

Communities, Rights and Gender TB Tools Assessment in Bangladesh

Report

2018

Prepared by:

Dr. Shahed Hossain, Dr. Md. Ashaque Husain, Md. Ali Imam,
Tapan Kumar Ghosh, Barrister Nishat Mahmood,
Md. Humayun Kabir, Nargis Sultana, Iffat Kabir
and Rashed Munsi



Message from Stop TB for Communities, Rights & Gender assessments reports

The tuberculosis (TB) response needs a paradigm shift – becoming people and community centered, gender sensitive and human rights based. There is a need for country specific data and strategic information key, vulnerable and marginalized populations. There is a need to facilitate an enabling environment to effective prevention, diagnosis, treatment and care – which requires legal and gender related barriers to be analyzed, articulated and alleviated. The Stop TB Partnership CRG Assessments are the tool for National TB Programmes to better understand and reach their epidemics. With TB being the leading cause of infectious disease deaths globally, and with over 10 million people developing TB each year, this disease continues to be a public health threat and a real major problem in the world. The Stop TB Partnership’s Global Plan to End TB and the World Health Organization (WHO) End TB Strategy link targets to the Sustainable Development Goals (SDGs) and serve as blueprints for countries to reduce the number of TB deaths by 95% by 2030 and cut new cases by 90% between 2015 and 2035 with a focus on reaching key and vulnerable populations. The Strategy and the Plan outline areas for meeting the targets in which addressing gender and human rights barriers and ensuring community and people centered approaches are central.

Ending the TB epidemic requires advocacy to achieve highly-committed leadership and well-coordinated and innovative collaborations between the government sector (inclusive of Community Health Worker programs), people affected by TB and civil society. Elevated commitment to ending TB begins with understanding human rights and gender-related barriers to accessing TB services, including TB-related stigma and discrimination. It has been widely proven that TB disproportionately affects the most economically disadvantaged communities. Equally, rights issues that affect TB prevention, treatment and care TB are deeply rooted in poverty. Poverty and low socioeconomic status as well as legal, structural and social barriers prevent universal access to quality TB prevention, diagnosis, treatment and care.

In order to advance a rights-based approach to TB prevention, care and support, the Stop TB Partnership developed tools to assess legal environments, gender and key population data, which have been rolled-out in thirteen countries. The findings and implications from these assessments will help governments make more effective TB responses and policy decisions as they gain new insights into their TB epidemic and draw out policy and program implications. This provides a strong basis for tailoring national TB responses carefully to the country’s epidemic – the starting point for ending discriminatory practices and improving respect for fundamental human rights for all to access quality TB prevention, treatment, care and support services. The development of these tools could not be more timely, and the implementation of these tools must be a priority of all TB programmes.

Lucica Ditiu,

Executive Director, Stop TB Partnership



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We, with gratitude acknowledge the contribution of the resource persons in preparing this document which will provide thoughtful recommendations for further developing the national tuberculosis control strategies under the stewardship of NTP addressing gender and human rights barriers and ensuring community and people-centered approaches.

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Acronyms

AIDS: Acquired Immune Deficiency Syndrome	IDU: Injecting Drug User
ART: Antiretroviral Therapy	ILO: International Labour Organization
ASP: AIDS/STD Program	JMM: Joint Monitoring Mission
BCCM: Bangladesh Country Coordinating Mechanism	KAP: Key Affected Populations
BDHS: Bangladesh Demographic Health Surveys	LEA: Legal Environment Assessment
BEPZA: Bangladesh Export Processing Zone Authority	LTFU: Treatment after loss to follow up
BGMEA: Bangladesh Garment Manufacturers and Exporters Association	MBD: Mycobacterial Diseases
BKMEA: Bangladesh Knitwear Manufactures and Exporters Association	MBDC: Mycobacterial Diseases Control
BSCIC: Bangladesh Small and Cottage Industries Corporation	MDG: Millennium Development Goals
CCM: Country Coordinating Mechanism	MDR: Multi-Drug Resistant
CDC: Chest Diseases Clinic	MOHFW: Ministry of Health and Family Welfare
CDH: Chest Diseases Hospital	NATAB: National Anti Tuberculosis Association of Bangladesh
COPD: Chronic Obstructive Pulmonary Diseases	NGO: Non-Governmental Organization
CWFD: Concerned Women for Family Development	NIDCH: National Institute of Diseases of the Chest and Hospital
DEPZ: Dhaka Export Processing Zone	NSP: New Smear-Positive
DF: Damien Foundation	NSPT: National Strategic Plan on Tuberculosis
DGHS: Directorate General of Health Services	NTP: National Tuberculosis Control Programme
DOT: Directly Observed Treatment	PBC: Pulmonary Bacteriologically Confirmed
DOTS: Directly Observed Treatment- Short course	PCD: Pulmonary Clinically Diagnosed
DR: Drug Resistant	PLHIV: People living with HIV
EPTB: Extra-Pulmonary Tuberculosis	PPM: Public Private Mix
EPZ: Export Processing Zone	PTB: Pulmonary Tuberculosis
FMR: Female to Male Ratios	SDG: Sustainable Development Goals
FYP: Five-year plan	SOP: Standard Operating Procedure
GAT: Gender Assessment Tool	SRHR: Sexual and Reproductive Health and Rights
GBV: Gender-based violence	STBP: The Stop TB Partnership
GDP: Gross Domestic Product	STD: Sexually Transmitted Diseases
GFATM: Global Fund to fight AIDS, Tuberculosis and Malaria	TAF: Treatment after failure
HIV: Human Immunodeficiency Virus	TB & L: Tuberculosis & Leprosy
HNPSP: Health, Nutrition and Population Sector Programme	TB: Tuberculosis
HPNSDP: Health, Population and Nutrition Sector Development Programme	UHC: Upazila Health Complex
HPSP: Health and Population Sector Programme	UN: United Nations
	UNAIDS: Joint United Nations Programme on HIV/AIDS
	UNDP: United Nations Development Program
	UNOPS: The United Nations Office for Project Services
	USD: United States Dollar
	VD: Village Doctor
	WHO: World Health Organization
	X'PERT: Xpert MTB/RIF

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1. Project Summary

Stop TB Partnerships in partnership with BRAC in Bangladesh is testing three tools, namely, *i. TB/HIV Gender Assessment Tool*, *ii. Legal Environment Assessment Tool* and *iii. Framework on key, vulnerable and underserved populations* in order to roll out globally. The major objectives are to assess the epidemiological and contextual analysis of gender and human rights differentiation in TB and HIV control policies and guidelines in the country context, prioritize Key population at larger risks of TB / HIV at National level, and get an indication to which extent the national TB and HIV programmes are gender-responsive in order to recommend gender interventions that would make the national TB and HIV programmes more effective. This report provides a preliminary narrative of the outcomes of the desk review, a stakeholder workshop with exercises with the tools in the workshop and findings from a qualitative inquiry into some of the issues recommended in the workshop. It is intended to hold another stakeholder workshop to validate and finalize the findings and recommendations that are made from the afore-mentioned activities.

The desk review noted that in 2017, Bangladesh continues to be one of the high TB burden countries of the world, having a high prevalence of TB among adult population, higher in males than females, among the elderly population (65+ Years) and more in urban than rural areas. The estimated incidence for all forms of TB was also higher among the males than the females. Disproportionate prevalence of TB has been reported from different sub-groups of population in Bangladesh including among the prisoners, the garments workers, the poor, particularly among the slum population. Along with the higher case notification rate among males (Female: Male ~ 1:2) indicates the possible roles of other socio-cultural and behavioural factors contributing to the TB burden in the country. Literature reviews also provided evidences indicating the presence of high stigma, fear and negligence in care seeking for TB. All the factors were highly associated with females than males. However, most of the studies are either observational or descriptive in nature or not currently carried out.

From programmatic point of view, it was noted that Bangladesh NTP remained very much dynamic since adoption of DOTS strategy in 1993, continued to change and embrace new strategies and policies to make the programme more accessible, equitable and effective. Major milestones are practice of shorter regimen MDR treatment, introduction Xpert to Upazila level, very recent change in diagnostic algorithm, and extending socio-economic support to the MDR, the poor, and PLHIV (People living with HIV) and suffering from TB. At the same time Bangladesh programme continued to maintain high cure rate as well as low default rates.

From the policy point of view TB services in Bangladesh are very much gender-sensitive and equitable in service provisions. In a policy statement which was equivocally endorsed by all participants that *“The NTP strives to make services equally available to all people in Bangladesh*

irrespective of age, sex, religion, ethnicity, social status or race". This policy is also fully endorsed by country policy environment-the Bangladesh constitution, which is considered as an engendering constitution. Similar full support also found in the Health Services Act of Bangladesh; the National Health Policy; the TB strategic guidelines and supported by the Tuberculosis-Leprosy and AIDS STD Programme (TB-L & ASP) guidelines.

The workshop participants analyzed the Gender assessment tool and remarked on several observations. Despite being availability of TB services free of cost and throughout the country yet some people cannot access the services fully due to many reasons. From gender and equity point of view the major constraints are:

- Lack of women-friendly service points in many areas
- No policy provision for disable population or initiatives to address disability
- The situation of hard-to-reach areas is a needed concern
- No inclusion of the third gender identity in the service formats
- Lack of specific policy to emphasis counseling

Similarly, from the legal point of view, there are several barriers in terms of either absence of clarity or ambiguities in the legal documents for the sexual workers, transgender, homosexual, illegal drug users or illegal migrants in accessing public services. However, the participants remarked that these barriers could not prevent in accessing TB services and full utilization of it in Bangladesh.

While working on the TB HIV response to the challenges the workshop reported several challenges, but mostly related to HIV than TB. For example, prevalence of gender-related impediments such as stigma, discrimination, gender-based violence etc., absence of provision for male circumcision in the programme and gaps in practice of principles of gender-based violence in every sphere of life. Several comments were made in the areas of HIV and TB prevention; Testing and Treatment; Care and Support; Gender-based violence and sexual and reproductive health rights. In summary the main gaps in addressing gender differences, the workshop commented that:

- In most cases data disaggregated by age, sex is not available
- Since the Transgender has been recognized as the "third sex", the national programme needs to think how to incorporate this sex in reporting formats

The workshop also commented that there have been attempts to address these barriers in the national policy through Public-Private Partnerships, Active case finding strategy, establishment and expansion of new diagnostic tools etc.

When explored the gender aspects in sub-groups of key population (Men and boys, Young men, elderly population etc.) several observations were made by the workshop participants. There is a national gender policy in Bangladesh but no specific focus to TB/HIV patients. However, they also commented that in real world these impediments do not create barriers to access services when needed. They also found areas to improve mainly in mass awareness on policy and its implementation.

- Policy exists but inadequate awareness on policy
- National guidelines for management of tuberculosis in children 2016 exists but implementation is not at the expected level
- TB screening is included in the guidelines but still scope of further improvement to increase the range of implementation
- Limited access to counseling for children <15 years
- Inadequate protection against gender-based violence

The workshop continued the discussion on gender-related issues and remarked that the gender assessment tool itself has several ambiguities to use. These include;

- Too many theoretical questions with overlapping and repetition among the steps
- Some questions need more clarification to elicit appropriate answers
- Some questions are not yet applicable to Bangladesh societal context

Key Population prioritization and risk assessment

Key populations are the population sub-groups facing higher risk of TB exposure compared to the general population. Key populations are often missed by the health systems, often unable to access health services, or suffer particularly detrimental consequences as a result of TB. The workshop prioritized 3 key populations (from a list 30 population) for TB epidemic in Bangladesh following a standardized framework also developed by Stop TB Partnership. Participants worked in groups by a scale coded method on the basis of epidemiological risk analysis for identification of the 3 prioritized key populations and then ranked them according to the score obtained. A consensus was arrived among the groups before a final list was prepared. The Workshop prioritized three key populations that they urged the programme needs to focus and work on;

- 1. The Garments workers / Factory workers**
- 2. The urban poor (particularly slum dwellers)**
- 3. The elderly population (65+ years)**

Subsequently the two groups worked intensively identifying the TB risks, risk drivers, and possible challenges for the programme to address those risks. They also commented on the potential responses for the programme to address those challenges.

The workshop discussed over the findings and commented that even though it was pointed out that TB is such a disease where the national programme is able to provide full length of services, but most of the other health programmes do not have such scope. Identifying key population who are at higher risks of TB and have risky habits of behavior could be useful to target and address. Since Bangladesh has good community responses, sound practices in gender and rights issues; such risks can be combated successfully. However, if there are any gaps in identification of any community, declining rights, or gaps in gender the programme must have to address those with much care.

The Validation Workshop:

The validation workshop endorsed most of the findings presented from the desk review, the outcomes from the first workshop and the field level data shared in the workshop. The major thematic area identified from all the data sources was the missing cases in the country; “who the cases are and where to find them?”. The agreements in the discussion was that the missing cases are not reported to the system, either remaining in the private sector unnoticed or not treated at all or mistreated in the hands of non-formal providers. There was not much debate that majority of the missing cases were probably poor, vulnerable population living in the slums. Specific suggestions were made for the garment workers, elderly population and male population in urban areas among the identified three key population. Reasons for missing cases included root causes like stigma with diagnosis, care seeking practices and gaps in knowledge on TB services. Similarly, several programme related factors were discussed like lack of child and EP TB diagnostic facilities and training at all levels, availability of services when needed (24x7), inadequate follow up with legal bindings with TB diagnosis and treatment (e.g. 14 days leave and mandatory notification) etc. The way forward suggested and discussed in general were i. judicial and relevant use of relevant use of Stop TB tools when needed, strengthening facilities for child and EP TB diagnosis with adequate logistics and training, addressing specific needs for the key vulnerable population and promoting TB services in areas of rights and gender issues. It was argued that communities, rights and gender- these three areas can be followed, and these will guide to identify the missing cases, but the programme must undertake challenges to bring these cases under notification. Specific discussions included mandatory 14 days leave legal right implementation at garments factories where most of the workers are female, probably semi-literate and poor. Involvement of civil society, more engagement with factory owners and other sectoral approaches of the government and alliance with other occupational group could be useful. But evidences in these regards are anecdotal and limited to personal experiences. A holistic approach to address all infectious disease under one platform, adoption of the DSD (Differentiated service delivery) model of HIV/AIDS could add value to the programme and can

be considered. However, there are still gaps in the basic data (information) segregated by age and sex at all levels, particularly from each of these identified key and vulnerable population. Activities will then be better focused and targeted once these kinds of data will be available. Overall, it can be said from the policy point of view and programmatic support that the NTP has dynamic and continuous backing and efforts in terms of gender, rights and communities. These tools are useful to identify specific needs and focus areas to work and will help to better understanding our situation and to undertake measures specific to our communities and context.

2. About BRAC

BRAC, a development organization started its journey in 1972 in the newly independent country Bangladesh with a dedication to alleviate poverty by empowering the poor. Since inception, it has been playing significant roles in recognizing and addressing several health issues associated with poverty. BRAC has developed community-based health care delivery model in which the female frontline community health workers play the pivotal roles. Through initiating a pilot project in one sub-district BRAC started community-based TB control programme in 1984 which has been emerged as an evolution of health programme of BRAC.

Bangladesh has achieved remarkable progress in Tuberculosis control despite the fact that it is one of the highest TB-burdened countries in the world. TB control strategy has been adopted as an integral part of the strategies of Bangladesh in strengthening health and social sectors. The government adopted internationally recognized DOTS (Directly Observed Treatment Short course) strategy for effective diagnosis and outcome in TB since 1993. In 1994, NTP has signed a MOU with BRAC to expand DOTS service countrywide. Currently BRAC implementing TB control programme as a principal recipient of the Global Fund in collaboration with several sub-recipients working in TB.

Despite increases in case detection and treatment success rates current WHO estimates indicate that 43% of all cases are not being diagnosed. Undetected cases may experience morbidity and contribute to mortality and remain as sources of infection in the community and perpetuate the TB epidemic. Revisiting the programme is important to identify gaps and take necessary measures.

3. Project background: History of tuberculosis control in Bangladesh

The history of tuberculosis control in Bangladesh dates back to the year of 1965 when a government funded National TB Programme (NTP) has been initiated. At that period only 44 TB clinics, 8 segregation hospitals and 4 TB hospitals were providing curative treatments for TB patients. The Second Health and Population Plan (1980-86) expanded the services to Upazila health complexes (UHC) under the “Strengthening TB/Leprosy Control Services” project, where during the Third Health and Population Plan (1986-91), the services operationally integrated leprosy under the “Mycobacterial Disease Control” (MBDC) Directorate.¹

The World Bank conducted a study on the TB controlling process in Bangladesh in 1990, where it found low case detection and cure rates at 10% and 40% respectively.² Prior to 1993 TB services in Bangladesh were mainly curative. The National TB Control Programme (NTP) hence from November 1993 adopted the Directly Observed Treatment, Short Course (DOTS) strategy in order to improve case detection and cure rates and started field implementation and progressively expanded to cover all 460 Upazilas by June 1998. However, in 1994, Memorandum of Understandings was signed between NTP and NGOs and in the very year the government and WHO conducted first external review and recognized DOTS as model in the region.³

A reformation of health and population sector had been executed in July 1998 where the services were available through a sector wide approach Health and Population Sector Programme (HPSP). Hence the Government of Bangladesh organized a second programme review in July 2001 and formulated a strategic plan within the context of HPSP subsequent to the International Call for Action (Amsterdam Declaration 2000). This HPSP hence tried to horizontally integrate the NTP management into an Essential Services Package (ESP). However, in March 2003, the Government of Bangladesh revised its strategic approach to public health and renamed HPSP as Health, Nutrition and Population Sector Programme (HNPSp) and NTP continues its operations under the directorate "Mycobacterial Disease Control", which functions under DGHS of the Ministry of Health and Family Welfare. HNPSp was formed with priority objectives being to reduce the maternal mortality rate, the total fertility rate, malnutrition, infant and children under-five mortality and the burden of TB and other diseases.⁴ During this period the NTP secured CIDA

¹ National Tuberculosis Control Program (NTP), DGHS of the Ministry of Health and Family Welfare website, available at <http://www.ntp.gov.bd/>

² *ibid*

³ *ibid*

⁴ *ibid*

grants and increased number of involvement of private practitioner was also possible through pilot projects⁵.

The Government of Bangladesh further revised its strategy approach prioritizing TB control under communicable disease in 2011 and renamed the HPNSP as Health Population and Nutrition Sector Development Programme (HPNSDP), where NTP continues its operations under the directorate "Mycobacterial Disease Control", which functions under DGHS of the Ministry of Health and Family Welfare.⁶

By the year 2003 the TB service under NTP expanded to metropolitan cities and DOTS in corporate sectors. By the year 2005 NTP initiated projects where both public and private organizations took part. One of the mentionable projects among these included TB services being launched in prisons. The same year, the NTP developed the National Strategic Plan for 2006 – 2010.⁷

In the year of 2006, the NTP received approval from Green Light Committee (GLC) for DOTS-Plus Project that targeted treatment of 700 MDR-TB patients. In 2007, the NTP scaled up the DOTS services in corporate sectors. That year it also established the National TB Reference Laboratory which was made functional the same year. In the year 2009 GLC review was conducted, a comprehensive HRD TB plan was developed and the National Strategic Plan for 2011-2015 was drafted. In the year 2011, Programmatic Management of DRUG-resistant TB (PMDT) guidelines were reviewed and Standard Operating Procedures (SOP) on c-PMDT & TB-infection control guidelines were developed.⁸

The overall goal of the NTP is to reduce morbidity, mortality, and transmission of TB until it is no longer a public health problem. Elimination of tuberculosis implies that incidence of TB would be less than one in per million population.

Finally, the National Strategic Plan for 2018-2022 has been formulated a public-private mix strategic plan with objectives to reduce the 33% gap in case detection, sustain treatment success of 90% (drug susceptible), increase access to diagnosis for multi-drug resistant TB (MDR-TB) and contribute to the reduction of MDR-TB incidence.⁹

⁵ Revised Strategic Plan for National TB Control Plan 2012-2016

⁶ ibid

⁷ ibid

⁸ ibid

⁹ National Strategic Plan on Tuberculosis 2016-2020

4. Justification of the Assessment

Communities, Rights and Gender TB Tools Assessments

The Stop TB Partnership (STBP) is focusing efforts to ascertain more effective roles of the communities in advocacy for all aspects of TB control including policies, planning, and implementation and monitoring, and thereby aiming to ensure increased access and better outcomes of TB services. In response to the call for End TB by 2035 and based on the lessons learnt from ongoing research, public health experiences, particularly from HIV programme implementation, the values of community engagement have been hugely emphasized (*Gender Assessment tool for national HIV and TB responses: Towards gender – transformative HIV and TB responses, Stop TB Partnership, UNAIDS*).

Evidences suggest that socio-economic, cultural and political factors influence the disease epidemic not only on its occurrence and transmission but also on the responses to tuberculosis (TB) epidemic and the programme implementation. Stigma, Gender and human rights all three separately or together impact the disease epidemiology and influence its control measures. In order to assess the country responses to TB epidemic in the perspective of gender, human rights and socio-economic factors the STBP has recently developed three tools, namely, *i. TB/HIV Gender Assessment Tool, ii. Legal Environment Assessment Tool and iii. An action framework on key, vulnerable and underserved populations. (Gender Assessment tool for national HIV and TB responses: Towards gender – transformative HIV and TB responses, Stop TB Partnership, UNAIDS)*.

STBP in partnership with organizations in six countries including Bangladesh is trying to field testing the tools in order to roll out globally. BRAC as local partner of STBP in Bangladesh is commissioned to undertake an assessment activity using these tools at national level and following objectives are outlined.

This report puts forward the findings of the TB Legal Environment Assessment (LEA) conducted for Bangladesh. This particular LEA report has been undertaken at the behest of Tuberculosis (TB) Control Programme of BRAC, the first NGO in the country to sign a memorandum of understanding with the government to expand Directly Observed Treatment Short Course (DOTS) services across the country, since the government, by initiating a program such as National TB Control Programme (NTP) as early as in the year of 1965, envisioned to ensure improved health and family welfare for the key population most vulnerable to Tuberculosis.

The purpose of this LEA is to evaluate the commitment of the government in regard to controlling communicable diseases such as Tuberculosis against the laws those are available to foster an enabling environment that reduces the vulnerability of the population from TB, alleviate the

sufferings (*i.e.* physical, economic, social and mental) of people living with TB and finally to assess the effectiveness of the services available or yet needed to be formed in order to serve the needs of community and society.

This LEA report shall be emphasizing on the laws and policies those ensure public health by obligating the government, state, public health agencies and private organizations those have undertaken the responsibility in collaboration with the government to secure public health in every sphere of the population.

4.1 Objectives of the Assessment

1. To assess the extent to which the national TB and HIV programmes are gender-responsive.
2. To conduct an epidemiological and contextual analysis of gender and human rights differentiation in TB and HIV control policies and guidelines.
3. To prioritize Key population at National level, identify gaps and develop framework.
4. To prepare recommendations and determine interventions that promote gender and human rights relating to TB and HIV control.
5. To recommend gender interventions that would make the national TB and HIV programmes more effective.

4.2 Status of Project plan

Activity report

Organization: BRAC

Funded by: Stop TB Partnership

Timeline: November 2017- November 2018

Sl. No.	Project Activities	Planned	Status
1	Conduct Desk review	1	Completed
2	Stakeholders Workshop	1	Completed
3	Research logistics	1	Completed
4	Conduct Research	1	Completed
5	Validation workshop	1	Completed

5. Summary of Project activities

The methodology outlined consists of undertaking several activities to reach the objectives of the project. Both quantitative and qualitative methods of data collection were proposed. The activities identified are:

1. An initial desk review and sharing with national stakeholders, implementing partners and other technical partners.
2. Organizing a workshop (preferably four days) to share the current situation after desk review and get the stakeholders familiarize with the tools developed by Stop TB partnership.
3. The workshop will exercise on the use of tools developed, assess their feasibility, applicability and will suggest any modifications.
4. The workshop will also undertake to map out key and vulnerable population to the TB disease and its response in terms of gender, human rights and socio-cultural aspects and then find out ways to determine how the approach, as determined by the workshop, can be implemented.
5. A quick field level qualitative data collection will follow mainly comprising focus group discussion and in-depth interviews.
6. Afterwards, the consultants undertake intensive meetings to develop the first draft of the report.
7. This draft will then be shared in the validation workshop which ultimately leads to developing the final report to determine the status of the three identifiable population groups.

This report provides the primary deliverable: a narrative of the outcomes of the first four activities (i.e. desk review, stakeholder workshop and exercise with the tools in the workshop) carried out in response to reach the first three objectives (Page 01) of this proposal. And then a narrative of the outcomes of the last three activities (i.e. a qualitative study, draft preparation and validation workshop with stakeholders) carried out in response to reach the last two objectives (Page 01) of this proposal.

5.1 Working/Core Group

A working/core group was formed with following members to plan and implement the project:

1. Md Akramul Islam, Director, Communicable Diseases & WASH, BRAC
2. Dr. Ashek Hossain, Former Director MBDC and Line Director NTP
3. Dr. Shayla Islam, Programme Head, Communicable Diseases (TB), BRAC
4. Md Niamul Kabir, Senior Legal Counsel, Legal & Compliance Department, BRAC
5. Monira Yasmin, Legal Counsel, Legal & Compliance Department, BRAC
6. Dr. Paul Daru, Regional Advisor (TB), University Research Co., LLC (URC)
7. Md. Ali Imam. Assistant Scientist, Icddr, b
8. Barrister Nishat Mahmood, Legal Consultant
9. Dr. Shahed Hossain, Professor, JPG
10. Tapan Kumar Ghosh, Consultant
11. Sardar Munim Ibna Mohsin, Programme Manager, Communicable Diseases (TB), BRAC
12. Dr. Saifur Reja, Senior Manager, Communicable Diseases (TB), BRAC
13. Isbat Azmary Rifat, Senior Sector Specialist, Communicable Diseases (TB), BRAC
14. Dr. Fatema Khatun, Senior Manager, Communicable Diseases (TB), BRAC
15. Dr. Farhan Kabir Patwary, Medical Officer, Communicable Diseases (TB), BRAC

5.2 Engagement of Consultants

Qualified consultants were hired to plan and implement the project within the given timeline. Consultants were selected following the BRAC procurement policy. They sat with programme personnel and worked together to complete the project as per plan and timeline. Consultants also prepared reports and submitted to the programme for review and feedback before finalizing it. This report was shared with stakeholders.

5.3 Desk review

The initial Desk Review was conducted with the view to provide an information guideline to all the tools assessment processes. To guide the desk review, the reviewers worked through the TB/HIV Gender assessment tool guidelines particularly guided by the checklists / questionnaires given in the step 7 (Epidemiological data on TB, HIV) and steps 8 and 9 (Social, cultural, and economic factor; and legal and political context) under stage 2: knowing the national TB and HIV epidemic and its surrounding context. The literature review looked into existing national documents as suggested in the proposal included:

- National Strategic Plan – Public-Private Mix in Tuberculosis (2016-2020)
- National Strategic Plan for TB Control (2018-2022)
- Mapping Study and Size of key population for HIV Program (2015-16), Bangladesh
- GFATM New Funding Models
- National Strategic Plan, HIV
- Bangladesh Demographic Health Surveys
- Annual Reports of the technical partners
- Directorate General of Health Services (DGHS) Bulletins
- Legal Documents
- Online resources (Pub Med, Goggle, Repositories, individual journal websites)

A post workshop review was being done based on the information shared by the participants of the workshop. Information was collected sometime through personal communication. All these were added to the final desk review outcomes.

ON STAGE 2 (KNOWING THE NATIONAL TB EPIDEMIC AND ITS SURROUNDING CONTEXT)

TB in Bangladesh: Epidemiology, context, Gender, Human rights and socio, economic and political perspectives

In 2017, Bangladesh continues to be one of the high TB burden countries, having a prevalence of bacteriologically confirmed TB among adults 287(244-330) /100,000 population (National prevalence survey 2015-16). The prevalence was higher among male 452(379-526) to female 143(109+178), among the elderly population (65+ Years) 954 (715-1194) and more in urban 316(239-392) than rural areas 270(220-324) (National Tuberculosis Prevalence Survey 2015-16 Preliminary Report (IEDCR, funded by WHO). The estimated incidence for all forms of TB was 221 (161-291), also higher among the males than the females (Table 1). Bangladesh has made considerable progress in DOTS implementation since its adoption in 1993. The NTP evolved considerably with adopting Stop TB strategies in 2006, expanding GeneXpert at the Upazila level and introducing newer algorithm for presumptive TB and diagnosis (Figure 1). High treatment success rate has been achieved from 2000 (> 90%) and prevailed and combating successfully to content the emergence of MDR TB under a limit (Annual Report 2017, NSP 2017, WHO Report 2017). Despite all these successes, the case notification lingered as at 62% (47-85) means that a marked proportion of these cases did not have any access to diagnosis and care or not reported under NTP (*Global Tuberculosis Report 2017, World Health Organization (WHO)*). Similarly, evidence on health care utilization, particularly accessing DOTS by socioeconomic groups is scarce. Even after nearly 25 years of DOTS implementation, TB related mortality rate remained as high as 40(26-58) / 100,000 population (*Global Tuberculosis Report 2017, World Health Organization (WHO)*).

There is marked difference in the case notification among the male and females in all forms of TB except in Extra Pulmonary TB (EPTB) and among the children age groups (Figures 2 and 3). Traditionally case notification is lower among < 14 years age group and among the females. It is not conclusive whether this difference is biologically determined or true epidemiological condition or related to behavioral, socio-cultural attitudes and practices. The recent prevalence survey of 2016 analyzed the situation looking at the interface gender and setting (higher prevalence among males and in urban areas) and concluded that urban males have a uniquely high prevalence of TB. Studies conducted in the urban slums also confirmed higher prevalence of TB in the slum areas as 253/100,000 population, in addition to higher prevalence of malnutrition among the detected cases (> 50% with low BMI of < 17 kg.m²) (Banu S et al 2013).

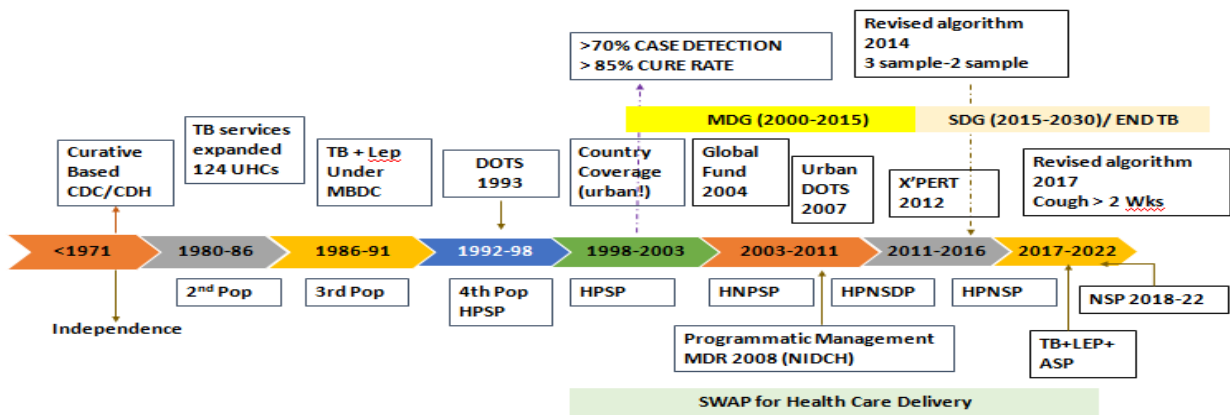


Figure 1: Bangladesh Progress in TB control: Policies and strategies

Disproportionate prevalence of TB has been reported from different subgroups of population in Bangladesh. Higher prevalence was recorded among the prisoners in the Dhaka jail (Banu S et al. 2010) and among the garment workers (Hasan M.R. et al. 2005). Findings of the Bangladesh National TB prevalence survey 2007-2009 revealed the prevalence of TB to be 10 times higher among lowest quintiles compared to the highest quintiles of the population (Zaman et al., 2011). Further analysis of prevalence data showed that nearly 90% of the TB cases detected routinely under DOTS programme were in the middle and upper wealth quintiles of the population, while 60% of the cases detected actively in the survey were among the lower wealth quintile of the population and who would not have been detected at all or detected markedly later if active household search was not undertaken (Hossain et al 2012).

Similarly, the higher case detection rate among males (Female: Male ~ 1:2) implies the role of existing stigma and other socio-economic factors, and some possible programmatic discrepancies. Gender inequity in TB case detection has severe consequences for public health

in terms of women's poorer access to health care, delays in diagnosis and treatments, and unnecessary spread of disease (Diwan et al., 1999; Long et al., 1999; Yamasaki et al., 2001).

The relationship between gender and TB in terms of care seeking, stigma related to TB and representation at the different clinical steps of TB management were studied in Bangladesh (Salim H et al. 2004, Begum V et al 2001, Ahsan G et al. 2004, Karim F et al., 2007; Karim F et al., 2007; Karim F et al., 2008) and recommended that there are huge needs to be addressed. These studies show that delay in TB diagnosis is unacceptably longer in women, especially elderly women; mean delay was more than 8 weeks and women experienced more delays than men in different stages of delay in diagnosis and treatment (Karim F et al., 2007). These studies also showed that delays in TB diagnosis are unacceptably long and women are more likely to experience delays than men in total delay, total diagnostic delay and patient delay (Karim F et al., 2008). Early diagnosis and initiation of treatment are the key elements of a TB control program. One study on TB delay shows that older age, rural residency and perceived high stigma are significantly associated with delay of TB diagnosis and treatment (Khatun F, 2011).

It is estimated that nearly 95% of the entire health workforce in Bangladesh is made up by the informal sector, the number of which is steadily increasing; of the people who seek treatment for illness, 65% utilize the services of the Village Doctors (VD) (Bhuiya A., et al 2009; Bangladesh Health Watch 2008). Approximately 69% of patients with chronic cough visit informal health care providers for treatment and a longer delay to diagnosis has been observed among patients who attend informal health care providers for their first consultation (Rifat M et al., 2011, Hossain et al., 2010). Rifat and colleagues compared the distribution among patients who first consulted qualified practitioners with those who first consulted informal practitioners. They reported that prolonged total delay (13 or more weeks) occurred in 47% of those who first consulted an informal practitioner compared with 27% of those who consulted a qualified practitioner. The researchers also suggested that although patients seeking care from informal health care providers receive healthcare more promptly, they face delays in appropriate diagnosis and initiation of treatment for TB (Rifat M et al., 2011). The Damien Foundation, Bangladesh has successfully engaged village doctors (VDs) for patient referral and DOTS in some NTP intervention areas (Salim HMA et al., 2006). However, VDs have not been engaged in DOTS for the entire NTP program area.

Table 2: Tuberculosis and HIV in Bangladesh: 2017

Bangladesh Profile	
Total Population	: 163 million ¹⁰
Population Growth Rate	: 1.37%
Sex ratio (M/F)	: 100.3/100.0
Per capita GDP (current market price) in USD	: 1384
Access to tap and tube well	: 98.0% (Households)
Toilet: Sanitary	: 75.0% (households)
Mobile phone users	: 130 million
Internet subscribers	: 67 million

Tuberculosis (TB)^{1, 11}

Total number of cases reported (All Forms)	: 223 921
% Pulmonary	: 80
Prevalence rate: (Per 100,000 adults) ¹²	
Bacteriologically confirmed TB	: 295 (247-344)
Smear Positive TB	: 110 (85-135)
Incidence rate (All forms)	: 221 (161-291)

Estimated incidence by age and sex (in thousands)

	0-14 ears	>14 years	Total
Females	17 (12-22)	112 (79-144)	129 (91-167)
Males	19 (14-25)	212 (150-275)	232 (164-300)
Total	36 (26-47)	324 (229-419)	360 (262-474)

Mortality (Excludes HIV+TB)	: 40 (26-58)
Cure rate with DOTS (%)	: 95
Proportion of new TB cases with MDR-TB (%)	: 1.6
Proportion of retreatment TB cases with MDR-TB (%)	: 29

HIV/AIDS (ASP, 2017)²

People living with HIV (PLHIV) in 2016	: 4,721
Antiretroviral treatment (ART) coverage 2016	: 44.5%
HIV prevalence among key populations in 2016	: Less than 1%
New HIV infection reported in 2016	: 578
Number of ART recipients in 2016	: 1,881 (up to October 2017: 2,483)
Knowledge of all modes of transmission of HIV/AIDS among population (%) in 2016	: 59
Knowledge of at least one mode of transmission of HIV/AIDS among population (%) in 2016	: 61

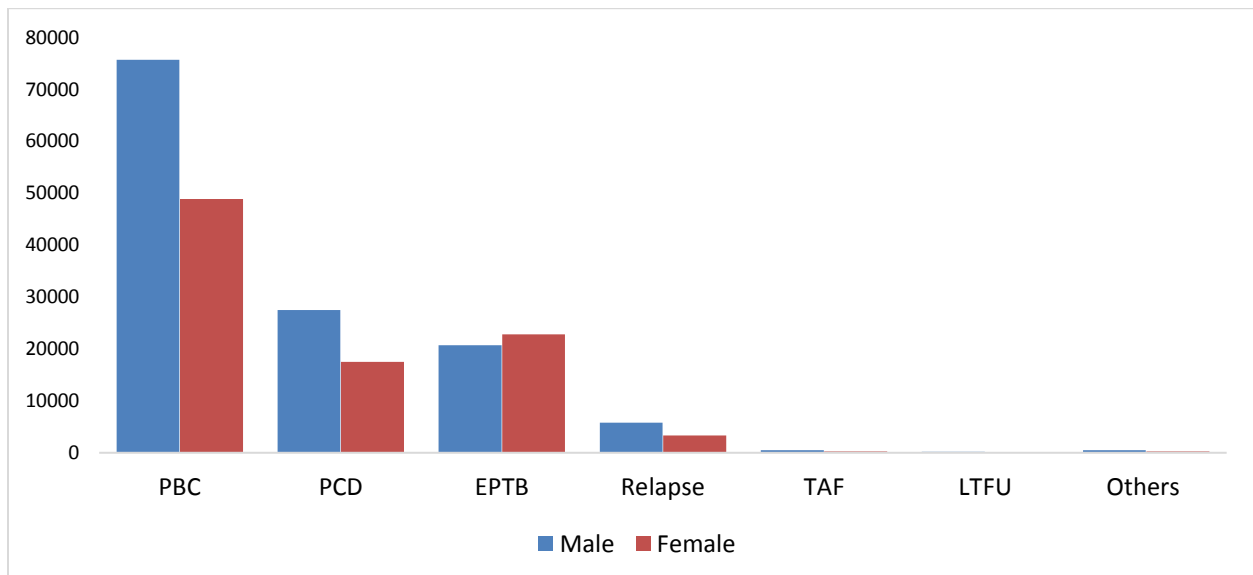
¹⁰ Global Tuberculosis Report 2017, WHO

¹¹ Bangladesh Health Bulletin 2017, DGHS

¹² Bangladesh JMM report 2016, MBDC

Other studies in Bangladesh suggest that features of stigma are more prominent in women than men and there is less female representation at the different clinical steps of TB management (Begum V et al 2001; Karim F et al., 2007; Karim F et al., 2008). It was reported that approximately 85.9% of patients had experienced stigma. The most frequent indicator of the stigma experienced by patients involved problems taking part in social programs (79.5%). Mean levels of stigma were significantly higher in women (55. %) (Chowdhury, et al. 2015). Stigma influenced in the pathway of care seeking as such: 55% of the patients wanted to keep their diagnosis hidden, more among women (82.7%). More than eighty percent of women patients (85.6%) had problems in their relationships with their relatives particularly with their spouses (61%) and family members (59%) (Ahsan G. et al. 2001). Women were systematically shunned from TB services which reflected in dissatisfaction with providers (39%) (Ahsan G. et al. 2001), Female-to-male ratios (FMR) declined at each step clinical care as 0.79 at the outdoor, 0.51 at the sputum microscopy, 0.36 among TB suspects, and 0.35 and the registered TB patients (Begum V et al. 2001). Almost similar findings were also reported later at out-patient care (0.81), TB suspects submitting sputum for testing (0.52) and smear-positive test results (0.38). However more female than male patients who underwent treatment achieved cure (93% vs. 89%) (Karim F et al 2008).

Progression from infection to disease is faster in woman than men in the reproductive years (Holmes et al., 1998). Women’s treatment seeking is lower than male (1:1.8) according to a study conducted by WHO in 2008. A number of factors contribute to this behaviour such as a weak and gender insensitive health care system; as well as personal (motivations, knowledge, attitude, illness experience, social stigma) and structural factors (poverty, poor decision-making power, discrimination, fear of isolation, rejection, family negligence) (Liefoghe et al., 1995 & 1997).



PBC: Pulmonary Bacteriologically Confirmed, PCD: Pulmonary Clinically Diagnosed
 EPTB: Extra Pulmonary, TAF: Treatment After Failure, LTFU: Treatment after Loss to follow up

Figure 2: Case notification by types of cases and sex 2016

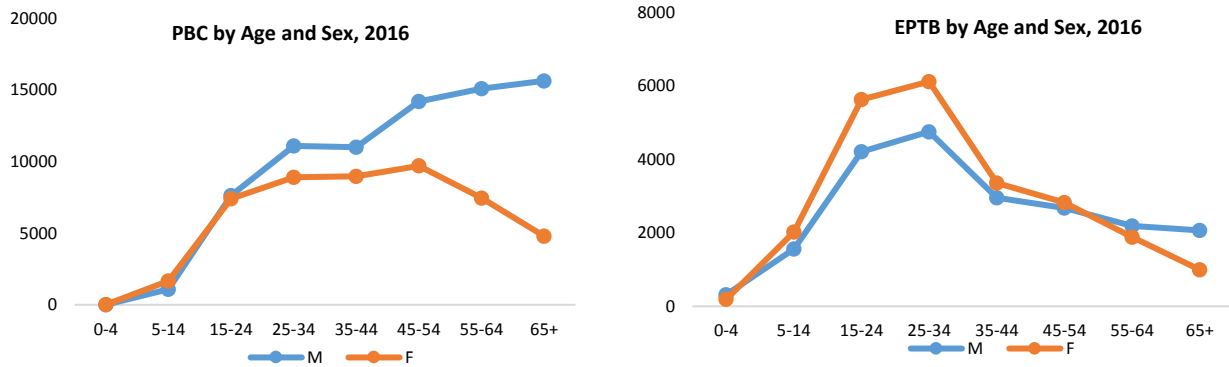


Figure 3: Case notification by age and sex, 2016

The National TB Control Programme (NTP) has also emphasized this inequity of TB control by endorsing the stop TB strategies which focused to “address the needs of the TB contacts and of poor and vulnerable population”. Similarly, delay in TB diagnosis is a problem which reflects a poorly functioning health system and lack of awareness in the population about TB.

Overcoming barriers to access and utilization of services by all sections of the population is a pertinent issue for improving the effective implementation of DOTS in Bangladesh. The major challenge is to increase case detection, especially amongst the women, the older population, the poor, and some of the key and vulnerable population where it is assumed that the most 'missing cases' are to be found. Low rate of attendance at a service point/facility is not only an indicator of low utilization but also of poor availability and quality of services (WHO, 1998).

5.4 Initial Stakeholders Dialogue

Initial Stakeholders dialogue was held through a two- days of workshop instead of four- days that was planned and conducted during 23 and 24 April, 2018. The stakeholder workshop was organized with relevant stakeholders in order to assess the Stage 2 (Knowing the national TB and HIV epidemic and its surrounding context), Stage 3 (Knowing the national TB and HIV response) and Stage 4 (Analyzing and using the findings of the gender assessment for a gender transformative TB response and gender responsive HIV response) of the “*Gender assessment Tool for the*

national HIV/ TB / responses” in Bangladesh. (Stakeholder Workshop Agenda in the annex 1- page 55).

The objectives of the workshop were:

- To familiarize the participants with key concepts on gender, Key population and related issues
- Introduction to TB gender tool and Key Population framework
- Exercise on the TB Gender tool and Key population framework
- Identify gender related key issues and gaps in TB services
- Coordinating a policy response guided by a matrix analysis using information obtained through the desk review and the exercises done over the guidelines provided in the steps 7, 8, and 9 under stage 2; and steps 10, 11 and 12 under stage 3.
- Identify and prioritize key population at national level, identify gaps and develop framework
- Prepare recommendations that promote gender and human rights in TB control
- Assessing the tools used and identify data requirements, further research

After an initial presentation on the current situation on tuberculosis in Bangladesh and orientation of the participants with the TB/HIV Gender Assessment Tool and Framework on key, vulnerable and underserved populations, the workshop was conducted in the following manner:

- On Day 1: Participants worked intensively on the TB/HIV gender assessment tool components in three groups mainly focusing to investigate the TB/HIV country status and context and responses by working through three checklists in the Stage 3 of the Gender assessment tool;
 1. Gender equality in TB/HIV policies and programs (step 10),
 2. A comprehensive TB and HIV responses (step 11)
 3. Gender consideration per community (e.g., women, men, transgender etc.) (step 12)
 4. Matrix analysis
- On Day 2: Participants worked in two groups on two frameworks;
 1. Key and Vulnerable Populations Prioritization Framework: Identification and prioritization of at least most important 3 key populations from an identified larger list of key population (see definition of key population in the annex 1).
 2. Risk assessment Framework: Group analysis on the risk factors for the identified and prioritized key population

- Intense discussion during Group and Brainstorming session to response to the guideline / tools focus areas and questionnaires.
 - Identification of relevant resources that will aid in the framework tool.
- (List of participants of Stakeholder Workshop in the annex 2-page 57).*

5.5 Key Informant Interviewees and Focus Group Discussions

The team undertook an initial desk review of relevant documents in relation to the objective of this assessment and subsequently shared the findings with NTP, ASP (and other technical partners) in the two-days Stakeholder workshop. All the participants agreed to a scale coded method for identification of priority key population for TB in Bangladesh and prioritization exercise was done. It was also suggested to gather further information directly from the finalized three population groups as well as programmatic approaches to address the gaps identified earlier through the gender assessment group work in the workshop. This additional information helped in mapping out the individuals at the specific areas and found out ways to determine the approaches.

Objectives:

- To prepare recommendations and determine interventions that promote gender and human rights relating to TB and HIV control
- To recommend gender interventions that would make the national TB and HIV programmes more effective

Methodology:

Study approach

The study explored these objectives through qualitative methods. In-depth interviews (IDI), Key Informant interview (KII) were carried with selected participants. Focus Group Discussions (FGD) were organized among certain groups to supplement findings obtained through IDI.

Study design

Data was collected cross-sectionally from across the identified key population during May 05, 2018 to June 15, 2018.

Study sites

The qualitative part of the study was carried out at different BRAC DOTS centers, Damien Foundation, CWFD, Nari Maitree and BGMEA service centers setting of Dhaka city and Gazipur district, Bangladesh.

Study population

The study populations were from the three prioritized groups or their family members or the providers who were engaged in the care of the patients among these identified key population in different centres. They were Pulmonary TB and extra-pulmonary TB patients (elderly 65+ and garment workers) who were under DOTS from BRAC, CWFD and BGMEA and already cured TB patient (garment worker) who got treatment from BGMEA DOTS. The urban slum dwellers were another study population and also NGO based health care providers who were involved in TB diagnosis and treatment.

Sampling technique

The participants were enrolled using non-random purposive sampling from the above-mentioned settings. The urban slum dwellers were sampled through NGO based services. NGO based health care providers were chosen from BRAC TB control programme.

Sample size

Ideally reading, coding and generating pattern from the transcripts of the IDI and KII is the process to consider the saturation level of information to determine the number of IDI and KII. So, in total 8 IDI, 6 KII and 3 FGD were carried out. See Table 2 for more detail. However, it was expected that this sample might reach to the saturation level even through carried out in quickly under short time frame.

Table 1. Methods, Sample size, Population and Place

Methods	Sample size	Population	Place
IDI*	8	IDI with female TB patient from garment factory having service centre, IDI with female TB patient from garment factory not having service centre, IDI with female TB patient who is already cured, IDI with elderly female, IDI with elderly male, IDI with disable child, IDI with SS, IDI with MO	Garment factories, Dhaka; BRAC Gazipur, Urban Slum, Dhaka; BRAC Shastho Sebika, Dhaka; BGMEA, Dhaka
FDG	3	Male, Female, Mixed group of male and female	Urban Slum, Dhaka; Garment factories, Dhaka
KII	6	Policy level representatives & Programme Organizer	Damien Foundation, BGMEA, CWFD, BRAC

*Among the 6 patients 5 informants are TB patients currently ongoing treatment under DOTS centres, and one is a cured TB patient who got treatment from the DOTS centre.

Data collection

Study techniques and tools

As mentioned earlier, data for this assessment were collected in three ways through: (a) in-depth interview (IDI); (b) focus group discussion (FGD) and (c) Key Informant Interview (KII).

Data were collected using qualitative instruments like guidelines based on research objectives. All the interviews were recorded and transcribed verbatim by verbatim, by the team members (research assistant, senior research assistant, research associate and also by the consultants). If recording was not possible then written field notes were taken as details as possible.

Data collection methods:

In-depth Interview (IDI): After building a possible rapport written consents were taken on a printed consent form. In order to have an uninterrupted information flow, one to one interaction in private sitting were organized at different DOTS centre or in patients' household also. Three interviewers were trained prior to conduction of the process.

Key Informant Interview (KII): After discussion with the responsible officials, key informant interviewees were identified who were more experienced and agreeable to talk. Verbal consent as well as written consent was taken in a printed consent form (see annexure: 2).

Focus Group Discussion (FGD): After building a possible rapport the written consent was taken on a printed consent form. In favor of uninterrupted interaction private sitting arrangement was arranged at BGMEA DOTS centre or in a suitable place in the slums. IDI, KII and FGD were conducted according to a general IDI and different KII and FGD guidelines developed based on research question.

Data Management, Analysis and Validation

Interviews were conducted in Bangla. When the respondent provided consent, the interview was digitally recorded; otherwise, verbatim notes were taken in Bangla. All interviews were transcribed and translated into English. Data familiarization was done by reading the transcripts. Initial codes were drawn from the STOP TB Gender assessment guidelines and keeping the study objectives in mind. The codes were subsequently refined and expanded over the course of the study. Transcripts were coded manually. Sub-codes were identified during the analysis process (i.e. exposure to information, factors for care seeking etc.) and inductive codes emerging from the transcripts were defined and applied as the analysis proceeded. Cross-checking and comparison among data sources were made during the analysis process. To examine interview data, the content analysis methods were applied, whereby data displays are created to identify and explore patterns and themes in a systematic manner, was employed. Data displays were analyzed collaboratively by several members of the research team, and analytic memos developed.

Data Reporting

- All the consultants participated in the analysis and documentation.
- Qualitative analysis of the gaps and challenges were undertaken. It leads to establishing discrepancies in the situation of gender basis of human rights related to TB and vulnerable populations.
- A preliminary draft of the report consisting of background and objectives, key epidemiological context analysis, key response from the field levels, emerging issues and recommendations was prepared and shared with the donors. It will be published and disseminated electronically to technical partners for intense review. This will act as a basis for the final validation workshop.

Ethical consideration

Before conducting the study, an official approval for data collection was taken from the BRAC TB Control Programme authority. By describing benefit and harm informed written consent was taken prior to all interviews from the interviewees. Confidentiality of information and anonymity was ensured at all levels and was never disclosed without their consents.

Data validity

The three methods (IDI, FGD and KII) together would triangulate and verify data collection. All of the interviews were transcribed the very day they were conducted by listening carefully to the tapes made and going through the notes.

Biases and assumption

As anthropologist the interviewers and facilitators tried to maintain the objectivity as best as it will be possible. It was expected to be a balanced reciprocity in between interviewers and interviewee. Abstaining from leading questions and prompting comments was useful to find out the inner expression of the interviewees.

Findings: Qualitative study

This study pointed out some gender-based barriers to diagnosis and barriers to initiate treatment of TB whether pulmonary or extra pulmonary in type.

Health seeking behavior from gender perspective:

Barriers to proper diagnosis:

Slum women's psychological, economic and social dependency to male counterpart to initiate TB treatment:

- During FGD with urban poor (slum dwellers) most of the women pointed out the economic hardship as cause of delay to initiate diagnosis of TB. Nonetheless, only one participant knew about available free treatment of TB. Most of the women somehow exposed psychological, economic and social dependency to either on their husband or son to even initiate primary discussion about treatment of TB.

Gender discrimination:

- During FGD (female slum dwellers) 4 out of 6 participants worried about husband's opinion before initiate any treatment at outside home, since the women experienced in their day to day life that husbands are not ready to accept the sickness of wife.
- In addition, in many cases husband's reluctance to accompany makes women demotivated to seek any treatment, since most of the women don't feel comfortable to seek treatment alone.

A slum woman said,

"Many women don't go for treatment. They don't feel courage to go. They fear about husbands' anger. I know a woman feels demotivated while husband is reluctant to accompany her."

- Moreover, husbands of poor women often deny spending money for quality treatment. Most of the participants were self-motivated to start prompt TB treatment to their sons whereas they only expressed feeling bad if TB has occurred to their daughters.

Lack of knowledge about EPTB:

- The IDIs with garments worker explored and noted adequate knowledge about symptoms of pulmonary TB; however, there was paucity of knowledge about EPTB.
- There was inadequate dissemination of information and absence of awareness raising activities regarding EPTB in the workplaces. As the garment workers were not aware, they neglected the symptoms thinking these were pustules or swellings and nothing infectious or serious. These led to delays in consulting a proper health care provider. The table 3 shows the diagnosis delay of the two EPTB cases are respectively 2 months and 7 months.
- The cost and time related to FNAC test as well the unavailability of this specific test often lead to diagnosis delay of EPTB.

The medical officer of BGMEA health service centre reported,

*“Detection of EPTB case is tough. The workers don’t perceive it as TB. They think it is a simple pustule or swelling that may recover soon. So, they don’t want to come for treatment. Rather go to **kabiraj**-traditional healers for **jhar phuk**- spiritual medicine. Moreover, they have limitation of money but FNAC test needs at least 1200-1300 TK. Moreover, there is also matter of time to continue the treatment. In total the EPTB case becomes unreachable most of the time”.* KII-01, Medical Office, M

Table: 8 Characteristics of informants and health seeking behavior

Participant ID and type	Type of TB	Age	Gender	Education	First contact	Number of contacts before diagnosis	Place where finally diagnosed as TB/EPTB	Types of Diagnosis that confirm EPTB	Diagnostic delay	Referred to DOTS by	Treatment delay
IDI-01 Garment s worker	Pulmonar y TB	18 years	F	Class 8	Pharmacy	03	Private hospital	X-ray	1.5 month s	Private doctor	2 days
IDI-02 Garment s worker	EPTB (Gland TB)	27 years	F	Class 4	Nurse Garments	03	Private diagnostic lab	FNAC	2 month s	Medical officer Garment s	1 day
IDI-03 Garment s worker	EPTB (Gland TB)	30 years	F	Class 7	Specialize d TB hospital	02	Public ENT hospital	Biopsy	7 month s	Self	1 day
IDI-04 Elderly woman	EPTB (Gland TB)	>65 years	F	No formal educatio n	Private clinic	04	Private hospital	FNAC	7-8 years	Private doctor	3 days

IDI-05 Elderly man	Pulmonary TB	>65 years	M	No formal education	BRAC DOTS centre	01	BRAC DOTS centre	Sputum examination	1.5 months*	Self	1 day
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*it was actually patient delay

Knowledge on TB symptoms: How Slum women describe clinical features of TB?

- The slum women were not so clear about describing clinical features of TB. However, only 1 out of 6 participants specified characteristic symptoms such as blood in sputum. Other participants discussed continuous cough as symptom of TB but none of them mentioned the two weeks long cough as symptom of TB. Rather 3 out of 6 participants perceived 3 months long cough as symptom of TB.

A slum woman mentioned about symptom of TB,

“At first there would be cough and cold. The cough remains for 3 months. If that cough remains for three months then you have to seek treatment of doctor. Then the doctor can recognize the cough as TB.”

Point of First contact to informal providers:

- Table 3 shows that out of the 3 IDI samples (garments worker) one informant’s first contact point of seeking treatment was the nearby pharmacy followed by nearby private hospital. In consequence, for this patient, it took almost 1.5 months to be diagnosed as TB, who had initial contact with an informal provider.
- Moreover, this patient could recall dissatisfaction taking medicines from informal providers. Ultimately in that case the gravity of disease condition became worse gradually that forced her to switch treatment to private hospital.

The TB patient (garments worker) reported,

“I felt so weak and I didn’t have appetite. I had so much pain in body. Such condition had been persisted for one month. At the very beginning I had only pain and cough and due to cough, I took lots of cough syrup. However, it was not recovered. I thought of cough due to cold. Therefore, I didn’t give so much importance. So, I took syrup from nearby pharmacy but it didn’t work”. IDI-01, Female, 18 years

- Moreover, 2 out of 6 female FGD participants (garments worker) also said about nearby pharmacy as first point of treatment seeking option whenever the sickness occurred residing at home as well whenever it was not possible to come at factory due to the severity of the disease.

As one garments worker said,

“If we became sick at home, then most of the time we don’t come at office. Rather we go outside. Outside doctors means who are available at community or at pharmacy.” FGD participant, Female Garment workers

Why garments workers chose informal providers

- The FGD also explored the theme like tendency of waiting when the gravity of disease is less.
- Lack of money often appeared as prior cause to be late for diagnosis or treatment initiation.
- Moreover, prompt decision on treatment initiation often depends on the disease types and severity. For example, fever and headache did not get so much importance as the pain in stomach got.

Slum women’s limited access to quality services:

- Available medicine vendors of pharmacies were also the first point of treatment to the poor slum women. The pharmacy-based chambers of doctors were the next treatment seeking option for them. They recognized those doctor as “normal doctor” whose fees were not more than 200 Tk.
- Most of the slum women didn’t know about specialized TB hospital at Mohakhali in spite of their slum dwelling very near to it. However, two women recognized BRAC *shastho shebika* as relevant to discuss about TB treatment as well the first referral point to appropriate place for TB treatment.

Patients lack of consciousness:

- To say about the reason behind first contact to informal provider, another opinion came from a medical officer of BGMEA health service centre who emphasized on the patients’ disinclination and their lack of tendency to go the qualified doctors as first contact. Moreover, according to him some **social fear of exclusion** may stay away the workers to come to be diagnosed as TB patient.

The medical officer of BGMEA health service centre reported,

“The main reason is their reluctance. Firstly, lack of education and lack of consciousness. They have been continuing the medicine of local medicine seller month after month. They will not come to me until the situation will be worsened enough. Moreover, there is superstition that marriage will not happen if somebody is diagnosed with TB. Many say TB may occur from mother to child. For these reasons of social fear of exclusion, they don’t want to share symptom of TB” IDI-06, Medical Office, Male

Why chose the nurse/doctor of factory for primary discussion but some limitations?

- Table 3 shows that out of the 3 IDI samples one informant’s first contact point of seeking treatment was the nurse of the garments.
- The same theme emerged from the FGD with garment workers. Most of the workers mentioned the available nurse or doctor at factory setting as their first point of discussion, counseling, consultation as well the referral points to BGMEA health service centers. They pointed out office instruction of coming to factory doctor first for primary discussion and if necessary, acquire allowed ‘gate passes’ - (leave document) to BGMEA health service centers.
- Free-of-cost available treatment during office hours was the main motivation for choosing either nurse or doctor at factory setting, since the workers spent most of the time (from morning to evening) at factories. Nevertheless, **unavailability of doctors sometimes stimulates them to seek treatment at nearby pharmacies.**

“Our doctor does not stay at office for whole day. Her duty may be for 4 to 5 hours. So obviously I shall not get her always. Then I must have to go to pharmacy.” IDI-3 Female Garment workers

- Moreover, although they get service from providers but many times, they had to buy medicine from outside. One informant even mentioned **the unavailability of medicine in BGMEA service centers.**

Dispelling TB myth: attitude changing

- Most of the participants were fearful of the disease and would feel embarrassed (and less dignified) if they would have TB. However, none of them were afraid of isolation if neighbours would come to know about it, since as reported people’s knowledge about the successful treatment outcome of TB has increased now-a-days.

- Counseling on need for treatment completion found well that indicates the smooth continuation of treatment adherence in workplace settings.
- The workers irrespective of male or female were quite knowledgeable about symptoms of pulmonary TB e.g. two weeks long cough and fever. They mentioned the visits of BGMEA people for routine scrutiny of TB through mike. Most of them had knowledge about free treatment of TB.

In spite of the harmonized continuation of workplace model and effective counseling through presence of at least one doctor in each service centre to minimize the fear of TB, still there are some limitations to implement the PPM workplace model that has been explored through FGD and KIIs.

- Although the mobility of garments worker is high, there are some gaps such as continuous refresher awareness meeting for the newly appointed workers.
- There is shortage of field TB workers to motivate workers for TB screening. Moreover, there is decreased rate of awareness meeting due to reduced fund from donor support.

“From the very beginning we had been conducted 50 awareness meetings with the garment workers in every three months, using the Global Fund supported budget allocation; but currently it has been reduced to only 5 in number. It has decreased gradually! Sensitization meeting with the garment owners need to be introduced again. Without field level motivation and follow up only outdoor support is not enough for combatting TB cases in garment sector” KII, BGMEA

- Since 2010, BGMEA has established 11 health centres which provide TB diagnosis, treatment services and anti-TB drugs and education in around 600 garment factories. Still there are a significant number of garments that are not included under the health service support of BGMEA to treat TB cases.
- BGMEA has introduced the 14-day sick leave with pay for workers who are diagnosed with TB and the policy letter has been circulated at the factories. However, due to decreased number of awareness meeting general workers are not well aware of the rights.

Fear of job loss or lost wages inhibits patients from seeking services, despite the fact that workers are legally entitled to two weeks paid leave to start treatment and job protection. While having tremendous potential, this approach will remain inefficient and ineffective if worker awareness of existing policies is not expanded and if policies and regulations are not enhanced to mandate routine health screening for factory workers.

- Two other themes came from the FGD and KIIs that may need prior concern. One is demand of in-service training and another is one-point service in workplace through outreach considering the busy schedule of the workers.

“One-point service should be introduced at workplace. We have to do so through mobile team who will execute X-ray. According to a fixture there should be continuous outreach where the medicines can be distributed. Actually, the workers have no time to go to the doctor, nurse of factory. For example, some of them enter in factory at 7 o’clock in the morning and may leave 10 o’clock at night.” KII, BGMEA

Case study 1: Female elderly, 65 yr. age EPTB patient at rural setting- a severe case of diagnostic delay-

The reasons related to diagnosis delay were the elderly woman’s dependency to her husband taking decision about diagnosis and treatment, story of multiple lab test before diagnosed as EPTB as well multiple treatment switching before diagnosed as EPTB. The woman could not avail the specific lab test e.g. FNAC, since it was not available in the health facilities where she sought treatment and the eventual diagnostic delay was almost 7-8 years.

Several themes also have been explored through IDI with an elderly female EPTB patient. The themes are lack of knowledge about EPTB, had fear of isolation and adverse outcome of TB. However, she did not experience any stigma from relatives and neighbors, since her husband thinks now-a-day people are well aware that death is not the ultimate outcome of TB and adherence to proper length of treatment can cure TB.

She faced financial crisis before diagnosed as EPTB and overcame through monetary support from relatives. Moreover, transportation was not trouble-free specifically for the female elderly. Fortunately, she did not face any treatment delay, since the private practitioner referred her to BRAC DOTS. Neighboring DOTS service at the home of one Shastho Sebika (SS) made the treatment uninterrupted and she got awareness counseling from SS to maintain compliance of medicine. Being an EPTB case, she was also advised to consult her doctor who referred her to BRAC, whether her treatment length ends after 6 months or it needs to be further extended.

Case study 2: Male elderly, 70 yr. age PTB patient at rural setting:

The male elderly, 70 yr. old PTB (sputum positive) patient was knowledgeable about symptom of PTB and didn’t feel fear. In spite of that patient delay was 1 and half month, for the reluctance on his part to seek treatment. His first treatment seeking point and first sputum examination point was BRAC Microscopy centre at nearby union parishad complex as he knew about the symptom of TB and the appropriate treatment option for TB disease. He went to the Upazila Health Complex (UHC) to get notified in the TB treatment register under the supervision of medical officer. After getting medicine for initial 3 days he was advised to undergo daily DOT from his neighbouring Shastho Sebika (SS) for the whole treatment length. Therefore, he has been getting free treatment since diagnosis to treatment. He had been informed that adherence to proper and adequate medicine can cure TB. Moreover, he had been informed from the SS about treatment duration and consequences of incomplete treatment. Hence, he has been maintaining medicine compliance from the house of SS. Neighboring DOTS service at home of Shastho Sebika (SS) made the treatment uninterrupted. He also expressed satisfaction about the behaviour of SS.

5.6 National Validation Forum

A one-day validation workshop was conducted on 18 September, 2018 in Cox's Bazar. The validation workshop was organized with relevant stakeholders (see annex ##) in order to share the findings from the final draft of the desk reviews, qualitative study and findings related to legal and rights issues in relation to TB control in Bangladesh. Four presentations were made on the above issues one by one followed by through discussions by the participants as well as by the moderators of the workshop. The discussions, remarks and recommendations made in the workshop contributed to the development of the final report.

The objectives of the workshop were:

- Overview of the primary workshop (April 23-24)-methods and findings
- Share outcomes of the prioritization of the key population at national level, risk assessment
- Share gender, communities, Rights related key issues, strengths and gaps in TB control in Bangladesh
- Discussion and Prepare recommendations that strengthen approaches to reach key population
- Promote gender and human rights in TB control
- Assessing the tools used and identify data requirements, further research
(Workshop Agenda in the annex 3-page-59)
(List of participants of Stakeholder Workshop in the annex 4-page 61)

ON STAGE 3 (KNOWING THE NATIONAL TB AND HIV RESPONSE)

Day 1: Findings from the stakeholder workshop

The TB/HIV *Gender Assessment Tool (TB/HIV GAT)* seeks to move the TB and HIV response along the continuum from gender-blind to gender-sensitive, and ultimately to gender-transformative *(See annex 5 page 63)*.

Knowing the current national TB/HIV policy response (Step 10)

This stage 3 of GAT helps to understand the national TB and national TB/HIV co-infection responses from a gender perspective. Since, it is important to understand the recognition of engendering national TB response, the gender assessment team in the workshop tried to build a picture of the country situation and made an informed decision on a list of priorities for TB and TB/HIV programmatic and policy responses.

The main gaps in addressing gender differences (findings from discussion after presentation of review data from step 10) in policy / programme response:

- No policy provision for disabled population or initiatives to address disability
- Lack of women friendly service points
- The situation of hard to reach areas is needed concern
- No inclusion of the third gender identity in the service forms
- Lack of specific policy to emphasis counseling

GENDER EQUALITY IN TB/HIVPOLICIES AND PROGRAMS

Overall policies and Human Rights in TB / HIV response in Bangladesh

NTP Bangladesh envisioning “TB Free Bangladesh: Zero deaths, disease and suffering due to TB” and set mission at “aims to strengthen the effort of TB control through effective partnerships, mobilization of resources and ensuring quality diagnosis and treatment services under defined DOTS strategy”. National TB control program Bangladesh also introduced the Stop TB strategy, the approach recommended by WHO to reduce the burden of TB in line with global targets in line with Millennium Development Goals (MDG) set for 2015 visioning “A TB- free world” (NTP Annual Report 2017).

In a policy statement which was equivocally endorsed by all participants that “The NTP strives to make services equally available to all people in Bangladesh irrespective of age, sex, religion, ethnicity, social status or race” (NTP Annual Report 2017).

Bangladesh constitution is also an engendering constitution, because it stipulates incorporation of specific space for women’s rights explicitly. The constitutional provisions (in articles 19 (3), 28(1), 28(2), 28 (3), 29(1), 29(2) and 65(I) which cover all aspects of equal rights of women with men in the State and public life, equal opportunity for all citizen irrespective of men and women, are fundamental principles to adopt democratic principle of gender equality, human dignity of men and women. In addition, the government adopted the “Women & Children Repression Prevention Act” in 2000 which was subsequently further strengthened time to time by Acts / frameworks like; Domestic Violence (Prevention and Protection) Act 2010; Bangladesh Labour Act 2006; Acid Crime Control Act 2002; Speedy Trial Tribunal Act 2002; Prevention of Repression of Women and Children Act 2000; Dowry Prohibition Act 1980; Child Marriage Restraint Act 1929 (further amended in 2017) (Bangladesh Constitution, Ministry of Law, Justice and Parliamentary Affairs, GoB) .

Health services Act

In Bangladesh constitution, health has been mentioned as a basic necessity of life along with food, clothing, education and shelter (Bangladesh Constitution, Ministry of Law, Justice and Parliamentary Affairs, GoB).

- 15 (a) the provision of the basic necessities of life, including food, clothing, shelter, education and medical care;

Public Health and Mortality

- 18. (1) The State shall regard the raising of the level of nutrition and the improvement of public health as among its primary duties, and in particular shall adopt effective measures to prevent the consumption, except for medical purposes or for such other purposes as may be prescribed by law, of alcoholic and other intoxicating drinks and of drugs which are injurious to health.
(2) The State shall adopt effective measures to prevent prostitution and gambling.

With the goal of ensuring quality and equitable health care for all citizens in Bangladesh, Ministry of Health and Family Welfare (MOHFW) is being implementing the Health, Population and Nutrition Sector Programme (HPNSP) for a period of five years from January 2017 to June 2022 (DGHS). In succession, to improve equitable access to and utilization of quality health services the Directorate of Tuberculosis-Leprosy and AIDS STD Programme (TB-L & ASP), DGHS also planned an operational plan mid 2017-2022 (TB-L & ASP, Operational Plan Report, 2017).

Similarly, during stakeholder workshop the participants also recognized the policy statement that all people have equal access to TB services irrespective of age, sex, religion, ethnicity, race or social status. (NTP Annual Report 2017). However, they also marked that though the NTP is addressing people with disabilities equally with others, but there are still scopes and areas to be addressed and strengthened.

Country situation and informed decision on TB/HIV programmatic and policy responses:

1. TB policy is mandated for equal access to everyone; while disability, race, ethnicity and indigenous status are not addressed separately. Moreover, the needs of men/boys and women/girl are addressed but the participants felt the different needs of different groups that have to be addressed in different ways.
2. NTP has undertaken a special strategy-active case finding, that has been recently initiated to open outreach smearing centres for accessing older men, women and under 15 years age and people at hard to reach.

3. There are some gender issues that have to be recognized, planned for or otherwise addressed by HIV, TB response to be gender-sensitive to gender-transformative. However, unlike ASP programme, national TB response does not have any specific plan to address issues like early and forced marriage; forced displacement, occupational risks (e.g. mining) as well smoking and alcohol abuse.
4. Recently, TB-L & ASP operation plan took an urban approach to address the rural/urban specificities and initiative for ultra-poor addressing socio-economic status.
5. According to workshop participants culture or religion does not have so much influence in the use of services but there is some stigma still attached to seek treatment. Due to stigma women are even uneasy to cough in front of any person.
6. To address the access to health care services barriers to care-seeking based on religious or cultural beliefs and traditions, in general, TB services at the community level are mostly conducted by female health workers in most parts of the country. This is increasing accessibility of female culturally. However, TB response does not include any gender-equality interventions yet.
7. Moreover, there is special programme available for the prisons. In recent time, TB programme took initiative for internationally migrated Rohingya population.
8. Government of Bangladesh funding to TB response is increasing, since government committed for all 1st line drugs for the first time. Government committed around 15% among total NSP funding for TB.
9. There is a formal system of accountability for the HIV/TB response for example BCCM with the participation of civil society, UN agencies etc. But there is no monitoring system for the spending on gender equality, since there is no specific intervention to address the issue.

MEANINGFUL PARTICIPATION

The organizations representing TB affected populations are engaged in decision-making at different stages, levels and sectors of the country TB response (including design and implementation). There are formal mechanisms (e.g. partnership forums, joint HIV theme group, TB technical working groups, National AIDS Councils/ Commissions and, National Stop TB Partnership, TB advisory committee and or CCM) that ensure the views, needs and rights of key affected populations are considered in decision-making processes in the response to HIV and TB.

Example: BRAC, in partnership with a number of associations, has integrated TB control services into workplaces with a focus on factory settings. Bangladesh Garment Manufacturers and Exporters Association (BGMEA) established DOTS centers in the 11 clinics which provide TB

diagnosis, treatment services and anti-TB drugs and education to workers of roughly 3,500 factories. **It has introduced the 14-day sick leave with pay for workers who are diagnosed with TB.** Damien Foundation is also working in Dhaka Export Processing Zone (DEPZ) covering approximately 80,000 garment workers. Other initiatives have targeted Bangladesh Knitwear Manufacturers and Exporters Association (BKMEA), Bangladesh Small and Cottage Industries Corporation (BSCIC) and Bangladesh Export Processing Zone Authority (BEPZA). Despite serving large populations of workers, roughly one million, these efforts have yielded relatively few TB cases to date; BGMEA, for example, identified roughly 300 TB patients, and DF identified 166 patients in 2015. (National Strategic plan on tuberculosis 2016-2020). Fear of job loss or wages loss inhibits patients from seeking services, despite the fact that workers are legally entitled to two weeks paid leave to start treatment and job protection. While having tremendous potential, this approach will remain inefficient and ineffective if worker awareness of existing policies is not expanded and if policies and regulations are not enhanced to mandate routine health screening for factory workers. In addition, a 2015 study by BRAC suggests that while workers in factories with TB outreach and services have a good awareness about TB symptoms (72%) and free-of-cost sputum test (86%), treatment (88%); but knowledge of TB prevention (11%) , transmission(48%), and the need for treatment completion is poor (11%), suggesting that appropriate IEC and mobilization campaigns to be taken to expand worker awareness on TB transmission, prevention and treatment adherence in workplace settings (Islam QS, 2015).

COORDINATION OF GENDER EQUALITY WITHIN THE HIV, TB RESPONSE

In general, there is coordination mechanism in TB/HIV response but there is no dedicated focus on gender equality. In addition, there is no additional mechanism in different government sectors. Civil society organization (e.g., NATAB) is working on TB but not working specifically on gender and human rights.

GENDER EQUALITY IN THE CONCEPTUAL FRAMEWORK AND DESIGN

Specifically, gender equality policy and guideline in TB response is not developed yet. But National TB Policy reflects a commitment to gender equality, since NTP declares in the mission statement that “it strives to make services equally available to all people in Bangladesh irrespective of age, sex, religion, ethnicity, social status or race.” Moreover, NTP has policies to cover high-risk populations across the whole country. Attention to gender will be an important element in the models (e.g. hospital model, social enterprise model, urban private provider pilot, informal health care provider model, workplace model etc.). That means there are needs of giving more emphasis on the commitment matched with a budget to undertake the implementation of gender-responsive and transformative initiative and service.

GENDER EQUALITY AWARENESS AND KNOWLEDGE

There are no indications that those involved in the HIV and TB response-policy makers and service providers demonstrate awareness and knowledge of the consequences of gender inequality between men and women or the marginalized populations in the context of TB.

A COMPREHENSIVE HIV AND TB RESPONSE: (STEPS 11 OF THE STAGE 3 OF THE TB/HIV GAT)

HIV and TB PREVENTION

1. There are gender-related impediments such as stigma, discrimination, gender-based violence, harmful societal gender norms, access to resources, and discrimination based on occupation, marital status etc.
2. There are gaps in the areas that partially respect, promote and protect the rights are-access to justice and benefit of the law; addressing violence in all cases (including from partners, family, community or state); disclosure and acceptance of HIV status, free of discrimination; gender identity; protection against harmful gender norms and practices; reproductive health and rights; sexual health and rights; sexual orientation etc.
3. Services like anti-retroviral treatment as prevention and male circumcision are not available in the programme at no cost for prevention of HIV and TB.

TESTING AND TREATMENT

1. There are gaps in implementing the principles in the areas of gender-based violence (including from their partners, family, community or state), protection against harmful norms and practices, safe abortion, sexual health, sexual orientation etc.
2. Gender and age-related disaggregated data on percentage, number etc. are not present.

CARE AND SUPPORT

1. There are no insurance schemes for the key affected populations.
2. There are gaps in implementing the principles in the areas of; access to justice and benefit of the law; gender-based violence (including from their partners, family, community or state); gender identity; protection against harmful norms and practices; safe abortion; sexual health; sexual orientation etc.
3. Limited financial compensation for primary and secondary caregivers (Partial. In some NGOs like BRAC-incentive to Shastho Sebika for providing DOT); recognition and effort to

address the burden and impact of care on women and girls (partially); training and support for palliative care (partial, for MDR only).

4. The policy does not recognize reliable access to home-based care supplies.

GENDER-BASED VIOLENCE (GBV)

1. The national HIV and/or gender policy guide is existing for HIV response to recognize the link between gender-based violence and HIV increases the risk of HIV transmission, including in conflict and post-conflict situations but implementation is not adequate.
2. There is no national TB and/or gender policy guide for the TB response in recognizing the link between gender-based violence and TB, in terms of increased violence as a result of being infected by TB.
3. There are laws in place to reduce and condemn violence against women and gender-based violence but there are limitations in upholding the laws. Most of the women do not get the shadow of justice they deserve in Bangladeshi society still; because of the stigma surrounding violence against women.

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

1. Sexual and Reproductive Health and Rights (SRHR) services are not equally accessible to young women, men, transgender people and other key affected population (e.g. special clinic timings, mobile units targeting specific groups, etc.). The issue of sexual health is not addressed in the policy.
2. The most common gender-related barriers and challenges to accessing integrated HIV, TB and SRHR services and commodities are:
 - *Less access to information*
 - *Less access to services*
 - *People at hard-to-reach*
 - *Slum*
 - *Tea garden*
 - *Attitude of service providers*

These have been identified from data of low case detection in some communities. There have been attempts to address these barriers in the in the national strategy through Public-Private Partnerships, Active case finding strategy, establishment and expansion of new diagnostic tools etc.

The main gaps in addressing gender differences (findings from discussion after presentation of review data from step 11)

- In most cases data disaggregated by age, sex is not available
- Since the Transgender has been recognized as the “third sex”, the national programme needs to think how to incorporate the sex in reporting formats

GENDER CONSIDERATIONS PER COMMUNITY (Step-12)

WOMEN AND GIRLS

There is a national gender policy in Bangladesh e.g. National Women Development Policy 2011 under Ministry of Women and Children Affairs and Gender Policy of Ministry of Environment and Forest 2016. ***In general, gender policy exists but no specific focus to TB/HIV patients. The participants found areas to improve mainly in people’s awareness on policy and its implementation.***

The workshop participants provided their opinions regarding following limitations of the above-mentioned policies for effective use of and access and adherence to TB and HIV services:

- *Access to economic empowerment, services including health for women/girls.*
- *Workplace policy e.g. gender equity.*
- *Social protection for gender-based violence.*
- *Access to legal support for key population.*
- *Gender equality in household decision making as well intimate relationships.*
- *Policy on stigma.*

Overall, according to the workshop participants, the existing gender policy does not guide the HIV and TB response in terms of recognizing and addressing both the gender aspects of the HIV and TB epidemic and the specific HIV and TB risks and vulnerabilities of women and girls.

Bangladesh is a signatory of SDG and determined to attain the targets within the stipulated timeframe. The 7th Five Year Plan (FYP) and the 4th HPNSP (2017-2022) also endorsed the SDG Goal 5: *Achieve gender equality and empower all women and girls.*

Gender and adolescent friendly services, together with availability of proper information for the adolescents will be ensured to protect themselves from health hazards. Health facilities will be maintained properly, and women will be given their due privacy and confidentiality regarding health matters. Alternative medical care services will be further strengthened and expanded through proper initiatives in education, service delivery, and regulatory arrangements. Similarly, the Bangladesh Health Workforce Strategy 2015 follows four cross cutting principles: gender balance, motivation, partnership, transparency and accountability.

MEN AND BOYS

There is inadequate data in the national HIV and TB and/or in gender policy to work with men and boys in addressing gender related cultural norms e.g. smoking and alcohol abuse that may negatively impact both HIV and TB vulnerability and access/adherence to HIV and TB services.

TRANSGENDER

Over policy decision, the cabinet approved on 11 November 2013 the recognition of Hijra as the “Third Gender”. On 16 January 2014 the government issued a gazette notification in order to secure their rights, enabling them to identify their gender as “hijra” in all government documents including passport and NID cards.

However, the workshop participants provided their opinions regarding following limitations of the above-mentioned policy for effective use of and access and adherence to TB and HIV services:

- *Inadequate awareness among transgender population e.g. lack of information to avail health rights/services.*
- *No social protection for them.*
- *Lack of access to general services (including health) due to negative attitude of the society.*

Overall, according to the workshop participants, the existing gender policy does not guide the HIV and TB response in terms of recognizing and addressing both the gender aspects of the HIV and TB epidemic and the specific HIV and TB risks and vulnerabilities of transgender.

KEY AND VULNERABLE POPULATIONS

The national strategic plan on TB and HIV has also been exist in Bangladesh. ***But no specific issue on HIV, TB and key population is addressed in the gender policy.***

YOUNG PEOPLE

The country has a youth policy 2003 namely Bangladesh National Youth Policy. In addition, the country has National Guidelines for management of tuberculosis in children 2016. However, according to the workshop participants following issues were not included in the policy/guideline:

- *access to condoms*
- *age of consent to access condoms*
- *access to information on sexual and reproductive health*
- *access to safe abortions access to sexual and reproductive health services*
- *access to sexuality education*
- *age of marriage*
- *age of treatment decision-making*
- *gender equity in access*
- *parental or spousal consent to medical treatment protection against gender-based violence*
- *protection for different sexual preference*
- *protection for multiple gender identity*

Young women, men and transgender people are able to access HIV, SRHR services, TB services and commodities under the same conditions as any adult. However, ***the identified Gender barriers to their access are as follows-***

- *Lack of awareness on gender issue*
- *Distance*
- *Family decision making process*
- *Poverty*
- *Stigma and discrimination*
- *Socio-cultural norms*

ELDERLY/SENIOR CITIZENS

There is no national elderly/ senior citizen policy *but there is a clause in Bangladesh constitution*. Constitution of the Bangladesh mentioned the rights of elderly people. In the constitution part II section 15 entitled “Provision of Basic Necessities” described social security of the elderly people as the “ provision of the basic necessities of life, including food, clothing, shelter, education and medical care; the right to reasonable rest, recreation and leisure; and the right to social security, that is to say, to public assistance in cases of undeserved want arising from unemployment, illness or disablement, or suffered by widows or orphans or in old age, or in other such cases mentioned in the 15 (a) (c) and (d) clause respectively 18.”

Ultimately, the specific HIV and/or TB risks and vulnerabilities of the elderly are not recognized and addressed in the national gender policy, national HIV and/or TB policy or the national strategic plan on HIV and/or TB.

The main gaps in addressing gender differences (findings from discussion after presentation of review data from step 12)

- ✓ *Policy exists but people’s inadequate awareness on policy*
- ✓ *National guidelines for management of tuberculosis in children 2016 exists but implementation is not at expected level*
- ✓ *TB screening is included in guidelines but still scope of further improvement to increase the range of implementation*
- ✓ *No access to counseling for children <15 years*
- ✓ *Inadequate protection of gender-based violence*

Usability of the step 10, 11 and 12 of the TB/HIV Gender Assessment Tool

1. Too many theoretical questions with overlapping and repetition among the steps
2. Some questions need more clarification to elicit appropriate answers
3. Some questions are not yet applicable to Bangladesh societal context

Day 2: Findings from the stakeholder workshop

ON STAGE 4 (ANALYSING AND USING THE FINDINGS OF THE GENDER ASSESSMENT FOR A GENDER TRANSFORMATIVE TB RESPONSE)

Identification, Prioritization and risk analysis of the key population

Key and vulnerable population:

The Global Plan to END TB specifies TB testing and treatment services must reach at least 90% of key populations as defined by countries across the world by 2020 through TB programs that are Human-rights-based, gender-responsive, multi-stakeholder and inclusive (The END TB STRATEGY, May, 2014, World Health Organization).

Each country must identify and engage the specific vulnerable populations that are central to their epidemic and response. This will be based on the epidemiological and social contexts of each country. The engagement of key and vulnerable populations is crucial to successful HIV and TB responses and for the gender assessment itself. It is essential that the gender assessment considers the full range of populations and takes a nuanced approach addressing the needs of key affected women and girls in all their diversity.

Definition and context (see annex 6- page 64): Key populations are the population sub-groups facing higher risk of TB exposure compared to the general population. Key populations in TB are at increased risk for TB due to where they live or work, have limited access to quality services and are at increased risk of developing TB due to biological and behavioural factors. Key populations vary from country to country. Key populations are often socially disadvantaged and their human rights frequently violated; and data are limited about them. Key populations are often missed by the health systems, often unable to access health services, or suffer particularly detrimental consequences as a result of TB.

Framework:

The Global Plan to End TB recommended developing a framework for key, vulnerable and underserved populations that to be used at country level. The framework includes identification of relevant key, vulnerable and underserved population groups, estimating their size and characteristics, identifying risks and barriers to services and developing customized approaches to provide them access to services. Additional support data came from the workshop findings of the first day exercise with the step 12 of the stage 3 of the HIV/TB GAT.

Methodology:

Process of key population identification

Step 1: Using the Stop TB key population identification tool (**Figure 11, p39**), the national consultants make a list of **30 key** populations. (Table 3 displays the list of 30 key populations). This list has been given to two divided groups of stakeholders in the 2nd day of workshop. Each group consisted of different expertise from different organizations (e.g. government, development partners, civil society, and implementers of TB programme)

Table 3: A List of National Key Populations

# Number	Key Populations to consider	# Number	Key Populations to consider
1	People Living with HIV	16	Homeless
2	People with Silicosis	17	People with Mental or Physical Disabilities
3	Miners	18	Urban Poor
4	Migrants	19	Rural Poor
5	Refugees	20	People with Diabetes
6	Internally Displaced People	21	Children
7	Nomadic Populations	22	Elderly
8	Prisoners & Detainees	23	Hospital Workers
9	People who Use Drugs	24	Prison Workers
10	People with Alcohol Dependency	25	Refugee Camp Workers
11	Smokers	26	Community Health Workers
12	Tobacco Users (except Smokers)	27	Outreach Workers
13	Sex Workers	28	Hospital Visitors
14	Lesbian, Gay, Bisexual & Transgender	29	Garment Workers
15	Indigenous People	30	Factory Workers

Step 2: Each group has been facilitated by consultants to conduct a brain storming session and experience sharing discussion. Prioritizing key population in own perspective is important to understand the risks the key population face, the risk drivers and challenges in providing services. Therefore, participants of each group were instructed to be flexible for inclusion or exclusion of any key population considering the Bangladesh country context. Such gathered information was then finally shared in between each group. Consequently, each group identified 10 key vulnerable populations of Bangladesh relevant for TB control programme. Exercises of each group for identification of 10 key vulnerable populations has been given below-

Table 4: Identification of a list of 10 National Key Populations Bangladesh relevant for TB control programme (the list is not according to the rank)

Group 1	Group 2
1. Garments/Factory workers	1.Garments worker
2.Children < 5 years	2.Urban poor
3.Urban poor	3.Elderly
4.Elderly	4.Rural poor
5.People with diabetes	5. Prisoners & Detainees
6. People living with HIV	6. Children
7.Migrants/ Refugees/Internally displaced people	7. Hospital workers
8. Smokers/Tobacco users	8. Prison workers
9. Rural poor	9. indigenous people
10.Tea/Rubber garden people	10. Refugees

Step 3: All the concerned bodies of each group in the workshop then determined by a scale coded method on the basis of epidemiological risk analysis for identification of the 3 prioritized key population. On the basis of scale coded matrix each group made a rank of top three key populations and if two or three key population got same score or rank then the participants came in consensus after open discussion to identify the context specific most vulnerable one. Then the identified key populations were matched with both groups and identified the final three key populations for TB programme. Stop TB scale coded matrix table has been given below-

Table 5: Key population Scoring matrix

Key people to consider	Estimated Contribution to country's TB diseases burden (Active TB cases of all forms)	Faced with environmental risks (Overcrowded, poorly ventilated, space, reside in zoonotic TB areas)	Faced with biological risks (reduce immunity, poor nutrition)	Faced with behavioral risks (In / exhaling from/into other's mouth, sharing smoking equipment)	Legal & economic barriers to accessing services (criminalization/poverty)	Human rights & gender barriers to accessing services (Stigma/discrimination)	Total score	Prioritization discussion & rationale for prioritized key population
	1 very low (<1%)	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No		
	2 low (2-3%)							
	3 Medium (3-5%)							
	4 high (5-10%)							
	5 very high (>10%)							

Figure 4: Prioritization of Key Population (by Group 1)

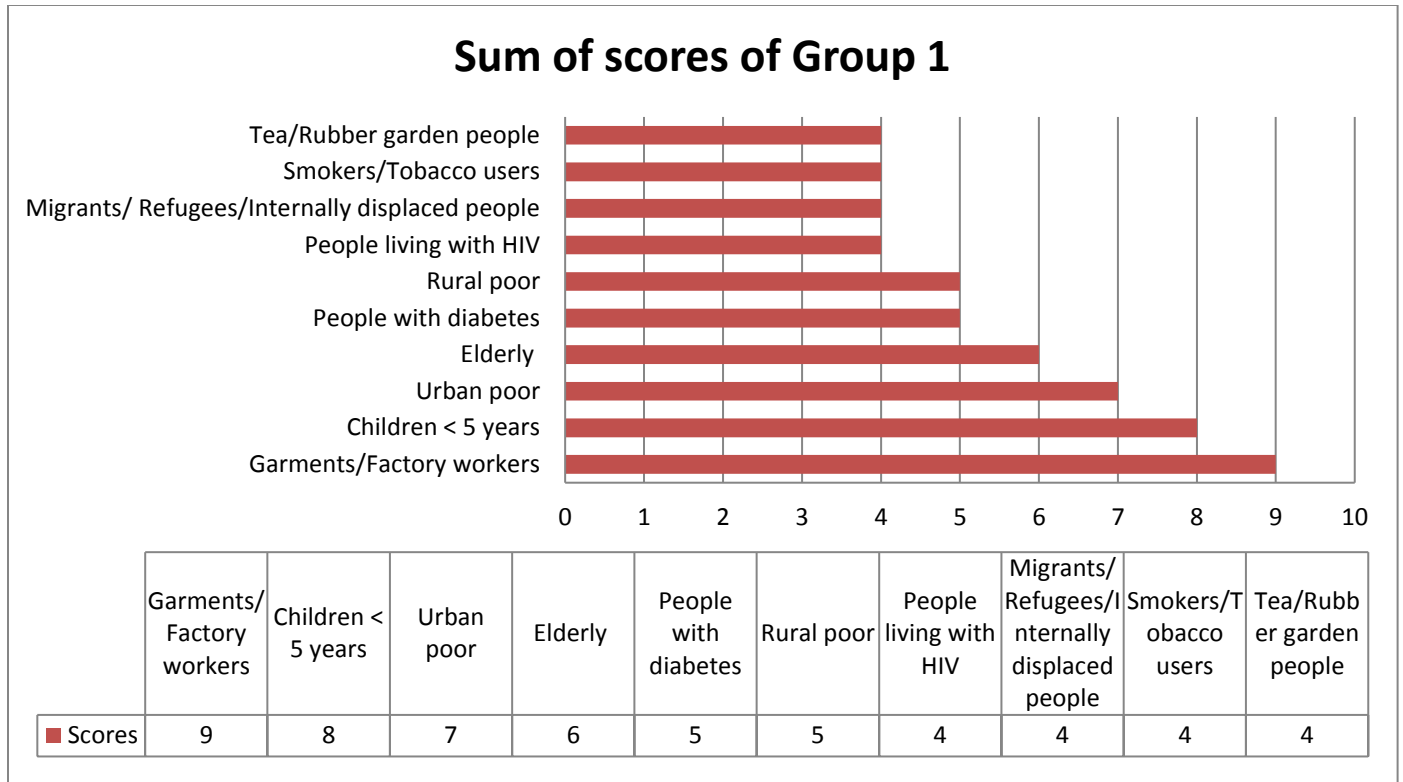


Figure 5: Prioritization of Key Population (by Group 2)

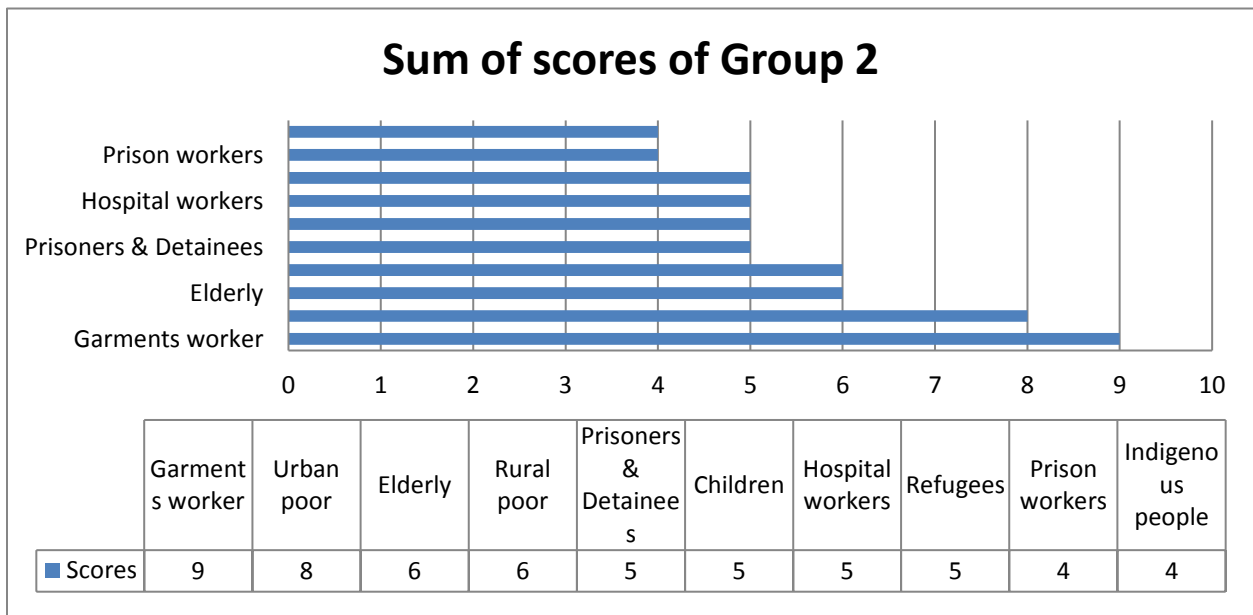


Table 6: Prioritization of key population by two groups of workshop participants

Group 1			Group 2		
Key Population	Rank (on the basis of scale coded method)	Remarks	Key Population	Rank (on the basis of scale coded method)	Remarks
Garments/Factory workers	1		Garments worker	1	
Children < 5 years	2		Urban poor	2	
Urban poor	3		Elderly	3	This group finally identified elderly as third ranked and the rural poor the fourth ranked key population
Elderly	4		Rural poor	3	
People with diabetes	5		Children	4	This group finally identified children as the fifth ranked key population

Step 4: Stop TB Partnership has brought an example on 5 key populations in the action framework e.g. mobile populations, miners, prisoners & detainees, people who use drugs, and people living with HIV. On the basis of such action framework each group of the workshop conducted a risk factor analysis of 3 most vulnerable key populations.

The Workshop ultimately came into consensus to prioritize three key populations that they urged the programme needs to focus and work on;

- 1. The garments / Factory workers**
- 2. The urban poor (particularly slum dwellers)**
- 3. The elderly population (65+ years)**

Subsequently the two groups worked intensively identifying the TB risks, risk drivers in terms of social, economic and gender / human rights point of views, and possible challenges for the

programme to address those risks. They also commented on the potential responses for the programme to address those challenges.

Table 7: Risk Assessment for the prioritized key population

Garment workers

TB risks				TB risk drivers	TB case finding and treatment service challenges
Environment (Over crowded, poorly ventilation)	Biological (reduce immunity)	Behavioral (prone to transmission)	Limited access to services (health, social and economic)	Legal & Economic (criminalization, poverty) Human rights & Gender (stigma, discrimination)	
<ul style="list-style-type: none"> - Most of them live in slums or peri urban localities those are overcrowded area. -Living spaces/rooms of garments worker are also congested e.g. many of them live without family in a mess sharing a room with 5-7 workers - Unhygienic living condition - Inadequate sanitation 	<ul style="list-style-type: none"> -Malnutrition - Underweight 	<ul style="list-style-type: none"> -Conceal about his/her disease to the workers. -Sharing living spaces with other -Negligence toward disease - Changes of garments at regular interval -Smoking or other forms of tobacco use 	<ul style="list-style-type: none"> -Economic problems -Inappropriate working hour of TB program - Lack of proper treatment knowledge - Don't go to qualified doctor - Wide range of therapeutic options 	<ul style="list-style-type: none"> -Stigma (if they get TB, they may be dismissed from their work. Because of contractual job, they may lose their job. -If they get TB, they may be separated from the community and work place. -Fear of not getting married. -Fear of divorce. - Harassment by manager and supervisor 	<ul style="list-style-type: none"> -Cannot go to the health facility at office time -Lengthy working hour -Lack of outreach Campaign. - Lack of annual screening - inadequate orientation program

-Poor working condition.				- Barrier to compensation during sickness	-Conflict with health facility time.
- Poor ventilation both in workplace and house					- Not favorable working hour for TB program
- Lack of factory accommodation				-Lack of TB program in garments which are not under BGMEA	
- Occupational dust					

Urban poor

TB risks				TB risk drivers	TB case finding and treatment service challenges
Environment (Over crowded, poorly ventilation)	Biological (reduce immunity)	Behavioral (prone to transmission)	Limited access to services (health, social and economic)	Legal & Economic (criminalization, poverty) Human rights & Gender (stigma, discrimination)	
-Living spaces of urban slum dwellers are over crowded - unhygienic living condition - Poor ventilation	-Malnutrition - Prevalence of different diseases - Many use drugs which causes to HIV infection	-Ignoring health seeking behavior/ delayed health seeking -Lack of family support -Not express behavioral health (if they	-Limited access to service and continuation of treatment. -Not identification/ screening/ neglect/ diagnosis/ lack of knowledge/lack of information &	-Stigma and discrimination. -Poverty and nutrition. - Women’s limited access to health service.	-They don’t get services at the convenient time or need to change health facility time -lack of availability of permanent TB

<p>- Their workplace may be factory which is poor ventilated and unhygienic</p>	<p>- Weakened immune system due to stress and malnutrition</p>	<p>feel sick, they don't care at all).</p> <p>-Lack of health seeking behavior</p> <p>(they do not go to the doctor, when they feel a little better from illness)</p> <p>- Reluctant to enter into public health services</p> <p>-Smoking or other forms of tobacco use</p> <p>-Inappropriate (if the health facility gives free medical checkups, people think it is not good.)</p> <p>- Local definition of illness</p> <p>- Discrimination toward child, women, elder</p>	<p>knowledge of health services</p> <p>-Low income</p> <p>- Prevalence of drug users, sex workers</p> <p>-Not have financial support/economic problems/ treatment expenditure</p> <p>- Fear of extra medical cost</p> <p>- Language barriers</p> <p>- Cultural beliefs</p>	<p>- Female TB patients are stigmatized mostly</p>	<p>services at slum</p> <p>- Lack of mobile TB screening</p> <p>- Poverty and stigma</p> <p>- Removal of superstition</p> <p>- Gender equity in pre-health service</p>
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		<ul style="list-style-type: none"> - Fear of social exclusion - Many use drugs by inhaling each other mouth - Limited or no knowledge about TB transmission 			
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Elderly people

TB risks				TB risk drivers	TB case finding and treatment service challenges
Environment (Over crowded, poorly ventilation)	Biological (reduce immunity)	Behavioral (prone to transmission)	Limited access to services (health, social and economic)	Legal & Economic (criminalization, poverty) Human rights & Gender (stigma, discrimination)	
- Poor living place with poor ventilation	<ul style="list-style-type: none"> -Reduced immunity -Presence of cough in maximum elderly TB patient -Many elders have diabetes and there is a 	<ul style="list-style-type: none"> -Intimacy toward grand children -Children living with elderly TB patient are more vulnerable to TB -Lack of hope for lengthy life 	<ul style="list-style-type: none"> -Limited access to health services. -Economic problems. -Loss of income source 	<ul style="list-style-type: none"> -Discrimination and poverty -Decision of treatment rests on sons which hinders treatment many cases 	<ul style="list-style-type: none"> -Symptoms are less prominent among the elder -Confused with other co-morbidities (COPD, diabetes)

	correlation between TB and diabetes	<ul style="list-style-type: none"> -Regard EPTB as normal pierce - Lack of respiratory protection -Smoking or other forms of tobacco use 	<ul style="list-style-type: none"> -Lack of caring by other family members -Prevalence of superstition 	<ul style="list-style-type: none"> - Cannot express their problems spontaneously -Are regarded as burden to other family members 	<ul style="list-style-type: none"> - Case detection is low - Special programs are not taken for them -Lack of mobile screening at house to house
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Risks, risk drivers, potential challenges and possible responses for the prioritized key population:

TB risks have been assessed in the relations to i. environmental risks (e.g., overcrowding, poor ventilation etc.); ii. Biological risks (e.g., reduced immunity); iii. Behavioural risks (prone to transmission) and iv. Systems risks (limited access to care-health, social and economic reasons). TB risk drivers explore the context, particularly legal and economic barriers like gender discrimination to care, stigma, and poverty in which TB occurs. The related challenges to case finding was also discussed (Framework for TB risk assessment-REF) (Table 7).

In all the 3 identified prioritized population groups there are many commonalities in their risks to develop TB. For example, majority of all 3 key populations live in slums or in overcrowded and poorly ventilated conditions, have chronic deficiency of nutrition, usually of poor economic condition and have limited access to care or specific services due to many reasons. The reasons in many cases are ignorance of availability of services, prevalence of stigma in case of TB, personal negligence and tendencies to conceal the diagnosis. Specific risks and risks drivers in case of garments worker include unhygienic and poor working condition (poor ventilation, exposure to industrial dust etc.), job insecurity, non-flexible working hours and lack of provisions of TB services in the vicinity of their workplaces. Similarly, the elderly population runs the risks of compromised lung functions, presence of co-morbidities like Diabetes, COPD and other conditions. Negligence by the family members also prevents them taking appropriate care in case of TB. Some behavioural risks and risk drivers are common the 3 populations, like; smoking or use of tobacco is common among them, delay in care seeking, discrimination for the females in the working place, at home and in the community in case of diagnosis with TB.

The major challenges identified by the workshop participants to access TB services by these 3 key population groups included;

1. Conflict with office hours / working hours and clinic time
2. Sometimes lengthy working hours (as in garments factories)
3. Non-availability of TB outreach or health facilities near to working place
4. Fear / stigma for exclusion from job; community
5. Confusion about TB symptoms (in elderly population, smokers)
6. Negligence and delay to seek care

To address these challenges and way forward was discussed in general. Suggestions were given to increase motivational campaigns, holding frequent and increase number of TB outreach, sincere involvement and motivation by the factory owners / supervisors, flexible working hours and support during initial phase of the disease if diagnosed.

NATIONAL LAWS & POLICIES RELATING TUBERCULOSIS

The Constitution of the People's Republic of Bangladesh: Provision on basic necessities

Article 15:

Article 15 of the Constitution entails right of food, clothing, shelter, education and medical care, right to work at a reasonable wages, entertainment & leisure, right to social security to unemployment, ill or disabled, or widows or orphans or elderly people, or in other such cases where undeserved want arises, the State must secure such rights of all citizens.¹³ This article particularly provides protection to the vulnerable citizens who are prone to suffer more of diseases due to lack of ability to afford medical treatment as well as other facilities due to their social and economic status. Hence, this article reflects the need of the most affected group of tuberculosis, as has been commonly known as the key population.

¹³ **Provision of basic necessities, Article- 15.** It shall be a fundamental responsibility of the State to attain, through planned economic growth, a constant increase of productive forces and a steady improvement in the material and cultural standard of living of the people, with a view to securing to its citizens –
(a) the provision of the basic necessities of life, including food, clothing, shelter, education and medical care;
(b) the right to work, that is the right to guaranteed employment at a reasonable wage having regard to the quantity and quality of work;
(c) the right to reasonable rest, recreation and leisure; and
(d) the right to social security, that is to say, to public assistance in cases of undeserved want arising from unemployment, illness or disablement, or suffered by widows or orphans or in old age, or in other such cases.

Article 18:

Article 18 of the constitution of Bangladesh recognizes public health and level of nutrition as a preliminary duty to development, thus aims to protect public health and morality¹⁴. This is particular article of constitution that serves as the basis of public health protection against TB.

Article 19:

Equality of opportunity is illustrated in article 19 of the constitution, emphasizing on the equality of opportunity of all citizens by adopting effective measures to remove social and economic inequality between men. This article also encompasses gender equality by ensuring equality of opportunity and participation of women in all spheres of national life.¹⁵ Hence, this article aims to achieve that every citizen of Bangladesh shall receive equal treatment while availing medical treatment for diseases such as tuberculosis.

Article 25

Article 25 of the constitution illustrates on Promotion of international peace, security and solidarity. Where article 25(b) offers the right to freely determine and build up its own social, economic and political system by ways and means of its own free choice to every people in this world without suffering discrimination.

Equality before law is ensured by the article 27 of the constitution, hence citizens of sexual minority have equal right to seek justice before the courts of Bangladesh as citizens of sexual majority.

Article 28:

This Article deals guarantees that no discrimination has been imposed on the ground of religion, race, caste, sex or place of birth and that the State have the power to making special provision in favour of women or children or for the advancement of any backward section of citizens to ensure equal treatment for all.¹⁶

¹⁴ **Public health and morality** - 18. (1) The State shall regard the raising of the level of nutrition and the improvement of public health as among its primary duties, and in particular shall adopt effective measures to prevent the consumption, except for medical purposes or for such other purposes as may be prescribed by law, of alcoholic and other intoxicating drinks and of drugs which are injurious to health.

¹⁵ **Equality of opportunity** - 19. (1) The State shall endeavour to ensure equality of opportunity to all citizens. (2) The State shall adopt effective measures to remove social and economic inequality between man and to ensure the equitable distribution of wealth among citizens, and of opportunities in order to attain a uniform level of economic development throughout the Republic.

(3) The State shall endeavour to ensure equality of opportunity and participation of women in all spheres of national life.

¹⁶ **Discrimination on grounds of religion, etc.**

Article 31:

Article 31 of the constitution guarantees enjoyment of the protection of law, and to be treated in accordance with law, and only in accordance with law, which is the inalienable right of every citizen.¹⁷ Article 31 hence imports the concept of due process, both substantive and procedural in regard to State action. Conversely, the Constitution of Bangladesh did not include a 'separate' provision addressing due process for TB patients in the prison.

Article 32:

As per article 32, the State ensures protection of right to life and personal liberty unless law says otherwise.¹⁸ However, currently patients of tuberculosis and family of the patient suffers stigma socially as well as at their workplaces which the State needs to address as the impediment for the patients to approach for treatment. The stigma any contagious/communicable diseases encompass, that has to be taken care of by the State in an effective manner.

However, the constitutional provisions, *i.e.* articles 19 (3), 28(1), 28(2), 28 (3), 29(1), 29(2) and 65(l) cover equal rights of women with men in the State and public life, equal opportunity for all citizen irrespective of men and women¹⁹, thus adopt democratic principle of gender equality, human dignity of all the genders.

Other National laws, regulation and policies relating tuberculosis

There are National Health Policy 2011, the TB Strategic Guidelines, the Tuberculosis-Leprosy and AIDS STD Programme (TB-L & ASP) guidelines and National Strategic Plans, which support the treatment services of Tuberculosis. On 22 January 2014, Bangladesh Government published a Gazette²⁰ announcing TB as a mandatory notify able disease. Though Bangladesh does not yet

28. (1) The State shall not discriminate against any citizen on grounds only of religion, race, caste, sex or place of birth.

(2) Women shall have equal rights with men in all spheres of the State and of public life.

(4) Nothing in this article shall prevent the State from making special provision in favour of women or children or for the advancement of any backward section of citizens.

¹⁷ **Right to protection of law**

31. To enjoy the protection of the law, and to be treated in accordance with law, and only in accordance with law, is the inalienable right of every citizen, wherever he may be, and of every other person for the time being within Bangladesh, and in particular no action detrimental to the life, liberty, body, reputation or property of any person shall be taken except in accordance with law.

¹⁸ **Protection of right to life and personal liberty**

32. No person shall be deprived of life or personal liberty save in accordance with law.

¹⁹ Available at http://bdlaws.minlaw.gov.bd/pdf_part.php?id=367

²⁰ Please see Annexure-I

have any enactment that precisely controls the implementation of TB treatment services, however, there are few enactments those partly deal with the contagious and communicable diseases upon various circumstances. Those are as follows:

- **THE EPIDEMIC DISEASES ACT, 1897**

- **Power to take special measures and prescribe regulations as to dangerous epidemic disease**

- Section 2 of the said Act mentions about the power of the Government to take special measures in case of an epidemic outbreak in order to prevent spread if the disease.²¹

- **THE CODE OF CIVIL PROCEDURE, 1908**

- **Release on ground of illness**

- Section 59 states the grounds under which a judgment-debtor would be released or the court would refrain from sending a judgment-debtor to a civil prison. The main ground for such action would be the existence of any **infectious or contagious disease** and other serious illness.²²

- **THE CANTONMENTS ACT, 1924**

- **Definitions - (xvii):**

- This sub-section defines infectious or contagious disease that includes TB. ²³

- **THE PUBLIC HEALTH (EMERGENCY PROVISIONS) ORDINANCE, 1944**

- **Power to require local authorities to take health measures**

- Since this enactment deals with the emergency situation, hence section 3 of the said Act says that the Government may instruct the Local Authority by written order to take necessary steps in emergency situations in a way mentioned in the written order. This enactment also covers the provision for water supply in section 7, that the Local Authority upon taking permission may supply water to another local authority if need arises.²⁴

- **THE CANTONMENTS PURE FOOD ACT, 1966**

²¹ Available at http://bdlaws.minlaw.gov.bd/print_sections_all.php?id=72

²² Available at **Release on ground of illness** http://bdlaws.minlaw.gov.bd/sections_detail.php?id=86§ions_id=14963

²³ Available at **Definitions** http://bdlaws.minlaw.gov.bd/sections_detail.php?id=133§ions_id=7056

²⁴ Available at http://bdlaws.minlaw.gov.bd/print_sections_all.php?id=210

Food poisoning:

S-13 (1) describes the responsibility of a Health Officer or an Inspector in case he suspects a food to be poisonous by chemical or bacteriological action, which includes keeping the food or any specified portion thereof to be kept separate or removed in the manner specified in the notice.²⁵ Whereas, s- 13 (2) describes the procedure a Health Officer would apply in cases where he has reason to suspect that **tuberculosis** is likely to be caused by the consumption of milk supplied from any dairy or other source. This subsection also mentions the procedures the Health Officer would undertake in order to prevent Tuberculosis bacteria to spread²⁶.

- **THE FISH AND FISH PRODUCTS (INSPECTION AND QUALITY CONTROL) ORDINANCE 1983 Handling, etc. of fish and fish product**

Section 6 of this Act identifies the persons who are allowed to catch, handle, carry or, process or cause to catch, handle, carry or process fish or, as the case may be, fish products or work in fish processing and fish packing plant and establishment, and also stipulates that any person suffering from leprosy, **tuberculosis** or such other contagious disease as the Government may, by notification in the official Gazette, shall not be allowed to carry out the above mentioned actions²⁷.

Moreover, there are laws, *i.e.* The Ports Act, 1908 & The Bangladesh Merchant Shipping Ordinance, 1983 those deal with the protection from the infectious or contagious diseases from port to port and prevent embarking of a ship consisting of such patients on board. ²⁸

These are the few enactments those partially deal with the prevention of Tuberculosis to spread. Hence, Bangladesh still lacks an enactment consolidating all the areas of prevention and cure of communicable diseases, *e.g.* Tuberculosis.

Communicable Diseases Prevention, Control and Eradication Bill, 2018

²⁵ Available at **Food poisoning** http://bdlaws.minlaw.gov.bd/sections_detail.php?id=346§ions_id=17624

²⁶ *ibid*

²⁷ Available at **Handling, etc of fish and fish product**

http://bdlaws.minlaw.gov.bd/sections_detail.php?id=640§ions_id=22407

²⁸ Available at http://bdlaws.minlaw.gov.bd/sections_detail.php?id=89§ions_id=22844
http://bdlaws.minlaw.gov.bd/sections_detail.php?id=642§ions_id=23830

The government of Bangladesh hence initiated the procedures of passing an Act that will eventually deal with all the communicable and contagious diseases in Bangladesh. The draft of the Communicable Diseases Prevention, Control and Eradication Bill, 2018 was approved in the cabinet on 20 August 2018 and was placed in the Jatiya Sangsad (the Parliament of Bangladesh) on 17 September 2018. The Bill so far dealt about 23 communicable diseases which includes TB.²⁹ More diseases may be added later by publishing Government gazettes.³⁰

The proposed bill shall replace few enactments those currently deal with communicable and contagious diseases in different situations, *i.e.* the Epidemic Diseases Act, 1897, the Public Health (Emergency Provisions) Ordinance, 1944, the Bangladesh Malaria Eradication Board (Repeal) Ordinance, 1977 and the Prevention of Malaria (Special Provisions) Ordinance, 1978.³¹

This particular proposed Bill since is dealing with epidemics it included provisions such as a patient or the affected person will have to be screened and isolated to protect common people from being affected. And that the affected person will also have to be examined in the related and specified institutes to detect the type of disease.³²

The said Bill made this an offence where a person spread or help spreading any communicable disease or hide the danger of coming in contact with a communicable disease in case of touching a surface. In these cases, the person shall be sentenced to maximum of 06-month imprisonment and/or maximum one lac taka fine. If any person make hindrance in performing duties or disagree to follow direction, he shall be punished with maximum of 2 months of imprisonment and/or a 25 thousand taka fine under the provisions of this Bill.³³

A committee consisting of 13 members shall be formed under this Bill to monitor the execution of the duties imposed on the Health Directorate by this Bill.

This mentioned Bill made it mandatory to notify the cases to the Government Authority with an immediate effect where a person is identified as affected by any of the communicable diseases.

There are provisions for keeping a person or an area under quarantine in case of an outbreak.

²⁹ Available at <http://www.bssnews.net/?p=88759&print=print>

³⁰ Available at

https://bangla.bdnews24.com/bangladesh/article1531696.bdnews?fbclid=IwAR0kXZWXHHYKULB1t9Jsd_1KBX9ToM8tCkdNs5rTMEgKn9km35-Puu61-Fc

³¹ Ibid

³² Ibid

³³ Available at

https://bangla.bdnews24.com/bangladesh/article1531696.bdnews?fbclid=IwAR0kXZWXHHYKULB1t9Jsd_1KBX9ToM8tCkdNs5rTMEgKn9km35-Puu61-Fc

However, currently the NTP is operating on the basis of guidelines and plans those the Bangladesh Government formed. Those are, National Health Policy 2011, Tuberculosis-Leprosy and AIDS STD Programme (TB-L & ASP) Guidelines (January 2017- June 2022) and National Strategic Plan on Tuberculosis (2018-2022). Moreover, in 2014, the Bangladesh Government published an official gazette³⁴ making TB a mandatory notifiable disease following the guidelines provided by the WHO.

INTERNATIONAL CONVENTIONS OF WHICH BANGLADESH IS SIGNATORY

- International Covenant on Civil and Political Rights, 1966 (ICCPR)
- International Convention on Economic, Social and Cultural Rights 1966, (ICESCR)
- Convention on the Elimination of All Forms of Discrimination Against Women 1979, (CEDAW)
- International Convention on the Elimination of All Forms of Racial Discrimination (CERD)
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)
- International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (MWC)
- Convention on the Rights of the Child (CRC)
- Universal Declaration of Human Rights, (UDHR)
- Convention on the Rights of People with Disabilities (CRPD)

LEGAL ENVIRONMENT ASSESSMENT ON ISSUES RELATING TB

Countering Discrimination

Stigma

There are several determinants of health and one of them is stigma that plays an enormous role in relation to TB. However, social determinants of health are directly linked to the economic and social condition shaped by distribution of money, resources and power at macro and micro levels.³⁵ However, stigma relating to TB patients is prominent regardless of the economic condition or availability of resources. Nevertheless, people living in slums, shanty places with toxic environment are more prone to contacting TB in their lifetimes. This stigmatization of people with TB was instigated by the fact that TB was a highly communicable and non-curable disease. Though with the advancement of medical science, there are at present various types of

³⁴ Please see Annexure-I

³⁵ WHO definition on social determinants of health, available at http://www.who.int/social_determinants/sdh_definition/en/

methods in which TB can be cured entirely, stigma still persists. As the other types of communicable diseases, the stigma relating TB stems from the fear of acquiring TB.³⁶ Stigma plays most brutal role to the vulnerable population such as, children, women and elderly population. The issues feeding stigma are those that there is lack of knowledge onto transmission and prevention methods of TB. Impacts of stigma can be brutal, *e.g.* ostracization, abandonment, and loss of employment. Hence, a person with TB suffers more out of stigma than the actual disease.

Social discriminatory norms as well as presence of discriminatory laws and policy³⁷ or lack of any non-discriminatory law or policy, often fuels in discriminatory behavior among the population thus bring about inequality. Discrimination occurs when a person is treated favorably than the other person in same situation on the grounds of their sex, race, gender, sexual orientation, gender identity, age, caste, religion, health status, etc.³⁸ Even though the presence of Articles 15, 18, 19, 28 in the Constitution of Bangladesh addresses inequality which is in accordance with many international conventions (*e.g.* UDHR, ICCPR etc. those deal with equality), since there are no specific enactment exists that deals with TB hence the oppression occurs due to the same. However, international treaties are not recognized as law in Bangladesh unless and until they are passed as the Act of Parliament. The law and policy can become a great tool in prohibiting the behavior of discrimination and reducing the effect of such behavior, *e.g.* stigma on people³⁹.

The National Health Policy 2011⁴⁰ and the National Strategic Plan on Tuberculosis (2016-2020)⁴¹ did not consider elimination of stigma is a strategy of ensuring proper health accessibility for people suffering from TB. However, an insight for not considering stigma as an obstacle was found at the Validation Workshop taken place on 17th September 2018 in Cox's Bazaar, Bangladesh. At that Workshop the participants discussed on the topic and came to conclusion that by not acknowledging stigma as a hindrance to access to health care, the stigma can eventually be eliminated by proper communication of health care program and other facilities in conjunct with the health care services available for people suffering from TB which will eventually eliminate the concept of stigma in this regard. This approach is hoping to be effectively executed since stigma is still considered to be the main cause of people not utilizing their right to health care when contacted with TB.

³⁶ Courtwright, A and Turner, A.N, "Tuberculosis and Stigmatization: Pathways and Interventions", Practice Articles, Public Health Reports, 2010 Supplement 4, Volume 125, pages 34-42

³⁷ Citro, Brian "Measuring structural stigma: Human rights and legal discrimination", Chapter 6 in KNCV

³⁸ Baral, S &ors., "Causes of stigma and discrimination associated with tuberculosis in Nepal: a qualitative study" BMC Public Health 2007, 7:211; doi:10.1186/1471-2458-7-211

³⁹ Burris, Scott "Stigma and the law", Lancet 2006: 367: 529-31, February11, 2006

⁴⁰ Available at -

http://www.mohfw.gov.bd/index.php?option=com_content&view=article&id=74&Itemid=92&lang=en

⁴¹ Available at <http://etoolkits.dghs.gov.bd/toolkits/bangladesh-program-managers/national-strategic-plan-tuberculosis-2016-2020>

Disabled and elderly people

Since the person suffering from TB, if approached for treatment very late at stage, there is an enormous possibility that the person may end up as disabled in many ways. However, the Persons with Disabilities Rights and Protection Act 2013⁴² defines the general and fundamental rights of a disabled person and protection of law of not being discriminated or abandoned by their family and the society and of course in obtaining employment and/or not being discriminated from other employees in terms of allowances and benefits.

However, the Convention on the Rights of People with Disabilities (CRPD) provides guidelines regarding the rights all the disabled people should receive and Articles 28, 29 and 12⁴³ describes the right for the disabled to receive equal opportunities in every sphere of their lives. However, these articles of the Constitution also apply for the elderly population of the country. State intends to provide the equal footing for all socially-backward population of the country.

However, regardless of laws and policies of the land, the treatment toward elderly and disabled people are not satisfactory. Since most of these populations are dependent on other people for taking care of them, they are often exposed to malnutrition and discriminatory treatments, which makes them vulnerable to the risk of developing TB. Here law can be used to blunt the effect of stigma and also to mitigate harmful, unfair conduct and secure the rights of the disempowered⁴⁴.

Law reforms and enforcement of the same are necessary in this regard where the general and fundamental rights are not properly protected for the disempowered population. There's a need to initiate an alternative dispute resolution and also legal aid scheme for these population wherever they come across discrimination. Building shelter homes and other facilities for people abandoned due to TB is also necessary.

TB in workplace

Survey has brought up the situation where we found that the people within the age limit of 35-45 has been the ones does not come forward for treatment if suffering from TB. Being the earning member of the family, they find themselves to be responsible not to take off from their job or responsibilities to their family. However, due to not approaching at the initial stage of TB, the workers with pulmonary and extra-pulmonary TB have found themselves to have lost their jobs and faced discrimination from co-workers due to their health status. Workers work in factory environment falls under the provision of the Factories Act. 1965,⁴⁵ where the environment of the

⁴² Available at -

http://www.apcdfoundation.org/?q=system/files/Persons%20with%20Disabilities%20Rights%20and%20Protection%20Act%202013_0.pdf

⁴³ Available at - http://bdlaws.minlaw.gov.bd/pdf_part.php?id=367

⁴⁴ Burris, Scott "Stigma and the law", Lancet 2006: 367: 529-31, February 11, 2006

⁴⁵ Available at- <http://www.ilo.org/dyn/natlex/docs/WEBTEXT/47346/65073/E65BGD01.htm>

workplace of a factory has been defined clearly. BRAC has integrated TB control services into workplaces with a focus to factory settings, in partnership with a number of associations. Bangladesh Garment Manufacturers and Exporters Association (BGMEA) and other organizations as such who deal with more than 80,000 garment workers each has a key role to change the work environment norm and eliminate the possibility of stigma if a worker suffers from any communicable diseases. TB prevalence is high among the garment workers. Nevertheless, BGMEA has already established DOTS centers in 11 clinics those cover 600 out of 3,500 factories and also incorporated in its policies 14 days of paid leave as well as job protection for the workers undergoing TB treatment that they provide. Despite serving large population of workers, which is roughly one million⁴⁶, these efforts have yielded relatively low TB case detection till to date. In this regard, employers such as BGMEA, must consider well communicating the incentive of receiving the treatment facility for free at the prescribed health care centers, knowledge of TB prevention, transmission and the need for treatment completion and of workers' right to have 14 days paid leave as well as job protection among the workers.⁴⁷ In this regard, there must be provisions where a worker or employee intends to join back to the work after prolonged absence from work for the purpose treatment; the employers should consider to take those workers or employees back to the work upon providing a fitness certificate.

However, since TB is a communicable disease, the healthcare workers are often exposed to getting contact with TB, which is termed as occupational risk of the Healthcare workers. In this regard, WHO articulated few measures those are needed to be taken to reduce the risk –

*in health-care facilities and congregate settings, a comprehensive set of infection control measures – comprising administrative, environmental and personal protection measures – should be implemented. Periodic assessment of TB infection control in health-care facilities is essential to ensure that appropriate measures are in place.*⁴⁸

The DOTS centers as well as the clinics in Bangladesh are ensuring the maintenance of infection control measures where there are separate wards dedicated for TB patients. Those wards are equipped with the administrative, environmental and personal protection measures for the healthcare workers. However, the occupational risk of the healthcare workers are well recognized in Government policies, but laws for protections and compensation is not very clear in that regard. Bangladesh Labour Act, 2006 or Factories Act, 1965 does not fit in every work

⁴⁶ This estimate includes 700,000 reached through BGMEA (roughly 14% of the total workforce covered by BGMEA, source interview with BGMEA TB project director) and 273,000 (73% of the total reported workforce of 374,008) for the BEPZA areas of Chittagong and Dhaka where TB interventions have been implemented. (20)

⁴⁷ National Strategic Plan on Tuberculosis (2016-2020) p. 21-22

⁴⁸ WHO, Global Tuberculosis Report, 2017, available at <http://apps.who.int/iris/bitstream/10665/259366/1/9789241565516-eng.pdf?ua=1>

situation and definitely not for healthcare workers. Therefore, there is still space on policy amendment as well as law reform where the right to safe working environment as well as compensation scheme shall find clear recognition. For that purpose, training on infection control and usage of well-established precautions, access to treatment and compensation regime is well needed. The healthcare centers must also acquire workplace policies related to TB healthcare services by law.

Moreover, these workers or employees from different setting suffering from TB do not approach the courts to contest the discrimination they face. The main reason behind this type of behaviour is having deep-rooted stigma attached to TB and insensitivity or not knowing the legal remedies available to them. For this purpose, it is highly recommended that there should be a provision for legal aid especially for patients with communicable disease and the employers must notify the rights to each of their employees via effective awareness program.

Women and gender equality

There are international Conventions, *i.e.* Convention on the Elimination of All Forms of Discrimination Against Women of which Bangladesh is a signatory and the Constitution of Bangladesh reflects the required provisions of gender equality of opportunity and participation of women in all spheres of national life in its Article 19. Nevertheless, women in some regard suffer more if contacted with due to their socio-economic position in the society, social inequities and traditional structure of patriarchy. Since women are more prone to degrading treatment in lower income generated families, hence, women with TB are naturally stigmatized, deal with ostracization and delayed or limited access to healthcare services in general.

In Bangladesh, there are enactments those came into effect to provide equal treatment to women in this patriarchal society, where women are abandoned by her husband and family for silly things like birthing a girl instead of a boy. Having TB is therefore not an option for women thus occurs delay in availing proper healthcare for TB and these delays are sometimes result in death of the patient. Women in Bangladesh tend to receiving less nutritional food than the male members of the family, as well as are often are assaulted physically and stay ill for many days without having any medical attention. In the given scenario, women are more prone to come in contact with TB than male members of the family.

Even though there are several legislations present to protect women from undergoing inhuman and degrading treatment in her family or elsewhere, it is rarely that women seek legal or medical attention due to the social structure. There are cases where men divorce their wives on the ground that the wives contacted TB. The opposite cases are rarely to be seen.

For this purpose, the National Health Policy 2011 has made the gender equality in availing healthcare facility as one of its main objectives to act upon⁴⁹. In this regard NTP has made the DOTS centers and clinics for TB women friendly and has staffed female health workers in those centers for encouraging women to avail healthcare facility at the early stage of contacting with TB. However, those centers being staffed with mostly with female health workers, there arises need to maintain balance so that male patients do not feel discouraged by it.

The legal system of Bangladesh still does not acknowledge the systematic inequality and social inequalities women face in an adequate manner. The reason behind it is, in the Parliament of Bangladesh, there are only 71 female lawmakers of which 50 of them occupy reserved seats. As, those reserved seat does not hold real power hence, the enactment suffers from gender inequality at the Parliament. Henceforth, women empowerment is crucial at this stage for them to be able to come forward to access health care for both mental and physical health. Therefore, law reforms are due in regard to incorporate provisions those reflect true social and systemic inequality among genders. Even though there are provision for legal aid is available for women to enforce their legal rights at court, only few women know about the facility available to them. Therefore, legal literacy of women, including knowledge of their rights and remedies; in regard to TB awareness as to health and nutrition related information, a gender-responsive public health system that caters all genders equality is a dire need at present.

TB in prison

In Constitution of Bangladesh and laws and regulations alike, the rights of the people in prison are not clearly articulated. On the other hand, The Prisons Act, 1894⁵⁰ regulates the administrative part of maintaining a prison. In this very enactment, there are provisions for having temporary shelter and safe custody of any prisoner in case of outbreak of any epidemic. Chapter VIII of the said legislation deals with the “Health of Prisoners” where it mentions how the mentally or physically ill prisoner may be treated by the medical officers.

Conversely, there is international guidance as to how the prisoners should receive treatments in case of sickness and the minimum floor space, ventilation, hygiene and sanitary condition, nutritional value of food, treatment of sick prisoners etc., in the form of the UN’s Standard Minimum Rules for Treatment of Prisoners⁵¹. Whereas, the WHO highlights the equity and equality among the prison inmates in regard to obtain medical treatment and other facilities as

⁴⁹ National Health Policy 2011, p. 10

⁵⁰ Available at - http://bdlaws.inlaw.gov.bd/print_sections_all.php?id=69

⁵¹ Adopted by the First United Nations Congress on the Prevention of Crime and Treatment of Offenders, held at Geneva, 1955, and approved by the Economic and Social Council by its resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977

there are often power imbalance all inmates face. Hence the healthcare workers must take all these factors into account while trying to treat prisoners with TB⁵².

However, since the initiative taken by the Government are not adequate in regard to TB treatment, the icddr, b, BRAC and DF has undertaken provisions of TB services in prison. Up till now, the screening of TB patients in prison is done by project staffs. Due to the fact that prisons in Bangladesh are over-crowded, poorly ventilated and sanitized and prisoners are not provided proper nutritional food, prisoners are more vulnerable to TB since the environment and conditions in prisons are more conducive to for spreading TB or other communicable diseases. Therefore, efforts are planned to train inmates as TB screeners. Availability of treatment facility is varied in different prison setting in Bangladesh, for example, only the largest national prison has a doctor and all other prisons has screening for TB only. At present DOTS are done by the prison paramedic with doctor's follow-up wherever available. Now NTP is considering TB in prison as special scenario where special initiative to be addressed outside the Public-Private Mix Strategic Plan.⁵³

For proper administration of the rights of the prisoners affected by TB there needs to be provisions for making prison officers and police to be accountable for death of such person or not receiving proper treatment in prison and not receiving separated cell for segregation from epidemic diseases. Thus, there should be provisions for prisoners to submit complaint against those officials in this regard. The prisoners should be made aware of the TB and the course of treatment there in the prison. If there is any need for isolating TB patients, making sure that that is being done as the last resort by following ethical and human rights principles. Ensuring the national as well as international guidelines are implemented and enforces is a must. There should be instances at the court where the prisoners are granted bail to avail treatment of TB outside the prison. Adequate training of prison paramedics and medical officers for prison for TB testing, treatment and management of the disease, including treatment with first line, second line, third line medicines and XDR and MDR medication, must be undertaken on an urgent basis.

Mobile Population

The population either incoming or outgoing from one place to another within Bangladesh or even incoming from outside of Bangladesh are commonly termed as mobile population. This population is often referred to as refugees. There are many reasons for this mobile population to change their place of inhabitation, namely, for obtaining secured livelihoods, ensuring access to education, housing and food, access to health services and often times due to strife-torn

⁵² WHO, Ethics Guidance for the implementation of the End TB Strategy, 2017, available at <http://apps.who.int/iris/bitstream/handle/10665/254820/9789241512114-eng.pdf;jsessionid=1EEE447A5B1A30D1B8CD6F8B5E2E85A6?sequence=1>

⁵³ National Strategic Plan on Tuberculosis (2016-2020) p. 22

conditions in the country of nationality. As has been known, there are currently approximately 300,000 non-Bengali citizens of the former East Pakistan are remaining stranded in the camps in Bangladesh⁵⁴, whereas, 897,733 refugees came from Myanmar are currently residing in Cox's Bazar camps in Bangladesh⁵⁵. There are the two largest refugee groups those currently are residing in Bangladesh.

Migration is determinant of ill health⁵⁶, as many of them begin to live in low socioeconomic status thus live in slums, shanty places like camps with limited access to health services and other facilities. Thus, they get more vulnerable to come in contact with diseases like TB.

Even though migrant workers have much better footing after entering the migrating country than the refugees, it is still very hard for the migrant workers to ensure safe and healthy environment of living and access to facilities. As the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (MWC) comes into place, the rights of migrant workers or population are often not protected in the allowing countries. In order to provide proper health and other facilities it is mandatory that the migrants have registered their names and made an identity card. The truth is, it is often times very hard for a migrant to get his name registered and obtain an identity/ration card to avail the services. Hence, it is often times quite distressing for mobile population to stay in a poorly sanitized, shanty places without any proper nutritional food available.

The Government of People's Republic of Bangladesh allows the refugees to apply for valid visa based on UNHCR requirements. Thus, the refugees can seek employment legally and also can have access to the facilities, *e.g.* healthcare easily. The Government must initiate laws and policy reform in regard for migrant workers and refugees receive proper health care and nutrition in order to reduce the risk of infecting with TB or even spreading the same.

People living with HIV

People living with HIV (PLHIV) are 30% more vulnerable to the risk of developing TB than people who doesn't have HIV. Hence, out of the 9.8 million new cases estimation of TB in 2014, 1.2 million were among PLHIV. TB is the major cause of death among PLHIV worldwide.

The main cause for making TB particularly deadly for the PLHIV is that there are weak TB and HIV service integration, HIV-induced immunosuppression, which is compounded by forms of discrimination, stigma etc. However, WHO recommendations must be integrated into our policies as soon as practicable. On top of it, the healthcare centers must always be well-staffed

⁵⁴ Available at <https://minorityrights.org/minorities/biharis/>

⁵⁵ Available at https://data2.unhcr.org/en/situations/myanmar_refugees

⁵⁶ Davies AA, Basten A, Frattini C. Migration: a social determinant of the health of migrants. *Eurohealth*. 2009;16(1):10-2.

along with having strong collaboration between vertical TB and HIV systems, thus ensuring timely delivery of urgent care to PLHIV with TB as is required by them.

However, laws and regulations of Bangladesh needs to be reformed in a manner which will not criminalize or put in a negative note under the laws of land so that they do not face any barrier in availing diagnosis and treatment for both TB and HIV patients. For better execution of such policies, a joint TB and HIV LEA process should be initiated.

Drug abusers and sex workers

Both drug abusers and sex workers fall under the category of population who are criminalized and stigmatized because of their lifestyle and occupation. This scenario contributes to devastating health disparities. Drug abusers are more prone to the risk of developing HIV thus are more vulnerable to developing TB as has been mentioned in previous paragraphs.

Conversely, UN Sex Worker Implementation Tool (SWIT) laid out practical and effective guidance for HIV and STI programs for sex workers. SWIT recommends programs and community outreach services for sex workers for TB screening and TB prevention and treatment. It was also recommended that the TB healthcare workers be always respectful towards sex workers while providing treatment. There are many unregistered sex workers alongside the registered sex workers. Since being unregistered sex worker there remains the possibility to get penalized under the Penal Code 1860 for vagrancy, loitering, disturbing public peace, or causing public nuisance, therefore, it is highly unlikely that even a registered sex worker would easily approach the health service dedicated for TB. These reasons cause delays in availing health care for TB by the sex workers thus enhances the possibility to spread TB in the given area.

Hence, laws and regulations of Bangladesh needs to be reformed in a manner which will not criminalize or put the sex workers under negative note under the laws of land so that they do not face any barrier in availing diagnosis and treatment for both TB and HIV patients.

Isolation

According to the Constitution of Bangladesh, State shall always ensure the utmost security of the public health. It also says in its Article 36 that,

“Subject to any reasonable restrictions imposed by law in the public interest, every citizen shall have the right to move freely throughout Bangladesh, to reside and settle in any place therein and to leave and re-enter Bangladesh.”

Here comes the concept of isolating persons with TB for the ultimate protection of public health. However, the Constitution of Bangladesh also provides other human rights, e.g. freedom of movement & rights to autonomy and privacy. Here, interference to these human rights is

justifiable only in cases where necessity arose for the sake of public good⁵⁷. In this regard WHO also mentioned that the public health necessity would require exercising reasonable but coercive measures in case any person demonstrates himself to be a threat to public health. However, while exercising these coercive measures, the authority must be reasonable, effective, proportionate and transparent. WHO made it clear here by stating, '*Involuntary isolation must always be the last resort to be considered only after all else fails,*'⁵⁸

The community-based TB treatment at Lesotho finds that,

*“the so-called opposition between public health and human rights proves to be a red herring: public health goals of treating and preventing the transmission of TB and the human rights interests of individuals can be reconciled in most cases of drug resistant TB. Only in exceptional cases, where patients resist treatment after all feasible programmatic solutions have been exhausted, should detention — with proper checks, balances, and safeguards — be considered.”*⁵⁹

In this context voluntary and involuntary isolation of TB affected population for the purpose of securing public health is a very fragile concept, where the Communicable Diseases Prevention, Control and Eradication Bill, 2018 incorporated provisions to put a place or a person under quarantine to stop spreading of an epidemic. In this regard, the Bill gave the security of public health the utmost priority. Hence, the Government authority must always take precaution in exercising involuntary isolation for the people affected by TB. Therefore, it is more important to use a right-based and inclusive public health approach rather than an isolationist approach.

In this regard, it is highly important that the health officials never use arbitrary power in case of isolating a TB patient and always adhere to the WHO Ethics Guidance in regard to involuntary isolation. The 2018 Bill must incorporate provisions those are in line with the WHO Guidelines and exercise involuntary isolation as the last resort.

Notification

As has been mentioned earlier that the Government of Bangladesh published a gazette⁶⁰ making TB a mandatorily notifiable disease, the Government is now intending to incorporate notification of the TB patients into the Communicable Diseases Prevention, Control and Eradication Bill, 2018

⁵⁷ WHO, Advancing the right to health: the vital role of law, 2017, available at <http://apps.who.int/iris/bitstream/10665/252815/1/9789241511384-eng.pdf>

⁵⁸ WHO, Ethics Guidance for the implementation of the End TB Strategy, 2017, available at <http://apps.who.int/iris/bitstream/handle/10665/254820/9789241512114-eng.pdf;jsessionid=1EEE447A5B1A30D1B8CD6F8B5E2E85A6?sequence=1>

⁵⁹ Available at - <https://www.hhrjournal.org/2009/10/limitations-on-human-rights-in-the-context-of-drugresistant-tuberculosis-a-reply-to-boggio-et-al/>

⁶⁰ See Annexure-I

with a provision to criminalize the health workers in case of failing to notify any case to the government authority.

Mandatory notification of persons affected by TB requires healthcare providers to report the cases to concerned health authority that enable the Government to receive exact information about the number and health status of TB patients in the country, will help planning for future, help mobilize funding, share progress in national and international reports and forums⁶¹ and more importantly enables the patients to avail appropriate and prompt diagnosis and treatment for TB.

The main issue here in Bangladesh is that the primary point of care will always be the drug-sellers and pharmacy staffs where there exists approximately 103,450 licensed drug shop and equal number of unlicensed shops in Bangladesh⁶². Therefore, those unlicensed drug-sellers is not liable under the law to notify about TB cases to the government health authority. This way, it will be very hard for the Government to identify the actual number of TB cases ever in given circumstances. Hence, it is recommended that, instead if criminalizing the healthcare providers, there needs to be provisions for ensuring them to have accountability and Government should initiate scheme to reward for notification of such cases to encourage the unlicensed drug shop sellers.

NTP has mentioned in its PPM strategy under Objective 1, *“increase annual case detection of all forms of TB to 230,000 by 2020.”* Mandatory notification provides NTP the opportunity to improve the identification and monitoring the TB cases in the country. However, there are still scopes to improve and a simple electronic referral and notification system can be initiated to support the private providers. Another aspect might also be considered that to initiate an online notification system for the patients to be able to notify their cases themselves which will reduce the risk of stigma in many cases.

Remarks and Recommendations from the validation workshop

The workshop started with presentations based on document review and qualitative data collected in the intervening period from the first workshop. Three presentations were made on i) key population identification and qualitative study findings/recommendations ii) community, gender findings/recommendations and iii) legal/rights of key population. After completion of each presentation, discussion and recommendations were made.

⁶¹ National Strategy Plan for Tuberculosis (2016-2020), p. 22

⁶² National Strategy Plan for Tuberculosis (2016-2020), p. 16

Major themes that have been identified from the discussion and recommendations in the workshop are:

The single most important theme identified from the document review, discussion with stakeholders at the first workshop and the qualitative data collection exercise was the **“missing cases”** in the country. The concerns and challenges to reach END TB targets were to identifying the missing cases and bring them under treatment. The major questions were **who the missing cases are** and **where to find them?** The reflections from the participants mostly concentrated on these and allied issues.

Missing cases:

Where are they /who are they:

Private sectors/ the slums / Garments workers / elderly population

Participants discussed and shared their experiences on who and where are the missing cases. The major thematic areas focused were;

- i. Missing cases” which may lie in the areas that are yet unidentified (e.g. missing cases in private sectors, but are not notified with NTP after diagnosed by private sectors. However, mandatory case notification supposed to be addressed.
- ii. Existence of most missing cases in the slums. With massive and continuous migration from other areas to urban slum and having poor socio-economic status the slum people are more vulnerable to TB infection and diseases and also remain undetected for long time.
- iii. It was pointed out that high prevalence of TB among the garment workers, many of whom are living in the vicinity of the garment factory and probably in the slums. One participant remarked-
 - ✓ “It is predicted that perhaps a big chunk of ‘missing cases’ are among the garment workers. There is a common trend among the garment workers- they sometimes **migrate** from one garment to another (expressed high mobility of garment workers); some workers may quit garment job and adopt a new one, like rickshaw pulling etc. So, you will find many people in towns and villages who had been garment worker earlier”.
- iv. One participant commented that many of the missing cases are among the elderly population. Since this population is vulnerable in many ways including less accessibility to available services due to many reasons. He insisted on a adopting a meticulous strategy that needs to be designed for elderly population, since the death rate is also high among elderly population due to TB.

Why missing:

Many aspects of the missing cases were discussed trying to focus to the root causes and how to overcome those:

- i. **Stigma: Social aspects like stigma with diagnosis of TB still could be one of the reasons for under diagnosis for TB.** One participant commented that the idea of stigma and gender that has generated in this workshop as reasons of missing cases can also be applicable in HIV programme. He opined to point out those and to work on accordingly. In this connection, one participant reminded that pathogenesis of HIV is different than TB. He urged that we would serve all people, keeping in mind our vision and mission. Some participants pointed out that sometimes the very **'nomenclature'** can further stigmatize the key population. So, we need to carefully deal with this issue. In general, it was discussed that still we need to work more on stigma. Without it, no success can be achieved.
- ii. **Knowledge gap and lack of information:** Comments on this aspect were: in addition to gaps on adequate knowledge on TB disease itself, many patients do not know about availability of care facilities and related social support. This gap is also existed even within the health care providers. One example was cited by one participant as

“Even in a medical college hospital, the principal was found unaware of the DOT corner that was established at his premises and run by BRAC”.

It was then clarified by one senior participant that -

“All the DOT corners are established and owned by the government. BRAC and other implementers support it. We all work in a common voice that can sensitize people”.

He mentioned that access to information is an important right.

- iii. **Gap in sufficient equipment/effective diagnostic tools:**

This gap has been discussed extensively, particularly in term of different types of TB cases and their different needs for diagnosis and treatment. One participant pointed out that child TB cannot be detected merely through microscopy. To identify child TB cases, we need equipment more than microscopy. And these other facilities are not always accessible. We have to go to service level with all types of equipment to find out the missing cases.

In this connection one senior participant commented that we do not have sufficient number of effective diagnostic tools. FNAC can serve only 40 percent of the demand. There are gaps in identifying EP-TB. So, we need to work more on-

✓ *Histopathology*

- ✓ *Biopsy (to understand how many centres we have, how good they are)*
- ✓ *Need to adopt special techniques for special cases etc.*

One of the previous patients (member PWLD) described his life-based experience as a TB patient. He was an EP-TB patient and got cured of TB few years ago. But to get identified as an EP-TB case he had to endure a series of hassles to arrive the final diagnosis by travelling from Naogaon (a peripheral town, his own town) to Dhaka (the capital city) and vice versa. He proposed that FNAC service need to be accessible to the patients in need. In this connection, the NTP informed that *a Task Force will be formed to find out meaningful work in FNAC services.*

iv. Gap in focus on ‘gender-based care-seeking pathway’:

One of the areas of gap as identified by the participants was in the gender-based care seeking pathway. It was suggested that since such experiences are often pointed out, it was necessary to find out solid evidences using the dimension of ‘care-seeking pathway’. One participant pointed out gap in gender segregated data and analysis. So, she urged for inclusive care along with focus on gender and rights. Otherwise, missing cases will remain as a concern. In this connection it was also pointed out less accessibility of 35-45 age groups to treatment services because they are busy with their livelihoods.

v. Existing timing of TB services-conflict of interest:

Another area of gaps was mentioned by some of the participants as existing timing of TB services does not fit to garment workers. As we know, time really means money in this sector, so we earnestly hope to get workplace service like ‘mobile X-ray service’.

vi. Gap in policy application of 14 days with pay leave

This important thematic area was discussed by many participants. Particularly being existence of a policy of providing 14 days leave with pay when diagnosed with TB, there is gap in applying it in practical field. In order to minimize gap in policy application of 14 days leave with pay, it was suggested whether “can there be an ‘Act’ to support 14 days leave with pay for the workers”.

While discussing on who are missing cases and where are they, the participants at the same time also discussed what can be done in the areas where gaps were discussed and identified. The following notes and comments were documented in specific situations, location, key population and in general:

What can be done?

i) Ensure rights and deploy counselor at garment sector:

- ✓ We can raise our voice on rights, now from the validation workshop.
- ✓ Counselors need to be deployed at chest diseases clinics (CDC) and the garment factories.

ii) Guarantee protection on gender and rights issues:

- ✓ Before starting treatment there should be adequate **legal protection** for workers from fear lest anybody should lose her/his job.
- ✓ There should be a public hearing (**civil society engagement**) before passing any law.

iii) Strengthen coordination and sensitization of garment owners:

- ✓ **Owners and the supervisors** of the garment factories are not sensitized well. So, we need more sensitization programmes in the garments.
- ✓ Representatives of Ministry of Labour (MoL) need to be oriented and involved in TB control programme.
- ✓ There are still prevailing some other vulnerable groups (e.g. occupational age group) who specially need to be addressed for addressing the 'missing cases'. So, it was emphasized on the need to work more with professional bodies.

iv) Expand ACSM activities and mobile screening in garment sector

- ✓ Can BGMEA come up with more support in expanding **ACSM activities**, as the activities eventually result healthy workforce in the garment.
- ✓ For timing, it was commented, "New diagnostic facilities set by BRAC are also opened after office hours and in Saturdays. Those can be used in a further beneficial way".
- ✓ How co-morbidities can be included within the services for KAP that need to be considered.

Directive comments came from the national level leader (Line Director MBDC and Line Director, TBL- ASP). He commented that a massive work in garment sector, like mobile screening is very much needed.

v) Relevant use of Stop TB tools:

Some comments were made on several related issues like;

a. needs of using Stop TB developed tools to identify missing cases.

b. correct identification of KAP (key and vulnerable population) as identified through the present study.

c. needs to promote our services in the areas of rights and in the areas of gender. It was also mentioned that we need to empower the demand side so that it can help identifying 'missing cases' significantly.

vi) Technical Committee on TB can be work as HIV

- ✓ Several participants emphasized on the continuation and strengthening the ongoing leadership of NTP for the TB programme, particularly working together with HIV

programme. Being the leadership same in TB and HIV programmes, it becomes easy to us to better deal with HIV issues.

- ✓ We will work in reciprocity- while we will work on HIV, we also will search for TB patients; similarly, in TB patients we will also screen for HIV.
- ✓ Key population identification is rather easy for HIV programme as we have already defined peer-based approach there.
- ✓ The Technical Committee on TB can be work as HIV.

*In response Director MBDC and Line Director, TBL- ASP commented since TB is a notifiable disease, the information of patient cannot be kept hidden in TB, somehow it needs to be made public for the sake of infection control. Our strategy is- **Inform about the disease, take treatment, get well.***

He urged all to consider –

- ✓ *The capacities of the government to run the national programmes with correct understanding.*
- ✓ *It is true that the government will enhance its services for the key vulnerable population. Though personal lifestyle is important to address HIV cases, but it is not much important in dealing TB.*

He informed that now the government is going to recruit ‘multipurpose health workers’ who would work on multiple health issues in the community.

vii) Need to address co-infection:

- ✓ Discussion was then continued around the recent findings that more than **71% HIV patients does not know about co-infection.** How we can proceed in HIV along with TB in a concerted manner so that both can be mutually benefited.

In this connection Director MBDC and Line Director, TBL- ASP responded that

- ✓ *All infectious diseases should have a common platform.*
- ✓ *Civil Surgeon is the health manager of TB of the district. He will be also the health manager for HIV.*
- ✓ *Now the public sector is more significant in serving people than any other time.*
- ✓ *We need to enhance efforts considering our present efforts.*
- ✓ *We will maintain our successes and address the deficiencies in gender and rights.*
- ✓ *He concluded that since we have identified our key populations, we will work on them accordingly. We will also address co-infection. After addressing these key populations, we can work on further key populations.*

viii) Need sex segregated data: this important area was pointed out by one participant:

- ✓ Since it is not in the presentation, is it possible to get sex-segregated data for delay!

- ✓ Sex-segregated data on causes of delay, and modalities needed to better understand the differences in prevalence.
- ✓ Key population for HIV is exposed to all TB causing factors, but is usually missed from the survey samples. This needs to be considered to ensure their adequate services.

ix) Promotion of DSD model and arrangement of training:

Further discussion concentrated overall on missing cases and all other related issues: One of the participants discussed there are also lots of successes in TB programme in informing people, treatment success is more than 94%. But to reach the highest success we need to mend our gaps in the areas of-

- ✓ Gender- Missing cases are at the bottom of the society. Have we approached there! She briefed on the DSD (Differentiated Service Delivery) Model in HIV programme. DSD is promoted by the latest World Health Organization (WHO) guidelines for preventing and treating HIV infection. There are four key components of DSD: (1) What: The type of service delivered, (2) Where: The location of service delivery (i.e., in a health facility or the community), (3) Who: Patient eligibility criteria and type of service provider, and (4) When: The frequency of services. This approach can be adopted in the framework of TB she mentioned.
- ✓ Rights- Messages regarding childhood TB, MDR-TB and EP-TB are inadequate and unclear in radio and TV. Information should be updated with time and made accessible to community people.
- ✓ Community- in HIV there is a term called 'bridging population'. Internal migrants, garment/factory workers constitute the bridging population. They are sometimes found as casual sex workers and have TB-HIV co-infection. This population can be addressed in concerted information on HIV and TB.

She also suggested that the training courses on HIV can be made comprehensive incorporating TB. Nutrition education can be incorporated there. It is also needed to think how better way the prisoners can endure multiple treatment loads on HIV and TB.

Director MBDC and Line Director, TBL- ASP commented that though much has been achieved in TB but there is no scope of complacency. We have yet to reach the people in char (a strip of sandy land of river), who have no alternative; like people living with HIV.

x) Ensure gender equity:

One of the participants discussed with reference to TB prevalence study. Since prevalence was found more among male, so she recommended about more preference/priority to male to ensure gender equity. This followed by remarks from another participant as that though the qualitative study findings say that the urban health centres are not fully women-friendly, his views are different. Rather he wants how the services can be made more male-friendly.

xi) Others:

Some other issues were discussed in the connection of the workshop, the findings presented and way forward. Commenting on the ethical issues in treatment initiation one participant pointed out that in case of taking consent from a patient before starting treatment, he argued that when a patient comes for TB treatment that is an implied consent from the patient. On another issue he argued that it is very much unlikely, as the field findings say that a mother feels comfortable in treating her son as a TB patient, but gets embarrassed when it comes treating her daughter. **However, he further mentioned that** he found a TB patient had to travel 50 kilometers for X-ray. He said that it is not ethical that a TB patient has to travel a long way just for X-ray. **Similarly, another participant discarded** the idea of isolation in TB treatment. He said that isolation can only be justified if it is harmful for public health, otherwise not required. He mentioned that limited isolation may be required in drug-resistant TB. **In this connection this was further suggested as** the cured patients are one kind of counselor and can be utilized if possible, and also, we need to consider those population like the rickshaw pullers whom we could not cover in prevalence survey needs to be considered.

Concluding remarks of validation workshop

Deputy Director, MBDC remarked that the validation workshop is a time-responsive programme. He said that communities, rights and gender- these 3 things if we follow in case of missing cases and notification, we need to take challenges. He hoped that under the guidance of the line director the medical colleges and others will become more sensitized about TB programme. He urged GO-NGO officials to work in a united way.

Dr. Ashaque Hossain, Ex. Line Director commented on the mandatory notification that the executive order for gazette notification was made in 2014. But legislation is yet to be done though it is not incompatible with the constitution. Similarly, for the rights issue- if we want to make it accessible to all that should be supported by enacting necessary law. Since it is mandatory there should be provision of punishment. He recommended all to take the tools into cognizance. If the national TB control programme adopt these it will help the missing cases identification, barriers can also be identified that would be beneficial to the programme.

Civil Surgeon, Cox's Bazar commented the urban TB is not good in the slums. He commented that people need to be involved first before enacting any law.

Dr. Md. Akramul Islam, Director Communicable Diseases and WASH, BRAC mentioned that every public health programme needs to be tailored over a period. We can rethink about our TB control programme and can revise it if change really needed, using the lenses of the tools. He hoped that after 2025 Bangladesh will be the donor for many countries. He suggested the national programme needs to think now where to invest, taking new initiatives and remodeling. BRAC as a civil society representative will continue support to the national programme.

Prof. (Dr.) Shamiul Islam, Director MBDC and Line Director, TBL- ASP commented that the suggestions made by the participants will be taken into consideration. Then in a short group we will sit again on the issues for further work on TB Control programme.

About the tools he suggested that though we have good understanding about our communities yet we need to think more about the working people and their workplaces as those are not conducive enough. He emphasized on extensive mobilization and campaign. About using the electronic media, he mentioned that their coverage needs to be taken into consideration. New innovative message is to be disseminated to mobilize community people. Policy advocacy is also important, he mentioned. He mentioned that late identification of TB patients proliferates spreading infection in the community. He commented that we still deficient in diagnosis of EP-TB. He mentioned that essential tools also helpful to guide the programme. The areas where the programme needs to focus are-

- ✓ *All the machineries are not well-functioning*
- ✓ *X-ray quality and its interpretation is not good in all cases*
- ✓ *Also needs to examine whether the collected specimens from the presumptive are quality sputum or saliva*
- ✓ *Good monitoring tools needs to be developed*
- ✓ *Enough care to be taken for treatment*

Regarding gender he said that the country has its most favorable conditions and good practices in gender now. He suggested considering separately the tools to be used in 'health seeking behaviour' and 'health care seeking behaviour' of people.

He acknowledged the fact that the programme is yet to reach that segment of people who are in real need of support. So, enough tasks have to be done to support the people who are lagging behind. He mentioned that development sometimes broaden social gaps. Our work should not be confined in the meetings only. Being a self-motivated person, everybody should take the challenges positively. Our sincerity in policy development and sincerity in implementation both are equally important, he added. Citing the example of the Prime Minister, he commented that

true commitment, urge in knowing in-depth made her a person of different quality. Similarly, he added, we who are in the programme need to be of different quality.

Additional Recommendations

TB in workplace

- i. The healthcare centers need acquiring workplace policies related to TB healthcare services by law.
- ii. Training on infection control and usage of well-established precautions, access to treatment and compensation regime is required.
- iii. There should be a provision for legal aid especially for patients with communicable disease and the employers must notify the rights to each of their employees via effective awareness program.
- iv. There needs to be proper communication to the garment worker of the available services and schemes relating to TB.
- v. Health care facilities needs to be open after office hours so that the working population can receive treatment at their leisure time and without affecting their daily pay.

Women and gender equality

- i. Reform in allocating seats for female lawmakers and representative at parliament and ensuring women are well represented at the parliamentary law-making process.
- ii. Initiation of awareness programme on legal rights for women and informing them about the services (*e.g. Legal aid*) those are available for them.
- iii. Ensure legal education of women, including knowledge of their rights and remedies; in regard to TB awareness as to health and nutrition related information, a gender-responsive public health system that caters all genders equality.
- iv. Making healthcare centers gender inclusive.

TB in prison

- i. Incorporate provisions for making prison officers and police to be accountable for death of such person or not receiving proper treatment in prison and not receiving separated cell for segregation from epidemic diseases.
- ii. Incorporate provisions for prisoners to submit complaint against those officials.
- iii. Create awareness among prisoners of the TB and the course of treatment available there in the prison.
- iv. Taking consent from a prisoner before isolating him from other prisoners for having TB.

- v. Courts should take into account the health condition of a TB patient and grant bail in order to avail treatment of TB outside the prison.
- vi. Adequate training of prison paramedics and medical officers for prison for TB testing, treatment and management of the disease, including treatment with first line, second line, third line medicines and XDR and MDR medication, must be undertaken.

Mobile Population

- i. The Government must initiate laws and policy reform in regard for migrant workers and refugees receive proper health care and nutrition in order to reduce the risk of infecting with TB or even spreading the same.
- ii. Provisions to ensure notification and medical treatment for migrant TB patients.

People living with HIV

- i. WHO recommendations must be integrated into our policies as soon as practicable.
- ii. The healthcare centers must always be well-staffed along with having strong collaboration between vertical TB and HIV systems, thus ensuring timely delivery of urgent care to PLHIV with TB as is required by them.
- iii. Laws and regulations of Bangladesh needs to be reformed in a manner which will not criminalize or put in a negative note under the laws of land so that they do not face any barrier in availing diagnosis and treatment for both TB and HIV patients.
- iv. A joint TB and HIV LEA process should be initiated for better execution of such policies.

Isolation

- i. The health officials must never use arbitrary power in case of isolating a TB patient and always adhere to the WHO Ethics Guidance in regard to involuntary isolation.
- ii. The 2018 Bill must incorporate provisions those are in line with the WHO Guidelines and exercise involuntary isolation as the last resort.

Notification

- i. Instead of criminalizing the healthcare providers, there needs to be provisions for ensuring them to have accountability and Government should initiate scheme to reward for notification of such cases to encourage the unlicensed drug shop sellers.
- ii. a simple electronic referral and notification system can be initiated to support the private providers.
- iii. Initiate an online notification system for the patients to be able to notify their cases themselves which will reduce the risk of stigma in many cases.
- iv. Ensuring protection of law for the notifiers of cases in order to avoid humiliation for those people.

General recommendations

- i. Circulation of Mandatory case notification in TB and ensuring access to information of available TB services for the key population specially.
- ii. Optimum use of provisions for arbitration, mediation and alternative dispute resolution for quick and fair redress.
- iii. Provisions ensuring privacy of the patient and confidentiality of a notified case.
- iv. Provisions for taking consent from the patient (parents in case of a minor) before undertaking any medical procedure.
- v. Provisions to encourage people to approach for TB screening at the onset of the symptoms at early stage.
- vi. Make medicines affordable to TB patients by starting manufacturing them in Bangladesh.
- vii. Building healthcare centers within reach of entire population so that they don't have to travel long distances after being ill.

6. Lessons learnt

- CRG tools are found useful in identifying specific needs of community groups and to undertake focused measures for them. Though the tools need to be made further practical considering societal context of the country.
- High stigma, fear and negligence among some segment of population hinder access to TB diagnosis and care -seeking.
- The healthcare centers need acquiring workplace policies related to TB healthcare services by law.
- Availability of disaggregated data by age, sex can help addressing the gaps in identifying key population.
- Mass awareness on the policy can improve people's participation in national programme.
- Implementation of policy is equally important as policy development. Policy decisions cannot be well implemented until the policy makers hold an office for a moderately long term.
- Circulation of Mandatory case notification in TB and ensuring access to information about TB services for the key population needs to be focused.
- Initiating an online notification system for patient referral can help missing cases to notify with national TB services.
- Instead of criminalizing the healthcare providers, the Government can initiate a reward scheme to encourage private doctors and pharmacists for mandatory notification.
- Political commitment needs to be revisited over time to see to what extent the existing services are helpful in addressing new issues emerged.

- Even a good national programme with wide geographical coverage, high detection and success rate may lack its holistic image if people cannot access the programme due to several economic and social barriers.
- A gender-sensitive programme needs to address hindrances to equitable services for the disable, elderly, poor people, and people living in remote places through specific policy provisions.
- The commitment of both the policy makers and the managers/implementers should be kept aligned.
- Negative attitude and apathy of the society curbs access of sex workers and transgender in general health services.
- Concerted efforts in TB and HIV services can yield better screening in co-infection.
- Gender and rights issues can be well-addressed through proper legal protection of the victim.
- Necessary legislation needs to be enacted to support executive order of mandatory notification of TB.
- It is necessary for service providers to have orientation on gender and rights to change their knowledge and attitude conducive to all-inclusive services.
- The new move to active case finding strategy and expanding new diagnostic facilities at the community level significantly help reducing wages loss of the patients and increased case detection in sputum negative and extra-pulmonary TB.
- District level Diabetic network can be used for screening diabetes of the adult TB patients and vice versa.
- Civil society organization that mobilizing on TB can specifically focus on gender and human rights issues in TB.

7. Conclusion

The desk review and the workshop focused that there are gender differences in the prevalence, incidence and case notification of TB cases among the adults in Bangladesh. As the male patient detection rate is two-fold of the female patients, it raises the question whether this difference is just a biological difference or social, economic and/or cultural aspects of TB are there; in terms of pattern and delay in care seeking, stigma and lack of awareness of TB symptoms and services has any role or not. Also, if there are any programmatic inadequacies in implementation and to reach the population who needs them more. Are we systematically missing female cases? If so, why then there are no differences in case notification rate in < 15 years or among EPTB cases? Literature also noted excess disease burden among some subgroups of populations like the poor, the slum dwellers, the prisoners, the elderly population and among the garment/factory workers.

However, it is not conclusive if these differences are true differences, or we are missing cases somehow during the course of cough to cure pathways.

The workshop participants discussed extensively on these issues and others and at the same time performed exercises with the STBP gender assessment tool to identify the TB/HIV situation in Bangladesh, the existing policies and responses to the status and finally worked over a list of population to identify and prioritize at least 3 key and vulnerable populations who are presumably at higher risks to TB transmission and acquiring the disease, from programmatic point of views, from social, cultural, economic and attitudinal point of views. Even though it was pointed out that TB is such a disease where the national programme is able to provide full length of services, while most of the other health programmes do not have such scope. Yet several gender and equity related issues are to be resolved in order to make the programme more available, equitable and effective. Several gender and equity related issues were identified by the workshop and discussed.

The workshop went on discussing the probable risks and risk drivers of the identified key population and the remaining challenges to be addressed in order to reach these key populations. The workshop pointed out that there are several gaps in data from these sub groups of population to support appropriate decision making at this moment. However, the risk approach is suitable to target and address. For example, smoking is highly prevalent not only in general population but also among the identified 3 key population groups. It was further discussed that good community responses prevail in Bangladesh and sound practices in gender and rights issues such risks can be combatted successfully. However, if there are any gaps in identification of any community, declining rights or gaps in gender, the programme must address those with much care.

The findings from this report suffered from several limitations. Most of the information came from desk review which may miss some important evidences if not accessible digitally or from any repository available at the time of review. Moreover, there are scarcity of data in many aspects of TB/HIV epidemics in Bangladesh, either not researched or published or remained in the grey literature format. However, the workshop on the other hand was participated by the most well-known programmatic persons in the field of TB in the country, academicians, implementers, civil society representatives, representatives from the donor communities and policy makers from the government. The exercises with Gender Assessment Tool and the Framework for the Key and vulnerable population was fruitful in the sense that the workshop identified many gaps in these aspects and came up with suggestions to address them. However, these are secondary data and probably cannot be generalized as such for the country situation. A quick field level data collection to supplement will further validate these findings. Despite these limitations, these findings provided some indications of the gender, policy and programmatic

aspects of TB situation and responses in the country and provided valuable aid in identifying and prioritizing the key and vulnerable population for this disease in the country.

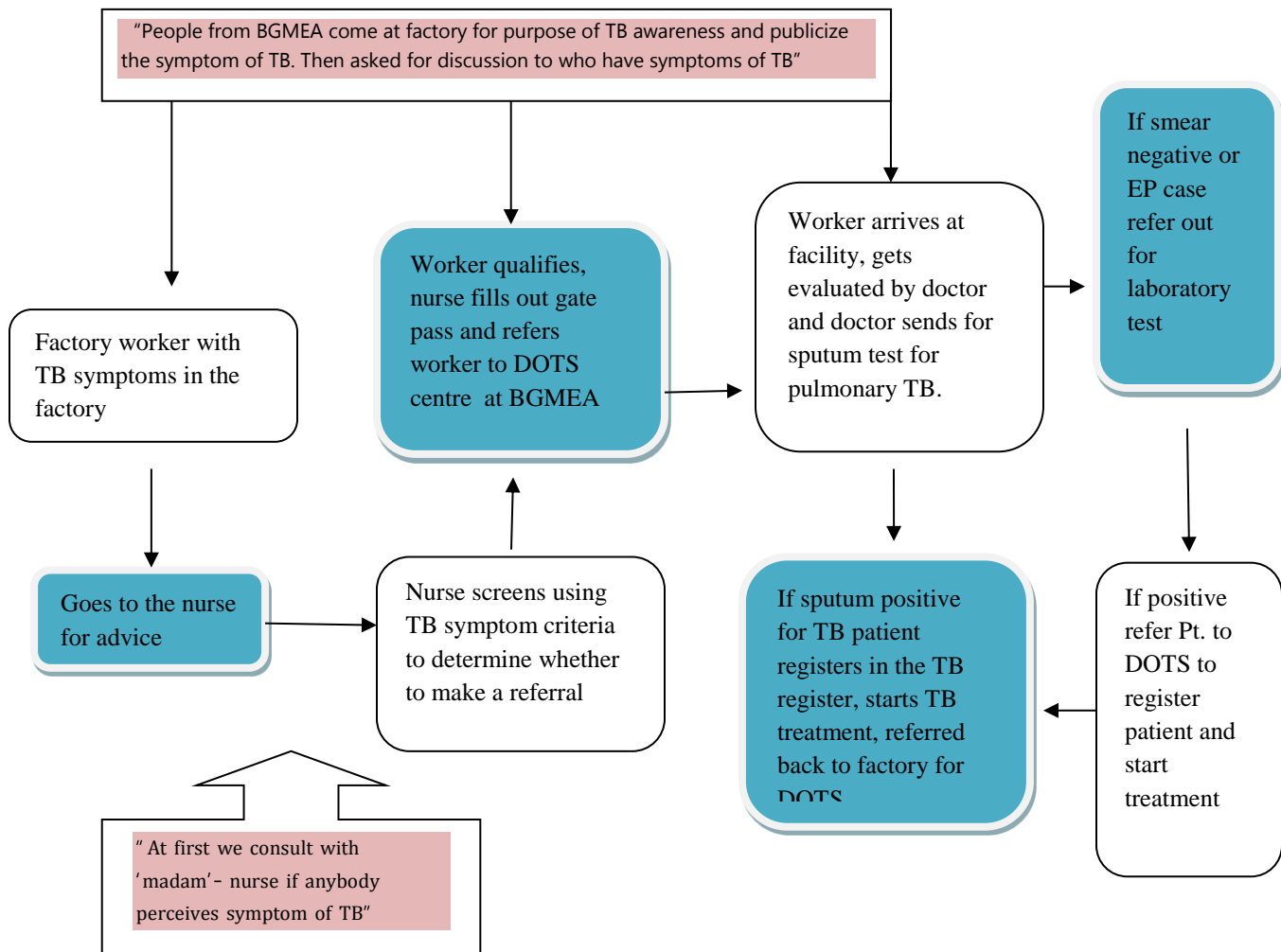
Some limitations and inadequacies or redundancies of the tools used, are also pointed out in the workshop.

EPTB is usually common in females of reproductive age (15-45 years), which is opposite to PTB which peaks at 30-40 years (Ozvaran et al., 2007; Musellim et al., 2005). In Bangladesh, EPTB is estimated to account for 10-20% of the newly diagnosed TB cases (Quddus, Uddin and Bhuiyan, 2014) and at present 21% (WHO, 2016). However, there was paucity of knowledge about EPTB among female garments worker. EPTB can be misdiagnosed making it diagnostically challenging (Yoon, et. al. 2004). Therefore, diagnostic delay was more frequently seen leading to greater potential for morbidity and mortality when compared to PTB (Hossain et al., 2014). EPTB had significant higher delay in diagnosis due to various patient and provider factors, the community behavior as well the health system itself (Farah et al., 2006; Storla, Yimer, & Bjune, 2008; Yimer, Bjune, & Holm-Hansen, 2014). This may be explained by multiple factors such as financial, physical barriers, stigma and health literacy (Yimer et al., 2014). A study in Bangladesh showed that socio-cultural barriers play a major role in care seeking of TB patients especially female patients (Ahsan et al., 2004).

This finding matches with other quantitative studies conducted in Bangladesh that showed, informal providers are the first point of contact for any disease including chronic conditions like TB and provide curative services to patients in 95% cases. (Ahmed et al., 2011; Hossain et al., 2014). Similarly, it has been reported that failure of detection of TB patients by informal providers leads to delay, misdiagnosis and improper treatment (WHO, 2015). Another study in Ethiopia showed that delay was strongly associated with first visit to non-formal health providers and self-treatment (Yimer et al., 2005).

Patient flow workplace model (BGMEA) is one of the priority models for PPM (Public-Private Mix) expansion that has been emphasized in National Strategic Plan Public-Private Mix in Tuberculosis (2016-2020) strategic plan. The workplace TB care model aims to improve the environment for TB control in workplace settings. It does this principally through the introduction of outreach, TB diagnostics and DOTS into workplace health services. The information of FGD participants has been quite harmonized with the flow of the workplace model that has been given below-

Figure 6: Schematic presentation of patient flow in the BGMEA factories



The validation workshop endorsed most of the findings presented from the desk review, the outcomes from the first workshop and the field level data shared in the workshop. Most of the discussion was around the missing cases in the country; “who the cases are and where to find them?”. In general, the agreement was that most of the missing cases could be identified in the identified key and vulnerable population, the garment workers, the urban poor and the elderly population. Both the environmental and transmission risks are higher among these group including the risks for not detecting as a TB case for their gaps in knowledge on TB and TB services, care seeking practices and for social causes. The risk of under-detection increases with child and EP TB for non-availability of universal facilities and skills at all levels of care. Similarly, one of the elements of under-detection could be under notification from sectors other than NTP even

though the TB cases are either detected and treated in these sectors. The role of mandatory notification if implemented strictly could ameliorate the situation positively.

Information gap by age and gender from key and vulnerable population could one the challenges to undertake and monitor specific activities and programme. The Stop TB tools for Gender, Community and rights if implemented for data collection in addition to routine information could supplement in this regard. More integrated management of Co-infections (e.g. HIV other infectious diseases) and holistic sectoral collaboration would always be useful particularly for the social support and overcoming stigma related to TB. Experiences from garments factory and other programmes (HIV) showed that involvement of civil society, more engagement with factory owners and other sectoral approaches of the government and alliance with other occupational group could help in addressing many challenges from legal to clinical support for the patients and the vulnerable population.

Overall the presented information indicated that *Bangladesh has its most favorable conditions and good practices in gender now, with sincere political support and commitment. It is to be noted that the programme is yet to reach fully to certain segments of people who are in real need of support. So, focus and tasks have to be made to support the people who are lagging behind.*

7. Some limitations and inadequacies or redundancies of the tools used, are to be considered. Despite these limitations, these findings provided some indications of the gender, policy and programmatic aspects of TB situation and responses in the country and provided valuable aid in identifying and prioritizing the key and vulnerable population for this disease in the country. *These tools can be used in conjunction with NTP routine data to plan and operationalize targeted activities to address the identified challenges particularly focusing to the key and vulnerable population*

8. Annexures

Annexure-I: List of Working /Core Group members

Sl. No.	Name	Designation
1	Dr. Shahed Hossain	Consultant
2	Dr. Md. Ashaque Husain	Consultant
3	Md. Ali Imam	Consultant
4	Tapan Kumar Ghosh	Consultant
5	Barrister Nishat Mahmood	Consultant

6	Md. Humayun Kabir	Research Associate
7	Nargis Sultana	Senior Research Assistant
8	Iffat Kabir	Research Assistant
9	Rashed Munsir	Research Assistant

Annexure-II: List of Key Informants

Sl. No.	Name	Designation	Organization
1	Nargis Sultana	Project Director, Advancing Universal Health Coverage (AUHC) Project	CWFD
2	Dr. Aung Kya Jai Maug	Country Director	Damien Foundation
3	Dr. Dipak Kumar Biswas	Medical Coordinator	Damien Foundation
4	Masud Quader Mona	Chairman, Standing Committee on Tuberculosis Control	BGMEA
5	Md. Mosaraf Hossain	FO-TB	BRAC, Kaligonj, Gazipur
6	Md. Rabiul Islam	PO-TB	BRAC, Badda, Dhaka

Annexure-III: List of Participants-Initial Stakeholders Dialogue

Stakeholder Workshop on “Communities, Rights and Gender TB Tools Assessment in Bangladesh”

Venue: Spectra Convention Centre, Gulshan

Dates: April 23 and 24, 2018

Sl. No.	Name	Designation	Organization
1	Prof (Dr.) Md. Shamiul Islam	Director MBDC and Line Director TBL-ASP	DGHS
2	Dr. Md. Ashraf Uddin	Deputy Director MBDC-TB	NTP, DGHS

3	Dr. Pronob Kumar Modak	Deputy Programme Manager	NTP, DGHS
4	Dr. Ahmadul Hasan Khan	M&E Expert	NTP, DGHS
5	Dr. Nazis Arefin Saki	Medical Officer	NTP, DGHS
6	Dr. Md. Monjur Rahman	Medical Officer	NTP, DGHS
7	Dr. Fatema Khatun	Senior Manager	BRAC
8	Naoshin Afroz	Communication and Advocacy Specialist	CTB, MSH
9	Tapan Kumar Ghosh	Consultant	TB Study Team, BRAC
10	Dr. Md. Abul Khair Basher	Senior Sector Specialist	BRAC
11	Peter Amit Halder	Director Operations	HEED Bangladesh
12	Munuru Jacob	Project Director	HEED Bangladesh
13	Dr. Md. Abdul Hamid Salim	Advisor to NTP Bangladesh on Global Fund and MDR-TB	NTP, DGHS
14	Dr. Sabera	National Professional Officer	WHO
15	Dr. Muhammad Sayadul Bashar	Medical Officer	NTP, DGHS
16	Dr. Md. Asaduzzaman	Medical Officer and DPM	NTP, DGHS
17	Dr. Md. Mokim Ali Biswas	Assistant Director	NTP, DGHS
18	Sardar Munim Ibna Mohsin	Senior Manager	BRAC
19	Dr. Afroza Islam	Senior Sector Specialist	BRAC
20	Isbat Azmary Rifat	Senior Sector Specialist	BRAC
21	Md. Akramul Islam	Director, Communicable Diseases, WASH and DMCC	BRAC

22	Milan Kanti Barua	Programme Head, TB Control Programme	BRAC
23	Khairuddin Ahmed Mukul	Secretary General	NATAB
24	Dr. Md. Kafil Uddin	Senior Sector Specialist	BRAC
25	Nargis Sultana	Senior Research Assistant	TB Study Team, BRAC
26	Iffat Kabir	Research Assistant	TB Study Team, BRAC
27	Rashed Munsif	Research Assistant	TB Study Team, BRAC
28	Monira Yasmin	Legal Counsel	BRAC
29	Md. Hadiujjaman	Legal Counsel	BRAC
30	M.A. Mazed	Senior Manager	BRAC
31	Dr. Md. Ashaque Husain	Ex. Line Director	NTP, DGHS
32	Dr. Shahed Hossain	Consultant, JPG	BRAC-icddr,b
33	Sk. Anwar Hossain	Member, PLWD Constituency	BCCM
34	Dr. Saima Khan	UCM	UNAIDS
35	Habibur Rahman	Project Director, AUHC	BAMANEH
36	Md. Humayun Kabir	Ex. Assistant Scientist	icddr,b
37	Dr. Paul Daru	Regional TB/DR-TB & Infection Control Advisor	URC
38	Dr. Syed Zakir Hossain	Project Coordinator	BGMEA
39	Md. Ali Imam	Senior Research Investigator	icddr,b
40	Dr. Sabrina Haque	Medical Officer	ASP, DGHS
41	Ezazul Islam Chowdhury	Senior Programme Manager	icddr,b
42	Dr. Golam Sarwar	Asst. Programme Manager, HIV and AIDS, IDD	icddr,b
43	Dr. SSM Hejbullah	Manager	Save The Children
44	Md. Niamul Kabir	Senior Programme Manager, Legal	BRAC

45	Dr. Mohammad Hossain	Senior Technical Advisor, PPM	CTB, MSH
46	Charles Lerman	TB Advisor	USAID
47	Dr. Aung Kya Jai Maug	Country Director	Damien Foundation
48	Dr. Dipak Kumar Biswas	Medical Coordinator	Damien Foundation
49	Dr. Oscar Cordon	Country Project Director	CTB, MSH
50	Dr. Saifur Reja	Senior Manager	BRAC
51	Dr. Nawrin Kabir	Senior Sector Specialist	BRAC
52	Md. Saiful Islam	Manager-TB	BRAC
53	Dr. Farhan Kabir Patwary	Medical Officer	BRAC
54	Sushanto Kumer Biswas	Manager-TB	BRAC
55	Md. Kamruzzaman Sarkar	Manager-TB	BRAC
56	Begum Zerina Reshma	Gender Advisor	Chemonics, AUHC
57	Piplu Barua	Microbiologist	BRAC
58	Syed Wahiduzzaman	Senior Deputy Secretary	BKMEA
59	Shahariar Hassan	Senior Sector Specialist	BRAC
60	Napal Kumar Paul	Senior Officer	BRAC
61	S.M. Golam Raihan	Manager-TB	BRAC
62	Tital Chakma	Senior MIS Officer	BRAC
63	Md. Nuruzzaman	Manager-TB	BRAC
64	Md. Zakir Hossain	Divisional Manager-TB	BRAC

Annexure-IV: List of Participants at Validation Workshop

Validation Workshop on “Communities, Rights and Gender TB Tools Assessment in Bangladesh”

Date: 18 September 2018

Venue: Ocean Paradise Hotel & Resort, Cox’s Bazar

Sl. No.	Name	Designation	Organization
1	Syed Wahiduzzaman	Senior Deputy Secretary	BKMEA
2	Md. Humayun Kabir	Research Associate	TB Study Team, BRAC
3	Dr. Aung Kya Jai Maug	Country Director	Damien Foundation
4	Dr. Fatema Khatun	Senior Manager	BRAC
5	Md. Ali Imam	Consultant	TB Study Team, BRAC
6	Md. Niamul Kabir	Senior Legal Counsel	BRAC
7	Monira Yasmin	Legal Counsel	BRAC
8	Dr. Saifur Reja	Senior Manager	BRAC
9	Dr. Md. Asaduzzaman	DPM	NTP, DGHS
10	Dr. Paul Daru	Regional Advisor	URC
11	Nargis Sultana	Research Assistant	TB Study Team, BRAC
12	Md. Aktaruzzaman	Senior Manager	ASP, DGHS
13	Dr. Quazi Al Mamun Siddique	Lead, Communicable Diseases Programme, Cox’s Bazar	BRAC
14	Dr. Shahed Hossain	Professor	JPG
15	Dr. Md. Belal Hossain	DD& PM	NASP, DGHS

16	Dr. Shayla Islam	Senior PMDT Advisor	IRD Bangladesh
17	Ezazul Islam Chowdhury	Senior Program Manager	icddr, b
18	Dr. Md. Saieef Uddin Yeahia	Assistant Director	ASP, DGHS
19	Dr. Md. Ahmadul Hasan Khan	M&E Expert	NTP, DGHS
20	Dr. Ashaque Hossain	Ex. Line Director	NTP, DGHS
21	Dr. Sabrina Haque	Medical Officer	ASP, DGHS
22	Dr. Saima	UCM	UNAIDS
23	Dr. Tapash Roy	Country Director	IRD Bangladesh
24	Sushanto Kumer Biswas	Manager-TB	BRAC
25	Dr. Syed Zakir Hossain	Project Coordinator	BGMEA
26	Sk. Anwar Hossain	Member, PLWD Constituency	BCCM
27	Dr. Nawrin Kabir	Senior Sector Specialist	BRAC
28	Dr. Md. Ashraf Uddin	Deputy Director	NTP, DGHS
29	Dr. Muhammad Sayadul Bashar	Medical Officer	NTP, DGHS
30	Dr. Shahrear Farid	Sr. Tech. Advisor(M&E)	CTB, MSH
31	Sardar Munim Ibna Mohsin	Programme Manager	BRAC
32	Dr. Md. Abul Khair Basher	Senior Sector Specialist	BRAC
33	Dr. Rupali Sisir Banu	NPC	NTP, DGHS
34	Dr. Lima Rahman	COP, HIV/AIDS Program	Save the Children
35	Dr. Bishakha Ghosh	Divisional TB Expert, Chattogram	NTP, DGHS
36	Dr. Mohammad Azizur Rahman Siddique	Civil Surgeon, Chattogram	DGHS
37	Barrister Nishat Mahmood	Consultant	TB Study Team, BRAC
38	Tapan Kumar Ghosh	Consultant	TB Study Team, BRAC

39	Dr. M. A. Hamid Salim	Consultant	NTP/USAID
40	Dr. Md. Akramul Islam	Director, Communicable Diseases and WASH	BRAC
41	Major (Retd.) Dr. Md. Lutfor Rahman	Senior Manager	BRAC
42	Dr. Fuad A Hamid	DPM	ASP, DGHS
43	AFM Jilhaj Azam Choudhury	District Coordinator, Cox's Bazar	ASP, DGHS
44	Dr. Pronab Kumar Modak	DPM	NTP, DGHS
45	Dr. Rana Chowdhury	Divisional TB Expert, Dhaka	NTP, DGHS
46	Dr. Md. Abdul Salam	Civil Surgeon, Cox's Bazar	DGHS
47	Dr. Muhammad Enamul Karim	Senior Sector Specialist	BRAC
48	Dr. Sultan Ahmed Siraji	Assistant Director, Cox's Bazar Sadar Hospital	DGHS
49	Prof (Dr.) Md. Shamiul Islam	Director MBDC and Line Director TB-ASP	NTP, DGHS
50	Dr. Nazis Arefin Saki	Medical Officer	NTP, DGHS
51	Dr. Shaheen Alam Chowdhury	RMO, Cox's Bazar Sadar Hospital	DGHS
52	Dr. Mohiuddin Alamgir	CDC, Cox's Bazar	DGHS

Annexure- V: Stakeholder Workshop Agenda

Stakeholder Workshop on “Communities, Rights and Gender TB Tools Assessment in Bangladesh”

Venue: Spectra Convention Centre, Gulshan

Dates: April 23 and 24, 2018

Day One: Monday April 23, 2018

09.30 am – 09.45 am Registration

09.45 am – 10.30 am Welcome Remarks

Dr. Akramul Islam, Director Communicable Diseases, WASH and Disaster Management and Climate Change, BRAC

Dr. Saima Khan, Country Manager, UNAIDS

Dr. Charles Lerman, TB Advisor, USAID

Inauguration remarks

Prof (Dr.) Md. Shamiul Islam, Director MBDC and Line Director- TBL-ASP

10.30 am – 10.45 am Tea Break

10.45 am – 11.00 am Over view of the workshop: Introduction to Gender assessment tool (Gender assessment, Key population identification in country context, Rights)

Dr. Shahed Hossain

11.00 am – 11.15 am Gender, Gender and TB

Md. Ali Imam

11.15 am – 11.30 am Current situation TB/HIV (gender, rights and communities)-

Dr. Shahed Hossain

11.30 am – 11.45 am Discussion on current situation and others

11.45 am – 12.45 pm Group work on Gender Assessment Tool

Three groups working on Steps 10, 11 and 12

12.45 pm – 01.30 pm Group presentation with discussion (15 minutes each group)

01.30 pm – 02.30 pm Lunch break

02.30 pm – 03.30 pm Group work on Epidemiological and Context Analysis

03.30 pm – 03.45 pm Tea break

03.45 pm – 04.30 pm Group presentation and discussion (15 minutes each group)

04.30 pm – Closing of the day

Day Two: Tuesday April 24, 2018

09.30 am -10.15 am Identification of the Key Population: Introduction of the framework

Tapan Kumar Ghosh

10.15 am – 10.30 am Discussion on the framework

10.30 am -10. 45 am	Tea Break
10.45 am – 11. 45 am	Group work Free listing of key population Prioritization of key population
11.45 am – 12.15 pm	Presentation and discussion
12.15 pm – 01.15 pm	Risk analysis of the key population and linking with program
01.15 pm – 02.15 pm	Lunch break
02.15 pm – 03.00 pm	Group presentation on linking exercise
03.00pm- 03.30 pm	Tea Break
03.30 pm- 04.15 pm	Summation of the two day's work and discussion
04.15pm -	Closing remarks

Annexure- VI: Validation Workshop Agenda

Validation Workshop on “Communities, Rights and Gender TB Tools Assessment in Bangladesh”

Date: 18 September 2018

Venue: Ocean Paradise Hotel & Resort, Cox’s Bazar

Agenda

Time	Particulars	Responsible Person
09.00 am to 09.15 am	Registration	
09.15 am to 09.20 am	Welcome and Introductory speech	Md. Akramul Islam, Director, Communicable Diseases & WASH BRAC
09.20 am to 09.25 am	Speech Special	Dr. Md. Azizur Rahman Siddique, Civil Surgeon, Chattogram
09.25 am to 09.30 am	Speech Special	Dr. Md. Abdul Salam, Civil Surgeon, Cox’s Bazar
09.30 am to 09.35 am	Chief Guest Speech	Prof (Dr.) Md. Shamiul Islam, Director MBDC and Line Director TBL-ASP
09.35 am to 10.00 am	Overview of the workshop	Dr. Shahed Hossain, Consultant, JPG and icddr, b
10.00 am to 10.05 am	Remarks	Dr. Tapash Roy, Country Director, IRD Bangladesh
10.05 am to 10.10 am	Remarks	Dr. Md. Belal Hossain, Deputy Director & Program Manager, National AIDS/ STD Program, (ASP), DGHS
10.10 am to 10.15 am	Remarks	Ezazul Islam Chowdhury, Senior Programme Manager icddr, b
10. 15 am to 10.45 am	Key population identification and Qualitative findings/ Recommendations	Md. Ali Imam. Assistant Scientist icddr, b
10.45 am to 10.50 am	Remarks	Dr. Md. Ashaque Hossain, Ex. Line Director, NTP

10.50 am to 10.55 am	Remarks	Dr. Md. Saieef Uddin Yeahia, Assistant Director National AIDS/STD Program, (ASP), DGHS
10.55 am to 11.30 am	Open Discussion and Recommendation	
11.30 am to 11.45 am	Tea Break	
11.45 am to 12.00 pm	Community, Gender findings/ Recommendation	Md. Ali Imam. Assistant Scientist Icddr, b
12.00 pm to 12.05 pm	Remarks	Dr. Md. Ashraf Uddin, Deputy Director, NTP
12.05 pm to 12.10 pm	Remarks	Dr. Aung Kya Jai Maug, Country Director, Damien Foundation
12.10 pm to 12.40 pm	Open Discussion and Recommendation	
12.40 pm to 12.55 pm	Legal/Rights of Key population	Barrister Nishat Mahmood
12.55 pm to 01.00 pm	Remarks	Dr. Saima Khan, Country Manager, UNAIDS
01.00 pm to 01.05 pm	Remarks	Dr. Lima Rahman, Chief of Party, HIV/AIDS Program, Health, Nutrition & HIV/AIDS Sector, Save the Children
01.05 pm to 01.35 pm	Open Discussion and Recommendation	
01.35 pm to 01.50 pm	Workshop Overall Discussion and Recommendation	
01.50 pm to 02.00 pm	Concluding Remarks	Prof (Dr.) Md. Shamiul Islam, Director MBDC and Line Director TBL-ASP
02.00 pm to 03.30 pm	Lunch Break	

Annexure-VII: Gender concept and programme response

UNAIDS defined “gender as a socially constructed set of norms, roles, behaviours, activities and attributes that a given society considers appropriate for women and men, with the inclusion of people who identify themselves as transgender”. Gender-based prejudice includes any kind of stigma, discrimination, or violence against somebody because of their gender, gender identity or their sexual orientation. The TB/HIV Gender Assessment Tool seeks to move the HIV and TB

response along the continuum from gender-blind to gender-sensitive, and ultimately to gender-transformative (Table below).

Type of intervention	Impact	Example
Gender negative or gender-blind	Fails to acknowledge the different needs or realities of women and men and transgender people Aggravate or reinforces existing gender inequalities and norms	Lack of disaggregated data because of a failure to acknowledge that programmes and policies have different effects on women, men and transgender people
Gender sensitive or gender responsive	Recognizes the distinct roles and contributions of different people based on their gender; takes these differences into account and attempts to ensure that women, men and transgender people equitably benefit from the intervention.	Clinic operational hours are changed to early mornings and late evenings to reflect the needs of men and women who work.
Gender-transformative	Explicitly seeks to redefine and transform gender norms and relationships to redress existing inequalities.	Challenges and changes both sexuality norms and uneven access to resources in order to strengthen men and women’s ability to insist on condom use by their sexual partners

Table: Gender Assessment tool for national HIV and TB responses: Towards gender – transformative HIV and TB responses,

Stop TB Partnership, UNAIDS. (www.stoptb.org/publication/acsm)

Data for Action for Tuberculosis Key, Vulnerable and Underserved Populations:

Working Document, September 2017,

Stop TB Partnership. (www.medbox.org/preview)

Legal Environment Assessment for Tuberculosis: An Operational Guide (UNDP, Stop

TB partnership)

(www.stoptb.org/assets/communities)

Annexure- VIII: Key and vulnerable population

To maximize gender-transformative responses, it is crucial to understand **key and vulnerable Populations** by TB. Stop TB call on countries to define the “specific populations that are key to their epidemic and response based on the epidemiological and social context. In the context of TB, consider Key and Vulnerable Populations under three distinct groups:

1. People who have increased exposure to TB bacilli (due to where they live or work – overcrowding, poor ventilation) like healthcare workers, household contacts of TB patients, workplace or educational facilities contacts, people living in urban slums and shared living facilities such as orphanages, slums, retirement homes, etc. are at risk of increased exposure to TB bacilli for a range of reasons including poor living and sanitary conditions, poor ventilation, overcrowding, malnourishment etc. Overcrowding in healthcare facilities, congregate settings especially prison and mining increases exposure to the TB bacilli and risk of developing TB.

2. People who have limited access to health services (due to gender, geography, limited mobility, limited financial capacity, legal status, stigma) like elderly and the mentally or physically disabled with limited mobility and support, remote population due to occupation like fishermen, miners, etc., the homeless, migrants, refugees, internally displaced, ethnic minorities and indigenous people who suffer stigma and discrimination. Also included are incarcerated people who may have limited access to health services.

3. People at increased risk of TB because of biological and behavioral factors that compromise immune function like people living with HIV, people with diabetes, people suffering from silicosis and lung disorders, those on long term therapeutic steroids, those on immune suppressant treatment and people who are malnourished are vulnerable to TB because their compromised immune system are less able to fight infections. Certain lifestyle activities like smoking and harmful use of alcohol and drugs increase their risk of TB infection.

Annexure-IX

রেজিস্টার্ড নং ডি এ-১

২০১৪ সনের ৫ নং

বাংলাদেশ



গেজেট

কর্তৃপক্ষ কর্তৃক প্রকাশিত

বৃহস্পতিবার, জানুয়ারি ৩০, ২০১৪

স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়

বিশ্ব স্বাস্থ্য-২ শাখা

বিজ্ঞপ্তি

তারিখ, ২২ জানুয়ারি ২০১৪

Government Gazette on mandatory notification

নং স্বাপকম/বিশ্বস্বাস্থ্য-২/Pro-1/GFATM-TB/2008(Pt-1)/৮০—
বাংলাদেশে যক্ষ্মারোগ একটি প্রধান জনস্বাস্থ্য সমস্যা। উল্লেখযোগ্য
সংখ্যক নারী, পুরুষ ও শিশু প্রতি বছর এ রোগে আক্রান্ত হন এবং
কিছু সংখ্যক মৃত্যুবরণ করেন। সময়মত রোগ নির্ণয় ও নির্দিষ্ট
মেয়াদের চিকিৎসায় এ রোগ সম্পূর্ণ নিরাময় করা যায়। কিন্তু ভুল
রোগ নির্ণয় এবং অসম্পূর্ণ চিকিৎসার ফলে এ রোগ জটিল আকার
ধারণ করে এবং বিস্তার লাভ করে। যথাযথ রোগ নির্ণয় ও
ব্যবস্থাপনার জন্য বাংলাদেশের সকল যক্ষ্মারোগীর তথ্য জাতীয় যক্ষ্মা
নিয়ন্ত্রণ কর্মসূচীর গোচরীভূত থাকা আবশ্যিক। সুতরাং সরকার এ
মর্মে সিদ্ধান্ত গ্রহণ করেছে যে, সরকারি এবং বেসরকারি সকল স্বাস্থ্য
সেবা প্রদানকারী যক্ষ্মারোগীর তথ্য নিকটস্থ সরকারি স্বাস্থ্য কর্মকর্তার
নিকট অবহিত করবেন।

কেস নোটিফিকেশনের জন্য যক্ষ্মারোগকে নিম্নোক্তভাবে
সংজ্ঞায়িত করা হল :

- Any patient diagnosed with sputum specimen positive for acid fast bacilli, or culture-positive for Mycobacterium tuberculosis, or NTP endorsed rapid molecular diagnostic test positive for TB

Or

- Any patient diagnosed clinically as a case Tuberculosis, without microbiological confirmation, and initiated on anti-TB drugs.

বিস্তারিত তথ্য ও ব্যাখ্যার জন্য জাতীয় যক্ষ্মা নিয়ন্ত্রণ কর্মসূচি,
স্বাস্থ্য অধিদপ্তর, মহাখালী, ঢাকা-১২১২ বরাবর যোগাযোগ করা
যেতে পারে।

২। এই বিজ্ঞপ্তি জারীর ফলে বাংলাদেশে যক্ষ্মারোগ
আবশ্যিকভাবে Notifiable Disease হিসেবে গণ্য হবে।

রাষ্ট্রপতির আদেশক্রমে

নাসিমা হোসেন

সিনিয়র সহকারী সচিব।

Annexure-X: Gender research in tuberculosis in Bangladesh

Gender analysis of Tuberculosis (Literature Review Findings) in Bangladesh

In Relation to TB:	Are there sex differences in	How do biological differences between women and men influence their :	How do the different roles and activities of men and women affect their	How do gender norms / values affect men and women's	How do access to, and control over resources affect men and women's
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<p>Vulnerability</p> <p>Incidence</p> <p>Prevalence</p> <p>(F/M)</p>	<p>The F/M ratio (0.33:1) of cases found was not higher than that observed through routine diagnosis (0.42:1) (Hamid, 2004).</p> <p>Smear-positive pulmonary TB</p> <p>Cases- F-31%, M-69% (Rifat, 2011).</p> <p>MDR TB- F- 33.3% and M- 66.7% (Rifat, 2015).</p>	<p>Not applicable as biological difference has no role in this</p>	<p>Male-specific risks of becoming ill with TB, for example, they tend to have more social contacts, work in high-risk settings, smoke, possible higher alcohol consumption, and limited health seeking behaviour.</p> <p>Outside the home, women and girls reported relevant contacts limited to the close neighborhood while men mentioned high relevant contacts beyond. This implies that, in theory, infectious diseases can easily be transmitted across age and sex groups in</p>	<p>Female-specific risks include higher stigma, delayed diagnosis, less access to treatment services and the previous WHO policy of passive case finding. High rates of extra-pulmonary TB among women also mean they are harder to screen and diagnose.</p> <p>Approximately 85.9% of patients had experienced stigma. The most frequent indicator of the stigma experienced by patients involved problems taking part in social programs</p>	<p>It has been assumed that the control over resources is less among female.</p>
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			and around the home (Feenstra, 2013).	(79.5%). Mean levels of stigma were significantly higher in women (55.5%) (Chowdhury, 2015).	
Health seeking behaviour	Female-to-male ratios (FMR) declined at the following clinical steps: respiratory patients seeking out-patient care (0.81), TB suspects submitting sputum for testing (0.52) and smear-	Not applicable as biological difference has no role in this	In general, males and young adults, ages 21-35, had greater awareness about transmission and prevention of TB than females and adults over 35. Patients with greater knowledge about TB were also less likely to experience	The median interval from symptom onset to diagnosis was longest in India and shortest in Malawi. With adjustment for confounding, female sex (Bangladesh), and status of married	NA

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	<p>positive test results (0.38), but the decline ceased at treatment initiation (0.41). Compared to 1997, the FMR in 2000 had decreased for out-patient clinics and sputum submission for testing, but had increased for smear-positive test results and treatment initiation. More female than male patients who underwent treatment</p>		<p>delays in seeking treatment (Mondal 2014).</p> <p>Women tended to describe the clinical features more vaguely than men, and often specified fewer characteristic symptoms such as blood in sputum (Karim, 2011).</p> <p>Women faced with adverse consequences more often than men, such as trouble in ongoing and prospective marital affairs. Coughing up</p>	<p>woman (India) and housewife (Malawi) were associated with problem delay (Gosoni, 2014).</p> <p>Women felt shame more prominent in compare to men due to high-flying stigma. Attributes of stigma related to women includes fear of refusal and avoidance by others and thinking less</p>	

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	<p>achieved cure (93% vs. 89%). Lower female representation at the different clinical steps of TB management persists (Karim, 2008).</p> <p>Multidrug resistant tuberculosis patients experienced a health system delay of median 7.1 weeks where it was 45 days for female and 51.5 days for</p>		<p>sputum in public by women is culturally frowned upon, resulting in enormous suffering. (Karim, 2011).</p> <p>55% of cases wanted the diagnosis of TB remain confidential to avoid being labelled as TB patients, where 82.7% were female. 85.6 % female TB patients had problems in their relationships with their</p>	<p>of themselves. On the other hand, male patients did not like to disclose their condition to intimate (Karim, 2007). Such psychosocial complication may hinder help seeking and treatment adherence.</p>	

Annexure-X: Gender research in tuberculosis in Bangladesh

Gender analysis of Tuberculosis (Literature Review Findings) in Bangladesh

In Relation to TB:	Are there sex differences in	How do biological differences between women and men influence their :	How do the different roles and activities of men and women affect their	How do gender norms / values affect men and women's	How do access to, and control over resources affect men and women's
	male (Rifat, 2015)		spouse (61%) and family members (58%) after being diagnosed with TB. The undiscovered reservoirs of female TB cases were the fact because half of the females delayed (patient delay) more than 60 days (Ahsan, 2004).		
Ability to access health services	Yes	Not applicable as biological difference has no role in this	Females are less mobile and therefore health facility's distance may affect timely and appropriate care seeking. Women in Bangladesh	Stay at home may restrict female ability to access health services.	Female do not have economic autonomy to access health care when needed

Annexure-X: Gender research in tuberculosis in Bangladesh

Gender analysis of Tuberculosis (Literature Review Findings) in Bangladesh

In Relation to TB:	Are there sex differences in	How do biological differences between women and men influence their :	How do the different roles and activities of men and women affect their	How do gender norms / values affect men and women's	How do access to, and control over resources affect men and women's
			<p>appear to have less access to public out-patient clinics than men, and if they present with respiratory symptoms they are less likely to undergo sputum smear examination. If examined, women are less likely than men to smear – positive (Begum, 2001)</p> <p>Correct knowledge about TB transmission was very low among married women in Bangladesh.</p>		

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Gender analysis of Tuberculosis (Literature Review Findings) in Bangladesh

In Relation to TB:	Are there sex differences in	How do biological differences between women and men influence their :	How do the different roles and activities of men and women affect their	How do gender norms / values affect men and women's	How do access to, and control over resources affect men and women's
			Factors such as education and access to media, especially television, could play an important role in improving knowledge about TB transmission among women in Bangladesh (Khandoker, 2011).		
Experience with health services and health providers	No.	Not applicable as biological difference has no role in this	The results of the service factors found that 39% of females were not satisfied with their provider's behaviours, which was significantly associated with		No data

Annexure-X: Gender research in tuberculosis in Bangladesh

Gender analysis of Tuberculosis (Literature Review Findings) in Bangladesh

In Relation to TB:	Are there sex differences in	How do biological differences between women and men influence their :	How do the different roles and activities of men and women affect their	How do gender norms / values affect men and women's	How do access to, and control over resources affect men and women's
			treatment seeking behaviour (Ahsan, 2004).		
Preventive and Treatment options, responses to treatment or rehabilitation	No	NA	Women, in comparison with men, had significantly longer mean and median delays in total delay (63.2 and 61.0 days vs. 60.3 and 53 days, respectively), total diagnostic delay (61.2, 60.0 vs. 58.5, 52.0 days), patient's delay (51.9, 50.0 vs. 48.7, 42.0 days) and treatment delay (2.0, 1.0 vs. 1.9, 1.0 day). Patient's mean and median		.

Annexure-X: Gender research in tuberculosis in Bangladesh

Gender analysis of Tuberculosis (Literature Review Findings) in Bangladesh

In Relation to TB:	Are there sex differences in	How do biological differences between women and men influence their :	How do the different roles and activities of men and women affect their	How do gender norms / values affect men and women's	How do access to, and control over resources affect men and women's
			delays were longer than the health system delay. However, patient gender showed strong association with total delay, total diagnostic delay and patient's delay. Older age of women was significantly associated with longer patient and treatment delay categories, respectively (Karim, 2007).		
Outcome of health problem	NO	NO	NO	NO	NA
Consequences (economic & social,	NA	NA	NA	NA	NA

Annexure-X: Gender research in tuberculosis in Bangladesh

Gender analysis of Tuberculosis (Literature Review Findings) in Bangladesh

In Relation to TB:	Are there sex differences in	How do biological differences between women and men influence their :	How do the different roles and activities of men and women affect their	How do gender norms / values affect men and women's	How do access to, and control over resources affect men and women's
including attitudinal)					

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