents who use drugs and/or sell sex;
- siblings and friends (peers) of those who inject drugs and or sell sex;
- juvenile offenders, school dropouts, runaways, homeless or migrant adolescents including those in institutional care centres like Residential school, Juvenile detention center... and prison settings;

- different sexual orientation and gender identity i.e. those exploring same-sex relationships;
- who are non-injecting drug users (NIDU);
- adolescents in early marriages;
- sexually or physically abused whether in or outside their home;
- minorities or socially marginalized groups; and
- orphans and those without any adult supervision and care, e.g. street children

### **MARA - Most-at-risk adolescents (MARA)**

These are key adolescent populations who are at higher risk for HIV exposure. The term most at-risk adolescents (MARA) is used throughout this strategy to include adolescent populations at higher risk for HIV:

- inject drugs using non-sterile or HIV contaminated injecting equipment;
- involved in commercial or transactional sex work including those who are trafficked for the purpose of sexual exploitation; and
- males who have unprotected anal sex with other males

### **FSW – female sex worker**

The term female sex worker is used to cover a broad range of transactions. Female (and male) sex workers are not a homogenous group. A broad definition is: 'the exchange of money or goods for sexual services, either regularly or occasionally, involving female adults, young people and children, where the sex worker may or may not consciously define such activity as income generating'. 'Involuntary trafficking of females to serve as sex workers is also a component.

### **MSM – Men who have sex with men**

These are males who have sex with males but do not sell sex.

### **MSW – Male sex workers**

These are males who sell sex in exchange of money or compulsory gift. Therefore all MSW are MSM but not all MSM sell sex

### **NIDU – Non injecting drug user**

'Non-injecting drug user' includes especially vulnerable adolescents who use harmful drugs but do not necessarily inject them, e.g. heroin smokers.



## **PWID**

This refers to people of all ages who inject drugs and are at risk for HIV exposure due to the use of non-sterile injecting equipment that may be contaminated with HIV or other blood borne infections, e.g. hepatitis.

## **TG - Transgender**

This term has many definitions. It is often used as an umbrella term to refer to people who deviate from their assigned gender at birth including cross-dressers. Some transgender people feel they exist not within one of the two standard gender categories, but rather somewhere between, beyond or outside of those two genders.





# 1. Introduction





# 1. Introduction

## Context

The Government of Bangladesh has consistently demonstrated leadership in its national response to the HIV epidemic. The National AIDS Committee (NAC) was formed in 1985 as the highest decision making body in Bangladesh regarding HIV, AIDS and sexually transmitted infections (STI), supervision of program implementation and mobilisation of resources. The National AIDS/STD Program (NASP) was established by the Ministry of Health and Family welfare (MOHFW) within the Directorate General of Health Services (DGHC) to manage the National AIDS Programme (NAP) in the country. Bangladesh adopted a comprehensive national policy on HIV/AIDS and STIs in 1997 and since then three National Strategic Plans have been developed for the years 1997-2002, 2004-2010 and 2011-2015.

The 3rd National Strategic Plan for HIV and AIDS Response (2011-2015)<sup>ii</sup> provides the overall framework for the national response. The Strategic Plan is a roadmap to minimise the spread of HIV and the impact of AIDS on individuals, families, communities and society. Key principles that underpin the Strategic Plan include multi-sectorial engagement, stigma reduction, broad political commitment, civil society involvement, evidence-informed programming, prevention to care continuum, human rights, use of gender based approaches, partnership and a coordinated approach.

The national response is supported by series of strategies and guidelines that included:

- The Safe Blood Transfusion Act (passed in 2002)
- The National Harm Reduction Strategy for Drug Use and HIV, 2004-2010
- National HIV Advocacy and Communication Strategy 2005-10
- National STI Management Guidelines, 2006
- National Policy and Strategy for Blood Safety, 2007
- National Curriculum on HIV/AIDS for students of classes 6 to 12, 2007
- National Standards for Youth Friendly Health Services (YFHS) 2007
- Population Size Estimates for Most at Risk Populations for HIV in Bangladesh, 2009
- Standard Operating Procedures for Services to People Living with HIV and AIDS, 2009
- SOP for care-givers, counselors and outreach workers for supporting PLHIV, 2009
- Management of Opportunistic Infections and Post Exposure Prophylaxis – Guideline-2009
- Clinical Management of HIV and AIDS – Doctors’ Handbook-2009

- Standard Operating Procedures for Drop-in-Centers for IDU and FSW, 2010
- Various training manuals and guidelines on counseling and peer education as per project needs for IDU, FSW and PLHIV-2008 to 2011
- National Strategic Plan for HIV/AIDS 2011-2015
- National AIDS M&E Plan 2011-2015
- National Anti-Retroviral Therapy Guidelines, 2011
- Training Manual on the reduction of Stigma and Discrimination related to HIV/AIDS, 2010
- HIV/AIDS-Opobad O boishommoProtirodh toolkit (stigma and discrimination toolkit), September 2011

Bangladesh's latest round of serological surveillance (National HIV Serological Surveillance Bangladesh: 9th Round Technical Report. IEDCR and ICDDR, B 2011)<sup>iii</sup> showed that HIV prevalence among all key populations remained below 1 percent with the exception of people who inject drugs (PWID). In Bangladesh, as in other countries in the Asia region, HIV risk arises mainly from unprotected paid sex, sharing of contaminated injection equipment, and unprotected sex between men who have sex with men (MSM). Recent data suggests that there are two key areas of focus for HIV in Bangladesh: PWID and returning international migrant workers. The latter group accounts for the majority of passively reported cases and may be a potential source of new HIV transmissions into the general population.

An epidemic may also be emerging among female sex workers (FSW) in towns bordering India and needs careful attention. There is some overlap amongst sex workers, as some inject drugs and some engage with migrant workers. A rising epidemic in one of these groups, therefore, could lead to a spread in others and eventually a 'bridging' of the epidemic into the general population. Bangladesh remains a low HIV prevalence country (<1%) though its population is highly vulnerable to an expansion of the epidemic.

In general, on-going risk behaviours are of major concern. Recent surveys indicate that knowledge about HIV, AIDS and STI is too low for some people to protect themselves.<sup>iv</sup> Condom use in Bangladesh is reportedly one of the lowest in Asia, although the figures have been rising due to interventions. Furthermore, a range of structural factors heighten the vulnerability of the general population to an evolving HIV epidemic. Bangladesh has low rankings for most global development indicators and about half of the population lives on less than one dollar a day.<sup>v</sup> Other structural factors include: a low adult literacy rate; low social status of women and the trafficking of women into the commercial sex industry; high population mobility within the country, including interstate and rural-urban as well as international labour migration, particularly across its porous borders with India and Myanmar, both of which are experiencing concentrated epidemics.<sup>vi</sup>

## Focusing on Adolescents

The Bangladesh HIV and AIDS Strategic Plan 2011-15 prioritises and requires the provision of age and gender appropriate services for Most at Risk Adolescents (MARA). According to the Plan services need to be informed by research and through pilot interventions within Bangladesh itself. In addition, the underlying vulnerability factors that contribute to adolescent involvement in sex work and drug use are to be addressed through linkages

and referral to support services. Guidelines for this service provision are to be developed at the national level and informed by robust evaluation of pilot interventions and research. This national commitment to adolescents serves as the basis for the development of this **National HIV Risk Reduction Strategy for MARA and Especially Vulnerable Adolescents (EVA)**.

In this Strategy **MARA** refers to both male and female (aged 10 – 19 years) who:

- inject drugs using injecting equipment such as syringes;
- involved in commercial or transactional sex work including those who are trafficked for the purpose of sexual exploitation; and
- men who have unprotected sex with other men

Other than MARA, there are other adolescents who are extremely vulnerable to HIV and AIDS (and STI) though they may not have progressed to the MARA category. This is due to unsafe behaviours and/or challenging lifestyles and living conditions that make them susceptible to harm and exploitation. Especially Vulnerable Adolescents (EVA) are often unable to protect themselves without adult or institutional support. Thus, this strategy is also intended to respond to Bangladesh's EVA and, in general, is part of the government's commitment to the health and well-being of Bangladesh's adolescents and other young people who are the nation's most valuable resource and its future.

**Especially Vulnerable Adolescents – EVA** refers to both males and females (aged 10–19 years)

- children of parents who use drugs and/or sell sex;
- siblings and friends (peers) of those who inject drugs and or sell sex;
- juvenile offenders, school dropouts, runaways, homeless or migrant adolescents including those in institutional care centres like madrasa, prison settings;
- different sexual orientation and gender identity i.e. those exploring same-sex relationships;
- who are non- injecting drug users (like Yaba);
- adolescents in early marriage;
- sexually or physically abused 'whether' in or outside their homes;
- minorities or socially marginalized groups; and
- orphaned and without any adult supervision and care, e.g. street children.

## Development process of National HIV Risk Reduction Strategy for MARA and EVA

The development of the Strategy was initiated in follow-up to the National Strategic Plan 2011-15 and is based on the Mapping and Behavioural Study of MARA in Specific Urban/Semi Urban Locations in Bangladesh<sup>vii</sup> conducted by NASP with support from UNICEF (2011). The process was led by the NASP MARA working group co-chaired by government and UNICEF. Membership of the working group includes representatives of pertinent government departments and agencies, INGOs such as Save the Children, FHI, Plan International, local NGOs such as Action Aid Bangladesh, Aparajeyo Bangladesh, APON, PIACT, BWHC, HASAB, UN bodies such as UNAIDS, UNODC, UNFPA and other organisations such as icddr,b.

Towards the development of the first draft, members of the MARA working group and key stakeholders completed a short course titled, 'Understanding the focus on Young People in Key Affected Populations in Concentrated and Low Prevalence HIV Epidemic' developed jointly by UNICEF, UNESCO, UNFPA, Burnet Institute, and the University of Melbourne with financial support from UNICEF Bangladesh. The training contributed to a greater understanding of the critical issues in programming for MARA/EVA and recommendations from the training served as input to the development of the Strategy.

The first draft was written after a desk review of relevant national, regional and global literature, consultations with experts and a review by the MARA working group (November 2012). Based on feedback from these consultations, the conceptual framework for the Strategy was formulated, including strategic results, objectives and strategic approaches. Additional feedback was solicited via e-mail and face-to-face discussions and resulted in the second draft and its review by the MARA working group (February 2013).

International review of the Strategy was undertaken by UNICEF Bangladesh, including its key strategic approaches, validation of concepts and harmonization with relevant global initiatives and subjected to national and international reference group.

The final version of the strategy which included the comments from all stakeholders and expert were finalised in a validation meeting to agree on roles and responsibility in September 2013.

The Bangladesh National HIV Risk Reduction Strategy for Most At Risk and Vulnerable Adolescents was approved for implementation by the National AIDS and STD Programme in October, 2013.



## **2. Situation of MARA and EVA in Bangladesh**





## 2. Situation of MARA and EVA in Bangladesh

According to the Bangladesh Household Census (2011)<sup>viii</sup>, there are 29.44 million adolescents aged 10 – 19 yrs. (20.4% of the total population) in Bangladesh. While HIV prevalence among adolescents is not known in Bangladesh, the overall HIV prevalence among key populations of all ages is reported at 0.7%.

Two behaviours have been identified to pose the greatest risk for the acquisition of HIV in Bangladesh – penetrative sex (vaginal or anal) with multiple partners without using condoms, and using HIV contaminated drug injection equipment.<sup>ix</sup> These behaviours can not only transmit HIV but also other sexually transmitted or blood borne infections. In addition, the non-use of condoms or other contraception can lead to unwanted or unplanned adolescent pregnancies. These risk behaviours are already exhibited by selected adolescents in Bangladesh and all adolescents are vulnerable because sexual risk taking and drug use is often initiated during adolescent years. Adolescence is, therefore, a window of opportunity to reach adolescents before high-risk behaviours begin. Table 1 shows the risk behaviour for HIV, STI and pregnancy in adolescents.

**Table 1: Adolescent risk behaviours for HIV, STIs and unwanted/unplanned pregnancies**

Risk Behaviour	HIV	STIs	Pregnancy
Vaginal sex without a condom	Yes	Yes	Yes
Anal sex without a condom	Yes	Yes	N/A
Multiple partners	Yes	Yes	Frequency of sex is more important than number of partners
Injecting drugs using contaminated equipment, e.g. sharing	Yes	Other blood borne infections such as hepatitis	N/A

### Mapping and Behavioural Study of MARA and EVA

In 2011, NASP carried out the *Mapping and Behavioral Study of Most at Risk Adolescents to HIV in Specific Urban/semi Urban Locations* among young people aged 10-24 yrs. The purpose of the mapping and surveys was to support evidence-based advocacy as well as effective programming for MARA/EVA and a broader range of at-risk young people (MARA/YP, EVA/YP). The results provided up-to-date information on estimated population sizes, geographical distribution of at-risk young people and information on practices related to HIV and AIDS. Moreover, it provided information on the determinants and contexts in which risky behaviors take place and bottlenecks to effective service provision. Lastly, the study helped to identify the elements required to create an enabling environment and responsive policies to address the physical, psychological, and emotional needs of MARA/YP and EVA/YP.

### **The study targeted the following groups aged 10- 24 yrs.:**

- a. female sex workers (FSWs) working on the street, hotels, at home and in brothels;
- b. PWID (male and female);
- c. MSM- biological males having both commercial and non-commercial transactional sex with other biological males;
- d. Transgender people (TG) or hijra- biological males who appear as or wish to be considered as females who have transactional sex with men; and
- e. Non-injecting users (NIDUs).

In addition, the survey included EVA/YP such as those living or working on the street, living in slums, children of sex workers who live in brothels, young people who take amphetamines ('Yaba') and those who live in confined settings such as tea gardens, madrasa, and hostels.

## **Findings from Mapping and Behavioral Study**

### **2.1 Female Sex Workers (FSWs)**

Based on the mapping, the total number of FSWs between the ages of 10-24 yrs. old nationwide is estimated to be around 31, 101. Among the 600 FSWs surveyed in the study, 33% were aged 10-18 yrs. and 67% were 19-24 yrs. The mean age was 19.6 yrs., with brothel-based FSWs tending to be somewhat younger (18.6 yrs.). Institutional education was higher among home based (79%) and hotel based FSWs (72%). The mean age at first sex was highest for hotel-based FSWs (14.8 yrs.) and lowest for brothel-based FSWs (13.8 yrs.).

FSWs were universally aware of condoms and most knew that they can protect against exposure to HIV (88%), STIs (72%) and unwanted/unplanned pregnancy (81%). One-third of the brothel based FSWs (33%), 13% of the hotel and 12% of the home based FSWs were under the impression that a condom is used to maintain 'cleanliness', that is, to protect men's semen from spreading to 'her' body.

A mixed and complex pattern of sex partners and condom use was evident. Overall, 86% of the FSWs had regular clients in the week previous to the survey (average 12.9 clients) and 88% had new/one time clients in the previous week. On an average, brothel based FSWs had 19.1 new clients, hotel based FSWs had 9.7 new clients, street based FSWs had 6.3 new clients and home based FSWs had 4.5 new clients. Non-commercial sex was higher among the home-based FSWs (51%) compared to street (47%), hotel (45%) and brothel based FSWs (31%). More than half of the street based FSWs (53%), and around two-fifths of the hotel based (40%), brothel based (38%) and home based FSWs (39%) had reported experiencing forced sex, ever. Of those experiencing forced sex (n=259), 44% admitted of encountering forced sex within the previous 12 months. Nine per cent reported to have experience of group sex, ever.

Condom use was not consistent according to type of sex partners and suggests multi-faceted HIV risks and vulnerabilities. Reported condom use among FSWs during last sex with regular sex clients was 96%, 94% with new clients and 64% with non-commercial

partners. In terms of drug use, 16% of the FSWs admitted to using drugs in the last 12 months. Drug use was more common among younger FSWs.

Awareness of the terms 'HIV' and 'AIDS' was high among all FSWs. However, only 7% spontaneously knew all the routes of transmission while 21% correctly responded when prompted. Only 2.3% of the FSWs had comprehensive knowledge and this percentage was similar across all age groups.

A large proportion of FSWs knew about symptoms that could indicate a STI infection. FSWs having no knowledge about symptoms varied among categories (brothel based 16%, hotel based 22%, street based 16% and home-based 12%). FSWs having no knowledge about symptoms of STIs were also higher among those who were below 14 years. Significant proportions of the FSWs reported having symptoms in the previous 12 months and usually purchased medicine from a pharmacy (36%) or health workers (28%). However, 12% of the brothel based sex workers had not sought medical treatment.

## 2.2 People who inject drugs (PWID)

The total estimated size after all adjustments for PWID in Bangladesh between aged 10-24 yrs. is 2,097. Of these 208 are in the age category 10-19 yrs. and 1,910 aged 20-24 yrs. The mean age for PWID surveyed (n= 403) was 21.5 yrs. and 17% were adolescents aged 10-19 yrs. While 37% had some secondary level education, 13% had never been enrolled in an educational institute.

The mean age of first injecting drugs was 17 yrs. A majority had started via friends (83%), followed by colleagues (10%), alone (9%) and close relatives (3%). More than half (57%) injected drugs every day. Although 90% reported using a new syringe in their last injection, during the month prior to the survey, they reported injected using a working syringe on an average 10.4 times.

In terms of sexual behaviours, 93% reported ever having had sex (males: 93%, females: 100%). The mean age at first sex was 16 years (males: 16.2 years, females: 13.4 years). Among male PWIDs who ever had sex (n=364), 99.5% reported that their first sex was unplanned or unintentional. Knowledge about the protection offered by condoms was rather high: prevention of HIV at 94%, avoiding pregnancy at 62%, and prevention of STIs at 59%. Consistent condom use was low with only 40% reporting consistent use with regular partners in the past 12 months (n=258).

Over half admitted of having commercial sex partners in the previous 12 months, the average number of commercial sex partner being 3.4 (n=222) (for male IDU: 3.4 partners and female IDU: 4.8 partners). Among those who had commercial sex in the past 12 months (n=222), 62% had always used condoms in the previous one month.

Despite high awareness about the terms 'HIV' and 'AIDS' only 8% could correctly recall all routes of transmission unprompted and 28% when prompted. Three percent possessed comprehensive knowledge. In terms of HIV testing, 58% knew about a facility where they could be HIV tested and more than half (57% of 229) had been tested.

## 2.3 Non-Injecting Drug Users (NIDUs)

One-hundred heroin smokers were included in the survey. It is estimated that there are 30,409 NIDUs in Bangladesh. Of the 100 smokers surveyed, 3% were under 14 yrs. old

and 67% aged 20-25 yrs. Besides heroin, the smokers took other drugs in the last six months. These drugs included cannabis (81%), Phensidyle (39%), Pethidine (8%), yaba (6%), and Cocktail (mixture of different drugs) (4%). Forty percent were found to have secondary education, 33% primary level of education and 16% never being enrolled to an educational institution. The mean age for first smoking heroin was 20.6 yrs. One-fifth reported that they had also injected drugs in the last six months, with an average of 9.7 times.

Ninety per cent of heroin smokers reported that they had experienced sexual intercourse and the mean age at first sex was 15.4 years (n=90). Approximately three-fifths of smokers had sexual intercourse with a regular partner in the last 12 months and 36% reported they had always used a condom in the previous month. Over half (55%) reported sex with a commercial sex worker in the last 12 months and 53% report they always using a condom. Six per cent had experienced forced sex and in these occasions condoms were used at 10%.

Nearly all smokers (98%) had heard about HIV and AIDS. However, only 9% could recall spontaneously all routes of HIV transmission and 15% recalled when prompted. Only one smoker possessed comprehensive knowledge about HIV transmission.

## **2.4 Males Who Sex with Males (MSM) and Male Sex Workers (MSW)**

For the mapping and survey, the following MSM and MSW definitions were used:

### **Male Sex Workers (MSW)**

Biological males who have engaged in sexual relationships (oral and/or anal sex) with another biological male, at least once, in the past 12 months prior to the date of the study/mapping in exchange for money or any other commodities. For the purpose of mapping, both commercial and non-commercial sexual interactions between two biological males were considered. The focus of the review as well as the survey was to classify men who have sex with men in a commercial and non-commercial context and unprotected.

### **Non-commercial/non-transactional MSWs**

Males aged 10-24 years who have had sexual relations (oral and/or anal sex) with another male in the last 12 months, without receiving cash payment or other commodities; with single or multiple partners including bi-sexual relationships.

### **Commercial/transactional MSWs**

Males aged 10-24 years who have had sexual relations, (oral and/or anal sex) with another male in the last 12 months in exchange for money or other commodities.

The estimated size of MSMs was 3,888 and that of MSWs 1,932. During the survey among 400 respondents, it was revealed that MSM (men who have sex with men – non-commercial) and MSW (male sex workers whosell sex to male/female clients) were engaged in similar and overlapping sexual behaviours. Many of the MSM respondents were revealed to also be MSWs. Thus, in the analysis of the behaviour survey, the two groups are referred to interchangeably.

The mean age of the MSM/MSWs (commercial or non-commercial) was 20 years, with 37% between 10-18 years and 63% 19-24 yrs. old. Forty-two per cent had a secondary level of education while 5% had never been enrolled in any form of educational institution. The average age for MSM/MSWs to have first sexual was 13.3years.

Overall, 86% of the MSM/MSWs had their first sexual act with a male, while 13% had sex first time with a female partner and 1% had with a transgender partner. Of these encounters, 18% of the sexual encounters were not planned or intentional and 26% were transactional or commercial. Forty-six per cent sold sex outside of the location they were living during the survey in the previous 12 months. During the past 12 months, 31% had sold sex outside the current city and went outside of their city on average 8.4 times for sex trade.

Awareness of condoms was universal among the MSM/MSWs (99.5%) though somewhat low concerning their use for pregnancy prevention (30%). Among those who had ever used a condom (n=386), 97% had reported that they had used a condom last time during receptive sexual intercourse and 92% used a condom during insertive sexual intercourse (in the last 12 months).

Sex partnerships and the nature of condom use among MSM/MSWs are complex and inconsistent. In the previous month, 75% of the respondents had sex with a regular male/transgender partners and 63% used a condom, always. In addition, 13% had sex with a regular female partner in the previous one month (without any transaction) and around half of them always used a condom. During the previous month, 7% of the MSM/MSWs bought sex from a woman, 17% had bought sex from a man and 3% bought sex from a transgender person. On the other hand, 4% sold sex to a woman, and 61% sold sex to a male in the previous one month. A quarter (25%) had experienced forced sex in the last 12 months and 26% had experience of group sex, ever.

Ninety-nine percent of MSM/MSWs were aware of HIV/AIDS. However, 6% of them could recall all the spontaneously all routes of HIV transmission and 25% responded correctly when prompted. Only 1.5% possessed comprehensive knowledge of HIV.

## 2.5 Transgender (TG)

For the MARA/EVA mapping and survey, TGs were defined as biological males, who appear as or wish to be considered as having undergone surgery to become female (transsexuals) and had sexual relations with a man in the 12 months in exchange for money or other commodities (commercial/transactional) or without (non-commercial/non-transactional). They dress in feminine attire (cross-dress).

A total of 400 TG were interviewed. From the mapping, 6,096 TGs were estimated in Bangladesh, Dhaka having the highest (1,560) and Barisal having the lowest estimate (59). The mean age of transgender people or hijra was 21 years with a majority (67%) aged 19-24 yrs. and 33% were within the 15-19 year age range. Mean age at first sex was 12.9 yrs. and was universally with a male partner. For a large majority (84%), their first sex was unintended or unplanned and 45% had first sex as a cash or in-kind transaction.

Awareness about HIV and AIDS was high, yet only 6% could recall all routes of HIV transmission without prompting and 27% when prompted. Only 1% of the TGs were found to possess comprehensive knowledge.

Awareness about the protection offered by condoms was high. However, specific knowledge on how condoms can protect against pregnancy was low at 26%. During the week before



the survey, 73% had sex with regular paying clients, 72% with new clients, and 65% with a non-paying sex partner. Forced sex had been experienced by 38%. Condom use at last sex was reported at 77% for regular clients and 72% with new clients.

## **2.6 Children on the street and living in brothels (EVA)**

Children living on the street were found to mostly live on their own (with or without family), and were more likely to be exposed to high risk behaviours without proper parental guidance lending them towards HIV vulnerability. On the other hand, children living in slums and brothels (children of sex workers) might have some parental guidance, yet due to their environment become eventually involved in high risk behaviours.

Almost all those who were surveyed mentioned that they had heard about HIV and AIDS, but could not mention in detail routes of transmission. There were some adolescents who did mention that condoms could protect a person from contracting HIV. For the children of sex workers, HIV knowledge was extremely low, yet knowledge of condoms as a protective measure was present to some extent.

Almost all the street children measured had been exposed to some type of drug, ranging from smoking or chewing tobacco to inhaling glue or injecting. Substance abuse was somewhat less among the children of FSWs living in brothels. Although the respondents did not admit to having any sexual exposure themselves, they stated it was not uncommon in the life of other children like them.

## **2.7 Young people who use 'Yaba' (EVA)**

A total of 160 young people, who are drug users, mostly Yaba (methamphetamine), were surveyed. More than one-third was in the age group 10-18 years (36%). Average age of the respondents was 19.3 years, with females being somewhat younger (18.5 yrs.) than males (19.6 yrs.). One-fifth (19%) were students of SSC or below. Another 37% were at HSC level and 42% were at graduate or above level of study.

Overall, 67% of the respondents admitted to taking other drugs before they started taking Yaba. Cannabis was found to be the most common drug to start with (88%) while 16% used tablets. Less than one-tenth admitted to injecting drugs before they took Yaba. More than one-tenth of males (11%) reported taking Phensidyl before starting Yaba.

About one-quarter (27%) admitted to ever having sex (females 43%, males 22%). The mean age at first sex was 17.9 yrs. for boys and 17.0 yrs. for girls. Twelve per cent of respondents reported they'd had group sex after using Yaba.

Rather high levels of knowledge regarding condom was found: 91% reported condoms could be used to prevent HIV transmission or exposure and 71% stated the prevention of STIs. Yaba users had heard about HIV and AIDS almost universally. For routes of transmission, they mentioned unprotected sex with people living with HIV and AIDS (96%), blood transfusion/organ transplantations (89%), contaminated injection equipment (87%) and HIV transmission from mother to child (86%). Overall, 40% of the Yaba-takers spontaneously knew all the correct ways of transmission. However, one-tenth was found to have comprehensive knowledge.



## 3. Strategic Framework





## 3. Strategic Framework

### 3.1 Purpose of the Strategy

The purpose of this Strategy is to enable public and private organisations (at multiple levels) to empower MARA and EVA to reduce their HIV risks by the end of 2015. This includes a focus on skills development, service delivery and improved life opportunities. Moreover, the intention is for the Strategy to set the agenda for longer term national engagement and investment beyond 2015.

### 3.2 Guiding Principles

The Strategy's guiding principles are aligned with the **3rd National Strategic Plan for HIV and AIDS response in Bangladesh (2011-2015)**. These principles serve as the minimum level of commitment to ensure effective implementation of the Strategy by all actors. The principles are:

- **Human Rights Based Approach:** The implementation of this strategy is premised on the realization of the Rights of MARA/EVA as individuals. Realizing these rights requires the recognition of the obligations of duty bearers (government, communities and families) to promote and protect the rights of MARA/EVA at all levels. This principle recognises the importance of MARA/EVA as 'right holders' to claim their human rights, and with appropriate capacity and means to do so.
- **Inclusiveness:** Neither risk behaviours nor HIV serostatus shall constitute a factor for the exclusion of adolescents or other young people from policies, programmes and services in Bangladesh. Instead, inclusive approaches free from stigma and discrimination that promote social cohesion and justice will serve as the bedrock for the implementation of the Strategy.
- **Equity focus:** Mindful of the challenges faced by adolescents in accessing services, and noting that MARA/EVA are subjected to even added challenges, this strategy prioritizes 'targeted' approaches for MARA/EVA as a demonstration of Bangladesh commitment to redress the current situation.
- **Continuum of Care:** Addressing issues of MARA/EVA requires not individual or solitary interventions but rather a series of actions across the life cycle of adolescents including those that are living with HIV and AIDS. The integration of HIV prevention, treatment and care service (and sexual and reproductive health services) is extremely important and needs to take into account adolescent's overall wellbeing by involving service providers, family, care givers, community-based organisations (CBOs) faith-communities and community in general. Such a continuum of care helps to ensure that MARA/EVA can access age appropriate and gender sensitive services. This principal also allows for actions to address underlying structural challenges such as lack of opportunity, inequality and poverty.
- **Age Appropriate and Gender Sensitive Approaches:** Mindful that adolescence is broad and composed of shifting developmental stages each with

its unique needs, this Strategy adopts two adolescent age categories: early adolescence (aged 10 – 14 years) and late adolescence (15 – 19 years). The special considerations of adolescent girls with regards to their unique biological, social and economic vulnerabilities are key issues in this Strategy including access to sexual and reproductive health (SRH) services.

- **Multi-sectorial engagement:** The implementation of this Strategy hinges upon multi-sectorial partnerships. The approaches presented in this document are vast, varied and cut across many sectors. Multi-sectorial engagement and partnership is vital in view of the mixture of behavioural risks and vulnerabilities as well as the impact of HIV and AIDS on MARA/EVA
- **Promotion of evidence informed activities:** This document brings focus on what is shown to be effective with adolescents in addressing HIV and AIDS risks and vulnerabilities. In addition, it encourages knowledge-based activities such as operations and other research, knowledge sharing and local pilot studies to develop effective and context specific models for MARA/EVA in Bangladesh

### 3.3 Strategic Objectives

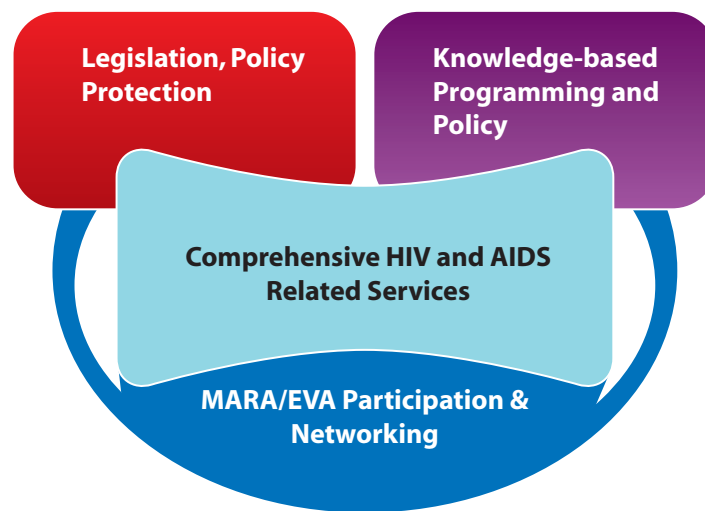
**The objectives for the Strategy Framework during 2013-15 are:**

1. Improve legislation, policy and programming for the protection of MARA/EVA in Bangladesh
2. Increase the development and use of evidence in designing and implementing HIV and AIDS programs for MARA/EVA as a basis for driving the national response
3. Facilitate the participation of MARA/EVA in the HIV & AIDS decision making that affects them while encouraging their civic engagement as a component of Bangladesh's social development
4. Increase the coverage and effective delivery of comprehensive HIV and AIDS related services for MARA/EVA at the primary, secondary and tertiary levels of care.

### 3.4 Strategic Approaches

To meet the objectives, four core strategic approaches will be used. The two expected outcomes for the approaches and their activities are enhancements in 1) policy on MARA/EVA and 2) comprehensive services:

**Figure 1: Strategic Approaches for HIV Risk Reduction among MARA/EVA in Bangladesh**



### **Strategic Approach 1: Protective Legislation and Policy Programmes**

There is ample evidence on the exploitation, violence and abuse of MARA/EVA in the sex industry and through early marriage. Within the principles of the Convention for the Right of the Child (CRC) and the framework of the Bangladesh National Children’s Policy , national mechanisms need to be advanced to enforce the protection of MARA/EVA. This would include protection from exploitation and abuse and the facilitation of MARA/EVA access to appropriate care and support services. Government should ensure that laws are strictly and not selectively enforced by its authorities nor used as a pretext for extortion, harassment or assault.

Indicator seven from the UN *High Level Meeting on HIV and AIDS* (June 2011) sets clear outcomes in the elimination of gender inequities and gender-based abuse and violence. Current national efforts to meet this outcome provide an excellent opportunity for advocating for the review and reform of punitive laws related to sex work, sexual orientation, gender identity and injecting drug use. There is also a need to advocate concerning the unique challenges of MARA/EVA such that they are included in the national discussion on adult key affected populations and HIV and AIDS.

To optimize service utilization by MARA/EVA, a national consensus needs to be reached concerning the issues of privacy and confidentiality and age of consent for access to services. Relevant services include HIV prevention, care and treatments services, HIV prevention and SRH commodities and harm reduction programmes.

## Legislation, Policies and Child Protection Programmes

### Strategic Interventions

- Promote the use of evidence to incorporate MARA/EVA issues into the ongoing engagement of parliamentarians, media, National Human Rights Commission (NHRC), National Law Commission (NLC), judiciary and private sector on the reform/review of punitive laws concerning sex work, sexual orientation and gender identity.
- Support capacity building among law enforcement agencies on the special protection needs and appropriate measures for MARA/EVA who are victims of exploitation and abuse
- Increase public awareness on the exploitation, violence and abuse experienced by MARA/EVA
- Support care and support services for adolescent victims of exploitation, violence and abuse
- Advocate for the inclusion of indicators of risks and vulnerabilities of MARA/EVA in national social protection programmes
- Promote national discussion and debate on privacy and confidentiality rights for MARA/EVA and establish an age of consent for social and medical services including HIV prevention, treatment, care and support

### Strategic Approach 2: Knowledge-based programming and policy

Taking forward the *Mapping and Behavioural Study of Most at Risk Adolescents to HIV in Specific Urban/semi Urban Locations* and the results from other surveys on young people requires further research on the situation, needs and behaviours of adolescents in general and MARA/EVA in particular. Future studies need to focus on the structural determinants of risks and vulnerabilities among MARA/EVA in different age groups, localities and contexts. The coverage, accessibility and effectiveness of service delivery need to be investigated. This includes gaining greater understanding of the supply and demand-side bottlenecks and barriers to MARA/EVA utilisation of services in the context of the structural, behavioural and biological components of combination HIV prevention.

Past and current data collection and analysis needs to be disaggregated by age and sex to facilitate improved knowledge about young people as well to gauge the effectiveness of programming. This information should be made accessible and shared through the development of a MARA/EVA knowledge hub. This could also include documentation on best-practices and lessons learnt to facilitate a national learning process.

As a national programme for MARA/EVA takes root, there will be a need to develop human capacities through direct programme exposure, participation in pilot model studies, operations research and sharing of programme documentation.

## Knowledge-based programming and policy

### Strategic Interventions

- Conduct an assessment of the structural determinants of risky behaviours and vulnerabilities among MARA/EVA of different age groups, contexts and across risk behaviours
- Invest in age-disaggregated data collection and analysis of past, future and on-going national studies
- Initiate South-South learning and knowledge sharing on MARA/EVA programming; design, implement and evaluate pilot model MARA/EVA interventions

## Strategic Approach 3: Youth Participation and Networking

'Participation' is a key principle of the CRC. The promotion of meaningful participation by MARA/EVA in programme design and implementation and in the decision making processes that affect them serves not only a participatory function but also empowers. Their first-hand understanding of the lifestyle and challenges of MARA/EVA can facilitate improvements in the coverage and uptake of services. In addition, an opportunity for MARA/EVA to share their aspirations, challenges and knowledge on HIV prevention with their peers are highly supportive and diffuses information.

## Participation and Networking

### Strategic Interventions

- Promote the establishment of a reference group consisting of MARA/EVA to support advocacy and programme design, implementation and monitoring
- Explore the use of social-media and other networking technologies among adolescents especially MARA/EVA
- Pilot adolescent-led peer approaches on HIV risk reduction among MARA/EVA
- Support the development of mentored sports and recreational programs among vulnerable adolescents

Social media networks and participatory approaches such as edutainment and mentored sports activities have been shown to be effective for improving civic engagement and healthier behaviours. These types of participatory approaches need to be facilitated and include information-communication technologies (ICT) and activities that increase empowerment and the leadership, decision-making and negotiation skills required for coping with daily life.

## Strategic Approach 4: Comprehensive HIV and AIDS Related Services

### Sub-approach 4.1: Mentoring and Counselling

MARA/EVA have very limited contact with positive peers and adult role models. It is essential that they receive adolescent-friendly mentoring and counselling on issues such as education, sexual and reproductive rights (SHRH), sexual violence, gender equality and new opportunities through learning and training. Mentoring creates opportunities for adolescents to develop positive relationships amongst their peers and with adults while building trust and self-esteem. Mentoring is also a strategy to reduce the level of adolescent risk taking by influencing their decision making and behaviors.

The training of adolescent volunteers and adolescent-friendly adults to mentor MARA/EVA and serve as gate keepers is greatly needed. These gatekeepers can also provide referral services to community-based social services such as supportive care and mental health services. These types of programmes are essential to promoting MARA/EVA social inclusion as well reducing their HIV risk taking and vulnerabilities.

#### Mentoring and Counselling

##### Strategic Interventions

- Conduct capacity building among adolescent-friendly service providers to improve their psycho-social and adolescent mental health skills especially concerning the challenges and lifestyles of MARA/EVA
- Pilot targeted adolescent-friendly mentoring services in formal and informal settings where MARA/EVA congregate to serve as a model to mainstream services into the national social welfare system

### Sub-approach 4.2: Combination HIV Prevention, treatment and care

Combination prevention involves the tailored effective delivery of structural, behavioural and biomedical HIV prevention programs that are combined in a set of programmes adapted to a specific group or community.<sup>xi</sup> Key to proper combination prevention is knowledge on the local HIV epidemic including modes of transmission, population demographics and dynamics, e.g. migration patterns, and the behaviours and practices putting people at risk. Recent research studies have provided new hope in regard to biomedical approaches in improving health and reducing HIV transmission. For example, anti-retroviral treatment (ART), voluntary male circumcision and pre- and post-exposure antiretroviral prophylaxis (Prep, PEP) are being shown to be effective in adult key populations such as MSM and PWID.<sup>xii</sup> However, it must be noted that the use of biomedical prevention requires specialized medical knowledge especially in the case of adolescents whose bodies are still maturing.

HIV exposure and transmission remains a major and growing concern for MARA/EVA and Bangladesh in general. The epidemic is currently stabilised within key population groups but there is growing concern that it could bridge to the highly vulnerable general



population. Global evidence has established five categories of core interventions that are effective with adolescents. The proper design and implementation of this mix of these core HIV interventions in the context of MARA/EVA needs to be age –appropriate, e.g. early vs. late adolescence.

What works to prevent HIV transmission among young people has been well established and is summarised in the UNICEF document *Opportunities in Crisis*.<sup>xiii</sup>

- Abstaining from sex and not injecting drugs
- Correct and consistent use of male and female condoms
- Medical male circumcision
- Needle and syringe exchange programmes as part of a comprehensive harm reduction programme
- Using antiretroviral drugs as treatment (which lowers the chance of transmission) or as pre or post-exposure prevention
- Communication for social and behavioural change

Interventions for early adolescents need to focus on developing healthy behaviours that reduce risks and increase protection from vulnerabilities such as social exclusion, exploitation, abuse and violence. This requires targeting interventions for parents and caregivers, government services, CBOs, working with local communities as well as educating the general public with BCC campaigns. Direct interventions for early adolescents include peer education, school based programme and mentored sports and recreational activities. Approaches for older adolescents can include peer education, sexual education, adult mentoring, provision of prevention commodities and access to adolescent-friendly services.

## HIV Prevention, treatment and care

### Strategic Interventions

- Empower adolescents through sexual education and increased access to condoms in appropriate settings
- Improve the adolescent-friendliness of national needle/syringe exchange programme and ensure utilization by MARA/EVA
- Conduct SBCC and outreach HIV/SRH programmes targeted specifically to MARA/EVA
- Establish a system to provide adolescent appropriate HIV and AIDS biomedical prevention, treatmentservices including HTC, ART, PMTCT, PREP and PEP.
- Conduct a bottleneck analysis of the access and utilization of key HIV and AIDS service to MARA/EVA
- Adapt existing communication materials and programmes to address the risks and vulnerabilities of MARA/EVA into multiple channels of

communication accessible by MARA/EVA and parents of younger adolescents, as well as the general adolescent population

### **Sub-approach 4.3: Second Chance Education and Empowerment**

The place of education in the empowerment of adolescents is well established. The promotion of inclusive education that provides MARA/EVA the opportunity to realize their right to development is central to reducing HIV risks and vulnerabilities. The MARA/EVA mapping survey reported low levels of formal education among MARP/EVA: 31% in the sex industry, 13% of PWIDs and 16% of NIDU. Education and work programs that keep potential and current MARA/EVA in school and offer them continuing community based learning must be prioritized.

This requires the commitment of education managers and administrators in the Ministry of Primary and Mass Education (MOPME) to address the high vulnerability of MARA/EVA to school failure. Advocacy is needed for the inclusion of MARA/EVA in school stipend programme criteria and procedures that take into account MARA/EVA challenges and vulnerabilities. The reintegration of MARA/EVA into the formal school system will be supported in partnership with MOPME.

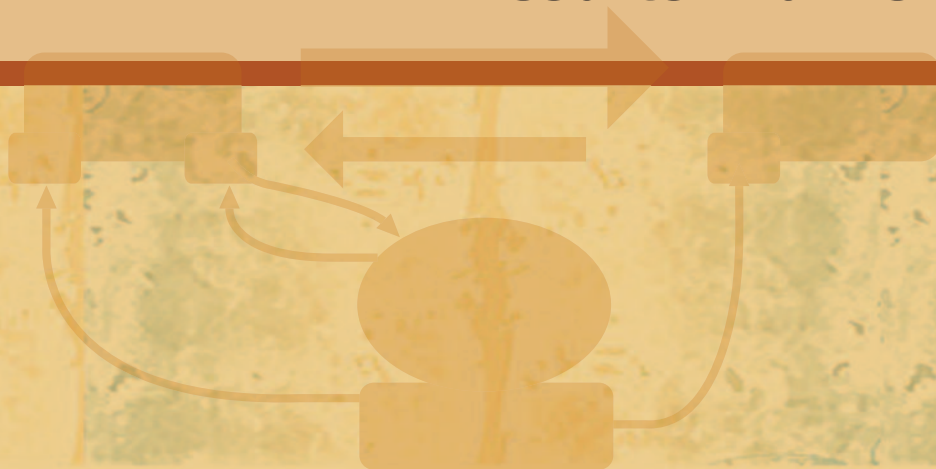
In the case of older MARA/EVA, there is a need for community based learning opportunities that offer accelerated education in literacy, numeracy and functional life skills. Community service opportunities for non-formal education and linking MARA/EVA to vocational and entrepreneurship skills training are essential.

#### **Second Chance Education & Empowerment**

##### **Strategic Interventions**

- Promote an inclusive education system free of stigma and discrimination against MARA/EVA
- Engage education managers and administrators on the high vulnerability of MARA/EVA to school failure and other special concerns
- Advocate for the inclusion of MARA/EVA sensitive indicators into the school stipend programme
- Support the Ministry of Primary and Mass Education, civil society, faith communities and the private sector to integrated MARA/EVA into community based accelerated literacy, numeracy and life skills programmes
- Promote the integration of MARA/EVA into vocational and entrepreneurship skills training

## 4. Results Framework

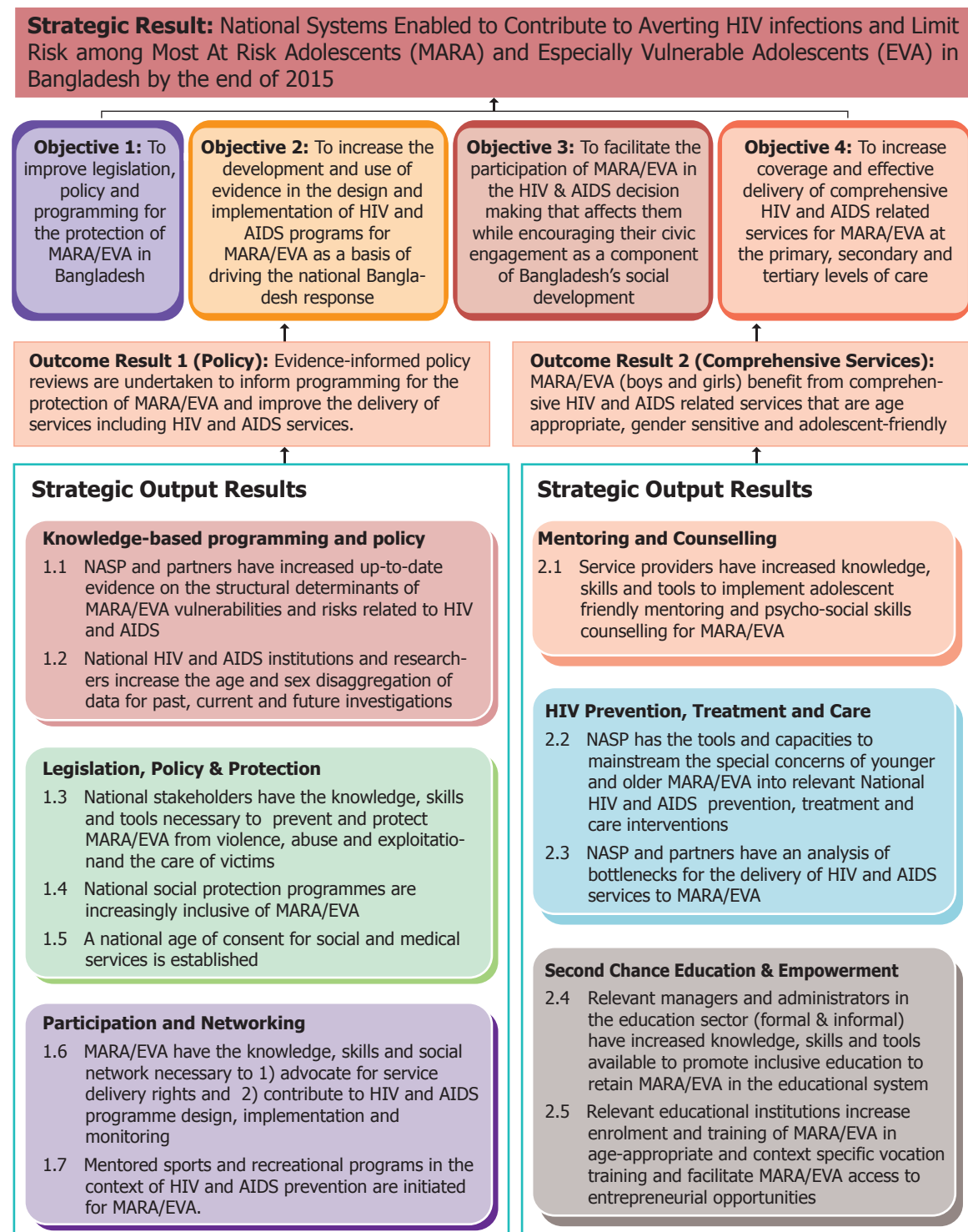




## 4. Results Framework

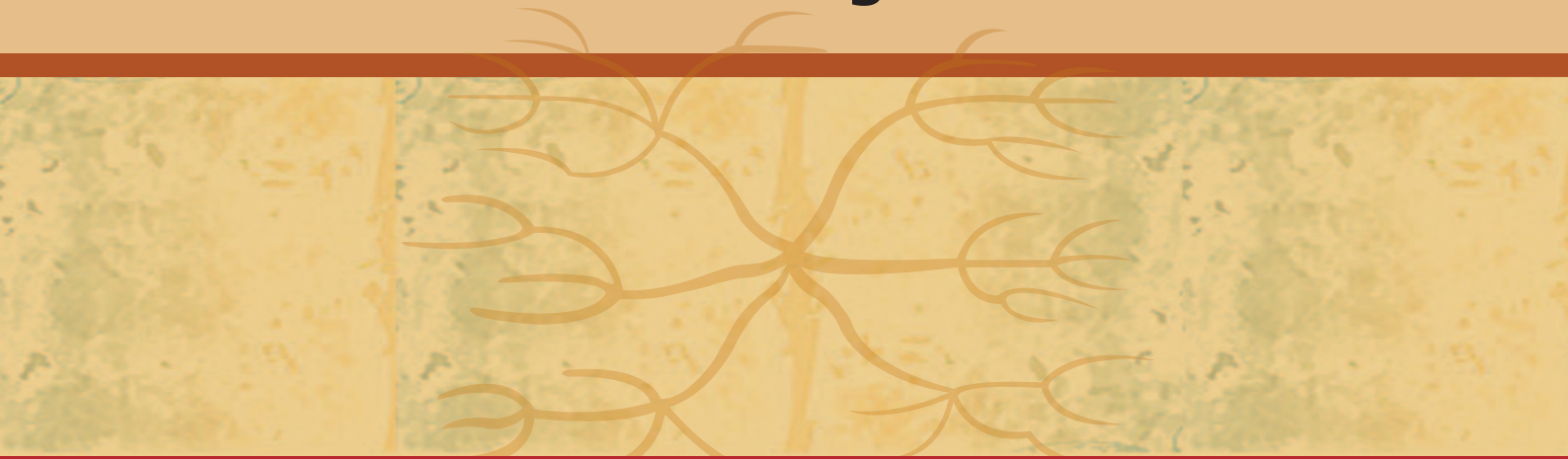
The key results to be achieved by this Strategy are detailed in the result framework below (Figure 2). It includes a set of strategic, outcome and output results upon which interventions/activities will be developed, monitored, evaluated and reported.

**Figure 2: Results Framework for the National HIV Risk Reduction among MARA/EVA in Bangladesh**





## **5. Logical Framework**







## 5. Logical Framework

**Strategic Result:** National Systems Enabled to Contribute to Averting HIV Infections and Limit Risk among Most At Risk Adolescents (MARA) and Especially Vulnerable Adolescents (EVA) in Bangladesh by the end of 2015

### Strategic Objectives:

1. Improve legislation, policy and programming for the protection of MARA/EVA in Bangladesh
2. Increase the development and use of evidence in designing and implementing HIV and AIDS programs for MARA/EVA as a basis for driving the national response
3. Facilitate the participation of MARA/EVA in the HIV & AIDS decision making that affects them while encouraging their civic engagement as a component of Bangladesh's social development
4. Increase the coverage and effective delivery of comprehensive HIV and AIDS related services for MARA/EVA at the primary, secondary and tertiary levels of care

### Outcome Results:

1. Policy: Evidence-informed policy reviews are undertaken to inform programming for the protection of MARA/EVA and improve the delivery of services including HIV and AIDS services.
2. Comprehensive Services: MARA/EVA (boys and girls) benefit from comprehensive HIV and AIDS related services that are age appropriate, gender sensitive and adolescent-friendly

Output Result	Strategic Interventions	Key Indicators	Baseline	Target	Means of Verification	Key Partner Responsible
<b>Outcome 1 Policy:</b> Evidence-informed policy reviews are undertaken to inform programming for the protection of MARA/EVA and improve the delivery of services including HIV and AIDS services.						
1.1 NASP and partners have up-to-date evidence on the structural	<ul style="list-style-type: none"> <li>Conduct an assessment of the structural determinants of risky behaviours and</li> </ul>	Availability of assessment report	N/A	1 Report	Assessment Report	NASP, UN, INGO& CSO

determinants of MARA/EVA vulnerabilities and risks related to HIV and AIDS	vulnerabilities among MARA/EVA of different age groups, contexts and across risk behaviours								
	<ul style="list-style-type: none"> <li>Invest in age-disaggregated data collection and analysis of past, future and on-going national studies</li> </ul>	# of studies, survey and programme reports that are age disaggregated	N/A	3 types of reports	Surveillance report, HIV Case Report and Programme Reports	NASP, IEDCR, ICDDR,B, UN, DGMIS			
1.2 Key national programme managers have increased knowledge on innovative programming to improve the coverage and effectiveness of HIV and AIDS services for MARA/EVA	Initiate South-South learning and knowledge sharing on MARA/EVA programming	# of partners exposed to external learning	-	10 partners	Mission Report	NASP / UN			
	Design, implement and evaluate pilot model MARA/EVA interventions	Type of lessons learnt from pilot interventions	N/A						
1.3 National stakeholders have the knowledge, skills and tools necessary to prevent and protect MARA/EVA from violence, abuse and exploitation and the care of victims	Promote the use of evidence to incorporate MARA/EVA issues into the on-going engagement of parliamentarians, media, National Human Rights Commission (NHRC), National Law Commission (NLC), judiciary and private sector on the reform/review of punitive laws concerning sex work, sexual orientation and gender identity	# of policy dialogues Type of resolution reached	N/A	4 policy dialogues	Programme report	NASP, UN, INGO, CSO			
	Support capacity building among law enforcement agencies on the special	# of law enforcement agencies (and	N/A	2 agencies (Police & Narcotics)	Training Report	NASP, UN, CSO			

	protection needs and appropriate measures for MARA/EVA who are victims of exploitation and abuse	agents) trained	N/A	400 Law enforcement agents	Training Report	NASP, UN, CSO
	<ul style="list-style-type: none"> <li>Increase public awareness on the exploitation, violence and abuse experienced by MARA/EVA</li> </ul>	# and type of stakeholders reached	N/A	500 stakeholders	Activity report	NASP
1.4 National social protection programmes are increasingly inclusive of MARA/EVA	<ul style="list-style-type: none"> <li>Advocate for the inclusion of indicators of risks and vulnerabilities of MARA/EVA in national social protection programmes</li> </ul>	# of social protection programme with MARA/EVA sensitive indicators	tbd	Additional 2	Progress Report	NASP, UN, INGO & CSO
	<ul style="list-style-type: none"> <li>Link care and support services for adolescent victims of exploitation, violence and abuse with social protection programme</li> </ul>	# of MARA/EVA enrolled	tbd	Additional 100	Programme report	NASP
1.5 A national age of consent for social and medical services is established	<ul style="list-style-type: none"> <li>Promote national discussion and debate on privacy and confidentiality rights and establish an age of consent for social and medical services including HIV prevention, treatment, care and support for MARA/EVA</li> </ul>	# and type of stakeholders reached	N/A	2 discussion session	Activity report	NASP, UN & INGO
1.6 MARA/EVA have the knowledge, skills and social network necessary to 1) advocate for service delivery rights and 2) contribute to HIV and	<ul style="list-style-type: none"> <li>Promote the establishment of a reference group consisting of MARA/EVA to support advocacy and programme design, implementation and monitoring</li> </ul>	# of reference group for MARA/EVA established	tbd	10 networks	Activity report	NASP, CSO

AIDS programme design, implementation and monitoring	<ul style="list-style-type: none"> <li>Explore the use of social-media and other networking technologies among adolescents especially MARA/EVA</li> </ul>	# of MARA / EVA connected via social media and linked to services	tbd	1,000	Communication tracking report	NASP, UN, INGO, CSO
	<ul style="list-style-type: none"> <li>Pilot adolescent-led peer approaches on HIV risk reduction among MARA/EVA</li> </ul>	# of MARA/EVA reached through PE and linked to services	tbd	1,000	Activity report	NASP, UN, INGO, CSO
	<ul style="list-style-type: none"> <li>Support the development of mentored sports and recreational programs among vulnerable adolescents</li> </ul>	# of MARA/EVA reached through Sports for development and linked to services	tbd	1,000	Activity report	NASP, UN, INGO, CSO
1.7	Mentored sports and recreational programs in the context of HIV and AIDS prevention are initiated for MARA/EVA.					
<b>Outcome 2 Comprehensive Services:</b> MARA/EVA (boys and girls) benefit from comprehensive HIV and AIDS related services that are age appropriate, gender sensitive and adolescent-friendly						
2.1	Service providers have increased knowledge, skills and tools to implement adolescent friendly mentoring and psycho-social skills counseling for MARA/EVA					
	<ul style="list-style-type: none"> <li>Conduct capacity building among adolescent-friendly service providers to improve their psycho-social and adolescent mental health skills especially concerning the challenges and lifestyles of MARA/EVA</li> </ul>	# of service providers trained	Tbd (from Psychosocial training)	300	Training report	NASP, CSO
	<ul style="list-style-type: none"> <li>Pilot targeted adolescent-friendly mentoring services in formal and informal settings where MARA/EVA congregate to serve as a model to mainstream services into the national social welfare system</li> </ul>	# of MARA/EVA reached with comprehensive risk reduction counseling services	N/A	4,000	Service Report	NASP, INGO, CSO

<p>2.2 NASP has the tools and capacities to mainstream the special concerns of younger and older MARA/EVA into relevant National HIV and AIDS prevention, treatment and care interventions</p>	<ul style="list-style-type: none"> <li>Implement and monitor community based HIV Counseling and Testing Services for MARA/EVA</li> </ul>	% of MARA/EVA that achieve effective coverage of HCT services in target locations <sup>1</sup>	tbd	40%	Programme report	NASP, UN, INGO, CSO
	<ul style="list-style-type: none"> <li>Improve the National PMTCT Programme to be Adolescent friendly and inclusive of MARA/EVA</li> </ul>	% of female MARA/EVA that achieve effective coverage of PPTCT services in target locations	tbd	30%	Programme report	NASP, UN, INGO, CSO
	<ul style="list-style-type: none"> <li>Empower adolescents through sexual education and increased access to condoms in appropriate settings</li> </ul>	% of MARA/EVA that achieve effective coverage of condom services in target locations	tbd	50%	Programme report	NASP, UN, INGO, CSO
	<ul style="list-style-type: none"> <li>Improve the adolescent-friendliness of needle / syringe exchange programmes and ensure utilization by MARA/EVA</li> </ul>	% of MARA/EVA that achieve effective coverage of Needle and Syringe exchange services in target locations	tbd	50%	Programme report	NASP, UN, INGO, CSO
	<ul style="list-style-type: none"> <li>Adapt existing communication materials and programmes to address the risks and vulnerabilities of MARA/EVA into multiple communication channels accessible by MARA/EVA and parents of younger adolescents, as well as the general adolescent population</li> </ul>	Number of materials developed / revised Number and type of communications channels adopted	tbd	6 materials targeting different sub-groups	Communication Materials	NASP

1 Target geographic settings are informed by the size estimation

<p>2.3 NASP and partners have an analysis of bottlenecks for the delivery of HIV and AIDS services to MARA/EVA</p>	<ul style="list-style-type: none"> <li>Conduct a bottleneck analysis of the access and utilization of key HIV and AIDS Intervention (HCT, PMTCT, Harm Reduction and Condom) among MARA/EVA</li> </ul>	<p>N/A</p>	<p>100</p>	<p>Training report</p>	<p>NASP, UN</p>
<p>2.4 Relevant managers and administrators in the education sector (formal &amp; informal) have increased knowledge, skills and tools available to promote inclusive education to retain MARA/EVA in the educational system</p>	<ul style="list-style-type: none"> <li>Engage education managers and administrators on the high vulnerability of MARA/EVA to school failure and other special concerns</li> <li>Support the Ministry of Primary and Mass Education, civil society, faith based communities and the private sector to integrated MARA/EVA into community based accelerated literacy, numeracy and life skills programmes</li> </ul>	<p>N/A</p>	<p>50</p>	<p>Training report</p>	<p>NASP in partnership with Min. of Education</p>
<p>2.5 Relevant educational institutions increase enrolment and training of MARA/EVA in age-appropriate and context specific vocation training and facilitate MARA/EVA access to entrepreneurial opportunities</p>	<ul style="list-style-type: none"> <li>Advocate for the inclusion of MARA/EVA sensitive indicators into the school stipend programme</li> <li>Promote an inclusive education system free of stigma and discrimination against MARA/EVA</li> <li>Promote the integration of MARA/EVA into vocational and entrepreneurship skills training</li> </ul>	<p>N/A</p>	<p>At least 3 key indicators</p>	<p>Statement of commitment</p>	<p>NASP</p>
		<p>N/A</p>	<p>30%</p>	<p>Training Report</p>	<p>NASP</p>
		<p>N/A</p>	<p>10%</p>	<p>Enrollment report</p>	<p>NASP</p>

## 6. The Way Forward







## 6. The Way Forward

The successful implementation of this Strategy will require actions from all stakeholders and partners. Commitment and synergetic partnerships between all actors and at every level is necessary. This partnership will need to be premised on the below.

### 6.1 Leadership and Commitment

The government (NASP) and partners need to commit to translating this Strategy into a costed operational plan that includes a monitoring and evaluation (M&E) plan to guide programme implementation. In addition, the MARA technical working group needs to be strengthened into a standing committee to oversee its implementation.

Secondly, this Strategy needs to be prioritised by NASP because it is multi-sectorial and involves advocacy for policy reforms and the engagement of high level policy makers, parliamentarians and senior ministerial and department officials.

### 6.2 Leveraging and Synergy

To avoid duplication, government deliberations aimed at leveraging results from existing national (public and private) programmes and investments must be prioritized. This includes investing resources to gain an understanding of existing programmes and identify entry points for MARA/EVA interventions.

### 6.3 Adolescent Participation

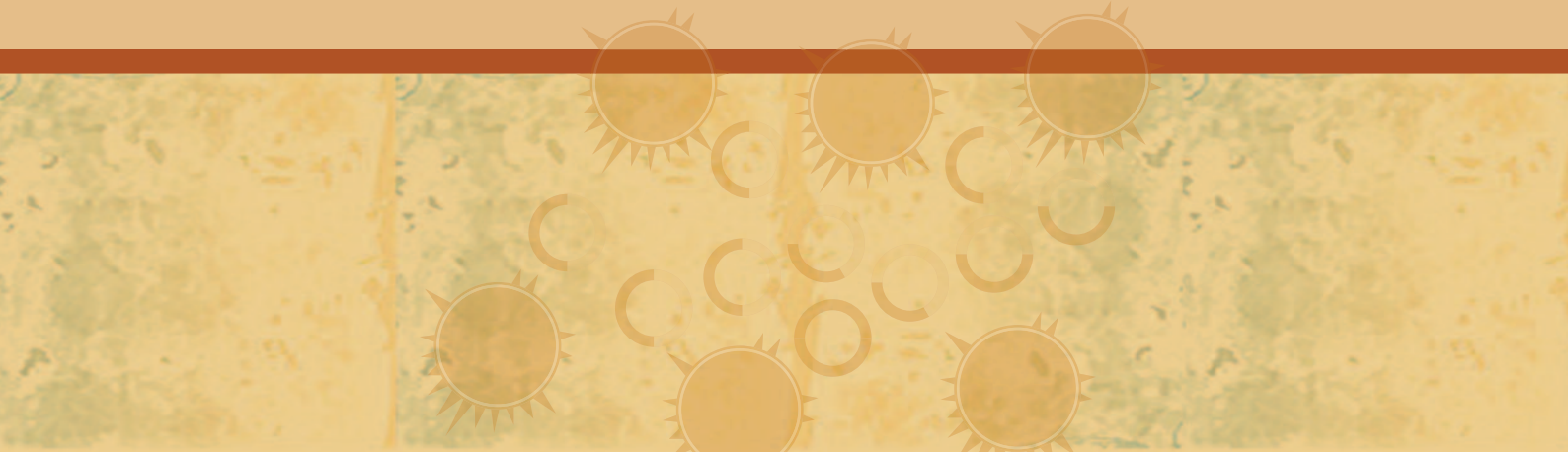
The direct involvement of adolescents is central to the successful implementation of this Strategy. Government and her partners must mobilize resources to promote meaningful participation of MARA/EVA in its implementation and monitoring.

### 6.4 Accountability

Though NASP has accountability for coordinating the implementation of this Strategy it is essential that all key actors - government ministries and departments, private sector and civil society are involved in its implementation to ensure buy-in and sense of ownership. In the operational plan, the roles and responsibilities of each partner should be clarified against specific results/deliverables.



## 7. Conclusions





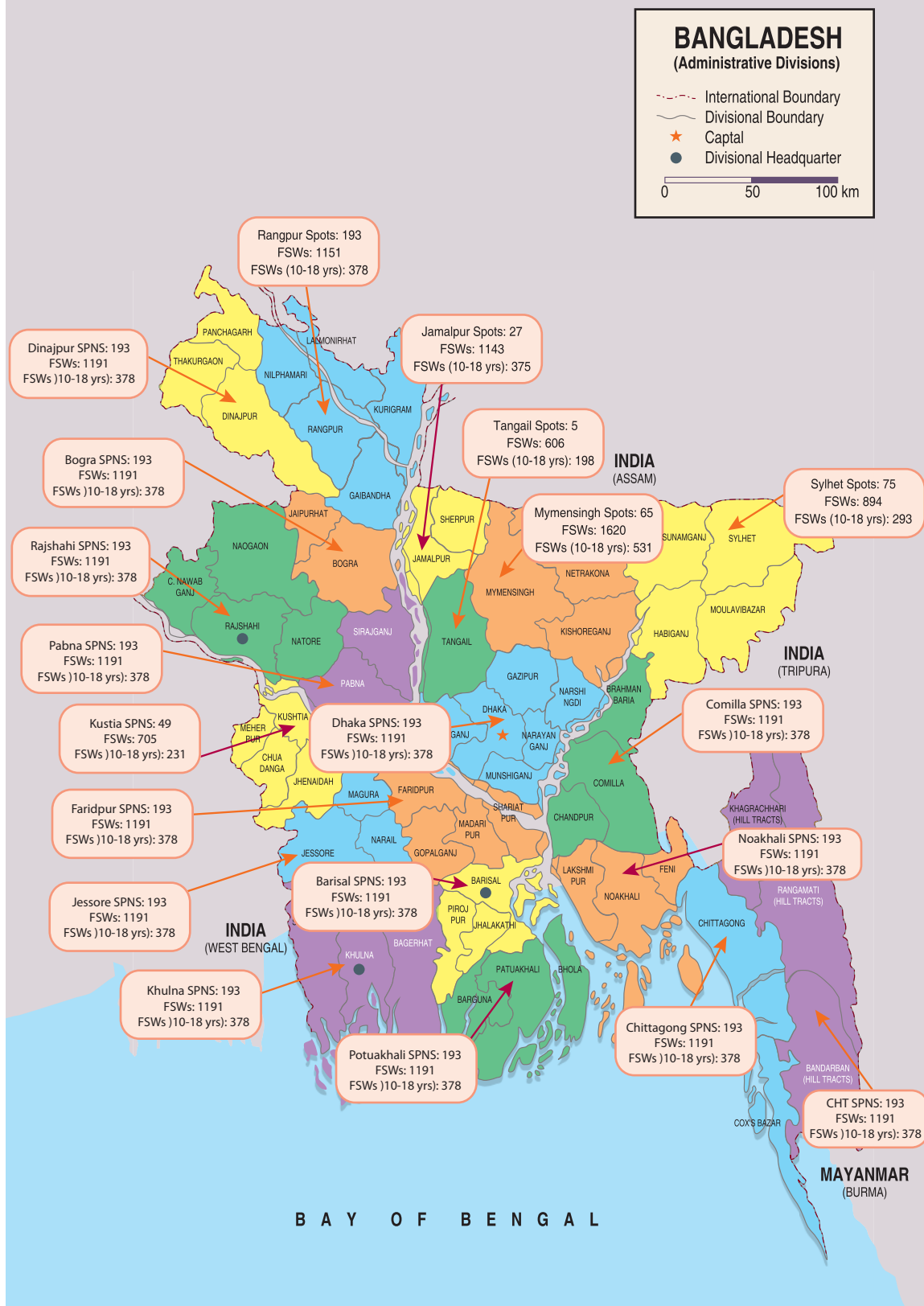
## 7. Conclusions

Achieving the universal human rights of adolescents require focus on every adolescent including MARA/EVA. This strategy describes the commitment of the Government of Bangladesh to the progress in the realization of the Rights of MARA/EVA in the nation. While HIV and AIDS serve as entry points, multi-sectorial actions are to be mobilized and monitored towards achieving set results and objectives.

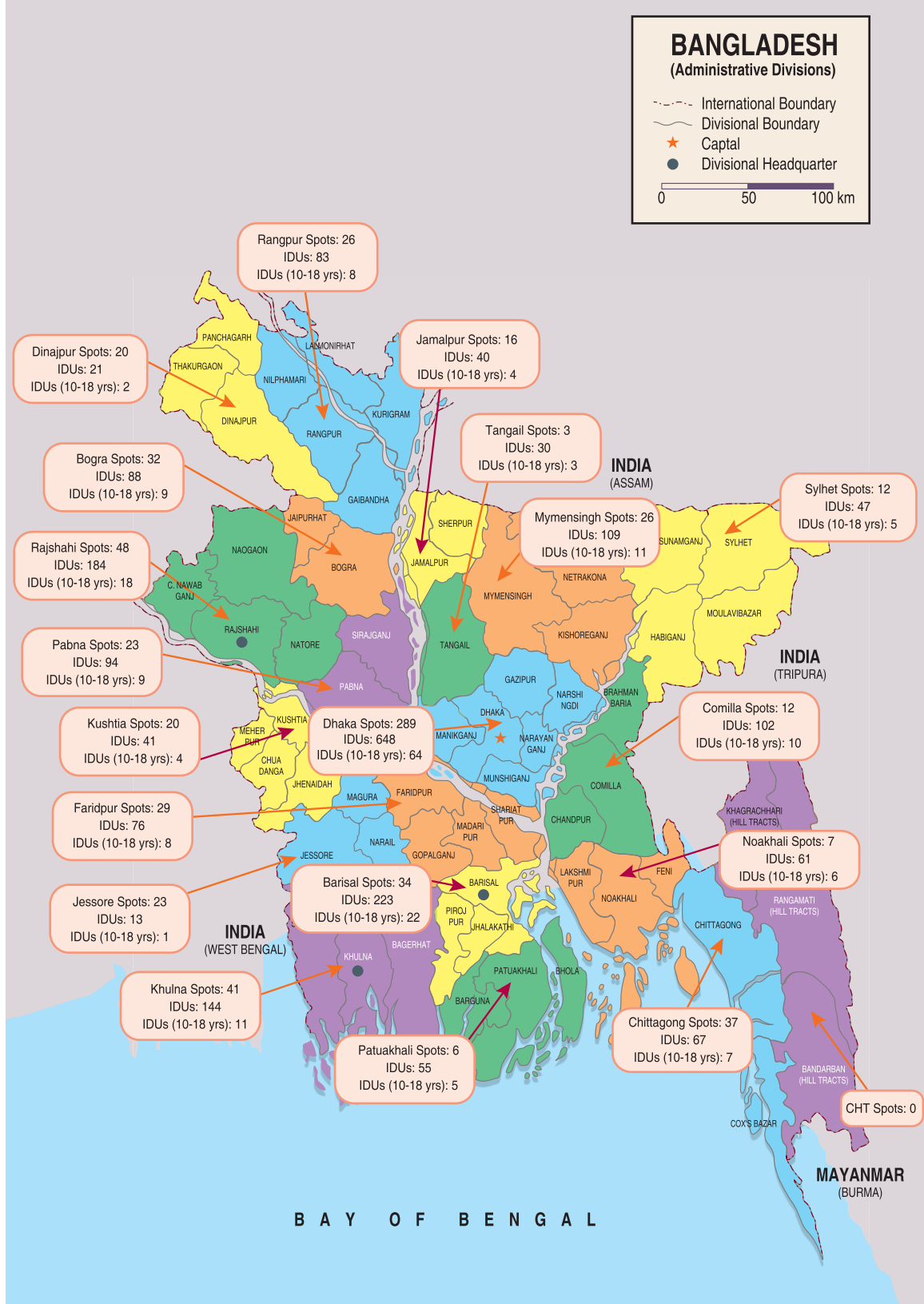
MARA/EVA are highly vulnerable to HIV due to their social exclusion and risk behaviours that can lead to transmission of HIV. Such behaviours include intravenous drug use, involvement in sex work and sexual practices that put them at high risk, e.g. unprotected vaginal and anal intercourse. The determinants of these behaviours are not just individually based but also the result of family, social and economic determinants that create conditions allowing them to become especially vulnerable. The government and people of Bangladesh will make a great stride in addressing MARA/EVA in its continuing efforts to contain the epidemic and address the human rights of its most valuable asset: the children and young people who are the nation's future. This includes bringing EVA/MARA into the mainstream of country actions against HIV and AIDS and reducing social exclusion and service delivery gaps for MARA/EVA.

Now is the time to act and the risks of non-action are great in terms of the HIV epidemic and the productivity and wellbeing of the nation. Government policy makers, decision makers, and managers as well as the citizenry of Bangladesh need to come into a serious national discussion concerning its adolescents.

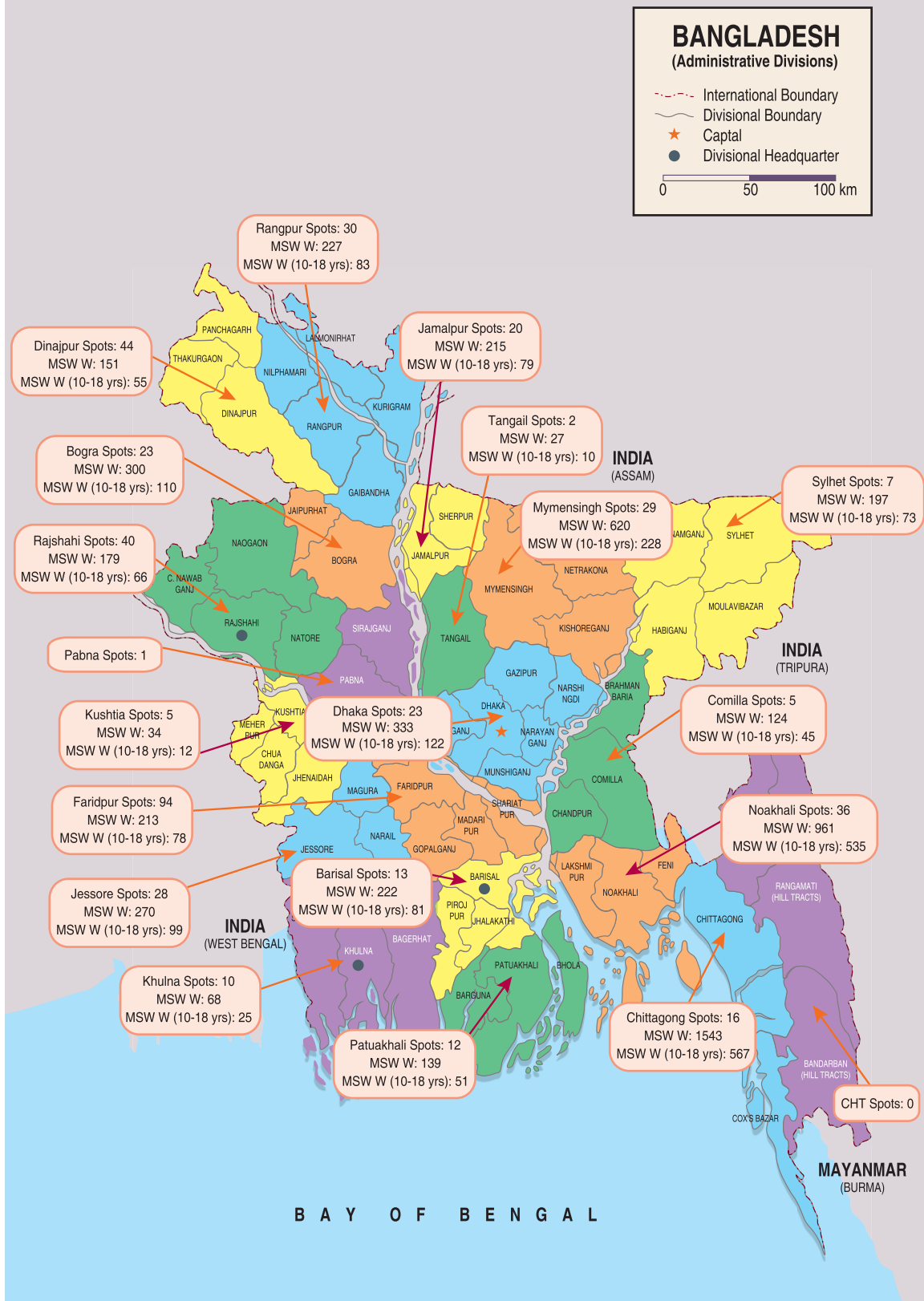
# Annex 1: Mapping and Size Estimation of Young Female Sex Workers (10 – 24 years) in Bangladesh



## Annex 2: Mapping and Size Estimation of Young Injecting Drug Users (10–24 years) in Bangladesh

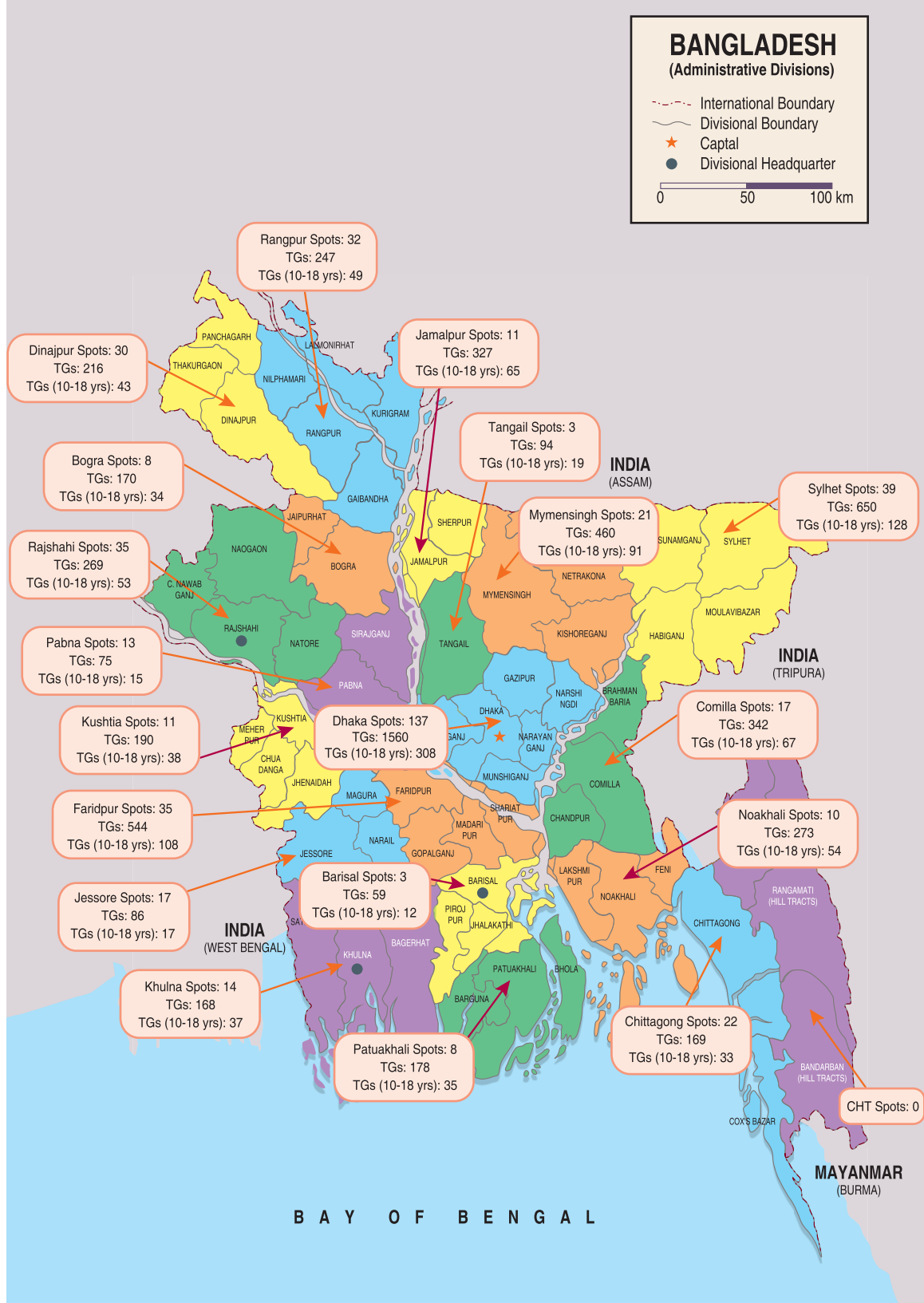


### Annex 3: Mapping and Size Estimation of Young Males who have Sex with Males/Male Sex Workers (10 – 24 years) in Bangladesh





## Annex 4: Mapping and Size Estimation of Young Transgenders (10 – 24 years) in Bangladesh



## References

- i UNAIDSHIV/AIDS, Gender and Sex UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS. HIV/AIDS, Gender and Sex Work. Geneva 2002.
- ii National AIDS/STD Programme (NASP), Directorate General of Health Services, Ministry of Health and Family Welfare. 3rd National Strategic Plan for HIV and AIDS Response (2011-2015). Dhaka 2011.
- iii National AIDS/STD Programme (NASP), Directorate General of Health Services, Ministry of Health and Family Welfare. National HIV Serological Surveillance, 2011 Bangladesh - 9th Round Technical Report. Dhaka 2011.
- iv 2013 HIV AIDS Asia Pacific Research Statistical Data Information Resources - AIDS Data Hub.<http://aidsdatahub.org/en/country-profiles/bangladesh>
- v Ibid.
- vi Ibid.
- vii National AIDS/STD Programme (NASP), Directorate General of Health Services, Ministry of Health and Family Welfare. Mapping and Behavioral Study of Most at Risk Adolescents to HIV in Specific Urban/semi Urban Locations in Bangladesh. Dhaka 2012.
- viii Bangladesh Bureau of Statistics (BBS) Statistics and Informatics Division (SID), Ministry of Planning. Dhaka 2011.
- ix National AIDS/STD Programme (NASP), Directorate General of Health Services, Ministry of Health and Family Welfare. Global AIDS Response Progress Report, 2012, Bangladesh. Dhaka 2012
- x Ministry of Women and Children Affairs, Government of Bangladesh. National Children Policy. Dhaka 1994.
- xi UNAIDS. Combination HIV Prevention: Tailoring and Coordinating Biomedical, Behavioural and Structural Strategies to Reduce New HIV Infections. Geneva 2010
- xii Kurth AE, Celum C, Baeten JM, Vermund SH, Wasserheit JN (2011). Combination HIV Prevention: Significance, Challenges, and Opportunities. *Curr HIV/AIDS Rep*, 8(1): 62–72.
- xiii UNICEF. Opportunity in Crisis. Preventing HIV from early adolescence to young adulthood. New York 2011.



