2008 UNGASS COUNTRY PROGRESS REPORT

BANGLADESH

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Prepared by

National AIDS/STD Programme (NASP)
Ministry of Health and Family Welfare

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ACRONYMS AND ABBREVIATIONS

AAS	Ashar Alo Society
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Vaccine
AITAM	AITAM Welfare Organization
BAP	Bangladesh AIDS Project
BDHS	Bangladesh Demographic and Health Survey
BSS	Behavioral surveillance survey
CCM	Country Coordination Mechanism
CRIS	Country Response Information System
CAAP	Confidential Approach to AIDS Prevention
DFID	Department for International Development
DGHS	Directorate General of Health Services
FHI	Family Health International
FSW	Female sex worker
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOB	Government of Bangladesh
GTZ	German Technical Cooperation
HIV	Human Immunodeficiency Virus
HNPSP	Health Nutrition and Population Sector Programme
ICDDR,B	International Centre for Diarrhoeal Diseases Research, Bangladesh
IEC	Information education and communication
IDU	Injecting drug users
MARP	Most-at-risk population
M&E	Monitoring and evaluation
MOHFW	Ministry of Health and Family Welfare
MOLE	Ministry of Labour and Employment
MOP	Ministry of Planning
MOSA	Ministry of Social Welfare
MOYS	Ministry of Youth and Sports
MSM	Men who have sex with men
MSW	Male sex worker
MAB	Mukta Akash Bangladesh
NAC	National AIDS Committee
NCPI	National Composite Policy Index
NMC	National Media Committee
NSP	National Strategic Plan
NASP	National STD/AIDS Program
NGO	Non-governmental organization
NHSS	National HIV Serological Surveillance
PLHIV	People Living with HIV
SAN	STI/AIDS Network

STD	Sexually transmitted disease
STI	Sexually transmitted infection
SW	Sex worker
TC-NAC	Technical Committee of National AIDS Committee
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children Fund
VCCT	Voluntary and confidential counseling and testing
WB	World Bank
WHO	World Health Organization

UNGASS COUNTRY PROGRESS REPORT

1. STATUS AT A GLANCE

1.1 The inclusiveness of the stakeholders in the report writing process

The UNGASS reporting process included a desk review of reports and data relating to the HIV/AIDS situation in Bangladesh; the identification of stakeholders and their various contributions to the reporting process; a review of other data needs for the report; development of a plan for information collection; and the development of tools for data collection. These initial steps and the collation and analysis of data were undertaken by the National STD/AIDS Programme (NASP) of the Ministry of Health in coordination with partner organizations. Many stakeholders, including representatives of other government agencies, civil society organisations, people living with HIV, and UN agencies and other development partners, were involved in the reporting process**.**

In November 2007, a consultative workshop involving all stakeholder groups was held in Dhaka to discuss the national HIV response, the UNGASS reporting process, and stakeholders' inputs into the report. Representatives from all groups were interviewed to gather information for the NCPI and other sections of this report, and to access pertinent national and sub-national research reports. Several meetings were held with members of the Monitoring and Evaluation Technical Working Group (M&E TWG) of NASP regarding the relevance and quality of available data. Another consultative workshop was held in January 2008 to share comments on the draft report and to reach consensus about progress made on addressing the AIDS epidemic, before the national UNGASS report was finalized and submitted to UNAIDS in Geneva.

The UNGASS reporting process included a training workshop on the country response information system (CRIS). This was held in December 2007, organized by UNAIDS-Bangladesh and attended mostly by the members of the M&E TWG. A UNAIDS consultant conducted the training which included an overview of CRIS, its utility in data capturing and report generation, its operation and management, and the planned expansion of the system to increase its flexibility and capacity to incorporate other data relating to HIV and health. Finally the document was peer reviewed by the experts including an international consultant provided by UNAIDS Regional Office.

1.2 Status of the epidemic

The prevalence of HIV in the general population of Bangladesh appears to be low, at under 0.1 percent. The prevalence is estimated to be below 1 per cent in all risk groups except for injecting drug users (IDU), thought to be a relatively small group of people.

The first HIV case in Bangladesh was detected in 1989. By 1st December 2007, the Ministry of Health and Family Welfare had confirmed 1207 cases of HIV. Of these people, 365 had developed Acquired Immune Deficiency Syndrome (AIDS) and 123 had died. In this UNGASS reporting period, however, the number of reported cases rose sharply. In 2006, 216 new cases of HIV were reported. In the past year alone, 333 new cases of HIV infection were reported, including 125 new cases of AIDS and 14 deaths.

Among the possible reasons for the low HIV prevalence are: high levels of circumcision among men; until recently, low levels of injecting drug use (IDU); a history of NGO targeted interventions with high risk groups; and relatively low risk behaviours. There is however consensus that risk factors for the spread of HIV are present in Bangladesh: a significant but somewhat hidden sex industry; low levels of condom use; increasing injecting drug use and persistent sharing practices; and rising HIV prevalence levels among IDU (Bondurant et al., 2007).

There is also little doubt that the country's limited facilities for sentinel surveillance and voluntary counseling and testing, as well as the social stigma and discrimination attached to HIV, contribute to an understatement of the real incidence of HIV. Already by the end of 2004, NASP estimated that 7,500 people were infected with HIV, and that somewhere between 2.2 and 3.9 million more people were at elevated risk of acquiring HIV, including injecting drug users, female sex workers and their clients, MSM, and internal migrants (NASP/ MoHFW, 2005). New estimates of these numbers are expected to become available in 2008.

1.3 Policy and Programmatic Response

The Government of the People's Republic of Bangladesh is firm in its political commitment to combat HIV. In 1985, over twenty years ago, it responded to the nascent HIV epidemic by setting up a National AIDS Committee (NAC), with the President as its Chief Patron and the Minister of Health and Family Welfare as Chairman. NAC remains an active body and comprises representatives of various government departments, civil society organisations, the business community, and self-help groups. The Technical Committee of the NAC includes experts in various fields of specialty that are relevant to the prevention and control of HIV and STD.

In 1997, NAC worked with various stakeholders to develop the National Policy on HIV/AIDS and STD Related Issues (NASP, 1997). After its endorsement by Cabinet the same year, the Bangladesh Government became the first among the SAARC countries to adopt such a policy. This was closely followed by the Strategic Plan for The National AIDS Programme of Bangladesh, 1997-2002 (NASP,1997), also approved by government in 1997.

In 2005, with the active involvement and support of government, civil society and UN agencies, NASP reviewed the first Strategic Plan and produced the 2nd National Strategic Plan of HIV/AIDS for 2004-2010 (NSP II) (NASP, 2005).

In 2007, with the assistance of UNAIDS, NASP developed the 'National AIDS Monitoring and Evaluation Framework and Operation Plan' (NASP, 2007a) and drafted the 'Operational Plan for The National Strategic Plan for 2006-2010' (NASP, 2007b). The operational plan document has yet to be shared with other stakeholders.

In recent years, Government has mobilized and secured credit funds through the World Bank (WB), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and other development partners to implement these policies and plans, specifically to support interventions aimed at preventing the spread of HIV among the most vulnerable groups, namely sex workers, IDU, men who have sex with men (MSM) and mobile populations. Since 2004, in partnership with NGOs and donor organisations, the government has implemented two national HIV prevention projects:

- The HIV Prevention Project (HAPP), jointly funded by World Bank, DFID and Government and executed by UNICEF, UNFPA and WHO; and

- The Project of Prevention of HIV among Youths and Adolescents, funded by the GFATM and executed by Save the Children (USA). The first phase, 2004-2007 had a budget of US$ 19 million. Under Round 6 of the GFATM, US$ 40 million will be provided over 2007-2012 for interventions targeted at a wider range of high risk populations.

In addition to these projects, USAID and Family Health International (FHI) support the Bangladesh AIDS Programme (BAP), 2005-2008, with a budget of US$ 13 million. This project provides a series of tailored and focused behaviour change interventions and clinical services aimed to increase accurate knowledge of STI/HIV transmission, promote risk reduction behaviours, reduce stigma and discrimination, establish an enabling environment for behaviour change and create demand for STI screening, VCCT, and care, support and treatment services.

1.4 UNGASS Indicators Data

Table 1 Core Indicators for the Declaration of Commitment Implementation (UNGASS) 2008 reporting

Indicators	*Data Available and Reported Yes or No*	*Method of Data Collection*
National Commitment and Action		
Expenditures		
1. Domestic and international AIDS spending by categories and financing sources	Data not available	National Health Accounts (data available by March 2008)
Policy Development and Implementation Status		
2. National Composite Policy Index	Reported	Key informant interviews
Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation		
National Programmes: blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphans and vulnerable children, and education.		
3. Percentage of donated blood units screened for HIV in a quality assured manner	Data not available	Patient records
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Reported	Key informant interviews
5. Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	Indicator not relevant	Patient records
6. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV	Indicator not relevant	Patient records
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results	Data not relevant	Population-based survey
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	Reported	BSS, 2006-7
9. Percentage of most-at-risk populations reached with HIV/AIDS prevention programmes	Reported	BSS, 2006-7
10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	Data not available	Population-based survey
11. Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year	Indicator not relevant	School-based survey
Knowledge and Behaviour		
12. Current school attendance among orphans and among non-orphans aged 10–14*****	Data not available	Population-based survey
13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	Reported	HIV/AIDS Baseline Survey among Youth in Bangladesh, 2005

Indicators	*Data Available and Reported Yes or No*	*Method of Data Collection*
14. 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	Reported	BSS 2006-7
15. Percentage of young women and men who have had sexual intercourse before the age of 15	Reported	HIV/AIDS Baseline Survey among Youth in Bangladesh, 2005
16. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	Reported for men only	An assessment of sexual behaviour of men in Bangladesh (ICDDR, B and FHI/USAID) 2006
17. 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*****	Reported for men only	An assessment of sexual behaviour of men in Bangladesh (ICDDR, B and FHI/USAID) 2006
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	Reported	BSS 2006-7
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Reported	BSS 2006-7
20. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	Reported	BSS 2006-7
21. Percentage of injecting drug users who report the use of a condom at last sexual intercourse	Reported	BSS 2006-7
Impact		
22. Percentage of young women and men aged 15–24 who are HIV infected*	Not relevant	NHSS 2006
23. Percentage of most-at-risk populations who are HIV infected	Reported	NHSS 2006
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Data not available	Programme monitoring
25. Percentage of infants born to HIV infected mothers who are infected	Indicator not relevant	Treatment protocols and efficacy studies

*Millennium Development Goals indicator

2 OVERVIEW OF THE AIDS EPIDEMIC

2.1 The regional situation

In South Asia, the HIV epidemic is quite heterogeneous in its dynamics and scope. Bangladesh borders with India and Myanmar and is in close proximity with Nepal, countries where the epidemic is severe. India alone has more than half of all the people living with HIV in Asia. With a population of more than 140 million, Bangladesh is one of the most densely populated countries in the world. Yet within the Southeast Asian region, Bangladesh continues to appear to have one of the lowest HIV prevalence rates, considerably less than one percent. It is, however, generally accepted that in the absence of a comprehensive case reporting system, Bangladesh has more HIV cases than is officially reported.

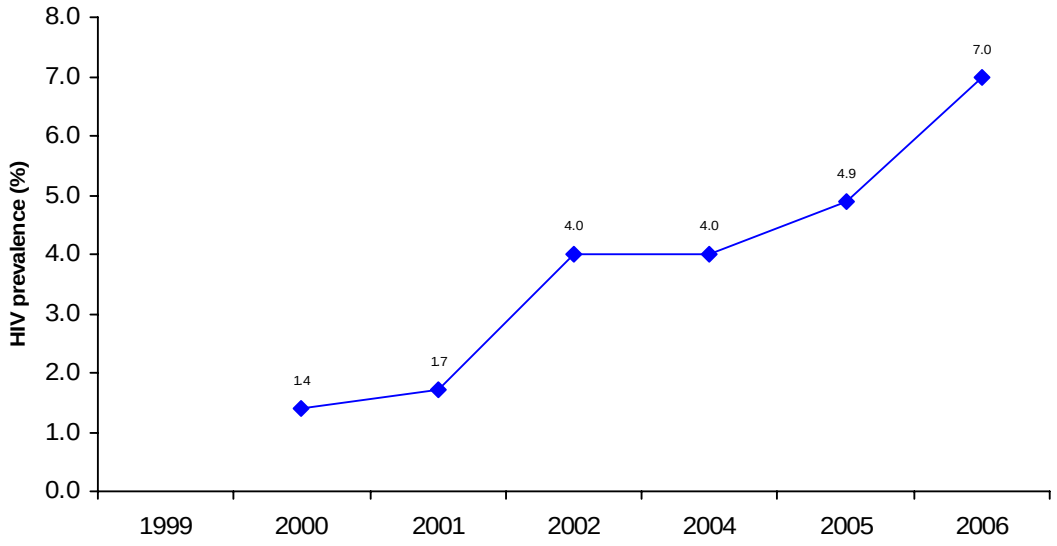
2.2 The country situation

The testing of donated blood for HIV gives an indication of HIV prevalence in the general population. Otherwise, almost all sero-surveillance has focused on known at-risk groups: sex workers, IDU, MSM (including both male sex workers and hijras, or transgendered people), and mobile populations. In 2005, a baseline nationally representative survey was conducted on youth, their sexual behaviour and knowledge of HIV (NASP and Save the Children USA, 2006). A small survey of adult men was also conducted in 2006 (ICDDR,B and FHI, 2006)

By the end of 2003, only 363 cases of HIV had been reported but there has been more than a three-fold increase in the four years since, to 1207 by the end of 2007 (MoHFW 2007). This indicates both the likelihood of incomplete reporting and the potential for a rapid growth in the epidemic.

The National HIV Serological Surveillance Survey conducted in 2006 covered a larger geographical area than previous surveys. It showed that the epidemic continues to be confined within certain risk groups, most particularly injecting drug users (IDU). The 2006 survey found that the prevalence of HIV among IDU in Dhaka City had risen to 7.0 percent, and in one particular neighborhood to 10.5 percent. The 2006 sero-surveillance survey of sex workers and MSM found that overall HIV prevalence in these groups remained below 1 percent.

Figure 1: HIV Prevalence among Injecting Drug Users, Bangladesh, 1999-2006



Source: National HIV Sero-surveillance surveys, 1999-2006

While the level of HIV infection evidently remains low, there are considerable vulnerability and risk factors. For more than a decade, government, NGOs and other agencies in Bangladesh have worked to reduce the risk of an HIV epidemic by educating groups at special risk and the general population about HIV prevention and common misconceptions about HIV and AIDS. Nonetheless, the latest behavioral surveillance and population-based surveys indicate that little progress has been made and there is considerable room for improvement (Save the Children (USA) 2006; BSS, 2007).

On top of the risks posed by sexual and other behaviours among particular groups of people, a range of structural factors heightens the vulnerability of Bangladesh's general population to an HIV epidemic. These include widespread poverty and inequality; a high level of adult illiteracy; the low social status of women; the trafficking of women into commercial sex; high population mobility, including rural-urban, inter-state, and international labour migration; and cultural impediments against discussing or addressing sexual issues.

National HIV programmes have so far focused on targeted interventions for most-at-risk groups, principally prevention activities, but increasingly they are working across the continuum of needs to treatment, care and support (Bondurant et al., 2007). A national Harm Reduction Strategy for Drug Use and HIV 2004-2010 has been produced by NASP and endorsed by Government, but not as yet systematically implemented. Given that harm reduction interventions remain the main priority and that the HIV epidemic evidently remains concentrated in the small population of IDUs, implementing the Harm Reduction Strategy together with recently endorsed oral substitution therapy (OST) will provide Bangladesh with an unprecedented opportunity to implement world-class HIV interventions to reduce the number of new HIV infections among IDUs and mitigate the impact among HIV-infected IDUs (Bondurant et al., 2007).

3 NATIONAL RESPONSE TO THE AIDS EPIDEMIC

3.1 Political leadership and the policy environment

The Government of People's Republic of Bangladesh remains firm in its political commitment to combat HIV, to maintain Bangladesh's status as a low prevalence country, and to achieve the goal of halting and reversing the spread of HIV by 2015. A lot of effort has gone into developing policies, guidelines and programmes. The task now is to translate them into action.

The government has endorsed its commitment to the "Three Ones" principles and advocated for their application, in order to strengthen the multi-sectoral approach to HIV and support human rights, gender equality and social protection (NSPII). Efforts to strengthen HIV prevention activities in other public sectors beyond the Ministry of Health and Family Welfare have included designating and training focal points for HIV in 16 government ministries.

Senior government officials often speak publicly in support of HIV prevention and related issues. Every year, in collaboration with civil society, UNAIDS and donors, the government observes the World AIDS Day throughout the country and organizes an HIV fair in the capital to both increase public awareness on HIV and reduce stigma and discrimination against PLHIV. Each year, the President's World AIDS Day message is published in newspapers throughout the country and reiterates government's commitment to prevent an HIV epidemic and its collaborative efforts with national and international partners. However, there remains some concern that political leaders fail to properly address the problems of stigmatization and discrimination against PLHIV or discuss in a sympathetic way the needs of groups that are most affected by the epidemic, or that they exacerbate the situation by adding to the perception that certain groups are 'guilty' of spreading HIV (Akhter, 2005).

Bangladesh has taken up some responsibility for political leadership on HIV in the South Asia region. In November 2005, leaders at the 13th SAARC Summit held at Dhaka called for a Plan of Action for cooperation among the countries on medical expertise and pharmaceuticals, the harmonization of standards and certification procedures, and production of affordable medicines. This declaration has yet to be put into action. In 2007, Bangladesh organized and participated in the South Asia Sub-regional Workshop of the Commission on AIDS in Asia, also held in Dhaka.

Initiatives to respond to HIV began in Bangladesh even before the first AIDS case was identified in 1989. Formed in 1985, NAC serves as the highest body of the government for policy decisions related to HIV and STD. It has been responsible for developing successive national HIV strategies, monitoring and evaluation frameworks, and operational plans.

The Technical Committee of the NAC (TC-NAC) comprises experts from various fields relevant to the prevention and control of HIV and STD. In 1995, the Directorate General of Health Services (DGHS) of the Ministry of Health and Family Welfare formed a Task Force convened by the TC Chairman. With political support from NAC and technical support from the TC-NAC, the Task Force led the process of developing a National Policy on HIV and AIDS, which was endorsed by the Cabinet in 1997. The Bangladesh AIDS Prevention and

Control Programme next developed the Strategic Plan for The National AIDS Programme of Bangladesh for 1997-2002[2], which was also approved by government in 1997.

In 1998, as recommended by the National Policy on HIV and STD, the National AIDS/STD Programme (NASP) was established under DGHS to oversee the HIV/AIDS programme in the country, under the guidance of NAC.

After the first Strategic Plan was reviewed in 2005, NAC guided the development of the 2nd National Strategic Plan for HIV/AIDS, 2004-2010 (NSP II), with the active involvement of a wide body of stakeholders, including UNAIDS. The objectives, strategies and priorities of this plan are closely aligned with the National Policy for AIDS and the Millennium Development Goals, and further guided by an analysis of the HIV situation and vulnerability factors in Bangladesh.

The main objectives of NSP II are to:

(i) Provide support and services for priority groups;

(ii) Prevent vulnerability to HIV infection in Bangladesh;

(iii) Promote safe practices in the health care system;

(iv) Provide care and treatment services to people living with HIV; and

(v) Minimize the impact of the HIV/ADIS epidemic.

In 2006, NASP produced the National HIV and AIDS Communication Strategy 2005-2010, again involving all relevant government ministries, NGOs, and UN and other development agencies.

In line with the NSP II, the Communication Strategy identified high risk populations - sex workers, drug users, MSM, and mobile populations (external migrants, border crossing people, transport workers, factory and other mobile workers, prisoners, uniformed forces and street children) - as priority groups for HIV prevention, and recognized the need to also involve these vulnerable groups in policy dialogue and formulation. However, the three major HIV prevention projects operating now in Bangladesh focus only on young people, sex workers, injecting drug users, MSM and mobile populations like transport workers and rickshaw pullers, not all of the groups identified as being at risk. Furthermore, while it is well understood that raising awareness on HIV in the at-risk population is important, knowledge improvement needs to be linked with changed behaviour, and it is not yet certain that this is happening.

The National AIDS Monitoring and Evaluation Framework and the Operational Plan for NSP II, both developed in 2007 by NASP with assistance from UNAIDS, will soon be distributed among stakeholders. The Operational Plan includes detailed assessments of the resources required for planned prevention, treatment and care activities.

[2] Strategic Plan for The National AIDS Programme of Bangladesh, 1997-2002, Bangladesh AIDS Prevention and Control Programme, DGHS, MOHFW, May 1997

A protocol for safe blood transfusion was formulated in 1997. The Safe Blood Transfusion Program was launched in 2000 and the Safe Blood Transfusion Act was passed in 2002, a milestone for the country. This law regulates the management of all blood transfusion centres, the collection and storing of blood, blood testing, and transfusion, in order to prevent unsafe transfusion of human blood. Government has expanded the program to 100 sub-district level hospitals (out of a total of 466 sub-districts) and equipped 50 of them, and plans to equip the rest in 2008. The National Policy and Strategy on Blood Safety, adopted in 2007, defines minimum standards and requirements for health facilities to qualify and be authorized to screen blood for HIV before transfusion. A Reference Laboratory has been set up in Dhaka Medical College Hospital to conduct HIV confirmatory tests. The overall number of blood centers, however, is still inadequate.

Other important national guidelines, manuals and strategy documents developed in recent years include the National Harm Reduction Strategy for Drug Use and HIV, 2004-2010; the National ART Guidelines, 2006; National STI Management Guidelines, 2006; Training Module for Health Managers on HIV/AIDS, 2006; National Standards for Youth Friendly Health Services, 2007; Training of Trainers Manual for School and College Teachers and Facilitation Guide, 2007; and the Training of Trainers Manual on Mainstreaming HIV/AIDS for NGOs and Five Key Ministries**,** 2007. However, while these policies and documents provide the necessary policy building blocks for resource mobilization and programme development, their implementation has been limited in some areas (Bondurant et al., 2007).

In short, while the coverage of HIV prevention activities was limited during the first part of this decade, the national HIV programme has been progressively scaled up in its quality and coverage. Government has mobilized loans and grants from development partners, including the World Bank, GFATM, UN agencies, and other multilateral and bilateral donors, to support interventions to prevent and treat HIV among particularly vulnerable populations. NASP has improved its capacity to coordinate TC-NAC, implementing agencies and donors.

There is now more consistent recognition by government that HIV is a development issue inextricably linked to cultural, social and economic determinants and, therefore, demands a wide and accelerated response. This is evident in the inclusion of HIV in national health, nutrition and gender planning and in the government's Poverty Reduction Strategy Paper, 2005.

Although Bangladesh has taken many positive steps towards preventing and controlling HIV, other challenges lie ahead. A comprehensive array of HIV-related policy documents and guidelines have been developed, and it remains now for these to be fully implemented. While NGOs and CSOs implement many of the activities, community participation in the policy and advocacy environment remains somewhat limited (Bondurant et al., 2007). Some legislative changes are required in order to enable universal access to injecting equipment for IDUs, condoms for sex workers and MSM, and to create an enabling environment for universal access by the wider population. The technical and organizational capacity of project implementing agencies across Bangladesh needs to be expanded in order to facilitate the scaling up of activities.

Table 2 reports estimated spending on HIV-related activities in Bangladesh in 2006 and 2007. The information required to complete the National Funding Matrix was not available. This situation may soon be remedied. A National Health Accounts survey is underway and is expected to be completed in March, 2008. This will include a full profile of HIV and AIDS related expenditures in Bangladesh, by both government and NGOs.

Table 2 Estimated AIDS spending in Bangladesh 2006-2007

Source	***Expenditure in US$ (million)***		***Total US$ (million)***
	2006	***2007***	
GFATM (Round 2)	4.7	7.9	12.6
WB/DFID in HAPP	9.1	4.1	13.2
GoB contribution in HAPP	0.9	0.5	1.4
USAID/FHI	4.2	3.7	7.9
Others (UN, GTZ and other donors)	3.0	3.0	6.0
Total	***21.9***	***19.2***	***41.1***

Sources: Collected from various agencies as part of UNGASS reporting process

3.2 The contributions of civil society

The Government of Bangladesh recognizes and values the contributions made by civil society to the national HIV response. There has been substantial civil society participation in the formulation of national strategies and the implementation of programmes to prevent and treat HIV, increase community awareness about HIV and AIDS, and reduce stigmatization and discrimination against PLHIV. However, community participation in policy development and advocacy has been limited, mostly focused on local actions and not systematically networked, and opportunities to expand the quality and reach of interventions have thereby been missed (Bondurant et al., 2007).

Besides international NGOs, approximately 400 local NGOs are working in the field of HIV. There is an even larger body of small community-based organizations, self-help HIV positive groups, faith based organizations, private organizations and media involved in HIV prevention. Most NGO programmes address the needs of specific groups for HIV prevention, treatment, care or support, such as young people, female or male sex workers, MSM, injecting drug users, or internal migrants. A small number of NGOs are extending legal services to some at-risk groups to help them to avoid problems such as harassment, but this is happening in a mostly haphazard manner.

All external funding for HIV activities is directed to civil society organizations. Even so, these organisations find that more financial support is required in order to implement comprehensive HIV programmes across the country. While many of these organisations have gained valuable experience in designing and implementing effective HIV programmes, they have also expressed their need to further improve their technical and organizational capacity, and thereby increase their capacity to use all available resources.

A great opportunity for an improved national response lies in better integration and coordination between government and NGOs. NGOs have acted to improve this situation by establishing an AIDS/STD Network in order to improve their own coordination and effectiveness.

Another opportunity lies in better coordination between government, NGOs and media organisations, particularly to promote public information and education. A National Media Committee (NMC) was formed in 2006, with assistance from UNAIDS. In 2007, this committee conducted two-day orientation courses on HIV for 20 journalists in three Divisional cities in Bangladesh and introduced an annual National Media Award.

3.3 Recognition and protection of human rights

The Constitution of Bangladesh includes a general provision for non-discrimination that guarantees equal rights to every citizen. This is reflected in all national policy documents, including those relating to HIV and AIDS which promise equal access for women and men to prevention and care.

Nonetheless, human right violations that do occur are likely to go unchecked as there is no independent institution to promote or protect human rights, or any focal points in the Ministry of Health or other government departments to monitor HIV-related human rights abuses or discrimination. Although government has shown strong leadership and commitment to increase awareness about HIV and help reduce stigma and discrimination, no changes have been made to laws in order to better protect PLHIV. The HIV-related legal framework is often vague, with outdated laws or without necessary supporting laws or regulations to ensure that the principles are adhered to, and some laws are applied in a haphazard fashion (Bondurant et al., 2007)

The non-discrimination provision of the constitution is often violated in primary health care services. Although the national HIV policy of the country explicitly states that ‘no health care institutions or health worker has the right to refuse treatment to people living with AIDS or HIV’, treatment is routinely denied or is simply unavailable, leaving affected people extremely vulnerable. The lack of enforcement of anti-discrimination laws forces many PLHIV to hide their status, justifiably fearing social stigma or discrimination. The silence of the law on transgender issues creates many situations where transgendered people face multiple forms of discrimination (Bondurant et al., 2007).

No laws or regulations in Bangladesh specifically protect most-at-risk groups from discrimination. These people are in fact put at considerable risk by laws that prohibit or punish their behavior, in particular, engaging in prostitution or having sex between men. Being outside of these laws, or the very vagueness of their provisions, makes these people vulnerable to sexual and physical harassment from police, mastaans and their clients. Even so, organisations that work with these groups of people report that any illegal status of participants does not create any serious obstacles against their implementing HIV programme activities.

In late 2007, a Letter of Agreement was signed between UNAIDS and a local NGO, Ain-O-Shalish Kendra, to support Ain-O-Shalish Kendra as an implementing agency to assist marginalized or most-at-risk groups to protect their legal rights.

3.4 National programmes

Table 3 National Programmes: ART, HIV testing and HIV prevention coverage

No.	*Indicator*	*Population group(s)*	*Indicator Value (%)*	
			2005	*2007*
3	Percentage of donated blood screened for HIV in a quality assured manner	All	Not available	Not available
4	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	PLHIV	Not available	13.3
5	Percentage of HIV positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	HIV positive pregnant women	Not available	Not available
6	Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV		Not available	Not available
7	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results		Not available	Not available
8	Percentage of most-at-risk populations who received HIV testing in the last 12 months and who know the results	Female sex workers Male sex workers MSM IDU All risk groups	1.6 1.1 0.0 3.2 1.3	5.1 7.8 6.4 3.4 4.9
9	Percentage of most-at-risk population reached by prevention programs	Female sex workers Male sex workers MSM IDU All risk groups	71.6 76.2 77.0 82.0 58.8	56.9 46.6 12.7 81.8 43.6
10	Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child		Not available	Not available
11	Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year		Not relevant	Not relevant

Sources: BSS 2003-4 and 2006-7. Further refer to CRIS for detailed survey methodology, sample size and other technical notes for the data reported above.

3.4.1 Blood safety

A safe blood supply is an important component of HIV prevention. Government passed the Safe Blood Transfusion Act in 2002 but a shortage of blood centers has hampered its implementation and enforcement. Of 98 blood transfusion centers throughout Bangladesh, only six have so far been upgraded to 'level 1' status. Government has also expanded the program to 100 sub-district level hospitals. Fifty were fully equipped in 2007; the rest are planned to be equipped in 2008.

As noted previously, the National Policy and Strategy on Blood Safety, adopted in 2007, defines minimum standards and requirements for health facilities to qualify and be authorized to screen blood for HIV before transfusion. A Reference Laboratory has been set up in Dhaka Medical College Hospital to conduct HIV confirmatory tests. The overall number of blood centers, however, is still inadequate.

Efforts to promote voluntary blood donation and the mandatory screening of transfusion has reduced the practice of professional blood donation remarkably from 70 per cent in 2001 to 16 per cent in 2006. Over the same period, voluntary donation increased from 10 per cent to 24 per cent, and donations from relatives increased from 20 per cent to 27 per cent.

The blood centers also provide important data about HIV prevalence throughout the country. Of 479,843 units of donated blood screened between 2001 and 2006, HIV was detected in only 44 units of sero-reactive blood, a negligible amount.

3.4.2 Antiretroviral therapy coverage

Although limited, access to HIV treatment has slowly expanded. To date, five organizations (four NGOs or self help groups and one public institution, the Infectious Diseases Hospital) all based in Dhaka, provide treatment, care and support services to people living with AIDS. However, this in no way meets the national demand for these services. Treatment of opportunistic infections, food and nutrition services that PLHIV need to maintain their immune system, and psychosocial support services are also scarce.

According to government records, 365 people have developed AIDS so far, of whom 123 have died, but this most likely is an undercount. Of the known PLHIV, approximately 150 receive ARV treatment from Ashar Alo Society (AAS), Mukta Akash Bangladesh (MAB), Confidential Approach to AIDS Prevention (CAAP) and the AITAM Welfare Organization The Infectious Diseases Hospital provides treatment services for opportunistic infections, but not ARV drugs.

By Bangladesh standards, the cost of treatment is very high. The monthly cost of treatment per person per month using locally produced ARV is about Taka 3,700 (USD$ 54.00). The cost of drugs for opportunistic infections ranges from Taka 1000 to 5000 per month, an unaffordable sum for most people. The cost of a CD4 count is 1,150 taka in Combined Military Hospital and 2,500 taka in ICDDR,B.

The situation may soon improve. The government developed ARV treatment guidelines in 2006 in order to improve the quality of treatment. Organizations that now fund treatment

include Action Aid, Swiss Red Cross, Dutch Bangla Bank Limited and GTZ. In December 2007, AAS received funding from GTZ to treat 150 more AIDS cases. The Health, Nutrition and Population Sector Programme, through the various donor-funded projects, will provide resources for treatment, care and support services including ART and opportunistic infections treatment, and increase the capacity of service providers.

3.4.3 Prevention of mother-to-child transmission

While some treatment of AIDS is available for adults in Dhaka, no pediatric AIDS treatment or treatment is available for HIV-positive pregnant women in Bangladesh. In 2007, a national programme was being planned (UNICEF, 2007). The detection of HIV in pregnant women and the prevention of mother-to-child transmission is challenged by the fact that in Bangladesh VCCT facilities are very limited. As well many women have home deliveries and do not receive antenatal care (UNICEF, 2007).

3.4.4 Co-management of TB and HIV treatment

There is a negligible amount of known co-infection of Tuberculosis (TB) and HIV. TB is, however, a major public health problem in Bangladesh. In 2006, WHO ranked Bangladesh sixth among the world's 22 high-burden TB countries, and the malaria situation in the country is worsening, particularly in the hilly and forested areas in the Hill Tract Districts and along the border areas. There are problems of drug resistance in 13 districts. Like HIV and AIDS, people marginalized by poverty, ethnicity and social status are particularly vulnerable, and a strong stigma is attached to people who contract the disease.

3.4.5 HIV Testing

Voluntary and confidential HIV counseling and testing (VCCT) is an important part of the national prevention program yet these facilities are very limited in Bangladesh. There are only around 60 HIV testing centers, private and public, in the country, of which only seven facilities truly provide VCCT. Many have limited capacity to provide counseling.

VCCT facilities are now being expanded across Bangladesh, mostly funded through the FHI/USAID project. Currently, FHI operates 47 VCCT centers to which HAPP and other projects refer clients. NASP is developing counseling modules and guidelines on minimum standards of VCCT. The availability of rapid HIV testing in many centers is encouraging people to seek these services. VCCT services are, however, still targeted at at-risk populations and there is little coverage of the general population.

The better-run VCCT centres provide one-to-one and group counseling, training and monthly health check up and pathological tests. In some VCTs, staff hold courtyard meetings and community sensitization meeting with PLHIV family and community members and provide treatment services to PLHIV. Some provide vocational training to a small number of PLHIV.

3.4.6 Prevention programmes

The HIV epidemic in Bangladesh appears to be mostly confined to most-at-risk populations such as injecting drug users, female and male sex workers, MSM, and mobile populations.

HIV prevention activities therefore focus on these groups and, more generally, on young people. The geographical distribution of vulnerable populations was identified in 2005 through a social mapping exercise throughout the country (FHI, 2005).

In 2006-2007, two national HIV prevention projects were implemented throughout Bangladesh, funded mainly by external donors.

(i) The HIV/AIDS Prevention Project (HAPP) 2003-2007, a collaborative effort of Government, World Bank and DFID, provided education, advocacy and blood safety programmes for most-at-risk populations, namely IDUs, sex workers (based in brothels, on streets or in hotels and residences, respectively), MSM and transgender populations. These activities were implemented by NGOs with management support from UNICEF, WHO and UNFPA, and with overall coordination provided by NASP. NASP was also a beneficiary of the project through resources provided to strengthen its institutional capacity. A significant achievement of this project was to increase the geographical coverage of these activities. The 2006-2007 BSS nonetheless revealed that there remains considerable need for even wider, effective coverage.

(ii) The Adolescents and Young People Project, funded by GFATM, in its first phase (2004-2007) aimed to avert a generalized HIV epidemic by addressing young people (aged 15-24) through mass and print media, training, and special services. These services included life skill education, youth friendly health services, access to condoms, the integration of HIV/AIDS education in school and college curricula, the sensitization of religious leaders, parents and policy makers on HIV/ AIDS issues. The project also conducted national baseline surveys, operations research and monitoring and evaluation activities.[3] Project activities were implemented by NGOs under the management of Save the Children, USA (Bangladesh), and with technical support from NASP. Successful outcomes included the inclusion of HIV/AIDS information in curricula for grades 6 to 12, development of teacher manuals and guidelines, the training of 36,000 school teachers who in turn trained a similar number of subject teachers from 6,375 institutions, and the training of many religious leaders in community advocacy about HIV.

    The project recently received funding for its second phase, 2007-2012. Now named the HIV Prevention and Control Among High Risk Populations and Vulnerable Young People in Bangladesh Project, it aims to increase the coverage, quality and comprehensiveness of interventions for young and vulnerable populations, and build the capacity of government and NGOs to implement these activities at both national and district levels. The School HIV programme which now operates in 20 districts will be scaled up to cover 40 of the 64 districts in the country.

The National HIV and AIDS Communicational Strategy 2005-2010 aims to provide HIV information, education and communication (IEC) for both the general and most at risk populations, to reproductive and sexual health education for young people. However, providing information to other groups at risk, such as mother to child HIV transmission, out-

[3] Stop AIDS Keep the Promise Take the Lead, Souvenir, World AIDS Day, 1 December 2007, NASP

of-school youth, street children and drug users other than IDUs, is not sufficiently addressed in the strategy.

In 2007, the Bureau of Health Education of MOHFW intensified its health education and promotion programme to increase awareness about HIV throughout the country. Under this initiative, a renowned Bangladeshi magician traveled to 220 riverside locations by boat, communicating HIV and reproductive health messages to otherwise hard to reach rural communities.

The Bangladesh Armed Forces HIV education and life skills intervention programme is often cited as a best practice in keeping HIV infection low among peacekeepers (National Strategic Plan 2004-2010). Since 1988 up until October 2007, around 73,290 Armed Forces personnel have been sent to various peacekeeping missions and only three HIV positive cases have been detected (two in 1993 and 1 in 1994) on their return from UN Missions.

Major challenges for the national HIV prevention programme now are to:

- Improve its quality and coverage, properly monitor its impact, and improve its coordination at all levels, among both government agencies and NGOs.
- Halt and reverse the concentrated epidemic among high risk groups, particularly IDU; and
- Train a sufficient number of government and NGO health workers to effectively respond to the HIV epidemic.

3.4.7 Services for orphans and vulnerable children

Very few children are known to have been orphaned by AIDS in Bangladesh. AAS and MAB provide some services for these children.

Based on official reports of AIDS deaths, UNICEF (2007) estimated in 2004, somewhere between 44 and 132 children would have lost one or both of their parents due to AIDS. Based on the estimated incidence of AIDS, in 2002 there may have been less than 100 orphans (i.e., children who had lost both parents to AIDS), a very small number in Bangladesh's population. There are no more recent estimates. UNICEF reports that the experience of orphaned children in Bangladesh – whether orphaned by AIDS or any other cause – is very difficult (UNICEF, 2007).

3.4.8 Education

There is no life-skills programme in Bangladesh's schools, although some schools may provide this education on an *ad hoc* basis. The Adolescents and Young People Project (2004-2007) provided some life skills education to out-of-school, vulnerable youth.

A major achievement of the GFATM-funded project was to integrate education about HIV and AIDS in school and college curricula. This has included developing curricula and teacher manuals and guidelines, and training 36,000 school teachers who in turn trained a similar

number of subject teachers from 6,375 institutions. The content of the curriculum was developed following a needs assessment and pre-tested in 10 selected educational institutions. The curriculum was then revised based on the feedback and recommendations obtained from 88 educational institutions including madrasas, vocational training institutions and English medium schools. Since January 2007, HIV/AIDS information has become part of secondary and higher secondary school curricula for grades 6 to 12. It is now mandatory for all students to learn about HIV issues, which will be tested through examination. The School HIV programme which now operates in 20 districts will be scaled up to cover 40 of the 64 districts in the country, during 2007-2012.

3.5 Knowledge and Behaviour

Table 4 Knowledge and behaviour indicators for Bangladesh: 2005 and 2007

No.	*Indicator*	*Population group(s)*	*Indicator Value (%)*	
			2005	*2007*
12	Current school attendance among orphans and among non-orphans aged 10–14	All children aged 10-14	Not available	Not available
13	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Males Females All 15-24	Not available Not available Not available	24.1 20.6 22.3
14	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	Female sex workers Male sex workers MSM IDU All risk groups	24.0 28.2 13.2 14.3 17.0	30.8 29.6 27.3 20.2 25.9
15	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Males Females All 15-24	Not available Not available Not available	4.0 0.8 2.3
16	Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	Females Males	Not available Not available	Not available 17.5
17	Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse	Females Males	Not available Not available	Not available 35.2
18	Percentage of female and male sex workers reporting the use of a condom with their most recent new client	Female sex workers Male sex workers	30.9 44.1	66.7 43.7

No.	Indicator	Population group(s)	Indicator Value (%)	
			2005	2007
19	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	MSM Commercial sex Non-commercial sex	 49.2 37.0	 29.5 24.3
20	Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	Male IDU: Commercial Non-comm. sex Female IDU: Commercial sex Non-comm. sex	 23.6 18.9 78.9 43.9	 44.3 30.5 54.8 42.1
21	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Male IDU: Female IDU:	51.8 60.0	33.6 73.8

Sources: ***All data sources are from BSS 2003-4 and 2006-7 except indicator number 13, 15 and 17. In addition, Female IDU data comes from an IDU Cohort Study. Please refer to Table 1, page 8 for detail sources. Further refer to CRIS and Annex 3 of this report for detailed survey methodology, sample size and other technical notes for the data reported above.***

3.5.1 School attendance of orphans

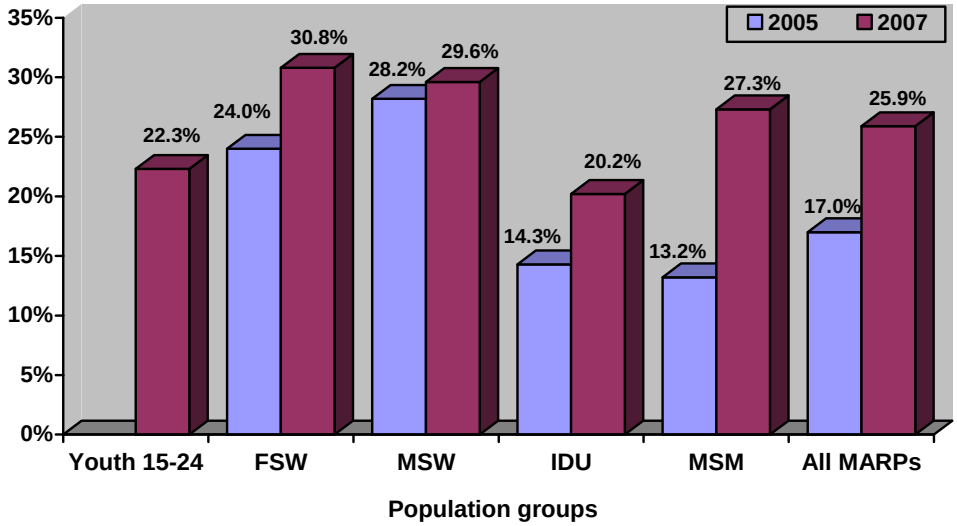
This information is not available (Planning Commission, 2007). Although 5.3 million children (or 9% of all children under the age of 18 years) have lost one or both parents, surprisingly little systematic information is available about the status of orphans in Bangladesh society (UNICEF, 2007). In both law and custom, an orphan is defined by the loss of their father. This definition of orphanhood is not consistent with international definitions, and this adds to the difficulty of correctly reporting on this indicator.

3.5.2 Young peoples' knowledge about HIV and sexual behaviour

Youth, aged 15-24 years, comprise almost one-sixth of the total population of Bangladesh (23 million). They are at particular risk of HIV and STI infection because of their limited access to sexual and reproductive health information and services.

A nationally representative survey of youth aged 15-24 years was conducted in 2005 by ICDDR,B, ACPR and the Population Council in order to better understand the extent of young peoples' knowledge about HIV and their use of condoms (NASP and Save the Children, USA 2006). The study found a generally low level of knowledge about HIV transmission and prevention (22.3 percent) among both young males and females. Around 22 percent of unmarried males reported having premarital sex. One in four of them reported visiting sex workers, and half did not use condoms. Few married males reported having sex outside marriage, at 7 percent, but of this number more than half (57 percent) had used sex workers.

Figure 2: Young population and risk-groups knowledge of preventing sexual transmission and misconceptions about HIV, 2005 and 2007.



Source: BSS, 2004, BSS 2006-7 and youth data from Baseline Youth survey.

3.5.3 The knowledge of most-at-risk groups about HIV

Figure 2 presents data from the two most recent BSS, conducted in 2003-4 and 2006-7. It shows a fairly low, but rising, level of knowledge about HIV. Female sex workers were the best informed, with 31% reporting correct knowledge, and IDU were the least well informed, with only 20% reporting correct knowledge. The average scores for the most-at-risk groups included in the 2006-7 BSS was 25.9%, up from 17% in 2004, but a fairly low figure nevertheless.

3.5.4 Early sexual experience

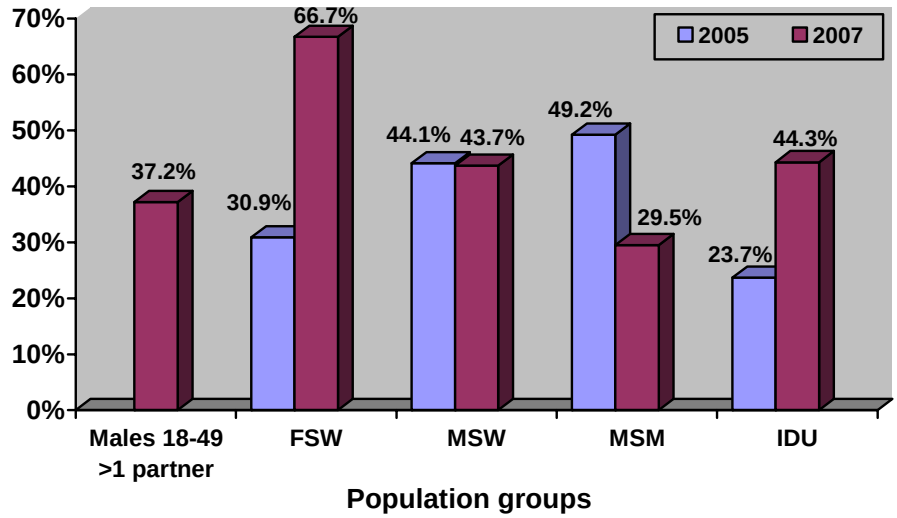
The 2005 survey of youth aged 15-24 years found that very few young people under the age of 15 years engaged in sexual intercourse. The number of males was higher than females, at 4% and 0.8%, respectively, with an overall figure of 2.3%.

3.5.5 Multiple sexual partners and condom use

Not much is known about the sexual behaviour of general male population in Bangladesh although some small surveys have been conducted. The 2006 ICDDR,B and FHI assessment of sexual behaviour of men aged 18-49 years in three urban and three rural areas revealed quite high levels of non-marital sex (either pre- or extra-marital). Almost 27 percent of never married men and 13 percent of ever-married men reported non-marital sex in the previous 12 months. Of those who had non-marital sex, one in every five reported more than three sexual partners. Overall condom use rate in last sex was around 40 percent with female sex workers, and even lower condom use was reported (30 percent) with casual female partners (ICDDR,B and FHI 2006).

There is no information available about the sexual behaviour of the general female population. A few small-scale studies have been undertaken, but this information cannot be expanded to a national level.

Figure 3: Condom use among different population groups, 2005 and 2007.



Source: BSS 2003-4, 2006-7 and FHI/ICDDR,B male sexual behaviour study (2006)

3.5.6 Sex workers and condom use

BSS conducted in 2003-4 and 2006-7, show there has been a marked recent increase in condom use among female sex workers, but little change among male sex workers. However, the fact that many female sex workers serve a large number of clients raises some doubt about how reliable their recall on condom use might be, or the consistency of their condom use. Almost four out of five hotel and residence based sex workers in Dhaka and Chittagong reported serving more than 20 clients in the previous week. The figures for hotel based sex workers were particularly high, with means of 42 and 60 clients in Dhaka and Chittagong respectively. Hotel based sex workers also reported lower rates of condom use (48 percent) and less involvement in prevention programmes (23 percent) than did brothel based sex workers (70 percent and 75 percent respectively) or street based sex workers (76 percent and 64 percent respectively).

3.5.7 MSM and condom use

BSS conducted in 2003-4 and 2006-7 show there has been a considerable decline in condom use by MSM, from 49.2% in 2004 to 29.5% in 2006-7. One reason why this may have happened is a shortage of supply of condoms and lubricants for MSM, as was reported to a data vetting workshop for this report.

3.5.8 IDU, condom use and safe injecting practices

IDU accounted for almost 9 out of 10 HIV positive cases found in the 2006 sero-surveillance survey. Among male IDUs in Dhaka City, HIV prevalence increased from 1.4 percent in 1999 to about 7 percent in 2006 (NASP 2007). This was evidently caused by the common practice of using contaminated injecting equipment; only 33 percent of injectors reported using safe injection practices (BSS 2006-2007). Behavioral surveillance surveys conducted in 2004 and 2007 found that IDUs were at elevated risk of acquiring and transmitting HIV also through unsafe sex practices. One in every five injectors reported buying sex from sex workers in 2004 but only 21 per cent said they used a condom. A positive sign, however, is that reported condom use among injectors had more than doubled by 2007, to 44 per cent.

The special vulnerability of female IDUs was highlighted by the 2006 ICDDR,B cohort study. Beyond their vulnerability to HIV through unsafe injection and sexual risk behaviour, female injectors (many of whom were sex workers) reported more anal sex and serial sex with multiple partners, as well as other hazardous experiences such as being victims of sexual violence or being jailed (Azim *et al* 2006).

While the focus is on IDU prevalence and risk behaviour, vulnerability and risk factors for other drug users, particularly heroin smokers, needs also to be considered and further researched. The 2004 BSS noted that heroin smokers also engaged in significant risk behaviours, in that more than one-third (34.4%) of them also injected in last six months and almost all (96.3 percent) shared their syringes. In addition, many sexually active heroin smokers engaged in unprotected commercial sex (73.6 percent had sex with female sex workers in the previous month and condom use was only 3.8%) having multiple sexual partners (the reported median number of partners was four). Although the 2007 BSS indicated that many of the risk behaviours of heroin smokers had reduced significantly, the still high level of needle sharing (72.6 percent) was a major concern.

3.6 The impact of HIV interventions

Table 5 Impact indicators for Bangladesh: 2005 and 2007

No.	*Indicator*	*Population group(s)*	*Indicator Value (%)*	
			2005	*2007*
22	Percentage of young women and men aged 15–24 who are HIV infected*		Not relevant	Not relevant
23	Percentage of most-at-risk populations who are HIV infected	Female sex workers Male sex workers MSM Male IDU Female IDU All risk groups	0.3 0.0 0.4 4.9 - 0.6	0.2 0.7 0.2 7.0 0.8 0.9
24	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy		Not available	Not available
25	Percentage of infants born to HIV infected mothers who are infected		Indicator not relevant	Indicator not relevant

Source: National HIV Serological Surveillance for round 6 and 7 (2005, 2006)

3.6.1 Infection levels among young women and men aged 15–24

This information is not required for Bangladesh, as there is not a generalized epidemic here. Data from donated blood samples, however, suggests the general level of infection is low, somewhere much lower than 1%.

3.6.2 Infection levels among most-at-risk populations

Since 1998-9, serological surveillance surveys of most-at-risk groups have been conducted approximately every second year. Table 6 below shows that infection levels have remained below 1% but have risen over the past 2-3 years.

Table 6 Infection levels among most-at-risk populations

Surveillance rounds	*Year*	*Numbers tested*	*HIV (%)*
1	1998-9	3886	< 1% (0.4)
2	1999-2000	4634	< 1% (0.2)
3	2000-1	7063	< 1% (0.2)
4	2002	7877	< 1% (0.3)
5	2004	10445	< 1% (0.3)
6	2005	11029	< 1% (0.6)
7	2006	10368	< 1% (0.9)

Source: NASP (2007) Serological Surveillance for HIV in Bangladesh Round VII

3.6.2 HIV-positive adults and children on ARV treatment

In 2007, approximately 150 people are on ARV treatment, but no data is available about their age or sex. At present, approximately less than 15 per cent of the estimated number of people who require ARV treatment receive it (AAS, MAB and CAAP). In December 2007, AAS received funds to provide ARV treatment to another 150 people. However, there are significant amount of uncertainty for the continuation of such support over a longer period of time while the issue of monitoring the standards, protocols and guidelines for treating HIV positives remained largely uncharted.

4 BEST PRACTICES

Bangladesh has been implementing HIV prevention programme through awareness raising activities since 1987, at a time when there were no identified cases of HIV in the country. Over the past twenty years, the HIV programme has grown in size and quality, involved a wider network of stakeholders, and increased its coverage of most-at-risk populations, including young people. Experiences gathered and lessons learned are described below.

4.1 A supportive policy environment

The HIV epidemic in Bangladesh remains largely confined within the most-at-risk populations. This may be so because of the government's immediate and targeted interventions among high-risk populations and vigorous awareness raising programmes for the general population. An array of national policies, strategic plans, communication strategies, and monitoring and evaluation frameworks has been developed and implemented, as discussed above. This policy framework provides a sturdy platform from which to design programmes and mobilize donor support. The task now is to implement them.

Bangladesh has been conducting serological surveillance surveys and behavioral surveys since 1999. These national-level data are powerful tools in better understanding and addressing the HIV situation at both national and sub-national levels, and thereby designing prevention, treatment, care and support programmes.

4.2 Public-private partnerships and civil society participation

The National HIV programme demonstrates the great value of partnerships between the government and civil society in Bangladesh. The members of NAC, TC-NAC and Country Coordination Mechanism (in GFATM) represent government, NGOs, private sector, people living with HIV, professional bodies, academics, civil society and faith based organization.

Government has delegated management responsibility for the implementation of the national HIV programme implementation to NGOs. Under the coordination of NASP, the main

implementing agencies, Save the Children USA and UNICEF respectively, sub-contract a number of other NGOs to conduct HIV project activities. Under the UNICEF/HAPP program there are 14 NGO consortia representing 45 organisations, which in turn fund 10 self-help groups. The USAID-funded and FHI implemented BAP programme funds 27 local NGOs. (The new phase of the GFATM is in the process of identifying the NGOs they will work with.)

This net of local NGOs and CBOs as well as the networks established between NGOs and some most-at-risk groups, has proven to be an efficient and cost-effective way to develop programmes to otherwise hard to reach communities throughout Bangladesh and creating community ownership of the HIV programme. The difficulties experienced by these often small organisations, including their limited manpower and technical capacity, have been discussed and documented, and programme resources are being directed towards strengthening their capacity.

4.3 The scaling-up of effective prevention activities

There has been considerable success in recent years in scaling up prevention activities. However, HIV-related activities are only targeted at the most-at-risk groups, and the coverage of even these relatively small groups is quite limited. The present coverage of the prevention programme is in the range of 50 and 60 per cent. It is estimated that fewer than 15 per cent of people who require ARV treatment receive it. Only approximately 75% of the small population of known IDUs in four cities (Dhaka, Rashani, Champinawabganj and Chandpur) were covered by needle exchange programmes in 2006-7. The percent of high-risk groups who had been exposed to HIV/AIDS interventions in the previous year was only 44.5% in 2006-7. In some cases, coverage actually decreased. For example, the number of MSM who reported being exposed to intervention programmes declined significantly between 2004 and 2007, from 58.2% to 14.9% in Dhaka, and 97.2% to 10.6% in Sylhet. In short, it is proving a challenge to scale up prevention activities even for these high risk groups.

Scaling up prevention interventions to the general population is not yet a priority in Bangladesh, other than for young people. The GFATM-funded national programme will provide resources to achieve this, including the expansion of youth-friendly health services, life-skills education, and the up-scaling of education programmes through public media.

To achieve targets of universal access in prevention and treatment requires substantial and continuous support from external development partners. Significant support is also required to strengthen the technical and logistic capacity of organisations that are contributing to the national response to HIV.

5 MAJOR CHALLENGES

The low HIV prevalence among the general population in Bangladesh places the country in a good position to attain the MDG goal of halting and reversing the spread of HIV by 2015. There are, however, major difficulties yet to be overcome, some of which were identified in Bangladesh's 2006 UNGASS report and some of which are new.

Since October 2006 there has been a change in political leadership in Bangladesh, with a caretaker government now running the country with only 10 Ministers (Advisors) under one Chief Advisor. The Health Advisor, who is the Chairman of the NAC, now looks after several ministries.

5.1 Policy and management issues

5.1.1 Coordination

Coordination is one of the greatest challenges of the HIV programme because of its multi-sectoral nature and the many stakeholders. NASP has been strengthened with additional staff and resources to strengthen its stewardship role. Nonetheless, its coordination and interaction mechanisms are weak mainly because of inadequate staff and their limited training, and fragmentation among the various coordinating bodies. The Secretariat of the TC-NAC could become more dynamic and effective through their more regular reviewing and monitoring of action plans.

Despite the multi-sectoral design of HIV plans, programme implementation and budgetary allocation for HIV-related activities is still heavily concentrated in the health sector. Budgets need to be allocated for HIV activities to be implemented by all relevant ministries, with NASP providing overall coordination. The roles and responsibilities of designated focal points in each ministry need to be activated.

5.1.2 Policy development

The National Strategic Plan needs to be revised to include wider definitions of at-risk populations. These groups include children at special risk (orphans, street children, and children in hard-to-reach communities, such as river island communities), prison inmates and drug users other than IDUs, groups that currently are left out from the NSP II Although prison inmates are included in the national HIV policy, this has not translated into action as they are excluded from NSP II.

There has been no recent comprehensive review, verification or update of the national laws and regulations to bring them into line with the National HIV Policy. Legislative change is particularly needed in areas relating to human rights.

5.1.3 Prevention

One of the largest challenges is to bring about behavior change and to break the social stigma associated with HIV and AIDS, and this requires more effective public discourse on HIV and related issues. Updated IEC/BCC materials for general and risk populations are needed for effective information, education and communication. The prevention programme need to be scaled up the across the whole country and to the general population.

Most school teachers still remain insufficiently skilled in providing HIV and reproductive and sexual health education to their students. More refresher training for trained teachers and basic training for the new teachers is required.

There is no national system to estimate the required numbers of condoms, needles and ARVs, and the supply of these materials is therefore not regular. There is also a lack of MSM specific condom and lubricants.

The number of VCCT centers was increased to 60 in 2007, including both public and private, where rapid HIV kits are used for HIV testing. However, these centers are inadequate in their number and distribution to reach all vulnerable populations. No thorough needs assessment has been conducted to assess national requirements for VCCT facilities, particularly in the border areas. Guidelines for a minimum standard of VCCT and counseling training modules need to be developed, to ensure the proper implementation of VCCT.

The Safe Blood Transfusion Law was enacted in 2002 but its enforcement and implementation remains limited by the shortage of blood centers. The blood safety programme needs to be quickly scaled up to provide comprehensive coverage of both the public and private sectors.

The future size of Bangladesh epidemic depends on the effectiveness of HIV programmes for most-at-risk populations, namely IDUs, sex workers and their clients, MSM, and mobile populations. The government should expand the coverage and quality of prevention efforts among these groups.

5.2 The participation of civil society

Civil society organizations and institutions are represented in the National AIDS Committee, CCM, and consultation meetings for planning. They are also the primary implementers of HIV activities that are funded by development partners. More space for civil society participation nevertheless needs to be provided in regard to national policy formulation and leadership. The greater involvement of local NGOs can facilitate the greater sense of ownership of the HIV programme by the community. This sense of local ownership will in turn be a large step towards addressing the profound stigma attached to HIV that currently dampens the national response (Bondurant et al., 2007), At the same time, civil society organizations need to address their issues of sustainability, transparency and accountability.

Limited access to funds and technical capacity are recognized to be the two biggest restrictions on the effectiveness of civil society organisations in addressing HIV. Ways to overcome these limitations need to be found, including strengthening the role of the HIV/AIDS Network.

The involvement of electronic and print media in promoting public education and information is fragmented and not institutionalized. Representatives of the National Media Committee should be included in the National AIDS Committee in order to strengthen the contribution of media organisations to HIV prevention and other activities, can play an important role in prevention and control of HIV, including their ‘watch-dog’ role. Cost-effective strategies to promote better HIV information, education and communication to the general population should be explored and developed.

5.3 Access to treatment

At present, approximately less than 15 per cent of the estimated number of people who require ARV treatment receive it. The high cost of medicines, together with the unavailability of other forms of treatment, such as medicines for opportunistic infections and nutrition care, leaves many people without treatment. Only a limited amount of first line drugs are produced in the country, not any alternatives or second line drugs, and locally produced medicines are not accredited by WHO. Government needs to take urgent steps to motivate local drug manufacturers to gain WHO certification or to import ARV drugs with WHO approval, by declaring them as essential drugs for the treatment of AIDS.

Very few civil society organizations have the technical capacity to provide treatment, care and support services. Referral linkages among the implementing partners for VCT, treatment, care and support services are limited. Institutions providing treatment of HIV/AIDS need assistance to increase their technical and financial capacity for universal access to services. Government needs to seek increased donor funds for treatment and care. Treatment institutions need to increase their referral system for treatment and care.

Government facilities at the district and division level provide very limited treatment for PLHIV and no ARV medicine. Because of the currently low prevalence of HIV and the small number of known PLHIV who need ARV treatment, the setting up of new infrastructure for treatment at the district level may not be feasible. Integration of HIV/AIDS treatment with existing government facilities at some districts and division level could be piloted.

5.4 Protection of human rights

The involvement and participation of PLHIV in different aspects of the national response, particularly planning, care, treatment, support and advocacy, has increased. As public awareness about HIV has risen, aided by community groups and religious leaders, there has been some reduction in the stigmatization and discrimination against PLHIV. Nonetheless, many PLWH are still forced to hide their status, and are thereby deprived of proper treatment, care and services. Cost-effective awareness raising avenues (e.g. print media, electronic media, religious leaders, frontline health workers) need to be explored and developed, in order to create a more comprehensive, efficient and sustainable HIV programme.

Some behaviours associated with higher risk of HIV transmission are criminal offences according to Bangladesh law, such as involvement in prostitution and MSM. Another type of legal barrier against effective HIV prevention is the condom promotion policy that allows their use only by married couples. These laws need to be reviewed in line with the National HIV Policy, in order to assist effective HIV prevention programmes.

The observation and protection of human rights is also handicapped by the lack of any independent institution to promote and protect human rights or to monitor human rights abuses.

6 SUPPORT FROM DEVELOPMENT PARTNERS

Development partners, including multilateral bodies such as UN agencies, bilateral donors, international NGOs, and research organizations are playing a significant role in the prevention and control of HIV in Bangladesh, and building the capacity of government to plan, design, implement and monitor the national HIV programme.

Three institutions have been involved to proved research support; USAID/ FHI, ICDDRB and IEDCR, the later one is the national organization. While all of the above support is heavily towards conducting both biological and behavioural surveillances, little focus is directed in carrying out operations research and evaluative studies. FHI through its Advocacy and Analysis (A^2) initiative emphasizing on the collection of additional data for the estimation and projection of the epidemic as well as linking it with future resource requirement.

To date, most external funded HIV projects focus on HIV education and prevention among high-risk groups, PLHIV and young people. The revised HNPSP Programme (2006-2010) and the sixth round GFATM project both includes the scaling up of treatment, care and support services, including ART and treatment of opportunistic infections.

Long-term planning is required by both government and donors in order to achieve the universal access targets and the MDGs for HIV. In line with the NSP II, Bangladesh has developed a national monitoring and evaluation framework and an operational plan of NSP II that itemizes the resources required to implement the plan and scale up responses to the HIV epidemic. Use of the operational plan by all stakeholders should improve coordination of support for different components of the programme.

7 MONITORING AND EVALUATION

7.1 The current situation

NASP serves as the national monitoring and evaluation unit for the HIV programme in Bangladesh, under the guidance of NAC and TC-NAC. It has endorsed 'The Three Ones" principles to ensure an active leadership, coordination and accountability for effective HIV prevention among many partners. However, due to lack of expertise and limited resources, these monitoring and evaluation activities have largely been fragmented and based upon the requirements of specific projects, each with their own data collection and reporting formats and schedules.

Government, donors, and other stakeholders all recognize that developing and implementing effective monitoring and evaluation systems is a critical step towards improving the national response to HIV and using resources more effectively. A monitoring and evaluation consultant was recruited by NASP in September 2007.

NASP has a multi-agency Technical Working Group (TWG) on monitoring and evaluation comprising 12 members from government, civil society and UNAIDS. However, the TWG

has had infrequent meetings, lacks coordination with TC-NAC, and has limited capacity to influence policies. The reformation of the TWC with dedicated and qualified personnel from government and civil society, who will have leverage in policy decision, is in progress.

With assistance from ICDDRB and other organizations, and under the guidance of a Surveillance Advisory Committee, NASP has commissioned various research studies, behavioral and serological surveillance since 1999, and this information has guided policy decisions and program design.

The National AIDS Monitoring & Evaluation Framework and Operational Plan, developed in July 2007, outlines priority activities, budget and time frames in line with national programme objectives. However, full funding has not been secured. A gap of 23 per cent remains between the estimated budget and committed funds.

7.2 Planned remedial actions

The National AIDS Monitoring and Evaluation Framework and Operational Plan aims to standardize the monitoring and reporting system by requiring all implementing partners to use the reporting formats, and report to NASP on the national M&E indicators, key programmatic indicators and surveillance and survey results. NASP will review, analyze and use the information for improvement of the programme and report to its higher authority and donors. The framework also requires information about sources of data, indicator references, frequency of collection of data and institutional responsibility for collecting and managing data sources.

The operational plan proposes to strengthen the monitoring system phase-wise: from the current fragmented Monitoring and Evaluation phase to a functional Monitoring and Evaluation phase between 2007 and 2009, and to a comprehensive Monitoring and Evaluation phase by 2010.

7.3 Priority Monitoring and Evaluation actions planned

- Establishment of a functional Monitoring and Evaluation Unit within NASP with adequate, skilled and technical human resources and with logistical support;

- Capacity enhancement of NASP staff through training in research, monitoring and evaluation of the National HIV Programme;

- Establishment of health & management information system (HMIS), a national data base, for National HIV monitoring and evaluation systems, and harmonization of all partners' monitoring and evaluation systems with the National HIV Monitoring and Evaluation System for tracking and supporting the monitoring response;

- Production and regular dissemination of national monitoring and evaluation reports;

- Use of the information system for effective programme monitoring, management, implementation, policy decision and sustainability of the monitoring and evaluation system;

- Knowledge sharing and performance analysis with civil society at the national level;
- Prioritization of research activities and secondary analysis of available HIV data;
- Utilization of research findings into policy decisions, thus, increasing the linkage between Monitoring and Evaluation Unit and TC-NAC;
- Coordination of monitoring and evaluation activities, regular meeting of the Monitoring and Evaluation Technical Working Group and other groups working with strategic information.

7.4 Technical assistance needed

- Setting up of a monitoring and evaluation infrastructure with adequate staff;
- Recruitment and training of staff for capacity enhancement in research, monitoring and evaluation;
- Identifying and defining priority indicators, and developing information flow, monitoring and evaluation guidelines and tools to track the progress of the national response and to meet needs at all levels;
- Adequate funds for institutional capacity building and for monitoring and evaluation and research; improving and strengthening surveillance system; conducting estimations and projections; and resource tracking;
- Increasing the linkage between the Monitoring and Evaluation Unit with its higher authority (TC-NAC) and other stakeholders.

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ANNEX 1: Consultation and Preparation Process

Consultation/preparation process for the Country Progress Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

Which institutions/entities were responsible for filling out the indicator forms?

a) NAC or equivalent	Yes	
b) NAP	Yes	
c) Others (please specify)		No

With inputs from

Ministries:	
Education	No
Health	Yes
Labour	No
Foreign Affairs	No
Others (Information)	Yes
Civil society organizations	Yes
People living with HIV	Yes
Private sector	No
United Nations organizations	Yes
Bilaterals	Yes
International NGOs	Yes
Others (please specify)	No

Was the report discussed in a large forum? Yes

Are the survey results stored centrally? Yes

Are data available for public consultation? Yes

Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

Name / title: Dr. S.M. Mustafa Anower
Line Director NASP and SBTP
Director CME
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Date: 27 January 2008

Signature: _____

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Annex 2: National Composite Policy Index 2007

COUNTRY: BANGLADESH

Name of the National AIDS Committee Officer in charge:

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Date of submission: 27 January 2008

ANNEX 3: Age specific breakdown of key 2008 UNGASS indicators

Indicator	*Risk groups*	*Indicator value (%)*		
		<25 years	*25+ years*	*All ages*
National Program: HIV testing and prevention program for most-at-risk populations				
8. Percentage of most-at-risk population who received HIV testing in the last 12 months and who know the results *(Source: BSS 2006-7)*	Female sex workers (FSW): Brothel based Street based Hotel based All FSW Male sex workers (MSW) Transgender MSM IDU Heroin smokers Rickshaw pullers Truckers All risk groups	 2.2 (n=409) 4.4 (n=575) 7.5 (n=487) 4.8 (n=1471) 5.6 (n=577) 11.8 (n=93) 4.5 (n=257) 3.1 (n=82) 0 (n=69) 0 (n=207) 0 (n=128) 4.4 (n=2884)	 4.0 (n=273) 6.1 (n=491) 7.4 (n=109) 5.6 (n=873) 14.0 (n=221) 15.9 (n=333) 7.3 (n=586) 3.4 (n=1114) 2.1 (n=270) 0.1 (n=539) 2.2 (n=345) 5.3 (n=4281)	 2.9 (n=682) 5.2 (n=1066) 7.5 (n=596) 5.1 (n=2344) 7.8 (n=798) 15.0 (426) 6.4 (n=843) 3.4 (n=1196) 1.7 (n=339) 0.07 (n=746) 1.6 (n=473) 4.9 (n=7165)
9. Percentage of most-at-risk population reached by prevention programs* *(Source: BSS, 2006-7)*	Female sex workers (FSW): Brothel based Street based Hotel based All FSW Male sex workers (MSW) Transgender MSM IDU Heroin smokers Rickshaw pullers Truckers All risk groups	 70.2 (n=410) 66.6 (n=575) 22.6 (n=487) 53.0 (n=1472) 43.1 (n=578) 33.3 (n=93) 20.3 (n=257) 73.2 (n=82) 42.5 (n=69) 0.6 (n=207) 0.9 (n=128) 41.7 (n=2886)	 83.2 (n=273) 61.5 (n=491) 23.0 (n=108) 63.6 (n=872) 56.2 (n=221) 38.4 (n=333) 9.4 (n=586) 82.4 (n=1114) 45.0 (n=270) 2.0 (n=539) 3.3 (n=345) 45.0 (n=4280)	 75.4 (n=683) 64.3 (n=1066) 22.6 (n=595) 56.9 (n=2344) 46.6 (n=799) 37.3 (n=426) 12.7 (n=843) 81.8 (n=1196) 44.5 (n=339) 1.6 (n=746) 2.6 (n=473) 43.6 (n=7166)
Knowledge and Behaviour				
13. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission *(Source: Youth Baseline survey, 2005)*	Male (15-24) Female 15-24) All (15-19) All (20-24) All (15-24)			24.1 (n=5794) 20.6 (n=6194) 22.0 (n=6143) 22.6 (n=5846) 22.3(n=11989)
14. 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 Street based Hotel based All FSW Male sex workers (MSW) Transgender MSM	 24.4 (n=410) 41.6 (n=575) 23.8 (n=487) 30.9 (n=1472) 22.1 (n=578) 58.1 (n=93) 23.1 (n=257)	 26.0 (n=273) 34.3 (n=491) 24.8 (n=109) 30.5 (n=873) 50.3 (n=221) 54.4 (n=333) 29.1 (n=586)	 25.0 (n=683) 38.2 (n=1066) 24.0 (n=596) 30.8 (n=2345) 29.6 (n=799) 55.2 (n=426) 27.3 (n=843)

Indicator	Risk groups	Indicator value (%)			
		<25 years		25+ years	All ages
(Source: BSS 2006-7)	IDU	28.1 (n=82)		19.6 (n=1114)	20.2 (n=1196)
	Heroin smokers	13.7 (n=69)		20.7 (n=270)	19.4 (n=339)
	Rickshaw pullers	17.9 (n=207)		9.8 (n=539)	12.1 (n=746)
	Truckers	7.1 (n=128)		7.9 (n=345)	7.7 (n=473)
	All risk groups	26.8 (n=2886)		25.3 (n=4281)	25.9 (n=7167)
15. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Male (15-24)				4.0 (n=5794)
	Female 15-24)				0.8 (n=6195)
	All (15-19)				2.1 (n=6143)
	All (20-24)				2.5 (n=5846)
(Source: Youth Baseline survey, 2005)	All (15-24)				2.3 (n=11989)
16. Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months		18-19	20-24	25-49	
	Male (18-49 years)	24.8 (n=677)	25.0 (n=1392)	14.4 (n=5053)	17.5 (n=7122)
	Female	No data	No data	No data	No data
(Source: FHI and ICDDR,B 2006)					
17. Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse		18-19	20-24	25-49	
	Male (18-49 years)	41.9 (n=176)	30.5 (n=387)	36.2 (n=702)	35.2 (n=1265)
	Female	No data	No data	No data	No data
(Source: FHI and ICDDR,B 2006)					
18. Percentage of female and male sex workers reporting the use of a condom with their most recent new client *(in last week)*	Female sex workers (FSW):				
	Brothel based	70.3 (n=394)		70.0 (n=240)	70.2 (n=634)
	Street based	78.9 (n=527)		72.0 (n=420)	75.8 (n=947)
	Hotel based	48.7 (n=472)		42.7 (n=101)	47.7 (n=573)
	All FSW	66.2 (n=1393)		67.6 (n=761)	66.7 (n=2154)
(Source: BSS 2006-7)	Male sex workers (MSW)	40.6 (n=347)		52.5 (n=130)	43.7 (n=477)
	Hijra (transgender)	59.8 (n=92)		68.4 (n=329)	66.5 (n=421)
19. Percentage of men reporting the use of a condom the last time *(in last month)* they had anal sex with a male/Hijra partner	Non-commercial sex				
	With male/Hijra	12.5 (n=249)		30.2 (n=498)	24.3 (n=747)
	With female	7.0 (n=26)		19.5 (n=296)	18.5 (n=322)
	Commercial sex				
	With male	17.2 (n=146)		33.5 (n=447)	29.5 (n=593)
	With female	6.5 (n=28)		44.5 (n=214)	39.7 (n=242)
(Source: BSS 2006-7)					
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	Male IDU^{+}:				
	Non-commercial sex	44.6 (n=19)		30.1 (n=681)	30.5 (n=700)
	Commercial sex	40.9 (n=57)		44.6 (n=608)	44.3 (n=665)
	Female IDU^{++}:				
	Non-commercial sex	0 (n=5)		57.1 (n=14)	42.1 (n=19)
	Commercial sex	57.1 (n=7)		54.2 (n=24)	54.8 (n=31)
(Source: BSS 2006-7 for male IDUs and Cohort study by ICDDR,B for female IDUs July-Nov 2006)					

Indicator	Risk groups	Indicator value (%)		
		<25 years	25+ years	All ages
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected *(Source: BSS 2006-7 for male IDUs and Cohort study by ICDDR,B for female IDUs July-Nov 2006)*	Male IDU**: Female IDU***:	35.3 (n=82) 71.4 (n=14)	33.4 (n=1114) 74.5 (n=47)	33.6 (n=1196) 73.8 (n=61)
Impact				
23. Percentage of most-at-risk population who are HIV infected (Source: 7th round National HIV Serological Surveillance, 2006)	Female sex workers (FSW): Brothel based Street based Hotel All Male sex workers (MSW) Hijra Men having sex with men Male IDU+++ Female IDU Heroin smokers Rickshaw pullers Truckers All risk groups	 0.2 (n=1193) 0.3 (n=340) 0 (n=220) 0.2 (n=1753) 0 (n=157) 0.5 (n=206) 0 (n=243) 3.2 (n=93) 0 (n=38) 0 (n=49) Not done Not done 0.2 (n=3366)	 0.2 (n=1007) 0 (n=451) 0 (n=67) 0.1 (n=1525) 1.6 (n=127) 0.7 (n=147) 0.6 (n=158) 7.4 (n=979) 1.2 (n=83) 0 (n=352) Not done Not done 1.2 (n=7002)	 0.2 (n=2200) 0.1 (n=791) 0 (n=287) 0.2 (n=3278) 0.7 (n=284) 0.6 (n=353) 0.2 (n=401) 7.0 (n=1072) 0.8 (n=121) 0 (n=401) Not done Not done 0.9 (n=10368)

Note: n refers to the total number of observations in the corresponding age groups that was used as the denominator in calculating the percentages

** Participated in any NGO-run AIDS prevention programs in the last year*
*** Last time in last 2 months (among those who had injected in the last 2 months)*
**** Last time in last 6 months (among those who had injected in the last 6 months)*
+ Last time in the last 12 months (among those who had sex in the last 12 months)
++ Last time in the last week (among those who had sex in the last week)
+++ Data on male IDU is for Central A of Bangladesh that covers mainly Dhaka city and the other areas have been excluded because no HIV positive was detected