

NATIONAL POLICY ON HIV/AIDS AND STD RELATED ISSUES

**Drafted by
a TASK FORCE
Appointed by the Director General of Health Services
In collaboration with
NATIONAL AIDS COMMITTEE, BANGLADESH AND ITS TECHNICAL
COMMITTEE
(October 1995)**

**The Final Draft
Reviewed by a CORE GROUP formed by the Director General of Health Services &
through a MULTI-SECTORAL CONSENSUS WORKSHOP sponsored by PREVENTION
AND CONTROL OF SEXUALLY TRANSMITTED DISEASES PROJECT
(October 1996)
And also finally scrutinised by the Selected Committee formed by the NATIONAL AIDS
COMMITTEE, BANGLADESH
(November 1996)**

**DIRECTORATE GENERAL OF HEALTH SERVICES
MINISTRY OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF THE PEOPLE'S REPUBLIC OF BANGLADESH**

ACRONYMS

AFIP	Armed Forces Institute of Pathology
AIDS	Acquired Immune Deficiency Syndrome
AIDSCAP	AIDS Control And Prevention
ANC	Ante-natal clinic
BAP&CP	Bangladesh AIDS Prevention & Control Programme
BFUJ	Bangladesh Federal Union of Journalist
BMA	Bangladesh Medical Association
BWHC	Bangladesh Women Health Coalition
CCDB	Christian Commission for Development in Bangladesh
CG	Core Group
CSW	Commercial Sex Worker
DGFP	Director General Family Planning
DGHS	Director General of Health Services
DGMS	Director General Medical Services, Bangladesh Armed Forces
ELISA	Enzyme Linked Immuno-Sorbent Assay
ERD	External Resource Division
FP	Family Planning
GOB	Government of Bangladesh
HIV	Human Immuno-deficiency Virus
HRD	Human Resource Development
ICDDR,B	International Centre for Diarrhoeal Diseases Research, Bangladesh
IDU	Injecting Drug User
IEC	Information, Education and Communication
IEDCR	Institute of Epidemiology and Disease Control Research
ISBT	International Society for Blood Transfusion
IVDU	Intra-venous Drug User
MCH	Maternal & Child Health
MIS	Management & Information System
MOH&FW	Ministry of Health and Family Welfare
MW	Media Wing
NAC	National AIDS Committee
NBTC	National Blood Transfusion Council
NBTS	National Blood Transfusion Services
NFP	National Focal Point
NGO	Non-government Organization
PD	Project Director
PHC	Primary Health Care
PW(H)A	People Living With (HIV) AIDS
RTI	Reproductive Tract Infections
SEI	Socio-economic Infrastructure, Planning Commission
SHAKTI	Stopping HIV AIDS with Knowledge Through Information
STD	Sexually Transmitted Diseases
TC	Technical Committee
TF	Task Force
UDHR	Universal Declaration of Human Rights
UNAIDS	United Nations AIDS
UNDP	United Nations Development Programme
UNGA	United Nations General Assembly
UNICEF	United Nations Children's Fund
USAIDS	United States Agency for International Development
VHSS	Voluntary Health Services Society
VIPP	Visualisation in Participatory Planning
WHA	World Health Assembly
WHO	World Health Organization
WW	Women Wing
YW	Youth Wing

PROLOGUE

Infection with HIV is a major human problem having myriad of sinister dimensions. In view of the pandemic that started in the early 80s, Government of the People's Republic of Bangladesh formed a National AIDS Committee way back in 1985 for prevention and control of HIV/AIDS. By now it has completed a Short Term Plan of Action, an interim Plan of Action, a report on KABP and many other activities related to prevention and control of HIV/AIDS (vide NAC publications page 22). The National AIDS Committee, therefore, considered the necessity for a National Policy on HIV/AIDS. The Director General of Health Service, accordingly, formed a 11 member "Task Force" with the Chairman of the Technical Committee as its convenor (vide Government of People's Republic of Bangladesh. Directorate General of Health Services Memo No.: DGHS/AIDS dated February 02, 1995).

Composition of the TASK FORCE

- | | | |
|-----|--|------------|
| 1. | Maj. Gen. M.R. Choudhury (Retd)
(Chairman, Technical Committee of NAC) | - Convener |
| 2. | Dr. O. Masee Bateman, ICDDR,B | - Member |
| 3. | Dr. Enamul Karim, SSO, IEDCR | - " |
| 4. | Dr. Nasir Uddin, Director VHSS | - " |
| 5. | Dr. Stefano Lazzari, MO, WHO | - " |
| 6. | Legal Adviser, DGHS | - " |
| 7. | Representative from MOH&FW | - " |
| 8. | Ms. Shahnaz Ahmed, UNDP | - " |
| 9. | Ms. Salma Masud, Lawyer | - " |
| 10. | Dr. Mustafa Kamal | - " |
| 11. | Dr. Hasan Mahmud, Project Director,
Prevention & Control of Sexually Transmitted Diseases Project | - " |

The Draft Document

The Task Force and TC/NAC met a number of times, worked hard and drafted this Document divided into three main parts:

PART I	:	POLICY STATEMENT AND FUNDAMENTAL PRINCIPLES
PART II	:	BANGLADESH AIDS/STD PREVENTION AND CONTROL PROGRAMME
PART III	:	SPECIFIC GUIDELINES

This document was placed before NAC and was discussed.

Finalisation of the Draft document

The Director General of Health Services further constituted a 19 member Core-Group (vide Government of People's Republic of Bangladesh, Directorate General of Health Services Memo no.: Sha/Addhi/pa-o-woo-/41577/1(3) dated September 15, 1996) with the task of reviewing the document through a workshop and updating it.

The composition of the CORE-GROUP

- | | | |
|----|--|----------|
| 1. | Maj. Gen. (Retd.) M.R. Choudhury | Chairman |
| 2. | Mr. M. Azizur Rahman, Jt. Secretary &
National Focal Points on AIDS
MOH&FW, Bangladesh Secretariat | Member |
| 3. | Dr. Shahdat Hussain, Director (Planning Research & MIS), DGHS | " |

4.	Prof. Md. Nazrul Islam Project Director, Bangladesh AIDS Prevention and Control Programme GOB & UNDP	Member
5.	Mr. Abdul Jabbar Deputy Secretary	"
6.	Dr. Lisa J. Messersmith UNAIDS Country Programme Advisor	"
7.	Dr. Hasan Mahmud Project Director, STD Project	"
8.	Dr. Enamul Karim Sr. Scientific Officer, IEDCR	"
9.	Mr. Ahmed Ilias Director, Al-Falah	"
10.	Dr. Jerin Haydari Project Director, PSKP & MCH Project	"
11.	Mr. Maurice Bloem Consultant, CCDB	"
12.	Dr. Md. Arif VHSS	"
13.	Dr. Saifur Rahman AIDS/STD Network Secretariat	"
14.	Dr. Md. Monsur Ali Deputy Project Director Bangladesh AIDS Prevention and Control Programme GOB & UNDP	"
15.	Dr. Najmus Sahar Sadiq Programme Officer, UNDP	"
16.	Mr. Mustafa Kamal Mojumhdar Chairman, AIDS Writers' Forum	"
17.	Dr. Julia Ahmed Deputy Director, Bangladesh Women's Health Coalition	"
18.	Dr. Swarup Sarker Coordinator, SHAKTI Project CARE, Bangladesh	"
19.	Dr. M. Anwarul Huq Mian, Medical Officer, STD Project	Member Secretary

A Multi-sectoral consensus workshop (using Visualization In Participatory Planning (VIPPP) method) in which ten stakeholder groups participated, was held 8-9 October 1996. The draft document was reviewed and necessary amendments, additions and alternations were recommended. A sub-Core-Group further reviewed the recommendations of the workshop and revised the document accordingly. The members of the stakeholder groups endorsed the final draft document (please see Appendix-A).

M.R. CHOUDHURY
MAJOR GENERAL (RETD.)
Convener, Task Force & Chairman, TC/NAC
Chairman Core-Group

ACRONYMS
PROLOGUE
EXECUTIVE SUMMARY

INTRODUCTION

PART I

POLICY STATEMENT

Fundamental Principles

PART II

BANGLADESH AIDS PREVENTION AND CONTROL PROGRAMME

Programme Objectives and Strategies

National AIDS Committee

Technical Committee of the National AIDS Committee

Youth Wing, Women Wing and Media Wing of NAC

Ministry of Health & Family Welfare –the executing body

DGHS –the Implementing

Coordination Committee

The role of NGOs and the private sector

PART III

SPECIFIC GUIDELINES

1. **HIV/AIDS Epidemiological Surveillance**
 - AIDS surveillance
 - WHO case definition for AIDS surveillance in adults
 - Expanded WHO case definition for AIDS surveillance in adult
 - HIV Surveillance
 - Sentinel HIV Surveillance
 - Confidentiality
 - Reporting to external bodies, such as WHO
2. **HIV Testing Policy**
 - Introduction
 - HIV testing policy
 - HIV Testing Sites
 - Quality Assurance of HIV Testing
 - General Guidelines for HIV Testing
 - Contact Tracing and Partner Notification
 - Requirement for HIV Testing
 - HIV Testing of Blood Donors
 - HIV Testing for Diagnostic Purposes
 - HIV Testing in Research and Surveillance
 - Voluntary HIV Testing
 - Mandatory Testing
 - HIV Testing facilities
 - Definitions
3. **Management of AIDS and HIV infection**
 - HIV and Tuberculosis
4. **Counselling of HIV/AIDS patients and confidentiality**
 - Who should be counselled?
 - Status and role of HIV/AIDS counsellors
 - Counselling guidelines
 - Ethical aspects and confidentiality

5. **National Blood Transfusion Services**
 - Code of ethics for blood donations and transfusions
 - Establishment of a National Blood Transfusion Service
 - National Blood Transfusion Service
 - National Blood Transfusion Council
 - Bangladesh Blood Transfusion Committee
 - Testing for Blood Safety
 - Status of Blood Donors
6. **HIV/AIDS and women**
 - Altering the image of women
 - Perinatal Transmission
 - Breast-feeding
 - Birth Process
7. **HIV/AIDS/STD and Men**
 - Responsibility
 - Male sexual behaviour
8. **Children and HIV/AIDS**
9. **Adolescent and HIV/AIDS**
10. **HIV/AIDS/STD in Educational Institution**
11. **HIV/AIDS and the Work-place**
 - Protection of HIV infected employees
 - Protection of health workers from HIV transmission
 - Autopsy Policy
12. **HIV/AIDS and Mobility**
 - (Non)-restriction of travel for HIV infected
 - Refugees
 - Trafficking
13. **Commercial Sex**
 - Legal status of Sex workers
 - Health interventions on Sex workers
 - Social rehabilitation of Individuals in vulnerable situations
14. **Information, Education and Communication (IEC)**
15. **Condom Promotion and Distribution**
 - Female Control Methods
 - Promotion of Condoms for HIV/AIDS/STD Control
16. **HIV/AIDS and the Media**
 - Management of HIV-infected
17. **HIV/AIDS and the Media**
18. **Policies on STDs**
19. **Drug Users and HIV/AIDS**
20. **HIV/AIDS and Minority Communities**
21. **Social Science and Behavioural Research**
22. **Clinical/Vaccine Trials for HIV/AIDS/STD**
23. **Ethical Aspect of HIV/AIDS Research**
24. **Legal Aspects of HIV/AIDS**
 - Special Issues for Consideration
 - Policy for individuals with HIV who purposefully infect others
 - HIV/AIDS and sports
 - HIV/AIDS and the family
 - The New Delhi Declaration

References:

Appendix-A

EXECUTIVE SUMMARY

The existence of HIV/AIDS/STD poses a serious challenge to human kind. To date, there is neither a vaccine nor a cure for AIDS. It is now well known that the presence of STDs predisposes the individual to HIV infection. Unfortunately, many STD cases go undiagnosed and untreated.

HIV/AIDS is a human development problem fueled by poverty, the inequality of certain sectors of society, and the presence of other STDs. As a result, the socio-cultural, economic as well as health determinants of the transmission of HIV/AIDS/STD must be addressed. In formulating a national policy for HIV/AIDS and STD related issues, the need arises to incorporate the above as policy concerns as part of an action strategy for future programmes.

A National Policy Document on HIV/AIDS and STD, under the auspices of the Bangladesh STD Prevention and Control Project, was compiled by a 'Task Force' in early 1995 with the Chairman of the Technical Committee of the National AIDS Committee as its convener. Its limitation lay in the fact that it could not delve into all the issues with purported authority. This led to the formation of a 'Core Group' drawn from all disciplines of the social health strata. The group held a 'Multi-Sectoral Consensus' Workshop using Visualization in Participatory Planning (VIPP) method on 8 & 9 October 1996 in which various stakeholder groups participated. The participants reviewed and recommended necessary amendments and additions to the National Policy Document which are reflected in this final draft.

Four Cross-cutting and priority issues were given emphasis in the document. These were human rights, gender, behaviour and information, education and communication (IEC). The modern human rights movement envisaged in the Universal Declaration of Human Rights (UDHR) offers public health a previously unavailable instrument and approach for analyzing and responding to the societal dimensions of the vulnerability to HIV/AIDS/STDs. Gender receives an increasingly important dimension as women will account for almost half of all the HIV infections by the year 2000. One cannot proceed with a HIV/AIDS/STD policy by delinking women's and men's reproductive and behavioural health issues.

Over the last few years, there has been an attempt to differentiate between 'high risk group' and 'high risk behaviour'. Focusing attention on behaviour has proven more effective, because it targets all who are vulnerable. AIDS information, education and communication is an important strategy for HIV/AIDS prevention. The use of powerful media –both electronic and print –must be augmented to present balanced, informative and well judged news. Media must shun prejudices and value judgments in line with fundamental human rights and shape educative efforts to produce its impact on behavioural changes.

The policy statement endorses the Universal Declaration of Human Rights (UDHR) as a standard for policy making and action at all levels in the response to HIV/AIDS and STDs in Bangladesh. All the fundamental principles enshrined in the text of UDHR are to be followed in pursuance of policy making.

As regards the HIV/AIDS/STD Prevention and Control Programme, certain objectives and strategies have been delineated. Among the objectives are to:

- a) prevent HIV transmission;
- b) reduce the impact of HIV/AIDS on the individual and the community;
- c) prevent transmission of STDs; and
- d) provide STD management.

Among the strategies are:

- a) prevention of sexual transmission;
- b) prevention of transmission through blood and blood products;
- c) prevention of parenteral transmission;
- d) prevention of vertical transmission from mother to child; and
- e) reduction of the impact of HIV infection on individuals, communities and the society.

To carry out these specific objectives and strategies, the national programme has been assigned to several task formulating bodies with individual membership make-up and terms of references. The committees are:

National AIDS Committee

A multi-sectoral body with a strong political commitment. It is an advisory body to the Government of Bangladesh which oversees all the aspects related to HIV/AIDS and STDs.

Technical Committee of the National AIDS Committee

The Technical Committee is a body of experts supervising technical aspects of HIV/AIDS/STD prevention and control and is the technical arm of the National AIDS Committee. In addition the Technical Committee provides technical support to the Coordination Committee.

Co-ordination Committee

This group or body performs as the link to the tripartite coalition of NAC, MOH&FW and DGHS for smooth functioning in policy formulation and implementation. It consists of coordinators of surveillance, counselling, health education, blood transfusion, sterilization, nursing, case management, laboratories, primary health care and reproductive health services.

The above mentioned groups or bodies form the backbone of the HIV/AIDS and STD Prevention and Control Programme in Bangladesh. In addition to this, NGOs and the private sector form a vast non-formal sector in collaborating, assisting and complimenting the strategies and programmes enacted by the Tripartite Coalition in connection with the AIDS/STD programme.

In sum the Bangladesh AIDS Prevention and Control Programme will be hinged on a Tripartite coalition where the NAC will be acting as the advisory body, MOH&FW as the executing body and DGSH as the implementing body.

INTRODUCTION

Humankind is face to face with the global pandemic of AIDS. The vast majority of HIV infected people live in developing countries. Asian countries are now grappling with the health and socio-economic impacts of AIDS. AIDS is one of the most complex human development problems caused by health, socio-cultural and economic factors which fuel the spread of HIV and lead to adverse impacts on individuals, communities and societies.

In view of the impending epidemic of AIDS in Bangladesh, The Government of the People's Republic of Bangladesh, on the advice of the National AIDS Committee decided to formulate a policy on HIV/AIDS and STD related issues. This document reflects the critical issues which much be addressed in a coordinated manner to prevent the spread of HIV/AIDS in Bangladesh.

In order to effectively address the problem of AIDS, policy must include the prevention, diagnosis and treatment of other sexually transmitted diseases. STDs have been found to act as cofactors in HIV transmission. Diagnosis and treatment of STDs have proven effective in preventing HIV transmission. In view of this, STD prevention and control is an integral part of AIDS prevention. Those programmes which addressed STDs and other reproductive tract infections, such as reproductive health services for men and women, contribute to the HIV/AIDS prevention efforts in Bangladesh.

Bangladesh is a multi-sectoral and continually changing society. Therefore, there is the need to tailor each HIV/AIDS/STD intervention activity to the specific context. HIV/AIDS poses special challenges in formulating a national policy. Among these are:

- a) The consequences of HIV infection are life-threatening.
- b) There is at present no vaccine or cure for AIDS, and available antiviral treatment is expensive and not readily available in a developing country like Bangladesh. However, many of the opportunistic infections are amenable to specific therapies. The challenge is to ensure the availability and accessibility of essential drugs.
- c) Persons infected with HIV typically do not become sick for years and even decades after exposure, during which time they can continue to lead useful and full lives but may, mostly unknowingly, infect others.
- d) There are relevant limitations in the tests developed to detect whether a person who has been exposed to HIV has been infected. In particular, in low prevalence countries, the tests produce many false positive results.
- e) Because most of the tests detect antibodies, there is a "window period" between the time of infection and the time of a positive test result. This makes the present HIV test an incomplete assurance that a person whose test result is negative is in fact free from infection with HIV.
- f) Due to economic constraints, screening of blood before transfusion is still inadequate in this country.

- g) As demonstrated by centuries of efforts in all parts of the world, behaviour modifications in sexual activity or drug taking cannot be achieved solely through the use of law.
- h) Personal and public reaction to AIDS throughout the world has been of considerable depth and extent. Fear of AIDS and stigmatization of different groups (homosexual men, hemophiliacs, female sex workers) have become common. Wherever those free from HIV feel threatened by those infected with HIV, especially where the latter are perceived to belong to a definite groups, there may be calls for marking out and isolating those infected. As the toll of clinical diseases rises, there will be increasing pressure on the authorities to take further action and adopt approaches that may or may not be effective or have any rational justification.

HIV/AIDS policy therefore should not only emphasize the medical and technological aspects, but also be based on social and economic considerations. In addition, human rights must be addressed in a comprehensive national policy. The four cross-cutting themes reflected throughout the document are: human rights, gender, behaviour and “information, education and communication” (IEC). These themes constitute the conceptual backbone of the National Policy on HIV/AIDS and STD related issues.

The protection of the human rights of those vulnerable to and infected by HIV has been shown to be an essential component to HIV/AIDS prevention and care worldwide. Strategies designed to bring about necessary behaviour changes needed to prevent the spread of HIV/AIDS/STD are more likely to be effective if they occur in an enabling and supportive environment. Whether such an environment can exist depends on many factors some of which are discussed in detail in the document.

HIV/AIDS/STD policy must be gender sensitive because of women’s socio-cultural and economic vulnerability. In addition, the transmission of HIV from men to women has been biologically more efficient. Further, women are more exposed to transmission through blood and blood products due to reproductive health related problems. Gender in relation to HIV/AIDS/STD refers to relationships between men and women, their sexualities and sexual behaviour. The empowerment of women and men’s sexual responsibility are essential to the success of HIV/AIDS/STD prevention programmes.

HIV/AIDS/STD information, education, and communication (IEC) is the first major strategy for HIV/AIDS/STD prevention and care. In order to change behaviour, one must have knowledge of the means of transmission and the modes of prevention. However, it should be noted that IEC alone will not change behaviour.

Behaviour plays the most important role in the transmission and prevention of HIV/AIDS/STD. Experience has shown that behaviour change can and does occur, but requires an enabling and supportive legal and social environment. Behaviour change is a process which involves changes in sexual norms and values of societies. A shift has occurred from a sole focus on “core groups” or “risk groups” to a focus on behaviour as the main target of intervention. This shift has occurred due to the fact that many individuals may engage in high risk behaviour but these same individuals may not identify themselves as members of a so-called “high risk group”. People must understand their own personal vulnerability and be made aware that they can take steps to protect themselves and their loved ones.

PART I

Policy Statement

POLICY STATEMENT

The Government of Bangladesh,

recalling the Universal Declaration of Human Rights, Fundamental rights and Fundamental principles of state policy enshrined in the Constitution of Bangladesh and subsequent International Human Rights Instruments and universally recognized principles of ethics and humanity,

recalling also the resolutions of the United Nations General Assembly 42/8, the World Health Assembly 41.24, 40.26, the London Declaration on AIDS Prevention, and other resolutions relating to the programmatic, ethical and legal issues linked to HIV/AIDS,

reaffirming Article 1 on the Universal Declaration of Human Rights that proclaims that all human beings are born free and equal in worth, dignity and rights, are endowed with reason and conscience, and should act towards one another in a spirit of solidarity,

reaffirming also that the complete development of society requires that the equal rights of women should be respected as for their legal, economic and social status and access to the resources of society, and that children, due to the needs of their physical and mental development, require legal protection in condition of freedom, dignity and security and particular care and assistance,

recognizing that the Human Immunodeficiency Virus (HIV) has now spread worldwide, crossing division of race, class, age, gender, religion and sexual orientation, causing the pandemic of Acquired Immune Deficiency Syndrome (AIDS),

recognizing also the importance of the long standing problems of Sexually Transmitted Diseases (STDs) and their potentially severe impact on the well-being of the people, and the economic and social growth of the country,

acknowledging that action is under way both at international and national levels to address HIV and AIDS, but convinced that further urgent action based on respect for human rights and the principles of ethics and humanity is required at the individual, community, national and international levels to combat the further spread of HIV, care for the sick, and address the social and economics dimensions of HIV, AIDS and STDs,

undertakes also to protect the Fundamental Rights of HIV/AIDS affected persons,

undertakes, also, to devise a National Programme to prevent and contain the spread of HIV infection as part of the Bangladesh health system, and to involve to the fullest extent possible all governmental sectors and relevant nongovernmental organizations in the planning and implementation of such programme, in conformity with the Global AIDS Strategy,

commits to pursue any possible action to prevent the spread of HIV/AIDS in Bangladesh and to reduce its impact on the individual and the communities,

ensures progressive follow-up and monitoring of implementation of the National Policy for HIV/AIDS and STD related issues,

endorses the 1949 United Nations Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Other (UN General Assembly resolution 317 (iv) 1949),

proclaims the following principles as a standard for policy making and action at all levels in the response to HIV/AIDS and STDs in Bangladesh.

Fundamental Principles

1. Respect by all government sectors, international agencies, public and private authorities, institutions, corporations, organizations, professional associations and other groups and individuals for the human rights of everyone, and the principles of ethics and humanity are essential in addressing HIV and AIDS effectively.
2. All people living with illness or disability, including people with HIV and AIDS, are entitled to enjoyment of their fundamental human rights and freedom without any unjustified restrictions. These include respect for the rights of everyone to life, liberty and security of person; freedom from inhuman or degrading treatment or punishment; equality before the law without discrimination; freedom from arbitrary interference with privacy or family life, freedom of movement; the right to seek or to enjoy in other countries asylum from persecution; the right to contract a marriage and found a family; rights to work and to a standard of living adequate for health and well-being including housing, food and clothing; the right to the highest attainable standard of physical and mental health; the right for security in case of livelihood caused by employment, sickness, disability, widowhood or old age; the right to education, the right to information which includes right to know about STD related issues and the use of condoms, the right to participate in the cultural life of the community and to share in scientific advancement and its benefit.
3. Respect for the human rights norm that no one shall be subjected to arbitrary or unlawful interference with his or her privacy requires that no personal or medical information acquired by public or private authorities or their staff should be disclosed without strict justification based on law and professional ethics.
4. Respect for human dignity and individual autonomy requires that each individual should be free to make decisions concerning his or her own life in as far as such decisions do not conflict with the rights of others, and that each individual should be protected from unjustified interference by others.
5. Medical ethics require that health professionals must treat, to the best of their ability, all persons seeking their medical attention without discrimination and without prejudice based on the origin or nature of the patient's illness or disability.

6. Human rights principles require that laws and measures introduced to protect the public should not arbitrarily deprive individuals of enjoyment of their rights and freedom. There is no justification for penalizing an individual solely on the grounds of ill-health or infection. Thus, it follows that there is no justification to restrict the rights or freedom of persons solely on the grounds that they are, or may be, infected with HIV.
7. With respect to the protection of public health, international human rights jurisprudence and public health law and practice confirm that public health measures that restrict individual rights and liberties are justifiable only to the extent that:
 - they are provided for by a specific law;
 - they are strictly required for the protection of public health,
 - they are strictly proportional to the benefit to be gained from the policy or restrictive measure,
 - they represent the least intrusive and restrictive method of achieving the desired end,
 - they are not arbitrarily directed against a particular individual, group, or section of society.

PART II

BANGLADESH AIDS PREVENTION AND CONTROL PROGRAMME

BANGLADESH AIDS PREVENTION AND CONTROL PROGRAMME

HIV/AIDS/STD can be controlled only through a combination of aggressive national programmes and a maximum of national and international collaboration. Implementation of national HIV/AIDS/STD programmes is of the highest priority, for a national programme not only attacks HIV/AIDS/STD in this country but also contributes to global control of the epidemic.

The adverse effects of HIV infection are of profound importance to the individual, the family, and society. HIV infection threatens health gains and has enormous personal, social, economic, cultural and political costs. Economic development may be seriously compromised through the impact of HIV infection on persons in the reproductive age group 20-40 years, the group most affected, and on infant and child mortality. While the long-term implications are still difficult to analyze, there is no doubt that where many people are stricken with AIDS considerable changes in social, economic, and demographic fields are likely.

It is unlikely that either a vaccine or treatment will become available in the foreseeable future to combat the pandemic of HIV infection. The progression of the infection therefore can only be prevented by educational programmes designed to promote sustained behavioural change.

A national strategy requires the development of a strong and comprehensive national AIDS/STD prevention and control programme to coordinate national and international efforts. The highest priority must be given to national programme development.

Programme Objectives and Strategies

Objectives

- (a) to prevent HIV transmission.
- (b) to reduce the impact of HIV/AIDS on the individual and the community.
- (c) to prevent transmission of STDs, and
- (d) to provide STD management.

Strategies

Prevention of sexual transmission. Sexual transmission accounts for most HIV infection. Prevention of sexual transmission requires education leading to changes in sexual behaviour that reduce as much as possible the rate of transmission. Educational approaches seek to reduce the number of partners and promote the use of condoms.

Prevention of parenteral transmission. Transmission of HIV through blood can be reduced or prevented by universal screening of blood donations and recruitment of

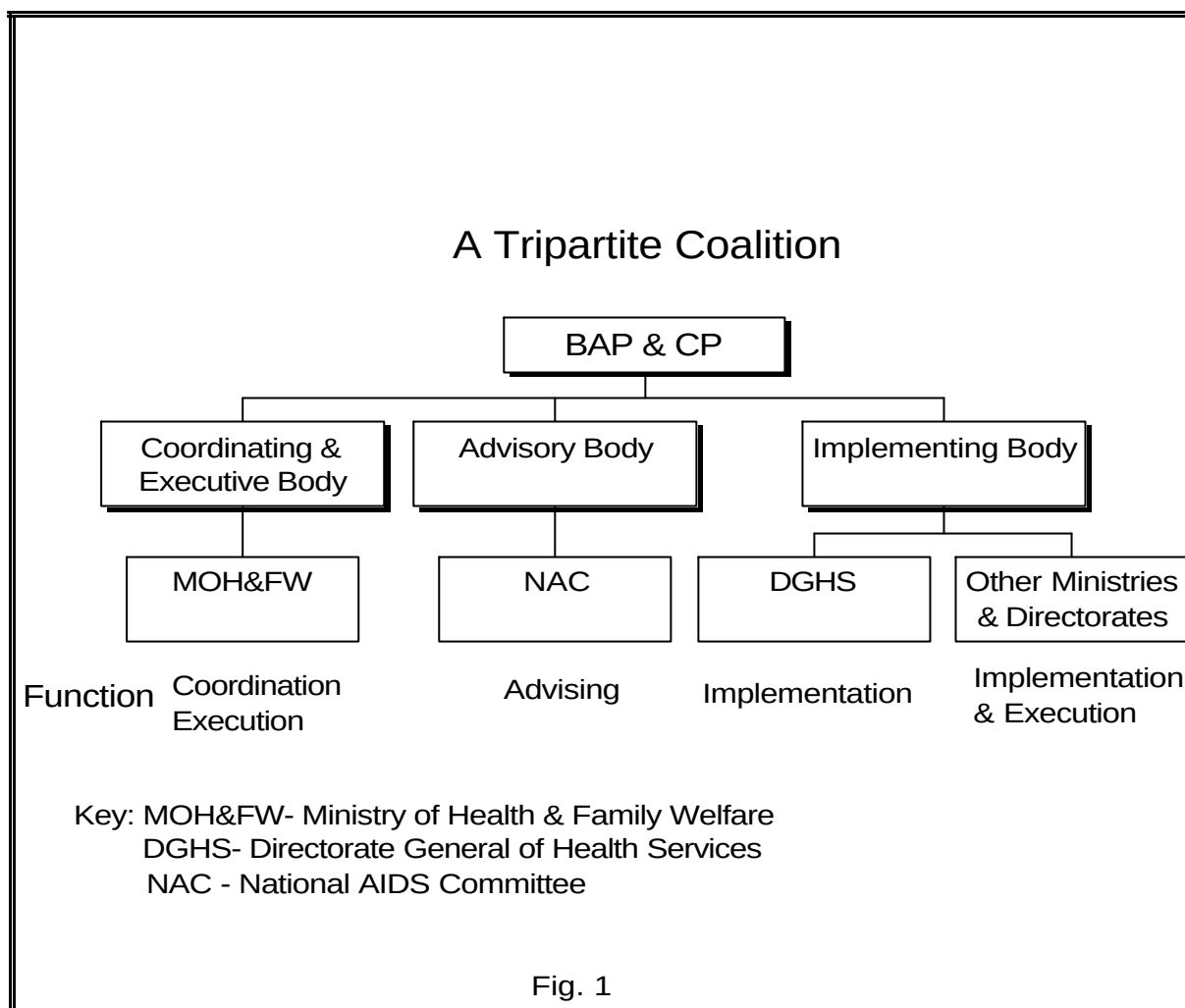
voluntary safe blood donors, use of sterile materials for injections and other skin piercing instruments, prevention of IV drug use and introduction of universal precautions in the health care setting.

Prevention of perinatal transmission. Prevention of perinatal transmission can be achieved by intensive and widespread education of the population on HIV/AIDS.

Reduction of the impact of HIV infection on individuals, groups and societies. Provision of appropriate counselling and care services is essential to address the psychological and other effects of HIV on both the infected persons, their relatives and the communities. Widespread education and the adoption of non-discriminatory policies are required to provide a supportive environment that will help those affected (whether infected or not) cope with the stress and burden of the situation.

The Tripartite Coalition.

In order to achieve the objectives through strategies as mentioned in the preceding paragraphs, the programme activities will be carried out through a so-called '**Tripartite Coalition**' among the three main functionaries i.e., National AIDS Committee (NAC), acting as an Advisory Body, Ministry of Health & Family Welfare (MOH&FW) as the coordinating and supreme Executive Body and Directorate General of Health Services (DGHS) and other ministries and directorates and agencies as the Implementing Body. The inter-relationship among these functionaries has been depicted in Fig.1.



National AIDS Committee (NAC) – the Advisory Body

NAC will be a multi-sectoral body with a strong Political Commitment. It is an Advisory body to the Government of Bangladesh on all aspects related to HIV/AIDS and STDs, including legal, ethical, managerial, financial, international, regional and technical issues.

The composition of the NAC WILL BE AS FOLLOWS:

- | | | |
|------|---|-------------|
| 1. | Hon'ble Minister
Ministry of Health & Family Welfare | Chairman |
| 2. | Hon'ble Deputy Minister
Ministry of Health & Family Welfare (if appointed) | Co-Chairman |
| 3-5. | 3 (Three) Members of the National Parliaments (MP)
Designated by the Speaker with at least one member from
opposition and one female member | Member |

6.	Secretary, Ministry of Health & Family Welfare	"
7.	Secretary, ERD, Sher-e-Bangla Nagar	"
8.	Secretary, Ministry of Information	"
9.	Secretary, Ministry of Education	"
10.	Secretary, Ministry of Finance, Finance Division	"
11.	Secretary, Ministry of Youth & Sports	"
12.	Secretary, Ministry of Civil Aviation and tourism	"
13.	Secretary, Ministry of Labour & Manpower	"
14.	Secretary, Ministry of Women Affairs	"
15.	Secretary, Ministry of Home	"
16.	Secretary, Ministry of Religious Affairs	"
17.	Secretary, Ministry of Law, Justice and Parliamentary Affairs	"
18.	Secretary, Ministry of Social Welfare	"
19.	Directorate General Medical Services, Armed Forces	"
20.	Commandant, Armed Forces Institute of Pathology (AFIP)	"
21.	Consultant Physician Bangladesh Armed Forces	"
22.	Director General Health Services	Member
23.	Director General Family Planning	"
24.	Director General, NGO Bureau	"
25.	Director General, Prime Minister's Office	"
26.	Director General, Bangladesh Television	"
27.	Director General, Bangladesh Betar	"
28.	Director General, Mass Communication	"
29.	Ex Chairmen, NAC	"
30.	President, BMDC	"

31.	Director, IPGMR	"
32.	One Eminent Medical Microbiologist	"
33.	One Eminent Medical Scientist	"
34.	One Eminent Physician	"
35.	One Eminent Gynaecologist or Surgeon	"
36.	One Eminent Transfusion Expert	"
37.	One Eminent STD Expert	"
38.	One Eminent Epidemiologist	"
39.	One Eminent Social Scientist	"
40.	One Eminent Psychologist/Psychiatrist	"
41.	One Eminent Educationist from Universities	"
42.	Divisional Chief, SEI, Planning Commission	"
43.	Chairman, BMRC	"
44.	President/Secretary General, Bangladesh Medical Association	"
45.	President, Bangladesh Private Practitioner's Association	"
46.	President, BFUJ	"
47.	President, FBCCI	Member
48.	President, Bangladesh Bar Council	"
49.	President, Mohila Parishad	"
50-54.	Chairpersons of Technical Committee & and Technical sub-Committees (Member to be adjusted according to the representation)	Members
55.	Chairperson AIDS Theme Group, UN Agencies, Bangladesh	Members
56-57.	2 (Two) Representative from NGOs (with at least one from AIDS/STD Network)	Members
58.	One Representative from the Human Right Activists	Members
59.	Focal Point HIV/AIDS (MOH&FW) –Full Time	"

*60. Project Director, STD Project "

61. Project Director, HIV/AIDS/STD "

* *It is preferable to get both the projects under one Project Director, Secretariat of NAC will be located in the project office till other facilities are made available.*

Recognizing the urgency, NAC has been constituted by the government in the absence of the Policy Document. While by and large, its composition meets the requirement, it would however need amendment in the light of his 'Policy Document'.

Terms of reference of National AIDS Committee

- i. To act as an Advisory Body to the Government of Bangladesh on all matters relating to control and prevention of HIV/AIDS & STD.
- ii. To update the National Policy on HIV/AIDS/STD related issues from time to time as required (preferably every two years),
- iii. to provide technical guidelines to the programme,
- iv. To receive and act upon recommendations from Technical Committee on matters relating to HIV/AIDS and STD and to convey those recommendations to the GOB,
- v. To liaise and coordinate with donor agencies and international organizations and thus help foster regional and international coordination and cooperation for effective implementation of programmes on HIV/AIDS and STD,
- vi. To co-opt any member as and when necessary,
- vii. To recommend legislation to ensure access to health services for HIV/AIDS infected persons.
- viii. To meet at least three times in a year,
- ix. To be reconstituted every two years,
- x. To ensure gender balance.

Technical Committee of the National AIDS Committee

The Technical Committee is the technical arm of the National AIDS Committee and is composed of several members who are experts in various fields of specialties relevant to the prevention and control of HIV/AIDS/STD. The Committee will be headed by a Chairman and assisted by a member secretary.

The Composition of the Technical Committee is as follows:

1.	An Eminent Medical Scientist	Chairman
2.	One Eminent STD Expert	Member
3.	One Eminent Epidemiologist	"
4.	One Eminent Virologist	"
5.	One Eminent Demographer	"
6.	One Eminent Transfusion expert	"
7.	One Eminent Psychologist or Psychiatrist or Counseling expert	"
8.	One Eminent Anthropologist (Medical)	"
9.	Health Economist	"
10.	One Media expert	"
11.	One Social Marketing expert	"
12.	One Clinician with expertise in AIDS management	"
13.	Director, Primary Health Care & Disease Control (PHC&DC)	"
14.	Director, Maternal Child Health (MCH,FP)	"
15.	Country Programme Advisor, UNAIDS	"
16.	National Programme Officer, WHO	"
17.	Director TB Control Programme	"
18.	One Eminent Educationist	"
19.	One Eminent Legal expert	"
20.	One Eminent Immunologist	"
21.	One Eminent Physician	"
22.	Director, Hospital, DGHS	"
23.	Chief, Bureau of Health Education	"
24.	Head Microbiology Laboratory, IPH	"

25.	Director, Nursing Services	"
26.	Focal Point IEC, MOH&FW	"
27.	One Eminent Gynecologist	"
28.	One Eminent Oncologist	"
29.	Project Director, HIV/AIDS	Member Secretary

Terms of reference of Technical Committee

- i. to assist NAC in the formulation of policy guidelines and programme frame-works for the prevention and control of HIV/AIDS/STDs,
- ii. to provide technical guidance to project directors in the design and development of the National HIV/AIDS/STDs Prevention and Control Programme and Methodology of its implementation,
- iii. to assist in setting standards of performance for HIV/AIDS related programmes/projects and in identifying measures to ensure quality assurance compliance by all participating agencies in HIV/AIDS/STDs activities in the country,
- iv. to advise in matters related to design and development of training of personnel and IEC activities in support of the HIV/AIDS/STDs related programmes and project,
- v. to draft technical guidance for reporting of the HIV/AIDS/STD case for incorporation in the overall MIS of the programmes/projects,
- vi. to assist in the development of performance indicators for HIV/AIDS/STD activities in their evaluation of various programmes and projects,
- vii. to assist NAC and Project Director in any matter pertaining to HIV/AIDS/STD related relevant programmes as and when NAC or the Project Director requests,
- viii. form Technical Sub-Committees as and when considered necessary and can coopt members,
- ix. to form a Research Review Committee that will review research protocols that will be funded by the GOB, and
- x. to 'Undertake scientific publications on HIV/AIDS/STDs related issues'.

A 'Technical sub-Committee' has been recently constituted by the Government due to urgency of the situation. Its composition largely meets the requirements but it should be designated as the 'Technical Committee' and reconstituted with appropriate TOR as mentioned in this 'Policy Document'.

Youth Wing, Women Wing and Media Wing of NAC

A Youth Wing (YW), a Women Wing (WW) and a Media Wing (MW), each will have a specific TOR may be constituted to complement the activities of NAC. NAC will be working out the composition and the TOR of each as early as possible.

Ministry of Health & Family Welfare – the Executive Body

There will be an Executive Committee (EC) in the Ministry of Health and Family Welfare (MOH&FW), with the Secretary as its Chairman. This Committee would review the recommendations of NAC, generate necessary executive orders for implementation by the Directorate General of Health Services (DGHS). The Committee will also review the progress of implementation from time to time. There will be a Focal Point (FP) preferably of the rank of a Joint Secretary in the Ministry to coordinate all the activities of the EC. GOB has already constituted an EC with proper TOR and membership.

Directorate General of Health Services – the Implementing Body

The DGHS would implement the ‘Recommendations’ of NAC under the executive instructions of EC through the project Director (PD). Action should now be taken to create a separate directorate of HIV/AIDS/STD as mentioned in the Document. The Coordination Committee (CC) also needs to be reactivated (**vide infra**).

Co-ordination Committee (CC)

Both for policy formulation and implementation purposes, the programme management depends on a well balance tripartite coalition of NAC, MOH&FW and DGHS as has been mentioned above. The CC’s prime responsibility would be to effectively maintain this balance for programme implementation. The CC is composed of coordinators of surveillance, health education (Training and IEC), blood transfusion, sterilization, nursing, case management and laboratories. A specialist from the Armed Forces is also included in the CC.

The role of NGOs and the private sector

Non-governmental Organizations (NGOs) in view of their contacts with and access to individuals and communities, their commitment and versatility, and their knowledge and experience, can make a special impact on individuals and society regarding AIDS and the needs of HIV infected people and those with AIDS.

The GOB recognizes the important role of Non-Governmental Organizations and the private sector in the fight against HIV/AIDS and STDs. The roles of Government and Non-governmental Organizations are complementary, allowing them to contribute to the national efforts in a manner commensurate with their respective qualities and potentials.

The AIDS/STD programme will have the responsibility of coordinating the activities by these sectors complement the National Programme. Mechanisms will be developed to

ensure that NGOs protocols and proposals go through sufficient and technically competent ethical and scientific review.

Representatives of NGOs and the private sector are also included in the National AIDS Committee.

PART III

SPECIFIC GUIDELINES

1. HIV/AIDS Epidemiological Surveillance

The surveillance of AIDS cases and sero-prevalence of HIV infection are critically important public health tools for both monitoring the course of the HIV epidemic and planning appropriate public health responses. The objectives of HIV/AIDS surveillance can be summarized as follows:

- detect and describe the geographic, demographic and risk factor distribution of HIV infection;
- monitor the progression of the HIV/AIDS epidemic;
- plan prevention activities and health and social services for persons with AIDS and HIV infection
- evaluate the impact of specific elements of the national AIDS programme;
- estimate the present and future impact of the epidemic;
- provide comparative data on the global and regional scope of the epidemic;
- influence decision matters and help them to set priorities.

AIDS surveillance

AIDS surveillance refers to the collection of data on diagnosed AIDS cases. However, because of the very long latency period of the disease, the incidence of AIDS provides an indirect and late description of the underlying and preceding HIV epidemic. More over, many AIDS patients may not be correctly diagnosed or some may not have contacted the health services. The data collected with the reporting of AIDS cases is therefore of limited value in understanding the current magnitude of the problem in the country or the dynamic of HIV transmission.

Nevertheless, AID surveillance at national level can provide information on the demographic and geographic characteristics of the population affected by the epidemic and on the relative importance of the various exposure risks (important for prevention. It can measure the extent of serious morbidity associated with HIV infection, providing useful information for organizing clinical management of patients with AIDS. Reporting cases also raises public awareness of the impact of the epidemic and can make international comparison of AIDS case rates possible.

Therefore, attempts should be made to report as accurately as possible the number of AIDS cases. The diagnosis of AIDS should be base on the revised WHO clinical definition that includes a positive HIV test. All health care providers should know how to diagnose a case and report to the appropriate health authority.

WHO case definition for AIDS surveillance in adults

For the purpose of AIDS surveillance, an adult or adolescent (>12 years of age) is considered to have AIDS if at least 2 of the following major signs are present in combination with at least 1 of the minor signs listed below, and if these signs are not known to be due to a condition unrelated to HIV infection.

Major signs

- weight loss 10% of body weight
- chronic diarrhoea for more than 1 month
- prolonged fever for more than 1 month (intermittent or constant)

Minor signs

- persistent cough for more than 1 month (not for TB patients)
- generalized pruritic dermatitis
- history of herpes zoster
- oropharyngeal candidiasis
- chronic progressive or disseminated herpes simplex infection
- generalized lymphadenopathy

Expanded WHO case definition for AIDS surveillance in adults

For the purpose of AIDS surveillance, an adult or adolescent (>12 years of age) is considered to have AIDS if a test for HIV antibody gives a positive result, and 1 or more of the following conditions are present:

- 10% body weight loss or cachexia, with diarrhoea or fever, or both, intermittent or constant, for at least 1 month, not known to be due to a condition unrelated to HIV infection;
- cryptococcal meningitis
- pulmonary or extra-pulmonary tuberculosis
- Kaposi's sarcoma
- neurological impairment that is sufficient to prevent independent daily activities, not known to be due to a condition unrelated to HIV infection (for example trauma, or cerebrovascular accident)
- candidiasis of the oesophagus (which may be presumptively diagnosed based on the presence of oral candidiasis accompanied by dysphagia)
- clinically diagnosed life-threatening or recurrent episodes of pneumonia, with or without etiological confirmation
- invasive cervical cancer

Definitions:

Notification: all cases must be reported to the Directorate General of Health Services (DGHS) with case details maintaining complete anonymity. Notification is binding on the private and public health sectors, employment clinics and the Armed Forces Services.

Mandatory reporting: numbers of cases must be reported but without identifying details of individual patients.

Mandatory reporting of AIDS cases will be carried out in Bangladesh. All medical practitioners and health care centres will be required to report to Institute of Epidemiology and Disease Control (IEDCR) of the DGHS, all cases of AIDS (or HIV infection) as and when they become known, using a specific form developed by IEDCR, without any identifying particulars from which the patient could be traced.

HIV Surveillance

The development of tests to detect HIV infection has made it possible to determine the prevalence of HIV infection and to monitor trends in populations. This surveillance information is of great value in designing, implementing, and monitoring public health programmes for the prevention and control of HIV infection and AIDS. However, testing of any population for HIV infection requires careful prior consideration of a variety of issues including logistic, laboratory, operational, legal, and ethical.

HIV infection should be monitored in populations for three reasons. First, the long latent period between the appearance of serological markers for HIV and the development of fully recognizable AIDS precludes waiting for case reports to assess the importance of the problem and select and adopt control measures. Second, information on current patterns of HIV prevalence and transmission is necessary for designing any programme to prevent or control the infection. Third, regular monitoring of HIV infection and transmission patterns will provide prompt and effective feedback to programme managers about the efficiency of their strategies. The surveillance of HIV infection also provides the basis for identifying high-risk population groups and geographic areas of high prevalence.

HIV surveillance should be conducted to measure and monitor the incidence, prevalence and distribution of the infection in defined population or study groups. The data collected should be used to establish baseline against which future trends can be assessed and to compare incidence and prevalence in various population or study groups.

The epidemiological objective of the public health surveillance of HIV infection is primarily to obtain information on the prevalence and incidence of the infection in selected population groups in a way that is as free as possible of participation and selection bias.

Sentinel HIV Surveillance

Sentinel HIV surveillance is the systematic cross-sectional surveying of the prevalence of HIV antibodies in selected populations that may be repeated at intervals over time. It is recommended by WHO as the principal method of data collection for detecting the presence of HIV infection and its geographic, demographic and temporal extension. However, HIV sentinel surveillance does not involve randomized selection of sites, and therefore data from different sentinel sites should generally not be aggregated. Sampling limitations and other biases in the selection of sentinel populations do not allow its use for precise estimates of the total HIV prevalence.

Populations particularly suitable for sentinel HIV sero-surveillance are persons attending antenatal and sexually transmitted diseases clinics, drug addiction treatment centers, and other groups at high risk of HIV infection who have blood drawn for other purposes.

Unlinked anonymous screening (the screening of blood specimens after the elimination of all information identifying the people from whom the blood was taken) is the preferred method of obtaining specimens as it minimizes participation bias. From an epidemiological perspective, this type of screening offers a distinct advantage for the public health surveillance of HIV infection.

To undertake unlinked anonymous screening, the following criteria must be met:

- a. Screening should not be carried out without informing the national public health authorities in advance (at least 2 weeks) regarding the procedure and method of data collection. The procedure must follow the norm mentioned in the policy guidelines. Violation of the procedure will make the organization liable for discontinuation of the programme.
- b. The specimens for screening should be taken for other legitimate purposes. To take blood primarily or solely for unlinked anonymous testing raises serious ethical concerns. The volume of blood taken should be the minimum necessary.
- c. No information besides that normally collected for these purposes should be requested.
- d. All data that could result in the identification of individuals must be removed from the specimens set aside for screening before they are tested by the laboratory.
- e. Confidential or anonymous voluntary testing with counselling should be available where appropriate to populations in which unlinked anonymous screening is being undertaken.
- f. The resources devoted to screening should be commensurate with its value for surveillance as part of a comprehensive programme for the prevention and control of HIV and STD. The screening should not detract from other important public health objectives, including the primary purpose for which the blood specimens were obtained.
- g. Health care providers taking specimens that may be sampled for unlinked anonymous testing should be aware of this potential additional use of the specimens.

Besides the information provided by AIDS surveillance and HIV sentinel surveillance, supplemental data sources should be used to fully monitor the epidemic and guide the control programme. These supplemental data could include cumulative statistics on HIV infections identified from case reports, STD and TB surveillance statistics, results of behavioural studies, prevalence in blood donors and estimations of the size of populations at increased risk. Data generated from surveillance will be regularly shared with all concerned groups in a systematic fashion. Protocol on surveillance (separately developed) lays out the mechanism of flow of information with IEDCR being the focal institute for surveillance.

Confidentiality

HIV surveillance and research may involve collection and storing data relating to individuals and groups, and such data, if disclosed to third parties, may cause harm or distress. Consequently, investigators should plan for protecting the confidentiality of data by, for example, omitting information that might lead to the identification of individual subjects, or limiting access to the data. Personal identifying information should be discarded when consolidating data for statistical analysis. When personal identifiers remain on records used for a study, investigators should explain to the review committee why this is necessary and how confidentiality will be protected.

The requirements for HIV testing for epidemiological purposes are listed in the Sentinel Surveillance protocol. HIV testing protocols for research purposes must be approved by the TC of the NAC. In reviewing the proposals, the TC of the NAC will consider the following issues:

- Balancing personal and social perspectives
- Assuring scientific soundness
- Assessment of safety and quality
- Equity in the selection of subjects
- Community participation and agreement
- Communication and use of study results
- Respect for social mores
- Relationship between religion, health and the individual rights
- Confidentiality

Reporting to external bodies, such as WHO

The MOHF&FW will inform WHO quarterly on reported AIDS cases and HIV prevalence data to allow for compilation of international statistics and comparison between countries and regions. Official HIV/AIDS surveillance data to be published on international scientific journals should be cleared by the TC of the NAC before publication.

Definitions:

Public health surveillance is the collection of information of sufficient accuracy and completeness regarding the distribution and spread of infection to be pertinent to the design, implementation or monitoring of prevention and control programmes and activities.

Unlinked anonymous screening is the testing of specimens for markers of infection after elimination (unlinking) of all personal identifying information from each specimen.

Bias: Occurrent types of bias may lead to inaccuracies in the results compared with the true situation in the community.

Selection bias occurs when those persons selected to participate in a study differ in some important way from those not selected to participate.

Participation bias occurs when in a selected group, those persons who elect to participate in a study differ in some important way from those persons who elect not to participate in the same study.

Mandatory testing or screening occurs where testing is required of all individuals who voluntarily decide they wish to avail of a service or activity. This is to be distinguished from **compulsory testing**, where both the testing and the service or activity are required.

Voluntary testing or screening occurs where participation in both the testing and the service or activity are up to the individual to decide.

2. HIV Testing Policy

Introduction

Laboratory testing for HIV became commercially available in 1985, enabling health care workers to diagnose HIV infection and individuals to know whether they were HIV infected. The availability of these tests has also led to various misconceptions regarding the role of HIV testing. These misconceptions were witnessed worldwide particularly during the early stage of the epidemic, and not unexpectedly are presently being noted in several countries in Asia. Many individuals, particularly health workers, seem to believe that the spread of HIV can be controlled by identifying people with HIV infection, and testing of hospital patients or groups of people practicing high-risk behaviours are often advocated.

HIV testing policy

HIV testing policy is aimed at all persons seeking or demanding HIV test, and all those providing HIV testing services. Because of fear, ignorance and the stigma attached to this disease, the community is divided on the issue of screening for HIV. On the one hand there are those who demand screening and on the other there are those who fear screening.

HIV testing is recommended by WHO only for selected purposes. These include:

- screening of blood, including blood products;
- epidemiological surveillance, particularly HIV sentinel surveillance using unlinked anonymous HIV testing methodology;
- diagnosis of symptomatic infection among those clinically suspected of having AIDS;
- early diagnosis of HIV infection among asymptomatic persons who would like to know their HIV status.

No situation other than the four above warrant HIV testing, and there is no place in national AIDS prevention and control programme for nominal testing without informed consent. Experience shows that any kind of HIV testing without the full and informed consent of the person concerned is counterproductive and wasteful of resources. Mandatory testing tends to drive those at high risk of HIV infection “underground”, as a result of which such persons do not have access to education and counselling programmes. Furthermore, such initiatives create a false sense of security among the public that all HIV-infected persons are known and that there is no need to take necessary precautions.

HIV Testing Sites

ELISA testing will initially be initially available in fifteen laboratories located in IPGM&R and Medical Colleges in the country. All other government hospitals will have HIV rapid testing kits for emergency screening of blood, before any blood transfusion is done. Supplementary Western Blot test will be available only in the referral laboratory.

Quality Assurance of HIV Testing

A National Quality Assurance system is required to ensure continuous delivery of accurate test results. In addition it serves as an important evaluation tool following a training programme and initiation of new techniques.

A quality control system for the identified laboratories and the selected testing methodologies will be established, with both national proficiency testing programmes and participation in the international programmes available through the World Health Organisation.

All participating laboratories carrying out HIV testing must conform to quality control standards defined as minimum by the Government. A separate guideline for internal and external quality control procedures will be produced by the DGHS.

General Guidelines for HIV Testing

- Respect for the right to physical integrity and the principles of medical ethics requires that no person be subjected to the taking of blood without his or her prior informed consent. Experience shows that mandatory screening policies, which are not based on informed consent, are likely to avoid contact with health authorities to escape identification and compulsory testing.
- HIV testing should be confidential or anonymous. Provisions should be made for persons to obtain test results who want to remain anonymous. Intentional or unintentional breaches of confidentiality destroy the trust that is essential between the testing programme staff and individuals and groups involved. This may have serious and sometimes irreversible effect on the prevention programmes.
- Unlinked (or blinded) testing, where all names and identifiers are removed from the blood specimens, is the optimal method of testing for surveillance purposes. If unlinked testing is not feasible, anonymous testing (e.g. coding) is preferred to taking names for all testing programmes, except in cohort studies, where informed consent will be required.
- No person should be notified of a test result who did not know his blood was tested or who says he/she does not want to know the results.
- Counselling services will be made available for all places where individuals are to be notified of test results. Counselling will also be confidential.
- For screening blood donations to ensure blood safety, identification and notification of results are unnecessary. For donors who want to know the results, alternate voluntary anonymous testing will be made available.
- Test confirmation is necessary before telling any patient or individual of a positive test result.
- HIV testing cannot be a requirement for marriage. Individuals are free to choose if they want to know their own HIV status and they should notify their partner, spouse or future

spouse of the test results if HIV status is positive. Counselling will play an essential role in dealing with this issue.

- Neither physicians nor anybody else are free to notify any other person other than the person tested of the test results, unless on the request of the person. Physicians should however encourage sero-positive persons to notify sexual partners in the context of adequate counselling for both persons.
- Screening for HIV infection or other STDs will not be mandatory for travelers or migrants into or out of the country. As an HIV infected person does not necessarily affect the state of health or performance of an individual, it is not by itself grounds for refusal of employment. HIV screening will not be mandatory for those seeking employment in any public or private organisation or enterprise.
- National authorities should cooperate with private insurance companies to elaborate a code of practice with a view of ensuring:
 - respect for the dignity and private life of the individual;
 - the seeking of informed consent with counselling for any form of testing;
 - protection of health-related data and any other confidential information affecting the privacy of the individual;
 - the adoption of unequivocal policies concerning HIV infection.
- Anyone who reveals the HIV status of a person or patient without his/her informed consent should be punishable according to the current law.

Contact Tracing and Partner Notification

Partner notification can be defined as the public health activities in which sexual and injection equipment-sharing partners of individuals with HIV infection are notified, counselled about their exposure, and offered services. Partner notification (contact tracing) has been an important public health strategy for many STD control programmes.

Partner notification programmes should be considered, but within the context of a comprehensive AIDS/STD prevention and control programme. However, partner notification raises serious medical, logistical, legal and ethical issues. Partner notification has potential benefits and risks, including the potential to help prevent HIV transmission and reduce the morbidity and mortality of HIV infection, but also the potential to produce individual and social harm. It should also be guided in consideration of human and legal issues.

In considering partner notification programmes, the following should be allowed for:

- a. Respect for the right of privacy requires that contact tracing, which involves inter alia the tracing of the sexual partners of a person infected with HIV, should be undertaken only when there is strong public health justification. The observance of the principle of beneficence requires that the potential benefit of contact tracing be weighted against the potential harms. Respect for the right to privacy and medical ethics precludes any unjustified disclosure of the identity of the people concerned in any contact tracing

programme. Always, contact tracing must be carried out with sensitivity and respect for human integrity.

- b. Respect for the principle of medical confidentiality requires that personal or medical information acquired by a health professional should not be disclosed to a third party without the consent of the patient concerned unless this is strictly necessary for the protection of the health of the third party. Disclosure may be justified when an infected person refuses to take the precautions necessary to protect his or her sexual partner and consistently refuses to inform the partner of the risk of infection.

Requirement for HIV Testing

HIV testing may be required in:

- 1) BLOOD DONORS SCREENING
- 2) DIAGNOSTIC PURPOSES - ADULTS
- CHILDREN
- 3) RESEARCH AND SURVEILLANCE
- 4) VOLUNTARY TESTING
- 5) MANDATORY TESTING

HIV Testing of Blood Donors

WHO CAN ORDER THE TEST?

All blood donated for purposes of transfusion must be screened for the presence or absence of HIV antibodies, hepatitis B, Malaria and Syphilis. This is a routine laboratory procedure and requires no additional authorization.

WHAT TESTS ARE REQUIRED?

- a) One positive screening test (ELISA or Rapid Test) is sufficient to decide to discard the unit of suspected unit of blood.
- b) If the results are to be disclosed to the donor, then the procedure for voluntary testing will apply.

WHAT COUNSELLING REQUIREMENTS NEED TO BE FULFILLED?

- If the donor is to be informed, consent and pretest counselling must be carried out, to prepare the blood donor for better understanding and the interpretation of results.
- Post-test counselling must be available at the time that results are given.
- Follow-up counselling must be given to provide the needed support.

WHO HAS THE RIGHT TO KNOW THE RESULTS?

- a) The blood donor has the right to know the results.
- b) The Blood Transfusion Service should be informed, to avoid repeated donations of infected blood.
- c) The counsellor responsible for post-test counselling and follow-up of the blood donor.
- d) It is the right of the blood donor to decide who else to inform about the results. On-going counselling is recommended in these situations to help the person reach a decision.

HIV Testing for Diagnostic Purposes

The clinical diagnosis of AIDS needs to be supported by a laboratory test. In children, the interpretation of the results may be more difficult because maternal antibodies may persist up to 15-18 months of age. Also some children may be HIV negative although they are actually infected. Therefore, HIV testing in patient care situation is divided into testing in adults and testing in children.

ADULTS

WHO CAN ORDER THE TEST?

The test can be ordered by the medical officer responsible for the care of the patient.

WHAT TESTS ARE REQUIRED?

- a) Two positive screening tests (ELISA and Rapid Test) run on different kits are sufficient to confirm the HIV status of persons symptomatic for AIDS/STD.
- b) If the results of the two ELISA kits differ, Western Blot supplementary testing is indicated.
- c) Two negative ELISAs do not rule out the infection. This is true in situations where clinical findings are not consistent with the laboratory results. In this situation reexamination of the patient is required, followed by repeat testing if still needed.

WHAT COUNSELLING REQUIREMENTS NEED TO BE FULFILLED?

- Informed consent and pretest counselling must be carried out, to prepare the patient for better understanding and the interpretation of results.
- Post-test counselling must be available at the time that results are given.
- Follow-up counseling must be given to provide the needed support.

WHO HAS THE RIGHT TO KNOW THE RESULTS?

- a) The patient has the right to know the results.
- b) The health care workers with direct responsibility for the care of the patient have a right to know the results. Only those who are directly responsible for the diagnosis and treatment of the patient should have access to his/her records to safeguard confidentiality. Re-training of staff in the ethics and procedures of confidentiality may be required.
- c) The counsellor responsible for post-test counselling and follow-up of the patient.
- d) It is the right of the patient to decide who else to inform about the results. On-going counselling is recommended in these situations to help the person reach a decision.

CHILDREN

It is recommended that wherever possible mother and child should be tested together. This will make subsequent explanation of results easier.

WHO CAN ORDER THE TEST?

The test can be ordered by the Medical Officer responsible for the care of the child.

WHAT TESTS ARE REQUIRED?

- a) **In children below 18 months of age:** the presence of HIV antibodies is inconclusive as the child may be having maternal antibodies without he/she being infected. The only conclusive tests are those detecting the antigen in the blood. If both mother and child are found positive on both tests of ELISA from different kits, this only confirms the HIV status of the mother. This positive result should not be used to bias the clinical management of the child.
- b) **In children over 18 months of age:**
 - i) Two positive screening tests (ELISA and Rapid Test) run on different kits are sufficient to confirm the HIV status.
 - ii) If the results of the two ELISA kits differ, Western Blot supplementary testing is indicated
 - iii) Two negative ELISAs do not rule out the infection. This is true in situations where clinical findings are not consistent with the laboratory results. In this situation re-examination of the patient is required, followed by repeat testing if still needed.

WHAT COUNSELLING REQUIREMENTS NEED TO BE FULFILLED?

- Informed consent and pre-test counselling of the mother or principal guardian of the child must be carried out to prepare them for better understanding and the interpretation of results.
- Post-test counselling must be available at the time that results are given.
- Follow-up counselling must be given to provide the needed support.

WHO HAS THE RIGHT TO KNOW THE RESULTS?

- a) The mother or the principal guardian of the child has the right to know the results.
- b) The health workers directly involved in the care of the child also have the right to know the results.
- c) The counsellor responsible for counselling and follow-up of the mother.
- d) It is the right of the mother to decide who else to inform about the results, including giving permission for the result to be revealed to the father.

HIV Testing in Research and Surveillance

Sero-surveys help clarify the epidemiological pattern of HIV, which is useful to assess the areas and groups that need specific educational programmes or other preventive services. These surveys can be conducted using methods that do not threaten human rights. Such surveys can either involve informed consent and counselling and ensure confidentiality or they may be anonymous (no record of name or other specific identifiers).

All research protocols or proposals involving HIV testing for subjects or patients must conform with these guidelines, the International guidelines on Ethics and Research and be approved by the MOH&FW, on advice of the TC NAC.

Voluntary HIV Testing

WHO CAN ORDER THE TEST?

The test can be ordered by the medical officer approached by the person interested in being tested.

WHAT TESTS ARE REQUIRED?

- a) Three positive screening tests (ELISA, simple or Rapid Tests) run on different kits are sufficient to confirm the HIV status of persons. Alternately, positive result by ELISA (simple or rapid) followed by Western Blot should be considered confirmatory.

- b) If the results of the two ELISA kits differ, Western Blot supplementary testing is indicated.

WHAT COUNSELLING REQUIREMENTS NEED TO BE FULFILLED?

- a) If the test is required by the person to be tested;
 - Informed written consent and pre-test counselling must be carried out, to prepare the person for better understanding and the interpretation of results.
 - Post-test-counselling must be available at the time that results are given.
 - Follow-up counselling must be given to provide the needed support.
- b) If the test is required because of the third party (i.e. Educational institution, scholarships etc.) test results will be given only to the tested individual, who will decide whether to inform or not the third party.

WHO HAS THE RIGHT TO KNOW THE RESULTS?

- a) The person requesting the testing has the right to know the results.
- b) The counsellor responsible for post-test counselling and follow-up of the patient.
- c) It is the right of the patient to decide who else to inform about the results. On-going counselling is recommended in these situations to help the person reach a decision.

Mandatory Testing

This is the test demanded by the third party using undue coercion. This type of testing is not ethically acceptable without consent by the person to be tested. Mandatory testing and other testing without informed consent have no place in an AIDS/STD prevention and control programme. The Forty-fifth World Health Assembly noted that:

There is no public health rationale for any measures that limit the rights of the individual, notably measures establishing mandatory screening (Resolution 45.35. 14 May 1992)

HIV testing should not be included as part of a normal medical examination without the knowledge and consent of the person undergoing medical examination. Once consent has been obtained the procedure to follow is the same as in voluntary testing.

HIV Testing facilities:

HIV testing facilitates: While HIV testing for transfusion safety will be extended to all transfusion centers, voluntary confidential testing with pre –and post-test counseling will be an integral part of primary health care. Mechanisms will be developed to send samples from Thana health complexes to testing centres at district/referral laboratories and to receive the result.

Definitions

Client: The person seeking or receiving HIV counselling and/or testing. In the case of a child or other person unable to consent to testing on his/her behalf, the client is the parent or other adult with the ethical and legal competence to do so.

Counselling: A confidential dialogue between a client and a care provider aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS. The counselling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behaviour.

Pre-test Counselling is carried out before blood is drawn. It explains the test, looks at the implications of whether to be tested or not. The person always has the right to refuse the test or postpone it to later date.

Post-Test Counselling is carried out at the time that the person receives the results. Counselling is essential whether results are positive or not. It helps the person in dealing with the results and implications of it.

Testing: is the application of an HIV test to determine if an individual is positive or negative for HIV antibody. For example, a person may wish to find out whether he/she is infected with HIV, or a physician may order an HIV test for a patient to determine whether an illness is related or due to HIV infection.

Screening: is the systematic application of HIV testing to a population of apparently healthy people to detect the number of people (or blood samples) infected with HIV. For example, a group of women attending an antenatal clinic may be screened to detect how many are or are not infected with HIV. The primary aim is not to diagnose HIV infection in a specific person. Screening may also be done to protect the blood supply or evaluate control efforts.

Surveillance: is the collection of information of sufficient accuracy and completeness regarding the distribution and spread of infection to be pertinent to the design, implementation or monitoring of prevention and control programmes and activities. The purpose of surveillance is to detect changes in the prevalence of HIV infection.

Testing with informed consent: HIV testing performed only after the client has given informed consent to it. Informed means that he/she has been made aware of all the ramifications of HIV testing, including risks, benefits and alternatives to such testing, in language he/she can understand. Consent means the giving of express agreement to HIV testing in a situation devoid of coercion, in which the client is equally free to grant or withhold consent.

Testing without informed consent: HIV testing in which informed consent has not been requested or given.

Mandatory testing or screening occurs where testing is required of all individuals who voluntarily decide they wish to avail of a service or activity, as when HIV testing is required before employment or marriage.

Compulsory testing, HIV testing without informed consent that the individual is compelled to undergo. A situation in which the individual clearly has no alternative, as when prisoners are tested involuntarily.

Anonymous testing: HIV testing in which the blood sample and test results are identified only by code, not by name, with no personal identifiers to link the sample to the donor source.

Linked anonymous testing: HIV testing in which the code is known only to the client.

Unlinked anonymous testing: HIV testing (e.g.: for surveillance purposes) after prior removal of all personal identifiers, so that retrospective identification is impossible.

Confidential testing: HIV testing in which only the client and the health professionals involved in the client's direct care know that the test was performed and have access to the test results. This information is not furnished under any circumstances to other health care providers, health authorities, employers, insurers, schools or other third parties without the patient's explicit consent.

Voluntary testing: Anonymous or confidential testing initiated by either the client or his/her health care provider and performed with the client's informed consent.

3. Management of AIDS and HIV infection

AIDS is a uniformly fatal syndrome of opportunistic diseases resulting from immunodeficiency. Currently, there are effective therapies for several of those opportunistic diseases, but there is no effective therapy for the underlying immunodeficiency. The goal of management of AIDS and HIV infection is to provide optimally human and supportive care for the patient and his relatives. This care must preserve confidentiality, avoid discrimination and allow patients, as much as possible, to live normal, productive lives.

- All health-care workers will receive specific training in the epidemiology and management of AIDS and HIV infection. The goal of this training will be to eliminate unreasonable fear among health-care workers and establish them as effective counsellors and sources of accurate information about AIDS, to optimize diagnosis and patient management, to ensure confidentiality, and to protect health-care workers from transmission.
- AIDS patients will be treated within the existing health care system. No health care institution or health-care worker has the right to refuse to provide treatment to AIDS patients or those with HIV infection. Isolation of AIDS patients is not necessary, unless they present with usually indications for isolation.
- In consultation with experts and the Technical Committee, the MOH&FW will prepare HIV/AIDS clinical management guidelines and a set of standard therapeutic regimens for AIDS and its underlying opportunistic diseases.
- The GOB will encourage the development of community-based supportive services for AIDS patients. These services will coordinate with the patient's health-care providers and make effective use of resources such as the patient's family, the teachers, social workers, religious institutions and humanitarian organizations.
- AIDS patients and HIV positive persons have the basic right to treatment and care as any other patient. Persons receiving advice, counselling and treatment for AID will be assured of the same rights to privacy and confidentiality as persons receiving treatment for any other disease.

According to the American College of Physicians and the Infectious Diseases Society of America, physicians, other health care professionals, and hospitals are obligated to provide competent and humane care to all patients, including HIV infected patients. The denial of appropriate care to a class of patients for any reason is unethical.

- Health-care workers will be provided with the basic equipment to ensure safety in the health-care setting. Care will be taken to ensure that all health-care workers have adequate training in the universal precautions to prevent occupational transmission of HIV, procedures for sterilization, and safe disposal of contaminated materials.
- All Government and Private Medical establishment must always use disposable or sterilized syringes and must ensure that the disposable syringes are immediately destroyed after use.

- Testing of patients before or during their stay in hospital (including surgical patients) solely for the benefit of health-workers safety is not admissible. HIV testing has been recognized as an expensive and ineffective method of reducing the risk of infection through sharp accidents. Strict rules of hygiene and observance of the Universal Precautions with all patients are recommended.
- All Government & Private Medical establishment must always use disposable or sterilized syringes and must ensure that the disposable syringes are immediately destroyed after use .

The role of the private health sector

Medical care and assistance provided to HIV/AIDS patients in private institutions should be subject to the same regulations and considerations considered valid for the public sector. In particular, private institutions must preserve confidentiality, avoid discrimination and allow patients to live normal and productive lives.

HIV and Tuberculosis:

HIV is a chronic infection and associated with various infections and malignancies. The median incubation period to develop AIDS from acquiring HIV is 8 years. The HIV epidemic will be followed by satellite epidemics in the population representing diseases associated with HIV. The presentation of the epidemic will vary from country to country depending on the endemicity of the prevailing diseases. The commonest epidemic anticipated is Tuberculosis in Bangladesh or South East Asia as the prevalence of Tuberculosis infection is very high in this region. Once the epidemic of TB sets in (possibly 6-8 years after the epidemic of HIV among the general population) TB would spread even by non sexual route to family members and contacts of HIV positive persons. It is estimated that there would be at least 6-18 times increase in the prevalence of Tuberculosis. Tuberculosis in HIV positive patient is often extra pulmonary or associated with atypical mycobacteria. Resistance to usual drugs will also emerge leading to further transmission of multi drug resistant Tuberculosis. As TB is considered an AIDS defining illness for persons with HIV infection the majority of AIDS patients are likely to die from Tuberculosis. Due to lack of acquaintance with HIV associated illness and lack of effective strategy of any prophylaxis, many AIDS patients would only be diagnosed for Tuberculosis. Strengthening of the TB control programme, training of physician, effective and proper management of TB with or without HIV, diagnostic facilities for TB, setting up laboratories for culture facilities and ensuring the supply of drugs at affordable price would be necessary.

4. Counselling of HIV/AIDS Patients and Confidentiality

Counselling is face-to-face communication in which one person helps another make decisions and act on them. The process of counselling includes providing information that allows individuals to make decisions that reduce the risk of transmitting the infection. In a wider context, this may involve the spouse, family, friends and others who take care of the HIV-infected person, and include support for persons with HIV infection or who see themselves as being at risk of HIV infection.

Counselling is a process that can help people understand better and deal with the problems, and communicate better with whom they are emotionally involved. It can improve and reinforce motivation to change behaviour. Counselling help people learn and deal with fear and anxiety. It can provide support at times of crisis. It helps them face up their problems and reduce or solve them.

Counselling may help people solve problems arising out of HIV infection in themselves, their families, or others to whom they are close. It is a means of ensuring that information on AIDS is correct and consistent, and of assessing lifestyles, personal expectations, and willingness and capacity to change behaviour.

Counselling can be used to make sure that individuals being considered for testing for HIV infection are well informed and appreciate the technical, social ethical and legal implications of testing.

Counselling as a service should ensure continuing access to the counsellor and consistent support from the health and social system. It must ensure adequate time for discussion and problem-solving. Ensuring time for discussion has an important symbolic value: it signifies society's willingness to provide support and care.

Counselling as a process respects the individual regardless of sexual preferences, socio-economic background, state of health, religions and ethnic origins.

Counselling is a means of helping people avoid discrimination against HIV-infected persons and of ensuring their continued integration in society.

In the context of the HIV/AIDS epidemic, the goals of counselling are:

- To support the ability of infected persons and those who care for them to cope with the stresses of HIV/AIDS/STD
- To prevent the transmission of HIV to others.

HIV/AIDS counselling should complement other preventive and support activities; it should be seen as a part of routine health care activities and integrated into the standard care programme.

Who should be counselled?

Counselling may be required in the following situations:

- Individuals considering being tested or screened for HIV infection need to be carefully prepared and supported. They need to know the facts about testing and its implications. Their decisions should be founded on correct information.
- Counselling is vital when a test shows HIV infection. It helps deal with the resultant fear and anxiety and often hostile attitudes on the part of both the patient and the patient's family, friends and other loved ones.
- HIV-infected but otherwise healthy persons may experience more stress than those who already have AIDS. They will often need special care and support. Counselling is needed as an integral part of the management of stress and for motivating them towards positive behaviour change.
- As HIV-related diseases develop, medical needs must be met quickly and efficiently. A function of a counselling service will be to mobilize support and refer patients to medical care and other services that can help maintain hope, dignity and quality of life.
- AIDS and other HIV-related diseases can result in unemployment, loss of educational possibilities, and other social disabilities. Counselling can help to reduce such effects. It can help to mobilize the continuing medical and psychosocial support that patients and those who are caring for them need.
- Sometimes a person may be infected but cannot or will not be tested. People with risk behaviours, such as intravenous drug users and sex workers, need to be counselled and helped to behave in ways that will reduce their risk of contracting HIV infection or passing it on to others.
- Counselling is also useful for those who are tested and found not to be infected. They too need to be advised about what they should do to avoid HIV infection.
- Health workers, family, friends, all who come into regular social or professional contact with HIV infected persons and AIDS patients, can benefit from counselling and the support it provides.

Status and role of HIV/AIDS counsellors

Who can give counselling? Anyone who works with patients and families can provide counselling. Counselling is an important aspect of the work of many professionals in the field of health, social work, and teaching, to name a few. All these professionals, while providing technical information and services, give guidance and support to clients who may be experiencing stressful situations and often need to change their behaviours. These professionals use basic counselling skills to help clients make personal decisions about their behaviour. All health workers have the opportunity and responsibility to provide psychosocial support of this kind almost every time they talk to clients.

Physicians are in a unique position to provide psychological support as basic counselling because they have already established a relationship with the patient and are usually trusted. In addition, being part of the community, they are aware of cultural related beliefs, practices and values.

A counsellor should be able:

- to communicate information about HIV infection and AIDS in an accurate, consistent and objective manner;
- to gain the trust of people who need help with their psychological and social difficulties;
- to listen sympathetically to people who are afraid, anxious, distressed, and possibly hostile;
- to understand other persons' feelings, to accept these feelings and their expression without criticism or censure, and to respond to them in such a way that the other persons can feel free to express their feelings;
- to help HIV-infected people understand their problems and those of the other people in their lives who are affected;
- to help people reduce or solve their problems.

Counselling guidelines

Counselling is a vital part of all strategies for preventing and controlling AIDS. It not only helps those who are already infected adapt to their problem, but also helps prevent the further spread of HIV infection.

Counselling needs to be integrated with all HIV testing, screening and medical care programmes. Counselling has to be recognized as an integral part of all health care programmes and activities for HIV control and prevention.

Many people need to be trained in the skills of counselling. New training programmes should be instituted. Existing programmes in counselling will need to include training in HIV infection and AIDS.

Counselling services should be readily available and accessible.

Ethical aspects and confidentiality

Anyone who counsels should care about people. Trust and confidentiality are cornerstones of counselling. Many of the things discussed are sensitive and personal. If the information is not kept confidential, trust may be lost and the counsellor may no longer be a source of positive support and change, but of harm.

5. National Blood Transfusion Services

A safe, effective blood transfusion service is an essential infrastructure to the provision of adequate health services. The Government of Bangladesh is committed to ensure that all patients have access to enough appropriate safe blood and blood products whenever needed. The Government is responsible for the establishment of a nationally controlled and coordinated blood transfusion service and to maintain self sufficiency for blood and blood products.

The Government of Bangladesh endorses the Code of Ethics for Blood donations and Transfusion approved by the ISBT and WHO (1980).

Code of ethics for blood donations and transfusions

- Blood donation shall, in all circumstances, be voluntary. No pressure of any kind must be brought to bear upon the donor. The donor shall be advised of the risks connected with the procedure. The donor's health and safety must be a constant concern.
- Financial profit must never be a motive either for the donor or for those responsible for collecting the donation. Voluntary non-remunerated donors should always be encouraged.
- Blood donation must not entail discrimination of any kind, either of race, nationality or religion.
- Blood must be collected under the responsibility of a physician.
- The frequency of donations and the total volume of the blood collected according to the sex and weight of the individual, as well as the upper and lower age limits for blood donations, should be defined by regulations.
- Suitable testing of each donor and blood donation must be performed in an attempt to detect any abnormalities that would make the donation dangerous for the donor or that for the recipient the most efficient therapy compatible with maximum safety.
- Maximum donation not more than three times a year, normally twice a year. (Vide Govt. memo ME-1/4M-5/76/517 dated 5-6-19765 Criteria for collection of blood from blood donors).
- Before any transfusion of blood or blood products, a written request signed by a physician must be made, which specifies the identity of the recipient and the nature and quantity of the substance to be administered.
- Except for the emergency use of type O blood(whole blood) after performing haemolysing test on red blood cells, every red cell or plasma transfusion requires preliminary blood grouping tests on the recipient, and compatibility test between the donor and the recipient.

- Blood and blood products must not be given unless there is a genuine therapeutic need. There must be no financial motivation on the part either of the prescriber or of the establishment where the patient is treated.
- Appropriate controls should be required by the Health Authorities to verify that blood transfusion practices meet internationally accepted standards and that the guidelines or regulations issued following this policy are effectively respected. The actual transfusion must be given under the responsibility of a physician.
- Before administration, one must verify that blood and blood products are correctly identified and that the expiry date has not been passed. The recipient's identity must be verified. As far as possible the patient should receive only that particular component (cells, plasma or plasma derivatives) that is needed.

Establishment of a National Blood Transfusion Service

A National Blood Transfusion Service should be established in Bangladesh. The Service will aim at extending blood transfusion to all rural health complexes, control the methods used in all blood transfusion centres in the country to ensure uniform high standards and will supervise the administrative, scientific and professional aspects of their activities.

The National Blood Transfusion Service will ensure the non-commercialisation of blood and its derivatives and encourage voluntary blood donation.

The Government of Bangladesh will subsidize the provision of blood for transfusion to ensure equity of access. At a later time, the government should consider prohibiting the sale of blood and other human tissues,

A National Reference Centre will be established for calibrating and standardizing equipment, reagents, training and for working as a reference centre.

The goal of the National Blood Transfusion Service is to provide effective blood and blood products, which are as safe as possible, accessible at reasonable cost, and adequate to meet patients' needs.

Specific objectives of National Blood Transfusion Service are:

- to establish and maintain a voluntary non-remunerated donor panel to provide sufficient blood to enable the transfusion service to meet its requirements;
- to establish and maintain a network of donor recruitment, selection, and blood collection stations to collect blood from selected donors;

- to establish and maintain appropriate blood testing and component preparation laboratories and centralized blood storage and distribution systems to provide hospitals with safe effective products in sufficient quantity to meet the needs of all patients who require them;
- to establish standards for blood and blood products for Bangladesh and to establish a quality assurance programme to ensure the predictability and safety of the products;
- to administer any funds received for these purposes and to report annually to the Committee and Council on its utilisation as per bylaws framed by the Government on 23-1-95 vide memo No. HOS/2/special /48/94/38, for operation of blood transfusion services and maintenance of funds; and
- to advise the Committee and Council on legislative protection required ensuring the conduct of its duties.

National Blood Transfusion Service

The Government should establish an executive board for blood transfusion service in Bangladesh. The Board should be given full responsibility for operating the Bangladesh National Blood Transfusion Service. The Board should appoint a suitable Chief Executive with authority and responsibility to carry out the policy of the Board. The Board should report regularly to the Minister for Health and Family Welfare or his delegates regarding the activities of the Service together with annual audited financial statements. The Government should require that all the Blood Banks will be regularly audited by the appropriate authority and that blood should be supplied from licensed premises.

National Blood Transfusion Council

The Bangladesh National Council of Blood Transfusion was constituted by the Government of Bangladesh on 5 May 1992, vide memo No. HOS-2/Trans-1/91/167. this should be reconstituted as under:

- The Chair to be appointed by the Minister for Health and Family Welfare
- Representatives of:
 - o Bangladesh Red Crescent Society
 - o Blood Transfusion Expert from each Medical College Hospital,
 - o IPGR& R and other Postgraduate Institutions.
 - o Bangladesh Medical Association
 - o Bangladesh National AIDS Committee
 - o Commandant AFIP
 - o Bangladesh Mahila Society
 - o Bangladesh Boy Scouts
 - o Girl Guides Association
 - o Bangladesh Rotary Club
 - o Bangladesh Lions Club

- o Bangladesh Sangbad Sangstha(BSS)
- o Shandani ,Central Committee

This policy document recommends a representative of Bangladesh Bar Council and at least one eminent human right lawyer in the above council. The head of Blood Transfusion (Transfusion Medicine) of PIPGR&R will act as Member Secretary.

The Terms of Reference of the Council are:

- i) To advise on donor recruitment;
- ii) To advise on donor safety;
- iii) To represent the users of blood transfusion as hospitals, doctors and patients; and
- iv) To act as a forum for the community to represent its views to the Bangladesh National Blood Transfusion Service.

Bangladesh Blood Transfusion Committee

The Bangladesh Blood Transfusion Committee was constituted on 5 May 1992 vide memo No. HOS-2/Transf-1/91/168 for operation of the Bangladesh Blood Transfusion Service known as “The Blood Transfusion Committee”. The Committee should be reconstituted as follows:

- The Chair to be appointed by the Minister for Health and Family Welfare
- Representatives of :
 - o Blood Transfusion Society of Bangladesh
 - o Directorate General of Health Services
 - o AIDS/STD and Blood Transfusion Directorate
 - o Bangladesh Medical Association
 - o Bangladesh Society of Surgeons
 - o Bangladesh Society of Physicians
 - o Bangladesh Society of Pathologists
 - o Bangladesh Society of Haematologists
 - o Bangladesh Society of Obstetrics and Gynaecologists
 - o Bangladesh Society of Anaesthesiologists
 - o Institute of Public Health
 - o Bangladesh Society of Immunology
 - o Consultant Surgeon Bangladesh Armed Forces
 - o Blood Transfusion Expert Bangladesh Armed Forces

The Terms of Reference of the Committee will be:

- i) To advise the Board of the National Blood Transfusion Service on matters relating to safety of blood supply;
- ii) To advise on the introduction of donor selection criteria; and
- iii) To advise on the introduction of tests for blood for transfusion.

Testing for Blood Safety

Screening facilities for HIV(both 1 and 2) HBV, Syphilis and malaria should be provided to all transfusion centres. All the imported blood and blood products should undergo screening at the reference laboratories.

Enough equipment, reagents and disposable materials such as plastic blood bags, syringes and needles, and gloves should be provided for safe blood transfusion at each Blood Transfusion Centre and their usage is mandatory. Safety measures should be strictly followed in disposing of the used equipment and materials.

The National Executive Board should obtain educational materials on HIV/AIDS and STDs targeted at blood donors. At least one staff of each blood transfusion centre must be trained in counselling the donors particularly the HIV infected individuals.

Status of Blood Donors

The principle of voluntary non-remunerated donations should be practiced at all levels. If family or “replacement” donors are used, their donations should be to the transfusion service and not “directed” to named recipients. Care should be taken to ensure that this is not a hidden (remunerated) system.

There should be a consistent and reliable system for donor selection and deferral. Procedures should be clearly set out for caring for the donor before, during and after donations and for deferral where necessary. (Criteria for collection of blood from blood donors, vide memo No. ME-1/4M-5/76/517 dated 5-6-1976)

Plans to motivate and recruit donors from safe low risk community groups should be introduced. Where appropriate, mechanisms for self-exclusion of donors can be introduced. Locally appropriate recruitment material, both oral and written, should be provided to facilitate response from donors.

Anybody neglecting to follow the code of ethics and the rules framed by the Government of Bangladesh is accountable to the Government and to the public, provided materials for screening of donors, laboratory reagents and equipment required for the purpose have been provided continuously. Without proper screening and proper testing of blood, blood should not be given to the recipient. Blood banks, hospitals, clinics and other institutions that supply and administer infected blood for transfusion should be held legally liable.

6. HIV/AIDS and Women

AIDS is having a major impact on women and children. AIDS affects women as individuals, but also as health care providers, educators, wives, mothers and income providers.

Women are more vulnerable to AIDS due to:

- **Biological vulnerability:** Women are at greater risk as the male to female transmission of HIV is 2-4 times as efficient as female to male transmission.
- **STD not diagnosed or treated:** Many women suffer from a symptomatic STD or have symptomatic STD that are not diagnosed or treated. Women have less access to health facilities in general and STD clinics in particular.
- **Unnecessary blood transfusions:** Women often receive blood transfusion related to childbirth or anaemia.
- **Other factors:** Women are at more risk from coercive sex, or from their economic status forcing them into prostitution. In addition, many women are at risk of HIV infection from their partners.

A most critical issue in curbing HIV and improving support for infected people is to empower women in relation to their decision-making capacity within the family. At present, they have little control over sexual relations within marriage, they have poorer access than men to education, training and employment, and they are economically vulnerable. Women's vulnerability to HIV infection is often related to their status in society, including social and cultural expectations about their sexuality. Many poorer women are forced into selling sex for survival, putting themselves at enormous risk of infection.

In many countries, women are seriously under-represented in all higher sectors of employment and policy-making level, they have poorer access than men to nutrition, health care and other services. Women are biologically more prone to contract HIV infection, and are usually infected at younger than men because many young women have much older sexual partners who have high rates of STDs. Finally, women are the main caregivers of the sick and of the family as a whole, and have an important role in socialisation and education of the family.

Many factors prevent women from taking control over their own sexuality and therefore over their risk of STDs and HIV. Infecting, although they may be more easily reached by awareness campaigns and be more easily motivated than men to safeguard themselves and their families.

Unfortunately, changing traditional relationships between men and women in the home and in marriage is particularly difficult. Yet it is precisely in this sphere that change is needed if the spread of HIV is to be reduced. Some changes that could be pivotal in curbing the transmission of HIV include:

- Putting some check and balances on men who indulge in frequent sexual contact other than with spouse or regular partners.

- Women insisting on condom use with their partners or having access to female condoms and the power to insist on using them;
- Women having sufficient economic security so that they do not need to depend on men within or outside marriage; this means better access to education, training and jobs.
- More women having viable economic alternatives to prostitution;

These changes may appear confrontational, difficult or impossible. However, they identify critical issues and may gradually change both women and men's perceptions of what is possible, desirable and of what should constitute norms of behaviour.

The education, awareness raising and empowerment of women must start in early stages of their life, e.g. primary school and continue in all areas of life, backed up by policy and legislation. Schools, women's groups, NGOs political parties, Government, labour and other mass organisations and the employment sector itself all have an important role to play in enhancing the position of women and changing accepted norms. Mass media are also influential in sustaining or changing societal norms and perceptions.

Altering the image of women

Women are sometimes stigmatised and /or blamed for HIV/AIDS and STD transmission to their male partners, and to their offspring(via perinatal transmission). This view both fails to focus on men's equal responsibility to prevent HIV/AIDS, and prevents programmes from developing services that meet the needs of women. To reduce stigmatisation and blaming of women for HIV infection, potential actions include:

- Ensuring that national AIDS/STD Programme don not stigmatise women n, for example, by blaming commercial sex workers and women with multiple partners, or by promoting the use of condoms with some categories or women;
- Ensuring the laws and policies do not contribute to stigmatisation of women with HIV(e.g. routine screening of pregnant women and/or abortion or sterilisation of women with HIV, mandatory testing of CSWs and /or arresting of CSWs with HIV).
- Funding programmes to work with families and communities of women with HIV to reduce the likelihood that the women will be ostracised because of their HIV status;
- Support programmes to educate employers, trade union organisers, law enforcement and prison personnel, medical and psychological health personnel to reduce discrimination against women with, or perceived to be at risk of HIV infection or AIDS.

Perinatal Transmission

Perinatal transmission is one of the HIV/AIDS is spread. Counselling should be provided to the couple as soon as it is known that an HIV positive woman is pregnant. Information that there is a 33% chance of their child being HIV/AIDS positive should be shared with them.

Support should be provided to them throughout the pregnancy if the couple decides to continue with pregnancy. Medical service providers should promote the decision of the couple. In case the couple decides to terminate the pregnancy, care should be taken that this is a decision by consensus and not by force of opinion of one dominant partner. If the couple decides on termination safe medical termination should be provided.

Breast-Feeding

There is evidence that HIV can be transmitted through breast-feeding. Counselling should be provided to the parents about risks of breast-feeding, from infected mother and on possible advantages/disadvantages associated with other methods of infant feeding. This should be case-to-case decision based on informed choice.

Birth Process

During all deliveries safe universal precautions should be ensured. Therefore, if these are in practice no added measures need to be taken in case of an HIV positive woman's deliver.

7. HIV/AIDS/STD and Men

Responsibility

The role of men as (supportive) partner in the decision-making process to contraception and taking responsibility for his own behaviour in sexual relationships does not always get the appropriate attention. AIDS concerns us all, everybody is at risk and responsible for her/his own behaviour. Experiences of the family planning programs have shown that men often do not consider the use of male contraceptives. Or more explicit in relation to HIV/AIDS/STD, very few men will inform their sexual partners their sexuality and /or behaviour. On the other hand, for men who are willing to take responsibility it is very difficult to get information and /or services. Often these services are not prepared to deal with their questions (i.e. no male trained provider present). These are serious issues that have to be looked into during the development of appropriate strategies in relation to male reproductive and sexual health.

Male sexual behaviour

While developing the appropriate prevention strategies, we need to understand the dynamics of sexuality, the constructions of gender, the psychosocial frameworks of sexual behaviours and the contexts in which they exist. The extramarital sexual affairs are covered in the section on commercial sex. Here, another area is touched upon: Although the term homosexual does not have direct equivalent in Bangla, it does not imply that same sex segments of society. These males are engaged in high-risk behaviour of which they are not aware. Although more information is needed on this topic, it is clear that this group needs special attention having access to IEC.

8. Children and HIV/AIDS

Though it would seem that the only way a child could get HIV/AIDS would be through vertical transmission from the mother, child prostitution, sexual abuse and trafficking of children also leave children vulnerable to infection. Therefore, any national programme on HIV/AIDS should address the needs of children.

International trafficking for the purpose of the sex trade, forced prostitution, rape, sexual abuse and sex tourism are violations of the human rights and fundamental freedoms of children.

Programmes must be established that will give girls and boys greater access to education and widen their opportunities. A range of activities and options should be available to meet the needs of different groups of children including, for example, refugees for children or training and job creation schemes. To ensure that the interventions are appropriate to children's needs, action should be drawn up in consultation with children who are involved in commercial sex work. They should be included in participatory research and other child-focused activities. The

programme should also have linkages with programmes dealing with sexual abuse of children and help in its prevention.

Trafficking of children within the country and across borders is a known fact. All measures and action should be taken to prevent this. But inter-country cooperation should be enhanced to put a stop to this practice.

9. Adolescents and HIV/AIDS

Adolescents are the most neglected section of society with regards to access to information and services regarding sexual health. Access to correct and relevant information about sexual health and safer sex practices should be provided to adolescent through peer awareness and education programmes. Sexual health services such as treatment of STDs should also be provided to adolescents without stigmatisation.

10. HIV/AIDS/STD in Educational Institutes

All levels of educational institutes should have HIV/AIDS/STD in their curriculum. Teachers can provide information to their students about the modes of prevention and can create awareness among students. Perhaps for the school such information should start at class eight level. Special attention should be given to non-formal education.

School health education on AIDS/STD aims to develop in the students the knowledge and skills needed for healthy human relationships, effective communication, and responsible decision-making behaviour that will protect themselves and others from HIV/STD infection and optimise health. The goals of such a programme include promoting behaviour that prevents the transmission of HIV/STD, fostering attitudes and behaviour that will prevent discrimination against those who are infected with HIV/STD, and promoting solidarity with them.

The problems of preventing HIV/STD infection and fighting discrimination are faced by the community as a whole, and school education activities to prevent their spread should also help promote ideas and values that are conducive to social concern, willingness to cooperate, and respect for human rights.

A school health-educating programme on AIDS/STD should be developed within the context of the traditions, beliefs, values and behaviours and educational norms of the Bangladesh society. It must address the needs and concerns of young people themselves and those who care for them and work with them.

Since teachers are in daily contact with their students and are well-equipped both to address their concerns and to integrate AIDS/STD education into the curriculum, formally and informally, teachers and their representative organizations should be actively included at all stages of the development, implementation and evaluation of the school curriculum.

It is essential that by the time they leave school, all students should have received the best possible education on AIDS/STD. The programme must be specific to the target group and aimed particularly at the grade level or age group before that in which risk behaviour is likely to occur. Besides increasing knowledge, AIDS/STD programmes should help students develop appropriate skills and attitudes, change risk behaviour, and counter discrimination.

11. HIV/AIDS and the Work-place

No discrimination for any staff who may be HIV positive should be practiced. Penalty may also be imposed on employers who discriminate on the basis of the HIV status of employees. Education programs for employees on HIV/AIDS prevention should be introduced and such staff education should incorporate issues such as misinformation and prejudice against people with HIV/AIDS.

Principle of non-discrimination of HIV infected people. People with HIV/AIDS and STDs are entitled to the same rights, benefits and opportunities as people with other serious or life-threatening illnesses.

Pre-employment HIV testing: employment practices should be based on the scientific and epidemiological evidence that people with AIDS or HIV infection do not pose a risk of transmission of the virus to co-workers through ordinary work-place contact. Business owners/managers should not require HIV screening as part of pre-employment should in the first instance be based on the person's ability to fulfil the employment requirements. Normal prescriptions, requiring the best qualified candidate to be capable of performing the relevant task, must be applicable.

Individual found HIV positive should not be fired. As long as HIV-infected employees are able to meet acceptable standards of work performance and work attendance and given that their conditions is not a threat to others, treatment of the employees should be sensitive and consistent with the treatment of other employees.

There should be no obligation of the employee to inform the employer regarding his or her HIV/AIDS status. Information attained as a result of a permissible medical examination must be collected and maintained on separate forms and in separate medical files and be treated as confidential medical record. It is unrealistic and expensive to conduct period screening of employees. It will be a better use of resources to implement education programmes on HIV/AIDS prevention.

Sick benefits, medical aid, leave, insurance indemnity, pensions, retirement policies etc. for people with HIV/AIDS should be in line with existing policies relating to other serious conditions and life threatening disease.

Protection of HIV infected employees

Persons who are HIV infected or have AIDS should be protected from discrimination and stigmatisation within the work-place. Correct information and appropriate educational programmes are essential to maintain a climate of mutual understanding necessary to ensure protection. It should be unacceptable for a co-worker to refuse to work with and infected person. In such case, the person should be appropriately disciplined.

Staff education in the work-place. Business owners/managers should provide employees with sensitive, accurate, and up-to-date information about risk –reduction in their personal lives. To prevent work disruption and rejection by co-workers of an employee with AIDS or HIV infection, business owner/managers should undertake education for all employees before such an incident occurs and as needed thereafter.

In those special occupational settings where there may be a potential risk of exposure to HIV (for example, in some health care settings) business owner/managers should provide specific ongoing education, training, and the necessary equipment, to reinforce appropriate infection- control procedures and ensure that they are carried out.

Protection of health workers from HIV transmission.

Surveillance and scientific studies show that the risk of work-related HIV infection for all health workers is low. However, there are documented cases of laboratory-acquired HIV infection. The laboratory staff should be aware that the skin and mucous membranes of the eye, nose, and mouth are considered as potential pathways for entry of the virus.

The main safeguard against HIV transmission among health workers is by avoiding needle stick injuries and blood splashes particularly on broken skin or in the eye. Plastic gloves are needed for any procedure involving blood, where appropriate, plastic aprons should be used. Midwives, obstetricians and dentists need to wear goggles. All health Workers should follow universal infection control precautions to reduce the risk of exposure and should be familiar with sterilization and disinfecting methods.

Disposable needles are preferred to the reusable ones. In situations where it is not possible to have disposable needles, proper sterilization has to be observe. Sharp instruments (sharps) must be handled with care at all times. Used “sharps must be disposed of carefully. Specially designed disposal containers for “sharps” must be in all hospitals wards, clinics and laboratories.

Autopsy Policy

Bodies of all deceased who were diagnosed with AIDS or as HIV positive should be handled carefully. The guidelines for burial arrangements should be prepared by a group of experts which will be reviewed periodically. Universal safety procedures should be strictly followed for autopsy or handling of any dead bodies.

12. HIV/AIDS and Mobility

Migrant workers often fall between the gaps of prevention programmes and therefore deserve special attention. Some migrant workers may be specially vulnerable because of a lack of access to information and health care; difficulties in comprehending prevention messages, because of language difficulties, but more importantly because of profoundly different meanings and approaches to sexuality or to relationships between the sexes; peculiarities in living conditions, for example, because of legal restrictions on family reunification, which may favour extramarital sexual relationships; and social and economic conditions.

Proper prevention and intervention programmes should be developed taking their specific circumstances into consideration. Regional and global networking of several countries is essential in this regard. Further, the Government of Bangladesh, with the support of the international community, should initiate a dialogue with countries receiving migrant workers to stop mandatory testing for HIV. Forced repatriation of HIV-infected foreigners has no public health rationale. HIV-infected non-nationals should be provided with counselling and leave on his/her own accord.

(Non)-restriction of travel for HIV infected

International travellers: It is generally accepted that screening programme of international travellers cannot prevent the introduction and spread of HIV infection. These screening programmes can, at best and at great cost, retard only briefly the dissemination of HIV both globally and with respect to this country. Even if there is no HIV infection in a single country, which is unlikely, screening of international travellers could not prevent the introduction of the virus, because returning nationals of the country would presumably have to be admitted and, in addition, some HIV positive individuals would remain undetected due to the window period and the limitations of the HIV tests.

In countries that already have HIV infections and AIDS, screening of travellers could be introduced to reduce the rate of spread of HIV within the country. However, the rate at which new HIV infections occur depends on the number of infected persons present and, especially, on the number of infected persons whose behaviours places other people at risk. Ultimately, the prevention of HIV transmission depends upon the behaviour of both the visitors and the nationals (while in the country or travelling abroad). Resources would be better allocated to changing these behaviours than on screening programmes.

Screening programmes for travellers presents major difficulties regarding on whom to screen (only foreigners or nationals), where to screen (before, departure or at the port of entry), when to screen (before, during or after travelling), and the management of HIV positive discovered.

The International Health Regulations limit the health measures that national authorities may take with respect to international travellers. No measure, and no health document, other than those provided for in the regulations, may be imposed on arriving travellers.

Educational material should be made available for international travellers to increase awareness of how HIV is transmitted and how it can be prevented. Since the routes of HIV transmission

have been documented to be the same throughout the world, preventive measures are also the same worldwide, regardless whether the individual is a traveller or a resident of a given country.

Travel of HIV infected persons by public conveyance. Use of any public conveyance (e.g. train, bus, plane. Boat) by persons infected with HIV does not create a risk of infection for others sharing the same conveyance. This is true both for symptomatic HIV positive and persons with clinical manifestations of AIDS. Therefore, there is no specific reason to limit the use of public conveyance by HIV-infected persons.

Refugees

Bangladesh like many countries in the region harbors refugees whose repatriation process is often slow. These refugees have been enjoying their rights as are guaranteed under various International Conventions and laws of the land.

The refugees communities have the responsibility to ensure that HIV/AIDS prevention and care programmes are distributed equitably among their members.

The National AIDS Committee, in respect of the refugees communities , will:

- ensure that they are informed about HIV/AIDS issues;
- promote and provide HIV/AIDS prevention information and education appropriately;
- adapt where necessary to respond effectively; and
- ensure that all people without any discrimination, whatsoever, have access to available HIV/AIDS/STD prevention and care programmes.

Trafficking

The issue of women and child trafficking is mentioned above, but needs attention here because it relates to HIV/AIDS and mobility. Other groups who are very mobile and need special attention (although some of them are addressed in other chapters of the document) are commercial sex workers, long distance truck drivers, garment factory workers, armed forces, street children and slum dwellers.

13. Commercial Sex

Prostitution, a transaction in which sexual services are provided in exchange for money, or things of monetary value provided to the sex worker or another party, is essentially a social phenomenon and is associated with economic, cultural, moral, behavioural and legal factors. It is often forgotten that large number of men and children are also involved in commercial sex. It is dynamic and adaptive, requiring the interpersonal interaction of at least two people: a sex worker(or sex workers) who is the provider and client, who is the buyer of sexual services.

Prostitution can be institutionalised as in brothel or it can be non-institutionalised as in floating prostitution. They may also cater to special clients, awareness and prevention programme should be designed.

Prostitution occurs virtually worldwide but there is considerable variation around the world in the organisation and characteristics of prostitution. Entry into prostitution may be voluntary (the decision of the sex worker) or coerced, particularly with child prostitution. Most sex workers are motivated by economic considerations. Reasons for persons becoming clients of sex workers may include loneliness, lack of social skills, desire for variety, or wish for specific sexual acts not enjoyed by a regular partner. Men, women and children are a part of this profession.

Sex workers and their clients have attracted the attention of health authorities for a long time because of the concern over their roles in the spread of sexually transmitted diseases. This concern has become more urgent due to the spread of HIV. However, the extent of HIV transmission arising from prostitution may depend on many interacting factors, including:

- Level of knowledge about HIV, STD and prevention of their transmission;
- Prevalence of HIV infection and STDs among clients and sex workers;
- Sexual activities of clients and sex workers;
- Availability, acceptability and use of condoms;
- Number and frequency of change of partners of sex workers and clients engaging in unprotected sex;
- The number of unprotected penetrative sex acts;
- Prevalence of STDs causing genital lesions in clients and sex workers.

Several studies have shown that while sex workers and their sex partners are affected by a disproportionately large number of episodes of STDs and high prevalence of HIV in many countries, among sex workers who are aware of and have access to the means of protecting themselves and their clients, incidence of STDs is low. Thus, interventions based on peer education and peer counselling, that address awareness and access to supplies of condoms may substantially lower the risk of HIV and STD transmission through prostitution.

Because of high rates of partner change among sex workers, and because sex workers are usually fewer and more easily identified than the larger group of clients, interventions directed at sex workers provide an important opportunity to slow the spread of HIV.

The prevention of HIV/AIDS/STD to CSWs and their clients can only be effective if the clients cooperate. Since CSWs are in a disadvantaged position and can not dictate terms to their clients and as the method of prevention is condoms, the use of which requires the cooperation and

participation of both sexual partners. Programmes on prevention and control should be targeted also to clients:

Legal status of sex workers

Since economic motives are the main reason for entry into prostitution, to prohibit prostitution by law without offering the sex workers any alternative work as a source of income is destined to failure. Indeed, such steps drive prostitution underground, thus making control of HIV and STDs more difficult.

Interventions to prevent HIV infection associated with prostitution have been most effective where sex workers are empowered to decide their working conditions. A major effect of legal and social restriction on prostitution has been to generate low self-esteem among sex-workers and the belief that they cannot control their lives. Restrictive laws and adverse working conditions inhibit their ability to negotiate with their clients and/or managers for adequate health care and safer sexual practices.

The imposition of legal sanctions is considered counterproductive and likely to discourage cooperation of high –risk groups, such as sex workers, in furthering control efforts. On the other hand, an emphatic approach and avoidance of discrimination against people engaged in prostitution will improve their cooperation in activities aimed at prevention and reduction of HIV and STDs.

Health interventions for sex workers

Sex workers and their sexual partners do not wish to become infected with any of the STDs. Furthermore, they do not want to transmit infections to their sexual partners or unborn children. STD educational programmes need to be designed and implemented to help sex workers and their sexual partners avoid HIV and STD infection. In setting up such programmes, it should be borne in mind that behavioural change is most likely to occur when sex workers and their clients are actively involved in prevention efforts, for instance by using current or ex-sex workers as educators, counsellors and coordinators collaborating with self-help groups.

Although screening for HIV and STDs can be an effective strategy for detecting and treating STDs in populations such as sex workers and their clients, potential benefits and risks should be considered before starting any screening programme.

Interventions aimed at changing HIV-related risk-taking practices associated with prostitution must urgently be promoted among all sex workers and their clients. It is recognized that interventions take time to develop, therefore if the spread of HIV is to be slowed, plans for interventions must be drawn up and budgets identified immediately.

Social rehabilitation of individuals in Vulnerable Situations

The ultimate goal with regard to prostitution should be to offer women, men and children realistic alternatives, so that they will not be induced into prostitution, neither by a person, nor by economic or social circumstances. However, the economic, social, cultural, and moral realities of

this country are likely to continue to favour the existence of prostitution and consequently the opportunities to spread HIV and STDs.

Nevertheless, reducing the risks associated with prostitution, abolishing forced prostitution and offering training and job opportunities for those who want to leave, may be seen as reasonable long-term goals. Very little will be achieved, however, without the active participation of the sex workers themselves in HIV/STD prevention efforts. An emphatic approach including decriminalisation of prostitution is more likely to succeed with regard to STD reduction than attempts to abolish prostitution and compel sex workers to undergo screening by punitive and harsh legislation that in practice is unenforceable and has proved to be counterproductive.

14. Information, Education and Communication (IEC)

Access to information about basic facts like modes of transmission of HIV/AIDS should be made available to the general public. An IEC campaign covering the whole country should be an integral part of the national programme. The programme can create:

- a. general awareness about the disease;
- b. awareness about the impact of the disease;
- c. provide information about how to prevent the spread of the disease; and
- d. clarify misconceptions about the disease.

Target oriented IEC programmes can help in dealing with prevention of this disease in specific vulnerable sections of society. Awareness must not be equated with change of behaviour. A specific IEC strategy for behavioural change needs further development.

15. Condom Promotion and Distribution

Properly used latex rubber condoms with lubricants are currently the only mechanical means of protection against sexual transmission of HIV. Condoms provide similar protection against sexually transmitted diseases that may also increase HIV transmission. The availability of quality condom at an affordable price to the high risk groups is an essential part of HIV/AIDS and STD control programmes.

The authority charged with procuring and distributing condoms share with the manufacturer the responsibility for ensuring that condoms are of good quality when they reach the user. In this regard, two major considerations are:

Female Control Methods:

Female control methods such as Femidoms, Spermicides, Microbicides, Virocides should be made available and information relating to these should be widely publicized so that women, specifically those at risk can make decisions regarding preventive methods that can be adopted. Programme managers involved in HIV and STD control activities should also consider for incorporating female control methods as a prophylactic tool.

Quality of design: The purchasing authority must select condoms with the correct design criteria, taking into account environment and level of infrastructure in which they will be stored and used, characteristics of the target population, and the system of marketing and distribution (considering also non-vaginal sex).

Conformance to Specifications requires vigilance by the purchasing authorities and programme managers and the use of few simple product tests at key points in the procurement and product management process.

Regulatory and health authorities should carefully and systematically scrutinize condom design and performance, and ensure that condoms procured and distributed meet WHO/GPA international specifications.

Promotion of condoms for HIV/AIDS and STDs control

Condom promotion is not any single action but a combination of activities to encourage the acceptance and use of condoms to prevent the sexual transmission of HIV and other STDs. There is no set method for promoting condoms; in fact a variety of approaches may synergism to create an even greater effectiveness.

One example is the Social Marketing approach that uses commercial advertising and distribution methods and in which the activities are driven by market research. This has been established as a very effective approach in different countries for promotion of condoms for AIDS and STDs.

In social marketing of condoms, large-scale promotion and extensive and intensive distribution make the target group aware of the need and the benefit of the product. At the same time, its availability at an affordable price to the targeted group is also ensured.

Social marketing takes the human factor into consideration. Establishing an elaborate system of distribution without creating demand for them will not be effective. People have to be continually stimulated to use condoms and urged to continue it. Social Marketing of condoms takes into account the socio-economic and the cultural aspects of the people, and accordingly addresses the potential users to inform, motivate and inspire to adopt condom use and sustain that use through well-planned promotion.

In this context, the use of various types of media, e.g. tape, video, films, billboards, print materials, folk media, electronic, stage and other mass media campaigns, plays a very important part in making the target groups aware of the safe sex through the use of condoms. Interpersonal communication will also play a very significant role in promoting proper use of condom in high-risk sexual activities.

16. HIV/AIDS in Prisons

All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discriminating, in particular with respect to their legal status and nationality. The general principles adopted by the National AIDS/STD Programme should apply equally to prisoners and the community.

Preventive measures for HIV/AIDS and STDs in prison should be complementary to and compatible with those in the community. Preventive measures should also be based on the prevailing risk behaviours actually occurring in prisons. Prison administrations have a responsibility to define and put in place policies and practices that will create a safer environment and diminish the risk of transmission of HIV to prisoners and staff alike.

Compulsory testing of prisoners for HIV is unethical and ineffective, and should be prohibited. Voluntary testing for HIV infection should be available at the same level that it is available in the community. Voluntary testing should be carried out with the informed consent of the prisoner. Test results should be communicated to prisoners by health personnel who should ensure medical confidentiality.

Prisoners and prison staff should be informed about HIV/AIDS and about ways to prevent HIV transmission, with special reference to the likely risks of transmission within prison environment. The information should be coordinated and consistent with that disseminated in the general community. Prison staff should also receive HIV/AIDS prevention information during their initial training and regularly after that.

Management of HIV-infected prisoners

Segregation, isolation, and restrictions on occupational activities, sports and recreation are not considered useful or relevant for HIV-infected prisoners. Decisions on isolation for health conditions should be taken by the medical staff only, and on the same grounds as for the general public, according to public health standards and regulations.

Isolation for limited periods may be required on medical grounds for HIV-infected prisoners suffering from pulmonary tuberculosis in an infectious stage. Protective isolation may also be required for prisoners with immuno-depression related to AIDS, but should be carried out only with a prisoner's informed consent.

If compatible with consideration of security and judicial procedures, prisoners with advanced AIDS should be granted compassionate early release, as far as possible, in order to simplify contact with families and friends and to allow them to face death with dignity and in freedom.

17. HIV/AIDS and the Media

HIV/AIDS has rarely been out of the headlines since the disease was identified in 1981. The media- newspaper, radio and television – has reported the global epidemic as a significant threat to the health and welfare of individuals and nations. At the same time, because the issues surrounding AIDS provoke strong emotional reactions, the media has also frequently presented the epidemic in inaccurate and sensationalist terms.

In Bangladesh, the main access to information about HIV/AIDS is through the media. The media can play a primary role both in providing information about the disease and in shaping public attitudes towards both the disease and those affected by it. However, there may be a conflict between the media's role in providing accurate information and its priorities in representing a particular political, social or religious point of view. Moreover, only certain forms of information have news value.

First, there is the need for news reporting on HIV/AIDS (new epidemiological information, new scientific information, new government policies). Second, there is a need for writing background articles on HIV/AIDS and sexual health (with general educational value).

Rather than focus on statistics or sensationalized stories of people who are ill or dying of AIDS, reporting on AIDS should include more of a human focus and practical materials. Examples of people who are managing to live productive, full lives despite their HIV infection will do a great deal to reduce the discrimination and despair associated with AIDS.

To enable media to play their role effectively, their right to information should be acted upon without shunning the issue of confidentiality. It is the duty and role of other actors in this field to provide the media with information so that they can write useful and relevant articles.

Individual journalists reporting on HIV and AIDS therefore have a huge responsibility to inform the public fairly and accurately about the virus. This responsibility outweighs their own attitudes and prejudices, and any pressure they may be under to provide sensational, badly researched and inaccurate stories.

In carrying out this responsibility, journalists should:

Be accurate. The Code of Conduct urges journalists to make sure that the information they disseminate is fair and accurate; to avoid expressing comments or conjectures as established fact; and to avoid falsification by distortion, selection or misrepresentation. Knowledge about HIV and AIDS is growing all the time, so journalists should check the facts with an appropriate organisation (Ministry of Health or the National AIDS Committee) each time they report on the virus.

Respect privacy. The code of Conduct says that, subject to the justification by overriding considerations of the public interest, journalists should do nothing that entails intrusion into private grief and distress. Journalists are urged to respect the privacy of people living with HIV and AIDS, including the family and friends of people infected with the virus. Identities and addresses should not be revealed or hinted without permission, and journalists should not pressurize people living with HIV and AIDS into publicly revealing their identity. Journalists

have a responsibility to ensure that all those working with them confidentially understand this by colleagues and.

Be relevant. The Code of Conduct states that someone's race; nationality or sexual orientation should be mentioned only if strictly relevant to a story. Leading the public to believe that HIV and AIDS are problems only for particular groups within society promotes complacency among people who consider themselves to be outside these groups, which could lead to more people becoming infected. It can also prompt prejudice leading to abuse, assault, job losses and homelessness among people identified as members of a particular group.

Avoid sensationalism. Journalists should resist the temptation to sensationalise issues in ways that could have harmful effects. Sensational language and images are likely to cause unnecessary anxiety to people with HIV and AIDS and widespread fear among the public. To avoid misunderstandings, journalists should ensure that every report on HIV and AIDS includes information on how the virus is and is not transmitted. There should be ban on mollified advertisement on sexuality and sex related issues.

Protect press freedom. While refusing censorship, journalists should understand that press freedom must be conditioned by responsibility. Press freedom should not be abused; it is too valuable to be treated lightly. Journalists should see to achieve wider, better and more balanced coverage of HIV and AIDS issues, research all aspects of HIV and AIDS, and consider the opportunities for human interest and campaigning stories.

18. Policies on STDs

The GOB should establish a programme for prevention and care of STD and this should be integrated or closely coordinated with the National AIDS/STD Control Programme. A separate Directorate for AIDS/STD should be established and STD care services should be extended up to Thana level with all logistic support. Such programme should have collaborative and coordinating role of the Family Planning workers.

The services forming part of the STD control programme should always be delivered with due respect for human rights and maintenance of the dignity of the individual with STD.

The STD programme will:

- promote accessible, effective and acceptable case management of persons with STD through the public and private general health system, including first level health care, using simple algorithms based on syndromic diagnosis.
- Include STD care in maternal and child health, antenatal and family planning services as and when human and economic resources allow.
- Target acceptable and effective STD care services to populations identified as at increased risk of STD infection, including HIV, due to their sexual behaviour.
- Promote STD related health care seeking behaviours with other sexual behaviour related education.
- Deliver primary prevention activities (promotion of safer sexual behaviour and condom provision) together with the National AIDS/STD Programme.

In-service training should be imparted to doctors and other health workers on syndromic as well as specialized care for AIDS/STD. However, a strategic and policy guidelines for STDs should be formulated. There should be provision for research activities and higher studies in STDs.

19. Drug Use and HIV/AIDS

The micro transfusion that occurs when two or more people use the same needle and syringes to inject illicit drug is an efficient means for transmitting infectious disease. Nothing has illustrated this more tragically than the spread of HIV among injection drug users (IDU). Once HIV is established among the local IDU population, the IDU become a source for both heterosexual and Perinatal transmission for HIV. In many countries particularly 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. It is also evident that strict legal approaches (prohibition, eradication of crops, large drives for seizure or arrests) are often followed by a switch from traditional substances such as alcohol or cannabis to heroin smoking and heroin smoking to injecting practices. Strict paraphernalia laws restricting procurement of syringes and needles without prescription or misuse of the such law (suspects are arrested for carrying injecting equipment) increases the risk of sharing needles and therefore of transmitting HIV. Once HIV is introduced in a local injecting population the rise in prevalence of HIV is rapid and at least 10% within one year. The rise of HIV within one year that are reported from neighboring regions of Bangladesh and the proximity of the "Golden Triangle", changing trafficking routes, and heightened control measures are exposing the whole population to injectable drug and injecting practices. Most vulnerable are the populations in ports, border towns and those along truck routes.

Prevention of HIV is however possible if 1) interventions are launched early, 2) drug users or community organizations of drug users are involved in prevention, 3) outreach and community based programs are implemented, 4) information of HIV is provided, 5) means of behaviour change (access to needles, syringes, bleach, condoms etc.) are made accessible, 6) options are offered to the IDUs as to how they will make a change in behaviour rather than a single approach, and lastly 7) policy makers are sympathetic and supportive to such programmes even if they might appear to have controversial policies towards drug use in the beginning.

Although it has been possible to reverse the epidemic of HIV even with high sero-prevalence (more than 70%) by adoption of strategies mentioned above, elimination of risk has not been achieved even in most developed countries or countries with highest legal or punitive measures. Reduction of HIV and safer injecting and sex practices rather than abstinence therefore remain a pragmatic goal for during drug users.

In the region, evidence indicates an increased illicit drug use, injecting practices and transmission of HIV among IDUs. Attempts to control drug related HIV has to be vigorous. The biggest obstacle to reduce the spread of HIV through out the world is however not lack of resources nor a lack of knowledge but a lack of political will. Drug use is often not recognized as a major problem. Programmes are often abstinence oriented in spite of high HIV prevalence. There is overwhelming evidence of the high effectiveness of needle exchange programmes or methadone programmes-although they are not endorsed by many governments. Sometimes it is socially difficult to introduce needle exchange programmes, if disposable needles are not available for regular injecting practices. Use of bleach for cleaning syringe should also be recommended before injection although it is not considered full proof.

Given the potential increase in drug injecting behaviours and its implications for HIV infection and AIDS/STD, specific targeted interventions for drug users should be carried out, including educational outreach programmes, needle and syringe exchange and /or cleaning programmes,

education programmes on HIV/AIDS and STDs and risk reduction and education of safe sex. Although targeted , the interventions should focus on risk factors and behaviours related to injecting drug use so as to not further stigmatise drug abuse and marginalize drug abusers.

The availability of drug treatment and rehabilitation services should be extended to ensure that all those who wish to enter treatment ;programmes can be accommodated and have confidentiality if so desired.

All HIV antibody testing initiative should follow the general criteria for testing and screening for HIV and consider the special social, legal and economic characteristics and needs of drug injectors. Mandatory testing is not warranted. It would make communication with drug injectors more difficult and reduce the number of drug injectors voluntarily seeking treatment and/or access to information about risk reduction.

20. HIV/AIDS and Minority Communities

Based on religious, ethnic, cultural, linguistic and behavioural consideration, minorities exist in Bangladesh. These communities have a lower level of community-based organizational development.

Where there is any service development around HIV/AIDS/STD it has been generally conceptualised within the needs of the majority culture, society or community. This has meant that minority communities cannot access these services, because of social, cultural and linguistic differences. This can lead to minority people living with HIV/AIDS/STD being doubly stigmatised. Too often minority communities find services imposed upon them and cannot actively participate in the decision making process.

Therefore, appropriate HIV/AIDS/STD strategies have to be developed with active participation of the concerned minority communities.

21. Social Science and Behavioural Research

An effective national HIV/AIDS/STD strategy must be anchored on an extensive, coordinated and adequately funded research programme. The pandemic has raised many complex, scientific, medical, legal, social, economic, sexual, environmental, cultural and ethical questions. Solutions to these problems will require the existence of a multi-disciplinary research effort of both national and international.

Social science and behavioural research has contributed much in the area of HIV/AIDS/STD prevention and care throughout the world. Research on sexuality and sexual behaviour has proven useful in the design of IEC messages and in adopting measures for behavioural change as well as in guiding national policy. In addition, research on health care seeking behaviour related to STDs has revealed the reasons and motivations for seeking care from various health care providers including allopathic and non-allopathic practitioners.

By combining qualitative and quantitative methodologies, researchers have been able to explore behaviour and the socio-cultural and economic determinants of behaviour in a comprehensive manner. In Bangladesh, the primary mode of transmission is sexual. To date there is a paucity of data on sexuality, sexual behaviour and the determinants of behaviour. In order to design effective HIV/AIDS/STD prevention and care programmes, the dynamics of sexuality and sexual behaviour within a changing society need to be explored and understood.

Despite the urgency of the problems, it is important that social science research conducted in Bangladesh maintain a high standard of scientific rigor and ethics. Whether studies be rapid assessments or long-term, longitudinal studies, whether employing qualitative and/or quantitative methods or operational research, validity of the information collected must be paramount. Therefore, mechanisms should be developed for improving research protocols with assistance of a research review committee or through linkage with well-known research institutes in –or outside the country. These mechanisms could include workshops to formulate certain research questions (with users i.e. policy makers, NGOs etc.), feedback workshops (again with the users to be sure the results will be used) and capacity building elements for translating experience into skills essential for the actual interventions. Research which leads to interventions must involve the people themselves. Their participation will contribute significantly to the feasibility of these interventions and is crucial in changing people's behaviour.

The NAC may recommend funding only those proposals that demonstrate rigorous scientific methods, a high societal relevance, and investigators and/or organizations with appropriate training and capacities to carry out the studies. For all types of research it is also essential that it conforms to international ethical guidelines. These ethical guidelines should be further developed and distributed to all involved partners (GOs, NGOs, research institutes and donors). All HIV/AIDS/STD research funded by/through the Government of Bangladesh will be reviewed (based on anonymous peer review) by research and ethical review committees. Research that takes place outside this mechanism is strongly advised to seek the advice/support of these review committees.

Operations research will play a critical role in testing pilot HIV/AIDS/STD interventions throughout the country. The results of research, including operations research, should be made available to the NAC and other bodies. Pilot interventions must be effectively monitored and have a rigorous evaluation design.

22. Clinical/Vaccine Trials for HIV/AIDS/STD

Guidelines for conducting Clinical/Vaccine Trials for HIV/AIDS in Bangladesh--

GENERAL

Clinical/vaccine trials in Bangladesh will be conducted only if the product has shown initial promise in the country of its origin. The product should be tested only if efficacy has been found in other countries could be replicated.

SPECIFIC

1. No product will be tested in Bangladesh unless first shown to be of benefit in the country of the product's origin.
2. A product can only be tested at the same level as tested in the country of its origin. For example, if the product has an impact on 'incubation period of HIV' in the country of its origin, it may only be tested for its impact on the same (end point) in Bangladesh. Under no circumstances will a product only shown to impact on 'morbidity' in the country of origin, be tested for its impact on 'mortality' in Bangladesh.
3. Having satisfied points '1 and 2' above and in the event that a product is still being considered for testing in Bangladesh, a legally binding (by US and European Law) document will specify the advantages to Bangladesh to include either of the following:

i) Patent exempt status for Bangladesh

Bangladesh will have the right to produce and market the product for national consumption for a determined period of time e.g. 10 years. In the event of such negotiation, provision for the production company to provide technical assistance to Bangladesh to meet production requirements should be met.

ii) Reduced product cost for Bangladesh

Bangladesh can purchase the product for a flat reduced fee (to ensure its availability to the average Bangladeshi citizen) for a specified period of time e.g. 10 years.

23. Ethical Aspect of HIV/AIDS Research

All research involving human subjects and HIV should be designed and conducted according to the four basic ethical principles, namely respect for persons, beneficence, non-maleficence, and justice.

Respect for persons incorporates at least two other fundamental ethical principles, namely:

- a) Autonomy, which requires that those who are capable of deliberation about their personal goals should be treated with respect for their capacity for self-determination;
- b) Protection of persons with impaired or diminished autonomy, which requires that those who are dependent or vulnerable be afforded security against harm or abuse.

Beneficence is the ethical obligation to maximize possible benefit and to minimize possible harms and wrongs.

Non-maleficence holds a central position in the tradition of medical ethics, and guards against avoidable harm to research subjects.

Justice requires that cases considered to be alike be treated alike, and that cases considered to be different be treated in ways that acknowledge the difference.

24. Legal Aspects of HIV/AIDS

From the very beginning, the HIV/AIDS pandemic has raised many complex legal and ethical issues. Responses to this issues have been marked by lengthy debates about the right of the individual versus the right of the public, a proliferation of restrictive and discriminatory measures applied to people infected with HIV and renewed attention to laws and legislation regarding marginalized groups often at higher risk of HIV infection, like homosexuals, IV drug users, Commercial Sex Workers, etc.

In analyzing the role of law in the HIV/AIDS policy, three main models have been described. The first is the traditional proscriptive model that penalizes certain forms of conduct. The second model focuses on the protective function of the law, particularly for those infected with HIV or at risk of infection. The third model seeks to use the law in its promotive function i.e. to promote actively the changes in values and patterns of social interaction that lead to susceptibility and vulnerability to HIV infection. Unless these different roles are recognized, there is a risk that the full potential of the law to assist HIV/AIDS policy will be overlooked or, worse, that the law may actively obstruct an appropriate response to HIV/AIDS.

The proscriptive role of the law

Some behaviours that increase the risk of HIV infection, like prostitution, IV drug use or homosexuality, are criminal offenses in many jurisdictions. In this context, the existing laws are often restrictive and have obstructed rather than facilitated effective implementation of prevention strategies. Examples are the prohibition of the sale of condoms, considering the possession of needles an offense, or the closure of brothel houses. These have caused those people who are most at risk of HIV infection to be reluctant to identify themselves for fear of adverse legal consequences.

Similarly, the enactment of prescriptive laws directed specifically at HIV/AIDS has often been counterproductive in the context of broader HIV/AIDS strategies. Examples are the compulsory reporting of HIV positivity, mandatory testing of certain population groups, and laws compelling the disclosure of individual's HIV status under certain circumstances. The coercive nature of these laws, which often impose criminal sanctions for non-compliance, far from encouraging conduct that will reduce the spread of HIV, may actively impede prevention efforts by driving the people at risk "underground".

In the case of prescriptive and punitive laws, therefore, an appropriate legal response to HIV/AIDS will most often have as its desired outcome the absence rather than the presence of applicable law. The particular dynamics of HIV/AIDS suggest that prescriptive laws will rarely be an appropriate policy response if they seek merely to target the conduct of people with HIV or activities that give rise to HIV infection risks. The challenges of HIV/AIDS are such that an effective policy requires more than negative prohibition.

The protective role of law

This role focuses on how the law can protect individuals or groups from harmful and undesirable occurrences and has been of central importance in the proliferation of discrimination against people with HIV. Laws that protect individual rights and interest must, to be effective,

incorporate certain penalties for non-compliance, but they are not essentially prescriptive in their thrust. The objective of the legislation is positive rather than negative: to engender respect for individuals and to promote human rights rather than merely to impose a prohibition.

Two protective functions of the law have been considered as most important: the protection against discrimination and the protection of confidentiality for people with HIV. Legislation is being enacted in many countries in trying to protect these rights. However, legal protection in theory may not always translate into legal protection in practice, while the community prejudice and general lack of sensitivity to the right and needs of people with HIV still may predominate.

While prescriptive and coercive laws may be counterproductive if they discourage the voluntary participation by people at risk of HIV in measures to reduce HIV transmission, protective laws may help to enlist the support and cooperation of these people in prevention strategies. Therefore, although decriminalization and the absence of laws may be what is sought within the context of the prescriptive legal model, decisive and firm legal intervention may be what is primarily sought to be achieved by a particular protective legislation.

The instrumental role of law

Whereas the prescriptive and the protective models of legal interventions focus on the conduct of individuals or on the adjustment of rights and obligations as between individuals, the third model suggests that the law can play a proactive role in seeking to change underlying values and patterns of social interaction that create vulnerability to the threat of HIV infection.

It is increasingly clear that risk factors for HIV infections do not relate to individual activities as such, but rather to socio-economic factors that promote or force people into risky behaviours. Because HIV infection is preventable, people who have access to information and appropriate preventive measures and have the means to implement those measures will be able to protect themselves against infection. Therefore, people who remain more vulnerable are those who are denied the means of protecting themselves against the risks of HIV because of economic need or powerlessness to control the basis upon which their sexual relationships take place. This may occur, for example, because a person's sexual activity is directed to his or her economic support, because preventive measures, such as condoms, are not accessible and affordable, or because poor health care increases transmission risks. For women, it may occur because their sexual relationships with men are determined by cultural values which are beyond their control and are compounded by economic dependence.

The challenge of HIV/AIDS policy is to recognize the need to address the underlying social and economic factors that deprive individuals of the power to protect themselves against HIV infection. In this context, the task extends far beyond what is most commonly perceived as the scope of HIV/AIDS policy. Nonetheless, efforts to address the socio-economic risk factors for HIV infection are a critical part of an effective strategy to reduce the spread of HIV.

The potential of the law to complement and reinforce other policy initiatives in bringing about social and economic changes should not be overlooked. Typically, for example, there exist legal regimes that entrench the economic dependence of women through land ownership and marital property laws, or through laws that deny women access to certain forms of paid employment. Laws can be enacted that help to ensure access by disadvantaged groups to relevant information about HIV.

Examples of specific laws:

Proscriptive laws:

- Laws that make homosexuality a criminal offense
- Offenses related to drug use and prostitution that have the effect of making it harder to reach drug users and sex workers with HIV care and preventive measures
- Laws restricting the availability of condoms and needles and syringes
- Censorship and broadcasting laws that restrict the dissemination of safe sex information
- Laws that allow HIV testing without consent or the detention of people with HIV
- Immigration and travel laws that restrict the movement of people with HIV between countries
- Laws restricting the access to school by healthy HIV infected students

Protective laws:

- Human rights laws that give legal effect to rights such as the right to privacy, the right to protection against unlawful search and seizure and detection
- Anti-discrimination laws that will provide redress in case of discrimination in employment, housing, access to health care, etc. against people with HIV or their family or friends
- Legal provisions that protect the confidentiality of a person's HIV status
- Laws compelling a person's consent to be given before HIV testing is undertaken
- Laws that encourage appropriate work-place practices, e.g. infection control procedures and HIV education for employees.

Instrumental laws

- Laws requiring brothel owners to insist upon condom use by their clients
- Laws promoting the empowerment of women to increase their socio and economic independence
- Laws dealing with consent to sexual relationships by women

SPECIAL ISSUES FOR CONSIDERATION

Formulation of a Legal Working Party: Legal experts and representatives from relevant ministries to report on existing public health laws and other legislation connected with health matters of the people in Bangladesh.

Therapeutics goods and HIV/AIDS:

- Quality and availability of condoms.
- Quality and availability of HIV testing kits.
- Availability of needles and syringes for needle exchange programmes. (Vending machines)
- Re-use or re-packing of used disposable syringes for marketing is unlawful and punishable.
- Government Hospitals, Private Hospitals and Clinics and Government of Private Physicians must always use disposable or sterilized syringes, and must ensure that the disposable syringes are immediately destroyed after use.

Housing: There is no public health rationale for restricting HIV-infected persons as for their housing. When a HIV-infected person has occupied and then left a dwelling, no special cleaning or other procedures are needed before occupancy by another person.

Employment: There is no public health rationale for restricting healthy HIV-infected persons from employment.

Schooling: There is no public health rationale for restricting the access to or full participation in school activities at the primary or higher levels by HIV-infected students who are healthy. HIV infection should not be a factor taken into account by education authorities with respect to school admission, transfers, attendance, or their powers of exclusion from school. Based on all the present evidence, there is no risk of transmitting HIV in school.

Confidentiality: Penalties for breaching of confidentiality.

Mandatory testing: Penalties for mandatory testing.

Risky behaviours:

Policy for individuals with HIV who purposefully infect others:

For a person who has been diagnosed to be HIV positive, there is no such freedom to knowingly transmit HIV infection, so such person should modify their conduct so to prevent further infection. This principle constitutes the core of AIDS/STD prevention and emanates from the basic human rights norms: Rights of any person are limited by equal rights of all others. Therefore irresponsible behaviour by those who might infect others negates the right of others to be protected from contracting infection.

HIV/AIDS and Sports

No evidence exists for a risk of HIV transmission when infected persons engaging in sports have no bleeding wounds or other skin lesions. There is no documented instance of HIV infection acquired through participation in sports.

However, there is a possible very low risk of transmission when one athlete who is infected has a bleeding wound or a skin lesion with exudate. The possible very low risk of HIV transmission through sport participation would principally involve the combative sports with direct body contact and other sports where bleeding may be expected to occur.

There is no medical or public health justification for testing or screening for HIV infection before participation in sports activities.

Sports organizations, sports clubs and sport groups have special opportunities for additional meaningful AIDS/STD education of athletes, sports officials and ancillary personnel.

HIV/AIDS and the family

- Today, for many people, not being married does not bar sexual activity. Therefore, a policy of mandatory premarital HIV testing, coupled with a denial of a marriage license in case of positive, is of little use in controlling or slowing down the AIDS epidemic. Prohibiting marriage may also not be an effective measure of preventing transmission of the HIV to children, as many children are born outside marriage.
- In case of people with HIV/AIDS, the marriage should be contracted with prior information about his/her HIV status to the marital partner and they would be at liberty to form the future family.
- Compulsory sterilization or abortion in case of HIV positively is unacceptable as a violation of human rights and considering that two out of three children born of infected mothers are free from HIV.
- Testing should not be required before a child is sent to foster homes. However, prospective foster parents should be informed if a child is known to be HIV positive.

A debatable question such as “Can AIDS justify divorce?” will have to be answered taking due care of the issues of human rights, cultural aspects and also ethical aspect.

The New Delhi Declaration: Summary

In view of the above, Government of Bangladesh considers it essential to have a concerted approach (both national and global) to the legal issues engendered by HIV/AIDS that will not only protect society against the spread of infection, but also respect the dignity and fundamental human rights of those who are infected or who are suspected of being infected, and their families and associates.

In this regards GOB attaches much importance to the document entitled 'New Delhi Declaration and Action Plan on HIV/AIDS' issued at the conclusion of an Interdisciplinary International Conference called "AIDS-LAW AND HUMANITY" held in New Delhi (December 6-10, 1995).

Principles

- The laws and policies on HIV/AIDS should be based upon sound and scientific data
- Adoption of a global approach. This includes a model global AIDS law which supports action at the local, national and international level.
- The approach should respect and protect the human rights of those at risk of HIV/AIDS and also against discrimination on the ground of HIV/AIDS/STD Programme Effective and enforceable laws should be made for prevention of HIV and for protection of persons affected by HIV/AIDS.
- Effective and enforceable laws should be made for prevention of HIV and for protection of persons affected by HIV/AIDS.
- The law makers must work in an interdisciplinary way with health care workers, government, NGOs, representative of the vulnerable groups, IGOs, CBOs etc.
- The moral spiritual and religious values should be respected

Objectives:

- To protect human rights and empower individuals
- To promote voluntary behaviours for protection of health of individuals families and children
- To prevent coercive and punitive action against PWHAs
- To protect society and to promote sense of responsibility
- To provide access to information about HIV/AIDS prevention, to health care services relevant to HIV/AIDS, and to legal services.

- The laws should protect individuals as well as the society
- Protection of human rights must include right to privacy and freedom from discrimination.
- To provide for allocation of adequate resources for prevention, care and anti-discriminatory efforts supporting government, NGOs institutions and networks of PWHAs.

International Action:

In envisages more global cooperation as indicated below:

- UNAIDS-Strategy for the defence fundamental rights in the context of HIV/AIDS mainly directed towards development of standards and promotion of laws protecting fundamental rights.
- Other organs on UN-At all levels should incorporate programmes designed to prevent and control of the spread of HIV/AIDS.
- High Commissioner for Human Rights and the Centre for Human Rights –Shoud incorporate in the programmes enlarged strategies for protection of human rights with regard to PWHA prevention and control of the spread of HIV/AIDS.
- Cooperations among all countries in promoting HIV/AIDS awareness and responding effectively to the epidemic in a way consistent with local laws, policies and cultural values.
- Dissemination of knowledge of “Best Practice” amongst all the countries.

National Action -Legislative

- Legislation to ensure safety of blood, blood products, organs and tissues before use. Provision of legal liability if such products are found to be contaminated with HIV.
- Introduction of anti-discrimination, equal opportunity, privacy and confidentiality legislation.
- Removal of any restriction on dissemination of full and accurate information and education about prevention of HIV infection and on the availability and quality of condoms and sterile injections.
- Appropriate legislative protection for women
- Measures to prevent spread of HIV/AIDS amongst drug injecting persons
- Appropriate legislative action to repeal those provisions of the penal code of all countries which are country to modern day concepts of human dignity and human rights.
- Forbidding discrimination in employment, education, housing, health care social security, travel, marital and reproductive rights and other privileges of people.

- Reforms with regards to CSWs. (Removal of stigma, provision of health care, education, arrangement for rehabilitation etc)

Executive action

- Introduction of education in schools, universities and general communities
- Prohibition of compulsory testing and screening for HIV/AIDS
- Prohibition of isolation, segregation and quarantines
- Protection of confidentiality and privacy of PWHAs
- Provision of facilities for voluntary screening with informed consent and for pre and post test counselling
- Introduction of “Universal Precaution” for prevention of occupational transmission of HIV infection to health care workers and patients
- Introduction of sexual and reproductive health counselling and services.
- promotion of mass media education
- Establishment of ethical review committees to ensure ethics in the provision of health care and in HIV related research.

Judicial action

The judiciary and law makers should respond to HIV/AIDS epidemic. The response include the following:

- Familiarizing the members of the judiciary with HIV/AIDS, the applicable statutory and common law
- Making the members of the importance of an informed approach to the spread of the virus and its impact upon the legal system.
- Prompt disposal of cases with HIV/AIDS related issues
- Judges are to play a leading role in proposing and suggesting reforms of the law where necessary to ensure that the law responds in an effective and just way to HIV/AIDS

Considering an alarming increase in the spread of HIV/AIDS in the Afro-Asian region, in recent years, it is abundantly clear that there is an immediate need for a greater sense of urgency. This urgency must flow into the judiciary and the government, into the health care system, media and to citizens in general.

In addition immediate steps should be taken to establish both national and international committees to address the national and international implications of HIV/AIDS from the point of view of law and humanity.

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Women and Children Affairs

APPENDIX B

Select Committee

Formulation of the Select Committee

As per decision in the 1st Meeting of the National AIDS Committee (NAC) in the MOHFW held on 9 November 1996, a Select Committee was formed with the following members and resource persons (1) to go through the draft National Policy on HIV/AIDS and STD related issues, make suggestions/recommendations from the members if any and (3) recommend necessary corrections/additions to the document and present it to the MOHFW.

Members:

1. Major General ASM Matiur Rahman, AFIP, (Convenor)
2. Prof. Md. Nazrul Islam, Project Director, Bangladesh AIDS Prevention and Control programme
3. Prof. Musharraf Husain, BTC, IPGMR
4. Prof. Maidul Islam, Skin & VD Dept., IPGMR
5. Dr. Nigar S Shahid, Sr. Scientist, ICDDRDB.

Resource Persons:

1. Major Gen. (Rtd.) M.R. Choudhury
2. Dr. Lisa J Messersmith, Country Programme Advisor, UNAIDS

Government of the People's Republic of Bangladesh
Directorate General of Health Services
Mohakhali, Dhaka

No.: DGHS/AIDS/STD Programme

Date:

MEMORANDUM

In view of the emerging need for formulating a legislation on HIV/AIDS and STD issues, the following Task Force has been formed. The Task Force will identify issues for Policy and also write a draft document for legislation incorporating ethical and legal aspects of STD/HIS/AIDS. The detail action plan is attached. The Task Force:

- | | | | |
|-----|---|---|----------|
| 1. | Maj. Gen. M.R. Choudhury (Retd)
Chairman, Technical Committee of NAC | - | Convenor |
| 2. | Dr. O. Massee Bateman
Epidemiologist, ICDDR,B | - | Member |
| 3. | Dr. Enamul Karim
SSO, IEDCR | - | " |
| 4. | Dr. Nasiruddin
Director, VHSS | - | " |
| 5. | Dr. Stelamo Lazarri
Medical Officer, WHO | - | " |
| 6. | Legal Adviser
DGHS | - | " |
| 7. | Representative from HOH&FW | - | " |
| 8. | Ms. Shahnaz Ahmed
Programme Officer, AIDS, UNDP | - | " |
| 9. | Ms. Salma Masud
Lawyer | - | " |
| 10. | Dr. Mostafa Kamal | - | " |
| 11. | Dr. Hasan Mahmud
Project Director, STD and AIDS | - | " |

The members of the Task Force (TF) is here by requested to expedite the conduction of activities out lined in the attached plan of action.

(Prof. .K. Shamsuddin Siddiquoy)
Director General of Health Services
Mohakhali, Dhaka-1212

No.: DGHS/AIDS/95/05

Date:

Copy for Information

1. Prof. A.Q.M.B Chowdhury, Chairman, National AIDS Committee.
2. Secretary, Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka
3. WHO Representative, Bangladesh, Dhanmondi, Dhaka

Copy for information & necessary action:-

1. Maj. Gen. M.R. Choudhury (Retd.) Chairman, Technical Committee of NAC, Convenor, Task Force
2. Member, Task Force

(Prof. .K. Shamsuddin Siddiquoy)
Director General of Health Services
Mohakhali, Dhaka-1212

গণপ্রজাতন্ত্রী বাংলা-দশ সরকার

স্বাস্থ্য অধিদপ্তর
মহাখালী, ঢাকা ১২১২

ন: স্বাঃঅধি/

তারিখ: ১৫-৯-৯৬ইং

আ-দশ

বাংলা-দশ যৌন-রাগ সমূহের বিস্তার প্রতি-রাধ ও ও নিয়ন্ত্রণ প্রকল্প HIV/AIDS/STD বিষয়ক ইস্যু-ত জাতীয় নীতিমালা ও আইন প্রণয়-নের লক্ষ্য, বিভিন্ন কার্যক্রম ---

ক্রমিক	নাম	পদবী/কর্মস্থল	পদ
১।	মেজর জেনা-রল (অব) এম,আর চৌধুরী	চেয়ারম্যান, টেকনিক্যাল কমিটি ন্যাশনাল এইডস কমিটি	সভাপতি
২।	জনাব এম, আজিজুর রহমান	এইডস বিষয়ক জাতীয় ফোকাল প-য়ন্ট স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয় অথবা তাঁহার একজন প্রতিনিধি	সভাপতি সদস্য
৩।	ডঃ শাহাদত হোসেন	পরিচালক, (পরিকল্পনা, গ-বয়ণা ও ----) স্বাস্থ্য অধিদপ্তর-র অথবা তাঁহার একজন প্রতিনিধি	"
৪।	অধ্যাপক মোঃ নজরুল ইসলাম	প্রকল্প পরিচালক, বাংলা-দশ এইডস প্রতি-রাধ ও নিয়ন্ত্রণ কর্মসূচী(ইউএনডিপি)	সদস্য
৫।	ডঃ লিজা জে মেনারমথ	প্রোগ্রাম অর্গানাইজার, ইউএনএইডস	"
৬।	ডঃ হাসান মাহমুদ	প্রকল্প পরিচালক, বাংলা-দশ যৌন-রাগ বিস্তার প্রতি-রাধ ও নিয়ন্ত্রণ কর্মসূচী	"
৭।	ডঃ ইনামুল করিম	ওএসডি, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়	"
৮।	জনাব আহ-মদ ইলিয়াস	পরিচালক, আল ফালাহ	"
৯।	ডঃ জেরীন হায়দারী	প্রকল্প পরিচালক, পিএস-কপি ও এসডিসএইচ প্রকল্প	"
১০।	জনাব মনসুর আলী	পরিচালক, সিসিডিপি	"
১১।	ডঃ মোঃ আরিফ	=====	"
১২।	ডঃ সাইফুর রহমান	এসটিডি/এইডস নেটওয়ার্ক	"
১৩।	ডঃ মনসুর আলী	উপ-প্রকল্প পরিচালক, বাংলা-দশ এইডস প্রতি-রাধ ও নিয়ন্ত্রণ কর্মসূচী (ইউএনডিপি)	"
১৪।	ডঃ নাজমুস সাহার সাদিক	প্রোগ্রাম অফিসার, ইউএনডিপি	"
১৫।	জনাব মোস্তফা কামাল মজুমদার	সাংবাদিক	"
১৬।	ডঃ সুফিয়া আহ-মদ	উপ-পরিচালক, বাংলা-দশ উই-মেন হেলথ কোয়ালিশন	"
১৭।	ডঃ ম, আনয়ারুল হক মিয়া	মেডি-কল অফিসার, বাংলা-দশ যৌন-রাগ বিস্তার, প্রতি-রাধ প্রকল্প	"

ডঃ আসাদ উদ্দীন
সহকারী পরিচালক (গ-বয়ণা)
স্বাস্থ্য অধিদপ্তর, মহাখালী, ঢাকা

অনুলিপি সদয় অবগতির জন্য প্রেরণ করা হ-লা

- ১। সচিব, (দৃঃআঃ ব্যক্তিগত সচিব), স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, বাংলা-দশ সচিবালয়, ঢাকা
- ২। === পরিচালক, (দৃঃআঃ সহকারী পরিচালক, সমন্বয়), স্বাস্থ্য অধিদপ্তর, মহাখালী, ঢাকা।