HIV PREVENTION AND EXISTING SERVICES FOR THE KEY POPULATION IN AFGHANISTAN, BANGLADESH AND NEPAL

Save the Children

THE PROGRAM

The Global Fund's Multi-Country South Asia (MSA) Grants started implementation in 2011 in seven South Asian countries (Afghanistan, Bhutan, Bangladesh, India, Nepal, Pakistan, and Sri Lanka). APCOM, a network and coordinating agency based in Thailand brought a regional lens to the program. The ultimate goal of the program is to reduce the number of new HIV infections in men who have sex with men (MSM) and transgender people (TG). This will be accomplished through three main outcomes:

i) Enhanced and enabling legal and policy environments;
ii) Strengthened community systems; and
iii) Development of strategic information and strengthened monitoring and evaluation capacity.

	Country (Province/District)
22 Focus Group Discussions (190 participants)	**Afghanistan** • Nangarhar • Kabul
17 Key Informant Interviews (17 participants)	**Bangladesh** • Dhaka • Comilla • Mymensingh • Sirajgang
128 Individual Questionnaires Survey 6 Case Studies	**Nepal** • Sunsari • Chitwan • Morang

SNAP SHOT

DURATION
November - December 2017

RESEARCH TITLE
To evaluate access to availability and satisfaction of Key Populations (MSM and TGs) with HIV prevention, testing and other services in Nepal, Bangladesh and Afghanistan.

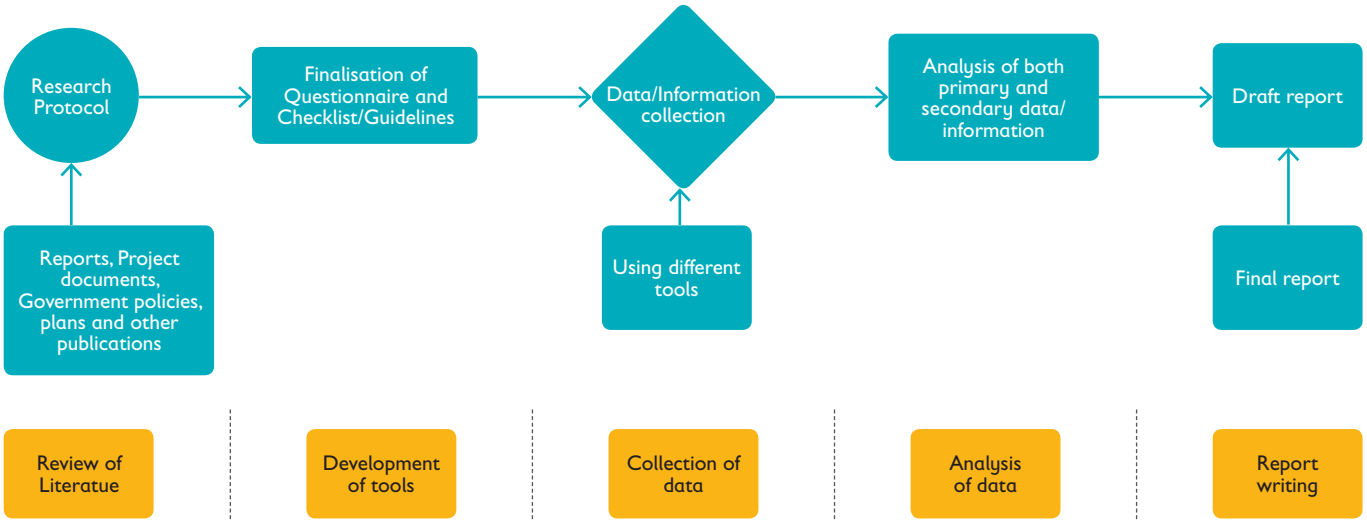
OBJECTIVES
1. To review the current legal framework and identify legal barriers for the HIV service provision.
2. To collect information on the scale and quality of existing HIV services provided for key target groups of the MSA project (MSM and Transgender population)
3. To conduct client's needs and satisfaction survey
4. To identify capacity-building gaps and recommendations for the potential scale-up and/or improvement of the program in respective countries.

PARTNERS AND COUNTRIES (RESEARCH CONDUCTED AREAS)

THE RESEARCH

The research was conducted by a team of individual consultants identified by Save the Children in Nepal. One international and three national consultants from each country (Afghanistan, Nepal and Pakistan) were engaged to undertake the assessment. Using purposive sampling, sample size from all the three countries were determined and both qualitative and quantitative methods were used.

Qualitative data were collected through focus group discussions and key informant interviews, and quantitative data were collected through a survey. Case studies were developed based on the willingness and suitability of respondents to complete a series of in-depth discussions. Qualitative information was objectively analyzed and thematically interpreted. Quantitative data were entered into Microsoft Excel, verified and checked for consistency, and tables were generated for interpretation.



MAJOR FINDINGS

Legal Framework and Barriers to Health Services

Same-sex relations are criminalized under different laws in Afghanistan and Bangladesh and Nepal has decriminalized men who have sex with men (MSM) between consenting adults. In Afghanistan, according to the key informant, male-to-male sex is illegal under both Sharia Law and the Penal Code with a maximum punishment of the death penalty. In the context of Bangladesh and Afghanistan, the punitive law (Sharia Law and the Penal Code) remains largely repressive. Findings from all three countries under the assessment illustrated that the denial the existence of MSM and TGs begins at home. In Afghanistan, the phrase *men who have sex with men (MSM)* is not acceptable in the legal framework, and the terminology used is *men with high-risk behavior (MHRB)*. Because of these, MHRB, MSM and TG people are reluctant to stay with their families and isolate themselves. It is also a common phenomenon in the countries that whenever MHRB, MSM or TG visit the hospitals for treatment, they are treated poorly by providers and other staff. As a result, they do not get enough attention for diagnosis and treatment. In some cases, they were removed from queues at hospitals. In Bangladesh, legal recognition of TG population immensely supported their status as equal citizens and assisted in more likeliness to access HIV prevention, treatment, care and other support services

Thought needs to be given to not only overturning the oppressive law and penalties associated with it that affect MSM and transgender people. Policy makers, other stakeholders and non-governmental organizations (NGOs) working to benefit key populations should advocate to introduce positive legal protections that provide remedies to the key population against the stigma and discrimination they are facing. This improved environment will support HIV responses for MSM and transgender people.

The National Strategic Framework on HIV/AIDS for Afghanistan–II 2011 – 2015 addressed MSM and operated two health centers catering to MSM and others are functional in Kabul and Mazar-i-Sharif. Due to the high stigma toward MSM, these centers are designed as male health clinics (MHCs). Services include syndromic case management of sexually transmitted infections (STI), knowledge on correct and consistent condoms use. In addition, blood borne diseases (BBD) tests, Hepatitis B vaccines and general primary health care have been made available.

Bangladesh, in their Third National Strategic Plan for HIV and AIDS Response 2011-2015, committed to minimizing HIV and STI transmission among female sex workers, MSM, Hijra, and people who inject drugs through targeted comprehensive intervention programs.. Bangladesh and Afghanistan have conflicting policies and how these two interact in the realm of service delivery needs formal research to fully understand.

Existing HIV Services

Community system strengthening is also very important to provide quality services. A total of 4 MHCs in Afghanistan, 27 community-based organizations (CBOs) in Bangladesh, 35 CBOs in Nepal have been strengthened to increase and enhance their capacity. Save the Children provided support on essential service delivery services for MSM Population to Youth Health Development Organization in Afghanistan. The National Global Fund HIV grant provided support in Bangladesh and Nepal for essential services (counseling, entertainment, STI, HIV testing and condom and water-based lubricant distribution) through the drop-in centers (DICs).

The quality of the existing HIV services offered by the DICs decreased due to funding constraints by the donors and non-prioritization of the disease by the national governments in Nepal and Bangladesh. The number of peer educators decreased and the catchment population grew leading to a ratio of peer educators to beneficiaries was 1:40 in Bangladesh and Nepal.

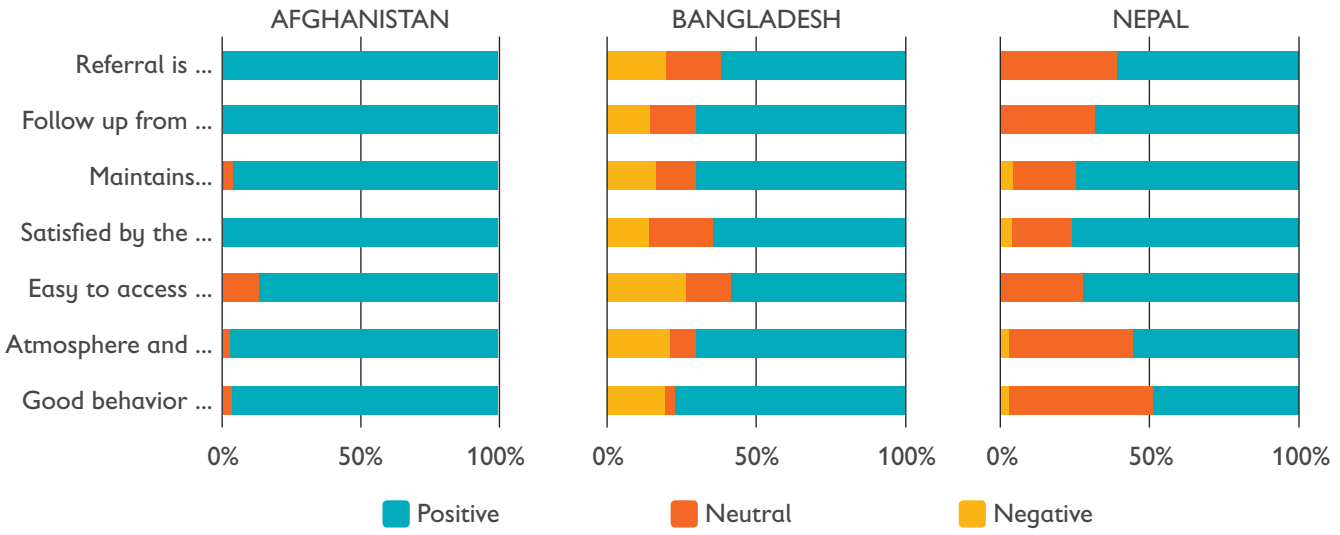
> 90% of the MSM and TG population are reluctant to visit the hospital, for 10% who have visited the hospital shared that when their identity was revealed they were treated inhumanely, stigmatized and discriminated. 100% of the respondents agree that revealing the identity increases the potential of risk.

Confidentiality for the key populations (KPs):

In Bangladesh and Nepal, privacy is seen as more of a concern compared to Afghanistan. The KPs suggested maintaining confidentiality to reduce stigma and discrimination. The KPs also need equal access and quality services provided by the hospitals. The HIV response for the KPs in the selected countries should follow theWorld Health Organization (WHO) guidelines. It is also required to explore better opportunities for mainstreaming MSM and TG populations within the public and private health sectors. Trainings received by the key populations as well as service providers and other stakeholders followed at country level to provide the optimum services. The countries provided services to the beneficiaries according to the WHO standard and each country has developed national standards with the country specific background and context.

Need and satisfaction of the key population

Satisfaction of the key population was measured in on a three-point scale (positive, neutral, negative) on seven areas. In Afghanistan, the client satisfaction on service provision is satisfactory in protected environment such as the DICs. On the other hand, in Nepal and Bangladesh, dissatisfaction is very high: 40-50% in most of the DICs. The target group in all three countries are reluctant to seek services in public and private centers, due to identity and disclosure of their status in all three countries. In the context of Afghanistan, during the FGDs and KIIs, respondents indicated that MHCs provide all HIV-related services to the MHRBs. However, primary healthcare is completely missing. These populations are not visiting local hospitals for general health-related problems because once their identities are revealed, the



health providers deny services. Similarly, in Bangladesh and Nepal, the MSM and TG population do not have equal access to the treatment or services at government hospitals. During the FGDs, participants said that when they visit any general hospitals, they do not disclose their identity because of the fear that the doctors would be reluctant to provide any services once their identities are revealed.

Needs identified based on the FGDs

- Long term funding should be there to accomplish most of the works
- More grassroots focused programs to support increasing numbers of MSM and TG
- Sustainability of CBOs and MHCs is important to continue the care to the key population
- Provision of income generation activities to MSM and TG population

Capacity gaps

During the FGDs, researchers assessed existing capacity of the CBOs and MHCs service providers exploring how they successfully carry out the work, what capacity building initiatives are taken, what indicators are used to monitor progress over the time, and what further steps are required for improvement. In KII sessions, researchers also asked what steps are required to mitigate capacity gaps. Certain gaps and opportunities to address them at scale were identified by the beneficiaries and stakeholders. Many of the capacity gaps identified were not necessarily related to clinical skills but rather overall institutional capacity. Documentation and provision of IT support at CBOs for record keeping was identified along with an inadequate skill mix among CBOs for advocacy and sensitization among different level of stakeholders. The CBOs may lack negotiation, fundraising and resource development capacity skills to advocate for and receive more resources. Likewise, weaknesses were found in coordination at different levels of stakeholders.

Capacity gaps	Recommendations
CBOs are weak in documentation and record keeping and were not able to do it properly	Documentation and provision of IT support at CBOs for record keeping
CBOs are weak in networking and coordinating with government and other stakeholders	Provision of enrolment of skill development program
CBOs have inadequate resources to continue and to protect their achievements	Commitment of longer funding support, including plan for CBO sustainability
Weak negotiation skills for sustainable financial resource allocation to CBOs	Need to create an avenue to support CBOs' decision-making processes

RECOMMENDATIONS

Legal support

There are conflicting policies, and we are yet to see how the two interact in the realm of service delivery. Much improvement has been observed on service provision in Afghanistan and Bangladesh. The HIV/AIDS Coordinating Committee of Afghanistan (HACCA) has been playing a key role to engage policy makers, community leaders, civil society and officials from the line ministries in addressing the stigma and discrimination associated with HIV. Similarly, Bangladesh has put in place policies and strategies related to public health and HIV but has not enacted laws or bills to protect the rights of people living with HIV, MSM and TG people.

Policy, guideline, and framework tools

Assist countries and organizations to work together for removing the legal and policy-level barriers that prevent MSM and transgender people from enjoying the rights to the highest attainable standard of physical and mental health, particularly in relation to access to the HIV prevention, treatment and care. Such guidelines and evidence-supported advocacy efforts to shift focus on the need to respect the human rights and the law to ensure the health for individuals and communities. Policies and legislation can impact favorably on human rights, while violations of human rights can detrimentally affect health, particularly among key populations.

Existing HIV Service

Ensure the minimum package is available for the all key populations and take steps to reduce stigma and discrimination.

CBO system strengthening

Empower CBOs to be equal partners. Capacity building of CBOs is at the core of the MSA grant. The MSA program develops institutional capacities to support strengthening organizational governance and management systems and processes, provides CBOs with organizational management tools and develops skills to use the tools to fast-track the augmentation of their organizational capacity. This support needs to continue for empowering these CBOs to be equal partners in journey to achieve their missions.

Networking and collaboration

Expand the network of CBOs across the countries and collaborate with different development entities. Increasing networks and partnerships will yield rich dividends, allowing individual groups to raise their collective voice. Local ownership will contribute to the local and national efforts help to protect rights and end stigma and discrimination for the fulfillment of the fast-track strategy to end AIDS by 2030.

Funding support

Establish sustainable structures for sustaining viable program for beneficiaries. A systematic approach is needed in the project design for the continuation of such efforts for a longer period of time.

CONCLUSION

The MSA Global Fund HIV Program is addressing critical gaps in reaching MSM and transgender people, thereby complementing national grants and programs. The MSA Grant focuses on community systems strengthening to ensure more effective linkages between community-led and government-led HIV services. The program provides a vital regional platform for advocacy on sensitive human rights issues in a way that supports action to address legal and policy barriers to the services for key populations at national and sub-national levels.