Country Progress Report: Bangladesh

COUNTRY PROGRESS REPORT
Bangladesh

Submission date: April 4, 2012

Table of Content

ACRONYMS

AAS	Ashar Alo Society
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Vaccine
BAP	Bangladesh AIDS Project
BBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic and Health Survey
BSS	Behavioural surveillance survey
BSWS	Bandhu Social Welfare Society
CAAP	Confidential Approach to AIDS Prevention
CBO	Community based organization
CCM	Country Coordination Mechanism
CS	Civil Society
CST	Care, support and treatment
DFID	Department for International Development
DGHS	Directorate General of Health Services
DIC	Drop- in-Center
DNC	Department of Narcotics Control
FHI	Family Health International
FSW	Female sex worker
GARPR	Global AIDS Response Progress Report(ing)
GiZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GOB	Government of Bangladesh
HAIS	HIV/AIDS Intervention Services
HASAB	HIV/AIDS, STD Alliance, Bangladesh
HCV	Hepatitis C Virus
HIES	Household Income and Expenditure Sourvey-2010
HIV	Human Immunodeficiency Virus
HPNSDP	Health Population, and Nutrition Sector Development Programme
ICDDR,B/icddr,b	International Centre for Diarrhoeal Diseases Research, Bangladesh
IDH	Infectious Diseases Hospital
IEC	Information education and communication
IEDCR	Institute of Epidemiology, Disease Control and Research and National Influenza Center
KAP	Key affected population
LSE	Life skills education
MAB	Mukto Akash Bangladesh
M&E	Monitoring and evaluation
MOHFW	Ministry of Health and Family Welfare
MSM	Men who have sex with men
MSW	Male sex worker

NAC	National AIDS Committee
NASP	National STD/AIDS Program
NCPI	National Commitments and Policy Instrument
NFM	National Funding Matrix
NGO	Non-governmental organization
NSP	National Strategic Plan
OKUP	Ovibashi Karmi Unnayan Program
OST	Opioid Substitution Therapy
OVC	Orphan and Vulnerable Children
PEP	Post exposure prophylaxis
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PMUK	Padakhep Manabik Unnayan Kendra
PPTCT	Prevention of Parent to Child Transmission
PR	Principal Recipient
PSA	Participatory Situation Assessment
PWID	People who inject drugs
PWUD	People who use drugs
RCC	Rolling Continuation Channel
RSRA	Rapid Situation Response Analysis
SC	Save the Children
SC USA	Save the Children USA
SHG	Self help group
SOP	Standard operating procedure
STD	Sexually transmitted disease
STI	Sexually transmitted infection
SW	Sex worker
TB	Tuberculosis
TC-NAC	Technical Committee of National AIDS Committee
TG	Transgender *(Hijra)*
TOT	Training of Trainers
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	The United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UPHCP	Urban Primary Health Care project
VCT	Voluntary counseling and testing
WB	World Bank
WHO	World Health Organization

I. Status at a glance

(A) The inclusiveness of the stakeholders in the report writing process:

The National AIDS/STD Programme (NASP) of the Ministry of Health and Family Welfare, Government of Bangladesh, played the role of the main coordinating body through taking leadership in the process of preparing the Global AIDS Response Progress Report, 2012, Bangladesh.

The coordinating role of NASP included:

- Ensuring full effort of key stakeholders from government and civil society organizations; particularly organizations working on HIV prevention and care. NASP also ensured coordination with UN agencies and other development partners. There were several consultations both one on one and in groups, to involve all national key stakeholders in the process of preparation of the GARPR

- On February 23, 2012, an introductory workshop on GARPR, 2012 was held in Dhaka, involving all stakeholder groups to discuss the reporting process and to seek the expected cooperation and inputs to complete the report. During this workshop a tentative plan of action was shared and modified as per feedback received. After the workshop process of data and information collection began. The National Consultant appointed to assist preparation of the GARPR, 2012 assisted in organizing the workshop.

- By February 29, 2012 formats for collecting program and finance data was shared with all stakeholders and the data collection process continued till March 20, 2012. Data compilation was started on March 15, 2012 and updates were made as data and information was incoming.

- By March 18, 2012, stakeholders were contacted to complete the National Commitment and Policy Instrument.

- An indicator review and validation meeting on “GARPR indicators” was held on 21st March, 2012 at NASP where NASP officials were present along with members of the National M&E Technical Working Group and other key stakeholders. The meeting was followed by further communication, verification and compilation of indicator data as per discussions.

- Individual consultation and interview with key informants to fill out NCPI was ongoing with government officials, Development Partners and civil society stakeholders.

- On March 27, 2012 NCPI data was reviewed through a Consultation with representatives of key stakeholder groups, who also provided information on other key sections of this report. The draft report was shared for final validation and feedback.

- Till April 3, 2012 feedback was received from technical experts and M&E persons on the report and data being used and presented. All feedback was incorporated.

(B) The status of the epidemic:

The prevalence of HIV in Bangladesh is less than 0.1%[1] in the general population and has remained less than 1% over the years, whether the total population is considered or when segregated for the most at risk and bridge populations (groups of men who are on the move and are likely to be clients of sex workers, such as truckers and rickshaw pullers[2].

According to the latest Serological Surveillance (Round 9, 2011) of Bangladesh, the HIV prevalence among PWUD, Female Sex Workers, MSW, MSM and Hijras was 0.7%. Although HIV prevalence was below 1% in most groups of female sex workers, in casual sex workers (those who were selling had either one or more other main sources of income) from Hilli (a small border town in the northwest part of Bangladesh), prevalence was 1.6. Active syphilis rates among street based sex workers significantly declined in three of the four sites sampled. Among hotel, residence based and casual sex workers no change was observed in syphilis rates except for hotels in Dhaka[3].

In the same surveillance round, none of the MSM or MSW tested was positive for HIV. Among the transgendered community (*hijra*) the HIV prevalence was 1% in two sites (Dhaka –the capital of Bangladesh and Manikganj-a peri-urban site adjacent to Dhaka) and one person was detected as being HIV positive among a small sample from Hilli. Though there were no changes in the rates of active syphilis in MSM, MSW and *hijra*[4], large proportions of MSM and MSW, report STI symptoms (MSW more than MSM), as well as multiple sex partners (including women), group sex (often associated with violence and without condoms) and very low condom use with all types of partners. MSMs are highly networked, so if HIV were to emerge, it could spread very rapidly in this population, if prevention efforts are not adequately scaled up[5].

The Round 9 surveillance, tested 7,529 drug users (PWID, heroin smokers and the combined group of PWID and heroin smokers) from 30 different cities. Overall HIV prevalence was 1.2% (PWID and heroin smokers), with low rates found in drug users from five cities. Prevalence of 5.3% was reported in Dhaka among male PWID. Though active syphilis rates among PWUD declined significantly over time in Dhaka, there were no significant changes in the other cities where trend analysis was possible. HCV was present in over 50% of PWUD in six of the cities. However, the highest prevalence of HCV was found among PWID in several cities, with 95.7% as the highest in a north-western city[6]

The estimated number of HIV/AIDS remains at 7,500[7]. In 2011 the NASP informed that there were 445 newly reported cases of HIV and 251 new AIDS cases, while 84 people had died. Thus the cumulative number of reported HIV cases till date in Bangladesh stands at 2,533, AIDS cases at 1,101 and deaths at 325[8].

[1] 20 years of HIV in Bangladesh: World Bank and UNAIDS, 2009

[2] The Round 9 surveillance, 2011 and Round 8 surveillance, 2007

[3] The Round 9 surveillance

[4] The Round 9 surveillance, 2011

[5] 20 years of HIV in Bangladesh: World Bank and UNAIDS, 2009

[6] The Round 9 surveillance, 2011

[7] World AIDS Day Souvenir, December 1, 2011, NASP

[8] WAD,2011, NASP, MoHFW

(C) The policy and programmatic response:

In Bangladesh, the National AIDS Committee (NAC) was formed in 1985, while the first case of HIV was detected in 1989. The NAC is a high-level advisory body which has the President of People's Republic of Bangladesh as Chief Patron and is chaired by the Minister of Ministry of Health and Family Welfare. The NAC is responsible for formulating major policies and strategies, supervising program implementation and mobilizing resources. An NAC Technical Committee (TC-NAC) of experts provides technical advice to the NAC and the NASP.

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 HIV prevention efforts in the country. NASP is also structured to ensure effective and efficient implementation of the National HIV/AIDS Strategy and national policies.

Other ministries including the ministries of Local Government, Finance, Religious Affairs, Home Affairs, Education, Information and Broadcasting, Women and Children Affairs, Youth and Sports, Labour and Manpower, Social Welfare, and Expatriates Welfare and Overseas Employment have been involved in various interventions at program and project level linked to HIV prevention . Interventions have included setting up of VCT (also termed ICT: Integrated counseling and testing) centers, supporting informative SMS messages, supporting teacher's training for classroom education on HIV, arranging for the insertion of HIV-related information into various in-service training courses etc. The Government has nominated focal points for HIV/AIDS in 16 ministries and departments, who have been advocated and trained on issues related to HIV and HIV response. Key roles of the focal points are to identify best practices for collaboration, develop collaboration and coordination mechanisms, and rationalize the roles and responsibilities of the key ministries for prevention and care of HIV.

The NASP has developed and supported the development of several national guidelines, manuals and policies/strategies on specific intervention areas. Below is a list of some of these guidelines and policy documents:

- 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 STI Management Guidelines, 2006
- National Policy and Strategy for Blood Safety, 2007
- National Curriculum on HIV/AIDS for students of classes 6 to 12, 2007
- National Standards for Youth Friendly Health Services (YFHS) 2007
- Population Size Estimates for Most at Risk Populations for HIV In Bangladesh, 2009
- Standard Operating Procedures for Services to People Living with HIV and AIDS, 2009
- SOP for care-givers, counselors and outreach workers for supporting PLHIV, 2009
- Management of Opportunistic Infections and Post Exposure Prophylaxis – Guideline-2009
- Clinical Management of HIV and AIDS – Doctors' Handbook-2009
- Standard Operating Procedures for Drop-in-Centers for IDU and FSW, 2010
- Various training manuals and guidelines on counseling and peer education as per project needs for IDU, FSW and PLHIV-2008 to 2011
- National Strategic Plan for HIV/AIDS 2011-2015
- National AIDS M&E Plan 2011-2015
- National Anti Retroviral Therapy Guidelines, 2011
- Training Manual on the reduction of Stigma and Discrimination related to HIV/AIDS, 2010
- HIV/AIDS-Opobad O boishommo Protirodh toolkit (stigma and discrimination toolkit), September 2011

Programmatic Response:

The 3rd National Strategic Plan (2011-2015) contains the following objectives, based on priority concerns of the country:

- 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

Though major programs in Bangladesh focus on the above objectives, most of the HIV related activities are based on prevention among most at risk populations, since Bangladesh is a low HIV prevalent country. Three major HIV programs were/are implemented under the stewardship of NASP and the three key contributors that support major prevention programs in the country are the World Bank, the Global Fund and USAID.

1. The HIV/AIDS Intervention Services (HAIS) 2009-2011

HIV/AIDS Intervention Services (HAIS) program implements the intervention packages for high risk groups. It was supported by World Bank financed Health, Nutrition and Population Sector Program (HNPSP) to implement the intervention packages for (i) brothel based sex workers, (ii) street based sex workers, (iii) hotel and residence based sex workers, (iv) clients of sex workers, MSM, MSW and hijra (v) IDUs with an approximate budget of 5.6 million USD.

Objectives of the program:

1. Increased access and use of quality targeted interventions for the most vulnerable groups
2. Increased access and use of prevention services for the general population
3. Increased access to and quality blood transfusion services
4. Increased access and use of quality treatment, acre and support services for the people with HIV
5. Increased and concerted action to reduce the impact of HIV on society and communities and
6. Increased NASP capacity and action to coordinate a national, multi-sectoral response

2. Global Fund to Fight AIDS, Tuberculosis and Malaria supported programs:

The Global Fund has been supporting the National Response since 2004, to continue with the HIV prevention efforts among youth and adolescents; to limit the spread and impact of HIV in the country by providing prevention services among the Most at Risk Populations (currently termed key affetcted population: KAP); to strengthen treatment, care and support among PLHIV; and to improve the capacity to deliver high quality interventions.

Since 2004 the Global Fund has invested a total of approximately 131 million USD in Bangladesh to continue HIV prevention and AIDS control efforts till 2015 through three grants termed as:

- Round 2 (March 2004-November 2009)
- Round 6 (Phase-I: May 2007 to April 2009; Phase 2: May, 2009 and merged with RCC from December 2009), and
- Rolling Continuing Channel (December 2009 to November 2015)

The **Rolling Continuation Channel (RCC)** grant aims to reduce HIV transmission among most at risk populations in Bangladesh through achieving the following objectives:

- To increase the scale of prevention services for key populations at higher risk (IDUs, female sex workers hijras and MSM)
- To increase the scale of the most effective activities conducted with the expiring Round 2 grant
- To build capacity of partners in order to increase the scale of the national response

The RCC grant has three Principal Recipients namely, NASP, Save the Children USA and icddr,b, working in collaboration to facilitate comprehensive approach to the prevention, treatment, care and support continuum to limit the spread and impact of HIV in the country.

3. Modhumita:

USAID is currently supporting Family Health International (FHI 360) to implement the Modhumita Project. The Modhumita Project started in October 2009 and will continue until September 2013 with an estimated budget of 12 million US dollars. Previously FHI 360 implemented the IMPACT project and Bangladesh AIDS Program (BAP) with the financial support from USAID from 2000 to 2009 through targeted interventions for groups most vulnerable to HIV and AIDS in accordance with Ministry of Health and Family Welfare (MOHFW). The Modhumita Project is the follow-on project of BAP and is implemented through a team comprising of FHI 360, Social Marketing Company (SMC) and Bangladesh Center for Communication Programs (BCCP), with an objective to support an effective HIV/AIDS prevention strategy through improved prevention, care, and treatment services for KAP and to strengthen the national response. The project is implemented throughout the country with the support of 24 implementing agencies and other collaborating partners.

4. South Asia Regional HIV/AIDS Programme:

The South Asia Regional HIV/AIDS Program is a five-year regional initiative, from 2010 to 2015, to reduce the impact of HIV and AIDS on men who have sex with men (MSM) and transgender (TG) in South Asia. To reach this goal, there are three main objectives:

- Improve the delivery of HIV prevention, care and treatment services for MSM and TG in South Asia;
- Improve the policy environment with regards MSM, TG, and HIV-related issues in South Asia; and,
- Improve strategic knowledge about the impact of HIV on MSM and TG populations in South Asia.

The program is being implementing in seven South Asian countries eg Bangladesh, India, Nepal, and Sri Lanka (where there are currently active community-led partner organizations), as well as Afghanistan and Pakistan (where partners will be developed), and Bhutan with a budget of approximately 156 million USD. In 2009, the South Asia Regional HIV/AIDS Program proposal was awarded funding from the Global Fund for AIDS, TB, and Malaria under Round 9. Bandhu Social Welfare Society (BSWS) is implementing as a Sub-recipient partner of the South Asia Regional HIV/AIDS Program.

5. PLHIV Response to AIDS in Asia and the Pacific – Regional Advocacy for Treatment Needs of PLHIV in Asia & Pacific:

In partnership with Asia Pacific Network of People Living with HIV & AIDS (APN+), Ashar Alo Society (AAS) is a Sub Recipient for the Global Fund Round 10 grant proposal titled as above with a total budget of approximately $64,170 USD. Beginning from October 1, 2011 till September 30, 2013, the goal of the approved proposal is to improve access of PLHIV to treatment, care and support services in Bangladesh, Indonesia, Lao, Nepal, Pakistan, Philippines and Viet Nam. The proposal objectives are:

- To improve policy environment on treatment, care and support of PLHIV by strengthening community based organizations
- To improve community acceptance of treatment, care and support services for PLHIV by strengthening community based organizations (PLHIV networks).

6. Other Development Partners:

UN agencies are also supporting the implementation of or implementing various HIV/AIDS prevention programs in the country which are managed by different local and international NGOs.

The following examples are cited:
UNFPA Bangladesh worked with brothel based sex workers and their self-help groups at two selected brothels, and with transgender through national NGOs to achieve the following outputs: *Improved awareness and prevention of RTI/STI/HIV/AIDS among young people and high-risk groups*:

UNFPA Bangladesh introduced “No Condom, No Sex Approach” at two selected brothels in Bangladesh with the following interventions:

(1) Life skill training for self-help groups and sex workers on negotiation skill for safe sex practice.
(2) Training of trainers for self-help groups.
(3) Condom programming (Condom distribution, demonstration for proper use and counseling).
(4) STI clinical services, referral services for ICT
(5) Local level advocacy for safe sex practice through local partnership forum
(6) Demonstration of IEC materials for safe sex practice through use of condom.
(7) Advocacy activities with madams, local administration, law enforcing agencies and local health authority for safe sex practice within the brothel

UNICEF has conducted training on PPTCT and size estimation of most at risk adolescents to support prevention activities.

UNAIDS has contributed to strengthen effective advocacy with Parliamentarians, and Human Rights Commission.

UNODC is supporting to introduce the Opiate Substitute Treatment (OST) using Methadone maintenance program for the PWID in collaboration with the Department of Narcotics Control and National AIDS and STD Programme. In collaboration with the Directorate of Prisons, UNODC is also supporting a HIV/AIDS prevention program in six prisons in Bangladesh, which is being implemented by the NGOs.

WHO provided technical assistance in updating the National ART Guidelines and assessing youth friendly health services.

(D) Indicator data in an overview table

Indicators (#)	Recommended guidelines		For Bangladesh		Remarks***
	Data collection frequency	Method of data collection	Data available and reported	Method of data collection	
Target 1: Reduce sexual transmission of HIV by 50 per cent by 2015					
Population: General population					
Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission* (1.1)	Every two years; minimum: every 3–5 years	Population-based surveys This indicator is constructed from responses to the following set of prompted questions: 1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners? 2. Can a person reduce the risk of getting HIV by using a condom every time they have sex? 3. Can a healthy-looking person have HIV? 4. Can a person get HIV from mosquito bites? 5. Can a person get HIV by sharing food with someone who is infected?	Data available	1. End line Survey in Bangladesh, 2008.	Previously reported as Indicator 13
Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 (1.2)	Every 3–5 years	Population-based surveys	Data available	End line Survey in Bangladesh, 2008.	Previously reported as Indicator 15
Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months (1.3)	Every 3–5 years	Population-based surveys	Data available. Reported for men only.	Data extrapolated from, "An assessment of sexual behaviour of men in Bangladesh"	Previously reported as Indicator 16
Percentage of adults aged 15–49 who had	Every 3–5 years	Population-based surveys			Previously reported as

Indicators (#)	Recommended guidelines		For Bangladesh		Remarks***
	Data collection frequency	Method of data collection	Data available and reported	Method of data collection	
more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse* (1.4)				(ICDDR,B and FHI/USAID) 2006.	Indicator 17
Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and who know their results (1.5)	Every 3–5 years	Population-based surveys	Only program records available (March 2011 to February 2012)	Program records	Previously Indicator 7
Percentage of young people aged 15–24 who are living with HIV* (1.6)	Annual	UNAIDS/WHO guidelines for HIV sentinel surveillance	Data not available		Previously Indicator 22
Population: Sex Workers					
Percentage of sex-workers reached with HIV prevention programmes (1.7)	Every two years	Behavioural surveillance or other special surveys Sex workers are asked the following questions: 1. Do you know where you can go if you wish to receive an HIV test? 2. In the last twelve months, have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic)	Data available	BSS 2006-7	Previously reported as Indicator 9
Percentage of sex workers reporting the use of a condom with their most recent client (1.8)	Every two years	Behavioural surveillance or other special surveys	Data available	BSS 2006-7	Previously reported as Indicator 18
Percentage of sex workers who have received an HIV test in the past 12 months and know their results (1.9)	Every two years	Behavioural surveillance or other special surveys	Data available	BSS 2006-7	Previously reported as Indicator 8
Percentage of sex workers who are living with HIV (1.10)	Annual	UNAIDS and WHO Working Group on Global HIV/AIDS and STI Surveillance: Guidelines among populations most at risk for HIV (WHO/ UNAIDS, 2011)	Data available	Serological surveillance 2011	Previously reported as Indicator 23
Population: Men who have sex with men					

Indicators (#)	Recommended guidelines		For Bangladesh		Remarks***
	Data collection frequency	Method of data collection	Data available and reported	Method of data collection	
Percentage of men who have sex with men reached with HIV prevention programmes (1.11)	Every two years	Behavioural surveillance or other special surveys	Data available	PSA among MSM, MSW and hijra, 2010	Previously reported as Indicator 9
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner (1.12)	Every two years	Behavioural surveillance or other special surveys	Data available	PSA among MSM, MSW and hijra, 2010	Previously reported as Indicator 19
Percentage of men who have sex with men that have received an HIV test in the past 12 months and who know the results (1.13)	Every two years	Behavioural surveillance or other special surveys	Data available	PSA among MSM, MSW and hijra, 2010	Previously reported as Indicator 8
Percentage of men who have sex with men who are living with HIV (1.14)	Annual	UNAIDS and WHO Working Group on Global HIV/AIDS and STI Surveillance: Guidelines among populations most at risk for HIV (WHO/ UNAIDS, 2011)	Data available	Serological surveillance 2011	Previously reported as Indicator 23
Target 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015					
Number of syringes distributed per person who injects drugs per year by needle and syringe programmes** (2.1)	Every two years	Numerator: Programme data used to count the number of syringes distributed Denominator: Size estimation of the number of people who inject drugs in the country	Data available	Numerator: Programme data /records Denominator: Size estimation of PWID	New indicator
Percentage of people who inject drugs who report the use of a condom at last sexual intercourse (2.2)	Every two years	Behavioural surveillance or other special surveys	Data available	BSS 2006-7	Previously reported as Indicator 20
Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected (2.3)	Every two years	Behavioural surveillance or other special surveys	Data available	BSS 2006-7	Previously reported as Indicator 21
Percentage of people who inject drugs that have received an HIV test in the past 12 months and who know	Every two years	Behavioural surveillance or other special surveys	Data available	BSS 2006-7	Previously reported as Indicator 8

Indicators (#)	Recommended guidelines		For Bangladesh		Remarks***
	Data collection frequency	Method of data collection	Data available and reported	Method of data collection	
the results (2.4)					
Percentage of people who inject drugs who are living with HIV (2.5)	Annual	UNAIDS and WHO Working Group on Global HIV/AIDS and STI Surveillance: Guidelines among populations most at risk for HIV (WHO/ UNAIDS, 2011)	Data available	Serological surveillance 2011	Previously reported as Indicator 23
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths					
Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission (3.1)	Annual or more frequently, depending on a country's monitoring needs	Numerator: national programme records aggregated from programme monitoring tools, such as patient registers and summary reporting forms Denominator: estimation models such as Spectrum, or antenatal clinic surveillance surveys in combination with demographic data and appropriate adjustments related to coverage of ANC surveys Programme monitoring and HIV surveillance	Only program records available, thus not reported	Program records	Previously Indicator 5
Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth** (3.2)	Annual or more frequently, depending on a country's monitoring needs	Numerator: Early Infant Diagnosis (EID) testing laboratories Denominator: Spectrum estimates, central statistical offices, and/or sentinel surveillance	Data not available		New indicator
Mother-to-child transmission of HIV (modelled) (3.3)	Annual	The mother-to-child transmission probability differs with the antiretroviral drug regimen received and infant-feeding	Data not available		Previously Indicator 25

Indicators (#)	Recommended guidelines		For Bangladesh		Remarks***
	Data collection frequency	Method of data collection	Data available and reported	Method of data collection	
		practices. The transmission can be calculated by using the Spectrum model.			
Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015					
Percentage of eligible adults and children currently receiving antiretroviral therapy* (4.1)	Data should be collected continuously at the facility level and aggregated monthly or quarterly. Most recent monthly or quarterly data should be used for annual reporting	Numerator: facility-based antiretroviral therapy registers or drug supply management systems. Denominator: HIV estimation models such as Spectrum	Data available	1. Facility-based records 2. Estimated projections and interviews	Previously reported as Indicator 4
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (4.2)	Data for monthly cohorts that have completed at least 12 months of treatment should be aggregated	Antiretroviral therapy registers and antiretroviral therapy cohort analysis report Form	Data available	Program records	Previously reported as Indicator 24
Target 5: Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015					
Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV (5.1)	Data should be collected continuously at the facility level, aggregated monthly or quarterly, and reported annually.	Numerator: Facility antiretroviral therapy registers and reports; programme monitoring tools Denominator: Programme data and estimates of incident TB cases in PLHIV	Data available	Numerator: Program records Denominator: Programme data and estimates of incident TB cases in PLHIV	Previously Indicator 6
Target 6: Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries					
Domestic and international AIDS spending by categories and financing sources (6.1)	Calendar or fiscal year data (as available): 2009-2011	The indicator on domestic and international AIDS spending is reported by completing the National Funding Matrix (NFM)	Data available	Filling of National Funding Matrix	Previously reported as Indicator 1
Target 7: Critical Enablers and Synergies with Development Sectors					
National Commitments and Policy Instrument	Every two years	Filling out National Commitments and	Data available	Filling of National	Previously reported as

Indicators (#)	Recommended guidelines		For Bangladesh		Remarks***
	Data collection frequency	Method of data collection	Data available and reported	Method of data collection	
(Areas covered: prevention, treatment, care and support, human rights, civil society involvement, gender, workplace program, stigma and discrimination and M&E) (7.1)		Policy Instrument		Commitments and Policy Instrument	Indicator 2
Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months** (7.2)	Every 3-5 years	Population based surveys that are already being used within countries	Data available	Bangladesh Demographic and Health Survey, 2007	New indicator
Current school attendance among orphans and non-orphans aged 10–14* (7.3)	Preferred: every 2 years Minimum: every 4–5 years	Population-based survey	Data not available		Previously Indicator 12
Proportion of the poorest households who received external economic support in the last 3 months (7.4)	Every 4–5 years	Population-based surveys Assessment of the household's wealth	Data available	Household Income and Expenditure Survey, 2010 (Bangladesh Bureau of Statistics)	Previously Indicator 10 Percent of household receiving benefit from Social Safety Nets Programs reported

** MDG indicators*
*** New indicator*
**** Indicators previously reported against have "reported as" in remarks*

Status of these Indicators with measurement value for the current Reporting period is given in the table below:

Target	Indicator	Population Group	Indicator value (in percentage)				Remarks on 2011 data
			2005	2007	2009	2011	
Target 1: Reduce sexual transmission of HIV by 50 per cent by 2015	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission* (1.1)	Males(15-24 years) Females (15-24 years) All males and females aged 15-24 years	Not available Not available Not available Source: National Baseline HIV/AIDS Survey among Youth in Bangladesh 2005 NASP, Save-USA, ICDDR,B	10.4 10.0 10.2 Source: National End Line HIV/AIDS Survey among Youth in Bangladesh, 2008, NASP, Save the Children, icddr,b	22.4 13.4 17.7 Source: National End Line HIV/AIDS Survey among Youth in Bangladesh, 2008, NASP, Save the Children, icddr,b	22.4 13.4 17.7 Source: National End Line HIV/AIDS Survey among Youth in Bangladesh, 2008, NASP, Save the Children, icddr,b	Comprehensive knowledge was also assessed among 15-24 year old mothers or females caretakers of children under the age of five of sampled households through the MICS 2009 (BBS and UNICEF), thus this is not comparable to previous data and may not be compiled with the data on young men. The result was 14.6% among the young girls
	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 (1.2)	Males(15-24 years) Females (15-24 years) All males and females aged 15-24 years	Not available Not available Not available Source: National Baseline HIV/AIDS Survey among Youth in Bangladesh 2005 NASP, Save-USA,	11.6 35.7 27.1 Source: National End Line HIV/AIDS Survey among Youth in Bangladesh, 2008, NASP, Save the Children,	11.8 30.6 24.3 Source: National End Line HIV/AIDS Survey among Youth in Bangladesh, 2008, NASP, Save the Children,	11.8 30.6 24.3 Source: National End Line HIV/AIDS Survey among Youth in Bangladesh, 2008, NASP, Save the Children,	

Target	Indicator	Population Group	Indicator value (in percentage)				Remarks on 2011 data
			2005	2007	2009	2011	
				ICDDR,B	icddr,b	icddr,b	
	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months (1.3)	Males (15-49 years) Females (15-49 years)	Not available Not available	12.9% Not available Source: Assessment of Sexual behaviour of men in Bangladesh FHI/ICDDRB 2006	12.9% Not available Source: Assessment of Sexual behaviour of men in Bangladesh FHI/ICDDRB 2006	12.9 Not available Source: Assessment of Sexual behaviour of men in Bangladesh FHI/ICDDRB 2006	Extrapolated data
	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse* (1.4)	Males (15-49 years) Females (15-49 years)	Not available Not available	35.0% Not available Source: Assessment of Sexual behaviour of men in Bangladesh FHI/ICDDRB 2006	35.0% Not available Source: Assessment of Sexual behaviour of men in Bangladesh FHI/ICDDRB 2006	35.0 Not available Source: Assessment of Sexual behaviour of men in Bangladesh FHI/ICDDRB 2006	Extrapolated data
	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and who know their results (1.5)	Males (15-49 years)	Not available	Not available	Not available	44.1	As question s are not applied in surveys among General Population, existing data from program records is shared
		Females (15-49 years)	Not available	Not available	Not available	18.5	

Target	Indicator	Population Group	Indicator value (in percentage)				Remarks on 2011 data
			2005	2007	2009	2011	
						Source: Program records from Urban Primary Health Care Project Phase II, March 2011 to February 2012	FHI 360 has similar data on KAP and other vulnerable groups, where 96% of males, 97% of females and 99% of transgender received their results
	Percentage of young people aged 15–24 who are living with HIV* (1.6)	All males and females aged 15-24 years	Not available	Not available	Not available	Not available	Only for countries with generalized epidemics
	Percentage of sex-workers reached with HIV prevention programmes (1.7)	Female Sex Workers Male Sex Workers	6.9 20.4 Source: BSS 2003-04	7.4 18.0 Source: BSS 2006-07	7.4 18.0 Source: BSS 2006-07	7.4 36.6 Source: For FSW: BSS 2006-07 For MSW: PSA 2010, icddr,b (unpublished)	
	Percentage of sex workers reporting the use of a condom with their most recent client (new clients in the last week) (1.8)***	Female Sex Workers Male Sex Workers	30.9 44.1 Source: BSS 2003-04	66.7 43.7 Source: BSS 2006-07	66.7 43.7 Source: BSS 2006-07	66.7 39.0 Source: For FSW: BSS 2006-07 For MSW: PSA 2010, icddr,b (unpublished)	Data provided on new clients to maintain consistency with previous reports

Target	Indicator	Population Group	Indicator value (in percentage)				Remarks on 2011 data
			2005	2007	2009	2011	
	Percentage of sex workers reporting the use of a condom with their most recent client (1.8)***	Female Sex Workers Male Sex Workers	Not available Not available	Not available Not available	Not available Not available	Not available 34.6 Source: For MSW: PSA 2010, icddr,b (unpublished)	Data provided as per indicator definition
	Percentage of sex workers who have received an HIV test in the past 12 months and know their results (1.9)	Female Sex Workers Male Sex Workers	1.6 1.1 Source: BSS 2003-04	4.1 4.1 Source: BSS 2006-07	4.1 4.1 Source: BSS 2006-07	4.1 37.7 Source: For FSW: BSS 2006-07 For MSW: PSA 2010, icddr,b (unpublished)	
	Percentage of sex workers who are living with HIV (1.10)	Female Sex Workers Male Sex Workers	0.3 0.0 Source: National HIV Serological Surveillance, 2004-2005.	0.1 0.7 Source: National HIV Serological Surveillance, 2006.	0.3 0.3 Source: National HIV Serological Surveillance, 2007	0.3 0.0 Source: National HIV Serological Surveillance, 2011	Data is from 13 different cities in case of FSW and from Dhaka (capital) in case of MSW
	Percentage of men who have sex with men reached with HIV prevention programmes (1.11)	Men who have sex with men	0.66 Source: BSS 2003-04	8.1 Source: BSS 2006-07	8.1 Source: BSS 2006-07	9.0 Source: PSA 2010, icddr,b (unpublished)	

Target	Indicator	Population Group	Indicator value (in percentage)				Remarks on 2011 data
			2005	2007	2009	2011	
	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner (in the last month) (1.12)***	Men who have sex with men *Commercial sex* *Non-commercial sex*	 49.2 37.0 Source: BSS 2003-04	 29.5 24.3 Source: BSS 2006-07	 29.5 24.3 Source: BSS 2006-07	 23.7 20.9 Source: PSA 2010, icddr,b (unpublished)	Data provided to maintain consistency with previous reports
	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner (in the last 6 months) (1.12)***	Men who have sex with men	Not available	Not available	Not available	26.1 Source: PSA 2010, icddr,b (unpublished)	Data provided as per definition
	Percentage of men who have sex with men that have received an HIV test in the past 12 months and who know the results (1.13)	Men who have sex with men	0.0 Source: BSS 2003-04	2.5 Source: BSS 2006-07	2.5 Source: BSS 2006-07	9.3 Source: PSA 2010, icddr,b (unpublished)	
	Percentage of men who have sex with men who are living with HIV (1.14)	Men who have sex with men MSM and MSW combined	0.0 0.4 Source: National HIV Serological Surveillance, 2004-2005.	0.2 Not sampled Source: National HIV Serological Surveillance, 2006.	0.0 0.3 Source: National HIV Serological Surveillance, 2007	0.0 0.0 Source: National HIV Serological Surveillance, 2011	MSM data is from Dhaka and combined MSM and MSW data is from 2 other cities
HIV among people who	Number of syringes distributed per person	People who inject drugs	Not applicable	Not applicable	Not applicable	263.7	

Target	Indicator	Population Group	Indicator value (in percentage)				Remarks on 2011 data
			2005	2007	2009	2011	
	who injects drugs per year by needle and syringe programmes** (2.1)					Program records: Save the Children and PMUK and National size estimation (2009)	
	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse (2.2)	Male PWID *Commercial Sex* *Non-commercial Sex* Female PWID *Commercial Sex* *Non-commercial Sex*	 23.6 18.9 78.9 43.9 Source: BSS, 2003-2004 for male IDUs and Cohort study by ICDDR,B for female IDUs baseline in Dec 2004-May 2005	 44.3 30.5 54.8 42.1 Source: BSS, 2006-2007 for male IDUs and Cohort study by ICDDR,B for female IDUs 3 rd round in July – Nov 2006	 44.3 30.5 54.8 42.1 Source: BSS, 2006-2007 for male IDUs and Cohort study by ICDDR,B for female IDUs 3 rd round in July – Nov 2006	 44.3 30.5 54.8 42.1 Source: BSS, 2006-2007 for male IDUs and Cohort study by ICDDR,B for female IDUs 3 rd round in July – Nov 2006	
	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected (2.3)	Male PWID Female PWID	51.8 60.0 Source: BSS, 2003-2004 for male IDUs and Cohort study by ICDDR,B for female IDUs baseline in Dec 2004-May 2005	33.6 73.8 Source: BSS, 2006-2007 for male IDUs and Cohort study by ICDDR,B for female IDUs 3 rd round in July – Nov 2006	33.6 73.8 Source: BSS, 2006-2007 for male IDUs and Cohort study by ICDDR,B for female IDUs 3 rd round in July – Nov 2006	33.6 73.8 Source: BSS, 2006-2007 for male IDUs and Cohort study by ICDDR,B for female IDUs 3 rd round in July – Nov 2006	

Target	Indicator	Population Group	Indicator value (in percentage)				Remarks on 2011 data
			2005	2007	2009	2011	
	Percentage of people who inject drugs that have received an HIV test in the past 12 months and who know the results (2.4)	Male PWID	3.2 Source: BSS, 2003-2004 for male IDUs and Cohort study by ICDDR,B for female IDUs baseline in Dec 2004-May 2005	4.7 Source: BSS, 2006-2007 for male IDUs and Cohort study by ICDDR,B for female IDUs 3 rd round in July – Nov 2006	4.7 Source: BSS, 2006-2007 for male IDUs and Cohort study by ICDDR,B for female IDUs 3 rd round in July – Nov 2006	4.7 Source: BSS, 2006-2007 for male IDUs and Cohort study by ICDDR,B for female IDUs 3 rd round in July – Nov 2006	
	Percentage of people who inject drugs who are living with HIV (2.5)	Male PWID Female PWID	1.5 0.0 Source: National HIV Serological Surveillance, 2004-2005.	1.9 0.8 Source: National HIV Serological Surveillance, 2006.	1.6 1.0 Source: National HIV Serological Surveillance, 2007	1.0 1.1 Source: National HIV Serological Surveillance, 2011	Data is from 30 different cities. Previous data were from 16, 18 and 21 cities respectively from 2005 to 2009.
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths	Percentage of HIV-positive pregnant women who receive ARVs to reduce the risk of mother-to-child transmission (3.1)	PLHIV	Not available	Not available	Not available	Not available	
	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth** (3.2)	PLHIV and infants	Not applicable	Not applicable	Not applicable	Not available	
	Mother-to-child transmission of HIV (3.3)	PLHIV and infants	Not available	Not available	Not available	Not available	
15 million PLHIV on antiretroviral treatme	Percentage of eligible adults and children currently receiving antiretroviral therapy*	PLHIV	Not available	13.3	47.7 Source: Numerator: Program records:	45 Source: Numerator: Program records: AAS, CAAP, and	

Target	Indicator	Population Group	Indicator value (in percentage)				Remarks on 2011 data
			2005	2007	2009	2011	
	(4.1)				AAS, CAAP, and MAB Denominator: GTZ supported and IHP conducted projection, 2008	MAB Denominator: GTZ supported and IHP conducted projection, 2008	
	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (4.2)	PLHIV	Not available	Not available	90.1 Source: Program records: AAS, CAAP, and MAB	84.2 Source: Program records: AAS, CAAP, and MAB	
Target 5: Reduce tuberculosis deaths in PLHIV by 50% by 2015	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV (5.1)	TB cases among PLHIV	Not available	Not available	Not available	13.97 Source: Numerator: Program records: AAS, CAAP, and MAB Denominator: TB/HIV in the South-East Asia Region, Status Report, December 2011, WHO	
Target 6: Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries	Domestic and international AIDS spending by categories and financing sources (6.1)	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Please see Annex-1

Target	Indicator	Population Group	Indicator value (in percentage)				Remarks on 2011 data
			2005	2007	2009	2011	
Target 7: Critical Enablers and Synergies with Development Sectors	NCPI (Areas covered: prevention, treatment, care and support, human rights, civil society involvement, gender, workplace program, stigma and discrimination and M&E) (7.1)	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Please see Annex-2
	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months** (7.2)	Ever married women aged 15-49 years	Not applicable	Not applicable	Not applicable	53.3 Source: BDHS, 2007	
	Current school attendance among orphans & non-orphans aged 10–14* (7.3)	All children aged 10-14	Not available	Not available	Not available	Not available	
	Proportion of the poorest households who received external economic support in the last 3 months (7.4)	Population households belonging to the poorest wealth quintile	Not available	Not available	Not available	24.57 Source: HIES, 2010 (BBS)	Reported for "Percent of household receiving benefit from Social Safety Nets (programs)"

** MDG indicators*
*** New indicator*
****Indicators outlined twice considering previous reports and current definitions*

II. Overview of the AIDS epidemic

Prevention efforts in Bangladesh had been initiated much before the first HIV case was detected in 1989, till date data has indicated that Bangladesh is effectively containing the HIV epidemic. Due to reportedly low prevalence there is no comprehensive national study to measure the prevalence of HIV among the general population, however, it is considered to be less than 0.1 percent[9].

In all of the nine HIV Serological Surveillance rounds conducted till date (Round 9, 2011) in Bangladesh, the HIV prevalence among the most affected key populations as a whole remained below 1 percent.[10]. Table 1 is a compilation of HIV prevalence among key affected populations over the years.

On December 1, 2011, on the occasion of World AIDS Day, the National AIDS/STD Program (NASP) had confirmed a total of 2,533 HIV cases reported in Bangladesh, of which 445 cases identified were new. In 2011, 251 persons had developed AIDS and a total of 84 deaths were reported. Cumulatively 1,101 people had developed AIDS in the country till date and 325 had died[11].

(A) Key Affected Populations and HIV

The key affected populations included in the 9th serological surveillance in Bangladesh are female sex workers (Street, Hotel, and Residence based and Casual), male sex workers (MSW), men who have sex with men (MSM), transgender or *Hijras*, people who inject drugs (PWID) and heroin smokers.

The National Strategic Plan (2011-2015) has also prioritized international migrant workers, transport workers, specially vulnerable adolescents and prisoners. Although the external migrant workers constitute a large proportion reported HIV positive cases in Bangladesh, due to various reasons, this group is still out of the national HIV surveillance system.

The following table depicts the overall HIV prevalence among different KAP over the last nine rounds of HIV serological surveillance in Bangladesh.

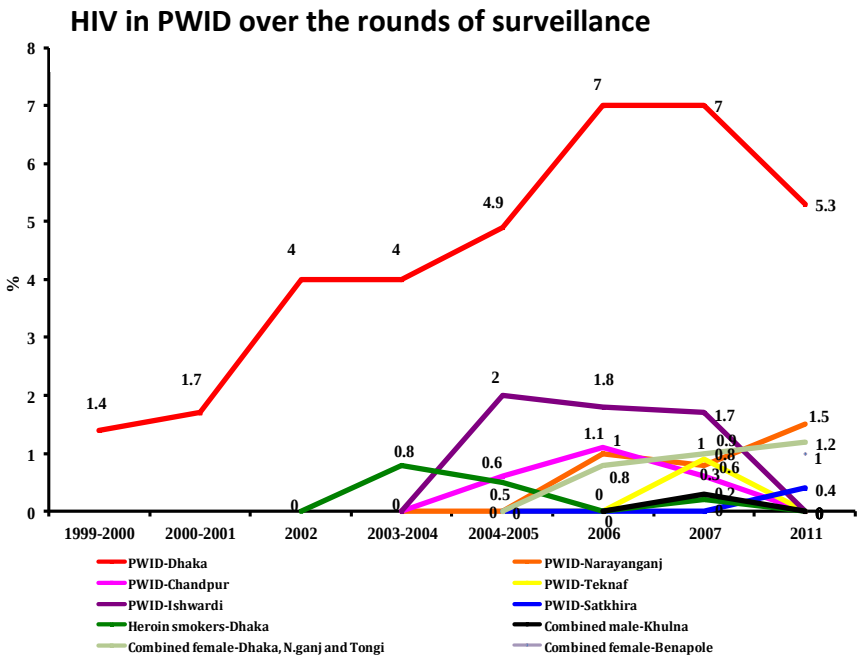
Table 1: HIV prevalence among key affected populations over the years

Surveillance Rounds	Year	Total sample	HIV prevalence in %
1st round	1998-1999	3,871	0.4
2nd round	1999-2000	4,338	0.2
3rd round	2000-2001	7,063	0.2
4th round	2002-2003	7,877	0.3
5th round	2003-2004	10,445	0.3
6th round	2004-2005	11,029	0.6
7th round	2006	10,368	0.9
8th round	2007	12,786	0.7
9th round	2011	12,894	0.7

[9] 20 years of HIV in Bangladesh: World Bank and UNAIDS, 2009
[10] The Round 9 surveillance, 2011
[11] WAD,2011, NASP, MoHFW

(B) Status of the Epidemic among the PWID – Indications of Progress in Dhaka

According to the 9th Serological Surveillance 2011 (NASP), the overall HIV prevalence among PWID was found to be stable. In Dhaka, overall prevalence was 5.3 percent. The HIV prevalence among IDUs in Dhaka rose up to five times in an interval of seven years (from 1.4 percent in the 2nd serological surveillance (1999-2000) to 7 percent in the 8th serological surveillance, 2007)[12].



A marker for unsafe injection practices is the prevalence of Hepatitis C. In Dhaka this declined significantly over the years,[13] which confirms that safer injection practices are being adopted.

In other cities however, the scenario is mixed with decline in HCV rates being documented in some cities and increase in others. The most alarming is the high rates of HCV in four cities in northwest Bangladesh ranging from 67.7 to 95.7%.

Few cases of HIV among male PWID and female PWUD (which are a group of PWID and heroin smokers) were detected in four new cities, in 2011, where the prevalence rates ranged 0.4 to 1.5%

Female PWUD are particularly vulnerable as most sell sex to support their addiction, and depended on their male partners to buy their drugs and then shared injections with them[14].

From the status of the concentrated epidemic among PWUD it maybe inferred that interventions to prevent HIV among PWUD (mainly PWID), are working in Dhaka, however, similar efforts to those applied in Dhaka need to be implemented in other areas where high rates of either HCV or active syphilis have been found.

[12] 8th Serological Surveillance, 2007

[13] 9th Serological Surveillance, 2011

[14] Vulnerability to HIV infection among sex worker and non-sex worker female injecting drug users in Dhaka, Bangladesh: evidence from the baseline survey of a cohort study. Azim T et al, Harm Reduction Journal 2006, 3:33

(C) Vulnerability of FSWs to HIV in some cities

Data from 3,568 FSW from 13 cities reveal that the overall HIV prevalence is 0.3% among FSW in Bangladesh and HIV was detected among different groups of FSWs in five cities (Table 2). Over the rounds HIV prevalence among FSW has been low. For sites where HIV was detected over the rounds, the changes were not significant. [15]

Table 2: HIV prevalence among FSW, 2007 and 2011[16]

FSW and Site	Prevalence in 2011	Prevalence in 2007
1. Street based FSW in Dhaka	0.5	0.2
2. Hotel based FSW in Dhaka	0.2	0
3. Hotel based FSW in Sylhet	0.4	0.6
4. Casual FSW in Hilli	1.6	2.7
5. Combined residence and hotel based FSW in Jamalpur	0.5	0
6. Combined residence and hotel based FSW in Jessore	0.4	0.5

Active syphilis rates had either declined or remained unchanged over the rounds of serological surveillance. In 5 cities approximately 5% or >5% of FSW had active syphilis.[17]

(D) Vulnerability of Hijra

From the 9th serological surveillance, HIV was detected in both sites from where Hijra were sampled. Active syphilis from two cities were at 6.1% and cross-border mobility was common. Attention needs to be given to Hijra so that HIV prevention services for hijra are appropriate and expanded. [18]

(E) Overlapping of risk among key affected population

A surrogate marker of unsafe sex is active syphilis. The significant decline in active syphilis in hotel and street based female sex workers in Dhaka suggests effective interventions. However over 5% of some population groups have syphilis, which is unacceptably high. These groups include PWUD, FSW, and Hijra from 10 different cities.[19] Genetic characterization of HIV subtypes helps to analyze overlapping risks. The extent of similarity in the HIV strains found in different populations points to overlap among those groups. Genetic analysis of HIV strains shows that the IDU and heroin smoker strains are almost identical confirming that spread is occurring within networks of IDUs through sharing of injection equipment. The HIV strains obtained from IDUs are distinct from those obtained from other population groups suggesting that transmission of HIV is still restricted within specific MARPs. HIV subtypes from migrants are genetically diverse and have little or no identity with locally circulating strains in IDUs and female sex workers[20]. However, recently, evidence of similarity of strains between those in returnee migrants and local FSW has been found (personal communication, T. Azim, icddr,b).

[15] 9th Serological Surveillance, 2011
[16] 9th Serological Surveillance, 2011
[17] 9th Serological Surveillance, 2011
[18] 9th Serological Surveillance, 2011
[19] 9th Serological Surveillance, 2011
[20] 20 years of HIV in Bangladesh: World Bank and UNAIDS, 2009

The recent behavioral survey of hijra in Dhaka, 2010, found that % currently married who had regular sex partners besides spouse was 58.8% and % currently unmarried who had regular sex partners was 62.6%. Most *hijra* had anal sex with male partners in the last month (87.5%). Taking illicit drugs (except alcohol) in the last year was reported by 14.3% of hijra. No one injected drugs in the last year but a small proportion said their regular partners (commercial and non-commercial) injected drugs. Thirty one percent of hijra travelled to another city in the last year. While travelling to another city, 60.7% of sex worker *hijra* sold sex of whom 22.5% used condom in the last sex.[21]

The recent behavioral survey of MSM in Dhaka reports that 71% MSM reported having anal sex with commercial or non-commercial males within a month prior to the survey. Among those who had sex with commercial or non-commercial *hijra* and females, 58.2% had anal sex with *hijra* and 62.6% had vaginal/anal sex with females within a month. Forty-five percent reported had anal sex with non-commercial male/*hijra* in the last month. Thirty percent of the respondents bought sex from female sex workers and a 46.7% bought sex from commercial males in the last one month. One in every ten MSM had group sex in the last one month. On an average MSM had 2.8 non-commercial male/*hijra* sex partner, 2.2 commercial female sex partners and 2.3 commercial male partners in the last month. The average number of group sex partners was 3.6 in the last month. Four in every five MSM had ever used of condoms and 26% reported using condom in the last receptive or penetrative anal sex act with a male sex partner. More than 60% of MSM reported travelling to another city in the last year. Among those who travelled, 37.1% bought sex and 27.2% used condom in the last commercial sex act. One third of the respondents reported taking illicit drugs (except alcohol) in the last year. Of the 457 sampled, seven MSM had injected drugs in the last year and among them approximately half reported sharing needles/syringes with others in the last year.[22]

(F) HIV Risk in General Population

Approximately 10 percent of men in Bangladesh reported *having ever bought sex* from female sex workers[23]. In the national survey among youth in 2008, almost 20 percent of unmarried males reported having premarital sex and for 28 percent of these respondents, the last sex was with a sex worker. The reporting of consistent condom use amongst this group with FSWs, however, has risen from 14 percent (2005) to 48 percent (2008). About one in three (28%) young people *who have ever had sex* reported one or more symptoms of an STI in the past 12 months, but only a quarter sought treatments from a trained provider. These data point to the need for more concerted prevention efforts also among the general population with specific focus on men especially young men.[24] These concerted efforts may include life skills education, improved access to condoms[25], involving power structures to provide information to young clients[26], creating public private partnerships with pharmaceutical companies[27], etc. as these types of interventions have been tested and proved to be effective in knowledge increase and behavior change within the Bangladesh context. A recent study among university students again emphasized the need for continued efforts of increasing knowledge

[21] A behavioural survey of hijra in Dhaka, icddr,b, 2010

[22] A behavioral survey of MSM in Dhaka, icddr,b, 2010

[23] Male Reproductive Health Survey, FHI/ICDDR,B, 2006

[24] Endline survey among young people, NASP, Save the Children, icddr,b, 2008

[25] Creating Conditions for Scaling Up Access to Life Skills Based Sexual and Reproductive Health Education and Condom Services, NASP, Save the Children, icddr,b, Population Council, 2008-2009

[26] Exploring acceptable and appropriate interventions to promote correct and consistent condom use among young male clients of hotel based female sex workers, NASP, Save the Children, icddr,b, 2008-2009

[27] Improving STI Services of non-formal providers through academic detailing by medical representatives, NASP, Save the Children, icddr,b, 2008-2009

and influencing behavior among young people. The study found that 26.8% of students never used condoms during the last sexual act with their boy or girl friend.[28]

(G) Migration and HIV Risk in Bangladesh

Migration may be a factor in HIV transmission in Bangladesh. Migrants, both international and cross border, have generally not been targeted by HIV prevention efforts in the past and there is little understanding as to how such targeted intervention could be implemented[29]. The limited facilities for voluntary counseling and testing, as well as the social stigma and discrimination attached to HIV, remain a major challenge to reach these migrants.

There is no official data on overseas migrants living with HIV. However, the majority of passively reported HIV positive cases have been among returned international migrant worker s and their families. A recent analysis of existing data on PLHIV showed that of 645 adult PLHIV who had been employed, 64.3 percent had previously worked abroad[30]. Among the 219 confirmed HIV cases in 2002, returning emigrant workers comprised 50.7 percent of the total. Condoms are rarely used in family planning, because they are not preferred by men [HIV vulnerabilities faced by women migrants (OKUP, UNDP, 2009)].

[28] Knowledge, attitudes and practices towards HIV/AIDS-related risk factors among public and private university students in Bangladesh, Shah Ehsan Habib, *PhD (UNSW, Sydney)*, Associate Professor , Department of Sociology, University of Dhaka

[29] 20 years of HIV in Bangladesh: World Bank and UNAIDS, 2009

[30] Ibid

III. National response to the AIDS epidemic

(A) National policy environment and HIV programme

Historically Bangladesh has been active in combating HIV and AIDS as evidenced from formation of administrative and technical bodies, even before the identification of the first AIDS case. Bangladesh was the first country in the region to adopt a comprehensive national policy on HIV-AIDS and STDs (in 1997), Government in collaboration with NGOs and Self-help Groups has been instrumental in supporting various prevention, care, treatment and support activities. The national HIV program has been progressively scaled up in its quality and coverage in recent years and gender, equity, non-discrimination, human rights and fundamental freedom were addressed as cross-cutting issues in all programs to comply with UNGASS DoC and the Political Declaration on HIV/AIDS.

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 its general development plans, Poverty Reduction Strategy, Sector-wide approach. UN Development Assistance Framework also included HIV. In the new National Health Policy, HIV has been emphasized. However, Bangladesh has not evaluated the impact of HIV on its socioeconomic development for planning purposes.

The 3rd National Strategic Plan for HIV/AIDS, 2011-2015 upholds the declarations and commitments by outlining the components and interventions in detail to encompass human rights and gender perspectives in all areas including prevention, care, treatment, support, advocacy, capacity development, etc. (Annex-3). It was formulated through extensive consultation and involvement of ministries, NGOs, the private sector and the affected community. In addition, the results-based framework of the NSP (Annex-4) provides measurable outcomes to track the progress of Bangladesh in maintaining the strategic plan. Various priority groups are highlighted and the plan is costed based on required financial projections.

Good-progress has been made in policy/strategy development as evidenced by the NCPI. Some examples are shown in the following table to compare progress made as evidenced through the NCPI responses:

Table 3: Trend in policy/practices, 2010 and 2012 reports

Area	Response: National composite policy index, 2010	Response: National Commitments and Policy Instrument, 2012
Part A (filled out by Government officials)		
Strategic plan	Transportation sector was part of the multi-sectoral strategy	Overall score is mostly unchanged Transportation sector involvement has decreased as per country priority
	Strategy did not include operational plan with detail costs and indication of funding source	Strategy now includes operational plan Plan now includes detail costs and indication of funding source

	Overall achievements: Coverage increase Additional resource mobilization -GFATM Adding HIV topics in secondary/higher secondary education curriculum	**Overall achievements:** • 3rd National Strategic Plan,2011-15 updated and finalized • National HIV/AIDS M & E Plan updated and finalized • ARV Guidelines revised and updated • National counseling training manual for children, adolescent and MARPs developed • National counseling guidelines developed • Phase wise anti-retroviral therapy at Infectious Disease Hospital, BSMMU (medical university) and 8 medical college hospitals established • Opioid Substitution Therapy (OST) supported
Political support and leadership	Procurement and distribution of medications or other supplies was not well defined	Overall score is mostly unchanged Procurement and distribution of medications or other supplies Is ongoing mostly through civil society
	Review of laws and policies were yet to occur	Review of laws and policies occurred to determine inconsistencies
	Overall achievements: Not applicable	**Overall achievements:** Mostly in same areas as "Strategic Plan"
Prevention	No interventions with prison inmates	Prison inmates now receive: Condom promotion, HIV testing and counseling, Needle & syringe exchange, Targeted information on risk reduction and HIV education
	Blood safety was being initiated	Blood safety is in place
	PMTCT pilots were being planned	Some PMTCT initiatives have been piloted and are yet to be replicated
	Overall achievements: Blood safety Continue the high risk intervention programme	**Overall achievements:** • National Strategic Plan updated with detail operational plan and projected budget • Piloting of Opioid Substitution Therapy (OST) • Control of HIV among PWID and other KAP • Prison inmates too receive some HIV services • LSE for MARPs implemented
Treatment, care and support	Pediatric treatment, care and support services, psychosocial support for people living with HIV and their families, TB infection control in HIV treatment and care facilities, TB preventive therapy for people living with HIV, TB screening for people living with HIV, regional procurement and supply management mechanisms yet to be improved	Pediatric treatment, care and support services, psychosocial support for people living with HIV and their families, TB infection control in HIV treatment and care facilities, TB preventive therapy for people living with HIV, TB screening for people living with HIV, regional procurement and supply management mechanisms, improved
	Orphans and vulnerable children yet to be considered	Standard operating procedures for orphans and vulnerable children in place

	Overall achievements: Treatment has been scaled up to a level of 65%. Guideline has been developed for nutrition care and comprehensive care and support services for PLHA. Implementing partners capacity improved.	**Overall achievements:** • Establish treatment at IDH and BSMMU • Continued supply of ARV for four years
Monitoring and evaluation	Guidelines on tools for data collection yet to be detailed in M&E plan	Guidelines on tools for data collection incorporated in M&E plan
	M&E unit was planned	Functional national M&E unit in place in Ministry
	Central national database planned	Central national database gradually being developed
	M&E data not adequately used	Use of M&E data improved (eg. data used in proposal development, gaps analyses, project site selection, pediatric treatment, care and support, ARV drug procurement and dispensing, etc.)
	Overall score was 3	Overall score is 6
	Overall achievements: M&E framework finalized DIC -MIS database development is under process .	**Overall achievements:** • Costed National M & E Plan for 2011-15 drafted and approved by HIV technical sub committee • Midterm review of National M & E Plan for 2011-15 planned • Piloting of on-line posting of drop-in-center data completed
Part B (filled out by Civil Society representatives and Development Partners)		
Human Rights	"Legal aid systems for HIV casework" was "Yes" as it was realized that policy support and acknowledgement was pursued	Overall scores are mostly unchanged. "Legal aid systems for HIV casework" is "No", but it is realized that policy support and acknowledgement is now well in place.
	Overall achievements: Ongoing advocacy and capacity building of self help group Harm reduction issues in Police training course. GOB orders to support local interventions. No law, even there is law, no implementation. No institution to monitor from rights point of view	**Overall achievements:** • Human rights commission is now engaged with KAP to address their HR concerns • A core group of Parliamentarians are working to address HR issues of HIV infected and affected population • Sports icons and cultural activists are involved in national AIDS response. • Policy advocacy done at the highest level of Bangladesh's political leadership • Media is sensitized on human rights issues of Key population • Capacity of self-help groups/peer educators developed for advocacy on human rights issues. • Local administration/law enforcing agencies are sensitized on human right issues of key populations

Civil society participation	Average score was 3 – 4 in relevant questions In general civil society participation was rated as 6	Overall scores have increased to an average of 4 – 5 In general civil society participation is rated as 8
	Overall achievements: Since 2007 the coverage of HIV program has increased amongst different population except MSM/hijra but not at significant level. Consistent ART provided HIV program are implemented by CS Other than NGOs other civil society organization don't have that much involvement regarding this	**Overall achievements:** • Full participation of civil society implementers in the Assessment of National M&E System and the size estimation of MARPs and development of the National M&E Plan, National Strategic Plan, ART guideline, and counseling manual. • Participated in publications/ dissemination of research findings that includes Serological Surveillances • Civil Society is leading interventions among SWs, PWID, MSM, etc. to create awareness about HIV/AIDS., STI, VCT, etc and to ensure safer sex and other practices. • SHG of PLHV and SHG group of FSW are leading two separate intervention packages in national-level programs. • Civil Society is leading advocacy efforts with Government for continuing PLHIV Package. • For the 1st time in Bangladesh, a National Conference of Female Sex Workers on "Rights and Legal Issues" was held on November 23, 2011. Different Sex Worker organizations were involved in organizing this conference • Participated in the preparation of Nutritional Guidelines for PLHIV • Civil Society has initiated program for cross-border migrants and is increasing the participation of service providers and enhancing local level advocacy
Prevention	Implementation of HIV prevention interventions was yet to extend to testing, counseling and risk reduction for MSM, and to risk reduction among out of school children	It is now generally agreed that implementation of HIV prevention interventions now includes testing, counseling and risk reduction for MSM, and risk reduction among out of school children
	Overall score on prevention efforts was 5	Overall score on prevention efforts is 7

	Overall achievements: Development of M&E framework of national technical support plan Strategy for harm reduction and SW's interventions. SOP for PLHA Guideline for PPTCT Nutritional guideline for PLHA Scaling up ART Capacity building for M&E National HIV MIS piloting Initiation to form national PLHA network organization Coverage high Capacity of the NGOs built up Vulnerable people can raise their voice Sustained efforts.	**Overall achievements:** • The low HIV prevalence rate among KAP are well sustained • National level programs since 2008 and 2009 are smoothly ongoing (without interruption) for PWID, FSWs, young people, PLHIV, garments factory workers, MSW, MSM, Hijra and also general people through evidence based programming • STI rate is either unchanged or decreased in certain sites • Condom use rate has increased. • Capacity of members of self-help groups and service providers have increased. • OST has been piloted • Intervention program for prisoners has been piloted • High risk intervention program was in place, and partially funded by HNPSP from 2010 to June 2011 • Asia-Pacific regional-level interventions for PLHIV and MSM installed
Treatment, care and support	Country did not have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children	Country has defined standard operational procedures to address the additional HIV-related needs of orphans and other vulnerable children
	Implementation of treatment, care and support did not cover ART, nutritional care, pediatric treatment, treatment of common infections, HIV-TB co-infection, prophylactic cotrimoxazole	Implementation of treatment, care and support now covers ART, nutritional care, pediatric treatment, treatment of common infections, HIV-TB co-infection, prophylactic cotrimoxazole
	Overall score was 4	Overall score is 7
	Overall achievements: Scale up ART Funding increased SOP for PLHIV Infectious Disease Hospital Dhaka involved for treatment There are CBOs working Demand raised for care and support program Fund available Provide ART to the PLHIV free of cost	**Overall achievements:** • Around 600 identified PLHIVs are getting ARV through donor support. • Identified PLHIV are reached with care and support services • Availability of fund for ART ensured • National ART guideline updated • National guideline on TB-HIV co-infection developed • TB and HIV co-infection issues addressed both through National TB control Program and NASP • Service Providers are aware of HIV treatment, care and support

From the above table it maybe said that Bangladesh has prioritized interventions in a planned manner and gradually advanced towards upholding the national commitments to prevent HIV and pursue standardized treatment, care and support. The Government has mobilized credits and grants from development partners, including the World Bank, the Global Fund, UN agencies, and other

multilateral and bilateral donors and also recognizes their role and contribution to fight the HIV/AIDS epidemic.

Most importantly there are no gender discrepancies in prevention, treatment and care of HIV/AIDS in Bangladesh. Equal access is observed in all interventions. To further ensure the service access of women and young girls, HIV preventive services are expanded to reach vulnerable women. Specific facilities are established near vulnerable female communities. To achieve better access, most of the service facilities are run by female service providers and outreach workers. To address special need and context, for example, separate female service centers are opened for female injecting drug users.

(B) The National M&E System Assessment, 2010 and the National M&E Plan, 2011-2015

The overall goal of the National M&E Plan is to support development of a twelve component functional National AIDS M&E System based on the 12 component organizing framework (Annex-5) for a functional national HIV M&E System (UNAIDS 2009) that enables to generate, collect and use the strategic information for program improvement, recognizes accountability/reporting requirements, promotes transparency and allows further sharing, analysis and advancement of knowledge[31] [32].

Prior to the development of the updated National M&E Plan, the M&E systems of NASP, civil society and key ministries an departments were assessed to explore strengths and identify gaps / areas of improvement. The exercise took place involving multiple stakeholders through workshops, interviews and feedback systems. The assessment was conducted using the 12 component M&E system assessment tool. The National M&E Plan is based on the recommendations of the assessment and takes into consideration the results based framework of the NSP.

The specific objectives of the National M&E Plan are:

- To provide a common understanding on the scope and priorities of a national M&E system;
- To ensure more effective coordination, greater transparency, and better communication among all stakeholders involved in the national response;
- To guide the roles and responsibilities of the stakeholders and improvement of identified M&E capacity for different levels of policy makers, managers and relevant professionals/service providers for successful implementation of the M&E plan
- To guide implementing partners in the collection of priority data that are relevant to measure the progress of the National Strategic Plan;
- To provide stakeholders with the data collection tools, including recording and reporting formats and specifics on the needed frequency of collection, compilation and analysis of priority information
- To provide stakeholders the information on the future need of resources for conducting M&E activities and a roadmap for implementing the M&E Plan from 2011 through 2015

The M&E TWG recommended categorizing of Indictors into four programmatic areas keeping in mind the four objectives as well as the overall goals as outlined in National Strategic Plan 2011-2015:

1) National policy and leadership support and enabling environment

2) HIV prevention among most-at-risk populations, including the emerging risk and higher vulnerable populations, general populations and hospital based interventions;

[31] 12 Components Monitoring and Evaluation System Strengthening Tool. Geneva: UNAIDS, 2009

[32] 3rd National Strategic plan, 2011-15

3) Treatment, care and support.
4) Coordination, management, capacity building and strategic information

Under these 4 areas there are a total of 41 input, output, outcome and impact level indicators with data source, budget, collection frequency, etc. detailed.

(C) The National Response

National response to HIV is being guided by a number of well developed strategies/guidelines. Till date, through well documented collaboration between Government departments, civil society, private sectors, and the Development Partners the national response has been multi-dimensional to maintain a low prevalence status in Bangladesh. Some of the achievements of this multi-sectoral collaboration in Bangladesh include:

- Updating of:
    - National Strategic Plan for 2011-2015
    - National M&E Plan for 2011-2015 based on the national M&E systems assessment and linking to the NSP

- National policy on HIV/AIDS and STD related issues, 1995/96

- Ensuring continuous availability of funds/loans from various sources including the World Bank, the Global Fund, USAID, etc. and channeling of these funds through civil society to implement a diverse range of interventions in a low prevalent state.

- Containing the concentrated epidemic among PWID

- 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 world. 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[33].

- Piloting OST with support from the Drugs and Narcotics Control Department

- Facilitating the approval of two regional proposals (South Asian and Asia-Pacific region) on interventions supporting MSM and PLHIV to be implemented by a CBO and a self-help group.

- Updating national size estimates of KAP and conducting Participatory Situation Assessment among MSM, MSW and *Hijra*
- Maintaining the coverage among the KAP

- Piloting prevention interventions among prisoners

- Piloting of PPTCT program including ART for mothers, virological tests for infants and training of service providers in selected sites

[33] HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage, Mathers, B. Degenhart, l. Ali, H. Et.al. The lancet.com published online March 10, 2010

- Involving parliamentarians and law enforcers in various HIV and AIDS related decision-making, training and advocacy forums including harm reduction.

- Channeling of ARV among PLHIV in a continued manner since 2008

- Sustaining efforts among young people through the Ministry of Education and the Ministry of Youth and Sports, namely the Department of Youth Development through incorporation of HIV related information into in-service training courses and most importantly into the national education curriculum

- Mainstreaming reporting on Youth Friendly Health Services through the national health Management Information System

- Facilitating the investment of the garment sector in the training of garment factory workers on life skills education.

- Development of the stigma and discrimination training module and conducting the training among 48 doctors, nurses, counselors, program implementers, lab technicians/ technologists, pharmacy managers and in-patient attendants

- Revolutionizing media support towards HIV/AIDS issues among young people and among KAP. Through multiple media-channel approaches via partnership among government departments and private sector channels along with other collaborating agencies - issues relating to the use of condoms as dual protection, sex workers rights, MSM matters, injecting drug users, vulnerability of young people, etc. are being openly discussed and advertized pictorially through commercials, talk shows, local-level shows, newspaper features, bill-boards, etc.

- Overcoming several laws and acts that are still limiting the access of KAP to prevention services by implementing policy revisions and approved strategy documents and standard operating procedures. For example- the national AIDS policy recognizes harm reduction approaches and the NASP incorporated harm reduction services for IDUs in its strategic plan since 2004. Bangladesh started its NSP for IDUs in the late 1990s, expanded it over the years and has now piloted OST. In addition the process to support the review if these laws has started.

The following paragraphs will summarize the performance of the National AIDS Response vis-à-vis the GARPR indicators.

C1) Prevention among KAP

The prevention programs continue to be focused on the KAP s such as PWID, FSW, MSM, MSW, Transgender (Hijras),and their intimate partners. The three key funders in the country are USAID, World Bank and GFATM. The funding mechanism is usually through management agencies. A new National size estimation exercise of KAP, under the leadership of NASP and with support from UNAIDS, was conducted in 2009. The following table summarizes the latest estimates:

Table 4: 2009 Size Estimates for Most at Risk Populations in Bangladesh[34]

Population Group	2009 Size Estimate		Population Proportion (15-49)			
			Male		Female	
	Low	High	Low	High	Low	High
Male IDU	21,800	23,800	0.06%	0.07%		
Total FSW	63,600	74,300			0.19%	0.22%
Brothel	3,100	3,600				
Street	25,500	30,700			0.08%	0.10%
Hotel and Residence	35,000	40,000			0.10%	0.12%
Clients of FSW	2,714,000	3,733,000	8%	11%		
Returning Migrants	381,000	762,000				

Note: Numbers rounded to the nearest 100

The remaining groups (MSW, MSM, hijras) did not have enough data to warrant updates of the estimates. Updates for these groups are planned as and when new data become available.

Currently there are five key prevention intervention program being implemented in the country, which are, as discussed earlier: The HIV/AIDS Intervention Services (HAIS), Global Fund to Fight AIDS, Tuberculosis and Malaria supported national programs, Modhumita, and two Global Fund supported regional programs.

HAIS focused on intervention packages for four high risk groups: IDUs, street based sex workers, hotel and residence based sex workers, and clients of sex workers through a total of 8 NGOs who are consortium members of 4 lead NGOs. The HAIS ended in June 2011 and currently interventions are being planned to start under HPNSDP by mid-2012. Thus since July 2011 no intervention has been implemented in the project sites previously covered by HAIS. In addition during the whole reporting period there was no intervention for brothel-based sex workers.

The Principal and Sub Recipients of the Global Fund supported interventions have been working meticulously to help minimize any gap in targeted interventions for KAP. Currently the Global Fund supported programs comprise the largest targeted Intervention in terms of geographical and population coverage. Till 2011 the Global Fund has supported the set up of 70 DIC for PWID in 26 districts reaching almost 14,000 PWID, 100 DIC and 10 outlets for FSW in 51 districts reaching about 28,000 FSW and 65 DIC for MSM/MSW/hijra in 40 districts reaching about 33,000 MSM/MSW/hijra.

Another key programme is the Modhumita being implemented with support of USAID. Some of the key activities/components supported through Modhumita are: tuberculosis and family planning

[34] Size Estimation, NASP & UNAIDS,2009

integration into services for PLHIV and KAP-activities include TB awareness raising, sputum collection for screening and testing for TB, follow-up for DOTS, developing BCC materials etc.; integration of VCT in Public Health Sector (2 Upazila Health Complexes) in collaboration with DGHS; quality assurance and quality improvement (QAQI) approaches to ensure for example provider compliance with clinical guidelines and standards; satellite VCT to reach more people who inject drugs; and Medical Waste Management which is supported by a standard operating procedure and required training to guide Modhumita centers for using safe and environment friendly procedures that comply with local regulations. This project is currently reaching about 2000-2500 PWID with demand reduction services and 7,000 FSW in 17 districts.

The South Asia Regional HIV/AIDS Programme focuses on Community System Strengthening through building the capacity of 25 local community-based organizations to deliver high quality services, engage in policy development and advocacy initiatives, and take part in advocacy and research on HIV-related issues affecting MSM and transgender populations. The programme aims to strengthen community systems to support and sustain this work by training 450 MSM in this regard.

The PLHIV Response to AIDS in Asia and the Pacific – Regional Advocacy for Treatment Needs of PLHIV in Asia & Pacific focuses on conducting research to assess various needs of PLHIV regarding treatment, support, etc. in case of Bangladesh.

Analysis of Key GARPR Indicators Related to KAP

Number of KAP Reached

As per the information provided, KAP coverage with various interventions are impressive. For example of the approximately 74,000 female sex workers, over 35,000 are being reached with services and of the 23,000 PWID 14,000 are being reached with harm reduction service. However as there is no updated behavioral surveillance data this report must repeat the previous reported figure of around 7.2 percent service coverage among KAP[35]. To update this information based on recent scaling up of services a fresh behavioral survey is required urgently. The overall impact, ie. decrease of prevalence among IDU in Dhaka and no significant increase in any of the other KAP groups indicate that programmatic coverage data is reliable.

Information on MSW and MSM has however been updated and the PSA conducted in 2010 indicates that the MSW reached with prevention programs has doubled, while MSM reach has increased by 0.9 percent. Previously 22.9% of hijra (transgender) were reached (2010 UNGASS), while the 2010 PSA found 33.6% of hijra were reached with prevention program. Similar changes are also expected in other KAP groups, namely PWID and FSW.

Behaviour Change

Behavior change data to is mostly from the BSS conducted in 2006-2007 and recent evidence from serological surveillance data and program coverage data indicate that information on condom use and sharing of injecting equipment needs to be updated.

From the 2010 PSA it seems that condoms use has decreased in general among MSM, MSW and Hijra. Among MSW it is from 43.7% to 39% in case of new clients. In case of MSM the decrease is almost 6%. It is assumed that a fresh BSS accommodating the condom use definition as per the one

[35] BSS,2006-7

being used for this report would provide updated information on the status as interventions for about 33,000 MSM/MSW/Hijra have begun since 2009 and are well in place now. It would be especially interesting to note data on Hijra from a fresh BSS, as the recent PSA indicates that the condom use decrease is 47.6% among them since 2006/7 to 2010. Impact of intervention, sampling and data collection need to be considered for a more satisfactory comparison, not only in these three groups of KAP but also for FSW and IDU in future BSS.

Attempts had been made to motivate the KAP to get HIV testing and Save the Children, FHI360, icddr,b, Ashar Alo Society and it's consortium partners (of the RCC Grant) have coordinated to improve their access to testing facilities. Thus for the indicator – Percentage of sex workers who have received an HIV test in the last 12 months and know their results – a marked increase is seen among MSW from 4.1% to 37.7% as updated data is available. The same is the case for MSM, where the increase is almost 4 fold. In case of Hijra, their testing and knowledge of testing results have doubled from 14.3% in 2007 to 28.7 in 2010. Again, given the increased coverage of programs for IDU and FSW and increased coordinated efforts among implementers/management agencies updated data on IDU and FSW is required to understand progress.

Table 5: Progress made among MSM, MSW and Hijra as per available updated data

Indicator	**Population Group**	**Indicator Value (%)**			**% change between 2009 and 2011**
		2005	**2009**	**2010/11**	
Percentage of sex-workers / men who have sex with men / Hijra reached with HIV prevention programmes	MSW	20.4	18.0	36.6	18.6
	MSM	0.66	8.1	9.0	0.9
	Hijra (TG)	1.46	22.3	33.6	11.3
Percentage of sex workers reporting the use of a condom with their most recent client (new clients in the last week)	MSW	44.1	43.7	39.0	-4.7
	Hijra (TG)	15.6	66.5	18.9	-47.6
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner (in the last month)	MSM: *Commercial sex*	49.2	29.5	23.7	-5.8
	MSM: *Non-commercial sex*	37.0	24.3	20.9	-3.4
Percentage of sex workers / men who have sex with men / Hijra who have received an HIV test in the past 12 months and know their results	MSW	1.1	4.1	37.7	33.6
	MSM	0.0	2.5	9.3	6.8
	Hijra (TG)	0.0	14.3	28.7	14.4
Source:		BSS 2003-04	BSS 2006-07	PSA 2010, icddr,b (unpublished)	

For the indicator - number of syringes distributed per person who injects drugs per year by needle and syringe programmes – each IDU has received on average 263.7 syringes in a year. Needles and syringes are distributed as per the needs of IDU which maybe 2 to 3 per day to 1 per week.

Impact of the Prevention Programme on key affected populations

The latest serological surveillance conducted in 2011 shows the overall prevalence among the KAP is below 1% and remains unchanged since the last round in 2007. A major limitation of the serological surveillance is the lack of representation of the geographical areas. Besides, sampling is being done mostly through the NGOs who are providing prevention services to the KAP, thus the uncovered population is not included. Reasons for low prevalence might be lack of geographical representation of different KAP in the serological surveillance, high levels of circumcision among men, existence of prevention program for a long time etc.

The following table summarizes percentage of KAP who are HIV infected:

Table 6: Trends in percentage of sex workers / MSM / Hijra / PWID who are living with HIV*

Population Group	Indicator Value (%)			
	2005	2007	2009	2011
Female Sex Worker	0.3	0.1	0.3	0.3
Male Sex Worker	0.0	0.7	0.3	0.0
MSM	0.0	0.2	0.0	0.0
Combined MSW and MSM	0.4	Not sampled	0.3	0.0
Hijra	0.8	0.6	0.3	1.1
Male PWID	1.5	1.9	1.6	1.0
Female PWID	0.0	0.8	1.0	1.1
Combined PWID and Heroin Smoker (male and female)	Not sampled	0.0	0.1	1.1 M: 0.0 F: 1.1
Heroin Smoker	0.5	0.0	0.2	0.0
All risk groups	0.6	0.9	0.7	0.7
Source:	National HIV Serological Surveillance, 2004-2005	National HIV Serological Surveillance, 2006	National HIV Serological Surveillance, 2007	National HIV Serological Surveillance, 2011

** Note: 1. Number of geographical locations varies from year to year*
2. Brothel based sex workers not sampled since 2007

C2) Prevention among the General Population:

The National Strategic Plan for HIV/AIDS (2011 -2015) has included international migrant workers, transport workers, especially vulnerable adolescents and prisoners within it's framework and has set relevant indicators to track progress (Annex 4). The NSP suggests that while there is little evidence of effectiveness on which to base prevention interventions with these groups maybe formulated strong logical case can be made to continue the limited number of interventions already outlined, while, other interventions will be piloted and evaluated and those which prove to be effective scaled up.

For International Migrant Workers focus will be on HIV LSE, message reinforcement, and VCT for returning workers.

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 poverty (Interagency Task Team on HIV and Young People. Guidance Note: HIV Interventions for Most at Risk Young People. UNAIDS). Adolescents living on the street or in institutions are the most easily identified EVA. The immediate focus will be to strengthen 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.

Transport workers 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. Experiences from the pilot intervention among prisoners is planned to be scaled up.
In addition to the above, strategies have been outlined to minimize HIV and STI transmission among the young people and general population through BCC, VCT and PITC, STI service provision, condom access, LSE, YFHS and work-place based interventions.

The existing programs among the garments factory workers and youth implemented via Save the Children with the Global Fund support have been the main focus of interventions for the general population. Activities include: HIV prevention information through radio and television shows that have attracted very large audiences, open air concerts and print media (billboards, advertisements, posters, leaflets, stickers, calendars, T –shirts and caps); life skills education through youth organizations and clubs; integration of HIV prevention information into the secondary school curriculum; youth friendly services for sexually transmitted infections and outreach activities and peer education to promote safe sex and encourage more treatment seeking; and conducting research to guide evidence based programs.

Analysis of Key GARPR Indicators Related to General Population including Young People

Knowledge and Behavior

The data presented in this report is mainly reliable on the same two sources used in the previous UNGASS report (2010), as no new representative survey among men or young people have been conducted and the general population is not sampled in the behavioral surveillance surveys. As a result the data available in the country for indicators related knowledge and behavior is the same as the 2008 and 2010 UNGASS report.

The National End Line HIV/AIDS Survey among Youth in Bangladesh had been published and it reports an overall increase in HIV knowledge level for the male and female in the age of 15-24, from 10.2 percent to 17.7 percent (for males 10.4% to 22.5% and for females 10.0% to 13.4%). The findings from the BDHS 2007 and the Multiple Indicator Cluster Survey (PROGOTIR PATHEY-2009) also explored similar level of knowledge among the young population. In the BDHS-2007, 17.9 percent of the men and 8 percent of the women of age 15 -25 had comprehensive knowledge on AIDS. In the Multiple Indicator Cluster Survey (MICS) conducted in 2009, 14.6 percent of women aged 15-24 years have comprehensive knowledge of HIV prevention. A cross-sectional survey among two universities also found that the knowledge levels of young males were higher than females as did the endline.

In the baseline of National Survey on Youth, it was reported that 41.2 percent of the respondents in the age group of 15 to 24 reported use of condom during high risk sex contact (last six months) and the end-line study reported an increase to 55.3 percent in condom use in the same group. The same

study reported a decrease in STI prevalence from 0.6 percent in the baseline to 0.3 percent in the end –line study (specimen positive for both RPR and TPHA indicating current syphilis infection).

For the indicator – percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse, the study done by FHI/ICDDRB 2006 (Assessment of sexual behavior of men in Bangladesh) reported the result as 35.0 percent. Data on the females for this indicator is not available in the country.

For the indicator - percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months, the same study (Assessment of sexual behavior of men in Bangladesh) reported 12.9 percent and the data for females is not available for this indicator.

On the indicator – percentage of young women and men who have had sexual intercourse before the age of 15 - according to the National Baseline and End Line HIV/AIDS Survey among Youth (aged 15 to 24) in Bangladesh, done by NASP, SCUSA and ICDDR,B, overall there is a decrease from 27.1 percent (Baseline, 2005) to 24.3 (End line, 2008). In the male respondents, there is a very minor increase from 11.6 to 11.8 percent and among the female respondents there is a decrease from 35.7 to 24.3 percent.

As surveys on general population do not include questions on VCT, thus for the indicator - Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results – program records from the Urban Primary Health Care Project has been used as the project serves general populations of the major cities of Bangladesh in 12 districts. From the records it is seen that while 44.1% of males know about their results, only 18.5% of females know. FHI 360 has similar data on KAP and other vulnerable groups (hotel, residence and street based FSW; MSW; PLHIV; Hijra; TB patients), where 96% of males, 97% of females and 99% of transgender received their results.

Impact of HIV program
There has been no population based survey to detect the prevalence among the general population. However during 2001 to 2010, a total of 2,439,856 units of blood were tested, out of which 28,947 units were rejected (1.5%) due to the evidence of transfusion-transmitted infections (TTIs). Of the rejected units, 21,709 were for hepatitis B; 3,161 for hepatitis C; 2,799 for syphilis, 1,149 for malarial parasites, and 126 was for HIV[36].

The Safe Blood Transfusion Program made a good progress over the past years through reduction in the number of paid donors from 70% to 0%, capacity-building for blood-screening in all blood transfusion centers for HIV, hepatitis B and C, syphilis and malaria, and expansion of activities up to the upazila health complex level. Currently, 203 blood transfusion centers, with 89 in the upazila level, are functional under the program[37].

C3) Strengthening of treatment, care and support program for the PLHIV

Prevention of Parent to Child Transmission:
On the Indicator – percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission - it is not possible to calculate the denominator data as there is no representational accepted estimation on proportion of pregnant women who may be HIV

[36] Health Bulletin DGHS, 2011
[37] Health Bulletin DGHS, 2011

infected. However it is recorded by program implementers that 15 HIV-infected pregnant women received antiretroviral during the last 12 months to reduce mother-to child transmission.

Data on percentage child infections from HIV-infected women delivering in the past 12 months is not available due to lack of estimated data.

Early detection of HIV in infants

Data cannot be provided for indicator 3.2 as virological test for infants is not a routine practice in Bangladesh. However, a UNICEF funded study supported the virological tests for infant from 2010 to 2011. Under this study 3 infants were tested and all were negative. The denominator (number of HIV-infected pregnant women giving birth in the last 12 months) information is not available.

Care and Support for People with HIV and Anti retroviral Therapy Coverage

Currently 681 HIV positive persons are receiving ART from 5 ART centers in Bangladesh – all of which are run by civil society organizations. Three ART centers are situated in the capital city, one is in the port city and one is in the city recorded to have high external migration. Most of the ART centers provide holistic services including VCT, nutrition support, treatment for TB co-infection, etc. Of the 681 persons 415 are male and 266 are female.

On the indicator – percentage of eligible adults and children currently receiving antiretroviral therapy, the current ART coverage has been maintained at 45%. It was 47.7% in the previous report. About 84.2% of adults and children with HIV are known to be on treatment 12 months after initiation of antiretroviral therapy. Of them 82.6% are male and 87.3% are female. This is a slight decrease from 90.1% in the 2010 UNGASS report. Out of 424 persons initiating, 357 had continued for 12 months. Of the 67 who had discontinued – 46 had died, 9 had stopped therapy and 12 were lost to follow-up or transferred.

Currently plans are being formulated to procure ARV drugs through the HPNSDP, rather that the civil society.

Co-management of TB and HIV Treatment

The extent of TB/HIV co-infection is not exactly known in Bangladesh, where TB is a major public health problem. There is a clear need to keep the trend of TB/HIV co-infection under surveillance. The National TB Control Program (NTP) and National AIDS/STD Program (NASP) had initiated TB/HIV Collaboration with commitment of policy makers in MOH&FW and DGHS to reduce the burden of TB/HIV Co-infection and TB/HIV related morbidly and mortality. A National TB/HIV coordination Committee was established in March 08, 2008 with the approval of the Director General of Health Services, DGHS. The committee recommended establishing volunteer counseling and testing (VCT) centers at tertiary level TB Hospitals with an aim to screen HIV among complicated TB cases as well as to provide comprehensive support to the identified TB-HIV co-infected cases. Upon that decision FHI360 worked closely with NIDCH, BRAC and Damien Foundation and established 10 VCT center, with recruitment of counselor and lab technician, procurement of logistics and necessary renovation of the center. Now the centers are providing VCT services to TB patients.

In 2011 WHO reported the estimated number of HIV positive TB as 580. Based on this estimate and program records from organizations supporting PLHIV the estimated HIV-positive incident TB cases that received treatment for both TB and HIV is 13.97%.

C4) Tracking Critical Enablers and Synergies with Development Sectors

Violence against women

Certain aspects of Bangladeshi society, such as restrictions on women's movement outside their homes, unequal access to education, and restricted employment opportunities, limit women's ability to exercise their human rights and make them more vulnerable to domestic violence (Bennett and Manderson, 2003). Although Article 28 of the Bangladeshi constitution states, "The State shall not discriminate against any citizen on grounds only of religion, race, caste, sex or place of birth" (Mittra and Kumar, 2004: 211), women experience many forms of discrimination and inequality and have few protections particularly against domestic violence. Some claim that domestic violence is a mundane aspect of many women's lives in Bangladesh (Akanda and Shamim, 1985; Ameen, 2005; Begum, 2005). Bangladeshi women, however, are not an exception. Routine violence is part of many women's lives around the world, and most violence against women occurs within the home, typically perpetrated by husbands and in-laws (Momsen, 2004)[38].

Violence is closely linked to empowerment and decision-making, which inadvertently impact on the transmission of HIV-both in commercial and non-commercial sex. The proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months is 53.3%.

School attendance of Orphans

The data on the current school attendance among orphans & non-orphans aged 10–14 is not available in the country. In 2007 UNICEF estimated about 5,000,000 children (aged 0–17) are orphaned due to all causes.

Poverty reduction

For the indicator proportion of the poorest households who received external economic support in the last 3 months – exact data is not available, however percent of household receiving benefit from Social Safety Nets program was 24.57 in 2010.

[38] Momsen, 2004

IV. Best practices

Piloting Opioid Substitution Therapy with Methadone in Dhaka, Bangladesh

In Bangladesh, efforts to halt the spread of the HIV epidemic among people who inject drugs (PWID), are being intensified as evidence shows the presence of a concentrated epidemic as well as high risk behaviours among this group that can fuel the epidemic particularly in the capital city Dhaka.

UNODC and International Centre for Diarrhoeal Disease, Bangladesh (icddr,b) are working jointly with the Government of Bangladesh to introduce opiod substitution therapy (OST) among PWID. Advocacy on OST started in Bangladesh more than 10 years ago and finally in 2008 the National Narcotics Control Board (NNCB) of Bangladesh approved the pilot study on OST using methadone under the project "Prevention of Transmission of HIV among drug users in SAARC Countries" of UNODC Regional Office for South Asia (UNODC-ROSA) supported by AusAID. The pilot program started in June 2010 with the opening of the Methadone Maintenance Therapy (MMT) clinic at the Central Drug Addiction Treatment Centre (CTC) of the Department of Narcotics Control (DNC)) with support initially from UNODC ROSA and later also from Family Health International (fhi360).

The pilot intervention is aimed at reducing high risk behaviour leading to the spread of HIV, psychological distress and drug dependency with the goal of improving the quality of life of people who inject drugs. The MMT clinic at CTC has been providing different types of services to its clients along with regular dispensing of methadone (365 days in a year). These services include: outpatient services with general medicine; counselling, motivational enhancement and psychiatric services; laboratory investigations if required; community sensitisation and methadone anonymous meeting; providing free of charge HIV testing services; and referring patients if required to nearest hospital for TB screening and treatment and PLHIV self help group for ARV medication only for HIV positive patient. The study is being implemented for about a year and half and 150 clients have been enrolled. A major achievement of the pilot has been the successful weaning from drug dependence in 11 clients all of whom are free from drugs for at least four months. In case of all these 11 PWID earlier attempts to recover using conventional detoxification and rehabilitation services failed. Other notable features of the pilot have been the requirement of relatively low doses of methadone for stabilisation and a high retention rate (80%). The clients of the MMT clinic at CTC were stabilised on an average dose of 49 mg in the maintenance phase.

It is expected that another MMT clinic will be started soon at a Drop In Centre providing needle syringe program and other harm reduction services in to PWID Dhaka under Global Fund support managed by the Save the Children and implemented by CARE Bangladesh with technical assistance from icddr,b and the UNODC. Based on the success of the OST pilot project, the Ministry of Health and Family Welfare has incorporated the OST programme in its health sector programme.

Enhancing and assessing interventions among key affected populations

In the past two years Bangladesh has advanced in scaling up interventionsw among KAP and has also documented program performance and innovations to help guide future program design.

In case of MSM, MSW and Hijra icddr,b with support from the Global Fund had conducted behavioral surveys and size estimations to create evidence in setting intervention site and design at micro-level. Information on risk behaviors, mobility, violence, knowledge, etc. was gathered and when published will serve as a national resource, especially for the context of the capital city.

Save the Children and icddr,b with Global Fund support documented the following studies (unpublished draft reports) all of which would contribute on developing focused proposals in the future:

1) **Title:** Effects of changes in the Drop-in-Centre operations on the service utilization and changes in advocacy strategies on adoption of safer sex practices among female sex workers in Dhaka:
   The study found that majority of the FSWs suggested to open the DICs for all types of sex workers, and the highest of such suggestion came from street based FSWs. For those who opposed integrated DICs, it is suggested to initiate counseling to the FSWs and develop guidelines for the FSWs to maintain for staying and utilizing DIC oriented services. This study did not find much change in level of harassment the FSWs faced during the last one year of baseline and endline surveys (68% vs 70%) but mean number of harassment faced decreased significantly (15 vs 7). The study also provides constructive recommendations.

2) **Title:** HIV prevention services for female sex workers (FSWs): effects of changes in STI management and condom promotion strategies:
   The study recommended that existing DIC services should emphasize on consistent condom use; and in case of a physician providing STI services the hours need tol be extended (as per the demand of the FSW).

3) **Title:** Assessing the effectiveness and quality of harm reduction services for injecting drug users delivered through their peers in Dhaka and identifying gaps and barriers to effective service provision:
   This study provides insight onto the advantages and disadvantages of peer-based and non-peer-based approaches for PWID interventions to help guide programmers in monitoring and implementation design.

UNFPA also in collaboration with NASP, HASAB and Human Development Research center conducted studies on interventions among Hijra and brothel-based sex workers to suggest further enhancement of interventions:

1) Operation Research on Activities among Transgender for prevention of STI and HIV/AIDS: Practical recommendations are made in terms of improving health seeking behavior, IEC and BCC materials, usefulness of vocational training, knowledge and capacity retention (of all interventions provided), family level advocacy, implications of life skills education, etc.

2) Operations Research on Brothel Based Sex Workers and Self-Help Groups for Prevention of STIs and HIV/AIDS:
Condom use, addiction, dimensions of bonded and independent sex workers, violence, role of media, etc. were explored to make recommendations such as addressing illiteracy, condom use barriers, active participation of power structures in planning and implementation of all HIV prevention program components, strengthening of self-help groups towards promotion of safer sex and human rights even after withdrawal of project, medical services, condom affordability, use of female condom, etc.

Mainstreaming Life Skills Education among Young People and Adolescents

Since 2004 the Global Fund, NASP, Save the Children and HASAB have been jointly supporting interventions among young people through life skills education exploring means to increase access to condoms and establishing youth friendly health services. UNICEF too had conducted pilots on life skills education. In addition recently UNAIDS supported a cross-sectional survey among university students. These processes are being well documented and are further adding to the information Bangladesh has through the National Endline Survey among Youth in Bangladesh, 2008.

Some achievements documented through the implementation of life skills education among young people include:

- The training of 810,174 young people on HIV and life skills, equipping them with information on access and empowerment.
- Development of an LSE manual for community based Life Skills Education to prevent HIV / AIDS among 15-24 years olds and subsequent development of an LSE curriculum for Department of Youth Development (DYD) officials, which was adapted and finalized by respective officials of the training division of central DYD. LSE mainstreaming is now and on-going training program of DYD.

The DYD officials enlist youth club/organizations, organize group meetings on health/income generating activities etc.

Knowledge, attitudes and practices towards HIV/AIDS-related risk factors among public and private university students in Bangladesh

The cross-sectional survey of 456 students (49% females and 51% males) between ages 18 through 24 was conducted in November 2011. The participants in the present study were recruited from the University of Dhaka and Independent University, Bangladesh. The study adopted quantitative research method and used a random sampling technique.

Knowledge on the difference between HIV and AIDS was highest (54%) among students from public university and the lowest (46%) among those from private university. The main source of information for AIDS awareness as reported by the students was television (86%). A total of 9% respondents indicated that HIV is a curse of God, or a healthy and well-built person cannot have HIV (12%). Students held considerable misconceptions about HIV transmission by mosquito bite (2.6%), kissing (2.9%), sharing pubic toilet (1.1%) and drinking/sharing a meal with an HIV infected person (1.5%). On an average, males compared to females had better knowledge on HIV and AIDS in terms of mode of transmission and prevention.

On the whole, majority of the respondents were well versed on the various ways in which one can protect him/herself from HIV/AIDS. However, more than one-third (20.7%) of the students perceived

themselves as having no knowledge about the symptoms of AIDS (IUB 25.9 vs. DU 15.4%). A significant proportion of students stated that HIV can be cured (IUB 12.7 vs. DU 4.8%).

In addition the participants said that tests for HIV were performed during donating blood. Private university students were more likely than public university students to get tested for HIV (24.1% vs. 8.8%, $P < 0.005$). The most reported site visited for HIV testing was private clinics (54.7%), followed by government clinics (44%).

The majority (63%) of the students reported having boy/girl friend. Among all 123 students who reported engaging in sexual act with their current boy or girl friend, 26.8% of students never used condoms with these partners during the last sexual act. The most common reason for not using condoms included having a feeling of not being at risk (38.9%) followed by a response indicating that they trust their partner (33.3%) or did not have condom during sex (38.9%). Around 2.6% (n= 12) of the young people in the survey reported having sex with a commercial female sex worker. Analyses conducted among the students who reported ever having had sex with a commercial sex worker revealed that a higher percentage of Independent University students (58.33% n=7) than Dhaka University students (33.3%, n=4 P = NS) were engaged in commercial sex. Respondents were asked to assess their personal risk of acquiring HIV/AIDS. In the sample, 14.5% (DU 11.0 vs. IUB 3.5, $P = 0.000$) considered themselves at risk of acquiring HIV.

The study found that a large proportion (35.3%) of adolescents were not aware about sexually transmitted diseases. Only one-fourth could name the most common STIs such as rganizati and syphilis respectively.

On the level of tolerance towards people with HIV/AIDS most students claimed that they would take care if family members (97%) or friends (92%) are infected with HIV. A significant proportion also stated that they would blame people who have contracted HIV/AIDS through sex or drug use, and would not feel compassion towards those with AIDS as it is their own fault. Nearly one-third (28.1%) believe that “we should discriminate against people living with HIV and AIDS.”

Ganja was the most commonly used illicit drug, with 30% of the sample reporting that they were currently using it. Alcohol (26.7%) was the next most commonly used drug, followed by phensidyl (5.6%).

These findings underscore the need for HIV/AIDS-related health promotion and prevention efforts targeting young college and university students as well as younger age groups.

Addressing HIV vulnerability among Cross Border Mobile Population

Cross-border movement into India has become a necessity for economic survival of people living in bordering areas of Bangladesh. EMPHASIS (Enhancing Mobile Population’s Access to HIV & AIDS services, Information and Support) is the very first ground breaking 5 years (Aug 2009-Aug 2014) sub-regional initiative by CARE India, Bangladesh and Nepal funded by BIG Lottery Group of United Kingdom. The project works with highly vulnerable groups who are largely poor, with low literacy rate coming from rural Bangladesh and end up migrating to cities (specially at Mumbai and Delhi) in India with dreams and hopes of better jobs to support their family back home.

The baseline study identified the major **push factors** of cross border mobility are lack of employment and poverty at source; **pull factors** are more employment opportunity, higher wages, recreation opportunities, and peer pressure etc at destination. Unknowingly the mobile people fall into HIV & STI risk: men meet their sexual need unsafely at destination, women become involved in

sex trade for endurance at destination or in the course of mobility they are abused / harassed by power people at source and destination. This continues as frequent phenomena for years and it acts as driving force of stigma towards them (Ref: Baseline study of EMPHASIS Project).

The major objective of the intervention is to test model to reduce HIV vulnerabilities of the undocumented migrant population and their family members to demonstrate model intervention for future replication. Three areas for intervention were identified: creating access to information and services, enhancing capacities of service providers, research and advocacy. Strategies include:

Obtaining Broker's assistance to reach cross border mobile population
The approach to reach impact population (IP) at transit areas is to reach them through brokers at the place they are stopping over during their travel, a place where no one is going to find them. After one year implementation at selected border areas, outreach was built on trusting relationships with the brokers and reaching Ips with necessary HIV & service access information at locations selected by brokers. The outreach activity at transit has been established from field learning that People from different districts choose this transit for safe undocumented trespass and sometimes takes a stopover close to the land port to secure a safe time for the trespass. Migrants sometimes bring their family to villages near the porous border area. The outreach activity through contact with the broker is thus successful as it doesn't have any implication of facing law enforcement agency harassment.

Self Help Group of Wives of Migrant´s left at home to reduce stigma and discrimination related to HIV and Cross Border Mobility
A group of women left at home (Self Help Group) were brought together to try to address financial constrains in the absence of their husbands and they initiated the community action (ie. participated in family counseling and community sensitization) to reduce family violence and social stigma on them and the returnee females with the help of EMPHASIS. Community referral to services for the returnees and migrant´s family was another action point. It **resulted** to reduce violence and stigma against women left at home & returnee females of 22 families and they started to be reintegrated into family and community. Service access increased that was documented through qualitative evidence of STI services consumption by returnees and migrant´s family.

Capacity building of the health service providers to increase service access for the cross border mobile population
93 Health service providers (Government and nongovernment) at Jessore and Satkhira (two border-lying districts) were trained on Syndromic Management of STI, HIV/AIDS and Migration, Voluntary Counseling and Testing (VCT), Advocacy and Communication and HIVAIDS care and rational use of ART. This capacity building initiative resulted in increased service access of the bordering people. Formal MoU could not help activating effective referral but increased knowledge after training of the service providers facilitated them to render services to the clients. It was evident that the female clients were frequently referred to the gynecologist for any kind of STI and RTI related sign/symptoms; but after having the STI management training many of the male doctors and medical assistants also felt confident to treat clients

HIV Prevention In Prisons

HIV is a serious threat for prison populations, and poses significant challenges for prison and public health authorities. Prisoners are at exceptional risk for infection with HIV, Hepatitis B and C, TB, and sexually transmitted infections because of incarceration for short and long time stay, overcrowding, unsafe behavior and association of unsafe injection drug use.

In July 2010, UNODC initiated an HIV prevention program in prison setting under a UNODC regional program (RAS-71: Prevention of spread of HIV amongst vulnerable groups in South Asia) through sensitization and came to a partnership in Bangladesh with Directorate of Prisons and civil society organizations - CARE, Dhaka Ahsania Mission (DAM) and Padakkhep Manobik Unnayan Kendra to implement the project. At present, UNODC in partnership with the implementing partners is implementing a HIV prevention program in 6 prisons respectively Dhaka and Rajshahi by CARE, Barisal and Gazipur by DAM; and Jessore and Khulna by Khulna Mukti Seva Sangstha. A situational assessment has also been done in another 6 prisons. The major program activities include: advocacy and sensitization; training of health workers working under prison and health authorities on HIV/AIDS/ STIS, TB etc; development of Peer Educators and Peer Volunteers among the prison inmates; HIV/AIDS and STI education to prison inmates through peer educators and volunteers using different IEC specific to prison; behavior change education; STI treatment; TB treatment; ensure ART to HIV positive people.

The program envisages the principle “Prison Health is Public Health” as prisoners and prison staffs are in continuous contact with community – prisoners come from community and most go back to the community. It is experienced that accurate and adequate information for staff and inmates can reduce fears and ultimately affects institutional policies in ways that can alter prisoners' lives profoundly. All persons entering prison should be informed in clear, simple terms, and in their own language, about how to avoid transmission of HIV and other communicable diseases. Educational programs can reduce fears about HIV and its transmission among staff members and inmates.

Peer sputum collectors increase TB case detection among underserved groups at risk of HIV in Bangladesh

Bangladesh ranks 7th in the 22 high TB burden countries with 109 cases/100,000 population/year and a reported case detection rate of 72%. About 70,000 people die every year from this disease, for which, a very effective free of cost treatment (DOT) is available in Bangladesh. Here the KAP experience even higher TB prevalence due to social and demographic risk factors such as poverty, unemployment, homelessness, imprisonment, HIV infection, malnutrition and lack of access to health care . Therefore FHI360 directly works with the beneficiaries to create awareness for TB diagnosis and directly observed treatment services. Also as the vast majority of HIV infected people do not know their HIV status and seek health care from general health care providers, including TB centers, 10 TB-VCT centers were established and working as an entry point for HIV testing and counseling for TB patients.

In 2010, the Modhumita DIC package of services included TB screening, diagnosis and treatment by training peer sputum collectors to collect sputum and support directly observed therapy (DOT). At the same time, linkages were established with TB diagnosis and treatment centers of the National TB Control Program (NTP). The sputum collectors do a simple symptoms screen and collect samples from potential TB suspects. They then take the sample to a diagnosis center and return the results to the client. Treatment is provided through government and NGO DOTS centers nearby and sputum collectors play a vital role in follow-up of patients and maintaining adherence. The Modhumita centers also provide routine TB awareness sessions.

50 sputum collectors were trained by the NTP; all 40 Modhumita centers in Bangladesh now have sputum collectors. Between January 2010 and December 2011, around 14,165 persons were screened for suspected TB, 10,465 were smear tested and 802 were smear-positive for TB. Of 802 smear-positive cases 760 received DOTS and are being followed up by the centers.

Expanding TB services to sex workers, IDU, TG, MSM, PLHIV and COSW through integration with branded HIV drop-in-centers and peer sputum collectors has been cost effective and contributing to improving the case detection rate in underserved populations in Bangladesh.

V. Major challenges and remedial actions

(A) Progress Made on Key Challenges Reported in 2010 UNGASS Country Report

Following is a brief summarization of the progress made on some of the challenges mentioned in the 2010 UNGASS report.

Policy Environment

In the reporting period, review of National Policy on HIV/AIDS and STD lost is importance due to other competitive priorities. In fact, NASP was busy drafting new costed National Strategic Plan (NSP) for 2011-15, which is probably the biggest achievement of the national apex body during 2010-11 periods. The new NSP has emphasized on reduction of stigma and discrimination against vulnerable populations and PHIVs which is rife in Bangladesh.

National Health Policy has been drafted during the reporting period which is awaiting approval from relevant government organ where HIV/AIDS has been highlighted properly. Moreover, National Women policy has also been declared by government during the same time which is expected to bring positive changes in the lives of women and girl section of vulnerable population. However, like elsewhere in the world, changing an existing law is difficult and a lengthy process. Government, civil society implementers, development partners and UN agencies invested time and resources to orient member of parliaments, law enforcers and government high-ups and media moghuls in regard to discriminatory policies/laws that hinder access to HIV services. Involvement of high level stakeholders, including Parliamentarians in various decision-making forums is further strengthening a conducive environment to bolster national AIDS response. Sustained efforts are on from within Bangladesh parliament to declare a third gender for transgender population.

Leadership and Coordination

The National AIDS Committee (NAC) met for the first time in last eight years in 2011 and its technical committee met more than six times in the reporting period which has played a major role in the endorsement of new NSP, M&E Plan and ART guidelines.

In case of NASP however inadequate resources, in terms of personnel, funding, infrastructure, etc., remain to be a constraint for effective planning and coordination of the national response to HIV in Bangladesh. Despite many constraints, NASP provided much needed leadership in national AIDS response by efficiently guiding civil society implementers and management agencies to address programmatic gaps. For example, Bangladesh ensured uninterrupted supply of ARV drugs to PLHIVs during the reporting period. The same coordination across key ministries needs to be further strengthened, especially to address the needs of KAP that are beyond the scope of HIV prevention services, such as legal support, alternate livelihood options etc.

Since inception in 1997, NASP remained as an adhoc wing of DGHS while frequent staff turnover had been a constant problem for this organization. However, during the reporting period, NASP staffing situation got improved to some degree. In fact, NASP got uninterrupted service from same Line Director and two Deputy Program Managers since 2010 which is a mentionable progress.

Strategic Information Management

A “one agreed country-level monitoring and evaluation system” has been outlined in the National M&E Plan which is yet to be operationalized in Bangladesh due to various constraints. The data and information processing is implemented by different programs independently. The collection and collation of data through surveillance, surveys and research have progressed well in the reporting period as evidenced by the National Size Estimation of most at risk groups (2009-10) and the conducting of the 9th serological surveillance (2011). However, behavioral surveillance is pending for last five years while data on young people is pending for over 3 years.

Individual research on vulnerable groups have been conducted which is providing information and one example is collection of data from cross border migrant population in southwestern region of Bangladesh through a regional project called “Emphasis”, however, these data may not be always nationally representative.

Financing Targeted Interventions

A “one agreed country-level monitoring and evaluation system” has been outlined in the National M&E Plan which is yet to be operationalized in Bangladesh due to various constraints. The data and information processing is implemented by different programs independently. The collection and collation of data through surveillance, surveys and research have progressed well in the reporting period as evidenced by the National Size Estimation of most at risk groups (2009-10) and the conducting of the 9th HSS (2011). However, behavioral surveillance is pending for last five years while data on young people is pending for over 3 years.

Individual research on vulnerable groups have been conducted which is providing information and one example is collection of data from cross border migrant population in southwestern region of Bangladesh through a regional project called “Emphasis” , however, these data may not be always nationally representative..

Capacity

Capacity building initiatives still need to be coordinated to avoid duplication of effort and wastage of resources. There were fragmented initiatives by different DPs and UN agencies to strengthen skills of NASP personnel so that they could contribute to national AIDS response more effectively. Moreover, civil society tried to engage NASP in different capacity building efforts, but a system is yet to be developed to track previous efforts and advise newly proposed ones.

An initiative for strengthening the capacity of CBOs of different MARPs has been undertaken by GF RCC since 2010, with support from icddr,b as PR, aiming to enhance the capacity of the CBOs to enable them to contribute effectively in the scaling up of the national response. Under this project 60 Community Based Organizations (CBO) have been identified and supported (30 with FSW, 20 with MSM and hijra and 10 with PWID) which would continue up to November 2012.

Programmatic Gaps

Following are some of the major programmatic gaps that hamper achievement of scale, coverage and delivering quality services.

- There was no holistic intervention in brothel setting during most part of 2010-11, due to delays in release of funds from sector program.
- Programmatic coverage of KAP has increased significantly in last five years but this increase has not been validated by a fresh BSS or IBBS round since 2007.
- The definition of KAP varies across different donor funded programs. Standardization of operational definitions of KAP will ease efforts in creating a single database.
- Standardization of performance is ongoing and repeated monitoring visits have helped improve the situation. Also standard operational procedures for DIC functions and interventions with PLHIV are being implemented by relevant agencies.
- Size estimation of KAP was updated for FSW, male PWID, clients of FSW and returning migrants in 2009 and for MSM, MSW and Hijra in 2010.
- Community groups will be more involved now in designing program for themselves, as efforts have been taken to map CBOs and develop their capacity in such matters.
- The updated NSP has included new vulnerable groups (e.g. Migrants) and has costed interventions for them.
- Care and support services for PLHIV have expanded commendably in the form of continued ARV supply, maintaining nutritional support, VCT, treating HIV-TB co-infection, etc. Issues of stigma and discrimination have also been addressed through training and development of stigma and discrimination training module which is currently being implemented.
- Coordination between different funding mechanisms are being mitigated to a certain extent through meetings and information sharing (e.g. avoiding geographical duplication, arranging for VCT, etc.), but much more remains to be done, especially in terms of tracking past achievements to advise on incoming proposals (e.g. development of same training modules under different donor funded programs)
- Though the role of the focal persons of the 16 key ministries and departments are clarified, these roles are yet to be implemented effectively.

(B) Challenges Faced throughout the Reporting Period (2010-2011)

Development of permanent infrastructural setup of the National HIV/AIDS Program with adequate manpower, resource and logistics

NASP continued to be an adhoc wing of DGHS and remained understaffed with shorter tenures that hampered effective national AIDS response.. Despite repeated efforts this matter remains to be a challenge and leads to other challenges faced in the form of strategic information management, capacity building, coordination, sustaining funding flow for continuous services, etc. Consultants and Specialists have been hired on short-term basis to support NASP, but continued funding commitment is lacking. The role of NASP comprises policy guidance, information updating, coordination and regulation. The major roles maybe outlined as:

National Planner: Planner, programme designer, policy initiator and implementation facilitator.

Project Manager: Task allocator, coordinator, service package designer, procurement coordinator, facilitator.
M&E Manager: Programme monitor with functions of surveillance, monitoring, evaluation, MIS, national custodian of data/information, reporting to all stakeholders.

Contract Manager: Keepers and regulators of national/programme level contracts for HIV direct contracts between NASP and other agencies

Financial Manager: Resource mobilizer, resource allocator and finance manager.

Secretary: To all committees - NAC, TC, Coordination and Technical-Initiator of national agendas and agendas for all committees, Interpreter of national policies, strategies etc.

Regulator: Ensuring observance of policy and protocols by all concerned, ensuring voice of communities/ CBOs/NGOs especially PLHIV in HIV/AIDS programming at various levels.

The required human resources to fill out the major roles outlined above are yet to be available in a sustained manner. Despite its best efforts and endeavors, the NASP has not been able to play it's expected roles due to:

- ad hoc status of NASP within DGHS organogram
- frequent turnover of staff led to inconsistent leadership and lack of adequate knowledge retention and related oversight activities;
- the inconsistent staffing arrangements which involve the use of MoHFW out-posted staff, contract staff and consultants with differing levels of reward make it difficult to create a cohesive unit and a fully functioning skill-mix;
- inadequate use of program management tools and techniques;
- shortage of skilled specialists, especially in the fields of procurement, finance, M&E and research.

Sustained funding sources, especially for mainstreaming of activities

Significant part of Bangladesh's AIDS response is donor dependant; thus sustaining a continuous supply of drugs, VCT centers, DIC for key affected populations, logistic supply for prevention of HIV transmission, media efforts to disseminate knowledge – all have been either discontinued at some point or interrupted due to irregular fund flow. Some examples are as follows:

- The continuity of 27 VCT centers under the Urban Primary Health Care Project funded by the ADB: During mid-2012 a fact finding mission will decide the continuity of these centers that are now a part of a service delivery set-up.

- The performance based RCC grant: As the RCC funds are performance-based NASP is constantly under challenge due to inadequate support, namely in terms of human resources.

- The World Bank supported HIV prevention interventions: The interventions among high risk groups were implemented for only one year during the last 2 years due to lengthy time required in bidding, planning and fund release processes.

- The Global Fund supported ARV drug supply: Strong recommendations are being made for country ownership in supplying ARVs. A detail procurement and distribution plan with consensus of all stakeholders and proper laboratory set-up is yet to be in place prior to the ending of Global fund support.

Integrated data collection and update

The process of setting up an automated MIS linking to the national health MIS has been ongoing for the ;last two years, however progress has been very slow due to several reasons, including a lack of standard definitions and lack of infrastructure at implementation site level. Though a detail description is well-laid out in the updated M&E Plan, implementation of the MIS system is yet to begin. In addition to collection of routine data, conducting a fresh BSS round or an IBBS too has been delayed. Collection of data from young people and the general population is also delayed despite the information on young people being a donor requirement. Initiating these survey requirements and arranging for the compilation of routine data is an ever-challenging area as it requires elaborate collaboration and planning in a continued fashion – both of which are hampered due to inadequate human resources as outlined above.

(C) Remedial Actions

Integration of NASP into the central structure of DGHS

Policy steps need to be pursued from the hierarchical level, so MOHFW takes full accountability in upholding the structural status of NASP. This would also empower NASP as a stronger coordinating body among all donors and relevant ministries and departments.

Mainstream activities as part of HPNSDP

Mainstreaming of ARV supply, youth friendly health services, etc. are already on the planning process and much more needs to be done. However intensive policy and legal revisions are required to mainstream efforts among KAP in the true sense.

Regularize routine and survey data collection

- A complete inventory needs to be developed and updated regularly focusing all surveys and surveillances and related operations research. National guidelines, including standardized indicators with operational definitions, need to be fully developed/revised for all programmess
- National guidelines need to be developed for recording, collecting, collating and reporting programme monitoring data from health information system and civil society/community-based systems
- Develop tools for regular and standardized reporting by the umbrella organizations, NGOs and implementers as feasibly required
- The unique identifier mechanism needs to be implemented at service delivery center level to ensure confidentiality and avoid double reporting
- NASP–MIS should not be isolated or vertical; it should be linked with DGHS-MIS and MOHFW. M&E unit needs to be recognized and regularized (in alignment with organization's programs and

NASP) in terms of HR, JD, Capacity Building initiatives in collaboration with line ministries, development and implementing partners
- Develop and install a user-friendly software (could be open source)
- For sustainability of HIV related surveillance, Institute of Epidemiology Disease Control and Research (IEDCR) should be capacitated to conduct such surveys.

Capacity Building

Capacity needs to be developed in terms of:

- Structural positioning of NASP within the Government system i.e. to bring NASP under revenue budget
- Adequate human resources to play the vital roles as per national requirements
- Strengthening of coordination mechanisms among donors, ministries and technical working groups
- Maintenance of proper inventory and tracking systems to support effective advocacy and information disseminations/sharing

VI. Support from the country's development partners (if applicable)

Global Fund / Rolling Channel Continuation (RCC)

Since 2004, the Global Fund is supporting the HIV/AIDS prevention and control efforts in Bangladesh. In 2009, in the 6th year of the Global Fund's presence in the country the grant consolidated the two previous existing grants (the Round-2 and 6 grants) to be implemented as the Rolling Continuation Channels (RCC) grant for 6 years covering the period from 2009 to 2015 titled "Expanding HIV/AIDS Prevention in Bangladesh". The principal recipients (PR) of the RCC are National AIDS/STD Programme (NASP), Save the Children and ICDDR,B.

The project is implemented by national and international NGOs, private agencies, CBOs, self-help groups, research organizations, and academic institutions. Other significant stakeholders include BGMEA, and Ministries of Home Affairs, Education, Youth and Sports, Information, and Religious Affairs. The grants has set good examples in cost sharing, subsidizing and actively participating in and facilitating the implementation processes through public private partnership mechanisms.

The RCC will finance the continuation and scale of interventions from Rounds 2 and 6 with these objectives:

1. Increase the scale of prevention services for key populations at higher risk: Injecting Drug Users (IDUs), Sex Workers (FSWs), hijras (transgender) & Men who have Sex with Men (MSM)
2. Increase the scale of the most effective HIV/AIDS activities conducted through Round 2
3. Build capacity of partners to increase scale of national response to the HIV/AIDS epidemic.

Some remarkable achievements of the RCC Grant include;

- About 14,000 PWID, 28,000 FSWs and 33,000 MSM/MSW/Hijra have been reached with essential services for HIV prevention and additional support.
- Size estimations and needs assessments and behavioral surveys were carried out among key affected populations, PLHIV and garment factory workers.
- 588 People Living with HIV received Anti Retroviral Drug (ARV)
- 123 PLHIV received Opportunistic Infections (OI) prophylaxis prevention support
- 151 PLHIV are supported for hospital care
- Increased access to Youth Friendly Health Services (YFHS) by 705,964 young people and mainstreamed YFHS orientation into health service departments.
- Community-based LSE provided for about 190,000 young people and workplace LSE for about 242,000 garment factory workers (with supportive investment by factory owner as well) along with mainstreaming of LSE into the Department of Youth Development
- Insertion of HIV issues into the textbooks for students of classes 6 to 12.

World Health Organization

The main goals of HIV/AIDS programming at WHO Bangladesh are to prevent the spread of HIV and STIs, and to mitigate the impact of the dual HIV and AIDS in the society. The main objectives of HIV/AIDS programme are to provide technical support to develop national capacity for effective scaling up of HIV/AIDS and STI prevention, care and treatment with monitoring and evaluation and strengthening of surveillance system; To provide support to build capacity for voluntary counseling and testing (VCT) services for HIV/AIDS in the country; To assist in developing and updating manuals, guidelines and forms and organization of training programmes and To provide support for

equitable access to essential medicines for HIV/AIDS with rational use of quality drugs and strengthened diagnostic support for HIV/AIDS.

During the last biennium (2010-2011), World Health Organization in Bangladesh had completed the following activities in close collaboration with the National AIDS/STD Control Programme (NASP), Bangladesh i.e.

- Conduction of Operational Research on HIV/AIDS & STI
  - *Need assessment of Voluntary Counseling & Testing (VCT) Services in the country*
  - *Knowledge, Attitude and Practice of Migrant Worker's Wives on HIV//AIDS in Bangladesh*

- Updating the National ART Guideline in close collaboration with National AIDS/STD Programme (NASP) and other stakeholders

- ToT for Voluntary Counseling & Testing (VCT) services

- Completed *Workshop on Global Health Sector Strategy for HIV/AIDS 2011-2015* (Bangladesh country Recommendation)

UNICEF

Major activities conducted during 2011 were:

- Developed HIV testing policy for children and adolescent under 18 years of age;
- Conducted National level mapping of HIV Most At Risk Adolescent (MARA) and their risk behaviour
- Refresher training for Peer Educators and Outreach supervisors and Orientation on PPTCT for PLHIV group, implementers and service providers of Sylhet region
- Commissioned of anonymous / unlinked ANC HIV surveillance study in greater Sylhet region.

UNFPA

UNFPA has committed to provide technical and financial support to national response according following UNDAF objectives:

- A comprehensive national response in place
- Increase capacity through the nation for an effective response
- People are able to protect themselves from HIV infection
- People who are infected and affected have taken their place in the national response;

UNFPA in Bangladesh have contributed to the UNDAF Outcome 6 ("Current low prevalence rate of HIV/AIDS is sustained through preventive measures and the needs of the affected and infected people are met") through its country program jointly with Government and implementing agencies (HASAB).

The project at two selected districts has been implemented by a partnership approach with the Government of Bangladesh taking the lead, and the NGOs (CARE Bangladesh and HASAB), self-help groups, individual consultants and research organizations have contributed in achieving the expected.

The UNFPA contributed to build capacity for prevention of sexual transmission of HIV among the female sex workers, transgender and young population. The UNFPA also supported for leadership development for self-help groups to be actively involved in the national response and advocate for prevention of sexual transmission of HIV. In addition, efforts has been undertaken to enhance a learning culture in the UN system supported by UN care team on HIV/AIDS issues.

UNODC

UNODC is supporting to introduce the Opiate Substitute Treatment (OST) using Methadone maintenance program for the PWID in collaboration with the Department of Narcotics Control and National AIDS and STD Programme. In 2011, UNODC concluded another HIV/AIDS prevention programme with the female drug users and female partners of male injecting drug users, implemented by the NGOs. The pilot program is being implemented by ICDDRB at the Central Treatment Center of DNC.

In collaboration with the Directorate of Prisons, UNODC is also supporting a HIV/AIDS prevention program in six prisons in Bangladesh, which is being implemented by the NGOs. In 2011, UNODC concluded another HIV/AIDS prevention programme with the female drug users and female partners of male injecting drug users, implemented by the NGOs.

World Food Programme

WFP Bangladesh has implemented nutrition initiative (NI) for PLHIVs project (2011 -2012) with the aim to improved nutritional recovery of the PLHIVs and improved adherence to ART. The duration of the project was for 12 months starting from April 2011. As intervention, WFP has supported the provision of micronutrient fortified biscuits to 348 PLHIV along with monthly nutrition education by using structured manual and flyers (Bengali). The target group of this project is PLHIV children, adolescents and adults. Home gardening training to the selected PLHIVs is also part of the nutrition support. Two divisional level advocacy workshops were organized through relevant stakeholders in Sylhet and Khulna. National level advocacy workshop was also organized jointly with UNAIDS and National AIDS and STD Programme (NASP). Most importantly the project plays advocacy role at the national level to strengthen the role of nutrition in the HIV/AIDS response.

The key contributions were as follows:

- Developed training manual and flyers on HIV & Nutrition
- Completed training on nutrition education to the doctors, nurses, counsellors, peer educators and volunteers of the self-help groups/partners
- Collected basic food security & nutritional data of the project participants as baseline.
- Completed food distribution & monthly nutrition education for 8 months
- Undertaken home gardening training to selected PLHIVs.

- Conducted routine quarterly nutritional assessment of target groups.
- Undertaken 2 divisional level advocacy workshops
- WFP has developed the National Nutritional Guideline for PLHIVs under the leadership of NASP and got approval from DG of MOHFW.
- WFP has translated this Guideline into Bengali which is under process for printing.

UNAIDS

During 2010-2011 UNAIDS Bangladesh provided the following support:

- Ensured proper functioning of CCM, its oversight committee and CCM-secretariat, UNAIDS also supported Govt/Global Fund bidding processes.
- UNAIDS advocated with MOHFW and World Bank to scale up of quality Targeted Intervention (TI) through sector program and to bring Migrant population under program coverage.
- Supported the new-size estimation of Key Affected Population (KAP), particularly sex workers.
- Supported working out measures to address punitive laws that are hindering national AIDS response by involving Lawyers, Parliamentarians and Human Rights Commission
- Advocated for ART through Government hospitals in high burden administrative divisions and advocated for procurement and provision of ART services at government health set ups utilizing sector program budget
- Facilitated integration of HIV in government Sexual Reproductive Health and Primary Health Care (PHC) settings.
- Continued to strengthen networks of PLHIVs, SWs, PWID, MSM/TG and civil society (STI/AIDS network of Bangladesh, Shandhani Blood donation society) and continued to provide technical support to sex workers network and PLHIV network to organize training for Sex Workers and Income Generation training for the HIV infected and affected women victims of violence
- Advocated with policy makers of Ministry of Home Affairs (DNC and Drug Administration authority), MOHFW and Parliamentarians to scale up Oral Substitution Therapy.
- Trained MPs and students of journalism department of public and private universities on HIV related violence against infected and affected women and sex workers and to reduce stigma and discrimination against KAP.
- Reduced stigma and discrimination about PLHIVs through orientations designed for media and involving sports bodies, academic institutions, parliamentarians, Red Crescent society of Bangladesh and through BBCA.
- Facilitated implementation of prison intervention and MMT scale up
- Supported replication of Sonagachi brothel cooperative scheme in Tangail brothel

VII. Monitoring and evaluation environment

In April 2010, the NASP in collaboration with SC USA, ICDDR,B and UNAIDS commissioned an (a) Assessment of the national HIV/AIDS M&E system, to prepare the next (b) National M&E Framework (2010-2015) and (c) Costed work plan (budget). The national HIV M&E assessment is a diagnostic exercise to enable stakeholders in HIV M&E to identify strengths and weaknesses in the current system and recommend actions to maintain its strengths and improve its weaknesses. The three Principal Recipients (NASP, Save the Children, USA and ICDDR,B) of the Global Fund HIV grants to Bangladesh and UNAIDS team worked with a range of stakeholders in Bangladesh to apply the 12 Components National M&E System Assessment Tool.

Key findings as revealed from the assessment say that the National HIV/AIDS M&E System in Bangladesh is in the early stages of development. The National AIDS/STD Programme is working to establish the structure and system required to fulfill the system. Human capacity within NASP as well as across the sector needs improvement particularly on Program Monitoring and Evaluation, MIS, information and communication technology. A Technical Working Group on M&E exists and contributes to a great extent to prepare national reports like UNGASS Country report, to generate strategic information like Size Estimates for MARPs, or to support piloting HIV MIS, however, it works mostly on adhoc basis. In addition, fully functional regular meetings and follow up actions are not pursued for Surveillance and Research Advisory Committee as well. Last behavioral surveillance was conducted in 2007. Data use though evident at national level is weak among most of the sectors.

Umbrella organizations and implementing NGOs have a project based HIV M&E System, but these are not harmonized and coordinated to operationalize “One M&E system” at national level. HIV MIS has been piloted though, it has far to go to be finalized integrating all the HIV interventions contributing to the national response. Some key ministries have developed HIV reporting system, which are neither hooked up nor coordinated by a central HIV M&E system. Though HIV is part of the national Health MIS, reporting mechanisms against the agreed indicators does not exist. .

Improvement of program monitoring capacity within NASP had been considered a priority. Awareness on the critical importance of monitoring and evaluation has developed within country; it has become an imperative to coordinate the M&E response. This requires reporting of output data (such as the number of people reached, number of condoms and needles/syringes distributed, etc.), which usually are collected by the intervention implementers (although using different recording tools) but not aggregated at the national level. This information is paramount in understanding the scale of interventions needed as well as planning/estimating logistics and resources for HIV programming and for providing timely feedback to programme managers for any necessary mid-course corrections that will lead to the desired programmatic effect/impact.

Improving programme monitoring data requires the building and strengthening of existing technical capacity of NASP staff responsible for implementing the national M&E system so that they can coordinate and perform their functions in a timely manner (and thus improve the effectiveness of the response). The capacity building of NASP staff needs to be a continuous process and should take a phased approach to developing and rolling out the system’s support structures and components.

In addition to the M&E Unit partnerships to plan, coordinate, and manage – the HIV M&E system needs to be maintained through collaboration of the members of the Monitoring and Evaluation Technical Working Group (M&E TWG) and other groups working with strategic information. An annual work plan of M&ETWG and inventory of stakeholders, partners and service delivery points needs to be maintained and individual members may take responsibility in a cyclical manner to ensure regular meetings and actions. Currently full responsibility lies with NASP.

References

1. *3rd National Strategic Plan for HIV/AIDS 2011-2015*: NASP, DGH, MoHFW,GoB.
2. *National Serological Surveillance, 2012.* 9th Round Technical Report: National AIDS/STD Programme (NASP),DGH, MoHFW, 2011.
3. *National Serological Surveillance,* 8th Round Technical Report: National AIDS/STD Programme (NASP), DGH, MoHFW, 2009.
4. *Health Bulletin 2011.* Dhaka: Management Information System,DGHS, MoHFW, 2011.
5. *Bangladesh Household Expenditure and Income Survey: Bangladesh Bureau of Statistics*: Ministry of Information and Planing,GoB. , 2010.
6. *Population Size Estimates for Most at Risk Populations for HIV in Bangladesh.* NASP, DGH, MoHFW & UNAIDS, 2009.
7. *HIV/AIDS: Situation and National Response, 2011*: National AIDS/STD Programme (NASP), DGH, MoHFW, 2011. 4-10.
8. *National Behavioral Survillance*: NASP,DGH,MoHFW, 2006-7.
9. *TB/HIV in the South-East Asia Region: Status Report.* World Health Organization, 2011.
10. *20 Years of HIV in Bngladesh: Experiences and Way Forwar*: The World Bank & UNAIDS, December, 2009.
11. *Bangladesh Demographic and Health Survey:* NIPORT, GoB, 2007.
12. *12 Components Monitoring and Evaluation System Strengthening Tool.* Geneva: UNAIDS, 2009.
13. *Estimating numbers of those most affected by HIV/AIDS in different locations to support efficient service delivery: Capacity building and community mobilization:* NASP, 2008.
14. *IHP conducted PLHIV projection.* GTZ, 2008.
15. *UNGASS country progress report,2010*: NASP,DGHS, MoHFW & UNAIDS, 2010.
16. *Risk of and vulnerability to HIV among hijra in Dhaka, Bangladesh: A behavioural survey of hijra in Dhaka*: icddr,b, 2011.
17. *Risk of and vulnerability to HIV among MSM in Dhaka, Bangladesh: A behavioural survey of MSM in Dhaka*: icddr,b, 2011.
18. *Risk of and vulnerability to HIV among MSW in Dhaka, Bangladesh: A behavioural survey of MSW in Dhaka*: icddr,b, 2011.
19. Endline HIV/AIDS Survey among Youth in Bangladesh, NASP, Save the Children, icddr,b. 2008

20. Vulnerability to HIV among sex workers and non-sex worker female injecting drug users in Dhaka:Evidence from baseline survey of a coho*t study." Azim T et al. Harm Reduction* , 2006: 3-33.

21. *Creating conditions for scaling up acess to life skill based sexual and reproductive health education and condom service:strengthing safe sex decision-making.* NASP, Save the Children & ICDDR,B , Population Council, 2008-09.

22. "Improving STI Services of non-formal providers through academic detailing by medical representatives." Dhaka, 2009*.* NASP, Save the Children & ICDDR,B , 2008-09.

23. *Improving STI Services of non-formal providers through academic detailing by medical representatives:.* NASP, Save the Children & ICDDR,B , 2008-09.

24. *An assessment of sexual behaviour of men in Bangladesh*: FHI & ICDDR,B, 2006.

25. *Process Documentation on Community based Life Skills Education (LSE).* Dhaka: NASP, HASAB & Save the Children., December, 2011.

26. *Knowledge, attitudes and practices towards HIV/AIDS-related risk factors among public and private university students in Bangladesh,* University of Dhaka, 2011

27. *Operations research on **b**rothel based sex workers and self-help groups for prevention of STIs and HIV/AIDS, UNFPA, HDRC. 2009*

ANNEXES

ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the 2011 Declaration of Commitment on HIV/AIDS:

- On February 23, 2012, an introductory workshop on GARPR, 2012 was held involving all stakeholder groups to discuss the reporting process and to seek the expected cooperation and inputs to complete the report. During this workshop a tentative plan of action was shared

- After the workshop process of data and information collection began.

- By February 29, 2012 formats for collecting program and finance data was shared with all stakeholders and the data collection process continued till March 20, 2012. Data compilation was started on March 15, 2012 with data already recived and updates were made as data and information was incoming.

- By March 18, 2012, stakeholders were contacted to complete the National Commitment and Policy Instrument.

- An indicator review and validation meeting on “GARPR indicators” was held on 21st March, 2012 with members of the National M&E Technical Working Group and other key stakeholders. The meeting was followed by further communication, verification and compilation of indicator data as per discussions.

- Individual consultation and interview with key informants to fill out NCPI was ongoing with government officials, Development Partners and civil society stakeholders.

- On March 27, 2012 NCPI data was reviewed through a Consultation with representatives of key stakeholder groups, who also provided information on other key sections of this report. The draft report was shared for final validation and feedback.

- Till April 3, 2012 feedback was received from technical experts and M&E persons on the report and data being used and presented. All feedback was incorporated.

ANNEX 2: National Commitments and Policy Instrument (NCPI): Attached separately

Annex-3

Objectives, Strategies and Summarized Components / Interventions Proposed, 3rd NSP, HIV/AIDS, 2011-2015

Objectives	Strategies	Components and key interventions
Implement services to prevent new HIV infections ensuring universal access	1.1 HIV and STI transmission minimized among FSW, MSM, Hijra and PWID through comprehensive targeted intervention	- Comprehensive service package for KAPs to achieve target group coverage of 80% for regular distribution of condoms/lubricant and injecting equipment and periodic coverage of other interventions: • BCC • STI diagnosis and treatment • VCT • PPTCT (for 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 mobilisation Additional harm reduction interventions for PWID: • Needle and syringe distribution • OST • Injecting related primary health care - Capacity development - Reducing stigma/discrimination, strengthening community acceptance of services and multi-sector responses - Reducing violence and exploitation and addressing legal/policy obstacles to service provision through working with the human rights commission and Ministry of Home Affairs - Enhancing local level management, advocacy and planning capacity as well as service delivery skills - Implementation of district based planning and coordination systems - Building the evidence base and service quality improvement - Injecting drug use prevention under prevention targeted at heroin users and especially vulnerable children as well as health system strengthening - Enhancing provision of primary-heath care, HIV treatment/care and drug treatment/prevention services - Strengthening Self Help Groups
	1.2 Basic services provided and pilot interventions initiated, implemented and scaled up for emerging risk and higher vulnerable groups	- Providing VCT, LSE, CD4 count, information, etc. services to internal migrants - Comprehensive multi-sector approach to social protection of especially vulnerable adolescents incorporating HIV and more immediately, 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. - Further investigate evidences for interventions with heroine smokers and inform pilot interventions for this group - Pilot interventions (among transport workers) based on findings from international and Bangladesh interventions previously conducted will be implemented and evaluated and then scaled up if justified by evidence. - 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 - Capacity development for staff implementing interventions for emerging vulnerable groups will be adapted from training outlined under prevention for MARPs. - Reducing stigma/discrimination, strengthening community acceptance of services and multi-sector responses - Advocacy for spectrum of drug services - Strengthening service delivery, collaboration and community development - Building the evidence base and service quality improvement - Mobilising private sector involvement, enhancing provision of primary-heath care, HIV treatment/care and drug treatment/prevention services
	1.3 HIV and STI transmission minimized among young people and general population through BCC, STI service provision and life skills education	- Basic HIV awareness will be promoted through paid and unpaid media 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. - 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. - Capacity development in counseling will be provided to staff of organizations providing testing services for overseas employment. - Periodic monitoring of VCT services to ensure compliance with Standard Operating Procedures. - Social marketing of condoms 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. - Teachers will be trained to provide life skills education and it will be provided in both the formal and informal education sectors as well as out of school settings (e.g. youth clubs) - 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). - Through strategies to build an enabling environment involvement of the private sector for workplace interventions
	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	- Blood Safety: Technical support will be provided to ensure policies and procedures ensure the risk of HIV transmission is minimized. - Infection Control: • Advocacy and support to strengthen infection control in the Bangladesh health system. • Clinical training for medical and nursing staff . • Support 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): • PEP should be available in health care settings. Awareness of the availability of PEP will be promoted to health care workers which will also reduce fear of providing treatment and care.

		• A national referral centre will be identified where case management can be provided on 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 • 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 • Utilize opportunities to enhance capacity of service providers outside the government to improve STI treatment • Establishment of specialist STI services for referral of unusual clinical presentations, provision of support to primary health care providers, and contribute to building STI expertise in Bangladesh - Prevention of Parent to Child Transmission (PPTCT) • Services for PPTCT 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 on 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. • 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. - Improving service linkages - Human resource development - Reducing stigma and discrimination - Multi-sector involvement - Providing STI services through a comprehensive service package
Provide universal access to treatment, care and support services for people infected	2.1 Services will be provided for the medical management of people with HIV in government, non-government and	- Clinical treatment of a relatively low number of people living with HIV in Bangladesh requires a focused approach to HIV clinical management. The population of PLHIV is dispersed across Bangladesh and services need to be geographically accessible. - Continuum of Care and Clinical care coordination will be upheld through on-going monitoring of HIV progression, likely life- long treatment with ART once commenced supported by capacity building, changes in treatment/medication as new developments, management of complex co-morbidities related to ART (e.g. diabetes), inpatient palliative care for some PLHIV, primary health care including nutrition support

and affected by HIV	private sectors, on a shared care basis	- Specialist Facilities (including those for pediatric HIV management) 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. Organizations involved in provision of care and support should be included in case management and shared care arrangements. - Coinfection with TB will be addressed by 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.
	2.2 Systems will be established for ongoing policy development / revision and capacity development	- For high standard of training for doctors a system of accreditation will be established. - A technical working group will be established to advise NASP on policies, protocols and guidelines.
	2.3 A comprehensive approach to care and support will be implemented	- A care and support needs assessment will be undertaken when individuals are diagnosed with HIV. The assessment will be against the required service 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) - 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. - 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. - Greater Involvement of PLHIV: 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. - Reducing stigma and discrimination and protection of human rights - Engagement of faith based organizations - Facilitating team based shared care for management of HIV treatment - Strengthening resources, capacity building, leadership and accountability
Strengthen the coordination mechanisms and management capacity at different levels to ensure an effective multi-	3.1 Strengthen the NAC and TC-NAC with appropriate support and structure to be more functional in guiding national HIV response	- Conduct annual meeting of the NAC - Develop annual report to 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 institutionalized.
	3.2	- A clear alignment of the structure of the NASP with the objectives of the National Strategy will strengthen its capacity to manage

sector HIV/ AIDS response.	Strengthen the NASP through providing appropriate structure, human resource and other logistics	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. The four units will be: • Monitoring ,evaluation and strategic information • Management, coordination and capacity development • Prevention • Treatment, care and support - 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
	3.3 Conduct forums to coordinate, review and discuss HIV response among the stakeholders and at different levels	- Creating forums (members of various forums would include: representatives of key agencies, donors, focal points of key ministries, program managers, policy makers, service providers, researchers, district health administration, etc.) at national, district and local level to share information, engage new participants form partnerships and improve planning and coordination. - Each of the forums will have specific ToR to function effectively.
	3.4 Conduct advocacy to strengthen an enabling environment	- Advocacy will occur for legal and policy reforms, removing barriers to service delivery and resource mobilization 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.
	3.5 Facilitate development and implementation of activities and plans in key sectors	- 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 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

		- 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 programing (e.g. ensuring policing procedures don't act as a barrier to service access by MARPs, involvement of police in local level advocacy) - 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 organizations (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. - Technical support, policy advocacy and capacity development with the garment industry will be continued and leveraged strategically as an example for other 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). - 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 through cross sector human resource development; health system strengthening and community system strengthening
	3.6 Develop human resource capacity	- 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

	across the HIV sector for enhanced response	management roles - 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 focused on: • Service Delivery • Program 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 skilling training for other staff. Training of volunteers and peer workers will be by implementing agencies.
	3.7 Strengthen the health system response to HIV	- Human resources: HIV specific content will be included in areas such as laboratory services, logistics, and infection control. Capacity to manage HIV will be integrated into specializations such as pediatric care. A basic understanding of HIV will be mainstreamed into the training of primary health care service providers. - Drug and essential commodity supplies: Technical support will be given to ensure a regulatory framework governing private sector involvement: • 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
	3.8 Strengthen the community system response to HIV	- Development of an enabling environment: 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 (contracting a number of implementing agencies through a lead agency) 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. - Resources and Capacity Building: Funds will be allocated for: • Core management functions (financial management, human resource management, planning and reporting) • Resource mobilisation • Representation functions • Material infrastructure –eg. office space and communication systems. • Human resource development to deliver quality services for HIV and STI prevention, care and support and will include an assessment of individual staff capacity against these competencies and a training plan. - Community activities and service delivery for access and legitimacy with marginalised populations, organisational flexibility and ability to generate resources that might not be available to government. - Leadership and accountability: Core competencies, capacities and related standards for governance and management in community based organisations will be defined and assessed in order to guide capacity development and related planning. Core competencies and capacities in governance and management will also contribute to: • Providing common benchmarks against which performance can be measured and compared • Establishing a common framework against which institutional capacity can be assessed to manage funding • Facilitating NGO participation in processes to harmonize aid delivery - Monitoring, evaluation and planning: 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.
Strengthen the strategic information systems and research for an evidence based response	4.1 Conduct comprehensive surveillance to strengthen capacity to respond	- 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. - Behavioral surveillance systems will be continued as before through probability sampling. These locations for both serological and behavioral surveillance will be selected according to epidemiological criteria, including size of the group and risk profile. - In places where probability sampling is recommended for both serological and behavioral surveillance, these can be integrated into one survey. Existing data from different sources will be triangulated to decide which population groups and geographical areas are to be covered by surveillance and where only serological surveillance and/or behavioral 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. - 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 minimize 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.

	4.2 Conduct relevant research to inform the national strategic response	- National size estimations/revisions will be undertaken at the commencement, mid-point and end point of the national strategic plan. - 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., - 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 database will provide information that can be used for monitoring and evaluation indicators and to provide information relevant to program planning (e.g. emergence of drug resistance, adherence to treatment)
	4.3 Strengthen monitoring and evaluation of the National HIV Strategic Plan	- 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 an 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. - 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.
	4.4 Improve systems for knowledge management	- 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

Annex-4

Results Based Framework, National Strategic Plan for HIV/AIDS, 2011-2015

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[39]**	**Midline 2013**	**End line 2015**
Impact						
HIV Prevalence minimised[40]	Percentage of most at- risk populations who are HIV infected[41][42]	National HIV serological surveillance		Male PWID 1.6% Female PWID 1% FSW0.3%	< 5% For all groups	< 5% For all groups

[39] : 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.

[40]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.

[41]Where indicators are the same as indicators used for reporting for UNGASS, terminology used is that of UNGASS

[42]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.

				MSM 0.1% MSW0.3% Hijra 0.3%		
	Percentage of infants born to HIV infected mothers who are infected	Treatment Observational database[43]			< 10%[44]	<2%
STI incidence minimised[45]	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 [46]	BSS		Female 66.7	Female 75%	Female 80%

[43]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).

[44] 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 Recommendationsfor a public health approach 2010 version)*.

[45]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.

	Percentage of male sex workers[47] and *hijra* reporting the use of a condom the last time they had anal sex with male partners	BSS		Hijra 66.5%	Hijra 70%	Hijra 80%
	Percentage of menreporting the use of a condom the last time they had anal sex with a male partner	BSS		Paid Sex 29.5% Non paid sex 22.5%	Paid sex 40% Unpaid sex 35%	Paid sex 80% Unpaid sex 50%
	Percentage of PWID reporting use of new needle/syringe last time they injected	BSS		Male 33.6%[48]	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 months who report the use of a condom during their last intercourse[49]	Survey		Males 35%[50]	Males 45%	Males 50%
Outputs						
Provision of services for MARPs Number and % of MARPs reached with s services (BCC, condom /BCC,NSE) in past year PWID FSW MSW	Number and % of MARPs reached with services (BCC, condoms/BCC, NSE) in past year. PWID FSW MSW MSM	BSS Program data		FSW: 56.9 (UNGASS 2008) MSW: 46.6 PWID: 81.8 MSM 12.7 Hijra 37.3 (BSS 2006-07)	60% 50% 85% 35% 40%	80% 65% 85% 40% 60%

[46]UNGASS report
[47]Baseline to be collected in next BSS
[48]UNGASS 2008
[49]Baseline for females will be set in next survey. Targets to be determined
[50]Source: Assessment of Sexual behaviour of men in Bangladesh FHI/ICDDRB 2006

MSM Hijra	Hijra					
	Number and % of MARPs covered on a regular basis by services[51]	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 55.2% MSM 27.3% PWID 20.2%	>50% >50% >60% >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 pullers12.1% Truckers 7.7% EVA		
	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
	% of schools that provided life-skills based HIV/AIDS education within the last academic year[52]	Survey		0.14%		

[51]Standard service definitions will be developed. These will include regular coverage, but will differ between groups.
[52] Baseline; Numerator: Number of schools providing life skills based education reported by UNICEF in 2009;Denominator: number of secondary schools in Bangladesh

	% 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% Females55%
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[53] Observational data base				

[53]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%[54]	90%	90%
People living with HIV eligible for ART receive it	Percentage of adults and children with advanced HIV	Treatment operational database			90%	90%

[54]Baseline 2008.Reports from HIV ART service providers

	infection receiving antiretroviral therapy[55]					
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[56] HIV services	Treatment operational database		0		
Systems established for ongoing policy development/revision and capacity development	Number of service providers accredited to prescribe ART	Treatment operational database				
	Annual review of policies and protocols conducted	Annual report[57]			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

[55] Treatment observational database will be developed under strategic research. Baseline to be developed.

[56] A 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

[57] Unless 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[58]	Annual report		800[59]	8590	11610

[58]Included in GFATM RCC Round 9 Performance Framework
[59]Report GFATM Round 2, Phase 2. As at December 2008

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 HIV is strengthened	Percentage of donated blood units screened for HIV in a quality assured manner[60]	SBTP report	S BTP	100%	100%	100%
	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			60%	80%

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

		database				
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.[61]	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[62]	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[63]	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[64]	Annual report			80%	90%

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						

[61] Performance indicator in GFATM Round 9 RCC performance framework
[62] Indicator from: The Global Fund to Fight AIDS, Tuberculosis and Malaria. *Community Systems Strengthening Framework* .May 2010
[63] Ibid
[64] Ibid

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%

Annex-5

Basis of the National AIDS Monitoring and Evaluation Plan 2011–2015:

The twelve components for the Monitoring and Evaluation Systems Strengthening Assessment

(*12 Components Monitoring and Evaluation System Strengthening Tool. Geneva: UNAIDS, 2009)*

People, partnerships and planning
Component 1: Organizational structures with HIV M&E functions
Component 2: Human capacity for HIV M&E
Component 3: Partnerships to plan, coordinate, and manage the HIV M&E system
Component 4: National multi-sectoral HIV M&E plan
Component 5: Annual costed national HIV M&E work plan
Component 6: Advocacy, communications, and culture for HIV M&E

Collecting, verifying, and analysing data
Component 7: Routine HIV program monitoring
Component 8: Surveys and surveillance
Component 9: National and sub-national HIV databases
Component 10: Supportive supervision and data auditing
Component 11: HIV evaluation and research

Using data for decision-making
Component 12: Data dissemination and use