NATIONAL STRATEGY

ON

ADDRESSING GENDER BASED VIOLENCE FOR HIV RESPONSE IN BANGLADESH (2017-2021)

**National AIDS/ STD Control Program**

**Ministry of Health & Family Welfare**

***December 2016***

**ACKNOWLEDGEMENTS**

**FOREWORD**

**GLOSSARY**

| Sl # | Terminology | Definition |
| --- | --- | --- |
| 1 | Gender Based Violence (GBV) | GBV is defined as “*violence that is directed against a woman because she is a woman or that affects women disproportionately”*, thereby underlining that violence against women is not something occurring to women randomly, but rather an issue affecting them because of their gender. Further, GBV is defined as including ***“acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty*.”** GR 19 also specifies that GBV may constitute a violation or women’s human rights, such as the right to life, the right to equal protection under the law; the right to equality in the family; or the right to the highest standard attainable of physical and mental health. (Source: CEDAW General Recommendation No. 19 on VAW). |
| 2 | Working definition of Gender Based Violence | Any harmful act that is perpetrated against a person’s will and that is based on socially associated differences between males and females. As such violence is based on socially ascribed differences, gender-based violence includes, but it is not limited to sexual violence. While women and girls of all ages make up the majority of the victims, men and boys and **Hijra** are also both direct and indirect victims. It is clear that the effects of such violence are both physical and psychological, and have long term detrimental consequences for both the survivors and their communities  (adopted by the UN ECOSOC in 2006,and consultation in the expert in the workshop. Hijra is added here) |
| Sl. # | Key populations | Definition |
| *Female Sex Workers and their clients* | | |
| 1 | Street based Female Sex Workers (SBFSW) | Females who sell sex and are contracted through negotiation by clients on the street or any public place for sex during last 1 year |
| 2 | Hotel based Female Sex Workers (HBFSW) | Females who sell sex and are contracted by clients in a hotel or guest house setting, with the sex act taking place in hotels or guest house during last 1 year |
| 3 | Residence based Female Sex Workers (RBFSW) | Females who sell sex and are contracted by clients in the residence setting, with sex act taking place in residence or other place during 1 year |
| 4 | Brothel based Female Sex Workers (BBFSW) | Females who sell sex and are contracted by clients in the brothel setting, with sex act taking place in brothel |
| 5 | Casual Female Sex Workers | Females who are selling sex during last 1 year and had either one or more main source of income |
| **6** | Clients of female sex workers | Males who bought the sexual services of female sex worker during last 1 year is a client of a sex worker |
| *Males who have sex with males (MSM) and TG/Hijra* | | |
| 7 | Males who have sex with males (MSM) | Males who have had sex with males (with consent) within the last 1 year sex regardless of whether or not they have sex with women or have a personal or social gay or bisexual identity but do not sell sex |
| 8 | Male sex workers (MSW) | Male who sell sex to other males in exchange of money or gifts in the last 3 months |
| 9 | TG/Hijra  (TG/Transgender or third gender) | Those who identify themselves as belonging to a traditional hijra sub-culture and who maintain the guru-chela hijra hierarchy. They maybe sub-categorized as: Sex Worker Hijra, BadhaiHijra and Radhunihijra |
| *People who inject drugs (PWID)* | | |
| **10** | Male who inject drugs (PWID-Male) | Males who injected drugs within the last 1 year |
| **11** | Female who inject drugs (PWID-Female) | Females who injected drugs within the last 1 year |
| *Most at Risk Adolescent (MARA) for HIV* | | |
|  | MARA for HIV includes: | * Female adolescents and youth (10-19 years and 20-24 years) who are involved in commercial or transactional sex work including those who were trafficked, and/or forced for the purpose of sexual exploitation during last 1 year * Male adolescents and youth (10-19 years and 20-24 years) who injected drugs within the last 1 year * Female adolescents and youth (10-19 years and 20-24 years) who injected drugs within the last 1 year * Adolescents and youth (10-19 years and 20-24 years) males who had sex with other males within last 1 year * Adolescents and youth (10-19 years and 20-24 years) males who had commercial or transactional sex to other males in exchange of money or gift in the last 3 months * Adolescents and youth (10-19 years and 20-24 years) who identify themselves as belonging to a traditional hijra sub-culture |

**ACCRONYMS**

AIDS Acquired Immune Deficiency Syndrome

ART Antiretroviral Therapy

BBFSW Brothel based Female Sex Workers

DGHS Director General of Health Services

DIC Drop-in Canter

FHI Family Health International

FSW Female Sex Worker

GARPR Global AIDS Response Progress Reporting

GF Global Fund

GOB Government of Bangladesh

HBFSW Hotel based Female Sex Workers

HIV Human Immunodeficiency Virus

HTC HIV Testing and Counseling

icddr,b International Centre for Diarrhoeal Diseases Research, Bangladesh

IEDCR Institute of Epidemiology, Disease Control and Resear

KP Key Population

MARA Most at Risk Adolescent

MOHFW Ministry of Health and Family Welfare

MSM Men who have Sex with Men

MSW Male Sex Worker

NAC National AIDS Committee

NASP National AIDS/STD Programme

NGO Non-Government Organization

PLHIV People Living with HIV

PWID People Who Inject Drug

RBFSW Residence based Female Sex Workers

SBFSW Street based Female Sex Workers

STD Sexually Transmitted Disease

STI Sexually Transmitted infectio

TG Transgender (hijra)

UN United Nations

UNAIDS United Nations Joint Program on HIV/AIDS

UNFPA United Nations Population Fund

UNICEF United Nations Children’s Fund

YKP Young Key Population

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***Chapter One***

**INTRODUCTION:**

* 1. **Context**

The Government of Bangladesh has demonstrated its strong political commitment and consistent leadership in national response to the HIV epidemic. AIDS/STD Control Program (NASP), established by the Ministry of Health and Family Planning Welfare (MOHFW) under the Directorate General of Health services (DGHS), is the nodal body to manage the country HIV response. The ongoing Revised 3rd National Strategic Plan for HIV and AIDS Response (2011-2017) provides the overall framework of national response that presents the roadmap of minimizing the spread of HIV and the impact of AIDS on individual, families, communities and society. This strategic paper is also being used as a framework for a coordinated approach between government, implementing agencies, other partners and donors across programs to scale up and improve service delivery. The key principles of the strategic plan emphasized multi-sectoral engagement, stigma reduction, broad political commitment, civil society involvement, private sector involvement, evidence based response, and prevention to care continuum, human rights, use of gender based approaches, partnership and a coordinated approach[[1]](#footnote-1). And the national response is supported by a series of strategies and guidelines.

Bangladesh remains a low prevalence country with less that 0.01% prevalence among general population over the years and less than 1% in key population. The estimated number of People Living with HIV is 9,600[[2]](#footnote-2). Total number of reported HIV case is 4721 where 799 were AIDS related death[[3]](#footnote-3). Although the prevalence remains low, Bangladesh is one of the only four countries in Asia and the Pacific where prevalence has increased more than 25% over a decade till 2012[[4]](#footnote-4) and Persistent gender inequalities, widespread discrimination, injustice and other factor such as high levels of violence against women and girls and transgender populations is continuing to hamper the progress that have been made in HIV prevention and treatment response.

**1.2 Status of Women in Bangladesh**

Historically, socially prescribed roles have limited women's access to economic resources, political participation, and other forms of decision making. Bangladesh is a highly patriarchal society and gender discrimination is evident across all levels. But the situation has been improved in the recent years. According to the Global Gender Gap Report 2016, Bangladesh ranks 72 out of 144 countries with overall score 0.698[[5]](#footnote-5). In terms of ranking of sub-index Health and Survival (0.971) comes out top followed by Educational attainment (0.950), Political empowerment (0.462) and Economic participation (0.410). Bangladesh ranked 7th position out of 144 countries in the political empowerment sphere which is much encouraging. Bangladesh was awarded the prestigious Women In Parliament (WIP) the Global Forum award 2015[[6]](#footnote-6) and for its outstanding success in closing gender gap in the political sphere.

In spite of considerable improvements in a range of gender equality indicators in education, political empowerment, better job opportunities, greater movements and autonomy over the years, there continues to be persistent challenges with respect to realization of girls’ and women’s human rights and full potentials. The social, health and economic indicators indicate that women remain subordinated to men in all aspects and their access to education, health and other services remain limited. Women and girls are often subjected to early marriage, sexual abuse and violence in intimate and marital relationships.

Approximately, 11% of young girls (age group of 10-14 years) and around 46% (age group of (15-19 years)[[7]](#footnote-7) are married. In rural areas, up to 85% of girls are married by the age 16[[8]](#footnote-8) . The median age at first marriage among women age 25-49 is 15.5 years, and among men age group it is 24.2 years, indicating large differences in age between husbands and wives, which is one of the factors affecting women’s ability to negotiate safe sexual behaviors including for family planning[[9]](#footnote-9). As a result, one-third of adolescent girls begin childbearing between the ages of 15-19 years[[10]](#footnote-10).

Again, women are subject to frequent domestic violence, trafficking, acid attacks and rape. 54.7% of currently married women have experienced physical violence in their current marriage during last 12 months[[11]](#footnote-11). Estimated 300,000 girls trafficked to work in brothels in India and 200,000 to Pakistan in the last 10 years which put them into higher risk of violence and exposure to HIV.

**1.3 Focusing on target population (KP & other vulnerable group):**

The Revised 3rd National Strategic Plan for HIV and AIDS Response for 2011-2017 of Bangladesh prioritizes the provision of services for specific vulnerable and infected and affected group of people. The strategic plan targeted populations have been categorized for sustainable national response. For effective prevention of new infections tailor-made interventions have been designed for three broad groups

**i. Key populations:**

* Female sex workers brothels (BFSW), hotel/residence (HFSW) or street (SFSW))
* Male sex workers, MSW
* Hijra/Transgender
* Men who have sex with men, MSM
* People who inject drugs, PWID (male- female)
* Most At Risk Adolescent (MARA)

**ii. Emerging risk populations and vulnerable groups**

The following groups outside the key populations were identified in the original 3rd NSP as having higher rates of risk behavior and are more likely to be exposed to HIV:

* **International migrants** - can be divided into official and informal international migrants as well as cross-border migrants
* **Especially vulnerable adolescents (EVA)** - refers to adolescents who have an elevated risk but do not belong to any key populations, and are thus not considered MARA. It includes children and adolescents who are likely to develop high risk behaviors, for example those who use (but do not inject) drugs, children of sex workers, street children and others who suffer severe social circumstances
* **Heroin smokers** - are at risk as many shift to injecting drug use over time
* **Transport workers** – truck drivers, rickshaw pullers, dock workers etc. Mainly at risk due to a high level of commercial sex
* **Prisoners** – high prevalence of injecting drug use, high-risk sex and unsafe health Services put prisoners at elevated HIV risk

The NSP recognizesthat **Garments workers, Tea garden workers, refugee, displaced person and minority ethnic population** may have a heightened vulnerability but interventions are not prioritized considering unavailability of strong supportive evidence and low HIV prevalence in the country.

**iii. General population and young people**: All people have a basic human right to be provided with the information and basic services to protect themselves from HIV infection.

* 1. **Rationale of adopting strategy on addressing GBV**

In Bangladesh, though HIV prevalence is low among general population, it is significant among key population groups such as people who use drugs (PWID), Female sex workers (SW), transgender persons (TG) and Men who have sex with Men (MSM).Gender inequalities, gender-based violence (GBV) and harmful gender norms promote unsafe sex and reduce access to HIV and sexual and reproductive health services for women, men and transgender persons.

**Gender-based violence (GBV) is a cause and consequence of HIV.** Across Asia and the Pacific, key populations - including sex workers, men who have sex with men, transgender people, people who inject drugs, as well as persons living with HIV - are subject to gender-based discrimination and violence. Violence or the fear of violence can increase the vulnerability of key populations to HIV by making it difficult or impossible to set the terms of an equal relationship. It is more difficult for individuals to refuse sex when in a relationship, to get their partners to be faithful, or to use a condom. Violence can also be a barrier for key populations and PLHIV in accessing HIV prevention, care, and treatment services. This in turn limits their ability to learn their HIV status and adopt and maintain protective measures ranging from negotiating safer sex to getting and staying on treatment[[12]](#footnote-12).

**Harmful gender norms promote unsafe sex and reduce access to HIV services.** Norms of masculinity (including homophobia) can encourage high risk sexual behavior by men and make their partners more vulnerable. Norms of femininity can prevent women (especially young women) from accessing HIV information and services. More over Lack of education, social norms and positioning, and economic insecurity limits decision-making power, mobility and access to information and services. Health seeking behavior is influenced by gender and, stigma and discrimination. Persistent gender inequalities, widespread discrimination, injustice and other factor such as high levels of violence against women and girls and transgender populations will undermine the efforts in curbing HIV epidemic and progress made under MDG[[13]](#footnote-13). It will also continue to impact on country’s overall efforts in achieving Sustainable Development Goals (SDGs) for Bangladesh. Therefore addressing GBV, gender needs and rights of women, men, transgender persons in all their diversity, in particular those living with HIV and key populations at higher risk of HIV become urgent for sustainable HIV responses for Bangladesh.

***Chapter Two***

**SITUATION ANALYSIS**

**2.1 HIV situation**

The national HIV prevalence is less than 0.1% among general population. But HIV prevalence among Key Population varies across the country and is reported as 1.2% among PWID and heroin smokers nationally, with a prevalence of 5.3% among male PWID in Dhaka (2011, Round 9 Surveillance).[[14]](#footnote-14) 0.6% among Male sex workers (MSW) and 0.5% among Hijra (2013)[[15]](#footnote-15), 0.3% among Female Sex Workers, though as high as 1.6% among some areas like Hili.

Active Syphilis rates among key populations are reported relatively high: between 5% -8% among PWID in some districts, 2.2% among hotel based sex workers, 4.6% among street based sex workers in Dhaka and as high as 12.5 % among street based female sex workers in Hili[[16]](#footnote-16). Active Syphilis rates have declined among MSW and Hijra in Dhaka. For MSW it declined from 4.2% to 2.2% and for from 6.1% to 3% for Hijra because of increased outreach into these population[[17]](#footnote-17). Female Sex Workers experience significant obstacles and barriers in accessing reproductive health service in Bangladesh, high rates of unintended pregnancy and abortion are evident.

**National Response**

During the period of 2005-2010, there was expansion of the HIV/AIDS programmes in terms of coverage and involvement of different stakeholders. Global Fund joined with World Bank and USAID as a new funding source. The major programmes implemented or initiated during the period were:

1. **HIV /AIDS Prevention Project (HAPP)** 2004-2007
2. **The HIV/AIDS Targeted Intervention (HATI)** 2008-2009
3. **The Bangladesh AIDS Programme (BAP)** 2005-2009
4. **Modhumita** 2009-2014.
5. **GF Round 2: Prevention of HIV/AIDS among Young People in Bangladesh**f 2004-2009.
6. **b. GF Round 6: HIV Prevention and control among High-Risk populations and vulnerable Young People in Bangladesh**  2010-2015
7. **GF Rolling Continuation Channel (RCC) R2: Expanding HIV prevention in Bangladesh** (2010-2015)

The following two projects are going on for the country response

**1) Global Fund: The New Funding Model (2015-2017).** Bangladesh is planning to apply for continued HIV funding from GF under the new funding model for the period 2015-2017. The focus on prevention among key populations will remain, with special emphasis on HIV testing and counseling. However, as the allocated funds are likely to be substantially reduced, scaling up of basic prevention services among key populations may not be possible.

**2) Health, Population and Nutrition Sector Development Programme (HPNSDP)**

Estimates to allocate around US$ 36 million over five years (2011-2016) channeled through NASP. The funds are primarily dedicated to prevention among key populations and international migrants and care, treatment and support for PLHIV.

**Current Size Estimation and National Coverage**

|  |  |  |
| --- | --- | --- |
| **Key Population** | **Size Estimation 2016** | **% Covered** |
| Female Sex Worker (FSW) | 102,260 | 25% |
| MSM & MSW | 131,472 | 23.6% |
| Transgender/Hijra | 10,199 | 39.8% |
| People Who Inject Drugs (PWID) | 33,067 | 35% |

Source: Size estimation 2016 and Program Information

**2.2 GBV situation**

***Violence against women is a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women, and that violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men.***

— Declaration of the Elimination of Violence against Women, 1993

Bangladesh is high prevalent country on GBV. Prevalence of any type of violence among physical, psychological, sexual or economic aspect experienced at least once in lifetime among ever-married women by husband is 72.6%[[18]](#footnote-18), prevalence of any type of violence experienced at least once in last 12 months among ever-married women by husband is 54.7%, prevalence of any type of violence experienced at least once in life time among currently-married women by current husband is 80.2, prevalence of any type of violence experienced at least once in last 12 months among currently-married women by current husband is 65.1%. Legal and policy reforms to address gender-based violence have been limited in impact because less than 2% of married women who have experienced physical violence seek any kind of remedy or service. The situation is considerably worse for women living in urban slums.

**Gender Based Violence among Key population**

Key population in Bangladesh face several different types of GBV, ranging from being teased by people on the street to being raped and murdered, from a large range of different groups of people, ranging from boys on the street to religious leaders, police, and sex partners. Gender-based violence is included into physical, sexual, psychological or economic. Stigma, Discrimination, exclusion, harassment, blackmail, client refusing to pay after having sex, rejection or non acceptance by family or community members, disrespects, police ignoring GBV complaints, health care staff refusing to provide care and humiliation. The violence are often stated-sponsored, structural discrimination, some are associated to traditional or customary practices.

Key populations face GBV mainly at their venue of sex work, work place, service center, police stations and residence[[19]](#footnote-19). Those are

* Hotel and street-based sex work venues
* Transport terminal
* Entertainment venues
* Parks and roadsides
* Festival sites
* Drug use location
* Residence
* Police station
* Service centre

Engaging in sex work is a major source of GBV for FSW, MSW & Hijra. This makes them more vulnerable for GBV along with prevailing with Patriarchy, Social Norms, and Gender inequality both to their clients and to the community at large. The existence of sexual identities and feminine behaviors of Hijra and MSW go against societal norms. So they are viewed as” unacceptable” in the society by violating the norms that break traditional gender roles. Vicious cycle wherein an individual’s social marginalization makes it more difficult for FSW, MSW & Hijra to secure regular employment, wherein they engage in sex work as their only viable source of livelihood, which only further reinforces their marginalization and vulnerability.

Gender based violence is a key concern for key population that has a life threatening impact on them and dramatically increase the risk of HIV & STIs for the key population. According to the Behavioral Surveillance 2006-2007, female sex workers also report high levels of violence. Almost one-half of the street-based sex workers in all locations reported being beaten particularly by members of law enforcement agencies and by local mastans (extortionists). Among adolescent sex workers, forced sex ever was more experienced by street based FSWs (53%) than hotel based (40%), brothel based (38%) and home based FSWs (39%). A study in 2012 revealed, 44% of the FSWs, who ever had experience forced sex, admitted of having forced sex in last 12 months. A study in 2011 of the street and hotel based sex workers in Dhaka revealed that 43% of hotel based and 80% of street based sex workers had experienced violence resulting in injury in the last twelve months. 28% of hotel based and 54% of street based sex workers had experienced forced sex in the same period[[20]](#footnote-20) . Violence experienced by MSM, especially effeminate MSM and TG is also considerably high, especially intimate partner violence (IPV).

**Ongoing National Response on GBV**

The major national responses, currently going on, are as follows

**a. Multi-Sectoral Programme on Violence Against Women** is being implemented jointly by the Government of Bangladesh and Government of Denmark under the Ministry of Women and Children Affairs. This project supports the Bangladesh Poverty Reduction Strategy and also aligned to the UN Convention on the Elimination of All Forms of Discrimination Against Women. The pilot phase of the project took place from May 2000 to December 2003, the first phase from January 2004 to June 2008 and the second phase from July 2008 to June 2011. The programme is now in its 3rd phase, which will continue until June 2016. The project is being carried out in collaboration with the Ministry of Law, Justice and Parliamentary Affairs, Ministry of Information, Ministry of Social Welfare, Ministry of Home Affairs, Ministry of Health and Family Welfare, Ministry of Education, Ministry of Religious Affairs, Ministry of Youth and Sports and Ministry of Local Government, Rural Development and Cooperative.

Towards reducing incidences of violence against women and children and improved redress through joint collaboration between relevant ministries and non-government agencies, the project is providing the following services

* One Stop Crisis Centre
* DNA Laboratory
* National Trauma Counseling Centre
* VAW database
* One Stop Crisis cell
* National Helpline Centre

Key populations are not covered under this program.

**b. The Joint Program to Address Violence Against Women (JP‐VAW):**  Supported implementation of replicable interventions in addressing gender‐based violence by UN joint program and 11 ministries. The main outcome were

framework Policies and Legal This program incorporated HIV and key population is provided few services those are mentioned bellow.

- Initiatives to address violence, stigma and discrimination against key populations with respect to HIV included orientation and sensitization workshops among 600 budding doctors and nurses, 300 journalists and 200 military health service providers across the country.

-With the focus on gender based violence against key populations, 225 sex workers have been sensitized with support from Sex Workers Network about different forms of sexual abuse and violence, grievance mechanisms available at local and national level, importance of organizational capacity building. Capacity building of self‐help groups was also supported.

- Initiatives taken to reduce the economic vulnerability of 21 women infected and affected by HIV through training on Income Generating Activities (IGA) and grant support to start small entrepreneurial activities.

- Under capacity building initiatives and emergency support, two thirds of all identified HIV positive women have been empowered through leadership skills, peer counseling and home based care to improve their wellbeing, and 10 HIV positive survivors of gender based violence have found protection in shelter home facilities.

**c. Generation Breakthrough:** A multi -pronged approach to building healthy relations hips for primary prevent ion of Gender Based Violence and meeting SRHR needs of adolescents in Bangladesh 2012-2016 with the support of United Nations Development Assistance Framework (UNDUF) and the following approaches

* A multi-pronged community Approach
* Promoting Gender Equitable attitude as a ASRHR strategy and vice versa
* Involving boys and men in addition to women and girl
* A positive ABCD approach
* Use of ICT
* Private Sector Engagement
* Participatory Monitoring & Evaluation
* Model Building

**d. SAFE: VAW AT URBAN SETTING, Icddr,b**

* develop a mechanism to set up effective linkages between different service providers and the survivors
* building the capacities of the Union Parishad standing committees (UP-SC) on Women and Child Welfare, Culture and Sports, in collaboration with the DLAC, to ensure the provision of legal services to female survivors among marginalized groups.
* A database was piloted in 44 unions under six upazilas (sub-districts) in six project districts, with information on women survivors of violence and the services provided.
* The database was compiled with upazila-based information and first shared with the respective Upazila Women’s Affairs Officers. It was then further analysed and shared with the respective District Women Affairs Officers.

**e. Women Friendly Hospital Initiative, Ministry of Health and Family Welfare (MOHFA)**

**f. Protecting Human Rights Program, Plan Bangladesh**

**2.3 EXISTING LEGAL FRAMEWORK:**

**A. International human rights framework**

A number of international human rights standards that are agreed by governments are directly relevant to women in the context of HIV and violence against women. Among these:

**i. Vienna Declaration and Programme for Action** (1993) recognizes the importance of women’s right to enjoy the highest standard of physical and mental health throughout their lifespan. Article 41 reaffirms a woman’s right to accessible and adequate health care and the widest range of family planning services.32

**ii. Convention on the Elimination of All Forms of Discrimination against Women** (CEDAW, 1993), articles 2, 5, 11, 12, and 16, require state parties to take action to protect women from violence of any kind occurring in the family, at the work place, or any other area of life. The CEDAW committee in General Recommendation 19 (1992) noted that gender-based violence impairs or nullifies women’s enjoyment of human rights and is a form of discrimination; and in General Recommendation 24 (1999) noted that in unequal power relations based on gender, women and adolescent girls are often unable to refuse sex or

insist on safe and responsible sex practices.33

**iii. Declaration on the Elimination of Violence against Women** (DEVAW, 1993), in article 4, calls on state parties to condemn violence against women and not invoke any custom, tradition, or religious consideration to avoid their obligation to eliminate violence against women.

**iv. Cairo Programme for Action,** adopted at the International Conference on Population and Development (ICPD, 1994), set out key recommendations to address women’s vulnerability to HIV through reproductive health services.

**v. Beijing Platform for Action,** adopted at the Fourth World Conference on Women (1995), recommended the institution of gender-sensitive initiatives to address HIV, STIs, and sexual and reproductive health.

**Vi. Declaration of Commitment “Global Crisis-Global Action,”** adopted by the UN General Assembly Special Session on HIV (2001), noted that gender equality and women’s empowerment are fundamental elements to the reduction of women’s vulnerability to HIV

**vii. Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS,** adopted by the UN General Assembly (2011), reaffirmed commitments made in 2006 and committed to a specific target (7) to “eliminate gender inequalities and gender-based abuse and violence.”

**B. National Legal Framework**

1. **The Constitution of People’s Republic of Bangladesh,**  Article 15 (d), 18.2. 27, 28.2, 28.4, 31
2. **The Child Marriage Resistant Act, 1929**
3. **The Dowry Prohibition Act 1980**
4. **The Suppression of Violence Against Women and Children Act 2000**
5. **The Acid Crime Control Act 2002**
6. **The Acid Control Act 2002**
7. **The Citizenship Act (amended) 2009**
8. **The Mobile Court Act 2009**
9. **The Domestic Violence (Prevention and Protection) Act 2010**
10. **The Human Trafficking (Deterrence and Suppression) Act 2012**
11. **The Pornography Control Act 2012**
12. **The Children Act 2013**
13. **The Domestic Violence (Prevention and Protection) Rule 2013**

**C. High Court Directives to prevent Violence Against Women and Children**

1. **Sexual Harassment:** Ref-High Court Writ Petition no. 5916/2008
2. **Sexual Harassment Against Women and Children:** Ref-High Court Writ Petition no. 8769/2010
3. **The Extra Judicial Punishment in the name of Fatwa is illegal:** Ref-High Court Writ Petition no. 5863/2009 & 754/2010 & 4275/2010
4. **Nobody is compelled to obey Fatwa:** Ref-High Court Writ Petition no. 4275/2010
5. **Executive Order of the Ministry of Women and Children to prevent child marriage**
6. **The notification of Ministry of Education to Prohibit corporal punishment in educational institution:**
7. **Against Brothel Eviction**

**2.4 Correlation among HIV & GBV and Vulnerability Network among KP, PLHIV and general population**

It is globally recognized that there are strong linkages between violence against women and HIV. First, there is a strong link between actual or threat of violence and sexual risk taking, including unprotected sex and multiple sex partners. Second, actual or the threat of violence affects women’s ability to negotiate condom usage. And third, there is a link between intimate partner violence and unequal gender relations and HIV.

**Female Sex Workers, MSM, MSW, Hijra, PLHIV and general population are interlinked** in their sexual and marital relationship, Needle-syringe sharing and other high-risk behaviors and those are the potential spread of HIV and GBV. Married women have contracted HIV from having unprotected sex with their husbands. Stigma and discrimination against women living with HIV are severe. Often they are mistreated and even evicted from their in-laws home when their HIV status becomes known. So the family rights are being violated.

**As per 4rth round Serological Surveillance** portion of FSW are married who has sexual relationship with Truckers, PWID, Rickshaw puller, MSM and male from the society and part of them are intravenous drug user. MSW and Hijra have sexual relationship with MSM, Male client from the society and part of them are PWID. Portion of MSMs are married with women in the society.

**The emphasis on masculine gender roles and the expectation of heterosexual marriage**, in this context means that many Bangladeshi MSM also have female sexual partners as a means to be culturally masculine, and may feel shame for their homosexual feelings. It precipitates GBV as well as increased risk of HIV infection. For instance, low rates of consistent condom use among hijra persist even after intensive interventions, and are in part the result of “low self-esteem induced by stigma and social exclusion”. The chief perpetrators of GBV are the gangsters and police, who claimed that they are “allowed” to rape MSM and hijra persons because these individuals contradict traditionally masculine gender roles.

**Drug use and sex work are mutually reinforcing,** with sex workers who use drugs experiencing increased vulnerability to HIV and violence[[21]](#footnote-21). Needles and Syringes were sometimes shared between sex workers and their PWID clients who paid their services with drugs. Many of the FSW, who use drugs, had been coerced by clients who were un willing to use condoms. PWID sometimes sell or buy sex, FSW sometimes use drugs. Some MSM ad Hijra sell or buy sex, many MSM are married to women.

**2.5 Gaps & Challenges[[22]](#footnote-22)**

1. There is no specific linkage between National Women’s Advancement Policy and HIV Policy and National Plan of Action on VAW (2013-2027) Act; and Women’s Policy does not focus on any specific group of marginalized women.
2. Low literacy rates; poor knowledge and health seeking behavior among key populations.
3. Condom services by govt. are only for married couple; lack of sex education among YKAP.
4. Condom negotiation is challenging for sex workers as HIV prevention programs are not targeting and reaching clients of sex workers. This also implies that more needs to be done in terms of financial empowerment of sex workers.
5. Poor uptake of HIV and other health services. Inadequate OST and harm-reduction facilities.
6. Though prevention programs have been running for over 20 years, reaching highly mobile and hidden groups of key populations for outreach and service referral is still challenging.
7. HIV prevention services are not reaching YKAP groups, e.g. no age and sex representative outreach & BCC. There is also lack of legal and policy support for SRH and HIV services among YKAP. There are no specific program activities targeting YKAP.
8. There is overlap between sex work, drug use and MSM behavior- and programs are not catering to this issue. Partners of key populations are not intervened and there is lack of programs targeting couples/partners of key population (i.e. lack of partner counseling and testing).
9. Social exclusion, marginalization and criminalization of all key populations lead to wide-spread stigma and discrimination. The interventions addressing stigma and discrimination are inadequate and translating policy and program strategies into implementation is a challenge.
10. A high level of SGBV is faced by all key populations especially sex workers, hijras and women & girls.
11. Men lack understanding and awareness of gender norms and masculinity. There is poor realization of women’s rights (e.g. marital rape not recognized, existing property and inheritance rights, etc.).
12. Lack of social protection mechanisms including addressing poverty, unemployment, family/children issues (especially for female sex workers, hijras and spouses of migrant workers), etc. of key populations.
13. Weak multi-sartorial coordination mechanisms and lack of effective program linkages.
14. Gender is not included in the NASP Structure and frame work

**2.6 Strategy Development process**

Considering above background NASP has taken initiative to adopt a strategy to protect gender based violence which will help to achieve the goal in HIV and AIDS “Minimize the spread of HIV and minimize the impact of AIDS on the individual, family, community and the society”. 50 representatives from different the key and vulnerable population & HIV positive and their affected family members, partner organizations, stakeholders and government officials participated through three separate consultation meetings. For developing the GBV strategy a range of national and international documents have been reviewed. The draft document has been shared and incorporating the feedbacks the draft final report have been submitted.

***Chapter Three***

**THE FRAMEWORK OF THE STRATEGY**

Addressing GBV and HIV are addressing the twin epidemics. This involves a two-pronged way of integrating action on gender and GBV into existing programme packages for key populations and developing ‘key population- inclusiveness’ gender program, incorporate into mainstream development activities institutional governance structure. The balance between the two prongs will depend on the local context, such as the legal status of key populations (e.g. whether mainstream GBV services are even permitted to provide services to them). Combined, these approaches can add up to increased GBV awareness, information, support and services for key populations.

**3.1 Guiding Principle**

* **Gender Equity focused:** Gender inequality place women and Hijra at higher vulnerability (e.g. disempowerment in sexual negotiation) and creates stereotypes of masculinity that marginalize sexual minorities. Gender equity will inform all components of strategy implementation. Both Targeted interventions and integrated services will be equitable for KP, Vulnerable groups, PLHIV and affected family members.
* **Inclusiveness:** Service will be inclusive for the target people irrespective of their gender identity, sexual orientation, HIV serostatus, age group (e.g. MARA), livelihood options (e.g. sex work) or any other high risk behavior (e.g. drug use).
* **Integration:** GBV related activity will be integrated into all ongoing and future projects.
* **Broad political commitment:** To reach the commitment of three Zeros “Zero New Infection, Zero Discrimination and Zero AIDS related death” 90-90-90 targets has been taken.
* **Civil society involvement:** An effective response to GBV involves dealing with sensitive issues, mobilizing hidden populations and drawing upon the social and
* cultural strengths.
* **Private sector involvement:** Since the private sector employs a large number of
* workers who are among the vulnerable groups, their active involvement will be important for any effective workplace related interventions.
* **Evidence based response:** Decisions should be based on evidence collected through surveillance and research, and in accordance with a results based framework.
* **Prevention to rehabilitation continuum:** A keystone of the response to GBV is the recognition and adoption of gender programmes that address Gender Based Violence in a holistic manner from prevention to protection, response and rehabilitation. Effective response and rehabilitation will support to GBV victims to live in the society with dignity as well as contribute to minimize HIV.
* **Partnership:** An effective response draws upon the strengths of government, nongovernment, private sector and faith based organizations and involves GBV victims, HIV positive people as well as people from key populations.
* **Coordinated support:** Harmonization of efforts across programmes and between all partners including government and non-government sectors, implementing agencies, donors and technical agencies is fundamental to maximizing the success of this strategy.

**3.2 Approach**

* **Multi-sector engagement:** Addressing both GBV and HIV is a complex issue. Its impact is felt across society involving individuals, families, sectors and institutions. It therefore goes beyond the domain of the health sector and as such an effective response must be multi-sectoral.
* **Community Empowerment approach:** For achieving sustainable result and address inequality Key Population, Vulnerable groups and PLHIV & affected family members required to be empowered.
* **Human Rights Based Approach (HRBA):**

Rights holders are at the centre of HRBA. Rights can be claimed and protected only when rights holders are organized and mobilized as a constituency, aware of their rights, and conscious of why their rights are being violated. Key population, vulnerable groups, PLHIV and affected family members will understand their rights and claims their entitlements with appropriate capacity.

* **Gender Governance Approach[[23]](#footnote-23):**

Gender equality and equal opportunity between men and women a hijra and other target population impossible without incorporating gender into the governance system. Therefore, strengthening governance as a transversal theme also implies promoting gender equality. The five principles (accountability, transparency, participation, non-discrimination, and efficiency) of governance include de facto equal opportunities for men and women, hijra and other. Developing Gender-Governance toolkit for assessing project and Gender-Governance Charter signing will be ensured by the strategy.

**3.3 Time frame:** Five years from January, 2017 to December, 2021

**3.4 GOAL:**

The overall aim is to address Gender Based Violence among Key Population, Emerging & Vulnerable Groups, PLHIV & Affected Family members and general population for effective, efficient and sustainable HIV & AIDS response in Bangladesh.

**3.5 Purpose:** The purpose of the strategy is to contribute the Revised 3rd National Strategic Plan (2011-1017) towards providing Gender transformative HIV response

**3.6 Specific objectives:**

1. To enhance information and understanding of the actual scenario on Gender Based Violence (GBV) among the population group that the Revised 3rd National Strategic Plan has identified namely Key Population (KP), HIV infected and affected population (PLHIV & family members), emerging vulnerable groups and general population.

1. To prevent all forms of Gender Based Violence (GBV) through empowering people and promoting gender equality towards minimizing the spread of HIV and minimizing the impact of AIDS on the individual, family, community and the society (access to service)

1. To develop integrated and inclusive / focused response services for GBV victims to establish human rights and dignity in family and society (cure and rehabilitation ), linking SRHR
2. To enhance institutional capacity of National Aids/Std control Program (NASP), other government agencies and partner organizations for coordinated and quality service and action through ensuring Gender Good governance, sufficient Resource allocation, strengthening inter ministerial coordination mechanism
3. To create protective and favorable and legal and policy environment through evidence base policy advocacy

**3.7. STRATEGY & MAJOR INTERVENTION**

**Objective 1: To enhance information and understanding of the actual scenario on Gender Based Violence (GBV) among the population group that the Revised 3rd National Strategic Plan has identified namely Key Population (KP), HIV infected and affected population (PLHIV & family members), emerging vulnerable groups and general population.**

For effective evidence based response the actual Gender Based Violence situation among the above mentioned population required to explore through comprehensive surveillance and research among the target population

**Strategies & Interventions:**

Strategy 1.1: Conduct comprehensive study to explore the gender segregated information to assess the existing situation on GBV among them

Strategy1.2: Conduct relevant research to the empowerment, protecting and promoting human rights and gender equity

Strategy 1.3: Develop reporting/identification mechanism on incidence of GBV among

Strategy 1.4: Develop systems for knowledge management

**Objective 2:** **To Prevent all forms of Gender Based Violence (GBV) through empowering people and promoting gender equality towards minimizing the spread of HIV and minimizing the impact of AIDS on the individual, family, community and the society.**

Effective prevention of new Gender Based Violence (GBV) incidence among the target and general population requires the empowerment of Key Population, emerging risk population and vulnerable groups and general and young people and equitable services for them. Therefore improving human capability, economic gain, enhancing community voice and enabling environment interventions needed as per the need of specific group to cover the key aspects of their empowerment and gender equality.

**Strategies & Interventions:**

***Strategy 2.1 Improving Human Capabilities of Key Population, emerging and other vulnerable group, PLHIV and family members***

Increasing access to information and services are the main component of this strategy. Access to education, information, training, access to HIV & Health care, life expectancy, nutrition, reproductive health and other services enable the target population for better health and education in a gender equitable way which will contribute to make them free from Violence. All the awareness raising and life skills development interventions are included under this strategy. Both targeted and integrated intervention will be taken. The interventions will use target group wise gender disaggregated data to plan and address their need. The major interventions are given bellow

* + 1. Comprehensive Targeted interventions and service provisions including SRH for KP to gain freedom from Gender Based violence and coercion
    2. Risk behavior reduction intervention and provision of services for emerging risk populations and vulnerable groups
    3. Intervention for increasing access to services for PLHIV and affected family members

***Strategy 2.2 Increasing Economic Gains of Key Population, Vulnerable Groups and PLHIV and affected family member***

This strategy deals with the target people’s access to or control productive assets, resources, services, skills, property, employment, income and other economic opportunities. Intervention will consider target people wise barriers in economic participation and the comparison with people of mainstream society in a gender segregated for effective planning of intervention. Major interventions are mentioned bellow

2.2.1 Expanded life choices for Female Sex Workers (FSW)

2.2.2 Employment of Hijra, Spouses of migrant, MSM

2.2.3 Financial self dependency of PWID livelihood and job replacement

2.2.4 Vocational, entrepreneurship for MARA EVA

2.3.5 Enhance access to and control over productive resource sex workers, Spouses of migrant, PLHIV and spouses

***Strategy 2.3 Enhance community voice through strengthening Self Help Group (SHG)***

Leadership development and increasing community participate in decision making among the target population for claiming their entitlements and negotiating for equitable distribution of services and protecting themselves from Gender Based Violence. Community will be able to deal with perpetrators, negotiate with laws enforcement agencies, legal aid and other service providers, running human rights movements and strengthen their unity for their own protection. This is an outcome of attitudinal shift of target population. Major interventions are

2.3.1 Develop community based protection system as a model of effective protection mechanism

2.3.2 Good governance of Self Help Groups

2.3.3. Leadership development

2.3.4 Inclusion of Human Rights movement of FSW, Female PLHIV and wives of PLHIV into mainstream Women rights movement

2.3.5 Inclusion of Human Rights movements of Hijra, MSM, PWID, PLHIV, children of FSW and PLHIV and other vulnerable group to mainstream human rights movements

***Strategy 2.4 Establishing support mechanism for young people through education, information & involvement***

Develop secured feeling from GBV among young people namely MARA, EVA & general boys and girls through providing education and information on Adolescent Sexual and Reproductive Health Rights (ASRHR), good touch bad touch, cyber crime. This will involve both boys and girls and they will understand gender diversity, women rights and potentials, Gender Based Violence and services. Major Interventions are

2.4.1 Integrating ASRHR with HIV services for MARA& EVA

2.4.2 Increase participation on education, sports and cultural activities

2.4.3 Increase knowledge base on risk behaviors and vulnerabilities and uses of technologies

***Strategy 2.5 Addressing social exclusion and marginalization by Creating Positive Social Norms through collective attitudinal shift in family and society***

Collective attitudinal changes will contribute to transform the social norms positive which will create enabling environment target people. The enhanced social understanding will reduce stigma, discrimination. Women participation as well as target people’s participation will increase in the society and the society will more responsive to address gender based violence. Both family level and societal level interventions will be required.

2.5.1 Key population and other vulnerable group and PLHIV wise family Intervention & safe shelter

2.5.2 Media campaign through social, electronic & print media

2.5.3 Civil Society engagement at all level

***Strategy 2.6: Individual attitudinal change of Partner through increasing understanding and awareness of gender norms***

This strategy requires engaging Men and the intimate partner as they are the key perpetrator of the Gender Based Violence. Following two are the major interventions

2.6.1 Men engagement (Police and other uninformed perpetrators of GBV)

2.6.2 Couple intervention (Including intimate partner)

***Strategy 2.7: Provision of GBV prevention services along with HIV and STI and SRH services at DIC and public health care settings***

GBV prevention services and information will be available along with ongoing HIV & STI services and SRH services at DIC level and public health care setting through direct and referral mechanism. The selected 24 district[[24]](#footnote-24) for HIV program response is the priority area. DIC along with Community clinic, Union and Upazilla health complex in the rural area and the health care centers of metropolitan area will be covered under this strategy. Major interventions are

2.7.1 Intervention on GBV prevention services at DIC setting

2.7.2 Intervention on GBV prevention services at rural public health care settings

2.7.3 Intervention on GBV prevention services at urban public health care settings

**Objective 3: To develop integrated, inclusive and focused response services for GBV victims to establish human rights and dignity in family and society**

For addressing the immediate need and the long term requirements of a victim of Gender Based Violence integrated, inclusive and focused response services will be provided in a non-judgment way so that the victim becomes able to tackle immediate mental shock, get physical remedy, safe shelter and justice and live a dignified life by protecting human rights in the long run.

**Strategies and Interventions:**

***Strategy 3.1: Resist against all forms of violence sexual abuse, harassment against KP, emerging and vulnerable groups, PLHIV and affected family members through community based protection system.***

The service and le available at community the information of services will be available at community level. This strategy will include stakeholders, Service providers Law-enforcement agency and the Self Help Group with the protection system. The target people will utilize the protection facilities. Major interventions

* + 1. Hotline Services(initiation and linkages )
    2. Develop Alert & response mechanism
    3. Service mapping and establish linkages with service provider
    4. Access to justice, rights to occupational health and safety protection

***Strategy 3.2: Ensuring Medico- legal support for the victims of Gender Based violence***

This strategy will gather information of all the response services and make the information available at DIC and public health care centers for a victim of GBV in both rural and urban area. Medical, trauma management and legal support will ensure the immediate response to the Victim and the long term process of getting justice. This strategy will cover immediate support to the victim of Gender Based Violence. A directory of medical, legal and social services for sex workers and other victims of GBV will be compiled and working arrangement established with service providers to accept referrals and to accept high quality services. The strategy covers the following interventions

3.2.1 Intervention on health care service including clinical care

3.2.2 Intervention on Psychological care, including trauma and tress management in accordance with the WHO clinical protocols for mental health.

* + 1. Intervention for One stop crisis service center (initiation & referral)

***Strategy 3.3: Ensuring Rehabilitation by taking long term rehabilitation program***

Under this strategy safe shelter for GBV victims during legal procedure and trial period will be ensured for GBV victim through joint initiative and corporate engagement. The will be tried to integrated with the family in the society. Provide support for reintegration with education for young victim and for other enhancing economic capacity through job employment of entrepreneurship development. The major interventions are

* + 1. Intervention for Safe shelter
    2. Intervention for Family and Social integration
    3. Education and Economic capacity development Intervention

**Objective 4: To enhance programmatic and institutional capacity of National Aids/Std control Program (NASP), other government agencies, service providers and partner organizations for coordinated and quality service and action through ensuring Gender Good governance**

This programme objective deals with the readiness and skill of institutions working with GBV in the implementation, management and coordination of the national HIV response. The ongoing National HIV Strategic Plan involves 11 types of actors and their different functions[[25]](#footnote-25). HIV has been primarily incorporated into activities in various strategies of five ministries namely Ministry of Information (MoI), Ministry of Home Affairs (MoHA), Ministry of Youth and Sports (MoYS), Ministry of Education (MoE) and Ministry of Religious Affairs (MoRA). Ma Interventions are

***Strategies and Interventions:***

***Strategy 4.1: NASP Improved institutional capacity, accountability and oversight through integrating Gender with in ongoing program and in the governance system***

Being the Nodal body of national HIV response, NASP needs the following interventions to strengthen its capacity and ensure accountability under this strategy.

4.1.1 Integration of Gender Based Violence into all the ongoing projects

4.1.2 Gender integration with the Governance system of NASP

4.1.3 Development Gender Governance Charter among NASP, other government department Partner organizations, Donor agencies, Service Providers who are involved with HIV and GBV responses mended

4.1.4 Gender Audit

***Strategy 4.2: Strengthening capacity of NASP through Gender Responsive planning and Resource allocation (Human and Financial resource****)*

This strategy requires gender responsive planning and budgetary allocation involving designated staff in line with the “Guidelines for Gender Responsive Planning”, issued by ECNEC. This strategy also covers the need of initiating Gender Unit into the existing structure. Major Interventions are

4.2.1 Initiating Gender Unit/ new position for Gender component with designation, proper job description

4.2.2 Gender Responsive Planning and Budgeting

***Strategy 4.3: Strengthening institutional Capacity through Human Resource development of NASP, Partner organizations***

This strategy will cover the skill development of the staff members of NASP

4.3.1 Training, workshop, learning visit on GBV

***Strategy 4.4: Strengthen monitoring and evaluation through integrating into National HIV monitoring system and Result based framework***

Developing Monitoring and evaluation system on GBV and integrating into result based framework, information system development are being covered under this strategy.

4.4.1 Develop monitoring & Evaluation Framework on Gender activities and incorporate into the Result Based framework

4.4.2 Create Central Information and Data HUB on Gender at NASP

4.4.3 Soft ware and Apps development

***Strategy 4.5: NASP and key government agencies developed improved and consolidated inter-ministerial coordination and action in relation to GBV.***

This strategy requires smooth functioning of different committee of involving gender knowledgeable person among the members and gender balanced members in the committee. Inter-ministerial coordination, Lobby, donor liaison, involving parliamentary standing committee on GBV/VAW are being covered under this strategy. Major interventions are

4.5.1 Inclusion of Gender Expert, gender balance among the members of mechanism and committees that HIV program deals with namely NAC, BCCM and the10 type of institutions mentioned in the strategic plan

4.5.2 Smooth functioning of different committee and ensure activating active participation of NASP

4.5.3 Activating different Lobby and government and other agencies, international agency, involving parliamentary standing committee on GBV/VAW

4.5.4 Customized available services of the GoB, like involving FSW into the Protection schemes, VAW services from Multi sectoral program of Ministry Of Women and Children Affairs (MOWCA), inclusion of target people into Women Advancement Plan 2011, National Plan of Action on VAW (2013-2027)

**Objective 5: To create protective and favorable and legal and policy environment through evidence base policy advocacy**

This objective is to ensure positive legal and policy environment. Link with Human Rights Commission to address HIV related human rights issues[[26]](#footnote-26).

**Strategies & Interventions:**

Advocacy Strategy

* 1. *Effective execution of existing laws and policies*
  2. *Review of discriminatory and punitive laws and policies,*

Reform punitive laws, policies and law enforcement practices to protect sex worker’s rights including the rights to be free of violence

* 1. *Inclusion of different policies.*
  2. *Inclusion of FSW into the National Women Development Policy and National Plan of Action for VAW, protection scheme*
  3. *Law for Third Gender*

***Chapter Four***

**WAY FORWARD**

The successful implementation of the strategy will require actions from all stakeholders and partners. Commitment and synergetic partnership between all actors and every level is necessary. This partnership needs to be premised on the bellow.

**4.1 Leadership and Commitment:** NASP will take the lead to translate the strategy into costing operational plan for proper implementation jointly with National and International partner organizations. NASP will take this strategy on priority basis as it need a multi-sectoral and involves policy advocacy and the engagement of high level policy makers, parliamentarian and senior ministerial and department officials

**4.2 Leveraging and Synergy:** To avoid duplication and effective resource management NASP will take initiative to integrate the strategy into ongoing program, inclusion with existing government and non government facilities. For targeted intervention NASP will prioritize the make investment accordingly.

*Annex-1:*

**Bibliography**

Revised 3rd National Strategic Plan for HIV & AIDS Response (2011-2017)

Estimated range : 8400-11000, NASP/UNAIDS, 2015

WAD presentation-NASP, 2016

1. World AIDS Report 2011

Global Gender Gap report, 2016

Millennium Development Goals Bangladesh Progress Report 2015

Govt. of Bangladesh. 2014. Gender Assessment of National HIV Response, National AIDS/STD Programme.

Govt. of Bangladesh. 2006.Bangladesh Adolescent Reproductive Health Strategy, Ministry of Health and Family Welfare. Retrieved from:

1. National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF

International. 2013. Bangladesh Demographic and Health Survey 2011

Govt. of Bangladesh. 2006.Bangladesh Adolescent Reproductive Health Strategy, Ministry of Health and Family Welfare

1. VAW report 2015, Govt of Bangladesh
2. USAID/PEPFAR; 2013
3. Gender Assessment HIV program 2014

IEDCR& ICDDRB National HIV Serological Surveillance, Bangladesh 2011

Icddrb, A survey of HIV, Syphilis and Risk Behaviors among MSM, MSW & Hijra

IEDCR& ICDDRB National HIV Serological Surveillance, Bangladesh 2011

1. ICDDRB, A survey of HIV, Syphilis and risk behaviors, 2014
2. Violence Against Women Survey Report 2015, BBS
3. Consultation workshop report-GBV strategy development process 2016
4. K.Katz, M. Mcdowel, M.S Green, S.Jahan Understanding the Broader Sexual and Reproductive Health Needs of Female sex workers in Dhaka

Harm Reduction Impact Assessment 2014

1. Gender Assessment of the National HIV Response in Bangladesh 2014

Gender Governance mainstreaming concept of SDC

Size Estimation 2016

National consultation on punitive laws hindering HIV response 2013

National Women Advancement policy 2011

The National plan of Action on VAW (2013--2027)

Bangladesh\_narrative\_report\_2015- Annual Progress report-GARPR-Target 7

*Annex-2:*

**Person Involved at deferent Level**

|  |  |  |
| --- | --- | --- |
| **Name** | **Designation** | **Organization** |
| Dr. Anisur Rahman | Line Director | NASP |
| Dr. Tarit Kumar Shah | AD & PM | NASP |
| Dr. Belel Hossain | AD & DPM | NASP |
| Akhtaruzzaman | Senior Manager | NASP |
| Moses Hazra | Assistant Manager-T&A | NASP |
| Shahajadi Begum | Consultant -GBV | NASP |
| Halima Begum | Project Officer | MoWCA, MSPVAW |
| Professor Israt Sharmin | President & Consultant | Center for omen & children Studies |
| Mahtabul Hakim | Coordinator-EVAW | UN Women |
| Umma Salma Ahmed | Program Associate | UN Women |
| Dr. Nadia Rahman | HR &HIV Specialist | UNFPA |
| S.M. Naheeaan | Program Consultant | UNAIDS |
| Umme Salma | Gender Advisor | Save the Children |
| Md. Omar Faruque | Deputy Director-Partnership | Save the Children |
| Salima Sultana | Manager | Save the Children |
| Farzana Majid | Gender Specialist | Icddr,b |
| Ezazul Islam Chowdhury | Sr. Program Manager | Icddr,b |
| Gorkey Gourab | Senior Program Manager | Icddr’b |
| Nurun Nahar Begum | Project Officer | Actionaid Bangladesh |
| Md. Tajul Islam | TC-Program | Care-B |
| Md. Akash | OW | Care-B |
| Jaheda | PWID |  |
| Md. Siraj | PWID |  |
| Shafia Arifin | Coordinator | SWN |
| Md. Sazzad Hossain Khan | Project Coordinator | Steps Towards Development |
| Dr. Ismat Ara Hena | Team Leader | BSWS |
| Md. Delowar Hossain | PE | BSWS |
| Sabina Begum | DIC Coordinator | YPSA |
| Modira Khanam | POW | YPSA |
| A. A. Mamun | Program Manager | OKUP |
|  |  |  |
| Md. Mizanur Rahman | Project Director | MAB |
|  |  |  |
| Jafrin Veqarun | Social Worker | BWSWA |
| Mahfuza Rahman | Consultant | Independent |
| Akhtar Jahan Shilpy | Consultant | Independent |
| Mahbuba Rahman | Consultant | Independent |
| Jarina Aktar | OW | Light house |
| Rani | OW | Light House |
| Abdur Rahim Sumon | TC-Program | Light House |
| Dr. Kulsum | Tc-QA | Light House |
| Shahida Akter | PO | Ashar Alo Society |
| MD. Abdul Quddus | SW | Ashar Alo Society |
| Mariom | Member | Ashar Alo Society |
| Sajid | Member | Ashar Alo Society |
| Sherin Aktter | Secretary | NOP+ |
| Binu | Org. Secretary | Durjoy Nari Sangha |
| Parveen | Member | DNS |
| MD. Rakib | Social Worker | DNS |
| Najmul Rony | Program Specialist | BSWS |
| Samiyul Alim | LO | BSWS |

1. Revised 3rd National Strategic Plan for HIV & AIDS Response (2011-2017) [↑](#footnote-ref-1)
2. Estimated range : 8400-11000, NASP/UNAIDS, 2015 [↑](#footnote-ref-2)
3. WAD presentation-NASP, 2016 [↑](#footnote-ref-3)
4. World AIDS Report 2011 [↑](#footnote-ref-4)
5. Global Gender Gap report, 2016 [↑](#footnote-ref-5)
6. Millennium Development Goals Bangladesh Progress Report 2015 [↑](#footnote-ref-6)
7. Govt. of Bangladesh. 2014. Gender Assessment of National HIV Response, National AIDS/STD Programme. [↑](#footnote-ref-7)
8. Govt. of Bangladesh. 2006.Bangladesh Adolescent Reproductive Health Strategy, Ministry of Health and Family Welfare. Retrieved from: [↑](#footnote-ref-8)
9. National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF

   International. 2013. Bangladesh Demographic and Health Survey 2011 [↑](#footnote-ref-9)
10. Govt. of Bangladesh. 2006.Bangladesh Adolescent Reproductive Health Strategy, Ministry of Health and Family Welfare [↑](#footnote-ref-10)
11. VAW report 2015, Govt of Bangladesh [↑](#footnote-ref-11)
12. USAID/PEPFAR; 2013 [↑](#footnote-ref-12)
13. Gender Assessment HIV program 2014 [↑](#footnote-ref-13)
14. IEDCR& ICDDRB National HIV Serological Surveillance, Bangladesh 2011 [↑](#footnote-ref-14)
15. Icddrb, A survey of HIV, Syphilis and Risk Behaviors among MSM, MSW & Hijra [↑](#footnote-ref-15)
16. IEDCR& ICDDRB National HIV Serological Surveillance, Bangladesh 2011 [↑](#footnote-ref-16)
17. ICDDRB, A survey of HIV, Syphilis and risk behaviors, 2014 [↑](#footnote-ref-17)
18. Violence Against Women Survey Report 2015, BBS [↑](#footnote-ref-18)
19. Consultation workshop report-GBV strategy development process 2016 [↑](#footnote-ref-19)
20. K.Katz, M. Mcdowel, M.S Green, S.Jahan Understanding the Broader Sexual and Reproductive Health Needs of Female sex workers in Dhaka [↑](#footnote-ref-20)
21. Harm Reduction Impact Assessment 2014 [↑](#footnote-ref-21)
22. Gender Assessment of the National HIV Response in Bangladesh 2014 [↑](#footnote-ref-22)
23. Gender Governance mainstreaming concept of SDC [↑](#footnote-ref-23)
24. Size Estimation 2016 [↑](#footnote-ref-24)
25. Revised 3rd National Strategic Plan (2011-2017) [↑](#footnote-ref-25)
26. National consultation on punitive laws hindering HIV response 2013 [↑](#footnote-ref-26)