UNGASS Indicators Country Report Template

Bangladesh

National AIDS committee

Reporting period: January 2003 – December 2005

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
API	AIDS Programme Effort Index
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Vaccine
BDHS	Bangladesh Demographic and Health Survey
BSS	Behavioural Surveillance Survey
CRIS	Country Response Information System
CSW	Commercial Sex Workers
DHS	Demographic Health Survey
DoC	Declaration of Commitment
FHI	Family Health International
FSW	Female Sex Worker
GFATM	Global Fund to fight AIDS, TB and Malaria
GOB	Government of Bangladesh
HIV	Human Immunodeficiency Virus
HNPSP	Health Nutrition and Population Sector Programme
ICDDR,B	International Centre for Diarrhoeal Diseases Research, Bangladesh
IDU	Injecting Drug Users
MARP	Most-at-risk Population
M&E	Monitoring and Evaluation
MOE	Ministry of Education
MoHFW	Ministry of Health and Family Welfare
MSM	Men who have sex with men
MSW	Male Sex Worker
NAC	National AIDS Committee
NASP	National AIDS/STD Programme
NGO	Non-Governmental Organisation
PALR	Population-at-lower Risk
PLHIV	People Living with HIV and AIDS
SAN	STI/AIDS Network
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WB	World Bank
WHO	World Health Organisation

I. Status at a glance

National Commitment and Action	
Expenditure	
1. Amount of national funds disbursed by government on HIV/AIDS	Information on the actual public spending on HIV/AIDS is not available because there is no specific allocation for HIV/AIDS in the national budget. However, significant external resources including WB IDA credit ($20m), DFID ($6m) and GFATM Grant ($6m) for HIV/AIDS have been channelled and managed through govt. mechanisms
Policy Development and Implementation Status	
2. National Composite Policy Index	Multisectoral Strategic Plan (2004-2010) exists and detailed operational plan for scaling-up the response upto 2010 is being finalised
National Program: HIV testing and prevention program for most-at-risk populations	
1. Percentage of most-at-risk population who received HIV testing in the last 12 months and who know the results	Female sex workers (FSW): Brothel based (n=680) 0.0% Street based (n=1050) 2.9% Hotel based (n=389) 0.7% All FSW (n=2119) 1.6% Male sex workers (MSW) (N=731) 1.1% Transgender (n=410) 0.0% MSM (n=810) 0.0% IDU (n=1372) 3.2% Heroin smokers (n=353) 0.5% Rickshaw pullers (n=718) 0.0% Truckers (n=441) 0.2% *All risk groups (n=6,954) 1.3%* *(Source: BSS, 5th round, 2003-2004)*
2. Percentage of most-at-risk population reached by prevention programs	Female sex workers (FSW): Brothel based (n=680) 88.5% Street based (n=1050) 68.9% Hotel based (n=389) 48.9% All FSW (n=2119) 71.6% Male sex workers (MSW) (n=731) 76.2% Transgender (n=410) 15.4% MSM (n=810) 77.0% IDU (n=1372) 82.0% Heroin smokers (n=353) 7.0% Rickshaw pullers (n=718) 0.7% Truckers (n=441) 39.5% All risk groups (n=6,954) 58.8% *(Source: BSS, 5th round, 2003-2004)* *Note: BSS conducted mainly in the intervention areas*

Knowledge and Behaviour	
5. Percentage of most-at-risk population who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Female sex workers (FSW): Brothel based 36.6% Street based 12.7% Hotel based 32.1% All FSW 24.0% Male sex workers (MSW) 28.2% Hijra 3.7% Men having sex with men 13.2% Injecting Drug Users (IDU) 14.3% Heroin smokers 4.8% Rickshaw pullers 6.0% Truckers 19.8% All risk groups 17.0% *(Source: BSS, 5th round, 2003-2004)*
6. Percentage of female and male sex workers reporting the use of a condom with their most recent *(in last week)* client	Female sex workers (FSW): Brothel based 39.7% Street based 24.1% Hotel based 31.5% All FSW 30.9% Male sex workers (MSW) 44.1% Hijra (transgender) 15.6% *(Source: BSS, 5th round, 2003-2004)*
7. Percentage of men reporting the use of a condom the last time *(in last month)* they had anal sex with a male partner	Non-commercial sex With male 37.0% With female 20.2% Commercial sex With male 49.2% With female 44.2% *(Source: BSS, 5th round, 2003-2004)*
8. Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV i.e., who both avoid using non-sterile injecting equipment and use condoms, in the last month	Male: Non-commercial sex 14.7% Commercial sex 15.8% Female: Non-commercial sex 21.1% Commercial sex 40.4% *(Source: BSS, 5th round, 2003-2004 for male IDUs and Cohort study by ICDDR,B for female IDUs)*

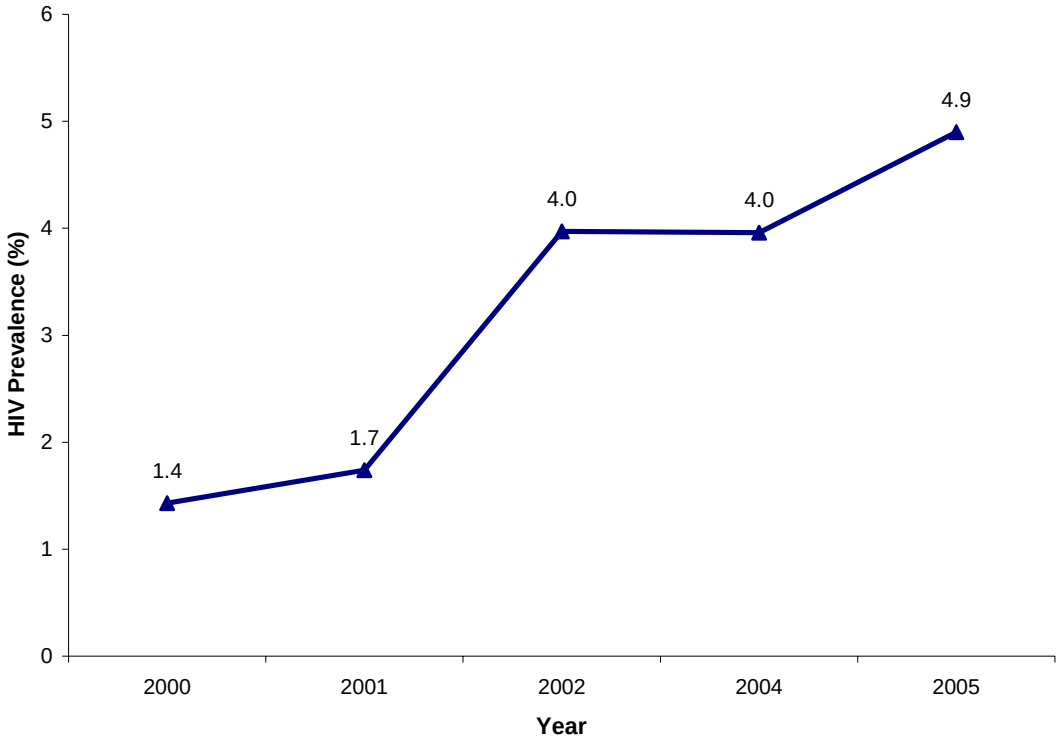
Impact	
9. Percentage of most-at-risk population who are HIV infected	Female sex workers (FSW): Brothel based <1.0% Street based <1.0% Hotel based <1.0 % All <1.0 % Male sex workers (MSW) 0.0 % Hijra 0.8 % Men having sex with men 0.4 % Injecting Drug Users (IDU)* 4.9 % Heroin smokers 0.5 % Rickshaw pullers 0.0 % Truckers 0.0 % All risk groups 0.6% (Source: 6th round National HIV Serological Surveillance (NHSS 2004-2005)

* Data on IDU is for Central A of Bangladesh that covers mainly Dhaka city

II. Overview of the HIV/AIDS Epidemic

According to available data from sixth round National HIV Sero-Surveillance (NHBS 2004-2005) Bangladesh still has a relatively low prevalence of HIV with a rate of less than one percent among most-at-risk-population groups. However, among IDUs in Central Bangladesh that mainly includes Dhaka city HIV infection rate has reached 4.9 percent that points towards a concentrated epidemic in this population group. Of major concern is the rapid and consistent increase in the prevalence of HIV among IDUs from 1.4 percent in 2000 to 1.7% in 2001, 4% in 2002 and 4.9% in 2005 as shown in the surveillance results below (Figure 2.1). While the average HIV infection rate was 4.9% among IDUs in Central Bangladesh there was a pocket where the infection level was as high as 7.1%.

Figure 2.1: Percentage of IDUs who are HIV infected, 2000-2005



The estimated number of people living with HIV and AIDS (PLHIV) is 7,500 as of end of 2004 (MoHFW/NASP) based on results using UNAIDS/WHO guidelines. Through this exercise the range of the size of the vulnerable groups has been estimated, which shows that there are large number of people who could be most-at-risk of HIV (approximately 2.2 million to 3.9 million, Table 2.1).

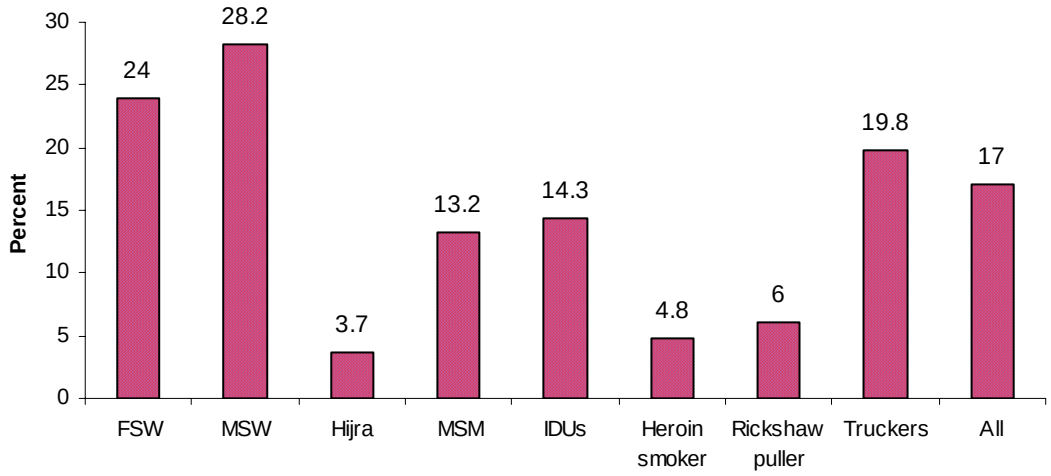
Table 2.1: Estimated size of vulnerable population groups and the average size of PLHIV in each group, 2004

Vulnerable Population Groups	Range of estimates of most-at-risk population		Number of PLHIV
	Lower limit	Upper limit	
IDUs	20,000	40,000	444
MSM/MSW	40,000	150,000	450
Brothel-based SW	3,600	4,000	55
Street-based SW	37,000	66,000	453
Hotel based	14,000	20,000	128
Clients of FSW	1,882,080	3,136,800	1,882
Hijra	10,000	15,000	62
Returnee migrants	268,000	536,000	3,015
National total (MARPs)	***2,274,680***	***3,967,800***	***6,489***
National total (PALR)	***1,191,559***	***2,012,376***	***1,188***
Total			***7,677***

Source: NASP/MOHFW, 2005 *PALR= Population at Lower Risk*

Although the level of HIV infection has remained low, vulnerability and risk factors are considerable. Data on knowledge and behaviour indicates that only 17% of most-at-risk population have correct knowledge about prevention and misconceptions on HIV/AIDS ranging from 3.7% among transgenders (Hijra) to 36.6% among brothel-based female sex workers (Figure 3.1, BSS 2003-2004).

Figure 3.1 Percentage of most-at-risk population who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconception about HIV transmission



Further the risk behaviour of unprotected sex as evidenced by low condom use among FSWs and MSWs is high. Data shows that overall condom use rate among all FSWs is 30.9% with only 24.1% among street-based sex workers. Among transgenders condom use rate is even much lower at 15.6%.

BSS (2003-2004) provides information on condom use among MSM during anal sex whereby it indicates that in non-commercial sex the rate is 37% while in commercial sex it is 49.2%. Additional data exists on condom use among MSM who reported anal sex with a female partner (for non-commercial sex 20.2% vs. 44.2% in commercial sex).

Only 14.7% of male IDUs are adopting safe practices as found from the BSS data. Information obtained from IDU Cohort study indicates that among female IDUs 21.1% are practicing safe behaviours.

Furthermore, according to reports and anecdotal evidence there are other associated vulnerability and risk factors that could trigger an expansion of the epidemic beyond its current level.

Gender violence and inequality exist in Bangladesh society that is largely male dominated and thereby putting women and girls at additional risk of HIV. This is further highlighted by the fact that according to BSS findings of 2003-2004 a large number of clients of sex workers were married men who could put their wives at risk of HIV even if they themselves remained faithful. The size estimation of vulnerable groups has also indicated a large of number of clients of sex workers of between 1.8-3.1 million.

Additionally there is high population mobility within the country and beyond its borders with the resultant increase in vulnerability to HIV and AIDS particularly among young people.

A population-based survey among adolescents and young people of 15-24 years of age indicates that only one out of three males in urban and one out of four in rural areas have correct knowledge of HIV and AIDS (Save the Children, USA and NASP 2005).

Despite that there is no empirical evidence on the extent and depth of stigma and discrimination around HIV/AIDS in Bangladesh, reports from PLHIV support groups, NGOs, the media and other sources indicate that their incidence is not uncommon.

III. National Response to the AIDS epidemic

3.1 National Commitment and Action

As far back as 1985 even before Bangladesh recorded its first case of HIV/AIDS, the National AIDS Committee (NAC) was established in recognition of the threat of HIV and AIDS and the need for effective policy and leadership support for prevention efforts. The National Policy on HIV and AIDS that was formulated and endorsed by Cabinet in 1997 continued to guide the national response during the reporting period. The legislation for safe blood transfusion that was enacted in 2002-2003 provides the much needed support and direction to ensure blood safety.

As the Chief Patron of NAC, the President of the People's Republic of Bangladesh addressed the nation on the World AIDS Day 2004 and reiterated Government's commitment to address HIV and AIDS in partnership and collaboration with all other national and international partners. The Minister of Health and Family Welfare and the Chairperson of the NAC launched the National Strategic Plan (NSP) on HIV/AIDS for the period 2004-2010. NSP endorses commitment to the "Three Ones" principles and advocates for their application to strengthen multisectoral action on HIV/AIDS. Further, NSP highlights the need to ensure effective involvement of PLHIV and other vulnerable populations in policy dialogue and formulation as well as programming on HIV/AIDS.

Realizing the threat of the HIV/AIDS epidemic, government mobilized and secured funding through WB/DFID and GFATM to support prevention initiatives among most vulnerable populations including the adolescents and young people. Further to this government has entered into partnership with NGOs/Civil Society for the implementation of relevant activities.

PRSP in which HIV/AIDS is covered under the section on health, nutrition and population was launched in November 2005.

Efforts to mainstream HIV/AIDS in other public sectors outside the Ministry of Health and Family Welfare were initiated through designation and training of focal points on HIV/AIDS in 16 government ministries.

Although progress has been made in the above areas significant challenges remained to ensure effective functioning of NAC for the purpose of galvanizing strong leadership and coordination of the national response. Also the issue of mainstreaming of HIV/AIDS into PRSP and other frameworks and sectors has not been adequately addressed as HIV/AIDS was largely considered as a problem to be dealt with mostly through the health sector. Where as the national policy on HIV/AIDS and other policies as well as legislations cover the issues of human rights and dignity there have been no specific legislation on stigma and discrimination around HIV/AIDS. While the establishment of *Parliamentary Group on Prevention of HIV/AIDS and Human Trafficking* has been important it has not had significant influence on this

issue. Also public funding on HIV/AIDS has not been specified as there was no dedicated allocation for HIV/AIDS in the national budget for 2003-2005.

The institutional and organizational arrangements of the national response have not been adequately placed and sufficiently empowered to facilitate more comprehensive action on HIV/AIDS.

3.2 Programme implementation and strategic partnerships

During the period under review implementation of HIV/AIDS initiatives mainly involved NGOs and Ministry of Health and Family Welfare based on the National Strategic Plan that identifies high-risk population groups as key priority for HIV/AIDS interventions.

More than 380 NGOs and AIDS Service Organizations have been implementing programmes/projects in different parts of the country. These initiatives focused on prevention of sexual transmission among high-risk groups involving mostly female sex workers, MSM, IDUs, Rickshawpullers and truckers.

To ensure safety of blood transfusion, Government has established 98 centres throughout the country for screening blood for HIV, Syphilis, Malaria, Hepatitis B and Hepatitis C. In addition, efforts have been embarked upon to promote voluntary blood donation as opposed to professional blood donation. To further support this legislation for blood transfusion has been put in place in 2002 but its enforcement and implementation remains a challenge.

Regarding voluntary counselling and testing only seven facilities have been established for this purpose. However efforts for expansion are underway through government collaboration with NGOs and development partners.

Communication and advocacy initiatives were introduced for social and leadership mobilization and motivation towards enhanced support for HIV/AIDS prevention, care and support. Through these initiatives it is intended that religious leaders would be oriented and sensitized to contribute to create awareness about HIV/AIDS utilizing more than 250,000 mosques which exist throughout the country.

Bangladesh Armed Forces HIV/AIDS education and life skills intervention programme is often cited and considered to be a best practice particularly in keeping HIV infection low among the peacekeepers (National Strategic Plan 2004-2010).

The key components of the GoB/WB/DFID (2003-2006) funded project ($26 million) include support for targeted interventions, communication and advocacy, blood safety and institutional capacity strengthening of the National AIDS/STD Programme (NASP) and are being largely executed through NGOs with management support from UNICEF, WHO and UNFPA.

To promote prevention of HIV among adolescents and young people government in conjunction with Save the Children, USA have been involved with GFATM ($ 6 million for phase I, 2004-2006 and $13 million for 2006-2009) funded project that is being implemented through NGOs.

The FHI/USAID supported project ($13 million, 2005-2008) is also focusing on selected interventions for some high-risk groups including expansion of VCT services.

There are two main support groups for PLHIV that operate in collaboration with NGOs to offer limited peer support to their members who are around 200 and mainly from Dhaka and few other cities.

There is however no comprehensive information on national coverage of HIV/AIDS prevention and other interventions. The limited data that is available from BSS 2003-2004 show that within the intervention areas 71.6% of 2,119 female sex workers reported that they were reached by prevention programmes. The survey further highlights the particularly low coverage among rickshawpullers (0.7%) and transgenders (15.4%), the details of which are shown below (Table 3.1). Given that the above estimates of coverage are generated through BSS for which the samples are drawn mostly from the areas exposed to HIV/AIDS intervention, the national coverage of these most-at-risk population groups therefore predictably be of even greater concern.

Table 3.1: Percentage of most-at-risk population reached with HIV prevention programmes, 2003-2004

Most-at-risk population	***Coverage (%)***
Female sex workers (FSW):	
Brothel based (n=680)	88.5
Street based (n=1050)	68.9
Hotel based (n=389)	48.9
All FSW (n=2119)	71.6
Male sex workers (MSW) (n=731)	76.2
Transgender (Hijra) (n=410)	15.4
MSM (n=810)	77.0
IDU (n=1372)	82.0
Heroin smokers (n=353)	7.0
Rickshaw pullers (n=718)	0.7
Truckers (n=441)	39.5
All MARP (n=6954)	58.8

Source: BSS 2003-2004

The actual number of PLHIV who are on ART is not known and there is no public programme providing anti-retroviral treatment. The only information from peer support groups shows that less than 50 people are currently on ART through private and NGO support for which long-term support is not ensured.

Although resources for targeted interventions among high-risk groups are a challenge there has recently been an added dimension particularly due to funding constraints as a result of reprogramming/policy issues by some partners for some components of HIV/AIDS initiatives for targeted interventions.

3.3 Funding for HIV/AIDS

Direct funding for HIV/AIDS has depended largely on external support as illustrated in the following table (Table 3.2):

Most of the funding though has been project based and of limited duration rather than programme oriented.

Even the Ministry of Health and Family Welfare (MoHFW) that is mandated to provide stewardship and oversight of the national response through NASP does not have a comprehensive allocation on HIV/AIDS in its budget. However, although government spending on HIV/AIDS is limited it is integrated into the overall health delivery system and other related public sector programmes and thus make it difficult to specify the actual expenditure dedicated to HIV/AIDS.

Table 3.2: Major External Funding Sources (US$, million)	
GoB/WB/DFID (2003-2006)	26
GFATM (2004-2006)	6
USAID/FHI (2005-2008)	13

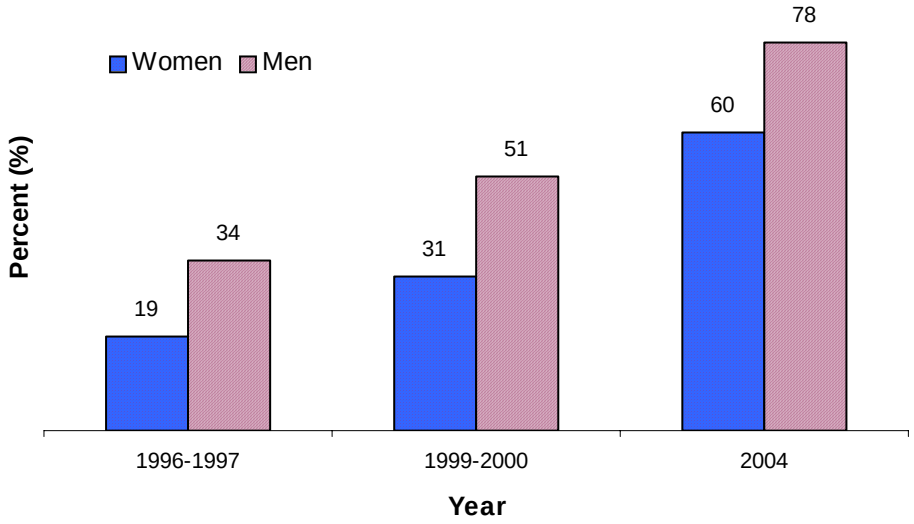
3.4. Programme outcome: Change in knowledge and behaviour

This section presents an overview of the knowledge and behaviour change among general and high-risk population using data from the 2004 Bangladesh Demographic and Health Survey (BDHS, 2004) and 5th round Behavioural Surveillance Survey (BSS, 2003-2004). Efforts have been made to collect additional/UNGASS related indicators from the above sources to further understand the outcome of national response in terms of behaviour change.

Ever heard about HIV/AIDS

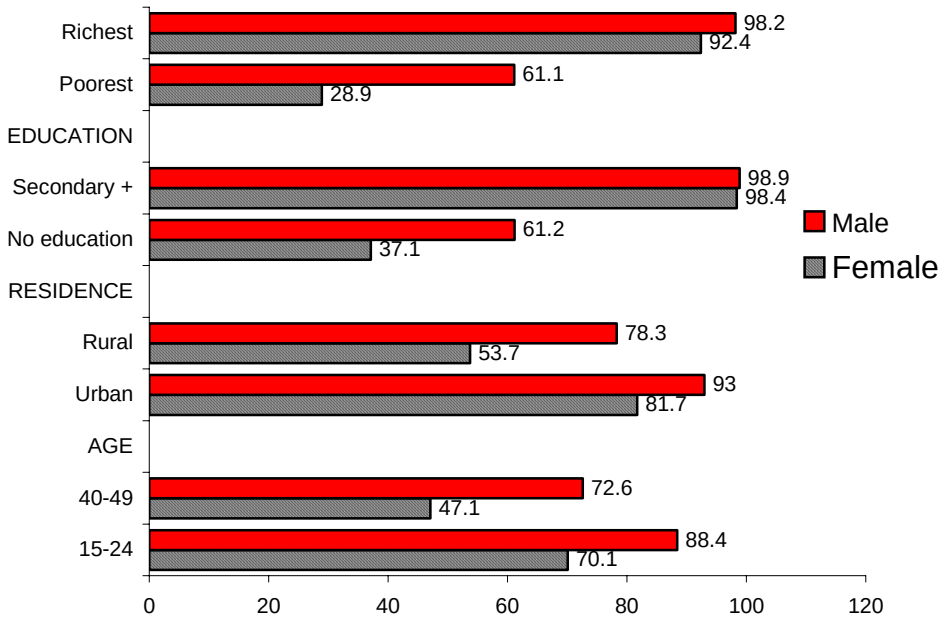
BSS indicates that there is universal knowledge in terms of whether ever heard of HIV/AIDS among most-at-risk population groups. However, DHS data reveals that among the general population although knowledge has improved over time it is still around 60 percent among ever-married women of 15-49 years of age and 78 percent for the currently married men of age 15-54 years *(Figure 3.1)*.

Figure 3.1: Percentage of ever-married women and currently married men who ever heard of HIV/AIDS, BDHS 1996-2004



Younger men and women are more likely to have ever heard of HIV/AIDS than their older counterparts. In addition, differences have also been observed in terms of other background characteristics including education, economic status and place of residence *(Figure 3.2)*.

Figure 3.2 Background characteristics of those who ever heard of HIV/AIDS, 2004

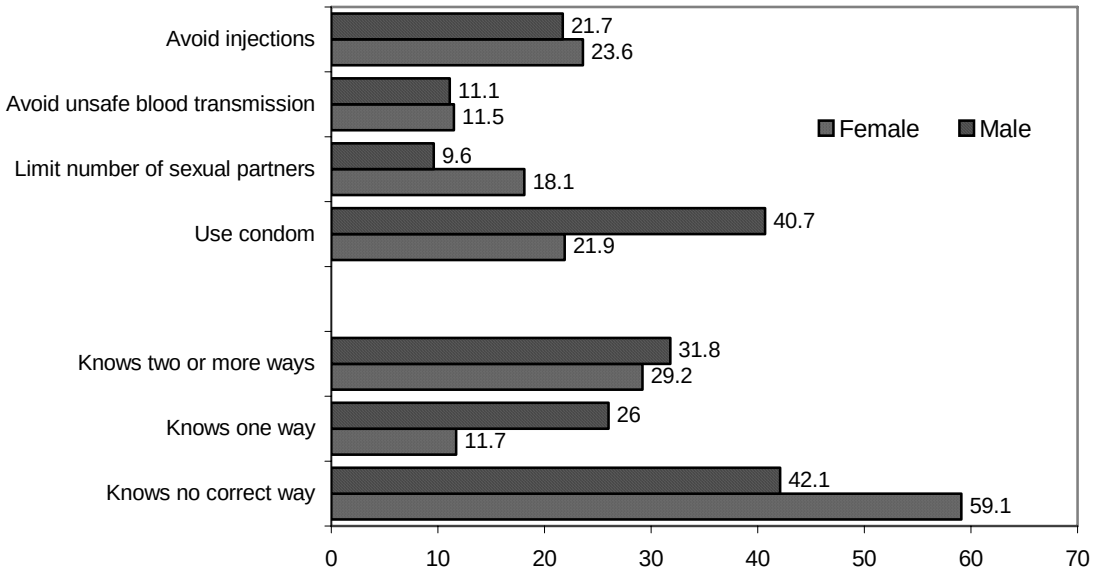


Source: Bangladesh Demographic and Health Survey (BDHS) 2004

Knowledge of ways to avoid HIVAIDS

DHS data on the knowledge of HIV/AIDS among general population indicated that 59 percent of ever-married women and 42 percent of men of age 15-54 could not mention a single way to avoid HIV/AIDS. About 30 percent of women and 32 percent of men were able to mention two or more correct ways to avoid getting HIV/AIDS (Figure 3.3).

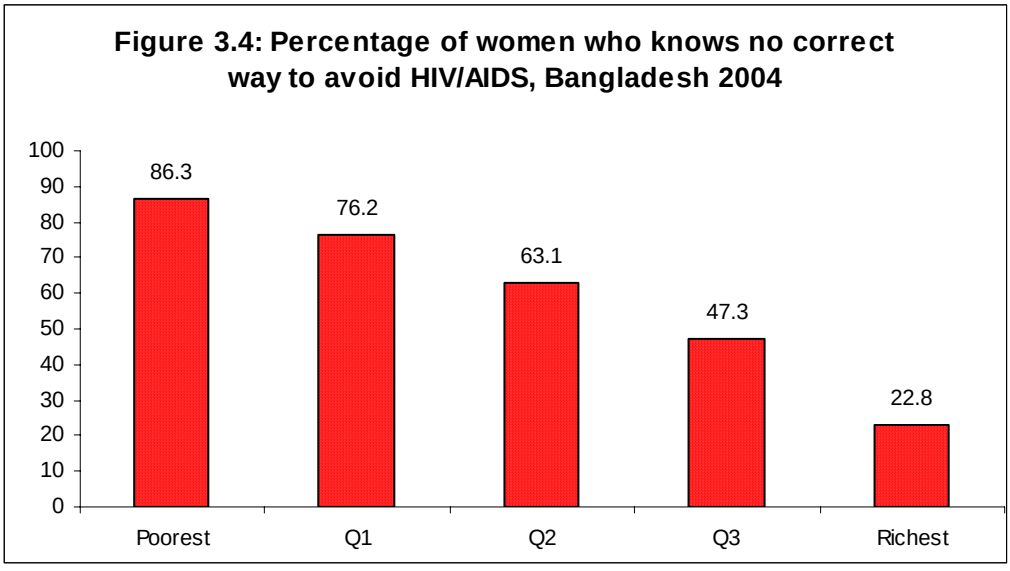
Figure 3.3 Knowledge of correct ways to avoid HIV/AIDS



Poverty linked with knowledge of HIV/AIDS

Knowledge of HIV/AIDS is likely to increase with the economic status. The quintal analysis using DHS data indicates that 86 percent of the poorest women do not know any correct way to avoid HIV/AIDS compared with 23 percent among the richest. However it would be important to factor in the issue of education levels if this data had been collected.

Figure 3.4: Percentage of women who knows no correct way to avoid HIV/AIDS, Bangladesh 2004

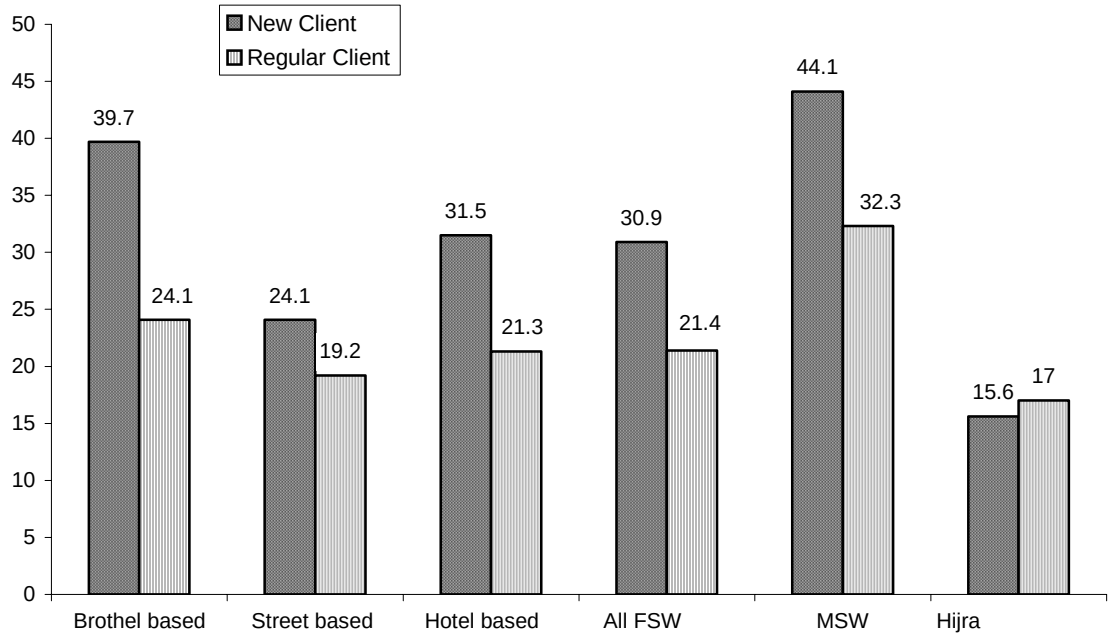


Source: BDHS 2004

Low level of condom use among sex workers

Although, Bangladesh has one of the highest rates of commercial sex among the Asian countries (MAP 2004), the rate of condom use is still very low particularly among the sex workers. About 16-44% of the commercial sex workers were reported to use condom with their most recent (during past one week) new clients. The rate of condom use is even lower with the regular clients (17-32%). MSW shows the highest rate of condom use, followed by brothel based sex workers and Hijra's (transgender) show lowest rate of condom use.

Figure 3.5: Percentage of sex workers reporting the use of a condom with their most recent client (in last week)



IV. Major Challenges Faced and Actions Needed to Achieve the Goals/Targets

In line with its National Strategic Plan (NSP) on HIV/AIDS, Bangladesh seeks to prevent spread of HIV infection and reduce the impact of AIDS. To attain this goal and meet the MDG target (*have halted by 2015 and begun to reverse the spread of HIV/AIDS*), there are significant challenges that should be addressed in a more comprehensive and rights-based manner. Experiences and lessons over the past years and particularly during the period 2003-2005 should provide the much needed guidance to further efforts to improve and scale up action on HIV/AIDS.

Policy and management issues of the national response to HIV/AIDS

Admittedly there has been a national policy on HIV/AIDS since 1997 and legislation on blood safety enacted in 2002, yet there is no comprehensive review, verification and update of the national policy to accommodate new developments for focused guidance and necessary legislative provisions and other key issues particularly relating to stigma and discrimination around HIV/AIDS.

Programming and partnerships

- There is a need for clearer and more specific policies to ensure appropriate and effective institutional and organisational arrangements necessary for a scaled up multisectoral response.

  National AIDS/STD Programme (NASP) has the stewardship role of the response to the epidemic. In accordance with NSP the scope and application of “Three Ones” principles should be assessed and necessary policy, management and programmatic decisions and processes taken so as to ensure their effective implementation. This will require appropriate restructuring and reorganization of NAC for revised and streamlined mandate as well as establishing relevant mechanisms for its linkages with the CCM and other existing bodies.

- There is a large NGO base mostly involved in targeted interventions on HIV/AIDS. As the quality of the interventions implemented by the NGOs varies considerably due to their limited capacity there is need for coordinating, strengthening and upgrading the skills of the implementing agencies. The STI/AIDS Network (SAN) was established to facilitate coordination and networking among NGOs involved in HIV/AIDS. However due to capacity constrains it has not managed to adequately fulfil this role and hence ways to strengthen it should be identified within the overall framework of partnership building towards an enhanced and better coordinated response to HIV/AIDS.

- Blood safety programme needs to be strengthened and scaled up for a comprehensive coverage both within the public and private sector. Also, enforcement of and advocacy on the blood safety act should be ensured.

Up scaling of responses

Although Bangladesh is still a relatively low prevalence country there is potential for substantial concentrated epidemics among IDUs with a rapid expansion of infection within this group and to other most-at-risk and vulnerable populations through sexual networks. This underscores urgency for a rapid scale up of IDU interventions for which the current coverage is very limited.

In addition to IDUs, up scaling of targeted interventions for other high-risk and vulnerable groups are also critical and the national response should prioritize for comprehensive coverage among those to avert an impending HIV/AIDS epidemic.

In order to mainstream and integrate HIV/AIDS into national development plans it is necessary to create a dedicated budget line to support HIV/AIDS activities and strengthen resource mobilisation. Financing and expenditure on HIV/AIDS should be included in the National Health Accounts.

Voluntary counselling and testing

Whereas there are seven VCT centres in the country only few of them are fully functional. Given this situation the need for expansion and up scaling of VCT services based on proper situation and needs assessment should be accorded priority. This should also be informed by lessons and experiences from the existing centres.

Care and support

There is a need to improve care and treatment through establishment of a comprehensive programme that includes introduction and expansion of ART. Given the relatively small number of PLHIV that may be in need of treatment, access to ART should be a key part of the national response to the epidemic not only to improve the quality of and prolong life but also as a prevention strategy. Furthermore, the importance of strengthening capacity building of health care providers should also be addressed.

Stigma and Discrimination

There is a need to adequately address the issue of stigma and discrimination around HIV and AIDS through greater involvement and participation of PLHIV in different aspects of the national response particularly in the areas of care, treatment, support and advocacy. Interventions and services need to be improved in quality, coverage and accessibility and in a manner that fully respects human rights and dignity. Initiatives to establish a national network of PLHIV should be expedited as part of empowerment of PLHIV and their capacity enhancement. The need for specific legislation to promote protection of PLHIV and other people affected by HIV/AIDS from stigma and discrimination should be considered within the framework of ensuring more effective policies on AIDS.

Sharing of strategic information

More effective mechanisms for sharing of strategic information necessary for policy and programming purposes on HIV/AIDS should be in place and applied accordingly. Further, documentation and sharing of best practices should be an integral part of the national response.

Surveillance and its use

The second generation surveillance has been undertaken consistently since 1998 and so far six rounds of sero-surveillance and five rounds of behavioural surveillance have been completed. However, there is a need to critically review the current surveillance process in order to strengthen it accordingly.

Advocacy and communication

Due to relatively low prevalence of HIV/AIDS in Bangladesh, a complacency is still prevailing among many policy makers and leaders of different sectors in society whereby HIV/AIDS is not given due consideration as a priority for action and resource mobilisation and support. Therefore advocacy and communication efforts should be directed towards improving better understanding of the epidemic and its consequences as well as strengthening commitment for effective leadership role in response to the epidemic. It is also critical that different population groups are reached with appropriate messages and other communication initiatives for improved awareness and social mobilisation on HIV/AIDS.

V. Support Required from Country's Development Partners

Bangladesh has developed its National Strategic Plan on HIV/AIDS for the year 2004-2010 and is preparing a costed operational plan that will indicate priority areas for support with a major focus for scaling up of the responses to HIV and AIDS. It is expected that the ensuing AIDS action plans should provide the basis upon which the different stakeholders will contribute to deal with HIV/AIDS including improved coordination and harmonization of support for different components of the multisectoral programme of action.

Largely, the support to HIV/AIDS initiatives in the country is financed through external resources. The current HIV and AIDS Prevention Project (HAPP) which government is implementing mainly through NGOs and other partners, ends in June 2006. Although there are prospects for extension of funding support for HIV/AIDS through new Health, Nutrition and Population Sector Programme (HNPSP) beyond June 2006, there are concerns that there may be funding gap due to delays in management and agreement processes. As HAPP is one of the major sources of support for targeted interventions, funding gap in this area will have considerable adverse implications for the national response. This is a critical area where significant support is required from the development partners to avoid any interruption of initiatives on HIV/AIDS and to scale up the responses to the epidemic. This further amplifies the need for more long-term resource commitment with a programme based focus and that is more sensitive to identified national priorities on HIV/AIDS.

In addition to funding for HIV/AIDS programme implementation, significant support is also required for strengthening technical and logistic capacity of stakeholders and partners involved in the multisectoral national response to HIV/AIDS in accordance with their comparative advantages.

Support is also essential to ensure mainstreaming and integration of HIV/AIDS issues into different donor assistance for other development and related programmes.

VI. Monitoring and Evaluation Environment

Although the National Strategic Plan endorses the “Three Ones” principles and includes a national M&E framework, there is a need to elaborate and operationalize this framework to ensure a comprehensive M&E system necessary for effective reporting and tracking of the response.

The M&E activities of the national response are currently fragmented and project based with different data collection and reporting requirements and priorities. The coordination and linkages among different partners for M&E of HIV/AIDS programme are still inadequate. The AIDS and STI related indicators are not integrated/harmonized with the existing MIS of health care services. Although behavioural and sero-surveillance system has been developed to provide information on the behavioural aspect and trends of the epidemic, however, due to lack of sound programme monitoring data proper assessment of the impact of the programmatic efforts are difficult to make.

There is a Monitoring and Evaluation (M&E) sub-committee to oversee the M&E activities which is supported by the Monitoring and Evaluation Technical Working Group with clear terms of reference to facilitate harmonization of indicators developed by different partner organizations and development of a comprehensive National HIV/AIDS M&E plan that includes standardized set of indicators, data collection tools and analysis strategy.

In addition there is also a Surveillance Advisory Committee (SAC) to guide the surveillance which is implemented through coordination with other partners.

The key challenges to develop an operational M&E system for HIV/AIDS include:

- Establishment of HIV/AIDS M&E structure at national and sub-national level
- Capacity enhancement of the national programme including M&E infrastructure for effective management, implementation and sustainability of the M&E system
- Defining and developing priority indicators and other M&E guidelines and tools to track the progress of the national response and meet the needs of all levels
- Harmonizing HIV/AIDS M&E with the existing health management information system and other related MIS systems for tracking and supporting the multisectoral response

ANNEX 1

Preparation/consultation process for the National Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

1) Which institutions/entities were responsible in filling out the indicators forms?

a) NAC or equivalent		Yes √	No
b) NAP		Yes √	No
c) Others		Yes √	No

2) With inputs from:

Ministries:	Education	Yes √	No
	Health	Yes √	No
	Labour	Yes √	No
	Foreign Affairs	Yes	No√
	Others	Yes√	No

Civil society organizations	Yes √	No
People living with HIV/AIDS	Yes √	No
Private sector	Yes	No√
UN organizations	Yes √	No
Bilaterals	Yes √	No
International NGOs	Yes √	No
Others	Yes √	No

3)	Was the report discussed in a large forum?	Yes √	No
4)	Are the surveys results stored centrally?	Yes √	No
5)	Is data available for public consultation?	Yes √	No

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Date: December 29, 2005_____

Signature: _____

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