HIV/AIDS

Bangladesh: Low prevalence but high vulnerability

A vulnerable group which is probably the most critical is the adolescents and the young people. Globally, everyday 13,000 people are infected and more than half of them are between the age of 15 and 24. Adolescents and youth are vulnerable, as they like to experiment and try new things whether it is sex or drugs.

SUNEETA MUKHERJEE

HIV/AIDS is not just a health issue. It is really a social development issue closely linked to poverty, gender inequity, low levels of literacy and knowledge about prevention. It is also a behavioral issue where unprotected sex and unsafe blood or sharing needles amongst the drug users inflames the spread of the disease. This is why we find that out of the 42 million HIV positive cases in the world, 95 per cent are in developing countries. Six point three million of these are in South and South-East Asia contributing to 14.5 per cent of the total numbers while over 29 million are in Sub-Saharan Africa contributing to 71 per cent of the total infected.

The disease wipes out the gains made by development. For example, Botswana, rich in mineral resources has 40 per cent of the adult population infected and has seen a fall in life expectancy from 75 to 35 years now and is expected to fall to 27 years by the year 2010.

Luckily, the prevalence in Bangladesh is still low: 13,000 estimated by UNAIDS/WHO in end 2001. Without going into a dispute on figures, it shows low prevalence. However, the 4th surveillance finds that it has reached to 4 per cent among the IDUs (Injectable Drug Users). Globally, reaching 5 per cent in any high-risk group is seen as an epidemic. Experiences from Indonesia, Thailand and India shows that the HIV amongst IDUs can increase sharply from 4 per cent to 50 per cent within four years.

About 33 per cent of the IDUs in Bangladesh visit female sex workers (FSWs). Seventy per cent of rickshawallas visit FSWs and have wives at home. The spread of HIV/AIDS from IDUs to sex workers and rickshaw-pullers would be very fast unless it is prevented. Men having sex with men (MSM) also have sex with female sex workers. This is how it could make inroad to general population.

The behaviour of high-risk groups in Bangladesh is critical and extreme. The commercial sex workers (CSWs) have the highest clientage in Asia (18.8 clients for brothel-based and 44 clients hotel-based per week). The IDUs have the highest uses of the shared needles (74%). The female sex workers also have the lowest use of condoms in Asia.

Another vulnerable group which is probably the most critical is the adolescents and the young people. Globally, everyday 13,000 people are infected and more than half of them are between the age of 15 and 24. Adolescents and youth are vulnerable, as they like to experiment and try new things whether it is sex or drugs. Studies in Bangladesh show that a large number of adolescents go to sex workers (unbelievable!) and most of them do not use condoms.

Herein comes the need for giving the right information and services to the young people, so that they can protect themselves. Studies all over the world show that giving information and services to the young people does not increase proximity. In fact, it enables the youngsters to handle their sexuality and understand the process of growing up and the physical and biological changes taking place within them.

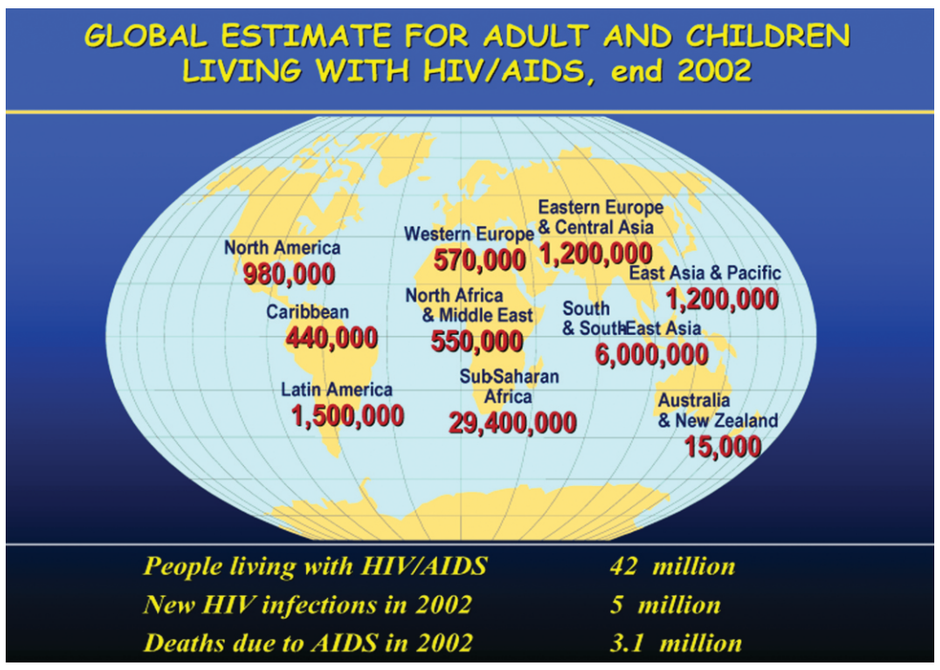
The main route of transmission of HIV/AIDS in South Asia is sex. Correct and consistent condom use provides protection against spread of HIV/AIDS. Women are especially vulnerable to HIV/AIDS as they are unable to negotiate safe sex and are vulnerable to sexual exploitation. According to data available 90 per cent of the women got HIV/AIDS from their husbands all over the world. Use of female condoms could be an empowering instrument for the women and also protect general population. They would supplement and not substitute male condoms. Promoting use of condoms is paramount if we have to prevent HIV/AIDS in the country.

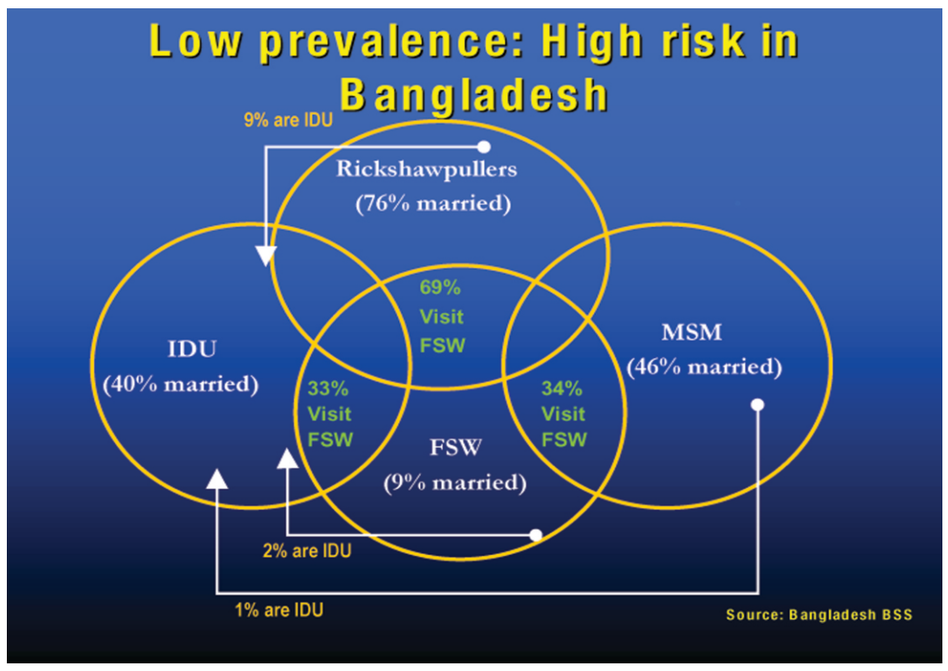
As yet, there is neither vaccination, nor is there a cure though anti-retroviral drugs can help. Prevention is the only cure against this pandemic and sure protection against this. Therefore, the message that we want to give on World AIDS Day is:

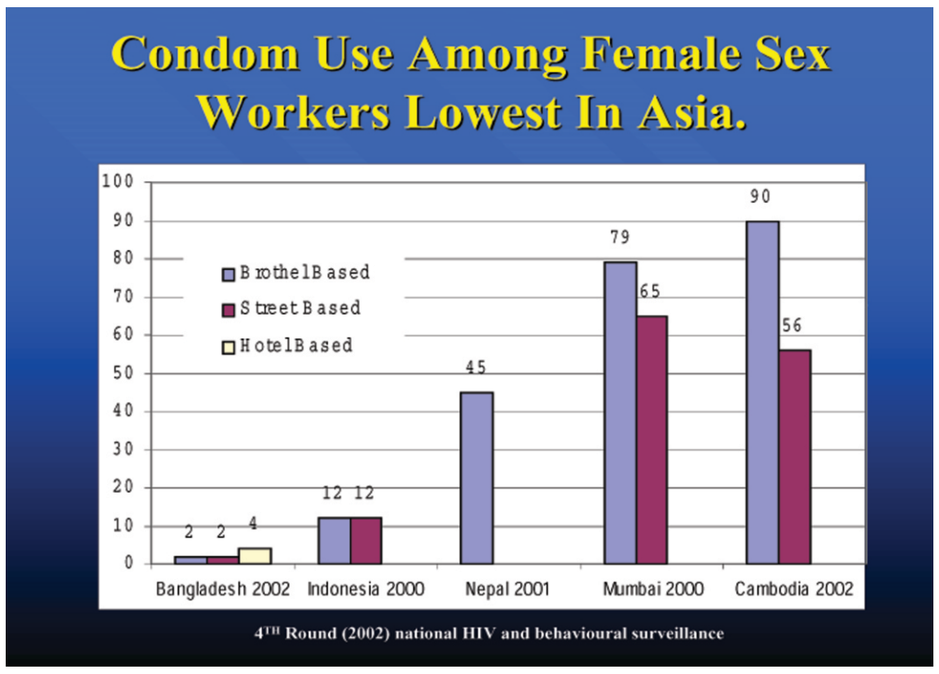
A: Abstain from sex (till marriage)
B: Be faithful to partner/Safe blood
C: Use Condoms
D: No to Drugs

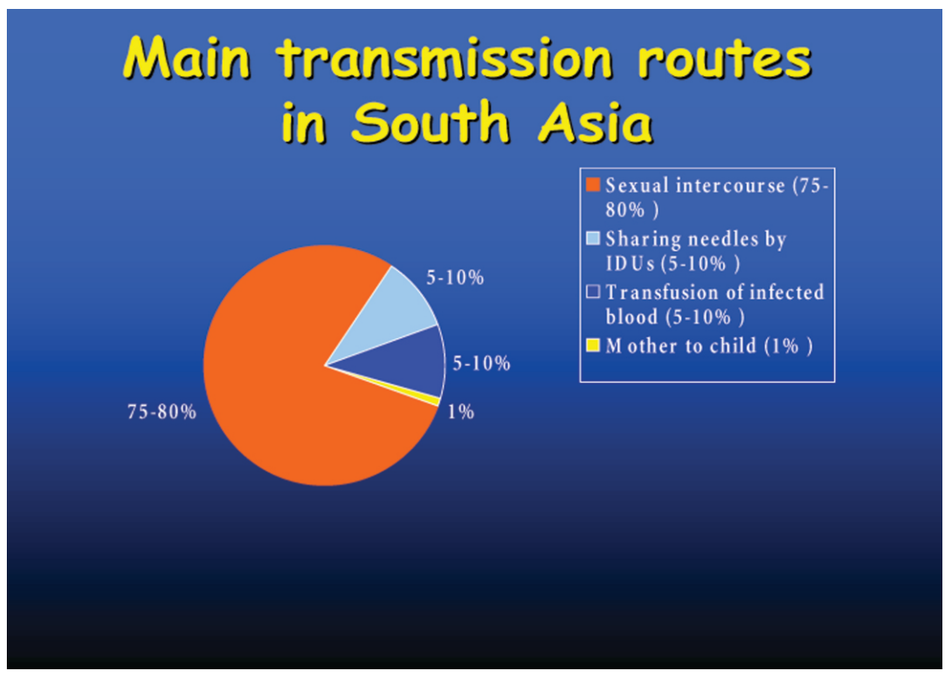
But let us also think of those who are living with HIV/AIDS. Let us empathise with them. It does not spread through touch or hugging or through social niceties. Let us help them as much as we can and avoid stigma and discrimination against them.

Suneeta Mukherjee is UNFPA Representative, Bangladesh.









Gender dimensions of HIV/AIDS

The question of women's human rights

The international community is increasingly recognising that the gender dimensions of HIV/AIDS can no longer be ignored. A critical turning point was the UN General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001, where 189 countries signed a Declaration of Commitment acknowledging that "gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS."

DR RIFFAT HOSSAIN LUCY

If women's health is really a matter of rights, and data suggest there are structural obstacles to the enjoyment of those rights -- such as pervasive gender discrimination and women's disproportionate economic dis-empowerment -- then health is a political and a politicised issue as it speaks directly to questions of social justice.

The World Health Organisation (WHO) data for women's health indicate that: "Although the status of women varies dramatically in specific locales around the world, when compared to male peers, women are virtually always less well educated, less well nourished, less politically active or powerful, and less economically viable. In most developing countries, the morbidity and mortality rate for females of all ages is higher, largely because women receive less health care, and receive it later in a medical syndrome. In addition to less access to health care, lower levels of nutrition and calorie consumption result in higher morbidity and mortality for female children."

Health, particularly women's health, could be explained through at least three possible paradigms: biomedical, public health, and structural. The most familiar paradigm to the clinicians is the biomedical one, which suggests health and ill health essentially as biological functions, diseases and disorders as physiological phenomena. By contrast, the public health paradigm attempts to incorporate a social dimension by observing how disease is distributed within and among populations and extrapolating risk factors for disease based on that observation. On the other hand, a human rights framework potentially provides the third structural paradigm, which perceives health and ill health as deeply rooted in social, political, and economic power structures and, in turn, perceives the promotion of health as inherently tied to the restructuring of those societal power relations.

From a human rights perspective, the reduction of social dimensions of risk to individual behaviours avoids challenging the underlying social, economic, and political structures that systematically put poor women at risk for multiple adverse health effects.

Starting from the United Nations Charter in 1945, the Universal Declaration of Human Rights in 1948, up to the recent progress to International Conference on Population and Development (ICPD) in Cairo in 1994, Fourth World Conference on Women in Beijing in 1995, all the traditional international human rights models have been limited by conceptions of overlooking the realities of women's lives. All too often, economic, legal, and social structures in the public realm create the conditions for violence against women, which is also played out in the family or other private institutions. That "structural violence" is, in turn, often ignored or denied by the mainstream human rights community or excused as a cultural difference instead of considering it as a deprivation of dignity.

Evidence suggest that violence against women is fuelling the spread of HIV/AIDS. Rape and sexual abuse are used as a weapon of war and are putting millions of women at risk of HIV infection. Situation is found to be worse among the women who disclose their HIV/AIDS status are also subjected to physical and psychological violence. The convention on the Elimination of All Forms of Discrimination against Women (CEDAW) is a critical tool for assisting all of us to understand what gender equality and the elimination of discrimination will require. It is a powerful mandate for bringing about concrete changes to realise women's human rights. Adopted in 1979 by the UN General Assembly and ratified by 169 governments, CEDAW sets up an agenda for national action to end gender-based discrimination. CEDAW can be applied in designing responses to HIV/AIDS in order to protect the human rights and fundamental freedoms of women and their families.

About twenty years after the first clinical evidence of acquired immunodeficiency syndrome was reported, AIDS has become the most devastating disease human-kind has ever faced. Since the epidemic began, more than 60 million people have been infected with the virus. HIV/AIDS is now the leading cause of death in sub-Saharan Africa. Worldwide, it is the fourth-biggest killer. At the end of 2001, an estimated 40 million people globally were living with HIV. In many parts of the developing world, the majority of new infections occur in young adults, with young women especially vulnerable. About one-third of those currently living with HIV/AIDS are aged 15-24, with about half of them women. Most of them do not know they carry the virus. Many millions more know nothing or too little about HIV to protect themselves against it. AIDS could not be defined just as a product of a virus, but as a global pandemic.

Now, question may arise that what does HIV/AIDS have to do with human rights? In fact, human rights are inextricably linked with the spread and impact of HIV/AIDS on individuals and communities around the world. A lack of respect for human rights fuels the spread and exacerbates the impact of the disease, while at the same time HIV/AIDS undermines progress in the realisation of human rights. This link is apparent in the disproportionate incidence and spread of the disease among certain groups which, depending on the nature of the epidemic and the prevailing social, legal and economic conditions, include women and children, and particularly those living in poverty. Example can be taken from the study of HIV infection among low-income, inner-city women, where Sikkema found that "the risk for the disease is not equally distributed across the entire population of women, but is disproportionately high among impoverished minority women in our inner cities."

It is also apparent in the fact that the overwhelming burden of the HIV/AIDS epidemic today is borne by the developing countries. Women in our perspective have been socialised through religion, cultural taboos and other social mechanisms to accept sexual subordination and even sexual oppression. Therefore, they are often precluded from the most basic means of prevention: safe sex. Lack of knowledge and bargaining power with their sexual partner is one of the many factors preventing women from the transmission of HIV/AIDS.

The international community is increasingly recognising that the gender dimensions of HIV/AIDS can no longer be ignored. A critical turning point was the UN General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001, where 189 countries signed a Declaration of Commitment acknowledging that "gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS."

If the status of women that WHO has suggested leads to differential access to facilities then it should be taken seriously as a rights violation under international law, then governments and intergovernmental organisations would redefine strategies to give priority to redressing it. Advancing women's health cannot be decoupled from political efforts to transform oppressive social relationships and institutions that deprive women of their fundamental rights.

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Treating the drug users

In the Narcotics Control Act 1990, there is provision for the establishment of narcotic addiction treatment centres and when it is deemed treatment is necessary the person is directed to a competent physician or a treatment centre. However, detoxification and rehabilitation programmes are scarce in the country and few drug users have the resources to attend them.

DR. MD. ABDUS SALIM

INJECTING Drug Users (IDUs) in Bangladesh is reported to be the high-risk sub-population getting HIV/AIDS and other blood born diseases like Syphilis and Hepatitis-B. They take drug through vein and muscles sharing same needle and syringe. Once they develop drug dependency, they cannot virtually get rid of it.

In South East Asia, injecting drug use has generated the first wave of the HIV epidemic, which quickly leads to successive waves of heterosexual transmission.

Once HIV is introduced in a local injecting population the rise in prevalence of HIV is rapid.

Type of drugs used and places where the drugs are available for IDUs: Among the currently drug users, the drug of choice is *buprenorphine*. This is frequently mixed in a cocktail with *diazepam, promethazine hydrochloride and chlorpheniramine*. Other injectables, such as *vitamin-B 50* are also used. Heroin is injected by 2 per cent of men, mostly dissolved in lemon juice. Less than 1 per cent reported injecting *pethedine*. In Rajshahi, almost all the men used the services of a professional injectors, however, this is not in case of Dhaka. The average duration of taking injectable drug among the drug users were 11 to 14 years in the sample population.

One professional injector pushes injection to about 80-90 times providing drugs to about 40-50 persons a day from one *Adda*. *Adda* injector usually uses the same needle for 20-50 people. He does not sterilise the needle and syringe.

Current situation of injecting drug users: In Bangladesh, the 4th round HIV serological and behavioral surveillance conducted in 2002 (Four sero- and behavioral surveillance have been conducted since 1998 and fifth one is underway) shows a sharp rise of HIV infection among the IDUs. The prevalence of HIV infection ranges from 2.5 per cent in 1998-99 (1st Round Surveillance) to 4 per cent in 2002 (4th Round Surveillance). The rate of buying sex from the sex workers in the past month are increasing from 2 per cent in 1st round to 54 per cent in the 4th round of surveillance. The condom use rate is found low among the IDUs ranging from 8 per cent to 15 per cent among the surveyed population. About 28 per cent to 74 per cent of IDUs under surveillance in the 4th round shared needles and syringes passively or actively (See table below).

The 4th HIV serological and behavioral surveillance shows that the HIV epidemic among the drug users has increased more than 100 per cent compared to last year. HIV-infection among the IDUs is now close to the critical 5 per cent marking a concentrated epidemic. In spite of programme intervention, those most vulnerable to HIV infection display highest risk behaviour and risk perception is still low among them and condom use among them is very low and needle sharing remains unacceptably high among the drug users.

Government response to illicit drug problems: In the Narcotics Control Act 1990, there is provision for the establishment of narcotic addiction treatment centres and when it is deemed treatment is necessary the person is directed to a competent physician or a treatment centre. However, detoxification and rehabilitation programmes are scarce in the country and few drug users have the resources to attend them. The Department of Narcotics Control has recently initiated a community level of coordination to streamline the activities of the non-governmental organisations (NGOs) to strengthen existing and future drug prevention activities in the country.

Government and non-government organisation's response to drug use: The Government of Bangladesh is aware of the link between HIV/AIDS and drug use. It has been acknowledged that Needle Exchange Programme (NEP) can play a role in reducing the amount of needle sharing and impact upon HIV prevention. Substitution therapy is currently not available. Information about HIV/AIDS, which directly targets the drug users, is reported to be inadequate.

The non-government organisation (NGOs) and private sectors are operating drug rehabilitation centres mostly for the oral drug addicts. CARE-Bangladesh, an international NGO in its SHAKTI Project (Strengthening HIV/AIDS knowledge through Training Initiative) started operating number of health centres (Drop-in-Centre) in Dhaka since 1999 to provide disposable needles and syringes, STI treatment, condom for safer sex practice, and awareness about HIV/AIDS for the IDUs under the NEP. CARE-Bangladesh has extended the NEP services to about 5,000 IDUs in Dhaka, Rajshahi and Chapai Nowabgonj, which covers about one of fourth of the total IDUs in the country.

Peer educators (who are either ex drug users or current drug users) identify the IDUs and bring them to the drop-in-centers where the IDUs receive information on HIV/AIDS, counseling about the side effect of drugs, treatment on STI and training on HIV/AIDS and STI. Peer educators have to distribute disposable needles and syringes at the site where the drug users are taking injecting drugs. This is mostly occurring at Dhaka whereas, at Rajshahi the IDUs receive services from the professional injectors.

National policy on HIV/AIDS and STD related issues: The national policy on HIV/AIDS has a special focus on IDU and approved of harm reduction as a useful strategy to prevent HIV/AIDS. However, the Ministry of Home Affairs, whose focus includes narcotic laws, does not approve of harm reduction believing such a policy cannot supersede the law of the land. As a result of these contradictions, serious threats from the Narcotics Department and police have emerged with this policy. In recent times, the Narcotics Department has indicated that they have acknowledged the existence of NEP and at this stage they have intended to support the operations of such programme.

The national policy on HIV/AIDS and STD related issues for the prevention of injecting drug use is aimed to (1) promote harm reduction by introducing needle exchange programme, promote safer sex practice among the IDUs and use BCC/IEC materials for them, (2) involve the drug users and community organisations of drug users in the prevention of HIV/AIDS, (3) implement outreach and community-based IDU intervention, (4) provide HIV/AIDS related information to the IDUs community, (5) make IDUs accessible to needles, syringes, condom and STI services, etc. to the IDUs so as to help them change their behavior, and (6) ensure getting support from the policy makers for the IDUs intervention.

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Table

Reports on HIV Serological & Behavioral Surveillance
(Injecting Drug Users: Values expressed in percentage)

Indicators for IDU	1st Round (1998-99)	2nd Round (1999-00)	3rd Round (2000-01)	4th Round (2002)
HIV Infection among the IDUS	2.5	0-1.4	0-1.7	0-4.0
Syphilis (Non-active)	-	-	-	9-19
Syphilis (Active)	13	13-23	9-18	2-4
Sold sex in the past week	-	-	-	2-9
Bought sex from sex workers in the past month	2-7	-	18-33	18-54
Condom use at last sex act with sex worker	-	-	14-24	17-31
Consistent condom use at last year	-	-	10-11	8-15
Received injected drugs in the past year	-	100	100	100
Sought STI treatment	42	-	25-35	30-46
Share needle/syringe passively in the past week	93-96	31-64	62-93	28-74
Share needle/syringe passively/actively last time	-	33-62	-	28-74