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**Human Rights Council**

**Fifty-third session**

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Agenda item 3

**Promotion and protection of all human rights, civil,
political, economic, social and cultural rights,
including the right to development**

 Visit to Bangladesh

 Report of the Special Rapporteur on the elimination of discrimination against persons affected by leprosy and their family members[[1]](#footnote-2)\*, [[2]](#footnote-3)\*\*

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| *Summary* |
|  In the report on her visit to Bangladesh from 7 to 15 February 2023, the Special Rapporteur on the elimination of discrimination against persons affected by leprosy and their family members, Alice Cruz, explores issues related to the progress made by Bangladesh in eliminating leprosy-related discrimination and stigma, as well as the challenges Bangladesh faces in this regard. Cruz also offers constructive recommendations in relevant areas, including how to address the social determinants of leprosy and the root causes of systemic discrimination, how to ensure independent living of affected persons and their family members, how to ensure unrestricted access to justice, how to allocate adequate resources to the national leprosy programme and how to include leprosy as a prohibited ground of discrimination in the Anti-Discrimination Bill 2022. |
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Annex

Report of the Special Rapporteur on the elimination of discrimination against persons affected by leprosy and their family members on her visit to Bangladesh

Content

 *Page*

 I. Introduction 3

 II. Hansen’s Disease Epidemiology in Bangladesh 4

 III. Legal and institutional framework 4

 IV. Gaps and challenges in the legal and institutional framework for protecting the of rights of persons affected by Hansen’s disease and their family members 6

 National Human Rights Commission 6

 National Legal Aid Services Organization 7

 National Leprosy Programme 8

 V. Interpersonal and systemic discrimination against persons affected by Hansen’s disease and their family members: intersections, violence and dehumanization 10

 VI. The interrelation of the right to health and disability rights: persons affected by Hansen’s disease are lagging behind in the healthcare system and in disability policies 12

 VII. Conclusions: the right to development for discriminated against groups 15

 VIII. Recommendations 17

 I. Introduction

1. The Special Rapporteur on the elimination of discrimination against persons affected by leprosy (also known as Hansen´s disease) and their family members, Ms. Alice Cruz, undertook an official visit to Bangladesh from 7 to 15 February 2023. The purpose of the visit was to identify persisting obstacles faced by persons affected by leprosy and their family members in accessing and enjoying fundamental rights, as well as discriminatory practices that hinder them from enjoying opportunities on an equal basis with others. The Special Rapporteur was also committed to identifying good practices in eliminating leprosy-based discrimination, with the aim of strengthening cooperation between the Government, key stakeholders, civil society organizations, and representative organizations of persons affected by leprosy. She aimed to present constructive recommendations to the government on how to eliminate discrimination on the grounds of leprosy as well. At her discretion as an expert on the subject, the Special Rapporteur henceforth uses the term Hansen’s disease instead of leprosy.

2. During her visit, the Special Rapporteur met with government representatives from the Ministries of Foreign Affairs, Health and Social Welfare. She also met with the Law Commission, the National Legal Services Organization, the National Human Rights Commission and the National Foundation for the Development of Disabled Persons. She also met with the United Nations resident coordinator and teams from United Nations agencies working in the country. The Special Rapporteur met a large number of stakeholders, including civil society organizations, healthcare workers and persons affected by Hansen’s disease living in different districts. She also had the opportunity to visit healthcare facilities and communities affected by Hansen’s disease in Nilphamari and Bogura. The Special Rapporteur was deeply impressed by the outstanding work done by the organizations of persons affected by Hansen’s disease to advocate for their rights and uplift the lives of their members through solidarity and economy strategies. She deeply thanks persons affected by Hansen´s disease for sharing their experiences, which they did with such a profound sense of dignity, pride and expertise.

3. The Special Rapporteur expresses her appreciation to the Government of Bangladesh for its initial invitation and for the support provided in the organization and facilitation of her visit. She also thanks the United Nations Resident Coordinator’s Office for its assistance, the team of the Office of the High Commissioner for Human Rights for their unmeasurable support, as well as civil society organizations that provided outstanding support, as well as valuable inputs.

4. The visit of the Special Rapporteur follows the latest review of the country by the Committee on the Rights of Persons with Disabilities (CRPD) at its 617th meeting. In its concluding observations on the initial report on Bangladesh,[[3]](#footnote-4) the Committee makes eighteen references to persons affected by Hansen’s disease. It expressly recognizes that persons affected by Hansen’s disease face discrimination in the country and calls for the government to duly enforce their disability rights with a comprehensive set of recommendations, which include the need to: develop a national strategy to ensure access for persons with Hansen´s disease´s related disabilities to mainstream community services; eliminate all barriers that hinder the enjoyment and participation of persons with Hansen´s disease´s related disabilities; and adopt and implement a national strategy on accessible, high-quality healthcare services, including accessible hospitals and healthcare centres. The Committee also referred to the particular situation of women affected by Hansen’s disease and to the State’s duty to adopt and implement the necessary measures to address multiple and intersectional forms of discrimination against women and girls with disabilities who are also affected by Hansen’s disease. Lastly, it has called on the State to intensify awareness-raising campaigns and initiatives and to adopt a national strategy on awareness-raising to educate the general public and public officials, in order to combat prevailing prejudices, stigma, stereotypes, use of derogatory language, and discrimination against persons persons with Hansen´s disease´s related disabilities.

 II. Hansen’s Disease Epidemiology in Bangladesh

5. Bangladesh is one of the 23 World Health Organization’s (WHO) global priority countries for Hansen’s disease. Such classification is based upon the country’s status regarding new case detection, age, gender, and disability. Bangladesh is also the fifth country in the world with the highest absolute incidence of Hansen’s disease. Annually, 3,000 to 3,500 cases are still detected in Bangladesh. Like in other countries, the Covid-19 pandemic had a profound impact on case detection. Underdetection can lead to an increasing in transmission and higher high probability of new cases being detected with long-term impairments and disabilities, also in children.

6. In 2021, only 2,872 new cases were detected (such number reflects the generalized decrease in detection during and after the Covid-19 pandemic), 156 of which with long-term impairments. This is a worrying trend, as it indicates delayed diagnosis and inadequate treatment. Children under 15 years old accounted for 8.4% of new leprosy cases in Bangladesh. The rate of new leprosy cases among children was 0.5 per 1 million child population, which is higher than the overall new case detection rate, indicating ongoing transmission. Of these, 12.6% had long-term impairments, a shamefully high figure. Both figures suggest that there may exist a considerable number of hidden cases. Such was corroborated by active case-finding activities held in districts considered to be non-endemic and which found such a high number of Hansen’s disease cases that the districts’ status changed from non-endemic to highly endemic.

7. There is not any official data on how many people live with Hansen’s disease consequences, whereas those consequences are medical complications, impairments or discrimination. The Special Rapporteur is concerned that such people are not only invisible in State’s statistics, but that they are also actively overlooked by the public health system.

8. Hansen’s disease affects all ages in Bangladesh but the majority of new cases are detected in people who are below 35 years old. More men are diagnosed than women, which aside epidemiological hypotheses that yet to be proved, clearly indicate poorest access of women to diagnosis and treatment than men. Such is the result of women’s dependency on third-party authorization, but also of stigmatization on the grounds of Hansen’s disease, which together with gender-based discrimination can make women hide their symptoms and avoid diagnosis.

9. Incidence has been stable over some years now, which (considering Hansen’s disease’s epidemiology and long incubation period) means that unless active case-finding is systematically conducted, transmission will not be broken in Bangladesh. For that purpose, proper budget allocation with clear targets, indicators, and benchmarks is of the essence.

 III. Legal and institutional framework

10. The 1972 Constitution of the People’s Republic of Bangladesh is the nation’s supreme law and expresses the will of the people. Article 7 of the Constitution establishes the authority of the Constitution and its supremacy over the other laws of the country.

11. The Constitution establishes the duty of the State to endeavor to ensure equality of opportunity for all citizens (Article 19). This duty unfolds in the adoption of efforts to elaborate effective measures to remove social and economic inequalities and ensure the equitable distribution of wealth among citizens, as well as to ensure equality of opportunity and participation of women in all spheres of national life.

12. The equality of all before the law is expressly referred to in Article 27 and the principle of non-discrimination is enshrined in Article 28 of the supreme law. The Constitution expressly states that women shall have equal rights to those of men in all spheres of the State and of public life. Specifically, regarding non-discrimination, the Constitution reinforces that “no citizen shall, on grounds only of religion, race, caste, sex or place of birth be subjected to any disability, liability, restriction or condition with regard to access to any place of public entertainment or resort, or admission to any educational institution.” Article 28 further opens space for the implementation of special measures and affirmative action policies, by mentioning that the State may make special provisions in favour of women or children, or towards the advancement and improvement of any situation of disadvantage affecting citizens.

13. The State of Bangladesh has a constitutional obligation to provide basic healthcare services. Article 15 of the Constitution stipulates as a fundamental responsibility of the State the provision of medical care. The social protection policies in Bangladesh are rooted in Article 15 of the Constitution, which establishes the fundamental responsibility of the State to ensure the basic necessities of daily life for its citizens and the right to social security. The Government adopted the new National Social Security Strategy (2015) with the subsequent adoption of an Action Plan for its implementation in 2018. Social safety-net programs have been adopted, especially in the following areas: a) monetary transfers; b) micro-credit; c) food security; and d) provision of education, healthcare facilities, and training.[[4]](#footnote-5)

14. Of the nine core human rights treaties, Bangladesh is a signatory party to eight.[[5]](#footnote-6) As a signatory party to these human rights treaties, the State of Bangladesh must implement them. There is full consistency between the international human rights standards to which the State has agreed and the framework of fundamental rights provided in the Constitution. There is room in the national legal framework for the application of the principles and guidelines for the elimination of discrimination against persons affected by Hansen’s disease and their family members.

15. Human rights, with a particular focus on women, but also on children, ethnic minorities, workers, and vulnerable groups, have been addressed in different legislation that have been passed in recent years. An example of such laws is the Persons with Disabilities’ Rights and Protection Act (2013). The government’s long-term vision to address development issues and the rights of the most vulnerable population is reflected in the Five-Year Plans and Perspective Plans.

16. It is also noteworthy that the Government’s commitment to human rights is expressed in adopting a sophisticated set of national plans and policies. Since the Universal Periodic Review of 2009, examples of relevant national plans being implemented by the Government of Bangladesh are the National Health Policy (2011), the Bangladesh Population Policy (2012), the National Policy on Older Persons (2013), Bangladesh’s National Women Development Policy (2011), the National Food and Nutrition Security Policy Plan of Action (2021-2030), and the National Action Plan to Prevent Violence Against Women and Children (2013-2025).

17. In the structure of promotion and enforcement of human rights, the National Human Rights Commission is responsible for monitoring and investigating cases of human rights violations, and the Law Commission has authority to recommend the enactment, amendment, or repealing of laws relevant in the context of fundamental rights. When it comes to guaranteeing access to legal remedies, the National Legal Aid Services Organization is mandated to develop the strategy of access to justice for the most vulnerable population.

 IV. Gaps and challenges in the legal and institutional framework for protecting the of rights of persons affected by Hansen’s disease and their family members

18. While there are some laws and policies that, in principle, should apply to persons affected by Hansen’s disease, they still fail to duly recognize the latter as being entitled to their provisions, hindering their access to and enjoyment of rights in the country.

19. One striking example is the Anti-discrimination Bill 2022, elaborated by the Law Commission and currently under discussion in the Parliament. The adoption of legislation specifically aimed at anti-discrimination was highly anticipated as part of an assertive and comprehensive government strategy to combat the different levels and types of discriminatory practices and situations that exist in the country. The Anti-Discriminatory Bill 2022 that is under discussion, has however raised concerns among experts, as well as civil society and human rights organizations.

20. One of the challenges pointed out is that the bill needs to overcome a tendency to bureaucratize the treatment of discrimination by creating several layers (district divisions and national forums) and steps that an aggrieved person has to go through in order to obtain remedy in case of violation of his or her rights. A second challenge concerns ensuring effective and independent monitoring mechanisms for human rights violations. A third aspect is the need for legislation to take into account the multidimensional and intersectional dimensions of discrimination, in order to address the root causes of discrimination and provide effective mechanisms for its prevention. A fourth aspect is the need for legislation to be more sensitive to gender and intra-religious discrimination.

21. Specifically with regard to the rights of persons affected by Hansen’s disease and their family members, according to the information received by the Special Rapporteur during her visit, the Anti-discrimination Bill 2022 fails to include Hansen’s disease as a prohibited ground of discrimination. Such failure may represent the loss of an important opportunity to protect the rights of persons affected by Hansen’s disease in the country. The Special Rapporteur has urged the Law Commission to review the law as to include a much necessary and rightful reference to Hansen’s disease.

22. It is a matter of concern that the State’s administration and government’s bodies are failing to do what is necessary to ensure that such a commitment is duly met. The Special Rapporteur was appalled by the widespread lack of knowledge about Hansen’s disease within the State’s administration and, particularly, among its civil servants, at both high and intermediary levels. There is no systematic collection of data about Hansen’s disease in the country aside from how many new cases are diagnosed per year, which due to the reasons mentioned above, are not entirely reliable.

23. Relevant bodies specifically mandated to address discrimination in the country (such as the National Human Rights Commission) and to enable access to justice and remedies by the more vulnerable layers of the national social tissue (such as the National Legal Aid Services Organization) are not aware of the enduring challenges faced by persons affected by Hansen’s disease. They do not collect systematic data about Hansen’s disease-related discrimination either. Furthermore, and in some cases, they do not seem to report information related to violations in the country transparently and in accordance with human rights standards.

 National Human Rights Commission

24. According to the National Human Rights Commission Act (Act n. 53 of 2009), the Commission is a statutory independent body. Main functions and powers attributed to the Commission include raiinge awareness, promoting human rights education and training, conducting research on human rights, and monitoring and investigating allegations of human rights violations.

25. During her visit, the Special Rapporteur was surprised to note the lack of knowledge aqmong members of the Commission not only of the epidemiological reality of Hansen’s disease in the country but also of the recurrent episodes of human rights violations faced by persons affected by Hansen’s disease and their families. It was particularly concerning to see the National Human Rights Commission affirming that Hansen’s disease-related discrimination no longer exists in the country. Such a statement reflects more than a limited understanding about Hansen’s disease and its related challenges, it also means that relevant bodies and institutions are not doing their job. nor reaching the entire country’s population as they should.

26. The Special Rapporteur has consistently called attention to the fact that quasi-judicial systems and human rights protection systems in general fail to ensure justiciability, availability, accessibility, good quality, provision of remedies and accountability for affected persons and their family members. States must recognize and act committedly to overcome the obstacles and constraints that prevent persons affected by Hansen’s disease from accessing justice and safeguarding their human rights on the basis of equality.

27. Since persons affected by Hansen´s disease face a severe and multifaceted context of discrimination, beginning in the family and extending to the community, public, and private institutions, it is not uncommon to find that persons affected by Hansen´s disease avoid claiming their rights in public services due to the fear of discrimination, contempt, and humiliation. The fact that the National Human Rights Commission has no complaints of human rights violations on the grounds of Hansen´s disease should not be read as an indicator of the absence of such violations. It should be interpreted as strong evidence that the right of those affected to have unrestricted access to the institutions responsible for protecting their rights is not guaranteed.

28. It is up to the State to develop and build the capacity of its bodies and institutions so they can respond in a sensitive manner to the reality of individuals affected by Hansen´s disease and their family members. It is up to the State to enable unrestricted access of this group pf people to the justice systems and government bodies and institutions with a mandate to protect human rights in the country. It is up to the State to empower marginzlied groups to achieve *de jure* and *de facto* equality.

 National Legal Aid Services Organization

29. The National Legal Aid Services Organization[[6]](#footnote-7) is a statutory government organization established in the Legal Aid Service Act. Under the aforementioned Act, the Legal Aid Service was structured nationally with the objective of ensuring legal aid to those people who are unable to access justice due to restrictions in their socio-economic status. The National Legal Aid Services Organization is organized in district legal aid offices where the Legal Aid Officers work. At the local level, the Upazila Legal Aid Committees and Union Legal Aid Committees have been organized. Also, special committees have been formed in the Chowki Court and labour courts.

30. Key functions of the National Legal Aid Services Organization include: ensuring access to justice for economically and socially disadvantaged people according to pre-defined eligibility criteria; developing projects to expand, improve, and promote legal aid programs; conducting educational and research activities to provide legal aid; ensuring proper training of legal aid officers and staff; and promoting public awareness on legal aid, rights and responsibilities.

31. During her visit, the Special Rapporteur was able to identify a shared pattern among government bodies and institutions mandated for protecting human rights. Such shared pattern reflects the absence of any action taken by same bodies and institutions to protect the rights of persons affected by Hansen’s disease.

32. At the root of such shared pattern are the multiple barriers persons affected by Hansen´s disease face in acceding justice. But the absence of complaints also point to the State’s failure in promoting a culture of human rights awareness that takes into consideration the specific context of discrimination that hiders access by persons affected by Hansen´s disease to public services. If persons affected by Hansen´s disease are not aware that they are human rights-holders and that the State has an obligation to ensure their rights, it is unlikely that they will report situations of discrimination or violations of their rights, nor will they appeal to public bodies and request services to which they are entitled to.

33. Human rights education and awareness raising about the mechanisms in place for seeking redress and remedies in the face of discrimination and human rights violations seem to be largely missing in the country, which hinders people from knowing their rights and how to claim them. Affected persons are among those who lack the means to fight back discrimination and access to justice is virtually impossible for them, even more so if relevant government bodies and institutions disregard Hansen’s disease as a ground of discrimination, as is the case in Bangladesh.

34. Special attention should be given to women affected by Hansen’s disease. Women are affected and subjugated by different forms of violence and suffer a higher degree of discrimination due to stereotypes and stigmas based on gender and patriarchal cultural norms. This context of discrimination has a direct impact on the ability and possibility of women affected by Hansen’s disease to access public bodies in order to protect their rights in the same way as men. Not surprisingly, the scarce data available indicates that legal aid mechanisms are seldom used by women, when compared to the use of these same mechanisms by men.[[7]](#footnote-8)

35. Among the human rights obligations assumed by the State under the core international human rights treaties, there is the duty to ensure that people have access to education and information about their rights and the remedies available to ensure them. In the case of persons affected by Hansen´s disease, education and information strategies should be especially designed taking into account the stigmatization they suffer in interpersonal relationships and in relations with public and private agencies. As part of an awareness-raising strategy on the rights of persons affected by Hansen´s disease, it is necessary to address social and cultural patterns of conduct that reinforce harmful stereotypes and customary practices that discriminate and stigmatize these individuals based on misconceptions about contagion and beliefs that associate Hansen’s disease with a curse.

36. Importantly, the right to an effective remedy and reparation, as provided for in Article 2 (3) of the International Covenant on Civil and Political Rights and subsequently clarified by the Human Rights Committee in its General Comment No. 31, is a fundamental component of the States’ obligations concerning human rights. It is expected that the State will be able to develop and implement effective measures to raise awareness and promote education on the rights of affected persons in close collaboration with communities, civil society organizations, and organizations of affected persons.

 National Leprosy Programme

37. The National Leprosy Programme (NLP) is implemented under the Line Director of TB-Leprosy and AIDS STD Programme and is supported by eight NGO partners.[[8]](#footnote-9) The programme envisions achieving targets at each of the endemic Districts and Upazilas (Sub-districts) and aims at strengthening case finding and treatment, improving surveillance, and increasing technical and operational capacity in collaboration with partners and other stakeholders.

38. The main targets of the National Programme’s strategic Plan are to: (a) achieve the long-term goal of a Hansen’s disease free Bangladesh, which refers to a situation where the community is free of morbidity, disabilities, and social consequences due leprosy; (b) reduce the number of Hansen’s disease cases in each Upazila to less than 1 case per 10,000 people at the end of the year 2020 (point prevalence); (c) achieve zero number of child cases (i.e. less than 15 years) diagnosed with long-term by the year 2020; (d) reduce stigma and discrimination, understood as no incidence of refusal of persons affected by Hansen´s disease into any general hospital and no incidence of separation among husband and wife when either one or both are affected by Hansen’s disease; (e) strengthening health systems-integration of Hansen’s disease services into general healthcare services; (f) introduce web-based surveillance and integrate Hansen´s disease to Health Management Information System under the Directorate General of Health Services; (g) strengthen government ownership and partners coordination (political commitment, increased fund flow, coordinated implementation of activities, and gear up of monitoring and evaluation).

39. Regarding the situation of Hansen’s disease in the country, the Bangladesh Leprosy Control Strategy 2016-2020[[9]](#footnote-10) has already pointed out that the geographical distribution of Hansen’s disease in the country was not uniform and the integration of the programme with the general health services was not fully functional due to operational deficiencies. Other problems highlighted in the national strategy included the shortage of expertise at all levels and the limited opportunities for sustaining expertise in the programme; the continuous delay in case detection without significative change over time; the poor awareness of service providers. Finally, the 2016-2020 national strategy recognized how deeply stigmatized Hansen’s disease is and the profound impact of stigmatization on women and poorer people, who are more unlikely to seek timely treatment and diagnosis.

40. Experts in the field have already pointed out how problematic it is that Hansen’s disease is gradually being pushed off the public health agenda, which consequently leads to a deterioration of services for Hansen’s disease treatment. A deterioration that is visible in the loss of technical knowledge and people with expertise in treating the disease and its complications.[[10]](#footnote-11)

41. When meeting with experts in the country, the Special Rapporteur received reports about challenges related to the coverage of healthcare services, which have an impact on ensuring early diagnosis and active case detection. The need for greater integration of Hansen´s disease into the work of community healthcare workers, especially for detecting new cases, was also mentioned. Experts in the field pointed out that the lack of resources ends up compromising adequate training of community healthcare workers, which ends up limiting outreach activities at the national level. Historically, the medical care of Hansen’s disease patients has been in the hands of non-governmental organizations, who have been filling formidable gaps. Ownership by the government of Hansen´s disease medical care is still to happen.

42. Most of the hospitals providing medical care for Hansen’s disease are managed by non-governmental organizations. There are 3 government hospitals that specialize in treating and supporting persons affected by Hansen’s disease in the Dhaka, Sylhet, and Niphamari districts. There are 7 hospitals specialized in Hansen’s disease treatment under the management of non-governmental organizations and funded by donour countries. They are: Danish Bangladesh Leprosy Mission (DBLM) Hospital, in Nilphamari; Christian Leprosy Center (CLC), in Chandraghona, Kaptai, and Rangamati; PIME Sisters TB and Leprosy Center, in Khulna; Damien Foundation TB and Leprosy Hospital, in Jalchatra, Madhupur, and Tangail; Damien Foundation TB and Leprosy Hospital, in Shambuganj and Mymensingh; Damien Foundation TB and Leprosy Hospital, in Netrokona; and Dhanjuri Leprosy Center, in Dinajpur.

43. Bangladesh achieved the elimination status of Hansen’s disease as a public health problem in 1998, well before the year 2000. After the global elimination of leprosy as a public health problem in the year 2000 (often misunderstood as eradication, when it solely meant prevalence of less than 1 per 10 000 population), efforts and political will to tackle the disease dramatically decreased worldwide. In Blangladesh, like in many other countries, persons affected by Hansen´s disease were left to resource to charity-based organizations for acceding healthcare, but also livelihoods.

44. A decline in the quality of services, equipment, and expertise of the healthcare workforce were mentioned to the Special Rapporteur during the meetings with representatives of civil society and medical experts. The lack of prioritization of the fight against Hansen’s disease by the health system also has a major impact on raising awareness activities and in eliminating harmful stereotypes about the disease. The Special Rapporteur has received accounts of serious deficits in knowledge of basic information about the disease and its treatment at the community level.

45. A very positive step taken in the country was the announcement of the zero leprosy initiative by 2030 by the Prime Minister.[[11]](#footnote-12) In 2019, as part of the National Conference 2019 on Zero Leprosy Initiatives by 2030, Bangladeshi Prime Minister, Sheikh Hasina, committed her government to ensure adequate treatment for persons affected by Hansen’s disease and overcoming discrimination and stigmatization on its grounds.

46. However, after a period of increased public attention to the disease, structural challenges in the area still prevail. Examples of challenges reported to the Special Rapporteur during her visit include: lack of resources for active case detection, difficulties in the bureaucratic structure of the health services, lack of intersectoral policies, delays in case detection and patient management, lack of communication between government districts, deficit in awareness-raising activities about the disease, lack of a public policy to address the mental health needs of persons affected by Hansen´s disease and their family members, lack of provision of assistive devices, deficiencies in ensuring the continuum of care to persons affected by Hansen´s disease.

47. Currently, the State´s administration is failing to do what is necessary to ensure the Prime Minister´s commitment is duly met. Hansen´s disease is, in fact, hidden in the country below multiple layers of exclusion and systematic discrimination.

 V. Interpersonal and systemic discrimination against persons affected by Hansen’s disease and their family members: intersections, violence and dehumanization

48. Having repealed the British colonial law “The Lepers Act of 1898” on November 24th, 2011, Bangladesh has currently no law that formally discriminates against persons affected by Hansen’s disease. However, State obligations to combat discrimination against persons affected by Hansen´s disease extend to direct and substantive discrimination. In its General Comment No. 20, the Committee on Economic, Social and Cultural Rights states that a person’s actual or perceived state of health cannot be a barrier to the realization of his or her rights. According to the Committee, the argument of protecting public health cannot be used to restrict the exercise of human rights and create differential treatment with regard to access to education, employment, health care, travel, social assistance, housing, etc. The Committee also mentions the duty of States to adopt measures to address the widespread stigmatization of people based on their health status. In same General Comment, the Committee details systemic discrimination as pervasive and persistent and deeply entrenched in social behaviour and organisation, often involving unchallenged or indirect discrimination. Under the provisions of the ICESCR, State must garantee both formal and substantive equality.[[12]](#footnote-13) In addition to not discriminating and/or expressly prohibiting discrimination in their laws and policies, States must take positive steps to prevent *de facto* discrimination against any group of people.

49. The State's duty not to discriminate against persons affected by Hansen´s disease and their family members relates to functions and activities where there are responsibilities to be assumed by public authorities and institutions, such as marriage, divorce, decisions on parental authority, access to public office positions and employment, access to social welfare benefits, production of identification documents, granting of citizenship, access to public schools and training programs, access to legal and health services, adoption of discriminatory language by State agencies and documents, etc. The obligation of non-discrimination may also include the responsibility to enact and enforce legislation that prohibits discrimination on the basis of Hansen’s disease and to ensure that private organizations, companies, initiatives, facilities, and services eliminate discriminatory practices. It is also the responsibility of States, through the responsible bodies, to take measures to prevent, investigate, punish, and redress discrimination and human rights violations.

50. Moreover, and in accordance to General Comment No. 6 of the Committee on the Rights of Persons with Disabilities, States must commit to eliminating barriers that prevent persons with disabilities from having the protection, benefits, and advantages that are provided by law for all persons. The duty to prohibit all types of discrimination includes recognizing that discrimination can be based on a single characteristic (gender) or on multiple, intersectional characteristics (gender, race, disability, poverty, etc.). According to the Committee, at least four types of discrimination can occur singly or simultaneously: discrimination, direct discrimination, indirect discrimination, denial of reasonable accommodation, and harassment/creating an intimidating, hostile, and degrading environment.

51. Neither Hansen’s disease nor discrimination on its ground have disappeared from Bangladesh. Both the disease and discrimination attached to it are just hidden among multiple layers of poverty, gender, disability, social class, and other grounds for discrimination. When meeting with a great number of persons affected by Hansen’s disease and their representative organizations, the Special Rapporteur realized that Hansen’s disease is still the cause of great suffering in Bangladesh.

52. Hansen’s disease intersects with poverty, gender-based discrimination, subordination of children, religious norms, and customary practices, leading to: community segregation, divorce and abandonment, loss of opportunities regarding marriage, separation from and within the household, refusal of buying items from persons affected by Hansen’s disease and of sharing food with them, abuses, and psychological and physical violence (especially against women and children), loss of jobs, exclusion from the education system, denial of medical care, prohibition of entering religious settings and of participating in religious practices, among other forms of dehumanization. However, no frameworks for protecting rights nor providing accountability and remedies for these violations seem to be guaranteed to persons affected by Hansen’s disease and their family members in the country.

53. The Special Rapporteur was deeply concerned by the number of people who reported experiences of segregation, discrimination and violence. As one person affected by Hansen’s disease told her: “everyone’s story is the same”. Testimonies show persistent dynamics of direct and substantive discrimination against persons affected by Hansen´s disease, which are reflected on out of pocket expenses for acceding healthcare, in particular on what regards the long distances travelling to healthcare services; on the separation from their family and community for receiving medical care far from home; on the difficulties they face until they can find healthcare workers properly trained to diagnose the disease; on the degrading treatment they receive from healthcare workers who refuse to deliver services to them due to baseless fears of transmission; on separation within the household; on the jobs people lose due to stigmatization; on the marriages or marriage proposals that are broken off when information about the disease is known to one of the spouses; on the fear they feel and humiliation they face when seeking public services; on the information to which they do not have access to and that could help people understand better the disease and guarantee them inclusion in the community; on the lack of opportunities, resources, assistive and support devices, mobility aids counseling, and rehabilitation that could contribute to an independent living.

54. Furthermore, the Special Rapporteur listened with concern about fear of Hansen’s disease leading staff from the penitentiary system to segregate individuals affected by the disease, who also faced significant difficulties to aceede medication within same penitentiary system. Misappropriation and loss of property and land due to Hansen’s disease were also reported by several persons. Family members of persons affected by Hansen’s disease are also the victims of stigmatization and discrimination, particularly at the community level, in education settings and with regard to prospects of marriage.

55. Due to the considerable gaps within the public health system to early diagnose and properly treat Hansen’s disease, persons affected by Hansen’s disease experience a serious deterioration of their health. Almost all of the people who met with the Special Rapporteur had visible and long-term impairments on their hands and feet. Long-term impairments, together with a low educational level, compromises livelihoods. As a result of deficient access to education by the poorest, persons affected by Hansen’s disease mainly rely on physically demanding labour, which aggravates impairments, keeping them in a spiraling chain of disadvantage.

56. The Special Rapporteur can also testify the profound effect that Hansen’s disease, discrimination on its grounds, and the failure of the State to take measures to eliminate harmful stereotypes have on people’s mental health, especially women and children. Women and children affected by Hansen’s disease are often abused and devoid of the means to fight back such abuses. Sometimes they are even devoid of the means to ensure their own survival. Bangladesh’s reservations to Articles 2 and 16(1c) of the Convention on the Elimination of All Forms of Discrimination Against Women hinder eliminating such systematic abuses. Counselling services and referral to mental healthcare services is manifestly lacking.

57. Counselling can play an important role in reducing stigmatization on the grounds of Haansen´s disease, although counselling should only be implemented with a clear understading of the particular context of implementation and of the specificity of each individual case. The Special Rapporteur listened to accounts of experiences where community efforts to combat stereotypes and discrimination have been able to create an enabling environment for persons affected by Hansen´s disease to remain in the community. Different examples were reported regarding successful practices implemented by non-governmental organizations in achieving positive effects in restoring the self-esteem and dignity of individuals through couselling and the formation of self-help groups.

 VI. The interrelation of the right to health and disability rights: persons affected by Hansen’s disease are lagging behind in the healthcare system and in disability policies

58. The Special Rapporteur has emphasized that the human suffering caused by Hansen’s disease is preventable. It is up to States to duly enforce and guarantee the right to health, as provided for in Article 12 of the International Covenant on Economic, Social and Cultural Rights for persons affected by leprosy.

59. The healthcare system in Bangladesh is largely underfunded. The lack of resources for Hansen’s disease control and the peripheral place of Hansen’s disease within the health agenda is evident when the public investment devoted to Hansen’s disease is compared with that devoted to tuberculosis. Although improvements of the National Leprosy Programme have been identified over the years, the advances and increases are also due to collaborative efforts on the part of non-governmental organizations.

60. Studies in the field have pointed to a diversity of problems in the country´s public health system, which include: lack of personnel and supplies; lack of adequately trained personnel; shortage of drugs, equipment and professionals; poor prioritization of expenditures; and management and coordination problems.[[13]](#footnote-14) During her meetings with public health experts, the Special Rapporteur also understood that, given the country’s accelerated urbanization process, there is still no consolidated health infrastructure in urban areas.

61. The health system in Bangladesh largely fails to ensure persons affected by Hansen´s disease the principles of Availability, Accessibility, Acceptability, and Quality as provided for in the General Comment No. 14 of the Committee on Economic, Social and Cultural Rights. The Government action seems to be restricted to providing multidrug therapy.[[14]](#footnote-15) Moreover, the monthly doses of one of the drugs of the multidrug therapy is only given at the Upazilla level, which carries out-of-pocket expenses for people who may need to travel to get their medication.

62. Despite being curable with multidrug therapy, if not detected early and treated, Hansen’s disease can become a chronic disease that demands a continuum of medical and psychosocial care, which includes medical treatment of Hansen’s disease reactions, wound care, rehabilitation, reconstructive surgery, the provision of assistive devices, and psychosocial support. Such a continuum of medical and psychosocial care should be fully addressed by effective referral within national healthcare systems. The Special Rapporteur verified in the field that, unfortunately, such a continuum of care is not available for persons affected by Hansen’s disease in public healthcare settings. The treatment of Hansen’s disease reactions, wound care, rehabilitation, reconstructive surgery, and psychosocial support is largely dependent on Non-Governmental Organizations, which is hardly sufficient, since it does not cover the entire country, nor ensure universal access to everyone.

63. The guarantee of the right to health is interdependent on the realization of other rights, such as the right to dignity, equality, and non-discrimination. An extremely worrying fact found during the visit concerns the discriminatory treatment received by persons affected by Hansen’s disease on the part of the healthcare workforce – who many times discriminate against affected persons and refuse to provide them medical care. As stressed by the Committee on Economic, Social and Cultural Rights, health facilities, goods, and services must be accessible to all, especially those most vulnerable or marginalized, such as persons affected by Hansen’s disease and their families, in law and in practice, without discrimination on any of the prohibited grounds.[[15]](#footnote-16)

64. The State should assume greater centrality in the health policy regarding Hansen’s disease in order to improve the current service model. The current model of services, fragmented into several agencies, public and private, with different authorities and competencies to deal with Hansen’s disease, should be replaced by a model of comprehensive, integrated, multisectoral, and comprehensive care. This model should address the various dimensions of care that Hansen’s disease demands, from timely diagnosis to care for complications, wound care, nerve damage, and adverse reactions to drug treatment, to mental healthcare, rehabilitation and provision of mobility aids and assistive devices.

65. It is also necessary to ensure broader access to health information. Health information about Hansen’s disease, including its symptoms, treatment, and the rights of those affected by it, is very limited. Budget allocation, expertise, and the integration of Hansen’s disease care into general healthcare services and in all levels of attention, from the primary to the tertiary, and with an effective referral system in place, is of the essence. Otherwise, stagnation of incidence around 3,000 new cases per year will endure as will the unacceptable suffering of those who fall ill.

66. Hansen’s disease seems to be lost in the State’s administration. Indeed, coordination among the different government bodies is not happening. Those work under a vertical and top-down approach, which hinders communication and promotes mutual ignorance. The problem of lack of inter- and intra-ministerial communication, which compromises the quality of health services in general, has a particular effect on the services that must be guaranteed to individual affected by Hansen´s disease, which cannot do without a provision of services that is multisectoral. The integration of the various services is essential because vulnerability of individual affected by Hansen´s disease is intensified due to the social and economic consequences of the disease, and the lack of coverage and quality of health services leads these people to live with the most severe and debilitating manifestations of the disease, making them, consequently, even more vulnerable. At the very least, cooperation between the health and the disability sectors is urgent and glaring.

67. Hospitalization of persons with Hansen’s disease-related impairments in NGOs’ hospitals for receiving wound care is ongoing, mainly due to the lack of proper care in community healthcare clinics, which takes people away from their homes. Although this is a great service that the NGOs are providing, it should be provided at government community clinics and under primary healthcare. Hospitalization for wound care would not be needed if the State would fulfill its obligations under Article 12 of the International Covenant on Economic, Social and Cultural Rights for persons affected by Hansen’s disease, as well as its obligations under Article 20 of the Convention on the Rights of Persons with Disabilities.

68. Late diagnosis of Hansen’s disease comes with great economic losses for the country, especially when it affects children and young people and when anti-discriminatory policies and disability rights are not duly enforced. There are important vacuums in both disability related laws and policies.. The 2013 Rights and Protection of Persons with Disabilities Act does not duly recognize Hansen’s disease as disability, failing to recognize invisible impairments and psychosocial impairments. Furthermore, issues such as accessibility and reasonable accommodation are yet to be addressed, alongside inclusive education as provided for in Article 24 of the Convention on the Rights of Persons with Disabilities. The country still implements a “special”, meaning a separated, education model for children with disabilities, which goes against the Convention’s spirit and provisions. The country’s disability related legal framework seems to be closer to a charity-based model than to a human right one.

69. Persons affected by Hansen’s disease refer to many barriers in their access to social protection and disability-related benefits. During her visit, the Special Rapporteur received reports about the difficulties faced by individual affected by Hansen´s disease to access the Disability Card. A significant part of these problems concerns the lack of knowledge about disabilities related to Hansen’s disease, including by health professionals in charge of conducting the medical examinations required to obtain the Disability Card. It has also been mentioned that the disability allowance, like other cash transfer benefits, is insufficient to guarantee an adequate standard of living for the recipients.

70. The barriers faced by persons affected by Hansen’s disease in accessing disability rights include complaints about corruption on the part of civil servants with regard to access to disability and other cash transfer social protection schemes, namely old age and widow allowances. Such complaints should be duly investigated by relevant government bodies and punished, and accountability mechanisms should be created for this purpose. More transparency regarding procedures for acceding social protection benefits, as well as accountability of civil servants in order to prevent possible practices of corruption is also in order.

71. Another example of how persons affected by Hansen’s disease are lagging behind concerns their access to quality mobility aids and assistive devices technologies, which are largely unavailable. It was reported that some hospitals are able to manufacture these devices but do not have the resources to provide them to patients. The health policy for Hansen’s disease should be sufficiently integrated into other relevant ministries, such as social welfare, to duly ensure not only biomedical treatment to persons affected by Hansen´s disease, but also their autonomy, including the freedom to make one’s own choices and the independence of persons, as provided in Article 3 of the Convention on the Rights of Persons with Disabilities, as well as their right to live independently and being included in the community, as provided for by Article 19 of the same Convention.

72. The social protection system, seen from the viewpoint of the lived experience of Hansen´s disease, does not seem to be consistent, nor aiming at promoting a transition to active citizenship. There is an evident need for a robust social protection system that could ensure an adequate standard of living, while simultaneously targeting the enablement of an active citizenship. Policies aiming at the transition from the informal economy to the formal economy are also lacking and needed, given the fact that the majority of persons affected by Hansen’s disease are, like many other national citizens, excluded from the formal work market.

 VII. Conclusions: the right to development for discriminated against groups

73. **In 2015, Bangladesh was moved out from the World Bank list of Low-Income Country (LIC) to Lower Middle-Income Country (LMIC), meeting in 2018 all the UN criteria to graduate from the list of Least Developed Country (LDC) to a Developing Country. The government expects to formally graduate from Least Developed Country in 2024 (Bangladesh 8th Five-Year Plan).**

74. **Bangladesh has made consistent progress regarding economic growth and considerable, even if not yet sufficient, improvement on what concerns WASH (water, sanitation, and hygiene), which comprises social determinants of diseases such as Hansen’s disease and other neglected diseases that are endemic to the country. With regard to other socioeconomic determinants of leprosy, there were positive advances in the country, particularly in women’s literacy and education, women’s mobility for accessing healthcare and basic services, and the increase in the number of poor women working and with an opportunity to achieve economic independence.** [[16]](#footnote-17)

75. **The efforts made by the government on this regard are commendable. However, an in-depth analysis of the intertwining and intersectional dimensions of discrimination, raises questions on whether such progress has been achieved in an equitable manner or not. The particular example of persons affected by Hansen´s disease shows that certain groups, who already faced serious situations of disadvantage, social inequality, and marginalization, remain trapped in pockets of poverty and disempowerment. These are people and communities whose reality does not refelect the indicators of development progress: the persistence of extreme poverty, social exclusion, and diverse vulnerabilities, and the irreducible exposure to indicators of poor health, such as malnutrition, propensity to infectious diseases, and victimization by different forms of violence, extreme events, and catastrophes. The human rights situation of persons affected by Hansen´s disease provides a strong example of the inequities to be overcome in order for development in the country to truly promote change for those who have been left behind.**

76. **Hansen’s disease is classified as a neglected tropical disease closely linked to poverty by WHO. According to WHO, infectious diseases contribute to lifelong disadvantages, perpetuating the vicious cycle of poverty and infection. As the Special Rapporteur has detailed in previous reports to the Human Rights Council and to the General Assembly, Hansen’s disease and its consequences are the product of structural violence, which is inherently cumulative and reflects the systematic restrictions that prevent people who occupy the bottom rungs of societies from meeting their basic needs. Structural violence is often invisible, accepted as the natural order of things, and perpetrated on a daily basis by dominant institutions.**

77. **Hansen’s disease and the persistence of discrimination against those affected, as well as against their family members, can say a lot about how far the State goes in terms of protection, promotion, and fulfillment of human rights, given that this group of people is among those furthest behind. Hansen’s disease is thus a strong indicator regarding the overall enforcement of human rights in a given country and, more particularly, on what concerns the right to development as it is framed by the Declaration on the Right to Development, adopted by the United Nations General Assembly on December 4th, 1986. The Declaration affirms in its preamble that development is a comprehensive economic, social, cultural, and political process, which aims at the constant improvement of the well-being of the entire population and of all individuals on the basis of their active, free and meaningful participation in development and in the fair distribution of benefits resulting therefrom.**

78. **The situation of persons affected by Hansen’s disease and their family members in Bangladesh shows that the outstanding economic growth (compromised by the COVID-19 pandemic) is not reaching the entire population and casts doubts on whether fundamental principles of the right to development, such as equity, self-determination, participation, and justice are being met. On the one hand, persons affected by Hansen’s disease and their families are still not enjoying the benefits of economic growth, nor are seeing discrimination against them duly redressed. On the other hand, meaningful and free participation in public affairs as a means for marginalized and discriminated groups to defend their interest does not find an enabling environment to prosper in the face of complaints about ongoing corruption, limited efficiency of oversight institutions, and essentially paternalistic approaches to people living in vulnerable situations.**

79. **A human rights-based approach to development requires attention to bottom-up dynamics in which radically excluded people and groups are breaking the spiralling of disadvantage, isolation, and stigmatization through collective action at the grassroot level. During her visit, the Special Rapporteur identified good practices on this regard that are being undertaken by grassroot organizations with the support of civil non-governmental organizations. Interventions at the group-level started with the creation of self-care group´s, which expanded to creating viable alternatives for ensuring economic empowerment and resilience of those most disadvantaged and enabling access to services that are not available in socially excluded areas, such as self-care and mental healthcare.**

80. **These groups make use of popular/community education approaches, offering the necessary guidance and supervision to ensure that other people can practice peer counselling and self-care. These are groups that bring together not only persons affected by Hansen's disease but also persons with disabilities and members of other disadvantaged groups. These practices based on solidarity are deeply rooted in the historical local culture of the country, which have been long used to overcome socioeconomic inequalities at the community level. These include a) solidarity economy actions, through seed funding, and savings/credit and collective economic activities to build livelihoods; b) advocacy, through political incidence actions, especially with subnational governments to defend rights and demand policies; c) mental care, through mutual help, active supportive listening and peer counseling; d) physical care, through practical guidance on how to deal with the physical and adverse manifestations of the disease in the body.**

81. **Interventions at the group level create strong dynamics of personal and social transformation, which benefit from the lived experience of the persons affected by Hansen´s disease to promote empathy, self-recognition, self-esteem, sense of purpose, motivation, and trust through mutual support. Such alternatives to development from below work as strong evidence of the integration of highly marginalized people into society from collective empowerment as a starting point that helps break the cycle of isolation, dependence, chronic poverty, and stigmatization.**

82. **These examples of good practices for eliminating discrimination on the grounds of Hansen´s disease are being mainly implemented by civil society organizations and should be scaled up by the government as part of a development strategy that places people's autonomy and active citizenship at the center of the actions, decision-making and that the process of development is locally owned through the promotion of an active citizenship among those furthest behind and historically discriminated against.**

83. **Besides that, it is of the essence that the country implements a rights-based to development, which garantees basic access to fundamental services on a non-discriminatory basis, together with the right to participate, as both a means and a goal of development, and contribute to the overall development policies and plan. Development strategies should always be empowering to those who have faced systemic discrimination and both outcomes and processes of any development policy should always be monitored in a transparent manner in order to ensure that.**

 VIII. Recommendations

84. **The Special Rapporteur recommends the Government to:**

(a) **Make every effort to redress persistent substantive discrimination, both in the social determinants of Hansen’s disease and the root causes of systemic discrimination. Efforts should simultaneously target socioeconomic disadvantage through redistributive measures that ensure a minimum standard of living, and stigma reduction strategies, through permanent awareness-raising programmes that should involve persons affected by Hansen’s disease, and be sensitive to local languages, gender, age, and disability. Efforts should also include guarantees for the autonomous development and independent living of persons affected by Hansen’s disease and their family members, with special measures in the fields of education and vocational training, decent work, and social protection. Such efforts require multisectoral governance and interministerial cooperation;**

(b) **Redress persistent direct discrimination against persons affected by Hansen´s disease. Harmonize the Anti-Discrimination Act Bill 2022, including Hansen’s disease as a prohibited ground for discrimination. Amend the 2013 Rights and Protection of Persons with Disabilities Act, which does not duly recognize Hansen’s disease as disability. Monitor, investigate, and punish perpetrators of discrimination against persons affected by Hansen’s disease and ensure due reparation to persons affected by Hansen´s disease for the damage caused.**

(c) **Ensure unrestricted access to justice and to the bodies responsible for monitoring rights violations by eliminating physical, cultural, and economic barriers, as well as discriminatory practices, attitudes, and behaviours of civil servants. Ensure the training of the public officials from these bodies on Hansen’s disease-related issues. Implement a human rights education plan with special focus on increasing access to justice for persons affected by Hansen´s disease. Put in place accessible mechanisms for persons affected by Hansen´s disease to complain on human rights violations and discrimination against them. Develop an information system with disaggregated data collection of episodes of violations and discrimination and carry out training on the basic human rights of persons affected by Hansen’s disease and their family members;**

(d) **Guarantee sufficient resources to the National Leprosy Programme to sustain expertise on Hansen’s disease in the country, ensure high-quality health services, reinforce the role of community health workers, ensure the continuum of care to persons affected by Hansen´s disease with integration, professional counselors, and mental health support in the health system. Counselling should be extended to include family members of persons affected by Hansen´s disease. Guarantee access to health care on a non-discriminatory basis through strategies that fight discrimination in health-care settings, ineffective public policies and geographical isolation; Guarantee the right to a continuum of medical and psychosocial care that encompasses the full spectrum of prevention, timely access to multidrug therapy, the proper management of leprosy reactions and complementary care, such as wound care, physiotherapy, rehabilitation and reconstructive surgery, alongside service delivery at the community level; Develop indicators and benchmarks to monitor the inequities on the provision of medical care to persons affected by Hansen’s disease, designing specific targets and monitoring mechanisms;**

(e) **Recognize persons affected by Hansen´s disease as active economic agents, respecting their legal capacity and realizing their rights to equal work opportunities in the open labour market and to equal remuneration; Guarantee the right to education through the creation of an inclusive and enabling education system that is non-discriminatory and that ensures the availability of education services, accessibility at all levels of education and the promotion of life-long training and skills development opportunities, as well as the provision of reasonable accommodation; foster empowerment, vocational and human rights training, and ensure freedom from want and violence for women affected by Hansen’s disease;**

(f) **Raise awareness among different government bodies regarding the CRPD´s provisions and recent review of the country. Develop informational material to share information and raise awareness about the UN human rights system and treaty bodies´ recommendations;**

(g) **Include persons affected by Hansen´s disease in public employment programmes, open social dialogue to organized groups of persons affected by leprosy working in the informal economy, and enable the right to collective bargaining for persons affected by leprosy, working both in the formal and informal economy, including by making available a defined interface with the institutions and government bodies with which the organizations must dialogue; Fulfill accessibility and reasonable accommodation rights in all productive sectors and work arrangements; Implement affirmative measures as a means to correct historical and structural disadvantage, which should encompass both work and education opportunities and come with targets and key performance indicators, as well as with effective enforcement mechanisms and remedies, while also following paragraph 11 (i) of ILO recommendation No. 168 concerning vocational rehabilitation and employment with regard to awareness-raising, and the eligibility criteria for which should be defined in consultation with grass-roots organizations and should ensure the accessibility of procedures.**

(h) **Appropriately address allegations of corruption of public officials in the distribution of social benefits and cash transfer programs, ensuring prompt and impartial investigations and punishment of those responsible. Develop mechanisms to ensure the transparency of procedures relating to social welfare benefits and to make public officials accountable in decision-making processes. ensuring a universal basic income for persons affected by Hansen´s disease;**

(i) **Approve legislation to officially change the name of the disease to Hansen’s disease, in order to prohibit discriminatory language and to fight against persisting harmful stereotypes.**

1. \* The summary of the report is being circulated in all official languages. The report itself, which is annexed to the summary, is being circulated in the language of submission only. [↑](#footnote-ref-2)
2. \*\* The present report was submitted after the deadline in order to reflect recent development. [↑](#footnote-ref-3)
3. CRPD/C/BGD/CO/1. [↑](#footnote-ref-4)
4. Government of Bangladesh. Gender Budget (2019-2020). Ministry of Social Welfare. Available at <https://mof.gov.bd/site/view/budget_mof/%E0%A7%A8%E0%A7%A6%E0%A7%A7%E0%A7%AF-%E0%A7%A8%E0%A7%A6/nolink/Vedio>. [↑](#footnote-ref-5)
5. The International Covenant on Civil and Political Rights, 1966 (ICCPR); The International Covenant on Economic, Social and Cultural Rights, 1966 (ICESCR); The Convention on the Elimination of All Forms of Discrimination against Women, 1979 (CEDAW); The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984 (CAT); The Convention on the Rights of the Child, 1989 (CRC); The Elimination of All Forms of Racial Discrimination, 1965 (ICERD); The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, 1990 (CMW) and Convention on the Rights of Persons with Disabilities, 2006 (CRPD). Bangladesh also ratified other relevant instruments such as, the Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict (2000); Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography (2000); Convention on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages (1964); ILO Convention No. 182 on Worst Forms of Child Labour (1999); Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women (1999) and Convention on the Political Rights of Women (1953). [↑](#footnote-ref-6)
6. [https://nlaso.portal.gov.bd/sites/default/files/files/nlaso.portal.gov.bd/annual\_reports-/4264134d\_fcc9\_487c\_906a\_8531a0539460/0559eb416edf65806136ac1b440b231d.pdf](https://nlaso.portal.gov.bd/sites/default/files/files/nlaso.portal.gov.bd/annual_reports/4264134d_fcc9_487c_906a_8531a0539460/0559eb416edf65806136ac1b440b231d.pdf). [↑](#footnote-ref-7)
7. Data from the Legal Aid Service Organizations Annual Report 2018-2019 pointed out that in fiscal year 2018/2019 while 7,767 women sought legal advice from the National help line call center, 25,490 men used this service. Id. Ibid. [↑](#footnote-ref-8)
8. See [www.nlp.gov.bd](http://www.nlp.gov.bd). [↑](#footnote-ref-9)
9. <https://www.nlp.gov.bd/_files/ugd/0f6e07_38cd504c4d1e4756a08ed08710ce77f4.pdf>. [↑](#footnote-ref-10)
10. Kabir, H., Hossain, S. Knowledge on leprosy and its management among primary healthcare providers in two districts of Bangladesh. BMC Health Serv Res 19, 787 (2019).<https://doi.org/10.1186/s12913-019-4525-z>. [↑](#footnote-ref-11)
11. See the Prime Minister’s speech in the Zero Leprosy Initiative <https://pmo.portal.gov.bd/sites/default/files/files/pmo.portal.gov.bd/pm_speech/61b63fa0_c308_4199_ac7c_870a6bd-dfebc/zero_leprosy_111219_en.pdf>. [↑](#footnote-ref-12)
12. See E/C.12/GC/20, par. 8 and 10. According to the Committee on Economic, Social and Cultural Rights: […] discrimination must be eliminated both formally and substantively: Substantive discrimination: Merely addressing formal discrimination will not ensure substantive equality as envisaged and defined by article 2, paragraph 2. The effective enjoyment of Covenant rights is often influenced by whether a person is a member of a group characterized by the prohibited grounds of discrimination. Eliminating discrimination in practice requires paying sufficient attention to groups of individuals which suffer historical or persistent prejudice instead of merely comparing the formal treatment of individuals in similar situations. States parties must therefore immediately adopt the necessary measures to prevent, diminish and eliminate the conditions and attitudes which cause or perpetuate substantive or de facto discrimination. Direct discrimination occurs when an individual is treated less favourably than another person in a similar situation for a reason related to a prohibited ground; e.g. where employment in educational or cultural institutions or membership of a trade union is based on the political opinions of applicants or employees. Direct discrimination also includes detrimental acts or omissions on the basis of prohibited grounds where there is no comparable similar situation […]. [↑](#footnote-ref-13)
13. Improving the quality of care in the public health system in Bangladesh: building on new evidence and current policy lever - <https://www.medbox.org/pdf/5e148832db60a2044c2d3c6d>. [↑](#footnote-ref-14)
14. The Multidrug Therapy is distributed by the WHO to countries free of charge and through an agreement between the pharmaceutical company Novartis and WHO, which began in 2000 and was recently extended to 2025. [↑](#footnote-ref-15)
15. See E/C.12/2000/4 par. 12 (b). [↑](#footnote-ref-16)
16. See Nazneen Akhter. Enduring Response in Embracing Urgency in Community Care: A Critical Perspective On Social Empowerment of Bangladesh. [↑](#footnote-ref-17)