Government of the People's Republic of Bangladesh

Operational Plan

NATIONAL AIDS/STD PROGRAMME (NASP)

July 2011 - June 2016

Health, Population and Nutrition Sector Development Program
(HPNSDP)

Directorate General of Health Services

Ministry of Health and Family Welfare
July 2011

INDEX

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-Behavioural 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

OPERATIONAL PLAN

1. Name of the Operational Plan (OP):
National AIDS/STD Program (NASP)

2. Name of the Sector Programme:
Health, Population and Nutrition Sector Development Program (HPNSDP)

3. Name of the sponsoring ministry:
Ministry of Health and Family Welfare (MOHFW)

4. Name of the Implementing Agency:
Directorate General of Health Services (DGHS)

5. Implementation period:
Commencement: July 2011
Completion: June 2016

6. Objectives of the OP:

General Objective: To halt and reverse the spread of HIV and minimize the impact of AIDS on the individual, family, community and society.

Specific objectives:

1. To implement services to prevent new HIV infections;
2. To provide universal access to treatment, care and support services for people infected and affected by HIV
3. To strengthen the coordination mechanisms and management capacity at different levels to ensure an effective multi-sector HIV response; and
4. To strengthen the strategic information systems and research for an evidence based response.

7. Cost estimate of the OP

7.1 PIP and OP cost

(Taka in lakh)

	Total	**GoB**	**PA (RPA)**	**Source of PA**
Approved cost of the PIP (Development Budget)	2217666.21	860350.12	1357316.00	Pooled, WHO, USAID, GFATM, UNAIDS, UNICEF, UNFPA.
Estimated cost of the OP	27291.90	1300.00	2599.00	GFATM, UNAIDS, UNICEF, UNFPA.
Cost of OP as % of PIP	1.23%	0.151%	0.191%	

7.2 Estimated Cost of OP (According to Financing Pattern)

(Taka in lakh)

Source	Financing Pattern	2011-12	2012-13	2013-14	2014-15 & 2015-16	Total	Source of fund
GoB	GoB Taka	160.00	160.00	160.00	320.00	800.00	GOB
	(Foreign Exchange)						
	CD-VAT	100.00	100.00	100.00	200.00	500.00	
	GoB Others (e.g. JDCF)	00	00	00	00 00	00	
	Total GoB	260.00	260.00	260.00	520.00	1300.00	
PA	RPA (Through GoB)	3858.20	4649.20	4589.20	7508.4	20605.00	Pooled fund.
	RPA (Others)						
	DPA	1032.98	1032.98	1032.98	2287.96	5386.90	WHO, USAID, GFATM, UNAIDS, UNICEF.
	Total PA	4891.18	5682.18	5622.18	9796.36	25991.90	
Grand Total		5151.18	5942.18	5882.18	10316.36	**27291.90**	

8. OP Management Structure and Operational Plan Components

(Attached organogram as Annexure – 1)

8.1 Line Director:

A Director from DGHS will be recruited as LD for this OP on OSD basis. He would provide the strategic and programmatic direction and oversee the implementation of OP.

8.2 Major Components of OP and their Program Managers /DPM:

Major Components	Program Manager	DPM
Component 1: Strengthen the management capacity of NASP for national program management	DD , DGHS (OSD)	DPM (Management)
Component 2: Increasing the scale and quality of targeted interventions for vulnerable population		DPM (Prevention, Care and Support)
Component 3: Achieve universal treatment, care and support for people with HIV		DPM (Prevention, Care and Support)
Component 4: Develop and implement one unified national monitoring and evaluation plan, including surveillance		DPM (M&E)

Component 5***:*** *Ensures NASP procurement, logistics and finance (new position proposed)*		DPM (Logistics & Finance)

There will be four Deputy Program Manager (Assistant Director Level on OSD) to ensure the component focused implementation. One Program Manager (Deputy Director) will be responsible for overall program implementation and management.

8.3 Proposed manpower in the development budget:

(Taka in Lakh)

Sl.No.	Name of the post	Number of post	Pay scale	Grade	Consolidated pay per person/month	Total month	Total Pay (Taka in lakh)
	A. Officer						
	B. Staff						

9. Description

a) Background information, current situation and its relevance to National Policies, Sectoral policy, MDG, Vision 2021, Sixth five year plan, MTBF etc.

Background information and current situation:

HIV prevalence in Bangladesh is currently low, with a prevalence of less than 0.1% of the reproductive age population in 2007. In high risk groups the prevalence is still quite low except for injecting drug users (IDU) where an epidemic is emerging. The prevalence is below 1 percent amongst female and male sex workers (FSW and MSW), men who have sex with men (MSM) and transgenders (h*ijra*) and just above 1 percent amongst (IDU)[1] except for one neighbourhood in Dhaka where it has reached 11%.

In Bangladesh the main routes of transmission are believed to be through hetero-sexual unprotected sex, sharing of used needles and syringes by IDU, and unprotected sex among MSM. HIV prevalence has

In Asia, an estimated 4.7 million [3.8 million–5.5 million] people were living with HIV in 2008.
The number of new HIV infections decreased from 400 000 in 2001 [310 000–480 000] to 350 000 [270 000–410 000] in 2008.

In 2008, an estimated 330 000 [260 000–400 000] people died of AIDS-related illnesses. While the annual number of deaths in South and South-East Asia in 2008 was approximately 12% lower than the mortality peak in 2004, the rate of HIV-related mortality in East Asia continues to increase.

Asia, home to 60% of the world's population, is second only to sub-Saharan Africa in terms of people living with HIV. **India** accounts for roughly half of Asia's HIV prevalence.

With the exception of **Thailand**, every country in Asia has an adult HIV prevalence of less than 1%.

While the regional epidemic appears to be stable overall, HIV prevalence is increasing in some parts of the region, such as **Bangladesh** and **Pakistan.**
In certain states in **India** (Andhra Pradesh, Karnataka, Maharashtra and Tamil Nadu), HIV prevalence among 15–24-year-old women attending antenatal clinics declined by 54% between 2000 and 2007.

The proportion of women living with HIV in the region rose from 19% in 2000 to 35% in 2008. In **India**, women accounted for an estimated 39% of prevalence in 2007.

UNAIDS Fact Sheet. Asia: 2009

[1] *20 Years of HIV in Bangladesh: Experiences and Way Forward*, World Bank and UNAIDS, December 2009

started to increase among IDU in Dhaka, pointing to emerging hotspots. International returning migrant workers are another emerging 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[1].

There are several possible reasons for the low prevalence: high levels of circumcision among men and the early and sustained implementation of HIV program targeted to the most at risk populations (MARP), informed by data from regular surveillance and behavioural surveys. A high sex community, low levels of condom use, increasing injecting drug use, and rising HIV prevalence levels among IDU are some of the risk factors associated with spread of HIV. Data from the 7th serological surveillance survey shows that the HIV rate has crossed the concentrated epidemic among IDU in central region of Bangladesh. Rates in this region rose from 1.4% to 7% since 1999, up to as high as 10.8% in one neighbourhood of Dhaka. Hepatitis C prevalence among IDU reached 83%, indicating that needle sharing is common. Data also show that 44 percent of female IDU are also sex workers.

The number of reported HIV diagnoses was 2088 as of 2010. Many are migrant workers who were screened before or during employment. The total number of people with HIV, estimated by NASP, is 7,500. Less than 500 people are currently receiving anti-retroviral therapy (ART) provided by non-governmental organizations (NGO). At present, there are no Government ART service providers while provision of diagnostic services and in-patient facilities are very limited.

Youth aged 15-24 years are approximately one-fifth of the total population of Bangladesh. Although their estimated HIV prevalence is negligible, a national survey of 11,188 youth conducted in 2008[2] showed that young people are at risk of contracting sexually transmitted infections (STI) and HIV because of their lack of knowledge and awareness regarding HIV, their risky sexual behaviour and their limited access to sexual and reproductive health information and services.

Policy response analysis

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 Directorate General of Health Services (DGHS) of 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 National Strategic Plan for HIV/AIDS (2011-2015) will guide the national response for HIV under HPNSDP. 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 AIDS Committee (NAC) is a multi-sectoral body, chaired by the Minister for Health and Family Welfare, mandated to govern the national response. Three technical sub-committees support the NAC. A state of the art surveillance system has been in place since 1998. Eight serological and five behavioural surveillance surveys have provided critical guidance to better target the populations at risk and make the interventions more effective. No surveillance, however, was done between 2007 and 2010.

Between 2005 and 2009, the main interventions for HIV prevention were funded by three main financing streams – GFATM (rounds 2 and 6), USAID's Bangladesh AIDS Program, and HIV/AIDS

[2] NASP, Save the Children USA, & ICDDRB, 2009 (forthcoming)

Targeted Interventions under MOHFW's Health, Nutrition and Population Sector Program (HNPSP). These interventions primarily focused on prevention services, implemented mainly by NGO, targeted at the MARP such as IDU, MSM, MSW, transgender, internal migrants, FSW and their clients. The intervention package included distribution of condoms (and lubricants), distribution of clean needle and syringe (for IDU), voluntary counselling and testing, and behaviour change and communication. GFATM funds ART for HIV positive people through NGO.

Past Achievements:

(Programmatic Response 2003 – 2011)

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 Hijra[3]);
- Advocacy and communication
- Blood safety
- 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 (HNPSP).
HATI focused 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.

[3]Hijra refers to male to female transgender people

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 were to

- Increase and sustain use of high impact HIV prevention
- Care and treatment information and services by MARPs through high 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 Youth and Adolescent in Bangladesh, 2004-2009
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 to young people through mass and print media
- Provision of HIV/AIDS orientation, training and services to young people via Life skills Education
- Youth Friendly Health Services and
- Condom Accessibility,
- Integrating HIV/AIDS prevention information into Secondary and Higher secondary Curriculum, advocacy and sensitization of Religious leaders, Community leaders, Parents and Policy makers on HIV/AIDS and
- Implementation of baseline, in-depth studies, rapid assessment.

Save the Children USA worked as management agency and 17 NGOs implemented the activities across the country.

GFATM Round 6: This included

- Scaling up of essential service package (ESP) for female sex workers and PWID
- Expansion of services for garments worker and
- Scaling of services under Round 2 programme.

A total of 38 NGOs/CBO and academic organizations through 8 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) 2010-2016: In 2009 Bangladesh received approval for GFATM RCC R2 proposal. The proposal was 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 total budget is US$ 71 million. Government of Bangladesh, Save the Children USA and ICDDRB are nominated as PRs.

Description of OP Components:

Target populations under prevention are categorized as:

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

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

- Condom/lubricant provision
- Behaviour change communication
- STI diagnosis and treatment
- VCT
- PPTCT (for sex workers and female IDU)
- Assessment of need and referral to health (e.g. TB, hepatitis B and C) and other services (e.g. legal services)
- Community mobilisation[4]

Additional harm reduction interventions for IDU will include:

- Needle and syringe distribution
- Injecting related primary health care
- OST[5] : (Scaling up opioid substitution therapy)

With financing from UNODC, ICDDR,B is currently piloting a one-year OST program which will end in June 2011. Under the pilot, 300 IDU are covered for methadone substitution. Methadone is being imported for this purpose with necessary clearances from the Department of Narcotics Control (DNC). Based on the lessons learnt from this pilot, OST will be scaled up gradually to cover at least 40% of all IDU under HPNSDP. GFATM has provisions for covering 500 IDU for OST. The rest will be covered by HPNSDP. NASP will coordinate across the financing streams to make the OST scale up effective and use the technical expertise of UNODC in this respect.

Emerging risk and higher vulnerable populations: Other emerging vulnerable populations (International migrant workers, Especially Vulnerable Adolescents [6](particularly institutionalised and street based), Heroin smokers, Transport workers, Prisoners) have been identified in the national strategic plan based on evidence in Bangladesh of higher rates of HIV infection and/or particular vulnerability contexts. Specifically targeted interventions will be outlined for these populations where there is evidence of effectiveness. To strengthen evidence on which to scale up interventions, it is

[4]Social 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.

[5]Detoxification where it is part of the initiation of OST, will be provided

[6]The 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.

proposed to pilot and evaluate additional interventions. Those interventions which are most effective will be scaled up.

General and Young population: A basic service package will be 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. Additional interventions for young people include life-skills education and strengthening the provision of youth friendly health services

People infected and affected by HIV:
Provide universal access to treatment, care and support services for people infected and affected by HIV. ART will be provided through public health system.

Service Modalities
Services will be provided from one stop service centre (Drop in centre (DIC) and Specific outreach services will be provided for each MARPs population group. Drop in Centres will be located in areas where the MARPs have easy access. Drop In centres will be used for more intensive interventions (group based peer education, STI diagnosis/treatment, community education, VCT etc) 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.
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.

Field level program implementation: NASP will contract out the services to the NGOs for providing the targeted intervention.

NGO implementing these packages will maintain close collaboration with the field staff of the National Tuberculosis Program (NTP) to ensure that the MARP are tested and treated for TB and there is regular follow-up. Program Manager of NASP will liaise with the Program Manager of NTP to ensure that this is facilitated at the field level. Co-infection with TB is high among PLHIV in Bangladesh. In 2008 there were estimated to be 324 new TB cases among PLHIV[7]. The successful application for round 10 Global Fund for Tuberculosis includes activities for strengthening of coordination between NTP and NASP through continuing 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 carry out surveillance to monitor the trends of TB/HIV burden[8].

[7]Country Coordinating Mechanism (CCM*), Bangladesh. Round 10 Tuberculosis Proposal.* July 2008. P9
[8]Ibid. p3

NGO coordination: NSAP will take the lead role to coordinate the implementation by the NGOs. Quarterly NGO coordination meeting in presence of NASP and other DPs will take place to exchange the learning sharing by the implementing agencies.

Role of Development Partners in HIV programming:

UN Agencies:
UNFPA: UNFPA is supporting in implementing HIV program in two brothels (one in Tangail and another in Mymensingh) out of eleven and will continue till 2015.
UNODC: UNODC is supporting the pilot study on OST implemented by ICCDRB at central treatment centre of Department of Narcotics Control (DNC)
UNICEF: UNICEF is supporting to develop the strategy of Most at risk adolescent, mapping MARA.

WHO:
WHO is supporting NSAP in finalising the national ART guideline for ART.

USAID:
USAID's HIV/AIDS program aims to keep HIV prevalence below 5% in the high-risk population and below 1% in the general population. USAID's HIV program, named Modhumita HIV Prevention Program, works in collaboration with the National AIDS and STD Program (NASP) to assist the NGOs that are engaged in delivering high impact HIV prevention services (targeted service delivery) for the high risk population which includes female and male sex workers, men-sex-with men groups, transgender, injecting drug users, clients of sex workers and returning migrants, and people living with HIV/AIDS. The Program also assists the NASP in strengthening government's leadership role in responding to national HIV situation.

Working through 20 local non-government organizations and 50 HIV service sites, USAID will reach 430,745 high-risk people with messages on HIV prevention, treat sexually transmitted infections for 14,404 individuals at high risk, and provide voluntary counseling and testing services to 22,100 individuals at high risk annually. USAID will also support distribution of 16,000,000 condoms to high-risk groups and educational outreach to 1.2 million people annually. Every year, USG will provide detoxification services to over 1000 IDUs and provide them education on HIV prevention and job skills training. USAID will also work with returning migrants and provide them with HIV prevention services including voluntary HIV testing and counseling services. HIV awareness and stigma reduction messages are also delivered through media and religious leaders. USAID support covers about 25% of the high risk population in high risk areas across the country.

USAID will use its resources to strengthen the capacity of the national program to ensure services for the high risk population and execute their stewardship in HIV prevention services. USAID's HIV Prevention program will be working closely with the National AIDS and STD Program (NASP) to build their capacity in curriculum development and training, management of information system, data audits, procurement of goods and services, supervision of implementing partners, coordination, monitoring and evaluation and revising national guidelines and manuals.

USAID will continue to provide support for the development of the National HIV/AIDS Strategic Plan and the National Stigma Reduction Tool Kit that will be finalized during 2011. USG program will focus on family planning integration in VCT in all USAID supported VCT centers. USAID will also initiate satellite VCT services to target sex workers and IDUs; an estimated 4,000 clients will be reached annually through satellite VCT.

GFATM:
Mentioned earlier under Past achievements that GF is supporting national HIV program through round 2, round 6 and RCC. NASP, Save the Children USA and ICDDR,B are the principal recipients (PRs) of RCC.

10 Priority activities of the OP:

- Technical Assistance for Program and financial management, procurement, contract management, monitoring and evaluation, operation research, etc.
- Advocacy at different level
- Voluntary Counseling and Testing (VCT)
- Distribution of clean needle and syringe
- Opioid Substitution Therapy (OST)
- Behaviour Change Communication (BCC)
- Diagnosis and treatment of Sexually Transmitted Infection (STi)
- PMTCT and couple based program
- Procurement of ARV
- Registration of all HIV positive patient with NASP to ensure that all those who are eligible are on ART
- Conduct serological surveillance and behavioural surveillance survey in every other year
- Monitoring and evaluation of program implementation and track the indicators regularly
- A National AIDS MIS that is currently being piloted will be maintained
- Supervision of the NGO services adequately and carry out performance evaluation of the NGOs by developing implementation guideline

11 Relevant Result Frame Work Indicators (RFW) and OP level Indicators:

11.1 Relevant RFW indicators

The activities under this OP contribute to ensuring the quality and equitable health care for all citizens of Bangladesh. More specifically, the activities under this OP contribute to the achievement of Result 1.1, increased utilization of essential HPN services, Result 1.2, improved equity in essential HPN service utilization and Result 1.3, improved awareness of healthy behavior.

Indicators	**Unit Measurement**	**Baseline (With year and data source)**	**Projected target (Mid 2016)**
Prevalence of HIV in MARP	Sero - Surveillance survey (SS) every two year	<1%, SS 2007	<1%

11.2: OP level indicators:

Sl	Indicators	Baseline with source	Projected target	
			Mid- 2014	Mid 2016
1	Prevalence of HIV among Injecting Drug Users	0.9% BSS	Sustained	Sustained
2	Prevalence of active syphilis among sex workers	BSS		
	Brothel based (female)	1.7 - 10.7,BSS	1.4 – 7.0	1.0 – 5.0
	Street based (female)	6.2 - 7.5, BSS	5.5 - 7.0	3.5 – 5.5
	Hotel based (male)	1.6 - 6.1, BSS	1.0 –4.5	0.5 – 3.0
3	Number of Medical personnel trained in HIV-	NA , NASP	500	800
4	Number of Health facilities with capacity to deliver care to HIV positive people	NA , NASP	40	60
5	Number of treatment of opportunistic infections.	NA , NASP	500	600
6	Number of eligible HIV+ on ART	510	700	800

11.3 Source and methodology of data collection to measure/preparation of annual progress report:

The following are the methodologies for collecting data for sector program during 2011-2016. However, national MIS on HIV/AIDS is currently under pilot phase which will be implemented throughout the HIV program on the basis of results of the pilot:

Methodology of data collection:

1) DIC level data collection: The outreach staff members collect data from field directly daily basis by set data collection formats. There are other data those are kept in the DIC also maintain. Then they compile the both data in set format in order to final submission to the Project Management Office/Lead NGO.

2) NGO Level: Project Management Office/Lead NGO collects all monthly basis data from all DICs for different services. They also collect data on various other project activities like advocacy, workshops etc.

3) Central level: NASP/Management agency collects data from different Implementing consortium/NGOs monthly and quarterly basis on the progress of implementation. NASP provided with the template for monitoring reports to the implementing agencies for this purpose. NASP is also planning in a way so that there is a uniform monitoring framework across all NGOs.

4) Internal Monitoring: In addition to the above, NGOs and DIC management conduct monitoring visit and collect data on various services. This will be both individual level and joint monitoring visit. This visit will be conducted according to Quarterly M&E plan.

5) External Monitoring: Other than internal monitoring by the implementing agencies, the NASP as well as by local MOHFW Offices supervise and monitor the activities of the DIC/ project activities at different field spot. They will also collect data in an irregular basis.
Source of data/record and maintenance:

The Service Provider will keep records of the location and identification of recipients of services and will make available to the recipients a list of services offered. They will also keep following registers and books which are sources of data for operation and maintenance of records at every DIC/Facility. However this is a suggestive list for the sector program which can be modified as per further need.

- Formats for data collection;
- Attendance Register;
- Movement Register of staff
- Inspection Book;
- Counselling Register
- STI management Register
- Patients Register
- Clients Register;
- Follow-up Register;
- Receipt and Issue Register;
- Stock Register of Furniture and Equipment;
- Register for Storage and Distribution of Medicines;
- Book of Accounts (journals, cash register and general ledger etc.); and
- Daily Diary.

21 Related Supporting Documents

a) National Strategic Plan
The 3rd National Strategic Plan (2011 – 2015) has been developed and already approved by the DG-Health which has been used as ready reference material to develop the OP.
b) NAC
ToR of National AIDS Committee (NAC) and list of members (updated)
c) TC-NAC
ToR of Technical Committee under NAC and list of members (updated)
d) TA Support
Number of National Consultant/Specialist required providing technical inputs to NASP in specific areas.

All the documents and TORs are annexed at VIII a, b, c and d.

22 Name and Designation of Officers responsible for the preparation of this OP:

a. Dr. Md. Abdul Waheed, Line Director, NASP, DGHS
b. Dr. S.M. Idris Ali, Programme Manager, National AIDS/STD Programme, NASP
c. Dr. Mahmud Hasan, Deputy Programme Manager, National AIDS/STD Programme, NASP
d. Dr. Sydur Rahman, Deputy Programme Manager National AIDS/STD Programme, NASP
e. Dr. Md. Anisur Rahman, Deputy Programme Manager National AIDS/STD Programme, NASP
f. Dr. Selina Ferdous, High Risk Intervention Specialist, NASP
g. Kazi Md. Obaidullah, Procurement Specialist, NASP
h. Md Jalal Uddin Khan, Accountant, NASP

23 Recommendation and signature of the Head of the Implementing Agency with seal & date:

Date……..Signature of the Head of the Executing Authority

24. Recommendation of the Signature of the Secretary of the sponsoring Ministry with seal & date:

Date……Signature of the Secretary of the Ministry of Health and Family Welfare