

**GOVERNMENT OF THE PEOPLE'S REPUBLIC OF
BANGLADESH**

**3rd NATIONAL STRATEGIC PLAN
FOR HIV and AIDS RESPONSE
2011-2015**

**NATIONAL AIDS/STD PROGRAMME (NASP)
DIRECTORATE GENERAL OF HEALTH SERVICES
MINISTRY OF HEALTH & FAMILY WELFARE**

Foreword

Bangladesh is still considered to be a low prevalence country but Bangladesh remains extremely vulnerable to HIV epidemic given its dire poverty, overpopulation, and gender inequality, high mobility of the population in country and high level of transactional sex. Immigration to other countries for employment is also very common, particularly amongst younger people.

It is recognized that HIV and AIDS is beyond the health issues; economic and social challenges for the most productive age range of the society that is infected. Bangladesh has an estimated 20,000 to 40,000 people who inject drugs, 23% of the total populations are young people. These young people have limited knowledge about HIV/AIDS because of societal barrier. There are also other Most at risk population exist here like different criteria's sex workers, MSM.

Bangladesh has a political history and commitment to the HIV response. The country has the unique position to succeed where several other developing countries have not, to keep the AIDS epidemic from expanding beyond this current level by initiating comprehensive and strategically viable prevention measures, avoiding a gradual spread of HIV from MARP's to the general population.

To a significant extent, this is probably attributable and willingness by government to acknowledge the existence of high risk groups and risk behaviors and a willingness to initiate effective interventions earlier than later, high quality interventions by NGOs, strong technical support from international agencies as well as local agencies, community, clear strategic focus by donor agencies contribution to the success.

The government of Bangladesh respond to HIV and AIDS from the first case detected in 1989, GOB formed NAC, TAC and the AIDS policy. There are several policy documents developed to guide the national HIV and AIDS Program intervention. The goal of the 3rd national strategic plan for HIV and AIDS Response 2011-2015 is, to minimise the spread of HIV and minimize the impact of AIDS on the individual, family, community, and society. The National AIDS/STD Programme (NASP) is one of the wings of Directorate General of Health Services (DGHS) under the Ministry of Health & Family Welfare (MOHFW) responsible for coordinating with all stakeholders and development partners involved in HIV/AIDS programme activities throughout the country.

The NASP has initiated the process of the 3rd national strategic plan, the next phase of program will build on the successes of the robust 3rd NSP and ensure completion of the reversal of the epidemic through enhanced prevention intervention linked with care support and treatment, coordination mechanism and management, the information system strengthening and research based program.

The 3rd national strategic plan was developed based on the synthesis of evidence and a through assessment with wide range of consultations with government

departments, civil society, public and private sector partners, NGOs, PLHA networks and community based organizations. The entire process was a local knowledge based but also gave consideration of the neighbour country programs and the trends of HIV in this region. The steering committee, the task force members and the working group's members are closely worked and involved with the process of developing the 3rd NSP. The 3rd NSP plan development was almost a year process and during this period several workshops have been taken place involving the wider stakeholders to share the documents and finalize the process of 3rd NSP.

Based on the principles of the 3rd NSP the various interventions will continue to provide care, support and treatment to all Most at risk (MARP's) population along with focused prevention services for the vulnerable populations. The 3rd NSP is adopting the inclusive, participatory and widely consultative approach to highly praise and successful planning efforts consolidating the gains and ensuring quality and coverage, policy and advocacy and to eliminate stigmatization and discrimination.

Finally, we would like to acknowledge the contribution to the organization, the individuals and all the different members of the 3rd NSP development process. We are thankful to all.

ABBREVIATIONS

AIDS	Acquired Immune-Deficiency Syndrome
ARV	Anti retro Virals
ART	Anti-Retroviral Treatment
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
DGHS	Directorate General of Health Services
DOTS	Directly Observed Treatment short-course
DP	Development Partner
FHI	Family Health International
FSW	Female Sex Worker
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with AIDS
GOB	Government of Bangladesh
HAPP	HIV/AIDS Prevention Project
HIV	Human Immunodeficiency Virus
HNPSP	Health Nutrition Population Sector Programme
IBBS	Integrated Bio-Behavioral Survey
IDU	Injecting Drug User
MARPs	Most at Risk Populations
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MIS	Management Information System
MOHFW	Ministry of Health and Family Welfare
MSM	Males who have Sex with Males
MSW	Male Sex Worker
NASP	National AIDS/STD Programme
NAC	National AIDS Committee
NGO	Non-Governmental Organization
NSP	Needle/Syringe Programme
NTP	National Tuberculosis Program
PEP	Post Exposure Prophylaxis
PITC	Provider Initiated Testing and Counselling
PPTCT	Prevention of Parent-to-Child Transmission
PLHIV	People Living with HIV
PR	Public Relations
PRSP	Poverty Reduction Strategic Paper
PWID	People Who Injects Drugs
SBTP	Safe Blood Transfusion Program
SHG	Self Help Group
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWAP	Sector Wide Approach
TC	Technical Committee
TC-NAC	Technical Committee of National AIDS Committee
UNFPA	United Nations Population Fund
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WB	World Bank

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Executive Summary

Bangladesh responded early and decisively to the potential threat of HIV. In the period since the adoption of the first national strategy in 1985, services have been established and scaled up, particularly for Most At Risk Populations¹ (MARPs). Most female sex workers and People Who Inject Drugs (PWID) are in contact with services. Among developing countries, Bangladesh (based on recent population size estimations) has achieved among the highest level of needle/syringe distribution per PWID among developing countries in the world². While there are weaknesses in the response and new challenges, the response to date has almost certainly reduced the level of HIV transmission and ensured many People Living with HIV (PLHIV) have received treatment. .

This strategy has been developed within a results based framework. The goal of the strategy and overall impact will be:

By 2015, minimise the spread of HIV and minimize the impact of AIDS on the individual, family, community, and society.

The objectives are:

- Implement services to prevent new HIV infections ensuring universal access
- Provide universal access to treatment, care and support services for people infected and affected by HIV
- Strengthen the coordination mechanisms and management capacity at different levels to ensure an effective multi-sector HIV/ AIDS response.
- Strengthen the strategic information systems and research for an evidence based response

Section one describes the background of the strategy. The strategy builds upon lessons learnt over more than twenty years in responding to HIV in Bangladesh.

Section two outlines the principles guiding implementation. They are based on partnership across sectors in implementing an evidence based approach within a human rights framework.

Section three provides an overview of the current situation, key challenges in achieving the goal and the response approach of this strategy. Key challenges are:

- To scale up coverage for MARPs and improve quality of service delivery
- To address emerging risk and higher vulnerability

¹MARPs in Bangladesh are identified as sex workers, People Who Inject Drugs (PWID), Males who have Sex with Males (MSM) and Hijras (male to female transgender people). Clients of sex workers are recognised as being at higher risk but are targeted through interventions for other populations (e.g. transport workers) and general population interventions.

²Mathers, B. Degenhart, I. Ali, H. et.al. *HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage* . The lancet.com published online March 10, 2010. (coverage has been recalculated based on latest high range size estimate of PWID population in Bangladesh)

- To meet increased need over the next five years for treatment, care and support coverage and improve quality

The response approach is based on the following directions:

- The National Strategic Plan will be used as a framework for a coordinated approach between government, implementing agencies other partners and donors across programs to scale up and improve service delivery.
- Prevention outcomes will be enhanced by ensuring services are planned and delivered to achieve coverage targets, and systems are in place to address emerging challenges and improve quality of services
- Increased need for treatment, care and support and improved quality will be met by facilitating involvement across sectors, improving coordination between service providers and providing specialist services
- Management and coordination will be enhanced by improving communication between all players and strengthening the capacity of NASP
- Stigma and discrimination will be reduce and multi-sector response strengthened through an enabling environment and advocacy
- Capacity to implement the national HIV plan will be strengthened through a comprehensive approach to human resource development, health system strengthening and community system strengthening
- Strategic information will be collected and used to guide all aspects of the national response.
- The impact of gender will be addressed by ensuring age and gender appropriate services are provided and working in partnership with other sectors to advocate for gender equality across public policy

MARPs will continue to be the highest priority for prevention. However a range of emerging risk groups are also identified for whom specifically targeted interventions will be implemented. These groups include:

- International migrant workers
- Heroin Smokers
- Transport Workers
- Especially vulnerable adolescents
- Prisoners

Section four outlines the goals, objectives and strategies to be implemented. Goals, objectives and strategies have been set within a results based framework and are intended to provide clear direction for program implementation.

Section five describes the content of each strategy. The key issues to be addressed under each strategy and the response approach are outlined.

A results based framework is outlined in section six. The framework illustrates the linkages between program outputs, outcomes and impact under each objective and provides indicators to measure results.

A detailed implementation plan and budget accompany the strategic plan.

Bangladesh is one of the few countries in the developing world that has maintained low HIV prevalence through deliberate and concerted action. This strategy provides a framework for harmonising the efforts of all partners to ensure that low HIV prevalence is maintained and people living with HIV (PLHIV) are provided with the best possible treatment and care.

1.0 Background

1.1 National Response

Bangladesh has a long history of strong political commitment in combating HIV and a response guided by data on the epidemic. Efforts began even before the first case of HIV was detected. From the start, emphasis was given to surveillance, which would provide evidence, on which to base programme decisions.

The National AIDS Committee (NAC) was formed in 1985, four years before the first case of HIV detected in the country. The Chief Patron of NAC is the President of Bangladesh, and the Minister of Health and Family Welfare is the Chair. The NAC is the highest decision making body on issues related to AIDS and STI and act as an advisory body responsible for formulating major policies and strategies on HIV/AIDS in Bangladesh. NAC also supervises program implementation and is responsible for mobilizing resources. The National AIDS/STD Program (NASP) is the body established by the Ministry manage the National AIDS Programme in the country.

Bangladesh was the first country in the region to adopt a comprehensive national policy on HIV-AIDS and STDs (in 1997), and then also developed the first National Strategic Plan for HIV/AIDS, 1997-2002. This was reviewed in 2005 and the Second National Strategic Plan for HIV/AIDS (2004-2010) was adopted.

1.2 National Policy environment and HIV Program

The NASP, within the Directorate General of Health Services of the Ministry of Health and Family Welfare (MOHFW), is the main government body responsible for overseeing and coordinating prevention and control of HIV/AIDS, and ensuring that the National HIV/AIDS Strategy and national policies are implemented. Other ministries carry out HIV prevention and control activities through their core administrative structures. The Government nominated focal points for HIV/AIDS in 16 ministries and departments.

HIV is integrated in Bangladesh's general development plans, Poverty Reduction Strategy, Sector-wide approach. In the new National health Policy (Draft-2009), HIV has been emphasized.

The national response to HIV is being guided by a number of well developed Strategies / guidelines. They include:

- The Safe Blood Transfusion Act (passed in 2002)
- The National Harm Reduction Strategy for Drug Use and HIV, 2004-2010
- National HIV Advocacy and Communication Strategy 2005-10
- National Anti-Retroviral Therapy Guidelines, 2006
- National STI Management Guidelines, 2006
- National Policy and Strategy for Blood Safety, 2007

- Guidelines for VCT
- National Standards for Youth Friendly Health Services (YFHS) 2007
- Standard Operating Procedures for Services to People Living with HIV and AIDS, 2009

Moreover some manuals/modules/guidelines were also developed. TOT manual for School and College teachers and facilitation guide 2007; Training modules for Health Managers on HIV/AIDS (2006); Training of Trainers Manual on Mainstreaming HIV/AIDS for NGOs and Five Key Ministries (2007).

1.3 Programmatic Response 2005 - 2010

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

1. HIV/AIDS Prevention Project (HAPP) 2004-2007 was the first major projects under NASP which was supported by World Bank and DFID. The goal of HAPP was “To control the spread of HIV infection within high-risk groups and to limit its spread to the general population, without discriminating and stigmatizing the high-risk groups”. HAPP had four major components: implementing targeted intervention among MARPs (PWIDs, FSW, MSM and Hijra³); advocacy and communication; blood safety; and institutional strengthening and programme support. HAPP was implemented through GO-NGOs collaboration with assistance from UNICEF, UNFPA and WHO. More than 100 NGOs were involved in implementation of HAPP. The total funding was US\$ 26.33 million.

2. The HIV/AIDS Targeted Intervention (HATI) 2008-2009 supported by World Bank financed Health, Nutrition and Population Sector Program (HNPS). HATI focuses on intervention packages for six high risk groups: PWIDs, brothel based sex workers, street based sex workers, and hotel and residence based sex workers, clients of sex workers, and MSM, MSW and hijra.

3. The Bangladesh AIDS Programme (BAP) 2005-2009: The activities included support to interventions for MARP (PWID, sex workers, MSW, hijras and clients of sex workers), support to NGO and FBO and groups addressing the needs of PLHIV, national serological and behavioural surveys, condom promotion, training of health providers in syndromic case management of STI, STI studies, VCT centres and training of VCT centre staff and advocacy. Bangladesh AIDS Program (BAP) was funded by USAID and implemented through a team consisting of FHI, Social Marketing Company (SMC), JSI Bangladesh and Masjid Council for Community Advancement with the assistance of 18 implementing partners. In 2009 Modumita was launched as the follow on to BAP and implanted through FHI, SMC and Bangladesh Centre for communication Programs and will continue until 2013.. The objectives of the project are to increase and sustain use of high impact HIV prevention, care and treatment information and services by MARPs through high

³Hijra refers to male to female transgender people

quality, evidence-based and holistic program approaches and strengthen government leadership, multi-level coordination and use of data for decision-making to support HIV/AIDS prevention efforts and effective programming for MARPs.

4. Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) supported programmes: Up to 2009, three programmes were funded by Global Fund. They were;

GFATM Round 2: Prevention of HIV/AIDS among Young People in Bangladesh, . The goal was “To prevent HIV infections in young people, ages 15-24, and thereby help avert a generalized HIV epidemic in Bangladesh”. The major components were;. Provision of HIV Prevention information through Mass, Print and creative local media, provision of Youth Friendly Health Services, Life Skills Education and improving access of condom, integrating HIV/AIDS information into secondary and higher secondary school curriculums, advocacy and sensitization with “gate keeper” - religious leaders, community leaders, parents and policy makers and generate evidence-base data for program and policies. Save the Children USA worked as management agency and 16 NGOs implemented the activities across the country. The fund commitment was 19.9 million USD for the period of 2004-2009.

GFATM Round 6: HIV Prevention and control among High-Risk population and vulnerable Young People in Bangladesh. The goal was to limit the spread and impact of HIV in the country. This included High Risk Interventions for Injecting drug users, Female sex workers, and people living with HIV and workplace intervention for garment workers, Scaling up of prevention strategies with young people under Round 2 and strengthen capacity of partners for effective implementation, monitoring and evaluation. A total of 45 NGOs/CBO and academic organizations through 13 consortiums implement the activities. The fund commitment was US\$ 40 million for the period of 2007-12. The Global Fund Round 6 programme was merged with Global Fund RCC Programme from 2010.

GFATM Rolling Continuation Channel (RCC) R2 Proposal: Expanding HIV prevention in Bangladesh. The goal was to reduce HIV transmission among most at risk populations in Bangladesh. In 2009 Bangladesh received approval for GFATM RCC R2 proposal. The proposal is intended for increase coverage of Injecting Drug Users, Female Sex Workers, Men having Sex with Men, Capacity building of National response, Strengthening national M&E and operation research. The proposed budget is US\$ 81 million. Government of Bangladesh, Save the Children USA and ICDDRDB are nominated as PRs.

1.4 National Strategy Plan for HIV AIDS 2005-2010: Lesson learned and challenges

The National strategic plan 2004-2010 had five major programme focuses. These were Provide support and services for priority groups, Prevent vulnerability to HIV infection in Bangladesh society, Promote safe practices in the health care system, Provide care and support services for people living with HIV/AIDS, Minimize the impact of the HIV/AIDS epidemic.

The strategic focus on providing support and services for priority groups was considered to be effective as last sero-surveillance showed epidemic is still low among MARPs and did not rise significantly other than PWID. The coverage of targeted intervention for the MARPs had been up scaled significantly but is still to reach the optimum level to contain the epidemic. However recorded HIV infection is higher among international migrant (who were not identified as a priority group) than MARPs.

To address the prevention of vulnerability to HIV infection in Bangladesh society, large scale mass communication campaigns were initiated, youth friendly health services and life skill education were introduced. The results were found to be mixed. There was a significant increase in HIV/AIDS awareness but comprehensiveness of knowledge and risk perception level remains low, behavioural changes were not significant and service utilization by the young people is increasing but remains low thus indicating a need for a more effective communication campaign that includes a focus on risk behaviours and utilization of services.

Blood safety in health care setting improved significantly but is yet to reach universal coverage. Considerable efforts and gains in the area of ensuring universal precaution have been made but significant gaps remains.

Treatment services for PLHIV, including ARV and management of OIs were initiated. Coverage of ART among the eligible PLWHAs has been significantly scaled up but the supplies of drugs were limited and consistent supply is a challenge. ART services are currently being provided mainly by the SHG of PLHIVs through Global Fund support and the private sector and the need for higher level specialised services within selected public health sector services had been noted.

Multi-sectoral involvement and coordination were not optimum and in future need significant improvement.

Overall the National Strategy provided general direction for the HIV response in Bangladesh but most activity has been planned and implemented within the frameworks of different programmes of funding agencies. This resulted in duplication of services in some locations while leaving gaps in others. The programme monitoring at national level was done on ad-hoc basis and needs systematic development.

The Strategic Plan itself had certain limitations. These included; the objectives were not elaborated to provide clear directions and were not measurable, target populations were not fully identified, strategies did not provide sufficient direction for operational planning, there was a lack of clear direction for operationalizing objectives. The strategy did not have any operation plan and was not costed.

1.5 Development of National Strategic Plan for HIV/AIDS 2011 -2015

Strategic Planning Process

In June 2010 the NASP established a steering committee with representation from all key sectors to oversee the development of the National Strategic Plan for HIV/AIDS 2011 -2015. A task force operating under the direction of the steering committee has conducted a series of workshops involving all key stakeholders to analyse the current situation and develop objectives and implementing strategies.

Mandate and Scope

The National Strategic Plan for HIV and AIDS 2011-2015 provides a framework for the national response to the HIV epidemic up to 2015. Its authority is derived from the National Policy on HIV/AIDS and STD Related Issues adopted by Cabinet in 1997. It builds on the National Strategic Plan for 2004 -2010 and learns from experience gained in its implementation.

This strategic Plan is intended to provide a framework to guide and harmonise the contribution made through all program responses in Bangladesh. As such it identifies overall priorities under the objectives and clearly defines priority strategies under each objective which are specific, measurable, attainable, and relevant and time bound in order to guide a more specific implementation plan. Target populations are prioritised on the basis of known risk and vulnerability and activities are aligned accordingly.

2.0 Principles

The complexity of HIV epidemic, the sensitivity of the personal and social issues involved and the rapidly changing medical and social dimensions of the disease create the potential for HIV programs to be riven by conflict, chaos and organisational gridlock. The principles underlying the strategy are intended to provide a framework through which conflict can be mediated by focusing on common goals, a shared commitment to evidence based programming and role delineation based on strategic planning. They also facilitate increased program reach and enable changes in environments and policies across sectors and organisations. The principles are:

Multi-sector engagement: The HIV epidemic is complex. Its impact is felt across society involving individuals, families, sectors and institutions. It therefore goes beyond the domain of the health sector and as such an effective response to it must be multi-sectoral.

Stigma reduction: The adverse impacts of stigma and discrimination are among the key barriers to an effective response to HIV and AIDS. All international conventions and the National HIV/AIDS Policy emphasize commitment to stigma reduction.

Broad political commitment: The UNGASS declaration states “Leadership by Governments in combating HIV and AIDS is essential and their efforts should include communities and private sector. Leadership involves personal commitment and concrete actions”.

Civil society involvement: An effective response to HIV involves dealing with sensitive issues, mobilising hidden populations and drawing upon the social and cultural strengths of a society.

Private Sector Involvement: Since the private sector employs a large number of workers who are among the vulnerable groups, their active involvement will be important for any effective workplace related interventions.

Evidence Based: Decisions should be in accordance with a results based framework

Prevention to care continuum: A keystone of the response to HIV/AIDS is the recognition and adoption of programmes that address the epidemic in a holistic manner from prevention to care, treatment, support and mitigation. Effective care and support do not only improve the quality and length of life of PLHIV and those affected by HIV/AIDS but also greatly enhance prevention of HIV

Human rights: All international declarations and standards including the HIV and AIDS recommendations and the National Policy on HIV/AIDS reference the absolute need to make human rights framework and approaches central to the response to HIV/AIDS. Human rights approaches reduce the vulnerabilities to the HIV/AIDS

epidemic, and include various rights such as access to health care, information, confidentiality and privacy and gender equity

Gender based approaches

Gender inequality place women at higher vulnerability (e.g. disempowerment in sexual negotiation) and creates stereotypes of masculinity that marginalise sexual minorities. Gender equity will inform all components of strategy implementation.

Partnership: An effective response draws upon the strengths of government, non-government, private sector and faith based organisations and includes the greater involvement of HIV positive people.

Coordinated Approach: Harmonisation of efforts across programs and between all partners including government and non- government sectors, implementing agencies, donors and technical agencies is fundamental to maximising the success of this strategy.

3.0 Situation Analysis⁴

Bangladesh is the 8th most populous country in the world. It is bordered by India on all sides except for a small border with Myanmar. The country has a high poverty rate. However, per-capita (inflation-adjusted) GDP has more than doubled since 1975, and the poverty rate has fallen by 20% since the early 1990s. The country has made significant progress in human development in the areas of literacy, gender parity in schooling and reduction of population growth⁵.

Bangladesh responded early to HIV. The National AIDS Committee was established in 1985 before the first case of HIV in the country was reported. The National AIDS/STD Program (NASP) was established within the Ministry of Health and Family Welfare (MOHFW) to manage and coordinate the national response. A series of national plans (beginning in 1988) has guided the response in Bangladesh.

The first case of HIV in Bangladesh was detected in 1989 and it is estimated that 6200 people have been infected with HIV by the end of 2009 (UNAIDS estimation). In December, 2010 the Ministry of Health and Family Welfare had confirmed 2088 cases of HIV among which 850 had developed AIDS and 241 had died.

HIV prevalence is estimated to be less than 0.1 percent among the general population in 2007; below 1 percent amongst female and male sex workers (FSW and MSW), males who have sex with male (MSM) and transgender people (Hijra) and just above 1 percent amongst People Who Inject Drugs (PWID)⁶ except for one neighbourhood in Dhaka where it has reached 11%.

In Bangladesh the main routes of transmission are through hetero-sexual unprotected sex, and sharing of used needles and syringes. HIV prevalence has started to increase among PWID in Dhaka, especially in one neighbourhood. International returning migrant workers are another risk group accounting for a majority of passively reported cases of HIV. An epidemic may also be emerging among FSW in towns bordering India and Myanmar.

Rapid economic growth and social change is creating new patterns of vulnerability. There is high population mobility within the country as well as people going overseas for employment. In this context established support structures are weakened and people, especially women are more exposed to exploitation, including sexual exploitation. However vulnerability is often hidden and therefore difficult to assess and address.

The response focus has been on preventing HIV in groups whose drug injecting and/or unprotected sex with multiple partners put them at most risk for HIV and other STIs. Policies, guidelines and strategic frameworks and services for both targeted

⁴A detailed situation analysis is an accompanying document to the National Strategy

⁵United Nations. *Country Profile: Bangladesh*. <http://www.un-bd.org/countryprofile.html>

⁶Azim, T; Khan, S.I; Nahar, Q. et.al. *20 Years of HIV in Bangladesh: Experiences and Way Forward*. World Bank. December 2009 pxiv

MARPs and the general population have been put in place. Most programs are implemented by the nongovernmental organizations (NGOs)⁷ through support from Govt.

Less than 500 people are currently receiving Anti-retroviral treatment from Global Fund sources through NGO sector and yet no government ART service centre is established. Provision of diagnostic services and in-patient facilities are very limited.

3.1 Key Challenges

To scale up coverage for MARPs and improve quality of service delivery

A significant percentage of street, hotel and residence based female sex workers as well as PWID have been reached with HIV interventions, however, there is limited coverage in brothels. Those who are in contact with services are more likely to use condoms and sterile injecting equipment. However for many the frequency of contact and the effectiveness of interventions are inadequate to achieve sustained behaviour change. Moreover, amongst most MARPs, many lack comprehensive HIV knowledge, have low self-perception of HIV risk, and do not seek STI treatment.

Scaling up of programmes has been a challenge because of lack of capacity at all levels especially management level staff - financial management, procurement and overall governance. This extends from top management to the DIC level.

Understanding how to access the hidden populations among MARPs (e.g. residence based sex workers, MSM who don't identify as such) that are unlikely to be accessed by current interventions is a significant challenge. Current methods used may not be appropriate to achieve access.

To respond to emerging risk and higher vulnerability

There are population groups among whom higher rates of risk behaviour or vulnerability have been clearly identified in Bangladesh or else clear evidence exists from other countries. These groups include international migrant workers, especially vulnerable children, adolescent and young, prisoners, heroin smokers and transport workers. Interventions for these groups are inadequate to achieve significant change.

There are other groups among whom higher vulnerability is suspected but supporting evidence is not strong. They include garment workers, refugees, displaced persons, some minority ethnic populations.

More generally across the population there are people who occasionally engage in high risk behaviour or are at times more vulnerable. Rapid economic and social development in Bangladesh, among other things, results in high levels of population

⁷Azim, T. et.al.*op.cit.* pxviii

movement in which established social support structures are fractured temporarily or permanently thereby increasing risk and vulnerability.

To meet increased need over the next five years for treatment, care and support and improve quality

The number of people believed to be infected with HIV (6,200) is much higher than the number currently diagnosed (2088). These numbers will increase substantially over the next five years.

There are limited treatment facilities for PLHIV in Bangladesh. Less than 500 PLHIV are documented as currently receiving ARV. ARV is not available through the government health system as yet. Provision of diagnostic services for Opportunistic Illnesses and monitoring disease progression is very limited. Only Dhaka Infectious Diseases Hospital (IDH) provide in patient services for the PLHIV among the public facilities and the number in private and non-government settings, is low.

Capacity to provide more complex HIV treatment needs (e.g. failure of first line ARV therapy; Hepatitis C and TB coinfection; elevated risk of other morbidities such as cervical cancer, diabetes) is extremely limited.

Mechanisms to ensure quality of treatment service provision are absent.

Care and support needs are largely met through PLHIV support groups. Capacity may be overwhelmed as numbers of PLHIV increase.

3.2 Response Approach

The National Strategic Plan will be used as a framework for a coordinated approach between government, implementing agencies other partners and donors across programs to scale up and improve service delivery.

The national strategic plan identifies priorities and describes the components of specific strategies. The strategies are specific, measurable, attainable, and relevant and time bound in order to guide a coordinated approach. A costed and more detailed implementation plan will be used for joint planning across programs. The implementation plan will be fully costed to guide resource mobilisation.

Prevention outcomes will be enhanced by ensuring services are planned and delivered to achieve coverage targets, and systems are in place to address emerging challenges and improve quality of services

Standardised service delivery packages based on evidence of best practice are described. Agencies will have flexibility to adapt implementation to local circumstances. Better coordination between service providers, use of strategic information and enhanced capacity development will improve quality of service delivery.

Where evidence is lacking on which to scale up service provision, pilot interventions will be implemented and evaluated.

Hidden population at higher risk and/or vulnerability will be reached through behaviour specific messages in communication targeted at the general population (e.g. inclusion of anal sex as a risk factor).

Increased need for treatment, care and support and improved quality will be met by facilitating involvement across sectors, improving coordination between service providers and providing specialist services

National training will be provided on HIV treatment (including ART) to a limited number of service providers across government, non-government and private sectors. On-going support (advice, mentoring, and supervision) will be available from specialist HIV services in selected hospitals.

Specialist services will be established in a limited number of hospitals to manage more complex HIV presentations. This will include a specialist paediatric unit at one or more hospitals. Other diagnostic services (e.g. CD4 counts) will also be coordinated from these facilities. Protocols will allow utilisation of diagnostic services by local service providers.

Enhancing laboratory capacity for measuring CD4 counts and better diagnosis of OIs is essential. It is not adequate to provide equipment only for these purposes, training (both at the time of installation as well as refresher), ensuring supply of reagents, capacity to store reagents appropriately, capacity to maintain equipment, etc. are all required. Quality Assurance of tests will be established

Care and support needs will be met through improved needs assessment of PLHIV, better linkages between services and strengthening of PLHIV organisations.

Management and coordination will be enhanced by improving communication between all players and strengthening the capacity of NASP

The structure of the NASP will be aligned with the National Strategic Plan through four units (prevention; treatment, care and support; management and coordination; strategic information) each headed by a deputy program manager supported by a technical specialist.

An advisory committee will operate for each of the four strategy components.

A national HIV conference will be held annually open to all organisations and individuals involved in the HIV response. Additional forums will be conducted periodically.

An agency in each district will support the local health authority in improving coordination and planning.

A human rights approach will be adopted to maximise service access by marginalised populations and empower them to be involved in all aspects of the national response.

The priority target populations of the national strategy (Most at Risk Populations and Emerging risk and higher vulnerability populations⁸) are among the most disempowered in Bangladesh. Human rights violations and related social marginalisation are key barriers to service access.

Community mobilisation to address barriers to service access and build self esteem among MARPs is a core component of service delivery for these groups. In addition specific strategies will be implemented with the Human Rights Commission to advocate for legal and policy reforms.

MARPs groups will be empowered to be involved in all aspects of the national strategy through capacity development in the areas of advocacy and policy development and their inclusion in decision making structures. The GIPA (Greater Involvement of People with HIV/AIDS) principle will also be observed in ensuring the involvement of PLHIV in all aspects of the national response.

Capacity to implement the national HIV plan will be strengthened through a comprehensive approach to human resource development, health system strengthening and community system strengthening

A national training plan will be implemented based on a functional analysis of the implementation needs of the national strategy.

⁸MARPS – IDUs, Sex Workers, MSM, Hijra

Emerging Risk and Higher vulnerability – Prisoners, Especially vulnerable children, adolescents and young, heroin smokers, international migrant workers

Technical support will be provided to address HIV needs in key related areas of health service provision (e.g. laboratory service)

Community system strengthening will occur through capacity development across key areas including leadership and management, advocacy and service delivery.

Strategic information will be collected and used to guide all aspects of the national response.

Surveillance, social research and operational research will be conducted on a timely basis to guide implementation of the national strategic plan.

One national monitoring and evaluation framework with standardised indicators and tools will be used across different programs.

A research and surveillance advisory committee will meet regularly to advise on research activities.

Knowledge management tools (e.g. web based access to reports, research inventory) will be used to improve access to and utilisation of strategic information.

4.0 Strategy Framework

This section describes the goals, objectives and strategies of the National Strategic Plan.

A more detailed description of the strategies is outlined in section five.

The national Strategic Plan has been formulated within a results based framework outlined in section six. That framework posits a causative relationship between impact, outcomes, outputs and inputs while recognising that factors external to the program modify results at each level. A focus on results has determined prioritisation at each succeeding level⁹.

A detailed costed implementation plan will be developed.

4.1 Goal, Objectives and Strategies

Goal

By 2015, minimise the spread of HIV and minimize the impact of AIDS on the individual, family, community, and society.

Objectives and Strategies

Programme objective 1: Implement services to prevent new HIV infections ensuring universal access

Strategies:

- 1.1 HIV and STI transmission minimized among FSW, MSM, Hijra and PWID through comprehensive targeted intervention
- 1.2 Basic services provided and pilot interventions initiated, implemented and scaled up for emerging risk and higher vulnerable groups
- 1.3 HIV and STI transmission minimized among young people and general population through BCC, STI service provision and life skills education

⁹ A results based framework is the standard format on which international agencies such as the Global Fund, UNAIDS and most donor agencies base their own assessment tools and reporting requirements. By using this framework, harmonisation of effort across different HIV programs in Bangladesh will be enhanced. It will also facilitate resource mobilisation.

1.4 Health care based services are implemented to reduce HIV and STI transmission in the following areas; Blood Safety, Infection Control, PEP, PPTCT, STI Management

Program objective 2: Provide universal access to treatment, care and support services for people infected and affected by HIV

Strategies:

- 2.1 Services will be provided for the medical management of people with HIV in government, non-government and private sectors, on a shared care basis
- 2.2 Systems will be established for ongoing policy development/revision and capacity development
- 2.3 A comprehensive approach to care and support will be implemented

Program objective 3: Strengthen the coordination mechanisms and management capacity at different levels to ensure effective national multi-sector HIV/AIDS response

Strategies:

- 3.1 Strengthen the NAC and TC-NAC with appropriate support and structure to be more functional in guiding national HIV response
- 3.2 Strengthen the NASP through providing appropriate structure, human resource and other logistics
- 3.3 Conduct forums to coordinate, review and discuss HIV response among the stakeholders and at different levels
- 3.4 Conduct advocacy to strengthen an enabling environment
- 3.5 Facilitate development and implementation of activities and plans in key sectors
- 3.6 Develop human resource capacity across the HIV sector for enhanced response
- 3.7 Strengthen the health system response to HIV
- 3.8 Strengthen the community system response to HIV

Program objective 4: Strengthen the strategic information and research for evidence based response.

Strategies:

- 4.1 Conduct comprehensive surveillance to strengthen capacity to respond
- 4.2 Conduct relevant research to inform the national strategic response
- 4.3 Strengthen monitoring and evaluation of the National HIV Strategic Plan
- 4.4 Improve systems for knowledge management

5.0 Strategy Components

This section outlines the strategic focus of national strategy components. Where relevant, under each objective reference is made to other interventions elsewhere in the strategy. The components are:

- 5.1 Prevention
- 5.2 Treatment, Care and Support
- 5.3 Management and Coordination
- 5.4 Strategic Information

5.1 Prevention

Programme objective 1: Implement services to prevent new HIV infections ensuring universal access

Overview

Target populations under prevention are categorised as:

- Most At Risk Populations
- Emerging risk and higher vulnerable populations
- General Population and young people

The most comprehensive range of services with the highest coverage targets will be provided for MARPs. MARPs are given highest priority because of relatively higher risk of HIV transmission and potential contribution to increased incidence in the wider population. This prioritisation is supported through international evidence and epidemiological modelling.

Other emerging vulnerable populations have been identified based on evidence in Bangladesh of higher rates of HIV infection and/or particular vulnerability contexts. Specifically targeted interventions are outlined for these populations where there is evidence of effectiveness. To strengthen evidence on which to scale up interventions, it is proposed to pilot and evaluate additional interventions. Those interventions which are most effective will be scaled up.

A basic service package is outlined for the general population and young people. This includes provision of basic HIV information, access to VCT and STI services and access to condoms/lubricant. Service provision will be less intensive and mainstreamed. The inclusion of the general population is based on three considerations:

- All people have a basic human right to be provided with the information and basic services to protect themselves from HIV infection
- Some members of MARPs and other vulnerable populations are hidden and unlikely to access specifically targeted services
- Enhancing accurate knowledge in the general population will reduce stigma and discrimination

Additional interventions for young people include life skills education and strengthening the provision of youth friendly health services.

Vulnerability mapping will be undertaken to identify sub populations whom experience higher levels of vulnerability and interventions designed and implemented if justified on the basis of cost effectiveness.

Strategy 1.1 HIV and STI transmission minimized among SW, MSM, Hijra and PWID through comprehensive targeted intervention

Most at Risk Populations are:

- Injecting drug users
- Female and Male Sex Workers and clients
- Males who have Sex with Males (MSM)
- Hijra

Comprehensive Service Package

A comprehensive service package will be available to MARPs. The program implementation plan is designed to achieve target group coverage of 80% for regular distribution of condoms/lubricant and injecting equipment and periodic coverage of other interventions. A standard package of services available to all MARPs will include:

- Condom/lubricant provision
- Behaviour change communication
- STI diagnosis and treatment
- VCT
- PPTCT (for female sex workers and female PWID)
- Assessment of need and referral to health (e.g. TB and hepatitis B and C) and other services (e.g. legal services)
- Community mobilisation¹⁰ and local level advocacy

Additional harm reduction interventions for PWID will include:

- Needle and syringe distribution
- OST¹¹
- Injecting related primary health care

¹⁰Social marginalisation and poor self-esteem also contribute to risk taking behaviour. Community mobilisation interventions with the objective of building more positive group identity, and improving utilisation of services are included under prevention service delivery and community system strengthening.

¹¹Detoxification where it is part of the initiation of OST, will be provided

Services will be encouraged to adapt core interventions to the specific patterns of risk and vulnerability in their local area (e.g. hours of operation, distribution points for condoms and needles/syringes, content of behaviour change communication).

Referral for support services

Individual and group assessment of conditions (e.g. sexual exploitation, lack of shelter) which might increase vulnerability to HIV risk behaviour will be a core function of MARPs service provision. In response, relevant services will be identified and clients will be referred to those services.

Prevention of drug use is not a core function of HIV service. The scope of drug use in Bangladesh is vast (as with other countries) and requires a comprehensive approach encompassing supply reduction, demand reduction (including primary prevention and treatment¹²), and harm reduction. Provision of technical support for the Ministry of Home Affairs (under enabling environment) will include advice on development of a comprehensive drug policy. The primary focus of services for PWID in responding to clients who want to stop using drugs will be referral to drug treatment services and support (provision of meeting space) for self- help groups.

Most at Risk Adolescents (MARA)

Provision of age and gender appropriate services will be a requirement of service provision. The services will need to be informed by research and pilot interventions. Underlying vulnerability factors contributing to involvement in sex work and drug use will be addressed through linkages and referral to other support services. Guidelines for MARA service provision will be developed at the national level, informed by evaluation of pilot interventions as well as other research.

Service Modalities

Specific outreach services will be provided for each MARPs population group with capacity to achieve coverage of core activities for 80% for IDUs, accessible sex workers and accessible MSM. Core activities will be distribution of condoms/lubricant and needles and syringes and outreach education. More intensive services (satellite based service delivery-STI counselling/treatment, VCT, group based peer education) will be provided to hotel and brothel based sex workers through outreach services. Drop in Centres will be located in areas most frequented by specific MARPs. Drop In centres will be used for more intensive interventions (group based peer education, STI diagnosis/treatment, community development) for other MARPs populations. Where the concentration of specific MARPs groups is less, composite drop in centres will be piloted initially and evaluated for the purpose of scale up.

¹²Some harm reduction services implement detoxification services for PWID. This can continue with funding from sources other than the HIV strategy. However the cost of providing such services and the high failure rate cannot justify investment of HIV prevention funds on the basis of cost benefit analysis.

Interventions for sex workers will be grouped separately as follows:

- Brothel based sex workers
- Hotel and residence based sex workers
- Street based sex workers
- Male sex workers
- Hijra sex workers

Based on population size and local appropriateness, services might target more than one of the above groups

Male sex workers will be able to access either sex work services or MSM services.

Transaction based sex and male to male sex is not confined to people who adopt an identity based on these activities and/or are willing to be publicly identified as such. New intervention modalities need to be explored. Selected services for street based sex workers will be tasked with piloting interventions for women involved in transaction based sex who don't identify as sex workers. Selected MSM services will be tasked with piloting interventions for MSM who are unlikely to access existing services. In the first two years of the program a limited number of service providers will be invited to participate in design and implementation of pilot interventions. Based on evaluation scaling up will occur in the following years.

Services will require sufficient flexibility to design more specifically targeted interventions for sub populations of MARPs (e.g. female drug users; IDU sex workers, regular partners of clients or PWID or MSM). These services will require piloting and evaluation of the pilot before scaling up is considered.

Community development to build positive group identity among MARPs and thereby address issues of self-esteem, improve access to services and facilitate greater involvement in management and design of services, will occur through strengthening MARPs organisations (included under community system strengthening) and using drop in centres as a base for localised organisation and activities.

Capacity Development

Training will be conducted annually for staff on:

- Behaviour change communication
- Life skills education
- Counselling skills
- STI service provision
- Management of volunteer staff and coordination with other service providers
- Monitoring, evaluation and planning
- Local level advocacy
- Drop in centre management
- Financial management, procurement and accountability

Training will be skills based but applied to the content, policies and procedures of the national HIV Program. Training of peer educators and volunteers will be provided at the service delivery level.

Key Related Interventions

Other activities designed to strengthen the response for MARPs are discussed under:

- Reducing stigma/discrimination, strengthening community acceptance of services and multi-sector responses under enabling environment
- Reducing violence and exploitation and addressing legal/policy obstacles to service provision through working with the human rights commission and Ministry of Home Affairs under supportive environment
- Enhancing local level management, advocacy and planning capacity as well as service delivery skills under Capacity development
- Implementation of district based planning and coordination systems under Management and Coordination
- Building the evidence base and service quality improvement under Strategic Information
- Injecting drug use prevention under prevention targeted at heroin users and especially vulnerable children as well as health system strengthening

- Enhancing provision of primary-health care, HIV treatment/care and drug treatment/prevention services under Treatment/ Care and Health System Strengthening
- Strengthening Self Help Groups under community system strengthening

Strategy 1.2 Basic services provided and pilot interventions initiated, implemented and scaled up for emerging risk and higher vulnerable groups

The following groups have been identified as having a higher level of vulnerability to HIV among the general population

- International migrant workers
- Especially Vulnerable Adolescents¹³(particularly institutionalised and street based)
- Heroin smokers
- Transport workers
- Prisoners

There is not enough evidence of effectiveness on which to base prevention interventions with these groups. While a limited number of interventions are outlined for which a strong logical case can be made, other interventions will be piloted and evaluated and those which prove to be effective scaled up.

International Migrant Workers

HIV life skills education will be integrated into existing services for pre departure preparation of all migrant workers as well as provision of information materials including free CDs. Message reinforcement will occur through airport advertising and through broadcast media on flights leaving Bangladesh.

HIV education interventions will also be piloted through community based organisations in locations where high numbers of international migrants are from. Interventions will be designed for departing and returning migrants.

Specifically targeted VCT will be provided to returning workers. These services will be promoted through different media including in-flight magazines. Potential risk of HIV transmission outside Bangladesh and particularly for international migrants will also be included in HIV education targeted at the general population.

Further research will be conducted regarding informal international migrant workers. Information is needed regarding industry groups and the context of risk behaviour. Based on this research interventions will be developed.

¹³The UN defines adolescents as those people aged 10-19. Some children who are especially vulnerable are under the age of 10. They will also be included under interventions for EVA.

Especially Vulnerable Adolescents (EVA)

Especially vulnerable adolescents are those who are most likely to adopt high risk behaviours. Factors that contribute to their vulnerability include displacement; ethnicity and social exclusion; having parents, siblings or peers who inject drugs; migration (internal and external); family breakdown and abuse; harmful cultural practice; and poverty¹⁴.

Adolescents living on the street or in institutions are the most easily identified EVA.

A comprehensive multi-sector approach to social protection of especially vulnerable adolescents incorporating HIV will be the key strategy for HIV prevention in this group over the medium to long term. However a more immediate response to HIV risk is also necessary. This will include outreach education for street based EVA and institution based life skills education for those institutionalised as well as distribution of low literacy (possibly pictorial) IEC materials. Other interventions will be piloted, evaluated and if effective and scaled up.

Heroin Smokers

Heroin smokers have a significant likelihood of shifting to injecting drugs. There is evidence of injecting drug use services in Bangladesh successfully reaching this population group and reducing injecting drug use¹⁵. This evidence will be further investigated and inform pilot interventions for this group. These interventions will be implemented and evaluated then scaled up if justified by evidence.

Transport workers

There have been interventions conducted internationally for transport workers and limited interventions in Bangladesh. In Bangladesh, transport workers will include among others, truck drivers, rickshaw pullers and dock workers. Pilot interventions based on findings from international and Bangladesh interventions previously conducted will be implemented and evaluated and then scaled up if justified by evidence.

Prisoners

Interventions in prisons will include condom/lubricant distribution, OST and drug education. To facilitate this, policy advocacy and reform will be required as well as training/orientation provided to management and staff Existing pilot activities supported by UNODC will be scaled up.

¹⁴Interagency Task Team on HIV and Young People. *Guidance Note: HIV Interventions for Most at Risk Young People*. UNAIDS

¹⁵Fowler, D. *The HIV/AIDS Prevention Program (HAPP) and HIV/AIDS Targeted Intervention Program (HATI): Documentation and Lessons Learnt in a Program of HIV Targeted Interventions for High Risk Groups in Bangladesh*. Draft Report. Dhaka, December 2008.

Capacity Development

Capacity development for staff implementing interventions for emerging vulnerable groups will be adapted from training outlined under prevention for MARPs.

Key Related Intervention Areas

- Reducing stigma/discrimination, strengthening community acceptance of services and multi-sector responses (including social reintegration) under supportive environment
- Advocacy for spectrum of drug services under supportive environments
- Enhancing human resource capacity under Capacity development
- Strengthening service delivery, collaboration and community development under Community System Strengthening and Management/Coordination
- Building the evidence base and service quality improvement under Strategic Information
- Providing support for the Ministry of Labour and Employment for development and implementation of tripartite national workplace policy.
- Mobilising private sector involvement under enabling environment Enhancing provision of primary-health care, HIV treatment/care and drug treatment/prevention services under Treatment/ Care and Health System Strengthening

Strategy 1.3 HIV and STI transmission minimized among the young people and general population through BCC, VCT and PITC and STI service provision

A basic service package will be available to the general population. This includes provision of basic HIV information, access to VCT and STI services and access to condoms/lubricant. Service provision will be less intensive and mainstreamed.

Addressing changes in patterns of risk and vulnerability in the general population will occur through piloting and scaling up interventions based on regular vulnerability mapping and mobilising the private sector to provide workplace interventions.

Provision of basic HIV information

Basic HIV awareness will be promoted through paid and unpaid media (PR) as well as the production and distribution of IEC materials. Basic HIV information will also be integrated into interventions to build an enabling environment. Specific messages will be included that address risk behaviours (e.g. unprotected anal sex, injecting drug use) rather than identification with a risk population.

Access to VCT and STI service provision

Promotion of VCT and STI services will be primarily targeted at MARPs and Higher risk and vulnerable populations. However the availability of these services will be included in HIV awareness messages for the general population.

There is extensive HIV testing (outside the context of VCT and PITC) for the purpose of overseas employment and other reasons in Bangladesh. Although current guidelines state that counseling should be provided, this often does not occur. Capacity development in counseling will be provided to staff of organizations providing these testing services.

Periodic monitoring of VCT services will occur to ensure compliance with current (or future revised) Standard Operating Procedures.

Condoms

Condom accessibility needs to be improved to prevent transmission of the HIV and other sexually transmitted diseases. Promotion of condom faces different socio-cultural barriers and needs context sensitive interventions. Condoms are also promoted for family planning purposes; hence promotion of dual use of condom can be an effective strategy. To increase the access of condom to general population including young people, social marketing will be strengthened along with appropriate BCC campaign. Condom promotion will be integrated with activities like STI management and others. To find different innovative ways of marketing condom, pilot interventions will be initiated.

Life Skills Education

It is essential that all young people are equipped with the life skills and knowledge to make informed decisions regarding sex. Life skills education needs to include specific skills such as assertiveness and negotiation as well as clear and unambiguous knowledge regarding sexual behaviour and risk. It also needs to take account of young people's understanding of their relationships with each other (e.g. concepts of love and romance often based on modelling through popular culture). Teachers will be trained to provide life skills education.

Life skills education will be provided in both the formal and informal education sectors as well as out of school settings (e.g. youth clubs)

Youth friendly health services

HIV education and STI service provision will be integrated into youth health strategies to establish youth friendly health services. The availability and location of youth friendly health services will be promoted through media activity, life skills education and integrated into more targeted interventions likely to be accessed by young people (e.g. workplace interventions for garment workers).

Workplace based interventions

Through strategies to build an enabling environment involvement of the private sector in the HIV response will be promoted.

Pilot interventions for more vulnerable populations

Vulnerability mapping will be undertaken. On this basis priorities will be identified, evidence of best practice in interventions reviewed, cost benefit assessed of implementation in Bangladesh and if justified pilot interventions designed, evaluated and scaled up if effective. All interventions will ensure that human rights are not violated. Further investigation of some groups which have been identified but insufficient evidence currently exists (e.g. refugees, garment workers, ethnic populations) will also occur. Where interventions are already being implemented (e.g. garment workers) they will be evaluated, including a clear cost benefit analysis and scaled up if warranted.

Key Related Interventions Areas

- Increasing HIV case identification under counselling and testing
- Prevention of Parent to Child Transmission
- Increasing awareness through media and Faith Based Organisations under enabling environments
- Mobilising private sector involvement in providing workplace based HIV education under supportive environments
- Improving understanding and early identification of changes in infection patterns through Serological and behavioural surveillance under strategic Information
- Vulnerability mapping under strategic information

Strategy 1.4 Health care based services are implemented to reduce HIV and STI transmission in the following areas; Blood Safety, Infection Control, PEP, PPTCT, STI Management

HIV transmission in health care settings can be reduced through good practice in the areas of:

- Blood Safety
- Infection Control
- Post Exposure Prophylaxis
- Prevention of Parent to Child Transmission
- STI Management

Blood Safety

Technical support will be provided to ensure policies and procedures ensure the risk of HIV transmission is minimised.

Infection Control

The risk of direct HIV transmission from patient to health care provider as well as on-going risk of transmission to patients through reuse of equipment is a significant barrier to the provision of HIV services. Advocacy and support will be given to increasing the priority given to strengthening infection control in the Bangladesh health system

In addition to advocacy, technical support will be given to strengthening coverage of Infection control in all clinical training for medical and nursing staff. Support will also be given to strengthening the systematic monitoring of infection control through the health management information system and inclusion of this information in HIV monitoring/evaluation.

Post Exposure Prophylaxis (PEP)

The provision of anti- retroviral therapy (PEP) can reduce risk of HIV transmission after HIV exposure. PEP should be available in health care settings. Awareness of the availability of PEP will be promoted to health care workers as a method to reduce risk of post exposure transmission and thereby also reduce fear of providing treatment and care.

A national referral centre will be identified where case management can be provided of PEP on a shared care basis with local service providers. Local service providers will be able to receive advice from the national centre on suitability of administering PEP, where and how to access PEP drugs and on-going support and monitoring while PEP is being administered.

STI Management

Increased attention will to be given to STIs in the HIV response. This includes:

- Better integration of STI knowledge in BCC strategies
- Sensitisation of service providers to the needs of MARPs
- Increasing capacity of laboratory services to test for a range of STIs
- Utilising opportunities to enhance capacity of service providers outside the government sector to improve STI treatment practices
- Establishment of specialist STI services for referral of unusual clinical presentations, provision of support to primary health care providers, enhance laboratory capacity to test for a range of STIs and contributing to building STI expertise in Bangladesh

Prevention of Parent to Child Transmission (PPTCT)

Services for the Prevention of Mother to Child Transmission of HIV will be provided at sites selected on the basis of likely higher HIV prevalence (geographic locations with high rates of international travel for employment or other purposes, services targeted at MARPs). Provider Initiated Testing and Counselling (PITC) will be introduced into selected ante-natal clinical service provision if there is evidence of higher risk. Voluntary HIV counselling and testing will be offered to pregnant women in the context of preventing vertical transmission of HIV. HIV Pre and post-test

counselling guidelines will be simplified for this context with a focus on preventing new HIV infection in children born to women living with HIV and the health benefit of ART for the mother that tests positive to HIV. Access to lifelong supply of ARV for mothers in need of it after delivery and to treatment for opportunistic infection for HIV exposed children will be guaranteed through appropriate referral and linkages. Development of human resource capacity for PITC will be integrated with the implementation of reproductive health services. Standard protocols to regulate the provision of services will be developed and compliance monitored. OI treatment for HIV exposed children will be ensured.

As part of PPTCT psychosocial and other necessary support including nutrition support, sexual and reproductive health, and family support services need to be provided to HIV positive mothers/families and their children. Mothers and their children will also require ongoing support after birth to minimise HIV transmission through breast feeding. Breast feeding is associated with a 5-20% risk of transmission¹⁶.

A specialist medical facility for paediatric HIV treatment will be identified. For mothers who test positive, this facility will be responsible for case management and coordinating shared care arrangements with local service providers.

Key related Interventions

- Improving service linkages under Health system strengthening
- Human resource development under capacity development
- Reducing stigma and discrimination under enabling environment
- Multi-sector involvement under enabling environment
- Providing STI services through a comprehensive service package under Prevention for MARPs

¹⁶. World Health Organisation (WHO). *ANTIRETROVIRAL DRUGS FOR TREATING PREGNANT WOMEN AND PREVENTING HIV INFECTION IN INFANTS Recommendations for a public health approach 2010 version*. p12

5.2 Treatment, Care and Support

Program objective 2: Provide universal access to treatment, care and support services for people infected and affected by HIV

Bangladesh is committed to universal access to HIV treatment, care and support for those in need. Because of limited capacity in the government sector and competing demands, HIV services will need to be delivered across government, non-government and private sectors. The complexity of HIV medicine requires different levels of expertise for undertaking different tasks. For example initiation and monitoring of ART is less complex than management of treatment failure. Services will be provided through a team based approach across different sites and functions (e.g. basic ART maintenance, provision of diagnostic services and management of related complications). Provision of care and support, which is often necessary to ensure treatment adherence as well as meet broader needs, also will be part of the continuum of care.

Strategy 2.1 Services will be provided for the medical management of people with HIV in government, non-government and private sectors, on a shared care basis

Clinical Treatment

The complexity of HIV treatment and the relatively low number of people living with HIV in Bangladesh requires a focused approach to HIV clinical management. It is not realistic to provide training across the medical workforce and expect knowledge and skills to be maintained in the absence of managing patients. However, while not currently high, the population of PLHIV is dispersed across Bangladesh and services need to be geographically accessible. The framework for service provision is outlined below:

Service Need	Service Type
Counselling and Testing	VCT and PITC through a range of outlets; HIV will be promoted as a manageable disease in counselling and testing as well as BCC messages
Initiation of treatment	Accredited doctors in Government, Non-government and private sector
Treatment Maintenance	Accredited doctors in Government, Non-government and private sectors; PLHIV organisation involvement in treatment education
Complex HIV management including co-infection	Specialist units with inpatient facilities that can be used if necessary; Shared care with local service providers when appropriate
Paediatric Care	Specialist facility for case management

	and coordination with local service providers
Opportunistic Illnesses	Prophylaxis through accredited doctors
Advanced HIV illness and inpatient services	Specialist units with inpatient facilities that can be used if necessary; Shared care with local service providers when appropriate
Palliative Care	Home based services; Limited facility based services
Care and support	Range of non-medical support services with PLHIV organisations having a lead role
Infrastructure support (e.g. storage, distribution of medications; laboratory services, infection control etc.)	Strengthened health systems

Continuum of Care and Clinical care coordination

Improvements in HIV medicine have made HIV a chronic life-long infection. With high quality treatment, many if not most PLHIV will have a life span approximating that of the general population. However this will require:

- On-going monitoring of HIV progression
- Likely life- long treatment with ART once commenced
- Changes in treatment/medication as new developments occur in the science of HIV medicine
- Management of complex co-morbidities related to ART (e.g. diabetes)
- Occasional inpatient care for complications related to HIV as well as co-infections (e.g. Hepatitis C and TB) and co-morbidities
- Inpatient palliative care for some PLHIV
- Primary health care needs including nutrition support

On-going patient management including initiation and maintenance of ART will be undertaken by doctors working at the primary health care level. This will be addressed through:

- Standardised treatment protocols
- Training with accreditation
- Periodic in service training to ensure practice is revised as new protocols are adopted
- Shared care arrangements (with other medical service providers as well as care/support services), referral protocols, systems for mentoring/supervision/support
- Robust systems for supply/distribution of medicines (including policy support for strengthening local production based on ensuring appropriate standards are met¹⁷) and provision of laboratory services

¹⁷ARVs are manufactured by two companies in Bangladesh but they provide only limited first-line treatment, and no pediatric formulations are available.

Specialist Facilities

HIV medicine requires the provision of specialist services to manage more complex presentations. Because of cost and limited capacity, these services should be placed in a small number of internal medicine units in hospitals. These units will serve as referral hubs and treatment coordination points for HIV clinical management. Treatment coordination will include mentoring/supervision arrangements for doctors operating at a primary health care level and ensuring effective logistical arrangements are in place for drug supply and provision of laboratory services.

It is also essential that related care and support needs of PLHIV are recognised as part of the overall management of HIV. Organisations involved in provision of care and support should be included in case management and shared care arrangements.

Coinfection with TB is high among PLHIV in Bangladesh. In 2008 there were estimated to be 324 new TB cases among PLHIV.¹⁸ Continued efforts at strengthening coordination between NTP and NASP through regular meetings for accelerating linkages between DOTS and VCT centres, increasing capacity building for managing TB/HIV co-infection, providing social support for TB/HIV co-infected patients and carrying out surveillance to monitor the trends of TB/HIV burden are required.¹⁹

Paediatric HIV medicine is more complex than routine HIV medical management. Specialist facilities (based on need and capacity) needs to be established for case management and shared care with local service providers

Strategy 2.2 Systems will be established for ongoing policy development/revision and capacity development and communication

The science of HIV medicine is complex and constantly changing. Policies and protocols need to be frequently updated to ensure treatment practice is aligned with these changes. On-going communication needs to be maintained with service providers (including in-service training) to ensure consistent implementation of changes in related treatment practice.

The complexity of HIV medicine requires a high standard of training for doctors to prescribe ART, treat opportunistic illnesses and recognise when more specialist support is needed. To minimise the involvement of service providers without the necessary expertise a system of accreditation will be established.

Policy development/revision (drafting policies, protocols and guidelines), pre service training and accreditation for prescribing HIV medicines, communication and in service training for accredited doctors will be undertaken. The constant changes that need to be integrated into these functions make it difficult to manage from within the government system. Consideration will be given to outsourcing these functions to an

¹⁸Country Coordinating Mechanism (CCM) *Bangladesh. Round 10 Tuberculosis Proposal*. July 2008. P9

¹⁹Ibid. p3

existing professional society or establishing a specialised HIV medical society. This will also facilitate:

- A dedicated workforce across government, non-government and private sectors willing to make a long term commitment to HIV treatment and care
- An interdisciplinary approach and partnership between different professional groups (e.g. medical, nursing, social work, counselling)

A technical working group will be established to advise NASP on policies, protocols and guidelines.

Key Related Interventions

- Reducing stigma and discrimination under supportive environment
- Care and support
- Treatment observational database under strategic information
- Health system strengthening (including promoting supportive attitudes and behaviours towards PLHIV among health care providers)

Care and Support

Strategy 2.3 A comprehensive approach to care and support will be implemented

HIV diagnosis for many people is a serious life changing event. Apart from individual health it impacts on personal/family and social relationships. These broader impacts in turn affect people's capacity to manage their illness.

The care and support needs of PLHIV range over the following areas:

- Psychological support
- Social and legal support
- Peer support
- Financial support
- Health education
- Extended care arrangements for people who are ill
- Support for affected children (children infected with HIV, children for whom one or both of their parents have died from HIV-related illnesses, children living in an HIV-affected household, or children at high risk of becoming infected with HIV²⁰)

A care and support needs assessment will be undertaken when individuals are diagnosed with HIV. The assessment will be against the service areas listed in the above paragraph. Mapping of existing services and facilitating access of PLHIVs to appropriate continuum of services from a range of agencies will be facilitated. This includes access to social safety net program to address issues like food insecurity. The provision of continuum of care for PLHIVs will be guided and regulated by the existing national SOP for care and support for PLHIV.

²⁰See Especially vulnerable adolescents under prevention component

Coordination of care and support also needs to occur. There are several service providers currently, or willing to be involved in the provision of care and support. Information regarding services being offered needs to be documented and communicated to PLHIV. Regular meetings need to be held between service providers and with PLHIV to ensure services are aligned with need.

The care and support needs of children affected by HIV need to be assessed and appropriate linkages made with other child social support services.

Greater Involvement of PLHIV

A principle of this strategy is the greater involvement of PLHIV²¹. PLHIV organisations in Bangladesh have already done a magnificent job in addressing the care and support needs. Their efforts need to be reinforced and strengthened through nationally agreed policies and protocols that formally recognise the need for and support the provision of services, and enhanced capacity development.

Key Related Interventions

- Reducing stigma and discrimination under enabling environment
- Protection of human rights under enabling environment
- Engagement of faith based organisations under enabling environment
- Facilitating team based shared care for management of HIV under treatment
- Strengthening resources and capacity building under community system strengthening
- Strengthening leadership and accountability under community system strengthening

²¹ The principle of GIPA (Greater Involvement of People with HIV/AIDS) has been endorsed by many countries and is also a principle underlying UNGASS.

5.3 Management and coordination

Program objective 3: Strengthen the coordination mechanisms and management capacity at different levels to ensure an effective national multi-sector HIV/AIDS response

Strategies:

- 3.1 Strengthen the NAC and TC-NAC with appropriate support and structure to be more functional in guiding national HIV response
- 3.2 Strengthen the NASP through providing appropriate structure, human resource and other logistics
- 3.3 Conduct forums to coordinate, review and discuss HIV response among the stakeholders and at different levels
- 3.4 Conduct advocacy to strengthen an enabling environment
- 3.5 Facilitate development and implementation of activities and plans in key sectors
- 3.6 Develop human resource capacity across the HIV sector for enhanced response
- 3.7 Strengthen the health system response to HIV
- 3.8 Strengthen the community system response to HIV

3.1 Strengthen the NAC and TC-NAC with appropriate support and structure to be more functional in guiding national HIV response

The functions of governance, management and coordination of the National HIV Strategy are described in the following table.

ORGANISATION	FUNCTION
National AIDS Committee (NAC)	Oversight of National Strategic Plan implementation; Strategy Revision; National Advocacy to Government
National AIDS Committee: Technical Committee (NAC-TC)	Strategic guidance to NASP and other stakeholders
National AIDS/ STD Program (NASP)	Program Management and Coordination
Technical working groups (Prevention; Treatment, care and support; Management and Coordination; Strategic Information)	Technical advice to NASP
Other government ministries and sector agencies	Development and implementation of sector plans

STI/AIDS Network	Representation of implementing agencies in governance structures
Implementing agencies	Service delivery
Representative bodies of PLHIV and target populations	Representation of PLHIV and target populations in governance structures;
Donor agencies	Provision of funding; Harmonisation of funding
UN agencies	Policy advice; Technical support; Advocacy
Private sector	Workplace policy; Involvement in sector policy development and implementation; Funding mobilisation
Faith Based Organisations	Involvement in building enabling environment; Involvement in provision and coordination of Care and support services

The NAC is the national advisory body for HIV response and has the broader responsibility of endorsing major policies and strategies on HIV/AIDS in Bangladesh, reviewing the national response and advocacy to Government for HIV related issues.

An annual meeting of the NAC will be conducted. The key agenda items at the annual meeting will be:

- Presentation of annual report on strategy implementation
- Approval of strategy and/or program revision
- Sustainability of the national response: review of any issues (e.g. funding) and endorsement of measures for rectification

An annual report will guide the deliberations of the NAC. It will review performance based on monitoring and evaluation, outline any key issues arising from strategic information and identify any threats to sustainability of the program (e.g. service interruption resulting from funding gaps).

The NAC Technical Committee will meet on quarterly basis between annual NAC meetings. It will provide advice to the NASP and other stakeholders on all technical issues and policy formulation. It will establish task specific and time limited working groups to assist. The NASP will provide secretariat support for the NAC-TC. An annual schedule of meetings will be institutionalised. This will assist members of NAC and NAC-TC to plan their calendars.

Strategy 3.2 Strengthen the NASP through providing appropriate structure, human resource and other logistics

The NASP is the mandated coordination body for HIV/AIDS programs within the country. Inadequate resources within NASP, in terms of personnel, funding, and structural issues have reduced its potential effectiveness.

A clear alignment of the structure of the NASP with the objectives of the National Strategy will strengthen its capacity to manage and coordinate the response. It is proposed that the NASP have four sub units headed by a deputy program manager supported by a senior technical advisor in line with NASP Restructuring proposal and previous Functional Task Analysis. The four units will be:

- Monitoring, evaluation and strategic information
- Management, coordination and capacity development
- Prevention
- Treatment, care and support

Each unit of the NASP will have a technical advisory committee. A key function of these committees will be to advise and mobilise technical support for adoption and revision of policies, protocols and guidelines.

A major structural impediment to the NASP performing its role has been turnover of staff. This will be addressed through:

- Long term positioning of staff with appropriate level of seniority
- Adequate staffing structure at the NASP through deputation from the department and contract positions on a long term basis

Specific staffing needs as per NASP restructuring proposal or Functional Task Analysis will be filled.

3.3 Conduct forums to coordinate, review and discuss HIV response among the stakeholders and at different levels

Broadening the engagement of organisations and individuals across sectors will strengthen the current response as well as provide a basis for an expanded response when the need arises. This includes creating forums at national, district and local level to share information, engage new participants form partnerships and improve planning and coordination.

Through the following forums NASP will facilitate coordination, review and discussion on HIV response among the stakeholders. Each of the forums will have specific ToR to function effectively. The outputs of the meetings will be documented and followed up. An annual schedule of meetings will be institutionalised.

Forum	Frequency	Participants	Activities
National			
NAC-TC	Quarterly	Representatives of key agencies	Review of programme progress;

			Identification and rectification of urgent issues
Donor coordination	Six monthly	Different donor	Harmonization of funding; Mobilization of funding
Multi-sectoral coordination	Six monthly	Focal points of key ministries	Review sectoral collaboration and coordination
HIV Congress	Annual	Programme managers; Policy makers; Service providers; Researchers; Others	Cross sector and multi-sector collaboration
Sub-national / District			
District HIV/AIDS coordination	Quarterly	District health administration, Organizations involved in implementation	Local level planning; Coordination of different activities; Cross sector collaboration

At the national level an annual HIV conference will be held. Participation in the congress will be from agencies throughout Bangladesh and across sectors. The purpose of the congress is to:

- Familiarise participants with key decisions from the NAC
- Provide a forum to share lessons learnt in program implementation over the previous year
- Be an opportunity for participants to be updated on latest regional and international developments
- Strengthen involvement across sectors
- Strengthen networks, collaboration and support for Ministerial Focal points in key Ministries outside Health
- Build partnerships across regions and districts of Bangladesh
- Strengthen morale of those involved in implementation
- Promote a supportive environment through media coverage

Other forums will also be held at a national level to bring partners across sectors together (e.g. National Partnership Forum on HIV and Sex Work Issues) or as the need arises (e.g. dissemination of major research reports).

Responding effectively to local variations in vulnerability and risk, reducing service duplication, improving linkages and mobilising a multi-sector response requires capacity for district level coordination and planning. An agency will be selected in each district to facilitate district health authorities coordinate and plan with the following objectives:

- Enhance coordination between implementing agencies

- Identification and response to local patterns of risk and vulnerability
- Build linkages between HIV specific agencies and services across the health system and in other sectors
- Mobilise involvement of agencies across sectors (including private sector and faith based organisations) to be involved in the HIV response

At the local level agencies will be encouraged to establish networks to enhance coordination.

Enabling Environment and Advocacy

To strengthen the current response to HIV in Bangladesh and build a sustainable base to address future challenges, developing an enabling environment is a strategic priority. An enabling environment is necessary to address human rights violations (e.g. harassment of MARPs) and gender inequality (e.g. disempowerment of women in negotiation of safe sex) which limit the effectiveness of current interventions. A multi-sector response is necessary for an enabling environment to address the challenges, risks and vulnerabilities emerging in a country experiencing rapid economic and social change.

Advocacy will be a key strategy for developing an enabling environment. It will be complemented by sector specific initiatives and creating opportunities at national, district and local levels through forums to facilitate multi-sector involvement in planning, coordination and implementation of the national response.

Strategy 3.4 Conduct advocacy to strengthen an enabling environment

Responding effectively to HIV involves addressing sensitive and sometimes controversial issue and implementing services that often meet local resistance and involvement from a range of sectors. Advocacy will occur for legal and policy reforms, removing barriers to service delivery and resource mobilisation by other sectors. Advocacy at all levels will be conducted - national, divisional, and local. Advocacy will be done with parliamentarians, different key ministries, law enforcement agencies, journalists, relevant professional bodies, program managers, etc. Advocacy will be conducted through discussions, workshops and meetings and exposure visits and be integrated in sector specific initiatives.

Local level advocacy will be included as a core function of service provision. Advocacy will be provided to key gatekeepers such as police and law enforcement agencies on effective HIV prevention, and on working with and protecting the rights of members of vulnerable groups, including PWID, sex workers, hijras and MSM

The establishment of district coordination agencies will also facilitate local level advocacy through mobilisation of agencies across sectors in the HIV response.

Strategy 3.5 Facilitate development and implementation of activities and plans in key sectors

Key government ministries and departments as well as other sectors will be given support in strengthening their involvement in the HIV response. Key Ministries include Education, Expatriate and Overseas Employment, Children and Women's Affairs, Labour and Employment, Information, Youth and Sports and Defence. The Ministry of Home Affairs will be given special priority because of its pivotal role in enabling the implementation of targeted interventions for MARPs. Other key sectors and organisations include: the private sector, faith based organisations and the Human Rights Commission.

Government Ministries and Departments

Government ministries and departments will be given technical, organisational and networking support to engage their sectors in the HIV response. Assistance will be provided in developing a simple and concise work plan for key Ministries and departments that:

- Identifies key priorities
- Outlines key actions
- Provides a framework for on-going collaboration
- Integrates HIV into their programs and identifies necessary additional resources and how to mobilise them

Response Focus of Ministry of Home Affairs

Ministry of Home Affairs has responsibility for a number of government departments that have a major impact on HIV program implementation. They include:

- Police
- Border guard
- Ansar and VDP
- Immigration and passports
- prisons
- narcotics control

Priority support will be given to development of a strategic plan for the Ministry of Home Affairs. That strategy will address:

- development of HIV enabling policies and protocols in each of the key departments
- addressing HIV prevention among members of Home Affairs Department who may be at heightened risk (e.g. police, border guards)
- enhancing the role of police as enablers of HIV programming (e.g. ensuring policing procedures don't act as a barrier to service access by MARPs, involvement of police in local level advocacy)

Human Rights Commission

A partnership will be established with the Human Rights Commission to address HIV related violation of human rights resulting in inequality, discrimination, social and

political exclusion and subordination resulting from behaviours, gender and sexual orientations and practices. Technical support will be provided to the Human Rights Commission in assessing the impact of human rights violations on HIV, understanding their causes and developing effective responses

Faith Based Organisations

Faith based organizations are powerful social forces in Bangladesh. The particular attributes in the following areas will be used to strengthen the HIV response.

- Strong roots within communities
- Depth of networks and breadth of infrastructure
- Respect and trust of their constituents
- Moral and ethical competence to work for positive social change

Issues of guilt, compassion, salvation, and forgiveness are framed by religious beliefs²². These issues affect the attitudes of people towards those living with HIV and the experiences and feelings of many people directly affected by HIV. FBOs will be mobilized to work in partnership with other agencies in addressing stigma and discrimination.

Technical support will be provided for advocacy, development of IEC materials and training for FBOs.

Private Sector

The rapid economic and social development of Bangladesh is resulting in extensive population movement from rural to urban area and changes in employment from local family and community based subsistence farming and cottage industries to large scale industrialised sectors. In many countries population mobility and weakening of family and local community support structures are associated with increased vulnerability to higher risk sexual and drug taking contexts.

The involvement of the private sector through workplace HIV interventions can provide a base to respond to some significant changes in vulnerability related to population movement for employment, in both a timely manner and on a sustainable manner.

The garment industry has been a pioneer in private sector development of workplace responses in Bangladesh. With technical support from the HIV sector, industry bodies and specific employers are (at varying levels of coverage and intensity) developing policies to protect employees from stigma and discrimination on the basis of HIV, providing HIV education, and integrating HIV and STI services into company provided health services (including condom distribution).

Technical support, policy advocacy and capacity development with the garment industry will be continued and leveraged strategically as an example for other

²²Fowler, D. *The East Asia and Pacific Regional Interfaith Consultation Meeting on Children and HIV/AIDS*. UNICEF East Asia and Pacific Regional Office. Bangkok 2008

industry groups. This will include policy advocacy for employers to provide a minimum service package including protocols to protect employees from HIV related discrimination, provision of HIV education, and integration of HIV and STIs into company provided health services

The private sector will also be mobilised as a contributor to the response through funding and/or contribution of services and commodities (e.g. provision of free air time by media companies for broadcast of HIV messages).

Currently Bangladesh has a vibrant electronic and print media. There are many satellite channels competing for the audience's attentions. There is increasing coverage of both land and satellite based channels. The print media circulation is increasing. There is significant scope for involvement of electronic and print media in promoting public education and information regarding HIV and AIDS prevention, care and reducing stigma to create an enabling environment.

The specific roles media will play are; creating awareness of everyone's risks of contracting HIV, developing understanding of the underlying causes and consequences of the epidemic, contributing to an enabling environment in which people with HIV and AIDS can live in dignity with full protection of their human rights. The focus of engagement with media will be to train relevant people to be accurate, respect privacy, and avoid sensationalism. The media will be mobilized to be involved more in HIV and AIDS prevention, care and support as public service activities.

CAPACITY DEVELOPMENT

This strategy categorises capacity development as follows:

- Cross sector human resource development
- Health system strengthening
- Community system strengthening

Strategy 3.6 Human resource capacity development across the HIV sector is strengthened:

Human resource capacity building will ensure that all relevant personnel in the HIV program have adequate skills to design, implement and monitor the program effectively. The capacity development initiatives will be guided by

- A functional analysis of roles and necessary competencies to implement the National Strategic Plan
- Development and implementation of a training plan based on the functional analysis
- Development of core curriculum, teaching aides and assessment tools will be developed for key service delivery and management roles

Based on the functional analysis, core curriculum, teaching aides and assessment tools will be developed. The content of teaching materials will be applied to specific

areas of service delivery (e.g. generic core competencies in peer outreach such as interpersonal communication skills but with specific target population content).

Specific training will be provided on policies, protocols and tools developed for program implementation. This training will be structured to include follow up assessment of application in the workplace and opportunities for remedial action. The broad functional areas of capacity building will be focussed on

- Service Delivery
- Programme management
- M&E and planning
- Financial management

Training for employed staff will be delivered by training agencies contracted nationally. This training will be provided annually and be delivered in two components – core training for new staff and refresher as well as up skill building training for other staff. Training of volunteers and peer workers will be by implementing agencies.

Strategy 3.7 Strengthen the health system response to HIV

Delivery of effective HIV services requires a strong underlying health system. Specific attention will to be paid to the following areas:

Human resources

The functional analysis of roles and competencies outlined under human resource development will inform overall human resource planning in the health system. HIV specific content will be included in areas such as laboratory services, logistics, and infection control. Capacity to manage HIV will be integrated into specialisations such as paediatric care (this will most likely be through training a small number of specialists in these areas). A basic understanding of HIV will be mainstreamed into the training of primary health care service providers. (Primarily for the purpose of addressing other primary health care needs in a non-discriminatory manner).

Drug and essential commodity supplies

There is significantly greater risk associated with system failure in supply management related to communicable diseases than in non-communicable disease areas. Examples include:

- Interruption in Anti-Retroviral Therapy is likely to create resistance to ongoing use of the same drugs as well as increase viral load and infectivity
- Failure to ensure supply of condoms/lubricant will result in people engaging in unsafe sex

Unregulated involvement by the private sector creates significant risk regarding the provision of substandard products and unethical (dishonest/misleading) marketing.

Technical support will be given to ensure a regulatory framework governing private sector involvement in this area mitigates risk.

Forecasting requirements in communicable diseases – particularly HIV – is also more challenging than non-communicable diseases²³. Needs can change and increase rapidly.

Technical support will be provided for:

- Reviewing the infrastructure for procurement, storage and distribution of essential drugs and other commodities (e.g. condoms/lubricant, reagents for HIV testing)
- Ensuring comprehensive protocols and procedures have been and are being developed
- Improving management systems and human resource capacity

Laboratory Services

Technical support and capacity development of staff to incorporate the VCT, CD4 testing and other laboratory requirements as well as viral load monitoring will be provided.

Health Information systems that provide strategic information for monitoring and quality improvement

The HIV Management Information System (MIS) will to be integrated with the broader health information system (HIS) This integrated system will effectively combine prevention, treatment, pharmaceutical supply, laboratory support, supervision, and program management at all levels.

Linkages between related service delivery areas (e.g. reproductive health and HIV)

Strong partnerships will be maintained with concerned Line Ministries, District line Departments particularly Health, Non-Governmental Organizations and the private Sector including the industrial sector to maintain standards by providing assistance/guidance through advocacy, training, monitoring and other means of participation and quality assurance.

Partnerships will be developed with local microfinance institutions, social health insurance schemes, and other locally based health financing mechanisms such as performance based financing (PBF) to ensure accountability through innovative ways of motivating health workers and institutionalizing performance improvements.

²³ In most areas of procurement forecasting is based in large part on previous usage patterns.

Strategy 3.8 Strengthen the community system response to HIV

The Bangladesh National HIV Strategy is based on the principle of partnership between government and community sectors. To enable the community system to undertake its rightful role strengthening is required in the following areas:

- Development of an enabling environment
- Building community networks, linkages, partnerships and coordination
- Resources and capacity building
- Community activities and service delivery
- Leadership and accountability
- Monitoring, evaluation and planning

Development of an enabling environment

Development of an enabling environment will be strengthened by capacity development of community organisations to engage in policy development and advocacy. This will require support for policy development capacity at the representative level of NGOs as well as representative organisations and self-help groups for MARPs.

Community networks, linkages, partnerships and coordination

The consortium model of service delivery in Bangladesh has reduced duplication of efforts and/or conflicting messages being delivered to target populations. Furthermore opportunities to share information, resources and knowledge have been enhanced. The model will continue to be used.²⁴

Resources and Capacity Building

Community organisations require financial, material and human resources to deliver services.

Funds will be allocated for:

- Core management functions (financial management, human resource management, planning and reporting)
- Resource mobilisation
- Representation functions

Funding will also be provided for the material infrastructure to effectively deliver services. Examples include office space and communication systems.

There are a set of core competencies that community organisation staff and volunteers need to deliver quality services for HIV and STI prevention, care and support. These will be defined under human resource development. Human resource management at service delivery level will include an assessment of individual staff capacity against these competencies and a training plan.

²⁴The consortium model involves contracting a number of implementing agencies through a lead agency. Implementing agencies share common administration procedures and meet regularly to share information.

Community activities and service delivery

Community organisations have certain advantages in service delivery including access and legitimacy with marginalised populations, organisational flexibility and ability to generate resources that might not be available to government. These advantages will be strengthened through capacity development in planning and quality management.

Leadership and accountability

Community based organisations need strong governance and institutional structures to:

- Effectively represent their respective constituencies
- Sustain their role over time
- Attract and manage significant funding from donors.

Without strong governance structures, including transparency and accountability in decision making and transparency in financial management their credibility with donors and government partners is weakened. Because the populations they work with are already marginalised, maintaining credibility is of critical importance.

Core competencies, capacities and related standards for governance and management in community based organisations will be defined in order to guide capacity development. Definition of core competencies and capacities in governance and management will also contribute to improved management practice through:

- Providing common benchmarks against which performance can be measured and compared (basis of any quality improvement system)
- Establishing a common framework against which institutional capacity can be assessed in determining feasibility of agencies to manage funding
- Facilitating NGO participation in processes to harmonize aid delivery²⁵

Activities to be supported in developing leadership and accountability include:

- Development of common standards and definition of core competencies in governance, institutional and management functions
- Undertake capacity assessment of community based organisations involved in implementing the HIV and STI strategy against the following functions:
 - Decision making
 - Financial management
 - Organisational structure accountability
 - Human resource management
 - operational planning

²⁵ The UN and other development partners have recognised the need for harmonisation in aid delivery to maximise efficiency and effectiveness. The non-government sector should be active participants in efforts directed at harmonisation.

- Develop 3 year capacity development plans for individual community based organisations operating in priority areas incorporating the following components
 - Initial capacity assessment against core competencies
 - Scheduling of training events and site visits
 - Identification of specific mentoring relationships
 - Integration of generic competencies into human resource development plans
 - Annual key performance management assessment of integration of competencies into organisational functions

Monitoring, evaluation and planning

Strengthening community system monitoring, evaluation and planning capacity is necessary to facilitate improvement in service delivery. The development of shared systems/processes, service definitions and indicators across organisations implementing the HIV strategy will reduce duplication in services, and provide a basis to compare performance and share learning.

To strengthen monitoring, evaluation and planning the monitoring/evaluation plan for the national strategy will be used as a framework for developing a common curriculum and tools across implementing agencies.

Based on the shared curriculum developed, training will be provided to staff.

5.4 Strategic Information

Program Objective 4: Strengthen monitoring and evaluation and strategic information systems and research for an evidence based response

A key principle of the Bangladesh HIV National Strategy is that decision making should be evidence based. An entire system for strategic information needs to be put in place and information gathered, analysed and disseminated in a systematic manner so that:

- Interventions can be targeted geographically
- Populations most affected identified and described (size estimations)
- Disease outbreaks identified;
- Changes in risk behaviours identified
- Contributing factors identified and monitored (e.g. knowledge, attitudes, structural factors)
- Relevant cultural practices addressed (e.g. use of traditional healers)
- Health service usage monitored
- Programs can be evaluated
- Service delivery models and specific interventions can be evaluated, revised and scaled up

To address these needs a comprehensive program of strategic information will be implemented in the following areas:

- Serological and Behavioural Surveillance for HIV
- Ad hoc surveys such as RSRA
- AIDS case reporting
- STI surveillance
- Relevant Research
- Monitoring and Evaluation

Knowledge Management systems will be implemented to ensure that the outputs of strategic information are disseminated in a timely manner in formats that can be used to monitor, evaluate and revise strategy implementation.

Strategy 4.1 Conduct comprehensive surveillance to strengthen capacity to respond

Serological Surveillance

Serological surveillance for HIV and active syphilis will occur in MARPS through the existing system of sampling through NGOs as well as probability sampling in selected sites. For PWID hepatitis C will also be measured. Behavioural surveillance systems will be continued as before through probability sampling. These locations for both serological and behavioural surveillance will be selected according to epidemiological criteria, including size of the group and risk profile. Trends will be

tracked in a way that is reliable and easy to interpret. In places where probability sampling is recommended for both serological and behavioural surveillance, these can be integrated into one survey. In general existing data from different sources in the country will be triangulated to decide which population groups and geographical areas are to be covered by surveillance and where only serological surveillance and/or behavioural surveillance will be conducted or IBBS. Such an exercise will be undertaken by a small technical group.

In accordance with internationally accepted guidelines, the proposed frequency for data collection will be a two-year cycle for the entire system with annual sero-surveillance in selected sites that are considered highly vulnerable or risky.

Behavioural Surveillance

Behavioural surveillance will be conducted as a basis for monitoring and evaluating the achievement of strategic outcomes. Behavioural research will also be designed to better understand knowledge, attitudes and other factors contributing to behaviour. This will assist in program design and revision.

HIV case reporting

Enhanced reporting of HIV will assist in identifying unanticipated patterns of HIV infection and monitoring overall demographic trends. Minimum data to be collected will include sex, age, area of residency, occupational and risk status. To protect confidentiality but minimise duplication, unique identifying codes will be used. Policy and systems for HIV reporting will be developed.

STI surveillance

The routine collection, analysis and reporting of STIs should be strengthened. This will entail identifying sentinel sites (e.g. NGO clinics, government run STI services) in key locations, and clearly defining algorithms for reporting STI syndromes over time. Routine STI monitoring facilitates the detection of unusual increases or spikes in the incidence of different types of STIs, which is helpful for triggering further investigation, potentially in places/populations with previously unidentified risk.

Strategy 4.2 Conduct relevant research to inform the national strategic response

Research will be conducted, utilising a range of research methodologies from different disciplines to develop a deeper understanding of the epidemic in Bangladesh.

National size estimations/revisions will be undertaken at the commencement, mid-point and end point of the national strategic plan.

Studies on emerging needs

In order to make an informed decision not only for the selection of population groups for surveillance but also for better interventions, information from other sources will be required. For example, more information on volume of clients for FSWs from the RSRA and other sources, on migration/population movement in and out of districts near the border, including information on whether the migration is to/from high prevalence areas, Population rates of migration for males and females in key migration source districts, information on drug trafficking routes for IDUs, etc.,

Serological survey focussing ANC sites in selected districts

Periodic serological survey (for HIV and syphilis) will occur at selected ante-natal clinics and STI services in districts where most PLHIV lives. Ante-natal clinics will provide access to a population group (pregnant women) that serve as a proxy for the wider population. STI clinics provide access to a cross section of the population (married and un married) that are sexually active. Sites will be selected on the basis of the purpose of surveillance (e.g. indication of general population prevalence or investigation of suspected higher vulnerability).

Treatment Observational Database

A treatment observational database will be established (if deemed feasible through piloting) to monitor HIV treatment provision. All doctors who are the primary medical service providers for PLHIV will be encouraged to include their patients (with consent) on the database. Patients will be given a unique identifying code to protect confidentiality. The purpose of the database is as follows:

- To provide information that can be used for monitoring and evaluation indicators
- To provide information relevant to program planning (e.g. emergence of drug resistance, adherence to treatment)
-

Strategy 4.3 Strengthen monitoring and evaluation of the National HIV Strategic Plan

Monitoring and evaluation will be used to inform program management and assess the impact of the strategy. The performance framework of this strategy will be used in revising the existing national monitoring and evaluation framework. The strategy itself will have a comprehensive mid- term review and end term evaluation. It is urgent that serological and behavioural surveillance be conducted in 2011 to provide baselines for indicators (as well as provide any relevant information on changes since 2007).

All information collected annually will be synthesised for inclusion in the annual report to NAC. Key variations in performance in targeted outcomes and outputs and any assessment of the cause of variation will be reported.

To strengthen priority setting and coordination of strategic information a monitoring/evaluation unit will be established. The M&E unit will begin with minimum staffing and operational system and gradually grow over a five-year period to a level where it is capable of meeting a wide range of country information needs.

The suggested staffing structure of the M&E unit will have one senior expert for providing technical leadership for coordinating the M&E activities. The unit will be supported by one data management Officer, One M&E specialist, one research officer, and two data entry/computer operator for the compilation, report preparations.

The unit will also develop a HIV Management information system which will be harmonised with the management information system of the Ministry of Health and Family Welfare.

A monitoring/evaluation technical working group will advise NASP on all aspects of strategic information. It will be composed of M&E experts from government, UN agencies, Development partners and Key HIV/AIDS NGOs, academic and research experts. The TWG will meet quarterly

All components of strategic information, will contribute to monitoring/evaluation. The monitoring/evaluation framework will inform specific needs to be addressed in other components of the strategy.

National guidelines and tools will be standardised to ensure quality of all data collected for monitoring/evaluation purposes. A management information system (MIS) database will be maintained containing all information collected to meet indicators of the M/E framework.

Strategy 4.4 Improve systems for knowledge management

Ensuring that strategic information is well used requires:

- A systematic approach to priority setting and synthesis of information gathered
- Accessibility and timeliness in information dissemination

. A technical working group will have the following functions:

- Oversight of all activities implemented under strategic information strategies and preparation of external reports (e.g. UNGASS)
- Development of an annual research agenda which will be the basis of discretionary fund allocation (e.g. surveys of non MARP populations; other research)
- Support for annual synthesis and triangulation of data collected through different sources
- Assistance in preparation of annual report on implementation of the National Strategic Plan for presentation to NAC and the national congress

Accessibility and timeliness in research dissemination will be facilitated by:

- A key indicator to be included in the M/E framework for all research including surveillance will be publication and dissemination of report within 6 months of final data collection
- Use of electronic and web based systems
- All reports will be published on national HIV website
- Development of an inventory of all relevant resources (published and unpublished). Inclusion on the national HIV website and linked with other web based depositories (e.g.HIV website as developed by UNAIDS Bangladesh through Independent University of Bangladesh)

6.0 Results Based Framework

Goal	By 2015, minimise the spread of HIV and minimize the impact of AIDS on the individual, family, community, and society					
Objective	1: Implement services to prevent new HIV infections ensuring universal access					
	Indicator	MoV	Role / Responsibilities	Baseline 2010 ²⁶	Midline 2013	End line 2015
Impact						
HIV Prevalence minimised ²⁷	Percentage of most at-risk populations who are HIV infected ^{28,29}	National HIV serological surveillance		Male PWID 1.6% Female PWID 1% FSW 0.3% MSM 0.1% MSW 0.3% Hijra 0.3%	< 5% For all groups	< 5% For all groups
	Percentage of infants born to HIV infected mothers who are infected	Treatment Observational database ³⁰			< 10% ³¹	<2%

²⁶ : Government. of Bangladesh. *National HIV Serological Surveillance, 8th Round Technical Report*, Bangladesh. Dhaka: National AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh.

²⁷ Age and sex segregation will be reported. Currently age data for those under age 18 cannot be collected due to legal restrictions. Advocacy to adopt policy to allow collection of data will occur. At baseline only data for those over age of 18 will be collected.

Prevalence is being used as a proxy for incidence. It is recognised in a low prevalence country that prevalence may increase due to factors external to the program. Therefore the target is to maintain prevalence at less than 5% (definition of concentrated epidemic) for PWID, sex workers, MSM and Hijra.

²⁸ Where indicators are the same as indicators used for reporting for UNGASS, terminology used is that of UNGASS

²⁹ Prevalence is being used as an indicator of incidence. Currently incidence data is not collected. Transmission dynamics (e.g. HIV acquired overseas) even with reduction in risk behaviour may result in increased prevalence. End line target is to maintain prevalence below concentrated epidemic.

³⁰ The new HIV strategic Plan proposes the establishment of a treatment observational database in Bangladesh. The data base will include data on provision and cessation of treatment, illness progression, and a range of other information. The data base will be a tool for coordination of treatment and care as well as strategic information (operational research and monitoring/evaluation).

³¹ The percentage of infants born to HIV infected mothers who are infected if no intervention occurs is 15-30% (see World Health Organisation (WHO). *ANTIRETROVIRAL DRUGS FOR TREATING PREGNANT WOMEN AND PREVENTING HIV INFECTION IN INFANTS Recommendations for a public health approach 2010 version*).

STI incidence minimised ³²	Prevalence among all most at risk populations (for adults and young people)	National HIV serological surveillance		Male PWID 2.2% Female PWID 14.6% FSW 4.3% MSW 3% Hijra 7.7%	Male PWID: 2% Female PWID: <10% FSW < 3% MSW: <3% Hijra : <5%	Male PWID: <1% Female PWID: <5% FSW: <2% MSW: <2% Hijra <4%
	Prevalence among emerging risk and higher vulnerability populations			Heroin smokers (Dhaka) 4.2%		
Outcomes						
Reduced risk behaviour among MARPs	Percentage of female sex workers reporting the use of a condom with their most recent client ³³	BSS		Female 66.7	Female 75%	Female 80%
	Percentage of male sex workers ³⁴ and <i>hijra</i> reporting the use of a condom the last time they had anal sex with male partners	RCC Baseline 2010, ICDDR B		Hijra 17.5%	Hijra 30%	Hijra >40%
	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner in the last six months	BSS		Paid Sex 29.5% Non paid sex 22.5%	Paid sex 40% Unpaid sex 35%	Paid sex >50% Unpaid sex >45%
	Percentage of PWID reporting use of new needle/syringe last time they injected	BSS		Male 33.6% ³⁵	Male 45%	Male 50%
Reduction of risk behaviour in general population	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12	Survey		Males 35% ³⁷	Males 60%	Males >60%

³²Age and sex segregation will be reported. Currently age data for those under age 18 cannot be collected due to legal restrictions. Advocacy to adopt policy to allow collection of data will occur. At baseline only data for those over age of 18 will be collected.

³³UNGASS report

³⁴Baseline to be collected in next BSS

³⁵UNGASS 2008

	months who report the use of a condom during their last intercourse ³⁶					
Outputs						
Provision of services for MARPs Number and % of MARPs reached with services (BCC, condom /BCC,NSE) in past year PWID FSW MSW MSM Hijra	Number and % of MARPs reached with services (BCC, condoms/BCC, NSE) in past year. PWID FSW MSW MSM Hijra	BSS Program data		FSW: 56.9 MSW: 46.6 PWID: 81.8 MSM: 12.7 (UNGASS 2008) Hijra:29.8 (RCC Baseline 2010, ICDDR)	60% 50% 85% 35% 40%	80% 65% 85% 40% 60%
	Number and % of MARPs covered on a regular basis by services ³⁸	Program monitoring reports				
	Percentage of most at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	BSS		FSW 30.8% MSW 29.6% Hijra 27.2% MSM 27.3% PWID 20.2%	>50% >50% >40% >50% >50%	80% 80% 80% 70% >70%
Provision of services for emerging vulnerable populations	Percentage of emerging vulnerable populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	BSS		Heroin smokers 19.4% Rickshaw pullers 12.1% Truckers 7.7%		

³⁷Source: Assessment of Sexual behaviour of men in Bangladesh FHI/ICDDR 2006

³⁶Baseline for females will be set in next survey. Targets to be determined

³⁸Standard service definitions will be developed. These will include regular coverage, but will differ between groups.

	number of international migrants received pre-departure orientation				250,000	500,000
	% of international migrants receive counselling along with HIV testing and record kept properly					
Provision of services for general population, young people and newly identified higher vulnerability groups	% of more vulnerable populations reached through interventions			Nil	3	3
	Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year ³⁹	Survey		0.14%		
	Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission			Males 22.4% Females 13.4% All 17.7%	Males 60% Females 45%	Males 65% Females 55%
Provision of prevention services in health care settings	Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	Treatment ⁴⁰ Observational data base				

³⁹ Baseline; Numerator: Number of schools providing life skills based education reported by UNICEF in 2009; Denominator: number of secondary schools in Bangladesh

⁴⁰ The new HIV strategic Plan proposes the establishment of a treatment observational database in Bangladesh. The data base will include data on provision and cessation of treatment, illness progression, and a range of other information. The data base will be a tool for coordination of treatment and care as well as strategic information (operational research and monitoring/evaluation).

Goal	By 2015, minimise the spread of HIV and minimize the impact of AIDS on the individual, family, community, and society					
Objective	2. Provide universal access to treatment, care and support services for people infected and affected by HIV					
	Indicator	MoV	Role / Responsibilities	Baseline 2010	Midline 2013	End line 2015
Impact						
Morbidity and mortality among PLHIV is reduced (diagnosis, treatment, monitoring, care/support)	Post infection life span increased	Treatment operational database				
Reduced number of infants born with HIV infection	Percentage of infants born to HIV infected mothers who are infected	Treatment operational database				
Outcome						
People living with HIV receive OI prophylaxis, treatment and other non-ART clinical care according to their need	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Treatment operational database		90.1% ⁴¹	90%	90%
People living with HIV eligible for ART receive it	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy ⁴²	Treatment operational database			90%	90%
Outputs						
Services provided for the medical management of people with HIV in government, non-government and private sectors, on a shared care basis	Number of locations from which HIV ART is available	Treatment operational database				
	Number of specialist ⁴³ HIV services	Treatment operational database		0		
Systems established for ongoing policy development/revision and capacity	Number of service providers accredited to prescribe ART	Treatment operational				

⁴¹Baseline 2008.Reports from HIV ART service providers

⁴² Treatment observational database will be developed under strategic research. Baseline to be developed.

⁴³A specialist service is one that is recognised by the NASP as (1) able to provide diagnosis and treatment in context of existing treatment failure, as well as provides treatment support for other treatment providers (2) and/or provides treatment requiring HIV content knowledge in another discipline (e.g. dentistry, paediatric). Targets to be set upon advice from treatment advisory committee for treatment, care and support unit of NASP

development. and adoption of national tripartite HIV workplace policy and development of legislations to ensure non-discrimination in employment		database				
	Annual review of policies and protocols conducted	Annual report ⁴⁴			1	1
Comprehensive approach to care and support is adopted	Number of district in which care and support services are mapped	Annual report			45	64

⁴⁴Unless otherwise stated information required for annual report will be from routine reporting from implementing agencies

Goal	By 2015, minimise the spread of HIV and minimize the impact of AIDS on the individual, family, community, and society
Objective	3.Strengthen the coordination mechanism and management capacity at different levels to ensure effective national multi-sector HIV/AIDS response

Outputs						
Strengthened NAC and NAC-TC	NAC meeting conducted annually	Annual report			1	1
	Annual performance report produced	Annual report			1	1
	Meetings of NAC-TC conducted quarterly	Annual report			3	4
Strengthened NASP	Senior technical advisers appointed	Annual report				
	Sub units established	Annual report			4	4
	Senior adviser on institutional development appointed	Annual report			1	1
Forums conducted	The number of people attending the annual national HIV Congress The number of districts conducting at least four planning and coordination meetings in a year	Attendance sheet			Congress Districts 35	Congress Districts 54
Advocacy activities implemented	Number of policymakers and other stakeholders reached through sensitization and coordination workshops on HIV and AIDS ⁴⁵	Annual report		800 ⁴⁶	8590	11610
Activities and plans developed and implemented in key sectors	Number of Ministries with a HIV plan	Annual Report			7	7
	Ministry of Home Affairs has a HIV strategy	Annual report			1	1
Strengthened human resource capacity across the HIV sector	Functional analysis of roles and necessary competencies to implement the National Strategic Plan is produced	Annual report			1	1
	A training plan based on the functional analysis is developed and implemented	Annual report			1	1
	Core curriculum, teaching aides and assessment tools are developed for key service delivery and management roles	Annual report				
Health system response to	Percentage of donated blood units screened for HIV in a	SBTP report	S BTP	100%	100%	100%

⁴⁵Included in GFATM RCC Round 9 Performance Framework

⁴⁶Report GFATM Round 2, Phase 2. As at December 2008

HIV is strengthened	quality assured manner ⁴⁷					
	Specific HIV content designed and integrated into mainstream capacity development	Annual report				
	Number of occasions that stock outs of essential drugs and commodities reported (reported separately for ARVs, Needles/syringes, condoms)	Annual report				
	Number of PLHIV receiving CD4 counts in accordance with treatment protocols	Treatment observational database				
	% of PLHIV requiring treatment interventions from non HIV specific services receiving them	Treatment observational database			60%	80%
Community system response to HIV is strengthened	Number of CBOs/Self-help groups for MARPs capacitated to actively take part in planning, budgeting, monitoring and evaluation of HIV related activities. ⁴⁸	Annual report			60	60
	% of services reporting involvement of local gatekeepers acting as public advocates for services	Annual report			25%	50%
	Number and percentage of community based organisations that deliver services for prevention, care or treatment and that have a functional referral and feedback system in place ⁴⁹	Annual report			50%	80%
	Number and percentage of staff members and volunteers currently working for community based organisations that have worked for the organisation for more than 1 year ⁵⁰	Annual report			65%	75%
	Number and percentage of community based organisations that submit timely, complete and accurate financial reports to the nationally designated entity according to nationally recommended standards and guidelines ⁵¹	Annual report			80%	90%

⁴⁷Reported for only 116 SBTP centres(including Red crescent)Source: Health Bulletin DGHS, 2009

⁴⁸Performance indicator in GFATM Round 9 RCC performance framework

⁴⁹Indicator from: The Global Fund to Fight AIDS, Tuberculosis and Malaria. *Community Systems Strengthening Framework* .May 2010

⁵⁰Ibid

⁵¹Ibid

Goal	By 2015, minimise the spread of HIV and minimize the impact of AIDS on the individual, family, community, and society					
Objective	4. Strengthen the strategic information systems and research for an evidence based response.					
Outputs						
Comprehensive surveillance conducted	Serological and biannual behavioural surveys of MARPs conducted	Annual report		Serological Behavioural	Serological 5 Behavioural 3	Serological 5 Behavioural 3
	Periodic behavioural surveys of emerging vulnerable populations conducted	Annual report			2	2
Relevant research conducted	Annual research plan developed	Annual report			1	1
	Annual budget allocation for social and operational research	Annual report			1	1
1Monitoring and evaluation strengthened	Monitoring and evaluation plan produced	Annual report			1	1
	% of known PLHIV included on treatment observational database	Annual report			60%	75%
Knowledge management improved	Number of times per year strategic information subcommittee of NAC-TC established and meets	Annual report			4	4
	Number of times per year HIV web based site for dissemination of HIV strategic information is updated	Annual report			4	4
	% of commissioned research reports published within six months of final data collection	Annual report			75%	85%

National Steering Committee of the National Strategic Plan

Chairperson:

Line Director, National AIDS/STD Programme

Member Secretary:

Programme Manager, NASP

Member:

1. Director, IEDCR
2. Director Health MIS, DGHS
3. Director, Department of Narcotic Control
4. Representative, Ministry of Expatriate Welfare and Oversees Employment
5. Dr. Salil Panakadan, Country Coordinator, UNAIDS
6. Misti Mc Dowel Country Director, FHI
7. Dr. Tasnim Azim, Head, HIV/AIDS Programme, ICDDR'B
8. Dr. Nizam Uddin Ahmed, Director, HIV Sector & South Asia HIV Programme Advisor, Save the Children, USA
9. Bridget Job Johnson, HIV Specialist, UNICEF
10. Assistant Country Representative, UNFPA
11. Representative, DFID
12. Representative, World Bank
13. Representative, PLHA
14. Representative, STI/AIDS Network
15. Representative, WHO
16. Representative, GTZ
17. Representative, JICA

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