Country Progress Report: Bangladesh

COUNTRY PROGRESS REPORT
Bangladesh

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Table of Content

Contents	Page #
Acronyms……	4
I. Status at a glance:	5
(A) The inclusiveness of the stakeholders in the report writing process……	5
(B) The status of the epidemic……	6
(C) The policy and programmatic response ……	7
(D) Indicator data in an overview table:	11
II. Overview of the AIDS epidemic:	26
(A) Key Affected Populations and HIV……	26
(B) Status of the Epidemic among the PWID – Indications of Progress……	27
(C) Vulnerability of FSWs to HIV in some cities	28
(D) Vulnerability of Hijra……	28
(E) Overlapping of Risk among MARPs……	28
(F) HIV Risk in General Population……	29
(G) Migration and HIV Risk in Bangladesh……	30
III. National response to the AIDS epidemic:	31
(A) National policy environment and HIV programme……	31
(B) The National M&E Plan, 2011-2015……	36
(C) The National Response……	37
C1) Prevention among KAP……	38
C2) Prevention among the General Population……	42
C3) Strengthening of treatment, care and support program for the PLHIV……	44
C4) Tracking Critical Enablers and Synergies with Development Sectors……	46
IV. Best practices……	47
V. Major challenges and remedial actions:	54
(A) Progress Made on Key Challenges Reported in 2010 UNGASS Country Report……	54
(B) Challenges Faced throughout the Reporting Period (2010-2011)……	56
(C) Remedial Actions……	58
VI. Support from the country's development partners (if applicable)……	60
VII. Monitoring and evaluation environment……	64
References	65
Annexes	67

ACRONYMS

AAS	Ashar Alo Society
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
ARV	Anti-Retrovirals
BAP	Bangladesh AIDS Project
BBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic and Health Survey
BSS	Behavioural surveillance survey
BSWS	Bandhu Social Welfare Society
CAAP	Confidential Approach to AIDS Prevention
CBO	Community based organization
CCM	Country Coordination Mechanism
CS	Civil Society
CST	Care, support and treatment
DFID	Department for International Development
DGHS	Directorate General of Health Services
DIC	Drop- in-Center
DNC	Department of Narcotics Control
FHI 360	Family Health International 360
FSW	Female sex worker
GARPR	Global AIDS Response Progress Report(ing)
GiZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GOB	Government of Bangladesh
HAIS	HIV/AIDS Intervention Services
HAPS Project	HIV/AIDS Prevention Services Project
HASAB	Health and Social Action Bureau (previously: HIV/AIDS, STD Alliance, Bangladesh)
HCV	Hepatitis C Virus
HIES	Household Income and Expenditure Sourvey-2010
HIV	Human Immunodeficiency Virus
HPNSDP	Health Population, and Nutrition Sector Development Programme
HTC	HIV Testing and Counseling
ICDDR,B/icddr,b	International Centre for Diarrhoeal Diseases Research, Bangladesh
IDH	Infectious Diseases Hospital
IEC	Information education and communication
IEDCR	Institute of Epidemiology, Disease Control and Research and National Influenza Center
KAP	Key affected population
LSE	Life skills education
MAB	Mukto Akash Bangladesh
MARA	Most at Risk Adolescents
M&E	Monitoring and evaluation
MOHFW	Ministry of Health and Family Welfare
MSM	Men who have sex with men
MSW	Male sex worker
NAC	National AIDS Committee
NASP	National STD/AIDS Programme

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

I. Status at a glance

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

Various levels of stakeholders from government, civil society and UN agencies actively engaged in preparing the Global AIDS Response Progress Report (GARPR), 2014 for Bangladesh and the National AIDS/STD Programme (NASP) of the Ministry of Health and Family Welfare, Government of Bangladesh, facilitated the process with UNAIDS support.

The facilitative role of NASP included:

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

- On December 24, 2013, the 5th meeting of the Technical Working Group on M&E and Strategic Information on HIV and AIDS took place. During this meeting there was discussion on GARPR, 2014. All participants were requested to extend cooperation and provide inputs timely to complete the report. During this meeting the plan of action was discussed.

- On February 19, 2014, the 7th Technical Working Group on M&E and Strategic Information on HIV and AIDS took place. During this meeting there was detail discussion on GARPR, 2014 and registration information, guidelines, etc. was shared with participants. The plan of action for information collection was finalized. All guidelines, presentations, etc. was duly shared along with the minutes of the meeting.

- On March 9, 2014, NCPI Part B data was reviewed through a Consultation with representatives of key civil society stakeholder groups. The draft report was shared for final validation and feedback was received by the first week of April. Almost 40 participants from civil society agencies actively participated in the workshop.

- On March 10, 2014 a several meetings were arranged with 10 to 15 persons from relevant agencies to discuss in detail each indicator and the expected information. Various deadlines were agreed on for the information flow. Steps were taken to avoid duplication and gaps in data.

- From March 16 to March 25, 2014, key informant interviews were conducted with 13 relevant persons working within government system. The Individual consultations with key informants were conducted to fill out NCPI Part A.

- Indicator review and validation took place as data was compiled on a continuous basis to finalize all data entered. Feedback was received from technical experts and M&E persons on the information till April 20, 2014 and all feedback was incorporated.

(B) The status of the epidemic:

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

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

A midline assessment of the Global Fund supported interventions for MSM, MSW and TG was conducted in 2013 using the same methodology as the national surveillances. Till the reporting period information from Dhaka (capital city) was available. The HIV prevalence among MSW was 0.6%, among MSM 0.7% and among TG/Hijras it was 0.5%[4]. Though in the previous surveillance round, none of the MSM or MSW tested was positive for HIV; 0.7 MSW were tested positive in 2006 and 0.3 in 2007, and in 2006 0.2 MSM tested positive. Among the transgendered community (*hijra*) the HIV prevalence was 1% in two sites (Dhaka –the capital of Bangladesh and Manikganj-a peri-urban site adjacent to Dhaka) in 2011 and one person was detected as being HIV positive among a small sample from Hilli.[5] The rates of active syphilis in MSW and *hijra* seemed to be declining, while it remained unchanged in case of MSM where the rates were low. Condom use increased in Dhaka among all three groups.[6] MSMs are highly networked, so if HIV were to emerge, it could spread very rapidly in this population, if prevention efforts are not continued[7].

The Round 9 surveillance, tested 7,529 drug users (PWID, heroin smokers and the combined group of PWID and heroin smokers) from 30 different cities. Overall HIV prevalence was 1.2% (PWID and heroin smokers), with low rates found in drug users from five cities. Prevalence of 5.3% was reported in Dhaka among male PWID. Though active syphilis rates among PWUD declined significantly over time in Dhaka, there were no significant changes in the other cities where trend analysis was possible. HCV was present in over 50% of PWUD in six of the cities. However, the highest prevalence of HCV was found among PWID in several cities, with 95.7% as the highest in a north-western city[8]

The estimated number of HIV/AIDS was 8,000. In 2013 the NASP informed that there were 370 new reported cases of HIV and 95 new AIDS cases, while 82 people had died. Thus the cumulative number of reported HIV cases till date in Bangladesh stands at 3,241, AIDS cases at 1,299 and deaths at 472[9].

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

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

[3] The Round 9 surveillance, 2011

[4] icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished): Dhaka

[5] The Round 9 surveillance, 2011

[4] icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished): Dhaka

[7] 20 years of HIV in Bangladesh: World Bank and UNAIDS, 2009

[8] The Round 9 surveillance, 2011

[9] WAD,2013, NASP, MoHFW

(C) The policy and programmatic response:

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

Ministries of Home Affairs, Local Government, Finance, Religious Affairs, Education, Information and Broadcasting, Women and Children Affairs, Youth and Sports, Labour and Manpower, Social Welfare, and Expatriates Welfare and Overseas Employment have been involved in various strategic directions linked to HIV prevention. Interventions have included setting up of HTC centers, supporting informative SMS messages, supporting teacher's training for classroom education on HIV, arranging for the insertion of HIV-related information into various in-service training courses, revising existing punitive laws that hinder the HIV response, supporting the OST program, etc. The Government has nominated focal points for HIV/AIDS in 16 ministries and departments, who have been oriented on issues related to HIV and HIV response. Key roles of the focal points are to identify best avenues for collaboration, develop collaboration and coordination mechanisms, and rationalize the roles and responsibilities of the key ministries for prevention and care.

The NASP has developed and supported the development of several national guidelines, manuals and policies/strategies on specific intervention areas:

2002 to 2005:

- *The Safe Blood Transfusion Act (passed in 2002)*
- *The National Harm Reduction Strategy for Drug Use and HIV, 2004-2010*
- *National HIV Advocacy and Communication Strategy 2005-10*

2006 to 2010:

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

2011 to 2013:

- *National Anti Retroviral Therapy Guidelines, 2011*
- *Training Manual on the reduction of Stigma and Discrimination related to HIV/AIDS, 2010*
- *HIV/AIDS-Opobad O boishommo Protirodh toolkit (stigma and discrimination toolkit), September 2011*
- *Nutritional Guidelines for PLHIV, 2012*
- *Risk Reduction Strategy for Young Key Populations and MARA, 2013*
- *ART Training Module for Doctors, 2013*
- *National HTC Guidelines, 2013*
- *National Guidelines for the Prevention of Vertical Transmission of HIV and Congenital Syphilis, 2013*

Programmatic Response:

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

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

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

1. The HIV/AIDS Prevention Services (HAPS):

HIV/AIDS Prevention Services (HAPS) program implements intervention packages for (i) brothel based sex workers, (ii) street based sex workers, (iii) hotel and residence based sex workers, (iv) MSW and hijra and (v) PWIDs with an approximate budget of about 8 million USD. The HAPS will also be rolling out interventions among PLHIV and migrants as well by 2014. It is supported by the Health, Population and Nutrition Sector Development Program (HPNSDP)

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

The Global Fund has been supporting the National Response since 2004, to limit the spread and impact of HIV in the country by providing prevention services among the Key Populations; to strengthen treatment, care and support among PLHIV; and to improve the capacity to deliver high quality interventions.

Since 2004 the Global Fund has invested well over 100 million USD in Bangladesh to continue HIV prevention and AIDS control efforts till 2015 through three grants termed as:

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

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

3. Modhumita:

USAID is currently supporting Family Health International (FHI 360) to implement the Modhumita Project. The Modhumita Project started in October 2009 and will continue until September 2013 with an estimated budget of 12 million US dollars. Previously FHI 360 implemented the IMPACT project and Bangladesh AIDS Program (BAP) with the financial support from USAID from 2000 to 2009 through targeted interventions for groups most vulnerable to HIV and AIDS in accordance with Ministry of Health and Family Welfare (MOHFW). The Modhumita Project is the follow-on project of BAP and is implemented through a team comprising of FHI 360, Social Marketing Company (SMC)

and Bangladesh Center for Communication Programs (BCCP), with an objective to support an effective HIV/AIDS prevention strategy through improved prevention, care, and treatment services for KAP and to strengthen the national response. The project is implemented throughout the country with the support of 24 implementing agencies and other collaborating partners.

4. South Asia Regional HIV/AIDS Programme:

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

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

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

5. Community Access to HIV Treatment Care and Support Services (CAT-S):

The study on `Community Access to HIV Treatment Care and Support Services (CAT-S) in Seven Asian Countries' namely Bangladesh, Indonesia, Laos, Nepal, Pakistan, Philippines and Vietnam has been conducted by Asia Pacific Network of People Living with HIV/AIDS (APN+) under the support of the Global Fund Round-10 grant. In Bangladesh, Ashar Alo Society (AAS), as a partner of APN+, has conducted this study with a budget of USD 64,170.

This cross-sectional study conducted during November 2012 to April 2013, is expected to serve as a baseline study to measure longitudinal changes in access to HIV treatment-related issues in Bangladesh as planned in the second phase of the study. HIV treatment-related issues such as access to pre-ART care, ART, ART adherence, treatment literacy, high risk behaviors, health seeking behaviors, etc. were the core issues of this study under its specific objective. A total of 600 PLHIV (randomly selected) participated in this study[10].

6. Enhancing Mobile Populations' Access to HIV & AIDS Services, Information and Support (EMPHASIS):

EMPHASIS aims to reduce the HIV vulnerability of mobile populations across the border areas of Bangladesh, India and Nepal. It works to mitigate the impact on affected communities, with a specific focus on women and operates as a pilot intervention is Jessore and Satkhira districts[11]. The project began in August, 2009 and is scheduled to end in August, 2014. This project is funded by the Big Lottery Fund, and the budget is approximately USD 8.5 million. Care Bangladesh is implementing the project in Bangladesh.

[10] Ashar Alo Society. 2013. CATS Report. Bangladesh

[11] Retrieved from: http://www.carebangladesh.org/cw_oproject.php

7. The Link Up Programme:

The Link Up programme, funded by the Dutch Ministry of Foreign Affairs, aims to improve sexual and reproductive health of young people most affected by HIV and to promote the realisation of young people's sexual and reproductive rights. This three-year programme (2013-2015) is improving the integration of SRHR interventions into existing community- and facility-based HIV programmes, and vice versa, in Bangladesh, Burundi, Ethiopia, Myanmar, and Uganda. The programme seeks to increase health-seeking behaviours and reduce unintended pregnancies, HIV transmission and HIV-related maternal mortality among young people affected by HIV aged 10-24 by increasing their uptake of quality integrated SRHR and HIV services[12]. In Bangladesh Marie Stopes Clinic Society, Population Council and HASAB are implementing the Link up project with a budget USD 10 million.

8. Other Development Partners[13]:

UN agencies are supporting the implementation of various HIV/AIDS prevention programs in the country which are managed by different local and international NGOs. UNAIDS, WHO, UNFPA, IOM, UNICEF and WFP have supported government in developing relevant guidelines and strategic documents on nutrition, PMTCT, MARA, migration, ART, HIV-TB co-infection, etc.

Complementary work by the UN and other partners have focused on reducing stigma, discrimination and violence against people living with and affected by HIV through orientation and education. In 2013, 600 doctors and nurses, 300 journalists and 200 military health service providers were sensitized on these issues. A national legal consultative workshop was organized to provide strong recommendations in addressing punitive laws and laws hindering the HIV response.

Prevention of HIV transmission from infected mothers to their unborn children is a global priority area where significant progress has been achieved in Bangladesh through UNICEF support over the past year; HIV testing and syphilis screening was initiated at the antenatal clinics of three national reference facilities and HIV treatment coverage for pregnant women has increased.

The UN has also supported training and other interventions for HIV affected women and children. In 2013, two thirds of all identified HIV-positive women have been empowered through leadership skills, peer counselling and home based care to improve their wellbeing, 225 sex workers have been trained to support the sex worker's network, 21 infected women have received grant support for income generating activities and 10 HIV positive survivors of gender based violence have found protection in a shelter home. Furthermore, UN support has provided psychosocial counseling and care to 456 children infected and affected by HIV/AIDS.

With support from UNODC, opioid substitution therapy (OST) has recently been piloted and found to contribute effectively to avert HIV/AIDS. In 2013, a new OST center has been scaled up, which makes a total of 3 operational Methadone Maintenance and Treatment Clinics. In 2013 about 15,000 inmates in 12 central and district prisons received services for preventing HIV and other sexually transmitted diseases.

Refugees are accessing services for prevention and management of HIV and other sexually transmitted infections through UNHCR support. Syndromic management has been mainstreamed in the refugee camps under the general health services provided by the Ministry of Health, and is led by 25 health workers who have undergone special training on HIV.

Government, UN and Civil Society partners used the AIDS Epidemic Model to estimate transmission dynamics, number of averted infections and lives saved.

[12] International HIV/AIDS Alliance. 2012. Link-up Project Overview Brochure

[13] 2013. Excerpts from the UN Development Assistance Framework Report are included in this section

(D) Indicator data in an overview table (i)

Indicators (#)	Recommended guidelines		For Bangladesh		Remarks
	Data collection frequency	Method of data collection	Data available and reported	Method of data collection	
Target 1: Reduce sexual transmission of HIV by 50 per cent by 2015					
Population: General population					
Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (1.1)	Preferred: every two years; minimum: every 3–5 years.	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey. This indicator is constructed from responses to the following set of prompted questions: 1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners? 2. Can a person reduce the risk of getting HIV by using a condom every time they have sex? 3. Can a healthy-looking person have HIV? 4. Can a person get HIV from mosquito bites? 5. Can a person get HIV by sharing food with someone who is infected?	Data available	End line HIV/AIDS Survey among Youth in Bangladesh, 2008, NASP, Save the Children, ICDDR,B	
Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 (1.2)	Every 3–5 years	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey.	Data available	End line HIV/AIDS Survey among Youth in Bangladesh, 2008, NASP, Save the Children, ICDDR,B	
Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months (1.3)	Every 3–5 years	Population-based surveys	Data available. Reported for men only.	Data extracted from, "An assessment of sexual behaviour of men in Bangladesh" (ICDDR,B and FHI/USAID) 2006.	
Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*(1.4)	Every 3–5 years	Population-based surveys			

Indicators (#)	Recommended guidelines		For Bangladesh		Remarks
	Data collection frequency	Method of data collection	Data available and reported	Method of data collection	
Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results (1.5)	Every 3–5 years	Population-based surveys: 1. I don't want to know the results, but have you been tested for HIV in the last 12 months? If yes: 2. I don't want to know the results, but did you get the results of that test?	Not available		
Percentage of young people aged 15-24 who are living with HIV* (1.6)	Annual	UNAIDS/WHO guidelines for HIV sentinel surveillance	Data not available		Only for countries with generalized epidemics
Population: Sex Workers					
Percentage of sex-workers reached with HIV prevention programmes (1.7)	Every two years	Behavioural surveillance or other special surveys Sex workers are asked: 1. Do you know where you can go if you wish to receive an HIV test? 2. In the last twelve months, have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic)	Data available	1. icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished) 2. National AIDS/STD Programme 2007. For FSW: BSS 2006-07	The 2013 midline survey represents only Dhaka (capital of Bangladesh)
Percentage of sex workers reporting the use of a condom with their most recent client (1.8)	Every two years	Behavioural surveillance or other special surveys	Data available	1. icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished) 2. National AIDS/STD Programme 2007. For FSW: BSS 2006-07	The 2013 midline survey represents only Dhaka (capital of Bangladesh)
Percentage of sex workers who received an HIV test in the past 12 months and know their results(1.9)	Every two years	Behavioural surveillance or other special surveys	Data available	1. icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished). 2. National AIDS/STD Programme 2007. For FSW: BSS 2006-07	The 2013 midline survey represents only Dhaka (capital of Bangladesh)

Indicators (#)	Recommended guidelines		For Bangladesh		Remarks
	Data collection frequency	Method of data collection	Data available and reported	Method of data collection	
Percentage of sex workers who are living with HIV (1.10)	Annual	UNAIDS and WHO Working Group on Global HIV/AIDS and STI Surveillance: Guidelines among populations most at risk for HIV (WHO/ UNAIDS, 2011)	Data available	1. icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished) 2. Govt. of Bangladesh. Serological surveillance 2011	The 2013 midline survey represents only Dhaka (capital of Bangladesh)
Population: Men who have sex with men					
Percentage of men who have sex with men reached with HIV prevention programmes (1.11)	Every two years	Behavioural surveillance or other special surveys: Respondents are asked: 1. Do you know where you can go if you wish to receive an HIV test? 2. In the last twelve months, have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic)	Data available	icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished)	The 2013 midline survey represents only Dhaka (capital of Bangladesh)
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner (1.12)	Every two years	Behavioural surveillance or other special surveys	Data available	icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished)	The 2013 midline survey represents only Dhaka (capital of Bangladesh)
Percentage of men who have sex with men that have received an HIV test in the past 12 months and who know the results (1.13)	Every two years	Behavioural surveillance or other special surveys Respondents are asked: 1. Have you been tested for HIV in the last 12 months? If yes: 2. I don't want to know the results, but did you receive the results of that test?	Data available	icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished)	The 2013 midline survey represents only Dhaka (capital of Bangladesh)
Percentage of men who have sex with men risk who are living with HIV (1.14)	Annual	UNAIDS and WHO Working Group on Global HIV/AIDS and STI Surveillance: Guidelines among populations most at risk for HIV (WHO/ UNAIDS, 2011)	Data available	icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished)	The 2013 midline survey represents only Dhaka (capital of Bangladesh)
Testing and counselling					
HIV Testing and counselling in women and men aged 15 and older (1.16)	Annual	Programme service statistics compiled from routine reports of number of people tested & know the results from all service points	Data available	Program records (Family Health International 360 and Family Planning Association of Bangladesh)	UA indicator

Indicators (#)	Recommended guidelines		For Bangladesh		Remarks
	Data collection frequency	Method of data collection	Data available and reported	Method of data collection	
Percentage of health facilities dispensing HIV rapid test kits that experienced a stock-out in the last 12 months - Bangladesh (1.16.1)**	Annual	Numerator: Number of health facilities dispensing rapid test kits that experienced a stock-out in the last 12 months. Denominator: total number of health facilities dispensing rapid test kits	Data available	Program records	UA indicator
Sexually Transmitted Infections					
Percentage of women accessing antenatal care (ANC) services who were tested for syphilis (1.17.1)	Annual	National programme records aggregated from health facility data should be used	Data available	Program data from three tertiary level health institutions	UA indicator
Percentage of antenatal care attendees who were positive for syphilis (1.17.2)	Annual	National programme records aggregated from health facility data, sentinel surveillance, or special surveys, using serologic tests to detect reaginic and/or treponemal antibody may be used	Data available	Program data from three tertiary level health institutions	UA indicator
Percentage of antenatal care attendees positive for syphilis who received treatment (1.17.3)	Annual	National programme records aggregated from health facility data should be used	Data available	Program data from three tertiary level health institutions	UA indicator
Percentage of sex workers with active syphilis (1.17.4)	Annual	Data from routine health information systems, sentinel surveillance or special surveys may be used	Data available	Data Sources: 1. Govt. of Bangladesh. (2011). National HIV Serological Surveillance 2. icddr,b, 2013. HIV Midline survey among MSM, MSW and TG (unpublished)	UA indicator The 2013 midline survey represents only Dhaka (capital of Bangladesh)
Percentage of men who have sex with men with active syphilis (1.17.5)		Routine health information systems, sentinel surveillance or special surveys.	Data available	icddr,b, 2013. HIV Midline survey among MSM, MSW and TG (unpublished)	UA indicator The 2013 midline survey represents only Dhaka (capital of Bangladesh)

Indicators (#)	Recommended guidelines		For Bangladesh		Remarks
	Data collection frequency	Method of data collection	Data available and reported	Method of data collection	
Number of adults reported with syphilis (primary/ secondary & latent /unknown) in the past 12 months (1.17.6)	Annual	Routine health information systems	Not available		UA indicator
Number of reported congenital syphilis cases (live births and stillbirth) in the past 12 months (1.17.7)	Annual	Routine health information systems	Not available		UA indicator
Number of men reported with gonorrhoea in the past 12 months (1.17.8)	Annual	Annual routine health information systems	Not available		UA indicator
Number of men reported with urethral discharge in the past 12 months (1.17.9)	Annual	Routine health information systems	Not available		UA indicator
Number of adults reported with genital ulcer disease in the past 12 months (1.17.10)	Annual	Routine health information systems	Not available		UA indicator
Target 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015					
Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programmes (2.1)	Every two years	Numerator: Programme data used to count the number of needles and syringes distributed Denominator: Size estimation of the number of people who inject drugs in the country	Data available	Program records: 1. Save the Children (Global Fund supported RCC) 2. NASP	
Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse (2.2)	Every two years	Behavioural surveillance or other special surveys. People who inject drugs are asked the following sequence of questions: 1. Have you injected drugs at any time in the last month? 2. If yes: Have you had sexual intercourse in the last month? 3. If yes in answer to both 1 and 2: Did you use a condom when you last had sexual intercourse	Data available	1. BSS, National AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, 2006-7 2. Cohort study by ICDDR,B for female IDUs 3rd round in July-Nov, 2006	

Indicators (#)	Recommended guidelines		For Bangladesh		Remarks
	Data collection frequency	Method of data collection	Data available and reported	Method of data collection	
Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected(2.3)	Every two years	Behavioural surveillance or other special surveys: 1. Have you injected drugs at any time in the last month? 2. If yes: The last time you injected drugs, did you use a sterile needle and syringe?	Data available	1. BSS ,NASP , 2006-7 2. Cohort study by ICDDR,B for female IDUs 3rd round in July-Nov, 2006	
Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results(2.4)	Every two years	Behavioural surveillance or other special surveys	Data available	BSS ,NASP , 2006-7	
Percentage of people who inject drugs who are living with HIV (2.5)	Annual	UNAIDS and WHO Working Group on Global HIV/AIDS and STI Surveillance: Guidelines among populations most at risk for HIV (WHO/ UNAIDS, 2011)	Data available	National HIV Serological Surveillance, Bangladesh. (2011)	
Estimated number of opiate users (injectors and non-injectors) – Bangladesh (2.6a)		Programme data, census data	Not available		UA indicator
Number of people on opioid substitution therapy (OST) (2.6b)		Programme data, census data	Data available	Program records and reports	UA indicator
Number of needle and syringe programme sites (2.7a.)		National programme data	Data available	Program records and reports	UA indicator
Number of opioid substitution therapy (OST) sites (2.7b)		National programme data	Data available	Program records and reports	UA indicator
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths					
Percentage of HIV-positive pregnant women who receive antiretroviral medicine to reduce the risk of mother-to-child transmission (3.1)	Annual or more frequently, depending on a country's monitoring needs	Numerator: national programme records aggregated from programme registers, reporting forms, etc. Denominator: estimation models, ANC surveys in combination with demographic data and adjustments to ANC coverage Programme monitoring and HIV surveillance	Data available	Program records	

Indicators (#)	Recommended guidelines		For Bangladesh		Remarks
	Data collection frequency	Method of data collection	Data available and reported	Method of data collection	
Percentage of women living with HIV who are provided with antiretroviral medicine for themselves or their infants during the breastfeeding period (3.1a)	Annual or more frequently, depending on a country's monitoring needs	Numerator: national programme records aggregated from programme monitoring tools, such as patient registers and summary reporting forms. Denominator: estimation models such as Spectrum, or antenatal clinic surveillance surveys in combination with demographic data and appropriate adjustments related to coverage of ANC surveys	Data available	Program reports	Formerly indicator 3.8
Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth (3.2)	Annual or more frequently, depending on a country's monitoring needs	Numerator: Early Infant Diagnosis (EID) testing laboratories Denominator: Spectrum estimates, central statistical offices, and/or sentinel surveillance	Data available	Program reports	
Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months (3.3)	Annual	The mother-to-child transmission probability differs with the antiretroviral drug Regimen received and infant-feeding practices. The transmission can be calculated by using the Spectrum model.	Data available	Spectrum outputs	
Pregnant women who were tested for HIV and received their results (3.4)	Annual	Numerator is calculated from national programme records aggregated from facility registers for antenatal care, labour and delivery and postpartum care Denominator is derived from a population estimate of the number of pregnant women giving birth in the past 12 months	Data Available	Program records	UA indicator
Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months (3.5)		National programme records compiled from facility registers.	Not available		UA indicator
Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing (3.6)		Numerator is calculated from national programme records aggregated from facility registers Denominator: Projection model such as that provided by Spectrum software	Not applicable		UA indicator

Indicators (#)	Recommended guidelines		For Bangladesh		Remarks
	Data collection frequency	Method of data collection	Data available and reported	Method of data collection	
Percentage of infants born to HIV-infected women provided with ARV prophylaxis to reduce the risk of early mother-to-child- transmission in the first 6 weeks (3.7)		Numerator is calculated from national programme records aggregated from facility registers Denominator: Projection model such as that provided by Spectrum software	Data available	Program records of three leading agencies implementing interventions with PLHIV	UA indicator
Percentage of infants born to HIV-infected women started on co-trimoxazole (CTX) prophylaxis within two months of birth (3.9)		Numerator is calculated from national programme records aggregated from facility registers Denominator: a projection model such as that provided by Spectrum software	Data available	Program records of three leading agencies implementing interventions with PLHIV	UA indicator
Distribution of feeding practices for infants born to HIV-infected women at DPT3 visit (3.10)		Numerators are calculated from national programme records aggregated from facility registers Denominator is calculated from the total number of exposed infants whose feeding was assessed	Data available	Program records	UA indicator
Number of pregnant women attending ANC at least once during the reporting period (3.11)		Report the number of ANC attendees with at least one visit during the reporting period	Data available	Program records	UA indicator
<u>Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015</u>					
Percentage of eligible adults and children currently receiving antiretroviral therapy* (4.1)	Data should be collected continuously at the facility level and aggregated monthly or quarterly. Most recent monthly or quarterly data should be used for annual reporting	Numerator: facility-based antiretroviral therapy registers and corresponding cross-sectional forms. Denominator: HIV estimation models such as Spectrum	Data available	Program records	

Indicators (#)	Recommended guidelines		For Bangladesh		Remarks
	Data collection frequency	Method of data collection	Data available and reported	Method of data collection	
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (4.2a)	As patients start antiretroviral therapy, monthly cohort data should be collected continuously for these patients. Data for monthly cohorts that have completed at least 12 months of treatment should then be aggregated	Numerator and denominator: Programme monitoring tools; ART register; cohort analysis forms.	Data available	Program records	
Percentage of adults and children with HIV known to be on treatment 24 months after initiation of antiretroviral therapy (4.2b)	24 months	Numerator and denominator: Programme monitoring tools; ART register; cohort analysis forms	Data available	Program records	UA indicator
Percentage of adults and children with HIV known to be on treatment 60 months after initiation of antiretroviral therapy (4.2c)	60 months	Numerator and denominator: Programme monitoring tools; ART register; cohort analysis forms	Data available	Program records	UA indicator
Number of health facilities that offer antiretroviral therapy (ART) (4.3a)		Numerator is calculated by summing of the number of facilities reporting availability of ART services ,a health facility census or survey can also provide information	Data available	Existing information provided through discussions and consultations	UA indicator
Number of health facilities that offer paediatric antiretroviral therapy (4.3b)		Numerator is calculated by summing the number of facilities reporting availability of paediatric ART services Denominator may come from programme records, facility listings, and/or national strategy	Data available	Existing information provided through discussions and consultations	UA indicator
Percentage of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV in the last 12 months (4.4)	Annual	Information is collected at central level, where health facilities submit their inventory control reports or requisition forms for ARVs	Data available	Existing information provided through discussions and consultations	UA indicator

Indicators (#)	Recommended guidelines		For Bangladesh		Remarks
	Data collection frequency	Method of data collection	Data available and reported	Method of data collection	
HIV Care: HIV treatment: Antiretroviral therapy (4.6)		Health facility services that received patients for ART assessment needs and ART registers	Data available	Program records	UA indicator
Percentage of people on ART tested for viral load who have a suppressed viral load in the reporting period (4.7a)		Viral load test results may also be recorded electronically and reported as part of cohort monitoring studies	Not Available		UA indicator
Percentage of people on ART tested for viral load (VL) with VL level ≤ 1000 copies/ml after 12 months of therapy (4.7b)		Viral load test results may also be recorded electronically and reported as part of cohort monitoring studies	Not Available		UA indicator
Target 5: Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015					
Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV (5.1)	Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly, and reported annually.	Programme data and estimates of incident TB cases in people living with HIV	Data available	Numerator: Program data Denominator: Global TB Report 2013 and Annual TB Report 2014-SEARO. (Estimates of incidence of HIV positive TB cases, rate per 100,000 population)	
Percentage of PLHIV newly enrolled in care who are detected having active TB disease (5.2)	Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly, and reported annually	Numerator: total number of adults and children newly enrolled in HIV care who are diagnosed as having active TB disease during the reporting period Denominator: total number of adults and children newly enrolled in pre-art care or on art during the reporting period	Data available	Program reports	
Percentage of adults and children newly enrolled in HIV care (starting isoniazid preventive therapy (IPT) (5.3)		HIV treatment card and modified HIV care register	Data available	Program reports	

Indicators (#)	Recommended guidelines		For Bangladesh		Remarks
	Data collection frequency	Method of data collection	Data available and reported	Method of data collection	
Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit (5.4)		Numerator: Number of adults and children in HIV care, who had their TB status assessed and recorded during their last visit. Denominator: total number of adults and children in HIV care in the reporting period	Data available	Program reports	
Target 6: Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries					
Domestic and international AIDS spending by categories and financing sources (6.1)	Calendar or fiscal year data	The indicator on domestic and international AIDS spending is reported by completing the National Funding Matrix (NFM)	Data available	NASA	Agencies provided either calendar or fiscal year data (July 2012-June 2013). All data adjusted to match the calendar year period.
Target 7: Critical Enablers and Synergies with Development Sectors					
Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months (7.1)	Every 3-5 years	Population based surveys that are already being used within countries, such as WHO multi-country surveys, DHS/AIS (domestic violence module), International Violence against Women Surveys (IVAWS)	Data available	Bangladesh Demographic and Health Survey, 2007	
Target 8: Eliminating stigma and discrimination					
Discriminatory attitudes towards people living with HIV (8.1)**	Every 3–5 years	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey: 1. Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV? 2. Do you think children living with HIV should be able to attend school with children who are HIV negative?	Not available		New indicator

Indicators (#)	Recommended guidelines		For Bangladesh		Remarks
	Data collection frequency	Method of data collection	Data available and reported	Method of data collection	
Target 10: Strengthening HIV integration					
Current school attendance among orphans and non-orphans (10–14 years old, primary school age, secondary school age) (10.1)	Preferred: every two years Minimum: every 4–5 years	Population-based survey (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey	Not available		Previously reported as Indicator 7.3
Proportion of the poorest households who received external economic support in the last 3 months(10.2)	Every 4–5 years	Population-based surveys such as Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other nationally representative survey	Data available	Household Income and Expenditure Sourvey-2010, Bangladesh Bureau of Statistics	Previously reported as Indicator 7.4

** MDG indicators*
*** New indicator*

Indicator data in an overview table (ii): Tabulated status of GARPR & UA Indicators with measurement value for the current Reporting period:

Target	Indicator	Population Group	Indicator value (in percentage)					Remarks on 2013 data
			2005	2007	2009	2011	2013	
Target 1: Reduce sexual transmission of HIV by 50 per cent by 2015	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (1.1)	Males(15-24 years)	Not available	10.4	22.4	22.4	22.5	Comprehensive knowledge was also assessed among 15-24 year old mothers or females caretakers of children under the age of five of sampled households through the MICS 2009 (BBS and UNICEF). This is not comparable to previous data and may not be compiled with the data on young men. The result was 14.6% among the young girls
		Females (15-24 years)	Not available	10.0	13.4	13.4	13.4	
		All males and females aged 15-24 years	Not available	10.2	17.7	17.7	17.7	
				Source: National Baseline HIV/AIDS Survey among Youth in Bangladesh 2005, NASP, Save-USA, ICDDR,B				
	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 (1.2)	Males(15-24 years)	Not available	11.6	11.8	11.8	11.8	
		Females (15-24 years)	Not available	35.7	30.6	30.6	30.6	
		All males and females aged 15-24 years	Not available	27.1	24.3	24.3	24.3	
				Source: National Baseline HIV/AIDS Survey among Youth in Bangladesh 2005, NASP, Save-USA, ICDDR,B				
	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months (1.3)	Males (15-49 years)	Not available	12.9%	12.9%	12.9	12.9%	Extracted data
		Females (15-49 years)	Not available	Not available	Not available	Not available	Not available	
				Source: Assessment of Sexual behaviour of men in Bangladesh, FHI/ICDDRB 2006				
	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse (1.4)	Males (15-49 years)	Not available	35.0%	35.0%	35.0	32.1	Extracted data
		Females (15-49 years)	Not available	Not available	Not available	Not available	Not available	
				Source: Assessment of Sexual behaviour of men in Bangladesh, FHI/ICDDRB 2006				
	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and who know their results (1.5)	Males (15-49 years)	Not available	Not available	Not available	44.1	Not available	As question's are not applied in surveys among General Population, data from program records was shared in 2011. The Urban Primary Health Care Project currently does not support VCT / HTC.
		Females (15-49 years)	Not available	Not available	Not available	18.5	Not available	
						Source: Program records: Urban Primary Health Care Project Phase II (Mar '11 – Feb '12)		

Target	Indicator	Population Group	Indicator value (in percentage)					Remarks on 2013 data
			2005	2007	2009	2011	2013	
	Percentage of young people aged 15–24 who are living with HIV (1.6)	All males and females aged 15-24 years	Not available	Not available	Not available	Not available	Not available	Only for countries with generalized epidemics
	Percentage of sex-workers reached with HIV prevention programmes (1.7)	Female Sex Workers	6.9	7.4	7.4	7.4	7.5*	2013 midline assessment data is representative of Dhaka only (capital city of Bangladesh) *Data from Save the Children International 2012: Mid-Term Survey on Expanding HIV/AIDS Prevention in Bangladesh RCC Program, may also be considered if calibrated and adjusted to provide estimates to include non-intervention sites as well (the mid-term survey covered respondents from program areas only). In order to adjust Mid-Term Survey findings; BSS 2006-07 was used as the sample was representative for respondents exposed and not exposed to intervention. The ratio of the two variables is used as a calibrating factor. As per the adjusted results: ***34.9% of female sex workers were reached***
		Male Sex Workers	20.4	18.0	18.0	36.6	62.2	
		TG Sex Workers	Not applicable				70.7	
			Source: BSS 2003-04			Sources: For FSW: BSS 2006-07 For MSW: Risk of and vulnerability to HIV among MSW in Dhaka, Bangladesh: A behavioural survey of MSW in Dhaka 2010. icddr,b (unpublished)	Sources: For FSW: BSS 2006-07 For MSW and TG: icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished)	
	Percentage of sex workers reporting the use of a condom with their most recent client (**new clients in the last week) (1.8)	Female Sex Workers	30.9**	66.7**	66.7**	66.7**	66.8*	2013 midline assessment data is representative of Dhaka only (capital city of Bangladesh) *Please see above indicator As per the adjusted results: ***75.1% of female sex workers reported the use of a condom with their last client.***
		Male Sex Workers	44.1**	43.7**	43.7**	39.0**	54.6	
		TG Sex Workers	Not applicable				45.3	

Target	Indicator	Population Group	Indicator value (in percentage)					Remarks on 2013 data
			2005	2007	2009	2011	2013	
			Source: BSS 2003-04			Sources: For FSW: BSS 2006-07 For MSW: Risk of and vulnerability to HIV among MSW in Dhaka, Bangladesh: A behavioural survey of MSW in Dhaka 2010. icddr,b (unpublished)	Sources: For FSW: BSS 2006-07 For MSW and TG: icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished)	
	Percentage of sex workers who have received an HIV test in the past 12 months and know their results (1.9)	Female Sex Workers	1.6	4.1	4.1	4.1	4.1*	2013 midline assessment data is representative of Dhaka only (capital city of Bangladesh) *Please see above indicator As per the adjusted results: ***40.9% of female sex workers received an HIV test and know their results***
		Male Sex Workers	1.1	4.1	4.1	37.7	35.1	
		TG Sex Workers	Not applicable				41.1	
			Source: BSS 2003-04			Sources: For FSW: BSS 2006-07 For MSW: Risk of and vulnerability to HIV among MSW in Dhaka, Bangladesh: A behavioural survey of MSW in Dhaka 2010. icddr,b (unpublished)	Sources: For FSW: BSS 2006-07 For MSW and TG: icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished)	
	Percentage of sex workers who are living with HIV (1.10)	Female Sex Workers	0.3	0.1	0.3	0.3	0.3	2013 midline assessment data is representative of Dhaka only (capital city of Bangladesh)
		Male Sex Workers	0.0	0.7	0.3	0.0	0.6	
		TG Sex Workers	Not applicable				0.5	

Target	Indicator	Population Group	Indicator value (in percentage)					Remarks on 2013 data
			2005	2007	2009	2011	2013	
			Source: National HIV Serological Surveillance, 2004-2005.	Source: National HIV Serological Surveillance, 2006.	Source: National HIV Serological Surveillance, 2007	Source: National HIV Serological Surveillance, 2011	Sources: For FSW: National HIV Serological Surveillance, 2011 For MSW and TG: icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished)	
	Percentage of men who have sex with men (MSM) reached with HIV prevention programmes (1.11)	MSM	0.66	8.1	8.1	9.0	24.4	Sources for 2011 and 2013 represent Dhaka only
			Source: BSS, 2003-04			Source: Risk of and vulnerability to HIV among MSM in Dhaka, Bangladesh: A behavioural survey of MSM in Dhaka 2010. icddr,b (unpublished)	Source: icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished)	
	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner (in the last month) (1.12)	MSM					49	Sources for 2011 and 2013 represent Dhaka only
		Commercial sex	49.2	29.5	29.5	23.7		
		Non-commercial sex	37.0	24.3	24.3	20.9		
			Source: BSS 2003-04	Source: BSS, 2006-07		Source: Risk of and vulnerability to HIV among MSM in Dhaka, Bangladesh: A behavioural survey of MSM in Dhaka 2010. icddr,b (unpublished)	Source: icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished)	

Target	Indicator	Population Group	Indicator value (in percentage)					Remarks on 2013 data
			2005	2007	2009	2011	2013	
	Percentage of men who have sex with men that have received an HIV test in the past 12 months and who know the results (1.13)	MSM	0.0	2.5	2.5	9.3	16.4	Sources for 2011 and 2013 represent Dhaka only
			Source: BSS 2003-04	Source: BSS, 2006-07		Source: Risk of and vulnerability to HIV among MSM in Dhaka, Bangladesh: A behavioural survey of MSM in Dhaka 2010. icddr,b (unpublished)	Source: icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished)	
	Percentage of men who have sex with men who are living with HIV (1.14)	MSM	0.0	0.2	0.0	0.0	0.7	
		MSM and MSW combined	0.4	Not sampled	0.3	0.0	Source: icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished)	
			Source: National HIV Serological Surveillance, 2004-2005.	Source: National HIV Serological Surveillance, 2006.	Source: National HIV Serological Surveillance, 2007	Source: National HIV Serological Surveillance, 2011		
	HIV Testing and counselling in women and men aged 15 and older (1.16)	All men & women aged 15 or older	Not available	Not available	Not available	Not available	26,105 Source: Data base of program records	Program data from Interventions under Family Health International 360 and Family Planning Association of Bangladesh
	Percentage of health facilities dispensing HIV rapid test kits that experienced a stock-out in the last 12 months - Bangladesh (1.16.1)	Health Facilities	Not available	Not available	Not available	Not available	0 Source :Data base of program records	
	Percentage of women accessing antenatal care (ANC) services who were tested for syphilis (1.17.1)	All pregnant women	Not available	Not available	Not available	Not available	31.6 Source: Program data from three tertiary level health institution	UNICEF is supporting PMTCT in three tertiary health facilities (Chittagong and Sylhet Medical College Hospitals and Bangabandhu Sheikh Mujib Medical University. The program began in 2013. Data from these institutions are provided.
	Percentage of antenatal care attendees who were positive for syphilis (1.17.2)	All pregnant women	Not available	Not available	Not available	Not available	0.3 Source: Program data from three tertiary level health institutions	
	Percentage of antenatal care attendees positive for syphilis who received treatment (1.17.3)	All pregnant Women	Not available	Not available	Not available	Not available	50 Source: Program data from three tertiary level health institutions	

Target	Indicator	Population Group	Indicator value (in percentage)					Remarks on 2013 data
			2005	2007	2009	2011	2013	
	Percentage of sex workers with active syphilis (1.17.4)	Sex workers	Not available	Not available	Not available	Not available	3.6 Data Sources: 1. For FSW: Govt. of Bangladesh. (2011). National HIV Serological Surveillance 2. For MSW and TG: icddr,b, 2013. HIV Midline survey among MSM, MSW and TG (unpublished)	
	Percentage of men who have sex with men with active syphilis (1.17.5)	MSM	Not available	Not available	Not available	Not available	1.7 Sources: icddr,b, 2013. HIV Midline survey among MSM, MSW and TG (unpublished)	
	Number of adults reported with syphilis (primary / secondary and latent / unknown) in the past 12 months (1.17.6)	All males and females	Not available	Not available	Not available	Not available	Not available	
	Number of reported congenital syphilis cases (live births and stillbirth) in the past 12 months (1.17.7)	Live births	Not available	Not available	Not available	Not available	Not available	
	Number of men reported with gonorrhoea in the past 12 months (1.17.8)	All males	Not available	Not available	Not available	Not available	Not available	
	Number of men reported with urethral discharge in the past 12 months (1.17.9)	All males	Not available	Not available	Not available	Not available	Not available	
	Number of adults reported with genital ulcer disease in the past 12 months (1.17.10)	All males and females	Not available	Not available	Not available	Not available	Not available	
Target 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes (2.1)	PWID	Not applicable	Not applicable	Not applicable	263.7	287	The National AIDS/STD Programme, (NASP) with support under the Health Sector programme, started prevention interventions since August, 2013. Thus both Save the Children (with Global Fund support) and NASP are implementing NSEP
						Sources: Program records: Save the Children and PMUK and National size estimation (2009)	Sources: Program records: Save the Children (with Global Fund support) and NASP are implementing NSEP program	

<table>
<tr><th rowspan="2">Target</th><th rowspan="2">Indicator</th><th rowspan="2">Population Group</th><th colspan="4">Indicator value (in percentage)</th><th rowspan="2">Remarks on 2013 data</th></tr>
<tr><th>2005</th><th>2007</th><th>2009</th><th>2011</th><th>2013</th></tr>
<tr><td rowspan="10"></td><td rowspan="8">Percentage of people who inject drugs who report the use of a condom at last sexual intercourse (2.2)</td><td>PWID (Male)</td><td></td><td></td><td></td><td></td><td rowspan="3">44.3*</td><td rowspan="8">*Data from Save the Children International 2012: Mid-Term Survey on Expanding HIV/AIDS Prevention in Bangladesh RCC Program, may also be considered if calibrated and adjusted to provide estimates to include non-intervention sites as well (the mid-term survey covered respondents from program areas only).
In order to adjust Mid-Term Survey findings; BSS 2006-07 was used as the sample was representative for respondents exposed and not exposed to intervention. The ratio of the two variables is used as a calibrating factor.
As per the adjusted results:
38.5% of PWID (male) reports the use of a condom the last time they had sexual intercourse.</td></tr>
<tr><td>Commercial Sex</td><td>23.6</td><td>44.3</td><td>44.3</td><td>44.3</td></tr>
<tr><td>Non-commercial Sex</td><td>18.9</td><td>30.5</td><td>30.5</td><td>30.5</td></tr>
<tr><td>PWID (Female)</td><td></td><td></td><td></td><td></td><td rowspan="3">54.8</td></tr>
<tr><td>Commercial Sex</td><td>78.9</td><td>54.8</td><td>54.8</td><td>54.8</td></tr>
<tr><td>Non-commercial Sex</td><td>43.9</td><td>42.1</td><td>42.1</td><td>42.1</td></tr>
<tr><td></td><td>Sources:
1. BSS, 2003-2004 for male IDUs

2. Cohort study by ICDDR,B for female IDUs baseline in Dec 2004-May 2005</td><td colspan="3">Sources:
1. BSS, 2006-2007 for male IDUs

2. Cohort study by ICDDR,B for female IDUs 3rd round in July –Nov 2006</td><td>Sources:
1. Behavioral Surveillance Survey, National AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, 2006-7

2. Cohort study for female IDUs 3rd round in Jul-Nov, 06. icddr,b</td></tr>
<tr><td rowspan="3">Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected (2.3)</td><td>PWID (Male)</td><td>51.8</td><td>33.6</td><td>33.6</td><td>33.6</td><td>33.6*</td><td rowspan="3">*Please see above indicator
As per the adjusted results:
>90% of PWID reports the use of sterile injecting equipment the last time they injected</td></tr>
<tr><td>PWID (Female)</td><td>60.0</td><td>73.8</td><td>73.8</td><td>73.8</td><td>73.8</td></tr>
<tr><td></td><td>Sources:
1. BSS, 2003-2004 for male IDUs

2. Cohort study by ICDDR,B for female IDUs baseline in Dec 2004-May 2005</td><td colspan="3">Sources:
1. BSS, 2006-2007 for male IDUs

2. Cohort study by ICDDR,B for female IDUs 3rd round in July –Nov 2006</td><td>Sources:
1. Behavioral Surveillance Survey, National AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, 2006-7

2. Cohort study for female IDUs 3rd round in Jul-Nov, 06. icddr,b</td></tr>
</table>

Target	Indicator	Population Group	Indicator value (in percentage)					Remarks on 2013 data
			2005	2007	2009	2011	2013	
	Percentage of people who inject drugs that have received an HIV test in the past 12 months and who know the results (2.4)	PWID (Male)	3.2	4.7	4.7	4.7	4.7*	*Please see above indicator As per the adjusted results: ***42.9% of PWID received an HIV test in the past 12 months and know their results***
			Source: BSS, 2003-2004	Source: BSS, NASP , 2006-7				
	Percentage of people who inject drugs who are living with HIV (2.5)	PWID (Male)	1.5	1.9	1.6	1.0	1.0	
		PWID (Female)	0.0	0.8	1.0	1.1	1.1	
			Source: National HIV Serological Surveillance, 2004-2005.	Source: National HIV Serological Surveillance, 2006.	Source: National HIV Serological Surveillance, 2007	Source: National HIV Serological Surveillance, 2011		
	Estimated number of opiate users (injectors and non-injectors) – Bangladesh (2.6a)	Opiate users	Not available	Not available	Not available	Not available	Not available	
	Number of people on opioid substitution therapy (OST) (2.6b)	Opiate users	Not available	Not available	Not available	Not available	411 Source: Program records and reports	
	Number of needle and syringe programme sites (2.7a.)	PWID	Not available	Not available	Not available	Not available	88 Source: Program records and reports	
	Number of opioid substitution therapy (OST) sites (2.7b.)	Opiate users	Not available	Not available	Not available	Not available	3 Source: Program records and reports	One OST site is conducted by the Department of Narcotics Control (Central Treatment Center - CTC) and 2 are DICs, one of which is supported by the Global Fund and the other by the Health Sector programme

Target	Indicator	Population Group	Indicator value (in percentage)					Remarks on 2013 data
			2005	2007	2009	2011	2013	
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths	Percentage of HIV-positive pregnant women who receive ARVs to reduce the risk of mother-to-child transmission (3.1)	PLHIV (pregnant)	Not available	Not available	Not available	Not available	13.04 Source: Program records and reports	Data is from program records of three leading agencies implementing interventions for PLHIV and from UNICEF supported institutions. Measures to avert duplication are in place.
	Percentage of women living with HIV who are provided with antiretroviral medicine for themselves or their infants during the breastfeeding period (3.1a)*	PLHIV (females) and their infants	Not available	Not available	Not available	Not available	1.4 Source: Program records and reports	Data is from program records of three leading agencies implementing interventions for PLHIV and from UNICEF supported institutions. Measures to avert duplication are in place. Breastfeeding infants born to HIV positive mothers began in August 2013
	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth (3.2)	PLHIV (females) and their infants	Not applicable	Not applicable	Not applicable	Not available	2.9 Source: Laboratory reports	EID started in May 2013 and diagnosis started during August, 2013 with support from UNICEF supported program with three tertiary institutions in collaboration with leading agencies implementing interventions among PLHIV and government.
	Mother-to-child transmission of HIV (3.3)	PLHIV (pregnant) and their infants	Not available	Not available	Not available	Not available	35.5 Source: Spectrum projections	
	Pregnant women who were tested for HIV and received their results (3.4)	PLHIV (pregnant)	Not available	Not available	Not available	Not available	729 Source: Program Records	Data is from program records of three leading agencies implementing interventions for PLHIV and from UNICEF supported institutions. Measures to avert duplication are in place.
	Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months (3.5)	Make partners of ANC attendees	Not available	Not available	Not available	Not available	Not available	
	Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing (3.6)	PLHIV (pregnant)	Not available	Not available	Not available	Not available	Not applicable	All HIV positive pregnant women are receiving ART irrespective of clinical staging or CD4 count, thus these are not considered any more

Target	Indicator	Population Group	Indicator value (in percentage)					Remarks on 2013 data
			2005	2007	2009	2011	2013	
	Percentage of infants born to HIV-infected women provided with ARV prophylaxis to reduce the risk of early mother-to-child- transmission in the first6 weeks (3.7)	PLHIV (females) and their infants	Not available	Not available	Not available	Not available	6.5 Source: Program records of three leading agencies implementing interventions with PLHIV	
	Percentage of infants born to HIV-infected women started on co-trimoxazole (CtX) prophylaxis within two months of birth (3.9)	PLHIV (females) and their infants	Not available	Not available	Not available	Not available	6.5 Source: Program records of three leading agencies implementing interventions with PLHIV	
	Distribution of feeding practices for infants born to HIV-infected women at DPt3 visit (3.10)	PLHIV (females) and their infants	Not available	Not available	Not available	Not available	Exclusive breastfeeding-2 Mixed feeding/other-7 Source: The implementing agencies or the relevant tertiary level institution.	9 infants were born, however, their **feeding practices are not recorded at DTP3 visit**; rather records of their feeding practices are with the implementing agencies or the relevant tertiary level institution. Of the 9 infants, 2 are receiving EBF and 7 are receiving replacement feeding.
	Number of pregnant women attending ANC at least once during the reporting period (3.11)	Pregnant Women	Not available	Not available	Not available	Not available	3,773,600 Sources: 1, Bangladesh Maternal Mortality and Health Care Survey, 2010 2. Bangladesh Bureau of Statistics, 2008	

Target	Indicator	Population Group	Indicator value (in percentage)					Remarks on 2013 data
			2005	2007	2009	2011	2013	
Target 4: Have 15 million PLHIV on antiretroviral treatment by 2015	Percentage of adults and children currently receiving antiretroviral **therapy among all adults and children living with HIV** (4.1)	PLHIV	Not available	13.3	47.7	45	11.3	Previous reports were based on: 1. Denominator: eligible adults and children 2. CD4 count of 200
					Source: Numerator: Program records: AAS, CAAP, and MAB Denominator: GTZ supported and IHP conducted projection, 2008	Source: Numerator: Program records: AAS, CAAP, and MAB Denominator: GTZ supported and IHP conducted projection, 2008	Source: Program records of three lead agencies implementing interventions with PLHIV	
	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (4.2a)	PLHIV	Not available	Not available	90.1	84.2	93.1	
		PLHIV			Source: Program records: AAS, CAAP, and MAB	Source: Program records: AAS, CAAP, and MAB	Source: Program records of three lead agencies implementing interventions with PLHIV	
	Percentage of adults and children with HIV known to be on treatment 24 months after initiation of antiretroviral therapy (4.2b)	PLHIV	Not available	Not available	Not available	Not available	80.2 Source: ART registers from three leading implementers of PLHIV interventions	
	Percentage of adults and children with HIV known to be on treatment 60 months after initiation of antiretroviral therapy (4.2c)	PLHIV	Not available	Not available	Not available	Not available	68 Source: ART registers from three leading implementers of PLHIV interventions	
	Number of health facilities that offer antiretroviral therapy (ART) (4.3a)	Health facilities that offer antiretroviral therapy	Not available	Not available	Not available	Not available	TOTAL: 11 Public-3; Private-8 Hospital-3; Health Center-8 Source: Existing information on consultation	Of the 11 facilities 8 are run by the leading entities involved in PLHIV interventions; and 3 are run by tertiary health centers that are focusing on PMTCT

Target	Indicator	Population Group	Indicator value (in percentage)					Remarks on 2013 data
			2005	2007	2009	2011	2013	
	Number of health facilities that offer paediatric antiretroviral therapy (4.3b)	Health facilities that offer paediatric antiretroviral therapy	Not available	Not available	Not available	Not available	TOTAL: 11 Public-3; Private-7 Source: Existing information on consultation	Of the 10 facilities 7 are run by the leading entities involved in PLHIV interventions; and 3 are run by tertiary health centers that are focusing on PMTCT
	Percentage of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV in the last 12 months (4.4)	Health facilities dispensing ARVs	Not available	Not available	Not available	Not available	0 Source: Existing information on consultation	Of the 11 centers dispensing ARV drugs, 1 center does not have provisions for ARV store and none have experienced stock-outs
	HIV Care: HIV treatment: Antiretroviral therapy (4.6)	PLHIV	Not available	Not available	Not available	Not available	A) Total number of adults and children enrolled in HIV care at the end of the reporting period- 243 (non-cumulative) B) Number of adults and children newly enrolled in HIV care during the reporting period- 308 Source: Clinic registers from three leading implementers of PLHIV interventions	
	Percentage of people on ART tested for viral load who have a suppressed viral load in the reporting period (4.7a)	PLHIV	Not available	Not available	Not available	Not available	Not Available	
	Percentage of people on ART tested for viral load (VL) with VL level ≤ 1000 copies/ml after 12 months of therapy (4.7b)	PLHIV	Not available	Not available	Not available	Not available	Not Available	

Target	Indicator	Population Group	Indicator value (in percentage)					Remarks on 2013 data
			2005	2007	2009	2011	2013	
Target 5: Reduce tuberculosis deaths in PLHIV by 50% by 2015	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV (5.1)	TB cases among PLHIV	Not available	Not available	Not available	13.97	28.3	
						Source: Numerator: Program records: AAS, CAAP, and MAB Denominator: TB/HIV in the South-East Asia Region, Status Report, December 2011, WHO	Source: Numerator: Program data Denominator: Global TB Report 2013 and Annual TB Report 2014-SEARO. (Estimates of incidence of HIV positive TB cases, rate per 100000 population 0.2)	
	Percentage of people living with HIV (PLHIV) newly enrolled in care who are detected having active TB disease (5.2)	TB cases among PLHIV	Not available	Not available	Not available	Not available	22.1 Source: Program reports	
	Percentage of adults and children newly enrolled in HIV care (starting isoniazid preventive therapy (IPt)) (5.3)	TB cases among PLHIV	Not available	Not available	Not available	Not available	0 Source: Program reports	
	Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit (5.4)	TB cases among PLHIV	Not available	Not available	Not available	Not available	52.8 Source: Program reports	
Target 6: Reach a significant level of annual global expenditure (US$22-24 billion) in low – middle-income countries	Domestic and international AIDS spending by categories and financing sources (6.1)	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Provided with online report Source: NASA	Some agencies had provided calendar year data, while some provided fiscal year data (July 2012-June 2013). All data have been adjusted to match the calendar year period.

Target	Indicator	Population Group	Indicator value (in percentage)					Remarks on 2013 data
			2005	2007	2009	2011	2013	
Target 7: Critical Enablers and Synergies with Development Sectors	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months** (7.1)	Ever married women aged 15-49 years	Not applicable	Not applicable	Not applicable	53.3	22.4	
						Source: BDHS, 2007	Source: BDHS, 2007	
Target 8: Eliminating stigma and discrimination	Discriminatory attitudes towards people living with HIV(8.1)*	Not available	Not available	Not available	Not available	Not available	Not available	
Target 10: Strengthening HIV integration	Current school attendance among orphans & non-orphans aged 10–14 (10.1)	All children aged 10-14	Not available	Not available	Not available	Not available	Not available	
	Proportion of the poorest households who received external economic support in the last 3 months (10.2)	Population households belonging to the poorest wealth quintile	Not available	Not available	Not available	24.57	24.57	
						Source: Household Income and Expenditure Sourvey-2010, Bangladesh Bureau of Statistics		

II. Overview of the AIDS epidemic

Prevention efforts in Bangladesh had been initiated much before the first HIV case was detected in 1989, till date data has indicated that Bangladesh is containing the HIV epidemic. Due to reportedly low prevalence there is no comprehensive national study to measure the prevalence of HIV among the general population, however, it is considered to be less than 0.1 percent[14].

In all of the nine HIV Serological Surveillance rounds conducted till date (Round 9, 2011) in Bangladesh, the HIV prevalence among the most affected key populations as a whole remained below 1 percent.[15]. Table 1 is a compilation of HIV prevalence among key affected populations over the years.

On December 1, 2013, on the occasion of World AIDS Day, the National AIDS/STD Program (NASP) had confirmed a total of 3,241 HIV cases reported in Bangladesh, of which 370 cases identified were new. In 2013, 95 persons had developed AIDS and a total of 82 deaths were reported. Cumulatively 1,299 people had developed AIDS in the country till date and 472 had died[16].

(A) Key Affected Populations and HIV

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

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

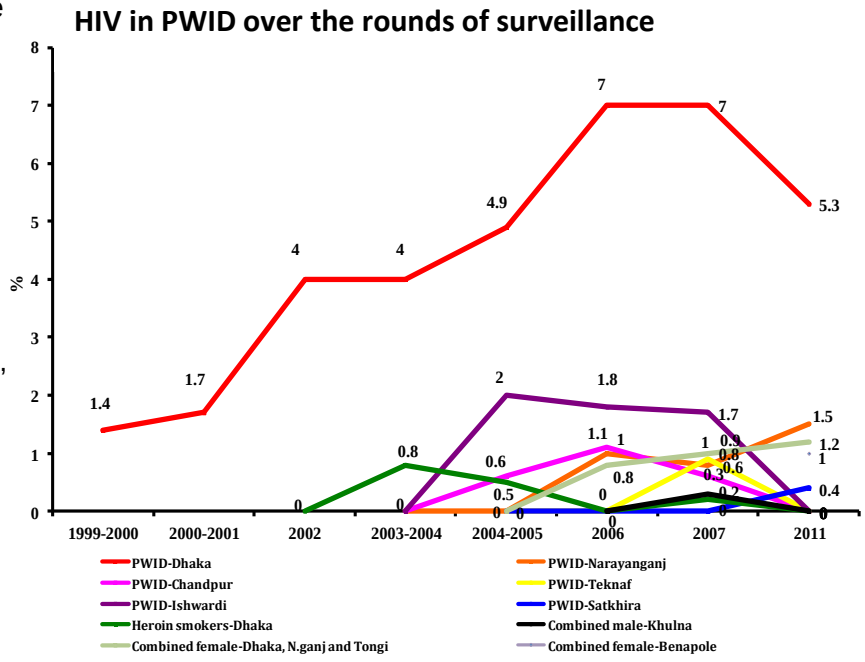
Table 1: HIV prevalence among key affected populations over the years

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

[14] 20 years of HIV in Bangladesh: World Bank and UNAIDS, 2009
[15] The Round 9 surveillance, 2011
[16] WAD,2013, NASP, MoHFW

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

According to the 9th Serological Surveillance 2011 (NASP), the overall HIV prevalence among PWID was found to be stable. In Dhaka, overall prevalence was 5.3 percent. The HIV prevalence among IDUs in Dhaka rose up to five times in an interval of seven years (from 1.4 percent in the 2nd serological surveillance (1999-2000) to 7 percent in the 8th serological surveillance, 2007)[17].



A marker for unsafe injection practices is the prevalence of Hepatitis C. In Dhaka this declined significantly over the years,[18] which confirms that safer injection practices are being adopted.

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

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

Female PWUD are particularly vulnerable as most sell sex to support their addiction, and depended on their male partners to buy their drugs and then shared injections with them[19].

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

[17] 8th Serological Surveillance, 2007

[18] 9th Serological Surveillance, 2011

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

(C) Vulnerability of FSWs to HIV in some cities

Data from 3,568 FSW from 13 cities reveal that the overall HIV prevalence is 0.3% among FSW in Bangladesh and HIV was detected among different groups of FSWs in five cities (Table 2). Over the rounds HIV prevalence among FSW has been low. For sites where HIV was detected over the rounds, the changes were not significant. [20]

Table 2: HIV prevalence among FSW, 2007 and 2011[21]

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

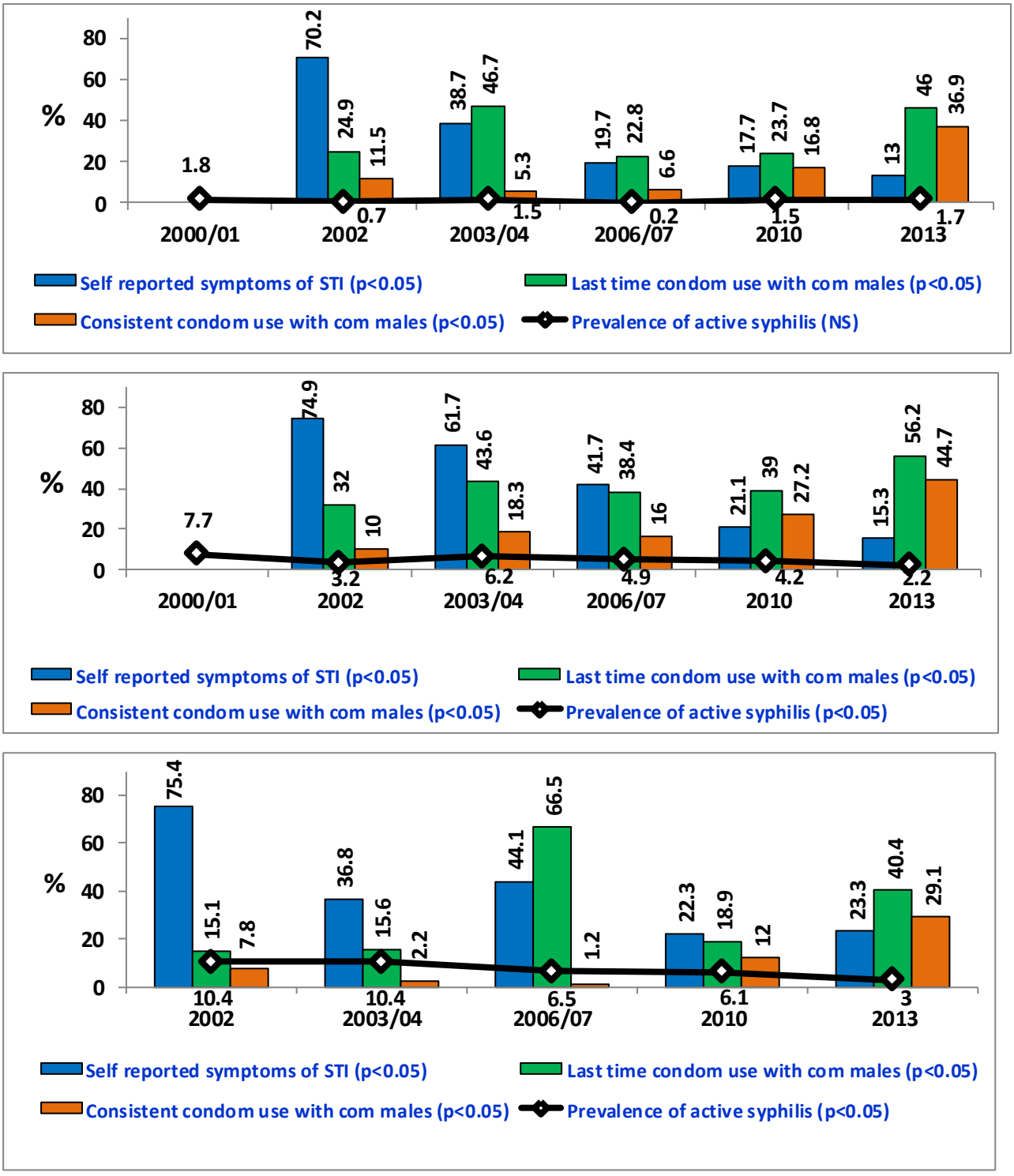
Active syphilis rates had either declined or remained unchanged over the rounds of serological surveillance. In 5 cities approximately 5% or >5% of FSW had active syphilis.[22]

(D) Vulnerability of Hijra, MSM and MSW

A midline assessment of the Global Fund supported interventions for MSM, MSW and TG was conducted in 2013 using the same methodology as the national surveillances. Till the reporting period information from Dhaka was available. The HIV prevalence among MSW was 0.6%, among MSM 0.7% and among TG/Hijras it was 0.5%[23]. Though in the previous surveillance round, none of the MSM or MSW tested was positive for HIV; 0.7 MSW were tested positive in 2006 and 0.3 in 2007, and in 2006 0.2 MSM tested positive. Among the transgendered community (hijra) the HIV prevalence was 1% in two sites (Dhaka –the capital of Bangladesh and Manikganj-a peri-urban site adjacent to Dhaka) in 2011 and one person was detected as being HIV positive among a small sample from Hilli.[24] The rates of active syphilis in MSW and hijra seemed to be declining, while it remained unchanged in case of MSM where the rates were low. Condom use increased in Dhaka among all three groups. MSMs are highly networked, so if HIV were to emerge, it could spread very rapidly in this population, if prevention efforts are not continued[25].

From the 9th serological surveillance, HIV was detected in both sites from where Hijra were sampled. Active syphilis from two cities were at 6.1% and cross-border mobility was common. Attention needs to be given to hijra so that HIV prevention services for hijra are appropriate and expanded. [26] Active syphilis rates were at 1.7% among MSM, 2.2 among MSW and 3 among hijra in 2013[27].

[20] 9th Serological Surveillance, 2011
[21] 9th Serological Surveillance, 2011
[22] 9th Serological Surveillance, 2011
[23] icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished). Dhaka
[24] National AODS / STD Program, 2006-2011. Serological Surveillance Rounds
[25] 20 years of HIV in Bangladesh: World Bank and UNAIDS, 2009
[26] 9th Serological Surveillance, 2011
[27] icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished). Dhaka



Prevalence of active syphilis and risk behaviours over time in Dhaka (from top to bottom: MSM, MSW and TG)[28, 29]

[28] National AODS / STD Program. 2000 to 2011. Serological Surveillance Rounds.

[29] icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished). Dhaka

(E) Overlapping of risk among key affected population

A surrogate marker of unsafe sex is active syphilis. The significant decline in active syphilis in hotel and street based female sex workers in Dhaka suggests effective interventions. However over 5% of some population groups have syphilis, which is unacceptably high. These groups include PWUD, FSW, and Hijra from 10 different cities.[30] Genetic characterization of HIV subtypes helps to analyze overlapping risks. The extent of similarity in the HIV strains found in different populations points to overlap among those groups. Genetic analysis of HIV strains shows that the IDU and heroin smoker strains are almost identical confirming that spread is occurring within networks of IDUs through sharing of injection equipment. The HIV strains obtained from IDUs are distinct from those obtained from other population groups suggesting that transmission of HIV is still restricted within specific MARPs. HIV subtypes from migrants are genetically diverse and have little or no identity with locally circulating strains in IDUs and female sex workers[31]. However, recently, evidence of similarity of strains between those in returnee migrants and local FSW has been found (personal communication, T. Azim, icddr,b).

The recent behavioral survey of hijra in Dhaka, 2010, found that % currently married who had regular sex partners besides spouse was 58.8% and % currently unmarried who had regular sex partners was 62.6%. Most *hijra* had anal sex with male partners in the last month (87.5%). Taking illicit drugs (except alcohol) in the last year was reported by 14.3% of hijra. No one injected drugs in the last year but a small proportion said their regular partners (commercial and non-commercial) injected drugs. Thirty one percent of hijra travelled to another city in the last year. While travelling to another city, 60.7% of sex worker *hijra* sold sex of whom 22.5% used condom in the last sex.[32]

The recent behavioral survey of MSM in Dhaka reports that 71% MSM reported having anal sex with commercial or non-commercial males within a month prior to the survey. Among those who had sex with commercial or non-commercial *hijra* and females, 58.2% had anal sex with *hijra* and 62.6% had vaginal/anal sex with females within a month. Forty-five percent reported had anal sex with non-commercial male/*hijra* in the last month. Thirty percent of the respondents bought sex from female sex workers and a 46.7% bought sex from commercial males in the last one month. One in every ten MSM had group sex in the last one month. On an average MSM had 2.8 non-commercial male/*hijra* sex partner, 2.2 commercial female sex partners and 2.3 commercial male partners in the last month. The average number of group sex partners was 3.6 in the last month. Four in every five MSM had ever used of condoms and 26% reported using condom in the last receptive or penetrative anal sex act with a male sex partner. More than 60% of MSM reported travelling to another city in the last year. Among those who travelled, 37.1% bought sex and 27.2% used condom in the last commercial sex act. One third of the respondents reported taking illicit drugs (except alcohol) in the last year. Of the 457 sampled, seven MSM had injected drugs in the last year and among them approximately half reported sharing needles/syringes with others in the last year.[33]

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[30] 9th Serological Surveillance, 2011

[31] World Bank and UNAIDS, 2009. 20 years of HIV in Bangladesh

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

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

(F) HIV Risk in General Population

Approximately 10 percent of men in Bangladesh reported *having ever bought sex* from female sex workers[34]. In the national survey among youth in 2008, almost 20 percent of unmarried males reported having premarital sex and for 28 percent of these respondents, the last sex was with a sex worker. The reporting of consistent condom use amongst this group with FSWs, however, has risen from 14 percent (2005) to 48 percent (2008). About one in three (28%) young people *who have ever had sex* reported one or more symptoms of an STI in the past 12 months, but only a quarter sought treatments from a trained provider. These data point to the need for more concerted prevention efforts also among the general population with specific focus on men especially young men. [35] These concerted efforts may include life skills education, improved access to condoms[36], involving power structures to provide information to young clients[37], creating public private partnerships with pharmaceutical companies[38], etc. as these types of interventions have been tested and proved to be effective in knowledge increase and behavior change within the Bangladesh context. A recent study among university students again emphasized the need for continued efforts of increasing knowledge and influencing behavior among young people. The study found that 26.8% of students never used condoms during the last sexual act with their boy or girl friend.[39]

An ANC survey was done to determine the distribution of HIV, hepatitis B and syphilis infection among pregnant women attending public and private health antenatal clinics in Greater Sylhet Area by age, district, selected obstetrical history and by selected risk factors. The survey targeted 15 - 49 year old pregnant women attending antenatal. Of the 7650 pregnant women interviewed blood samples were collected from 7535 of them. The survey found 2.9% (220/7535) blood samples positive for Hepatitis, 1.1% (85/7535) positive for syphilis and 0.066% (5/7535) positive for HIV.[40]

(G) Migration and HIV Risk in Bangladesh

Migration may be a factor in HIV transmission in Bangladesh. Migrants, both international and cross border, have generally not been targeted by HIV prevention efforts in the past and there is little understanding as to how such targeted intervention could be implemented[41]. The limited facilities for voluntary counseling and testing, as well as the social stigma and discrimination attached to HIV, remain a major challenge to reach these migrants.

The majority of passively reported HIV positive cases have been among returned international migrant worker s and their families. A recent analysis of existing data on PLHIV showed that of 645 adult PLHIV who had been employed, 64.3 percent had previously worked abroad[42]. Condoms are rarely used in family planning, because they are not preferred by men [HIV vulnerabilities faced by women migrants (OKUP, UNDP, 2009)].

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

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

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

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

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

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

[40] IEDCR, UNICEF. 2013. HIV, Syphilis and Hepatitis B among pregnant women in Selected Health Facilities of Greater Sylhet Area of Bangladesh. Sylhet (unpublished)

[41] 20 years of HIV in Bangladesh: World Bank and UNAIDS, 2009

[42] Ibid

III. National response to the AIDS epidemic

(A) National policy environment and HIV programme

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

Other ministries carry out HIV prevention and control activities through their core administrative structures. The Government nominated focal points for HIV/AIDS in 16 ministries and departments. HIV is integrated in its general development plans, Poverty Reduction Strategy, Sector-wide approach. UN Development Assistance Framework also included HIV. In the new National Health Policy, HIV has been emphasized. However, Bangladesh has not evaluated the impact of HIV on its socioeconomic development for planning purposes.

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

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

Table 3: Trend in policy/practices, 2012 and 2014 reports

Area	Response: National Commitments and Policy Instrument, 2014	Response: National Commitments and Policy Instrument, 2012
Part A (filled out by Government officials)		
Strategic plan	Mid-term review has started	Strategy Plan included operational plan and detail costs and indication of funding source

	Overall achievements: • Development of 3rd National Strategic Plan on HIV and starting its mid-term review. • Laying out the pathway towards the ten targets • Gender Assessment of National HIV Response • Starting review of punitive laws	**Overall achievements:** • 3rd National Strategic Plan,2011-15 updated and finalized • National HIV/AIDS M & E Plan updated and finalized • ARV Guidelines revised and updated • National counseling training manual for children, adolescent and MARPs developed • National counseling guidelines developed • Phase wise anti-retroviral therapy at Infectious Disease Hospital, BSMMU (medical university) and 8 medical college hospitals established • Opioid Substitution Therapy (OST) supported
Political support and leadership	Procurement and distribution of medications or other supplies Is now as per standard Government procedures	Procurement and distribution of medications or other supplies Is ongoing mostly through civil society
	National consultative process supported this	Review of laws and policies occurred to determine inconsistencies
	Overall achievements: Procurement mechanisms are strengthened and self-help groups are more empowered.	**Overall achievements:** Mostly in same areas as “Strategic Plan”
Prevention	Interventions are ongoing	Prison inmates received: Condom promotion, HIV testing and counseling, Needle & syringe exchange, Targeted information on risk reduction and HIV education
	Baseline assessment and size estimation conducted among MARA and YKP and risk reduction strategy paper developed.	MARA and YKP issues were not identified
	PMTCT is implemented in three government tertiary level health institutions	Some PMTCT initiatives have been piloted and are yet to be replicated
	Overall achievements: • Opioid Substitution Therapy (OST) expanded • PMTCT expanded • Government funds mobilized to expand KP interventions	**Overall achievements:** • National Strategic Plan updated with detail operational plan and projected budget • Piloting of Opioid Substitution Therapy (OST) • Control of HIV among PWID and other KAP • Prison inmates too receive some HIV services • LSE for MARPs implemented
Treatment, care and support	All programs sustained and training of health care providers also focused	Pediatric treatment, care and support services, psychosocial support for people living with HIV and their families, TB infection control in HIV treatment and care facilities, TB preventive therapy for people living with HIV, TB screening for people living with HIV, regional procurement and supply management mechanisms, improved
	CABA study conducted	Standard operating procedures for orphans and vulnerable children in place

	Overall achievements: • Development of National Counseling Training Manual for Children & Adolescent Most at risk of or affected by HIV/AIDS • Development of National Counseling Guidelines for Children & Adolescent Most at risk of or affected by HIV/AIDS • ARV supply continued smoothly	**Overall achievements:** • Establish treatment at IDH and BSMMU • Continued supply of ARV for four years
Monitoring and evaluation	Guidelines and tools are being revised	Guidelines on tools for data collection incorporated in M&E plan
	M&E unit at NASP supported by Global Fund	Functional national M&E unit in place in Ministry
	Central national database on KP interventions functional	Central national database gradually being developed
	Use of MIS data needs strengthening	Use of M&E data improved (eg. data used in proposal development, gaps analyses, project site selection, pediatric treatment, care and support, ARV drug procurement and dispensing, etc.)
	Overall score is 7	Overall score is 6
	Overall achievements: • MTR of costed M&E framework and implementation plan underway • Unified MIS developed	**Overall achievements:** • Costed National M & E Plan for 2011-15 drafted and approved by HIV technical sub committee • Midterm review of National M & E Plan for 2011-15 planned • Piloting of on-line posting of drop-in-center data completed
Part B (filled out by Civil Society representatives and Development Partners)		
Human Rights	**Overall achievements:** • Hijra recognized by government as 3rd gender, but overall. • Revision of the National Social Protection Strategy (ongoing) • National Legal consultation and publishing of the subsequent report • Maridpur brothel eviction has been stayed by high court • 150 children have been enrolled in social welfare department in Sylhet • The Law Commission and National Human Rights Commission are actively working together on non-discriminatory laws as per recommendations from the legal consultation. Both entities have mandated rights for marginalized and vulnerable groups, but key populations are not directly mentioned. • The national AIDS policy addresses the role of media	**Overall achievements:** • Human rights commission is now engaged with KAP to address their HR concerns • A core group of Parliamentarians are working to address HR issues of HIV infected and affected population • Sports icons and cultural activists are involved in national AIDS response. • Policy advocacy done at the highest level of Bangladesh's political leadership • Media is sensitized on human rights issues of Key population • Capacity of self-help groups/peer educators developed for advocacy on human rights issues. • Local administration/law enforcing agencies are sensitized on human right issues of key populations

Civil society participation	Overall score is 9	Overall scores have increased to an average of 4 – 5 In general civil society participation is rated as 8
	Overall achievements: • HPNSDP has mobilized funds for intervention packages including interventions among sex workers, injecting drug users (NSE and OST), MSM and Hijra. Currently efforts are ongoing to mobilize funds for migration and care and support as well. All of these interventions are being implemented through civil society. In addition to HPSNDP, the Global Fund, USAID and the Government of Netherlands' support is also rolled out through civil society. Civil Society is leading interventions among SWs, PWID, MSM, etc. to create awareness about HIV/AIDS., STI, VCT, etc and to ensure safer sex and other practices. SHG of PLHV and SHG group of FSW are leading two separate intervention packages in national-level programs. • The national MIS report is generated from civil society implementers, whilst it is being maintained by Government. • Civil Society is leading advocacy efforts with Government for continuing support towards marginalized groups. • The current CCM has over 40% of representatives from civil society. • The development and review of different guidelines, strategic papers, training modules, etc. such as the PMTCT guidelines, ART training modules, the strategic document on migration and MARA, the mid-term review of the national strategic plan have heavily engaged civil society inputs.	**Overall achievements:** • Full participation of civil society implementers in the Assessment of National M&E System and the size estimation of MARPs and development of the National M&E Plan, National Strategic Plan, ART guideline, and counseling manual. • Participated in publications/ dissemination of research findings that includes Serological Surveillances • Civil Society is leading interventions among SWs, PWID, MSM, etc. to create awareness about HIV/AIDS., STI, VCT, etc and to ensure safer sex and other practices. • SHG of PLHV and SHG group of FSW are leading two separate intervention packages in national-level programs. • Civil Society is leading advocacy efforts with Government for continuing PLHIV Package. • For the 1st time in Bangladesh, a National Conference of Female Sex Workers on "Rights and Legal Issues" was held on November 23, 2011. Different Sex Worker organizations were involved in organizing this conference • Participated in the preparation of Nutritional Guidelines for PLHIV • Civil Society has initiated program for cross-border migrants and is increasing the participation of service providers and enhancing local level advocacy
Prevention	CABA and MARA groups are also being focused on	It is now generally agreed that implementation of HIV prevention interventions now includes testing, counseling and risk reduction for MSM, and risk reduction among out of school children
	Overall score on prevention efforts is 8	Overall score on prevention efforts was 7

	Overall achievements: • The low HIV prevalence rate among key populations are well sustained • National level programs since 2008 and 2009 are smoothly ongoing (without interruption) for PWID, FSWs, young people, PLHIV, MSW, MSM, and Hijra through evidence based programming • New interventions were introduced for young people, including garment factory workers, to promote sexual and reproductive health services • STI rate is either unchanged or decreased in certain sites • Condom use rate has increased. • OST has been expanded • Asia-Pacific regional-level interventions for MSM is ongoing • Policy makers and administrators are sensitized on HIV prevention issues	**Overall achievements:** • The low HIV prevalence rate among KAP are well sustained • National level programs since 2008 and 2009 are smoothly ongoing (without interruption) for PWID, FSWs, young people, PLHIV, garments factory workers, MSW, MSM, Hijra and also general people through evidence based programming • STI rate is either unchanged or decreased in certain sites • Condom use rate has increased. • Capacity of members of self-help groups and service providers have increased. • OST has been piloted • Intervention program for prisoners has been piloted • High risk intervention program was in place, and partially funded by HNPSP from 2010 to June 2011 • Asia-Pacific regional-level interventions for PLHIV and MSM installed
Treatment, care and support	Country now has relevant evidence to address MARA and CABA	Country has defined standard operational procedures to address the additional HIV-related needs of orphans and other vulnerable children
	HTC sustainability is a main issue to be strengthened Updated ART guidelines are implemented	Implementation of treatment, care and support now covers ART, nutritional care, pediatric treatment, treatment of common infections, HIV-TB co-infection, prophylactic cotrimoxazole
	Overall score is 7	Overall score was 7
	Overall achievements: • Around 1000 identified PLHIVs are getting ARV through government and donor support. • HTC guidelines and ART guidelines, and ART service monitoring guidelines are in place • PMTCT guidelines are in place • National ART advisory committee is now the national ART and PMTCT advisory committee • Identified PLHIV are reached with care and support services • Availability of fund for ART ensured • National guideline on TB-HIV co-infection is being updated • TB and HIV co-infection issues addressed through National TB Control Program, NASP and CS organizations working on TB treatment and prevention interventions • Service Providers are aware of HIV treatment, care and support	**Overall achievements:** • Around 600 identified PLHIVs are getting ARV through donor support. • Identified PLHIV are reached with care and support services • Availability of fund for ART ensured • National ART guideline updated • National guideline on TB-HIV co-infection developed • TB and HIV co-infection issues addressed both through National TB control Program and NASP • Service Providers are aware of HIV treatment, care and support

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

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

It may be noted that a main issue of concern is sustaining and expanding HTC efforts to increase case detection.

(B) The National M&E Plan, 2011-2015

The overall goal of the National M&E Plan is to support development of a twelve component functional National AIDS M&E System based on the 12 component organizing framework for a functional national HIV M&E System (UNAIDS 2009) that enables to generate, collect and use the strategic information for program improvement, recognizes accountability/reporting requirements, promotes transparency and allows further sharing, analysis and advancement of knowledge[43] [44].

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

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

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

[43] 12 Components Monitoring and Evaluation System Strengthening Tool. Geneva: UNAIDS, 2009
[44] 3rd National Strategic plan, 2011-15

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

1) National policy and leadership support and enabling environment
2) HIV prevention among most-at-risk populations, including the emerging risk and higher vulnerable populations, general populations and hospital based interventions;
3) Treatment, care and support.
4) Coordination, management, capacity building and strategic information

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

Currently plans are underway to revise the National M&E Plan.

(C) The National Response

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

- Midterm review of High Level Meeting targets

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

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

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

- Facilitating the development of grant proposals and concept notes.

- Containing the concentrated epidemic among PWID and supporting related assessments

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

- Among developing countries, Bangladesh (based on recent population size estimations) has achieved among the highest level of needle/syringe distribution per PWID among developing countries in the world. While there are weaknesses in the response and new challenges, the response to date has almost certainly reduced the level of HIV transmission and ensured identified People Living with HIV (PLHIV) receive treatment[45].

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

- Supporting the updating of national size estimates the conducting of program assessment

- Maintaining the coverage among the KAP

- Piloting prevention interventions among prisoners

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

- Involving parliamentarians and law enforcers in various HIV and AIDS related decision-making, training and advocacy forums and facilitating national level legal consultations.

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

- Implementing updated ART and HIV-TB co-infection guidelines

- Expanding PMTCT

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

- Developing and disseminating guidelines and strategic documents on nutrition, ART, PMTCT, MARA, migration, etc.

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

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

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

C1) Prevention among KAP

The prevention programs continue to be focused on the KP s such as PWID, FSW, MSM, MSW, Hijras,and their intimate partners. The three key funders in the country are USAID, World Bank and Global Fund. A new National size estimation exercise of KPs, under the leadership of NASP and

with support from UNAIDS, is being planned. The following table summarizes the existing information available on estimates and KP counting:

Table 4: Size Estimates and counting of Key Populations in Bangladesh[46, 47, 48]

Year	Basis of conducting	Main findings		
2003-04	Information was collected from a very selected # of districts and studies and then multipliers were used as justifiable	Population	High Est	Low est
		IDU	20,000	40,000
		BBSW	3,600	4,000
		SBSW	37,000	66,000
		HBSW	14,000	20,000
		TOTAL FSW	54,600	90,000
		MSM & MSW	40,000	150,000
		Hijras	10,000	15,000
		Clients of FSW	1,882,080	3,136,800
		Returnee migrants	268,000	536,000
2009	Information was collected from 54 of the 64 districts nationwide through mapping and RSRA. However the objective of the base information was to set up intervention sites. This information and later program information was used for the estimates. The main sources were: · RSRA for IDUs and FSWs · Programme service delivery data (also known as "motherlists) · Behavioural Surveillance Surveys (BSS): sampling frame data and survey data for use in combination with programme-based multipliers Ultimately the RSRA, conducted in 2008 and covering IDUs and FSWs in 54 of 64 districts, was the most recent and comprehensive source of data available for the 2009 estimate. It provided direct size estimates for IDUs, street-based sex workers, and for the first time, hotel and residence-based sex workers. This was in contrast to 2004, when direct size estimates from mapping were available in only 24 districts for IDUs . The RSRA had to be used in combination with programme coverage data for the updated 2009 estimates, since the RSRA was designed to focus primarily on those KPs not covered by interventions services. Attempts to use other data sources (such as the kind of BSS multipliers and sampling frame data that were used in the 2004 estimate) did not improve the estimates, so they were not used.	Male IDU	21,800	23,800
		Brothel	3,100	3,600
		Street	25,500	30,700
		Hotel and Residence	35,000	40,000
		Total FSW	63,600	74,300
		Clients of FSW	2,714,000	3,733,000
		Returning Migrants	381,000	762,000
2010	Information was collected from all 64 districts, however, the objective was to set up intervention sites by counting reachable populations. **In case of MSM/MSW the following methods were used:** TIME LOCATION SAMPLING (TLS): For MSM and MSW who frequently visit cruising spots	MSM	21,833	1,10,581
		MSW	11,134	32,484
		Hijra	4,504	8,882

[46] NASP & UNAIDS. 2009. Size Estimation

[47] Icddr,b. 2010. PSA

[48] NASP & UNICEF. 2012. Mapping and Behavioral Study of Most at Risk Adolescents to HIV in Specific Urban/Semi Urban Locations in Bangladesh

	After listing all possible sites/spots, smaller teams visited spots to directly count the numbers of MSM and MSW available at the chosen time frame NOMINATION: For MSM and MSW who are hidden or do not regularly visit cruising spots the nomination method was used A "seed" was nominated from the community of MSM and MSW from the spots or from their peer networks who then identified his network members; the network members are then contacted who in turn identify more members and this is continued till the network saturation was reached **In case of Hijra:** Modified nomination method and Qualitative methods (FGDs, KIIs, etc) were used.			
2011 (only for YKP-ie. aged 10-24 yrs)	The "multiplier method" was used for data across 20 districts. Information collected from three mapping tools and one survey tool was used in estimating the size of MARA/YP of different categories. The information collected through the combination of mapping based method and survey based method, two adjustment factors were derived as multipliers to get the final estimates. The two multipliers were a) population turnover, and b) double-counting between sites.	Male IDU	2,097	
		Brothel based FSWs	4,569	
		Hotel based FSWs	4,055	
		Street based FSWs	21,081	
		Home based FSWs	1,394	
		TOTAL FSW	31,101	
		MSM	3888	
		MSW	1932	
		Hijra	6,096	

The prevention intervention programs implemented in the country are discussed earlier. The major intervention programs include: HIV/AIDS Prevention Services (HAPS), Global Fund to Fight AIDS, Tuberculosis and Malaria supported national programs, Modhumita, the Global Fund supported regional program and the UNICEF supported PMTCT program.

HAPS focused on intervention packages for: PWIDs, street based sex workers, hotel and residence based sex workers, and brothel based sex workers, MSM, MSW, hijra, migrants and PLHIV. Currently a total of 5 NGOs consortia are implementing interventions for PWID, FSW, MSM, MSW, and hijra.

The Principal and Sub Recipients of the Global Fund supported interventions have been working meticulously to help minimize any gap in targeted interventions for KP. Currently the Global Fund supported programs comprise the largest targeted Intervention in terms of geographical and population coverage. Till 2013 the Global Fund has supported reaching almost 14,000 PWID, about 28,000 FSW and approximately 40,000 MSM/MSW/hijra nationawide.

Another key programme is the Modhumita being implemented with support of USAID. Some of the key activities/components supported through Modhumita are: tuberculosis and family planning integration into services for PLHIV and KAP-activities include TB awareness raising, sputum collection for screening and testing for TB, follow-up for DOTS, developing BCC materials etc.; integration of VCT in Public Health Sector (2 Upazila Health Complexes) in collaboration with DGHS;

quality assurance and quality improvement (QAQI) approaches to ensure for example provider compliance with clinical guidelines and standards; satellite VCT to reach more people who inject drugs; and Medical Waste Management which is supported by a standard operating procedure and required training to guide Modhumita centers for using safe and environment friendly procedures that comply with local regulations. This project has targeted about 2000-2500 PWID with demand reduction services and 7,000 FSW in 17 districts.

The South Asia Regional HIV/AIDS Programme focuses on Community System Strengthening through building the capacity of 25 local community-based organizations to deliver high quality services, engage in policy development and advocacy initiatives, and take part in advocacy and research on HIV-related issues affecting MSM and transgender populations.

The NASP under the Ministry of Health and Family Welfare of Bangladesh, in collaboration with UNICEF, is undertaking PMTCT programs in three tertiary level health facilities - namely-Chittagong Medical College Hospital, Sylhet Medical College Hospital and Bangabandhu Sheikh Mujib Medical University. Within the purview of the PMTCT program 626 women (attending ANC services) were tested for syphilis at any ANC visit and 2 were tested positive. Of the 2 ANC attendees with a positive syphilis serology, 1 received at least one dose of benzathine penicillin 2.4 mU IM. Prior to this program records for STIs were scarce.

Analysis of Key GARPR Indicators Related to KAP

Number of KP Reached

As per the information provided, KP coverage with various interventions though have increased, maybe be further enhanced. About 55% of FSW, 84% of PWID, 28% of MSM and MSW, and 85% of hijra are covered through interventions. However as there is no updated behavioral surveillance data this report must repeat the previous reported figure of around 7.2 percent service coverage among KAP[49]. Recently Global Fund has supported the mid-term assessment of project sites supported by the grant and thus some updated data are available which may be used as proxy data. As per the midline assessments conducted by icddr,b and Save the Children 34.9% of street and hotel / residence based FSW, 62.2% of MSW, 70.7% of hijra, and 24.4% of MSM are reached with prevention programs.

Behavior Change

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

As per information and calibrated information from the midterm assessments 75.1% of FSW, 54.6% of MSW, and 45.3% of TG reporting the use of a condom with their most recent client and this implies that condom use is gradually increasing. About 35 to 40% of sex workers are tested for HIV and know their results. About 49% of men reported the use of a condom the last time they had anal sex with a male partner and 16.4% have received an HIV test and know their results. Attempts have been intensified to motivate the KP to get HIV testing and Save the Children, FHI360, icddr,b, Ashar Alo Society and it's consortium partners (of the RCC Grant) have coordinated to improve their access to testing facilities. Thus increase in this indicator (Percentage of sex workers who have

[49] BSS,2006-7

received an HIV test in the last 12 months and know their results) is noted. (Indicator data in an overview table (ii)).

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

Indicator	Population Group	Indicator Value (%)			
		2005	2009	2010/11	2013
Percentage of sex-workers / men who have sex with men / Hijra reached with HIV prevention programmes	MSW	20.4	18.0	36.6	62.2
	MSM	0.66	8.1	9.0	24.4
	Hijra (TG)	1.46	22.3	33.6	70.7
Percentage of sex workers reporting the use of a condom with their most recent client (new clients in the last week)	MSW	44.1	43.7	39.0	54.6
	Hijra (TG)	15.6	66.5	18.9	45.3
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner (in the last month)	MSM: *Commercial sex*	49.2	29.5	23.7	49
	MSM: *Non-commercial sex*	37.0	24.3	20.9	
Percentage of sex workers / men who have sex with men / Hijra who have received an HIV test in the past 12 months and know their results	MSW	1.1	4.1	37.7	35.1
	MSM	0.0	2.5	9.3	16.4
	Hijra (TG)	0.0	14.3	28.7	41.1
Sources: ***Please see Indicator data in an overview table (ii)***					

For the indicator - number of syringes distributed per person who injects drugs per year by needle and syringe programmes – each PWID has received on average 287 syringes in a year. Needles and syringes are distributed as per the needs of PWID which maybe 2 to 3 per day to 1 per week.

Impact of the Prevention Programme on key populations

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

The following table summarizes percentage of KAP who are HIV infected and updated data on MSM, MSW and TG are provided[50]:

[50] icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished). Dhaka

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

Population Group	Indicator Value (%)				
	2005	2007	2009	2011	2013
Female Sex Worker	0.3	0.1	0.3	0.3	Not done
Male Sex Worker	0.0	0.7	0.3	0.0	0.6
MSM	0.0	0.2	0.0	0.0	0.7
Combined MSW and MSM	0.4	Not sampled	0.3	0.0	Not done
Hijra	0.8	0.6	0.3	1.1	0.5
Male PWID	1.5	1.9	1.6	1.0	Not done
Female PWID	0.0	0.8	1.0	1.1	Not done
Combined PWID and Heroin Smoker (male and female)	Not sampled	0.0	0.1	1.1 M: 0.0 F: 1.1	Not done
Heroin Smoker	0.5	0.0	0.2	0.0	Not done
All risk groups	0.6	0.9	0.7	0.7	Not done
Source:	National HIV Serological Surveillance, 2004-2005	National HIV Serological Surveillance, 2006	National HIV Serological Surveillance, 2007	National HIV Serological Surveillance, 2011	icddr,b, 2013. HIV Midline survey among MSM, MSW & TG (unpublished). Dhaka

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

For and Impact Assessment study, the AIDS Epidemic Model was used to estimate impact of interventions among KPs. The following table summarizes the main findings:

Table 7: AEM output summary on impact for Dhaka

Indicators	Current coverage maintained		No KP interventions since 1995			
	2012	2020	2012	2020	Diff: 2012	Diff: 2020
New HIV infections:	**115**	**181**	**1,235**	**7,231**	**1,120**	**7,050**
Current PLHIVs:	**969**	**1,405**	**4,836**	**29,791**	**3,867**	**28,386**
Annual AIDS death:	**65**	**114**	**275**	**1,369**	**210**	**1,255**
Annual ART needs:	**191**	**582**	**525**	**9,512**	**334**	**8,930**
Number on ART:	**96**	**210**	**96**	**3,431**	**-**	**3,221**
Male-Female Inc Ratio:	**2.46**	**3.63**	**2.35**	**2.76**		
Cumulative infections:	**1,401**	**2,573**	**5,966**	**36,466**	**4,565**	**33,893**
Cumulative deaths:	**433**	**1,168**	**1,129**	**6,675**	**696**	**5,507**
Cumulative M/F Ratio:	**2.97**	**3.1**	**2.5**	**2.62**		

C2) Prevention among the General Population:

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

Over 300,000 cross-border migrants are reached across Bangladesh, India and Nepal through the EMPHASIS project with peer education, health services and capacity building. At the learning sites issues such as harassment at work place and rescue are addressed actively.

Especially vulnerable adolescents are those who are most likely to adopt high risk behaviors. Factors that contribute to their vulnerability include displacement; ethnicity and social exclusion; having parents, siblings or peers who inject drugs; migration (internal and external); family breakdown and abuse; harmful cultural practice; and poverty (Interagency Task Team on HIV and Young People. Guidance Note: HIV Interventions for Most at Risk Young People. UNAIDS). Adolescents living on the street or in institutions are the most easily identified EVA. The immediate focus will be to strengthen outreach education for street based EVA and institution based life skills education for those institutionalized as well as distribution of low literacy (possibly pictorial) IEC materials.

The Link Up Project in Bangladesh “Promoting better sexual and reproductive health and rights for young people most affected by HIV” is being implemented through a set of interventions and approaches which is addressing all the four outcomes of the Project. These interventions and approaches will be implemented to reach out around 510,000 young key populations including brothel based female sex workers; Street, Hotel and Residence based female sex workers , young vulnerable garments worker, MSM’s & Hijras; young male dockyard, fish processing zones workers and beach boys, PLHIVs; pavement dwellers ,young vulnerable students(including Yabba and glue users) with education, empowerment, capacity building and referral services for advance sexual and reproductive health and rights (SRHR) and HIV. Link up Bangladesh is being implemented in 59 districts in Bangladesh.

The implementation model of Link up Bangladesh is through peer education and outreach to create and provide a supportive environment at peer, family and community level for young key populations. According to the project implementation plan peer educators (PEs) will plan outreach services, including one to one contact and group education, referral for SRHR services, local level sensitization events, communication sessions and crisis management for the respective target groups. The topics of discussion of PEs are Harmful socio-cultural and gender norms, Early marriage, Violence, Safe motherhood, Stigma and discrimination, Sexual and reproductive rights. Till March 2014 Linkup reached 33,559 young key populations of whom, 8,653 young people were reached with integrated services in a facility based setting and 252 were sensitized or trained as role models in protecting or promoting SRHR.

Through PMTCT pregnant women now have a chance to avail HTC and treatment services through ANC in three tertiary level institutions.

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

Knowledge and Behavior

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

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

In the baseline of National Survey on Youth, it was reported that 41.2 percent of the respondents in the age group of 15 to 24 reported use of condom during high risk sex contact (last six months) and the end-line study reported an increase to 55.3 percent in condom use in the same group. The same study reported a decrease in STI prevalence from 0.6 percent in the baseline to 0.3 percent in the end –line study (specimen positive for both RPR and TPHA indicating current syphilis infection).

For the indicator – percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse, the study done by FHI/ICDDRB 2006 (Assessment of sexual behavior of men in Bangladesh) reported that >30 percent report the use of a condom during their last intercourse. Data on the females for this indicator is not available in the country.

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

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

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

Impact of HIV program
There has been no population based survey to detect the prevalence among the general population.

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

Prevention of Parent to Child Transmission and Early detection of HIV in infants :
About 13% of HIV-positive pregnant women received ARVs to reduce the risk of MTCT. The estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months is 35.5% and 729 pregnant women were tested for HIV and received their results. However, considering estimated populations requiring PMTCT services, 1.4% of women living with HIV who are provided with antiretroviral medicine for themselves or their infants during the breastfeeding period; 2.9% of infants born to HIV-positive women received a virological test for HIV within 2 months of birth, 6.5% of infants born to HIV-infected women are provided with ARV prophylaxis to reduce the risk of early mother-to-child- transmission in the first 6 weeks, and 6.5% of infants born to HIV-infected women started on co-trimoxazole (CtX) prophylaxis within two months of birth. Though PMTCT program has just begun expansion, Bangladesh needs to further expand efforts and look towards means of sustainability.

Care and Support for People with HIV and Anti retroviral Therapy Coverage
Currently 1093 HIV positive persons are receiving ART from 11 ART centers in Bangladesh – 8 of which are run by civil society organizations. Most of the ART centers provide holistic services including VCT, nutrition support, treatment for TB co-infection, etc. Though coverage has increased, only about 29.7% of eligible adults are receiving ART, implying that HTC needs to be expanded and strengthened.

About 93.1% of adults and children with HIV are known to be on treatment 12 months after initiation of antiretroviral therapy, and 80.2% after 24 months of starting treatment.

Government is now procuring ARV drugs and will soon be responsible for the supply chain as well.

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

The national HIV-TB co-infection management guidelines are currently being revised.

About 28.3% of estimated HIV-positive incident TB cases are receiving treatment for both TB and HIV.

C4) Tracking Critical Enablers and Synergies with Development Sectors

Violence against women

Certain aspects of Bangladeshi society, such as restrictions on women's movement outside their homes, unequal access to education, and restricted employment opportunities, limit women's ability to exercise their human rights and make them more vulnerable to domestic violence (Bennett and Manderson, 2003). Although Article 28 of the Bangladeshi constitution states, "The State shall not discriminate against any citizen on grounds only of religion, race, caste, sex or place of birth" (Mittra and Kumar, 2004: 211), women experience many forms of discrimination and inequality and have few protections particularly against domestic violence. Some claim that domestic violence is a mundane aspect of many women's lives in Bangladesh (Akanda and Shamim, 1985; Ameen, 2005; Begum, 2005). Bangladeshi women, however, are not an exception. Routine violence is part of many women's lives around the world, and most violence against women occurs within the home, typically perpetrated by husbands and in-laws (Momsen, 2004)[51].

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

School attendance of Orphans

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

Poverty reduction

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

[51] Momsen, 2004

IV. Best practices

Expanding Opioid Substitution Therapy with Methadone in Dhaka, Bangladesh

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

The pilot intervention was aimed at reducing high risk behaviour leading to the spread of HIV, psychological distress and drug dependency with the goal of improving the quality of life of people who inject drugs. The proportion of PWID who reported depression and anxiety in the last three months did not change over time, but their level of psychological distress such as depression, anxiety and stress scores on Depression Anxiety Stress Scale decreased significantly. At the time of enrolment, more than 50% of PWID had significant level of psychological distress that required clinical attention but after 12 months in MMT only 5% required attention. Suicidal ideation in the last month declined from 51% at baseline to 15% in the 4th quarter ($p<0.01$) among those who ever thought of committing suicide. Within a year, OST improved quality of life of enrolled PWID significantly as measured by the WHO quality of life BREF scale: mean sores in physical health improved from 11.2 to 17.4, psychological from 8.7 to 17.7, social relationships from 9.6 to 15.4 and environmental from 9.6 to 16.2. This was also apparent from different factors such as living conditions, economic independence, involvement in antisocial activities and improvements in their conjugal lives and family relationships. Fewer PWID were living in the streets (from 8.3% to 1.7%, $p<0.01$) and significantly more PWID were living with spouse or family (from 36.4% to 60.3%, $p<0.01$). Economic dependence on family declined from 57% to 33.1% ($p<0.001$) and fewer PWID were involved in antisocial activities from around 41% at baseline and only one PWID at the 4th quarter ($p<0.001$). The proportion of PWID who expressed marital satisfaction increased significantly ($p<0.001$) from 58% in baseline to 95% in the 4th quarter. Also, among the PWID who reported physical fights with others in the last month, fewer reported this with family members (from 76% at baseline to 40% at the end of one year, $p<0.01$).[52]

The MMT clinic at CTC has been providing different types of services to its clients along with regular dispensing of methadone (365 days in a year). These services include: outpatient services with general medicine; counselling, motivational enhancement and psychiatric services; laboratory investigations if required; community sensitisation and methadone anonymous meeting; providing free of charge HIV testing services; and referring patients if required to nearest hospital for TB screening and treatment and PLHIV self help group for ARV medication only for HIV positive patient.

[52] icddr,b. 2013. Piloting Opioid Substitution Therapy with Methadone in Bangladesh

Based on the pilot OST is now expanded to two more DIC to cover and additional 300 PWID. In the three OST centers currently 411 persons are enrolled and 299 persons are regularly taking methadone.

Addressing HIV vulnerability among Cross Border Mobile Population

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

The baseline study identified the major **push factors** of cross border mobility are lack of employment and poverty at source; **pull factors** are more employment opportunity, higher wages, recreation opportunities, and peer pressure etc at destination. Unknowingly the mobile people fall into HIV & STI risk: men meet their sexual need unsafely at destination, women become involved in sex trade for endurance at destination or in the course of mobility they are abused / harassed by power people at source and destination. This continues as frequent phenomena for years and it acts as driving force of stigma towards them (Ref: Baseline study of EMPHASIS Project).

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

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

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

Capacity building of the health service providers to increase service access for the cross border mobile population

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

Addressing Vertical Transmission and Expanding PMTCT in a Low Prevalence Setting[53]

The Government of Bangladesh with support from UNICEF has established a revised National Guidelines for the Prevention of Vertical Transmission of HIV and Congenital Syphilis in 2013[54]. The revise guidelines is aligned with the global commitment for the elimination of mother to child transmission of HIV and incorporate innovative context-specific dual service delivery model to increase effective coverage of PMTCT services in Bangladesh. The objectives of the guidelines are to:

- Establish approaches for the detection of HIV and Syphilis in pregnant women and ensure their access to treatment
- Set national level standard for the use of anti-retroviral drugs in pregnant women for their own health and for preventing HIV infection in infants and young children.
- Align national program approaches with global plan, strategies and experiences for prevention and elimination of vertical transmission.
- Update safe feeding options for HIV-exposed infants.
- Develop monitoring framework for measuring achievements towards national targets.

To support the strategic approach, “Targeted Services for Women in Special Population Group” the following is being implemented in partnership with civil society organizations:

- Active HIV counselling and testing targeted at women in key population groups at community levels and linked to existing HIV/AIDS programme sites
- Sexual and reproductive health and HIV/AIDS linkages with focus on treatment and control of sexually transmitted infections
- Couple counselling, access to appropriate contraceptive commodities and support to initiate pregnancy at choice for HIV positive woman (and spouse[55])

[53] UNICEF. 2013. Fact Sheet: Prevention of Mother to Child Transmission of HIV (PMTCT) and Congenital Syphilis in Bangladesh

[54] National Guidelines for the Prevention of Vertical Transmission of HIV and Congenital Syphilis (2013 Revised Edition). National AIDS/STD Programme, Directorate General of Health Services, MoHFW, 2013

[55] *Where applicable as most high risk women do not have spouse*

- Syphilis screening and treatment

- Referral to designated health facilities for PMTCT and Maternal, neonatal and child health care services for HIV positive pregnant women / most at risk adolescent girls including follow up care services

- Promotion of community based stigma reduction and social integration programme for the mother / baby pair

Considering the strategic approach, “Universal PMTCT Services for Pregnant Women” Government of Bangladesh and UNICEF collaborated to designate three public health facilities for PMTCT care in Bangladesh namely Bangabandhu Sheik Mujib Medical University, Dhaka; Chittagong Medical College Hospital, Chittagong and Sylhet Osmani Medical College Hospital Sylhet. The key interventions offered by these centers include:

- Provider initiated testing and counseling including syphilis testing and treatment for all pregnant women in the facilities

- Anti-retroviral (ARV) treatment for the prevention of mother to child transmission of HIV including linkage / referral to treatment programmes

- Safe delivery and care of the exposed infants of HIV positive mothers

- Infant feeding counseling in the context of HIV and support for adherence to ARV prophylaxis during the breastfeeding period

- Follow up care for mother and infant, including early infant diagnosis of HIV and treatment of infected children

- Integration of family planning services into maternal health care for HIV positive women

- Communication strategy targeted at both service providers and HIV positive women / girls and their families

The implementation of strategic approaches is supported by UNICEF Bangladesh to inform national practice towards reducing paediatric HIV infection. As at the end of 2013, the support to the three designated facility have led to an increase from 4% (in 2012) to 8.5% in the proportion of HIV positive pregnant women receiving ARV for PMTCT in Bangladesh.

To assure quality of service delivery, UNICEF and her partners are developing clinical protocols and community based guidance as well as rolling out national training programmes on PMTCT and Paediatric AIDS care in Bangladesh.

Initiating MIS for interventions with Key Populations

Various stakeholders implementing all key population interventions collectively provided feedback through a three-day workshop on indicators and monitoring, recording and reporting tools at various levels to provide standard data for national level reporting on interventions with key populations which would fulfill requirements of both government and global requirements and maybe enhanced to aid in local level monitoring.

Outputs of the workshop included revised M&E tools incorporating minimum standard requirements for reporting, agreed on formats which would feed into the national data base, standard definitions for uniform reporting and feedback on the existing indicators within the national M&E framework. The workshop was jointly organized by NASP, UNAIDS and NASP.

Currently reporting on KP intervention indicators are ongoing, however, more focus must now be made on effective report generation, decentralizing data entry mechanisms and enhancing public access to the data.

Recognition of transgender / hijra as the third gender in Bangladesh

Hijras are now considered as a separate gender in Bangladesh and will get priority for education and other rights. The decision was made at the cabinet meeting on November 11, 2013, which was chaired by Prime Minister. Currently steps are being taken to fully legalize this recognition. Hijras are already enlisted as voters in Bangladesh.

Mid-term reviews of Global Fund supported interventions

The survey "Mid-Term Survey on Expanding HIV/AIDS Prevention in Bangladesh RCC Program funded by the Global Fund" intended to assess the progress made by the RCC phase-I implemented by Save the Children International in Bangladesh. The study used robust multifarious analytical tools those consist of both advanced quantitative and qualitative techniques. The study was conducted in all 6 divisions of Bangladesh during the month of Oct-Nov, 2012 where the RCC phase-I have been implemented by SCI, SRs and SSRs. This study focused on the population groups who have received the services by SCI, SRs or SSR of the RCC phase-I. The respondents for this study were IDUs and their partners, FSW and their partners, YP aged 15 to 24, PLHIV, Key personnel related to power structure of IDUs and FSWs, and Key program personnel. Though the study did not follow standard BSS methodology and did not have a serological component, it provides valuable iformation on progress made among intervened groups and through adjustment and calibration using information from the 2006-07 BSS a generalized understanding at national level maybe obtained.

icddr,b conducted the Mid-line assessment amng MSM, MSW and TG in Dhaka, Chittagong, Sylhet and Hilli and used standard BSS methodology and also had a serological component. Thus the study is providing required information on improvements in behavior among these KPs considering ongoing interventions.

Given the delay in the BSS, the two assessments were vital to provide some updated information on behaviors of KP to further help us understand the impact of interventions.

Assessment of Impact of Harm Reduction Interventions among People Who Inject Drugs in Dhaka City

While several assessments of drug use have been carried out in the past in Bangladesh, a more comprehensive study was required to understand the effects of the dynamics of risk behaviour and to provide a description of the current situation of the HIV epidemic and its future projections for planning HIV/AIDS prevention programs in the country. This study supported by NASP, IEDCR, Save the Children, icddr,b, UNAIDS Bangladesh and CDC Atlanta has applied the AIDS Epidemic

Model (AEM) to assess the likely pattern of HIV spread in the country based on current risk indicators and HIV prevalence.

The aim of this assessment is to understand the HIV transmission dynamics in Dhaka city and to estimate the extent to which harm reduction interventions among PWIDs have contributed towards epidemiological trends and reduced HIV transmission in the city. It also aims to examine observed epidemiological trends among PWIDs in Dhaka city and other surveillance populations, with changes in HIV transmission modes and AIDS cases. Cost efficiency of the existing harm reduction interventions has also been examined that might have led to continued low HIV prevalence among PWIDs or in general among key populations.

Findings from the AEM also reveal that the prevalence of HIV among PWIDs in Dhaka city in 2012 was projected to be 17.5 percent if there was no harm reduction intervention. In contrast, the prevalence among the same group was projected to be 5.8 percent if existing intervention scenarios are considered, this con-incides with findings from serological surveillances (5.3% HIV prevalence among PWID in Dhaka). Similarly, the HIV prevalence in the absence of any intervention among female PWIDs in Dhaka city was projected to be nearly 3.1 percent in 2012 as compared to 1.1 percent, with existing interventions.

Information from the modeling implies that harm reduction interventions in Dhaka have been effective and need to be continued.

Community Access to HIV Treatment Care and Support Services Study: Bangladesh Report[56]

The study on `Community Access to HIV Treatment Care and Support Services (CAT-S) in Seven Asian Countries' namely Bangladesh, Indonesia, Laos, Nepal, Pakistan, Philippines and Vietnam has been conducted by Asia Pacific Network of People Living with HIV/AIDS (APN+) under the support of the Global Fund Round-10. In Bangladesh, Ashar Alo Society (AAS), as a partner of APN+, has conducted this study. It is hoped that this study will contribute towards effective mainstreaming and scale-up of HIV programs in Bangladesh.

This cross-sectional study, conducted during November 2012 to April 2013, is expected to serve as a baseline study to measure longitudinal changes in access to HIV treatment-related issues in Bangladesh as planned in second phase. HIV treatment-related issues such as access to pre-ART care, ART, ART adherence, treatment literacy, high risk behaviors, health seeking behaviors, etc. were the core issues of this study. A total of 600 PLHIVs (randomly selected) participated in this study. The participants were identified from different population groups through 7 service centers of 4 divisions. The data collectors were recruited from the respective community groups.

Results:

Participants of the study were mostly young adults (average age 36.06□7.345 years), 57% of them were male; half of them were from low socio-economic status. Seventy percent of the participants have spouse/ steady partners, of whom 45% partners were HIV positive and taking ARV. Among the other respondents, 60% had more than two irregular sex partners. By self-categorization of perceived HIV vulnerability, majority (41%) were international migrant workers, followed by wife of migrant workers (33 percent). Mostly reported reasons for HIV test were as, 'Husband/wife/partner/child tested positive' (28%), and 'Referred by doctor as suspected HIV case'

[56] APN+ and Ashar Alo Society. 2013. Bangladesh Report: Community Access to HIV Treatment Care and Support Services Study (CAT-S) in Seven Asian Countries

(27%) and ‘Overseas work requirement’ (17%). More than half agreed that some special person and/ or family supporting the respondents in need. HIV Treatment Literacy level was found poor among half of the respondents and moderate among 38%. Almost all received health workers’ counseling about child bearing. CBO led service centers were found the most preferred and trusted place of HIV diagnosis and management, which are mostly located at the capital city. It was reported that CD4 count was done in ninety percent cases but practically no viral load test was done in Bangladesh. As HIV co-infection, 81.2% of the respondents were diagnosed with TB, among them 85% already completed the treatment regime while the rest were still under treatment. All the respondents were under CBOs’ services, three-fourth had taken ART during 1-3 years. AZT+3TC+NVP and AZT+3TC+LPV/RPV were the most common ART regimens. Average duration to reach ART center is 4±3.2 hours. HIV Treatment Literacy level was found poor among forty percent of the respondents and moderate among 30 percent and excellent among rest thirty percent. Treatment delay was found higher (92.9%) among the respondents who were suggested for ART by physician. HIV Adherence level was found quite high (98 percent). No variable was found to be significantly associated with adherence.

Conclusions:
PLHIV in Bangladesh are mostly young adult, international migrant workers, wife of migrant workers. CBO led service centers were found most preferred place of HIV diagnosis, which are mostly located at the capital city. HIV Treatment Literacy level was found poor to moderate. Treatment delay and adherence level was found quite high.

V. Major challenges and remedial actions

(A) Progress Made on Key Challenges Reported in 2012 UNGASS Country Report

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

Policy Environment

The National Strategic Plan (NSP) for 2011-15, will be undergoing a mid-term review which will influence government funding allocations and integration issues. Steps are also progressing quickly towards bringing into the regular organogram of the DGHS.

Measures must now be taken to focus government attention to facilitate sustained interventions, and retaining public health leaders in HIV.

Like elsewhere in the world, changing an existing law is difficult and a lengthy process. Though the national legal consultation was a success, measures need to be strengthened to follow-up on the recommendations made from that consultative process.

Parallel systems still exist and coordination matters need to be strengthened in this matter.

Leadership and Coordination

The National AIDS Committee (NAC) met for the first time in last eight years in 2011 and its technical committee met more than six times in the reporting period which has played a major role in the endorsement of new NSP, M&E Plan and ART guidelines. Many discussions on the matter has taken place and efforts will be made to ensure annual meetings for clear understanding of all issues at the highest level of the nation.

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

However, steps have progressed well to integrate NASP into the regular organogram of the Directorate of Health Services. NASP staffing situation is also being supported by the Global Fund.

Strengthening coordination across donor support still remains a challenge, and is being addressed with immediate action. UNAIDS and NASP are playing a vital role in minimizing this issue. In addition, as donor funds are decreasing advocacy is ongoing to ensure government investment is increased.

Accountability mechanisms in AIDS spending needs further strengthening through a better functioning CCM and a more structured NASP.

Strategic Information Management

A “one agreed country-level monitoring and evaluation system” has been outlined in the National M&E Plan which is now operationalized for KP interventions. However, similar efforts need to be strengthened for PLHIV.

The collection and collation of data through surveillance, surveys and research is progressing slowly and proxy data from baseline and mid-term assessments are used. The last national behavioral surveillance was conducted in 2006-07 and the serological surveillance was conducted in 2011. A holistic national size estimation is yet to be conducted and it is being planned to be supported through government funds. well in the reporting period as evidenced by the National Size Estimation

Individual research on vulnerable groups have been conducted which is providing information and one example is information collected on MARA. In addition the impact assessment of harm reduction interventions, the CAT-S study, etc. are also providing vital information for the country, which needs to be translated into action.

Financing Targeted Interventions

USAID and the Big Lottery Fund support will be ending in 2014 and till date no alternate funding stream has been set up to address the upcoming gap. Government investment and new Global Fund support may help address the issue. The matter is of grave concern as all care and support systems will be closed and the supply chain of ARV drugs will be hampered.

Capacity

Capacity building initiatives are now well coordinated across all stakeholders and involve all relevant authorities. A system is yet to be developed to track previous efforts and advise newly proposed ones.

Programmatic Gaps

Following is an update of the major programmatic gaps reported in 2012:

Table 8: Progress made against programmatic gaps

Reported in 2012	Progress till 2013
There was no holistic intervention in brothel setting during most part of 2010-11, due to delays in release of funds from sector program.	Government is supporting interventions in all the brothels in Bangladesh
Programmatic coverage of KAP has increased significantly in last five years but this increase has not been validated by a fresh BSS or IBBS round since 2007.	Mid-term reviews are being used as proxy and next round of surveillance is underway.
The definition of KAP varies across different donor funded programs. Standardization of operational definitions of KAP will ease efforts in creating a single database.	All definitions are now standardized
Standardization of performance is ongoing and repeated monitoring visits have helped improve the situation. Also	NA

standard operational procedures for DIC functions and interventions with PLHIV are being implemented by relevant agencies.	
Size estimation of KAP was updated for FSW, male PWID, clients of FSW and returning migrants in 2009 and for MSM, MSW and Hijra in 2010.	A new size estimation is being planned to be conducted in 2015 with government funds
Community groups will be more involved now in designing program for themselves, as efforts have been taken to map CBOs and develop their capacity in such matters.	NA
The updated NSP has included new vulnerable groups (e.g. Migrants) and has costed interventions for them.	Funds of the government supported program for migration is yet to be mobilized.
Care and support services for PLHIV have expanded commendably in the form of continued ARV supply, maintaining nutritional support, VCT, treating HIV-TB co-infection, etc. Issues of stigma and discrimination have also been addressed through training and development of stigma and discrimination training module which is currently being implemented.	Funding support for HTC and other care and support areas including supply of ARV drugs will end in 2014. Continuation plans are yet to be in place.
Coordination between different funding mechanisms are being mitigated to a certain extent through meetings and information sharing (e.g. avoiding geographical duplication, arranging for VCT, etc.), but much more remains to be done, especially in terms of tracking past achievements to advise on incoming proposals (e.g. development of same training modules under different donor funded programs)	This continues to be a challenge
Though the role of the focal persons of the 16 key ministries and departments are clarified, these roles are yet to be implemented effectively.	This continues to be a challenge

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

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

NASP continued to be an adhoc wing of DGHS and remained understaffed with shorter tenures that hampered effective national AIDS response. However, repeated efforts in this matter have finally addressed this concern and NASP is progressing towards becoming a part of the regular DGHS organogram. The role of NASP comprises policy guidance, information updating, coordination and regulation.

The major roles maybe outlined as:

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

Project Manager: Task allocator, coordinator, service package designer, procurement coordinator, facilitator.

M&E Manager: Programme monitor with functions of surveillance, monitoring, evaluation, MIS, national custodian of data/information, reporting to all stakeholders.

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

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

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

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

The required human resources to fill out the major roles outlined above are yet to be available in a sustained manner. NASP needs to strengthen it's expected roles by addressing:

- frequent turnover of staff led to inconsistent leadership and lack of adequate knowledge retention and related oversight activities;
- inadequate use of program management tools and techniques;
- shortage of skilled specialists, especially in the fields of procurement, finance, M&E and research.

Sustained funding sources, especially for mainstreaming of activities

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

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

- The World Bank supported HIV prevention interventions: The interventions among high risk groups were implemented for only one year during 2009 to 2011 due to lengthy time required in bidding, planning and fund release processes. Interventions have started again in 2012 and hopefully will continue smoothly.

- USAID supported programs will end in 2014 and there is no continuation plan. This implies HTC, supply chain of ARVs and overall care and support functions will be discontinued.

- The Big Lottery Fund supported migration program will end in 2014as well and government funds for migration are yet to be mobilized.

Integrated data collection and update

The process of setting up an automated MIS for PLHIV is yet to be in place. In addition to collection of routine data, conducting a fresh BSS round or an IBBS too has been delayed. A new national size estimation of KPs is also pending.

(C) Remedial Actions

Mainstream activities as part of HPNSDP

Mainstreaming of ARV supply is already on the planning process and much more needs to be done.

Interventions with KPs are already rolled out with government funds.

Regularize routine and survey data collection

- A complete inventory needs to be developed and updated regularly focusing all surveys and surveillances and related operations research.
- National guidelines need to be developed for recording, collecting, collating and reporting programme monitoring data from health information system and civil society/community-based systems
- The unique identifier mechanism needs to be implemented at service delivery centers to ensure confidentiality and avoid double reporting, especially in case of PLHIV
- For sustainability of HIV related surveillance, Institute of Epidemiology Disease Control and Research (IEDCR) should be capacitated to conduct such surveys.
- Surveillances need to be conducted regularly
- MIS reports need to be generated
- Research agenda needs to be developed and coordinated by NASP to ensure relevance and systematic budget allocation and effective use of resources.

Capacity Building

Capacity needs to be developed in terms of:

- Adequate and sustained human resources to play the vital roles as per national requirements
- Strengthening of coordination mechanisms among donors, ministries and technical working groups
- Maintenance of proper inventory and tracking systems to support effective advocacy and information disseminations/sharing

VI. Support from the country's development partners

Global Fund / Rolling Channel Continuation (RCC)

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

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

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

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

Some remarkable achievements of the RCC Grant include;

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

UN Agencies

Please see sections:

1.I (Status at a glance), Part (c) (The policy and programmatic response), Number 8.

2. Addressing Vertical Transmission and Expanding PMTCT in a Low Prevalence Setting under Best Practices.

VII. Monitoring and evaluation environment

In April 2010, the NASP in collaboration with SC USA, ICDDR,B and UNAIDS commissioned an (a) Assessment of the national HIV/AIDS M&E system, to prepare the next (b) National M&E Framework (2010-2015) and (c) Costed work plan (budget).

Key findings as revealed from the assessment say that the National HIV/AIDS M&E System in Bangladesh was in the early stages of development. The National AIDS/STD Programme is working to establish the structure and system required to fulfill the system. Human capacity within NASP as well as across the sector needs improvement particularly on Program Monitoring and Evaluation, MIS, information and communication technology. icddr,b with Global Fund support is supporting the M&E unit of NASP, but sustainability is still an issue.

A Technical Working Group on M&E exists and contributes to a great extent to prepare national reports like GARP Country report, to oversee strategic information linked functions like Size Estimates for KPs, or to support piloting HIV MIS. Though regular meetings and follow up actions were pursued for Surveillance it is yet to start. Data use though evident at national level is weak among most of the sectors.

Umbrella organizations and implementing NGOs have a project based HIV M&E System, and these are harmonized and coordinated to operationalize “One M&E system” at national level. HIV MIS for KP interventions has been piloted and operationalized. However, using the data for monitoring purposes and generating MIS reports are yet to materialize. A PLHIV database is now being planned.

Improvement of program monitoring capacity within NASP had been considered a priority. Awareness on the critical importance of monitoring and evaluation has developed within country; it has become an imperative to coordinate the M&E response. This requires a robust and empowered M&E unit within NASP that will remain sustained irrespective of donor support.

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

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

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ANNEXES

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

The 2011 United Nations General Assembly Political Declaration on HIV/AIDS set ambitious targets to be achieved by 2015. A framework of core indicators was developed to reflect the new targets and elimination commitments. The Political Declaration requests a special report to the General Assembly on progress in accordance with global reporting on the Millennium Development Goals at the September 2013 review of the Goals. To this effect, in December 2012, the UNAIDS Executive Director sent a letter to all permanent representatives to the United Nations Office in Geneva encouraging Member States to conduct national midterm reviews (MTR) of progress against the targets of the Political Declaration on HIV and AIDS, referred to as the "Ten Targets". UNAIDS country and regional offices were subsequently requested to provide support to help conduct these reviews. These national MTRs combine a critical appraisal of progress made, guided by an assessment of progress against relevant Global AIDS Response Progress Reporting indicators and other information sources, with the identification of constraints and gaps in national responses leading to recommendations and commitments for future action.

Midterm review of HLM targets depends on two major pillars: 'Stocktaking exercise' and 'National Stakeholders' Consultation'. Each have different methods and activities. An essential step to complete the MTR is carrying out a stocktaking exercise to review progress, assess national targets and prioritize interventions and resource allocation, building on and contributing to on-going country-level processes. In Bangladesh, the 'Stocktaking exercise' involved a comprehensive review of evidence from sources like the National M&E Plan, UNAIDS Bangladesh Work-plan 2012-13, Bangladesh Global AIDS Response Progress (GARP) report 2012, latest serological & behavioral surveillances, program information from civil society, government, and the UN agencies, etc. to track the progress and obstacles in reaching the Ten Targets 2011 Declaration.

Gathering and collating information and inputs started with a brief orientation on the HLM targets and process of the MTR with the Technical Working Group for National M&E and Strategic Information in February 2013 followed by the initiation of desk review and subsequent sharing of the draft filled out tool. During the desk review, compilation of information was conducted for both the 'ten target' tracking tools and to prepare a supplementary information source as per an additional tool titled 'assessment of findings'.

Next step for mid-term review was conduction of 'National Stakeholders' Consultation' workshop with all relevant stakeholders on HIV/AIDS in Bangladesh. This workshop, held in April, 2013 created an opportunity of appraising progress assessed to address the 'Ten Targets' of the 2011 UN Political Declaration on HIV and AIDS and agreeing upon a set of recommendations to change course, accelerate action and re-program resources.

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

NCPI, Bangladesh - 2013

Is indicator/topic relevant: Yes

Is data available: Yes

Data Measurement Tool / source: NCPI

Data Collection Period:
From: 01/01/2014
To: 03/15/2014

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:
Dr. Husain Sarwar Khan, Line Director, National AIDS/STD Programme

Postal address: **House- 11B, Road-131, Gulshan 1, Dhaka 1212, Bangladesh**

Telephone: **880-2-882-9720**

Fax: **880-2-882-9720**

E-mail: **stdaids2008@gmail.com**

Describe the process used for NCPI data gathering and validation:
The data was gathered through a workshop with Civil Society held on March 9, during which each query was reviewed in terms of progress against the last report and feedback was recorded immediately. The filled out draft tool was shared with all the workshop participants for their feedback. Prior to the workshop the guidelines and the previous filled out tool was shared with all invitees. In case of government officials, key informants were identified and interviews were conducted with them to gather relevant data.

Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:
In both cases (i.e. workshop and interviews), there was detail discussion at length and all stakes were considered. In case of the workshop, the forums agreed when majority of the participants were in agreement on a matter after extensive debates. In case of interviews too agreements were reached after extensive discussions. However, at all times even if agreements were not reached, the majority consensus or key informant's opinion was prioritized.

Participants for NCPI - PART A [administered to government officials]

Organization	Names/Positions	Respondents to Part A
Ministry of Health & Family Welfare	AM Badrudduja, Additional Secretary	A1,A2,A3
Ministry of Health & Family Welfare	Azam E Sadat, Deputy Secretary	A1,A2,A3
National AIDS/STD Programme	Dr. Husain Sarwar Khan, Line Director	A1,A2,A3,A4,A5
IEDCR	Professor Mahmudur Rahman, Director	A1,A2,A6
National AIDS/STD Programme	Dr. Sydur Rahman, Program Manager	A1,A2,A3,A4,A5
National AIDS/STD Programme	Dr. Anisur Rahman, Deputy Program Manager	A1,A2,A3,A4,A5,A6
National AIDS/STD Programme	Mahbuba Begum, Deputy Program Manager	A1,A2,A3
National AIDS/STD Programme / icddr,b	Dr. Najmul Hussein, Sr. Program Manager	A1,A4,A5,A6
Dhaka Metropolitan Police	Mily Biswas, Additional Police Commissioner	A2,A3
Ministry of Law, Justice & Parliamentary Affairs	Shahinur Islam, Deputy Secretary	A2,A3
Ministry of Women and Children Affairs	Dr. Abul Hossain, Project Director, MSP-VAW	A2,A3
BCCM Secretariat	Manaj Kumar Biswas, Coordinator	A1,A2,A4,A5,A6
Government of Bangladesh	Tarana Halim, Member of Parliament	A2,A3

Participants for NCPI - PART B [administered to civil society organizations, bilateral agencies, and UN organizations]

Organization	Names/Positions	Respondents to Part B
National AIDS/STD Programme	Dr. Md. Anisur Rahman, Deputy Programme Manager	B1,B2,B3,B4,B5
Durjoy Nari Shangha	Humayun Kabir, Manager, Operations. Q/A	B1,B2,B3,B4,B5
Ashar Alo Society	Akhtar Jahan Shilpy, Team Leader	B1,B2,B3,B4,B5
Mukto Akash Bangladesh	Md. Mizanur Rahman, Program Manager	B1,B2,B3,B4,B5
Confidential Approach to AIDS Prevention	Dr. Halida H. Khondoker, Executive Director	B1,B2,B3,B4,B5
Confidential Approach to AIDS Prevention	Dr. Md. Rashidul Hoque, HIV Clinician	B1,B2,B3,B4,B5
icddr,b	Dr.Tasnim Azim, Director, Center for HIV/ AIDS	B1,B2,B3,B4,B5
icddr,b	Dr. Shariful Islam Khan, Project Director	B1,B2,B3,B4,B5
icddr,b / National AIDS/STD Programme	Dr. Nazmul Hussein, Senior Project Manager	B1,B2,B3,B4,B5
icddr,b	Dr. A.K.M Masud Rana, Project Coordinator	B1,B2,B3,B4,B5
icddr,b	Md. Masud Reza, Senior Manager, M&E	B1,B2,B3,B4,B5
Save the Children	Morshed Bilal Khan, Manager, Advocacy	B1,B2,B3,B4,B5
Save the Children / UNAIDS	Robyn Growett, Business Development Manager	B1,B2,B3,B4,B5
Family Health International 360	K.S.M Tarique, Program Manager	B1,B2,B3,B4,B5
Network of Positive People (NOP+)	Nicholas Purification, Treasurer	B1,B2,B3,B4,B5
Care, Bangladesh	Md. Abu Taher, Team Leader	B1,B2,B3,B4,B5
Care, Bangladesh	Dr. Babar, Team Leader	B1,B2,B3,B4,B5
Care, Bangladesh	S.M Rezaul Islam, Program Manager	B1,B2,B3,B4,B5
Population Services & Training Center	Akhtaruzzaman, Team Leader	B1,B2,B3,B4,B5

Light House	Ziauddin Ahmed Khan, Team Leader	B1,B2,B3,B4,B5
Dhaka Ahsania Mission	Zahid Iqbal, Project Manager	B1,B2,B3,B4,B5
Shusthhya Jeebon	Ms. Bobby, Executive Director	B1,B2,B3,B4,B5
Nalta Hospital &Community Health Foundation	Md. Ahsan Zakir Mithu, Program Coordinator	B1,B2,B3,B4,B5
HASAB	Dr.Sharmina Rahman, Deputy Director	B1,B2,B3,B4,B5
HASAB	Rehan Uddin Ahmed, Advocacy & Communication Specialist	B1,B2,B3,B4,B5
Marie Stopes Clinic Society	Dr. Md. Abul Khair, General Manager	B1,B2,B3,B4,B5
Bandhu Social Welfare Society	Md. Mizanur Rahman, M& E Specialist	B1,B2,B3,B4,B5
Peoples Development Community	SM Shirajul Islam, Executive Director	B1,B2,B3,B4,B5
CREA	Basudeb Sutradhor, Project Manager	B1,B2,B3,B4,B5
World Health Organization	Dr. Sabera Sultana, National Programme Officer, TB	B1,B2,B3,B4,B5
World Health Organization	Dr. Md. Enamul Haque, National Consultant	B1,B2,B3,B4,B5
UNAIDS	Leo Kenny, UNAIDS Country Director	B1,B2,B3,B4,B5
UNAIDS	Dr. M. Ziya Uddin, Consultant	B1,B2,B3,B4,B5
UNAIDS	Dr. Saima Khan, Strategic Information Advisor	B1,B2,B3,B4,B5
UNAIDS	Dr. Nadia Rahman, Social Mobilization Advisor	B1,B2,B3,B4,B5
UNAIDS	S. M. Naheeaan, Consultant	B1,B2,B3,B4,B5
National AIDS/STD Programme	Syed Anwar Hossain, Assistant Coordination Manager	B1,B2,B3,B4,B5

National Commitments and Policy Instrument (NCPI)

Part A **[administered by government officials]**

I) STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?
(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes	No

If YES what is the period covered?

The period covered is from 2011 -2015.

Current National Strategy has:

- Clearly identified key /vulnerable populations
- It is a costed National Strategy
- Most focused and prioritized in country context.

IF NO or NOT APPLICABLE, briefly explain why.

IF YES, complete questions 1.1 through 1.10; ***IF NO***, go to question 2.

1.1 Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?

- National AIDS/STD Programme under Ministry of Health & Family Welfare.

1.2. Which sectors are included in the multisectoral strategy with a specific HIV budget

For their activities?

SECTORS	Included in Strategy		Earmarked Budget	
	Yes	**No**	**Yes**	**No**
Education				
Health				
Labour				
Military / Police				
Social Welfare				
Transport				
Women				
Young People				
Other – **Expatriate / Migrant**				

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?

Some activities are implemented from external support (extra-budgetary sources): e.g. UNTF and MDGF

1.3. Does the multisectoral strategy address the following key populations/other vulnerable populations, settings and cross-cutting issues?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
Discordant couples	Yes	No
Elderly persons	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children[3]	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations[4]	Yes	No
SETTINGS		
Prison	Yes	No
School	Yes	No
Workplace	Yes	No
CROSS CUTTING		
Addressing stigma and discrimination	Yes	No
Gender empowerment and/or gender equality	Yes	No
HIV and poverty	Yes	No
Human rights protection	Yes	No
Involvement of people living with HIV	Yes	No

IF NO, explain how key populations were identified?

These populations are identified as emerging vulnerable groups

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country?

People Living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children[3]	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations: migrants, immigrants, garment workers and street based	Yes	No

1.5. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

Yes	No

1.6. Does the multisectoral strategy include an operational plan?

Yes	No

1.7. Does the multisectoral strategy or operational plan include:

a) Formal programme goals?	Yes	No	N/A
b) Clear targets or milestones?	Yes	No	N/A
c) Detailed costs for each programmatic area?	Yes	No	N/A
d) An indication of funding sources to support programme implementation?	Yes	No	N/A
e) A monitoring and evaluation framework?	Yes	No	N/A

1.8. Has the country ensured "full involvement and participation" of civil society[5] in the Development of the multisectoral strategy?

Active	Moderate	No

IF ACTIVE INVOLVEMENT, briefly explain how this was organized: This was organized through:

- Planning
- Consultation
- Group Work
- Participation
- Review with civil society organizations extending from international and national NGOs to CBOs to self-help groups and networks of key populations.

IF NO or MODERATE INVOLVEMENT, briefly explain why this was the case:

1.9. Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes	No	N/A

1.10. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners	Yes, some partners	No	N/A

IF SOME or NO, briefly explain why this was the case:

- There is need for strengthened internal coordination with different sections of Development Partners.

2.1. Has the country integrated HIV in the following specific development plans?

SPECIFIC DEVELOPMENT PLANS			
Common Country Assessment/UN Development Assistance Framework	Yes	No	N/A
National Development Plan	Yes	No	N/A
Poverty Reduction Strategy	Yes	No	N/A
National Social Protection Strategic Plan	Yes	No	N/A
Sector-wide approach	Yes	No	N/A
Other (write in)	Yes	No	N/A

2.2. IF YES, are the following specific HIV-related areas included in one or more of the development plans?

HIV-RELATED AREA INCLUDED IN PLAN(S)			
Elimination of punitive laws	Yes	No	N/A
HIV impact alleviation (including palliative care for adults and children)	Yes	No	N/A
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	Yes	No	N/A
Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes	No	N/A
Reduction of stigma and discrimination	Yes	No	N/A
Treatment, care, and support (including social protection or other schemes)	Yes	No	N/A
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes	No	N/A
Other (write in)	Yes	No	N/A

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

Yes	No	N/A

3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evaluation informed resource allocation decisions?

LOW					HIGH
0	1	2	3	4	5

4. Does the country have a plan to strengthen health systems?

IF YES, Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications.

HIV interventions historically have been NGO driven in Bangladesh. However GO-NGO collaboration, human resources, logistical support, etc. are much more strengthened, especially since the Health Sector Programme funds are channeled through government. Government is supporting all HIV targets set till 2016.

5. Are health facilities providing HIV services integrated with other health services?

AREA	Many	Few	None
a) HIV counseling & testing with sexual & reproductive health			
b) HIV counseling & testing and tuberculosis			
c) HIV counseling & testing and general outpatient care			
d) HIV counseling & testing and chronic non-communicable diseases			
e) ART and tuberculosis			
f) ART and general outpatient care			
g) ART and chronic non-communicable diseases			
h) PMTCT with antenatal care/ maternal & child health			
i) Other comments on HIV integration:			

6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in your country's HIV programmes in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:

- Development of 3rd National Strategic Plan on HIV and starting its mid-term review.
- Laying out the pathway towards the ten targets
- Gender Assessment of National HIV Response
- Starting review of punitive laws

What challenges will remain in this area:

- Rapid response to emerging risk and higher vulnerability.
- Scale up service delivery and improve quality of service.

II) POLITICAL SUPPORT AND LEADERSHIP

1. Do the following high officials speak publicly and favorably about HIV efforts in major domestic forums at least twice a year?

A. Government ministers

Yes	No

B. Other high officials at sub-national level

Yes	No

1.1. In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV?

Yes	No

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:

- Strengthened Bangladesh's Partnership with Global Fund
- Formation and operation of new Country Coordination Mechanism (CCM)
- Worked closely with the CCM in achieving all GF eligibility requirement and eligibility standard
- Participation in World AIDS Day activities.
- Support in Conducting HIV surveillances and other studies.
- Support in managing funding gap.
- Support in preparing for ICAAP

2. Does the country have an officially recognized national multisectoral HIV coordination body (i.e., a National HIV Council or equivalent)?

Yes	No

IF NO, briefly explain why not and how HIV programmes are being managed:

IF YES, does the national multisectoral HIV coordination body:		
Have terms of reference?	Yes	No
Have active government leadership and participation?	Yes	No
Have an official chair person?	Yes	No
IF YES, *what is his/her name and position title?* Bangladesh president is the Chief Patron of National The Chairperson of the National AIDS Committee is the Minister of Health and Family Welfare		
Mr. Mohammed Nasim, Minister –Ministry of Health &Family Welfare		
Have a defined membership?	Yes	No
IF YES, *how many members?* 61		
Include civil society representatives?	Yes	No
IF YES, *how many?* 28		
Include the private sector?	Yes	no
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes	No

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/ programmes?

Yes	No	N/A

IF YES, briefly describe achievements

- Districts AIDS Committee
- 18 Ministry Committee
- Advisory Committee-ART/PMTCT
- NGOs, CSOs involved in different committee
- NGOs, CSOs involved in Awareness building program
- CCM comprised of NGOs and CSOs.
- TWG on M&E and Strategic Information comprised of NGOs and CSOs.

What challenges remain in this area?

- Districts AIDS Committees are not functioning regulalrly
- Lack of Monetary allocation needs to be revised.
- Government to strengthen leadership mechanisms, frequent change of officials results in leadership gaps.

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?

80%

5. What kind of support does the National HIV Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Capacity-building	Yes	No
Coordination with other implementing partners	Yes	No
Information on priority needs	Yes	No
Procurement and distribution of medications or other supplies	Yes	No
Technical guidance	Yes	No
Other [write in below]: Policy Direction	Yes	No

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National HIV Control policies?

Yes	No

6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?

Yes	No

IF YES, name and describe how the policies / laws were amended

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:

- Punitive and discriminatory laws and policies fuelling AIDS epidemic.
- Lack of protective laws for marginalized populations.

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2013?

Very Poor										**Excellent**
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:

- Awareness
- Providing drugs to PLHIV
- Bringing PLHIV together (Network)
- Empowerment of self-help group.
- Other preventive measure (Needle sharing)

What challenges remain in this area?

- Sustain funding
- Building capacity of public health leaders
- Producing & retaining public health leaders.
- Bringing HIV program in main stream as NASP is still a program.
- Lack of supervision due to high dependency upon NGOs, and Donor driven mechanisms

III)HUMAN RIGHTS

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Circle yes if the policy specifies any of the following key populations and vulnerable groups:

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children[3]	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations	Yes	No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on nondiscrimination?

Yes	No

IF YES to Question 1.1. or 1.2., briefly describe the content of the laws:

- Constitution of People's Republic of Bangladesh: Article 29, 28, 27 mentioned non-discrimination. Discrimination is prohibited only for sex, race, cast, religion etc.

Briefly explain what mechanisms are in place to ensure these laws are implemented:

- High Court division of Supreme Court has powered to ensure the fundamental rights through its writ jurisdiction.

Briefly comment on the degree to which they are currently implemented:

- Constitution is in force in from 1972 but some key population sometimes not able to come to High Court for socioeconomic reasons.

2. Does the country have laws, regulations or policies that present obstacles[6] to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?

Yes	No

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
People living with HIV	Yes	No
Elderly persons	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children[3]	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations	Yes	No

Briefly describe the content of these laws, regulations or policies:

- Criminal Procedure Court, 1898; Penal Code, 1960; Dhaka Metropolitan Police Ordinance.
- Criminal Procedure Provisions to arrest key Population without warrant of Court.
- Section 377 of Penal Code prohibits unnatural sex.
- D.M.P act also empowers police to arrest arbitrarily.

Briefly comment on how they pose barriers:

- The above mentioned law hindering the HIV program, such as making obstacles to access to HIV services to key populations.

IV) PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?

Yes	No

***IF YES*, what key messages are explicitly promoted?**		
Delay sexual debut	Yes	No
Engage in safe(r) sex	Yes	No
Fight against violence against women	Yes	No
Greater acceptance and involvement of people living with HIV	Yes	No
Greater involvement of men in reproductive health programmes	Yes	No
Know your HIV status	Yes	No
Males to get circumcised under medical supervision	Yes	No
Prevent mother-to-child transmission of HIV	Yes	No
Promote greater equality between men and women	Yes	No
Reduce the number of sexual partners	Yes	No
Use clean needles and syringes	Yes	No
Use condoms consistently	Yes	No
Other [write in below]:	Yes	No

1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes	No

2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?

Yes	No

Is HIV education part of the curriculum in?		
Primary School	Yes	No
Secondary School	Yes	No
Teacher Training	Yes	No

2.2. Does the strategy include

a) age-appropriate sexual and reproductive health elements?

Yes	No

b) gender-sensitive sexual and reproductive health elements?

Yes	No

2.3. Does the country have an HIV education strategy for out-of-school young people?

Yes	No

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable sub populations?

Yes	No

Briefly describe the content of this policy or strategy:

- HIV life skill education
- Behavior change communication
- Access to VCT & STI services.
- Provision of Basic HIV information

3.1. IF YES, which populations and what elements of HIV prevention does the policy/strategy address?

Check which specific populations and elements are included in the policy/strategy

	IDU	MSM	Sex workers	Customers of sex workers	Prison inmates	Other
Condom promotion	■	■	■	■		
Drug substitution therapy	■		■			
HIV testing and counseling	■	■	■	■		
Needle & syringe exchange	■		■			
Reproductive health, including sexually transmitted infections prevention and treatment	■	■	■	■		
Stigma and discrimination reduction	■	■	■			
Targeted information on risk reduction and HIV education	■	■	■	■		
Vulnerability reduction (e.g. income generation)						

3.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:

- 3rd National Strategic Plan
- National Guideline of Anti-Retroviral Therapy
- National Counseling Guideline for Children & Adolescent Most-at risk of or affected by HIV/AIDS.
- National Counseling Training Manual for Children & Adolescent Most-at risk of or affected by HIV/AIDS.

What challenges remain in this area:

- Addressing gender equality issues comprehensively.
- Responding to emergent risk &high vulnerability.
- Scale up service delivery & improve quality of services.

4. Has the country identified specific needs for HIV prevention programmes?

Yes	No

IF YES, how were these specific needs determined?

- By identifying key vulnerable people and their needs
- Through stakeholders consultations
- Studies and research

IF YES, what are these specific needs?

- Policy support.
- Multisectoral continued advocacy.
- Expanding the program to cover more key populations.
- Intensifying the program to cover families and contacts of key populations.
- Stimulate law enforcers to facilitate social reform.
- Extending benefits under National Social Protection Strategy towards key populations.
- Resource mobilization to address intervention gaps.

IF NO, *how* are HIV prevention programmes being scaled-up?

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to…	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Blood safety	1	2	3	4	N/A
Condom promotion	1	2	3	4	N/A
Economic support e.g. cash transfers	1	2	3	4	N/A
Harm reduction for people who inject drugs	1	2	3	4	N/A
HIV prevention for out-of-school young people	1	2	3	4	N/A
HIV prevention in the workplace	1	2	3	4	N/A
HIV testing and counseling	1	2	3	4	N/A

IEC on risk reduction	1	2	3	4	N/A
IEC on stigma and discrimination reduction	1	2	3	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	3	4	N/A
Prevention for people living with HIV	1	2	3	4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	3	4	N/A
Risk reduction for intimate partners of key populations	1	2	3	4	N/A
Risk reduction for men who have sex with men	1	2	3	4	N/A
Risk reduction for sex workers	1	2	3	4	N/A
Reduction of Gender based violence	1	2	3	4	N/A
School-based HIV education for young people	1	2	3	4	N/A
Treatment as prevention	1	2	3	4	N/A
Universal precautions in health care settings	1	2	3	4	N/A
Other*[write in]*:	1	2	3	4	N/A

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2013?

Very Poor										**Excellent**
0	1	2	3	4	5	**6**	7	8	9	10

V) TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

Yes	No

If YES, Briefly identify the elements and what has been prioritized:

- Counselling and Testing
- Initiation of treatment
- Treatment Maintenance
- Complex HIV management including co-infection
- Paediatric Care
- Opportunistic Illnesses
- Advanced HIV illness and inpatient services
- Palliative Care
- Care and support
- PMTCT
- Infrastructure support (e.g. storage, distribution of medications; laboratory services, infection control etc.)
- Reducing stigma and discrimination under enabling environment
- Protection of human rights under enabling environment
- Engagement of faith based organisations under enabling environment
- Facilitating team based shared care for management of HIV under treatment
- Strengthening resources and capacity building under community system strengthening
- Strengthening leadership and accountability under community system strengthening

Briefly identify how HIV treatment, care and support services are being scaled-up?

- It is not being scaled up at the moment.

The majority of people in need have access to…	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Antiretroviral therapy	1	2	3	4	N/A
ART for TB patients	1	2	3	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3	4	N/A
Early infant diagnosis	1	2	3	4	N/A
Economic support	1	2	3	4	N/A
Family based care and support	1	2	3	4	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	2	3	4	N/A
HIV testing and counselling for people with TB	1	2	3	4	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	1	2	3	4	N/A
Nutritional care	1	2	3	4	N/A
Paediatric AIDS treatment	1	2	3	4	N/A
Palliative care for children and adults	1	2	3	4	N/A
Post-delivery ART provision to women	1	2	3	4	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	2	3	4	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	3	4	N/A
Psychosocial support for people living with HIV and their families	1	2	3	4	N/A
Sexually transmitted infection management	1	2	3	4	N/A
TB infection control in HIV treatment and care facilities	1	2	3	4	N/A

TB preventive therapy for people living with HIV	1	2	3	4	N/A
TB screening for people living with HIV	1	2	3	4	N/A
Treatment of common HIV-related infections	1	2	3	4	N/A
Other*[write in]*:	1	2	3	4	N/A

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?

Yes	No

Please clarify what kind of support is provided?

- -Policy is there but few activities have been undertaken.

3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?

Yes	No

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms, and substitution medications?

Yes	No	N/A

If yes, for which commodities?

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2013?

Very Poor										**Excellent**
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:

- -ART procurement & supply by Government.

What challenges remain in this area:

- -Scale up of efforts in ART, logistics & manpower

6. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?

Yes	No	N/A

6.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

6.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2013?

Very Poor										**Excellent**
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:

- Development of National Counseling Training Manual for Children & Adolescent Most at risk of or affected by HIV/AIDS
- Development of National Counseling Guidelines for Children & Adolescent Most at risk of or affected by HIV/AIDS

What challenges remain in this area:

Developing a response mechanism to emergent risk and higher vulnerability related to orphans and vulnerable children

VI) MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan for HIV?

Yes	No	In Progress

Briefly describe any challenges in development or implementation:

- Donor specified M&E indicators may not always harmonize with national ones.
- Delay in reporting
- Using the standard definitions

1.1. IF YES, years covered** [write in]**: 2011-2015

Briefly describe any challenges in development or implementation:

1.2. IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners	Yes, some partners	No	N/A

Briefly describe what the issues are:

- Most indicators are aligned
- Reports are generated regularly and submitted through National MIS and there is scope for improvement
- Central level coordination challenging as structured M&E unit is not present

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy	Yes	No
IF YES, does it include:		
Behavioural surveys	Yes	No
Evaluation / research studies	Yes	No
HIV Drug resistance surveillance	Yes	No
HIV surveillance	Yes	No
Routine programme monitoring	Yes	No
A data analysis strategy	Yes	No
A data dissemination and use strategy	Yes	No
A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate)	Yes	No
Guidelines on tools for data collection	Yes	No

3. Is there a budget for implementation of the M&E plan?

Yes	In progress	No

3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?

5-10%

4. Is there a functional national M&E Unit?

Yes	In progress	No

Briefly describe any obstacles:

- Government is yet to develop a structured M&E Unit within the National AIDS/STD Programme.
- There is no approved plan or budget in place.

4.1. Where is the national M&E Unit based?

Ministry of Health?	Yes	No
National HIV Commission (or equivalent)?	Yes	No
Elsewhere? (Write in) National AIDS/STD Programme (NASP)	Yes	No

4.2. How many and what type of professional staff are working in the national M&E Unit?

POSITION (permanent staff)	**Fulltime**	**Part time**	**Since when?**
DPM			2010
Senior M& E Specialist			2012
MIS Officer			2012
M & E Program Officer			2012
Data Manager			2012
Data Manager			2012

POSITION (temporary staff)	Fulltime	Part time	Since when?

4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes	No

Briefly describe the data-sharing mechanisms:

- No binding mechanism for other organization to submit M&E data to NASP.
- After a series of workshops, implementers have started to submit data within Government run MIS program
- Implementers submit to lead agencies. They submit to MIS department and NASP may use the data

What are the major challenges in this area:

- Equipment, logistics, & training

5. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

Yes	No

6. Is there a central national database with HIV- related data?

Yes	No

If yes, briefly describe the national database and who manages it

- NASP designated M&E unit.

6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?

Yes, all the above	Yes, some of the above	No, none of the above

IF YES, but only some of the above, which aspects does it include?

National Level	Yes	No
Sub-National Level	Yes	No
IF YES, at what level(s) It is functional from the community level centers to central level including at NASP, M & E unit	Yes	No

7.1. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of current and future needs	Estimates of current needs only	No

7.2. Is HIV programme coverage being monitored?

Yes	No

(a) IF YES, is coverage monitored by sex (male, female)?

Yes	No

(b) IF YES, is coverage monitored by population groups?

Yes	No

IF YES, for which population groups?

- MSM, SW, PWID

Briefly explain how this information is used

- Geographical prioritization
- Understanding extent of problem
- High risk group needs
- WAD report
- Program evaluation
- UNAIDS data hub
- Program planning, advocacy.

(c) Is coverage monitored by geographical area?

Yes	No

IF YES, at which geographical levels (provincial, district, other)?

- District wise and bordering areas and some urban locations.

Briefly explain how this information is used:

- High risk areas, and groups are assess and program planned accordingly for improvement.

8. Does the country publish an M&E report on HIV, including HIV surveillance data at least once a year?

Yes	No

9. How are M&E data used?

For programme improvement?	Yes	No
In developing / revising the national HIV response?	Yes	No
For resource allocation?	Yes	No
Other *[write in]*:	Yes	No

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:

- M&E data on HIV testing was used to incorporate HTC into the DICs
- Data and monitoring information of key populations reached is used to improve programs and data quality
- Tracking of new infections allows geographical prioritization and strategic re-thinking for proper resource allocations (eg. PWID interventions in Dhaka)

10. In the last year, was training in M&E conducted

At National level?	Yes	No
IF YES, what was the number trained: 45		
At subnational level?	Yes	No
IF YES, what was the number trained: 90		
At service delivery level including civil society?	Yes	No
IF YES, what was the number trained: 120		

10.1. Were other M&E capacity-building activities conducted other than training?

Yes	No

IF YES, describe what types of activities

- Manual, Guidelines and definitions were revised

11. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2013?

Low										**High**
0	1	2	3	4	5	**6**	7	8	9	10

Since 2011, what have been key achievements in this area:

- M&E framework
- Costed implementation plan
- Unified MIS developed
- Harmonization in donor stream
- Data collection strategy and guideline develop

What challenges remain in this area:

- Dedicated manpower
- No permanent unit, only project based structure working
- Inadequate equipment, human resource & training.

National Commitments and Policy Instrument (NCPI)

Part B **[administered by civil society organizations, bilateral agencies, and UN organizations]**

I. CIVIL SOCIETY INVOLVEMENT

1. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

Low					High
0	1	2	3	4	5

- National / international NGOs worked together on the 3rd National Strategic Plan
- (NSP) of HIV ('11-'15). Similar process will be followed for the mid-term review of the NSP.
- Restructured CCM comprises of Govt, >40% CSO, and DP & UN representatives. CCM elections for CSO were broadly advertised and inclusive of relevant sub-constituencies.
- Advocacy among community and top leaders of political parties have led to awareness about the needs and rights of PLHIV. Govt is supporting care, support and treatment activities through national operational plans.
- Govt will support laboratory provisions to count CD4 from five government hospitals. Future plans are in consultation with PLHIV groups. - Initiatives of STI/AIDS, Sex-workers and PLHIV networks are creating supportive environment for implementation
- Self-help group members actively participate in supporting activities for PWID, SW, etc. - Largest MSM CBO of Bangladesh is implementing the South Asia Regional HIV/AIDS Program, a multi-country programme with seven countries (Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan, Sri Lanka). The project aims to strengthen community systems.
- UN agencies, research institutes and NGOs are jointly engaging in relevant ministries and departments
- (Department of Narcotics Control/DNC and National AIDS/STD Programme/NASP) in implementing OST mainly by the involvement of DNC and NASP. Currently there are 3 OST centers running through GO-NGO collaboration.
- Participation via media and sports personalities is noted in supporting HIV issues.
- Civil society is piloting HTCs in Government health centers.
- Civil society is engaged in organizing the upcoming ICAAP conference
- Government Health Sector programme has mobilized funds through NGOs to implement prevention, care, support and treatment interventions. Save the Children and GOB are engaged in higher level advocacy for policy support
- Continued commitment of Religious Leaders

2. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?

Low					High
0	1	2	3	4	**5**

Comments and examples:

- The process had started under the leadership of the Government through Civil Society and UN facilitation, through the formation of steering committee, and task force
- In June, 2010 six working papers were drafted on situation analysis, NGO/CBO and other Civil Society Organizations, coordination and technical support, vulnerable population, PLHIV in Bangladesh, and Most at Risk Population (MARP).
- In July a series of workshops took place, through which multiple stakeholders including civil society members participated though 6 working groups for IDU, SWI, BCC and Advocacy, M&E, PLHIV, and Health System Strengthening. There was also a separate working group on finance, coordination and capacity building. Thus scaling up OST and expansion of HIV prevention services in the prison setting, inclusion of vulnerable young people, etc. issues were taken into account
- The results framework of the NSP too was finalized with participation of all stakeholders.
- Gap analysis were done among " Key Population:" with civil society (CS) representatives
- Currently, the mid-term review of the national strategic plan is ongoing. In January and February 2014 a series of meetings took place with 10 working groups comprising of NGOs, community based organizations and self-help groups; these working groups finalized 10 working papers which will be interpreted into policy briefs and used for observations and recommendations for the review of the current strategic plan.
- The results-based framework and the implementation plan will also be reviewed based on the feedback from the working groups and inputs will be taken again for finalization of all documents.

3. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:

a. The national HIV strategy?

Low					High
0	1	2	3	4	**5**

b. The national HIV budget?

Low					High
0	1	2	3	4	**5**

c. The national HIV reports?

Low					High
0	1	2	3	4	5

Comments and examples:

Major interventions are carried out by civil society, thus almost all services conducted by civil society are included in various reports and, in some cases, the reports are also prepared by civil society. Following are some examples:

- The MIS reporting system for HIV is in collaboration with the Directorate of MIS, and all implementing entities at field level are reporting into the national MIS, in the case of key population interventions. Information from the MIS is also added to the national annual health bulletin.
- The Global AIDS Response Progress Reports are always prepared through an inclusive process with civil society organizations and the technical working group on M&E and strategic information.
- The mid-term review of the progress towards the high level meeting targets was conducted in collaboration with major civil society representatives, who are implementing prevention, care, support and treatment programmes.
- The legal consultation workshop was conducted involving all civil society stakeholders and the report was prepared, bringing together all recommendations made.
- The Gender Assessment Workshop was also conducted engaging all civil society representatives and the report is currently being finalized.
- NGOs have contributed a lot in the area of National HIV Report. They provided different need based data, research data, base line data etc for preparing meaningful report. Besides these they provide case studies.

4. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. Developing the national M&E plan?

Low					High
0	1	2	3	4	**5**

b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?

Low					High
0	1	2	3	4	**5**

c. Participate in using data for decision-making?

Low					High
0	1	2	3	4	5

Comments and examples:

The technical working group on M&E and strategic information comprises of the major civil society organizations implementing HIV/AIDS programmes. It also consists of relevant Government Departments. All M&E and strategic information related matters are discussed in this group, and recommendations are made through this group for further planning and decision-making. Following are some examples:

- The GARP reporting process is initiated through engagement of the technical working group, and the same group is also required to review all information prior to submission. In addition to the technical working group, other stakeholders are also engaged, as required.
- Planning for the next size estimation was in consultation with the technical working group.
- Planning for the next round of surveillances, and ongoing surveillance, is shared with the group.
- Civil society consultations took place to finalize standardized definitions for uniform reporting.
- The roll-out of the national MIS for key population interventions was planned as per recommendations from the technical working group.
- Currently, the national PLHIV database is being structured, in consultation with relevant members of civil society.

Despite the advancements and engagement of civil society, it was voiced that there should be more involvement from civil society in different decision making processes. In addition to this, it was requested that there should be broader access to MIS data, however this needs to be carefully considered as individual organizational confidentiality issues need to be addressed. It is planned that civil society will be engaged in the preparation of elaborate MIS reports.

5. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society representation in HIV efforts inclusive of diverse organizations (e.g. organizations and networks of people living with HIV, of sex workers, community-based organizations , and faith-based organizations)?

Low					High
0	1	2	3	4	**5**

- Civil Society organizations include SHG of FSW, former and current drug users, and
- PLHIVs and CBOs of MSM and hijra. These organizations and groups are implementing HIV interventions under the Global Fund, USAID and Government, etc. funding
- PLHIV, STI/AIDS and sex workers networks in Bangladesh actively participated and reflected their views based on their experience and organizational perspectives in various forums and are also involved in advocacy to support HIV-linked interventions. They have also been engaged in post-MDG initiatives.
- Interventions to serve the undocumented mobile sex works and their clients, PLHIVs, etc. are also carried out by CS. Private drug treatment and rehabilitation centers are also run by CSO.
- A capacity enhancing initiative for CBOs of different KAPs has been undertaken under which 60
- CBOs have been identified and supported (30 with FSW, 20 with MSM and hijra and 10 with PWID). The main objective of the project is to enhance the capacity of the CBOs to enable them to contribute effectively in the scaling up of the national response. - The CCM now comprises of representatives from NGOs, key populations, PLWD, academic institutions, research organizations, faith based organizations and private sector.
- Diversified civil society agencies, including academic departments of Universities, research organizations, self-help groups, NGOs, COBs, (etc.) are engaged in organizing the ICAAP 2015.
- Civil society agencies are also leading national level advocacy functions on behalf of the NASP.
- There should be re-invigorated engagement of faith-based organizations, academic organizations and youth organizations.

6. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society able to access:

a. Adequate financial support to implement its HIV activities?

Low					High
0	1	2	3	**4**	5

b. Adequate technical support to implement its HIV activities?

Low					High
0	1	2	3	**4**	5

There are adequate funds available for civil society, especially within the Health Population Nutrition Sector Development Program (HPNSDP), however, the systems dictating mobilization of these funds are complex and only limited civil society organizations can actually access them due to inability to meet the eligibility criteria.

Civil society organizations do not have an adequate financial base to be able to fund activities for later reimbursement, which is a prerequisite to access HPNSDP funds. This system adds to the complexity of procurement processes. Accessing financial support is conducted through transparent procedures as per donor / government guidelines and recommendations – thus civil society has good opportunity in accessing such support.

Whilst the transfer of responsibilities from the Global Fund to Government is a step forward in terms of long-term sustainability, there has been a loss of traction in engaging civil societies, predominantly in community engagement activities, and continuity in other general activities.

In addition to support for activities, funding support is also available for technical assistance both national and international in the areas of capacity development, coordination and documentation. However, facilitation to mobilize and access those funds needs to be improved. On the other hand, civil society organizations need to be more proactive and organized in requesting funding, and communicating needs. For example, to access financial support civil society must deliver programmatic and financial audits, for which technical assistance is available.

Sector wide, information sharing and coordination regarding activities and fund mobilization needs to be improved. Inter-ministerial coordination and budgeting must be more consultative too.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for Key Populations				
People living with HIV	<25%	25-50%	51–75%	**>75%**
Men who have sex with men	<25%	25-50%	51–75%	**>75%**
People who inject drugs	<25%	25-50%	51–75%	**>75%**
Sex workers	<25%	25-50%	51–75%	**>75%**
Transgender people	<25%	25-50%	51–75%	**>75%**
Palliative care*	<25%	25-50%	51–75%	>75%
Testing and Counseling	<25%	25-50%	51–75%	**>75%**
Know your Rights/ Legal services	<25%	25-50%	51–75%	**>75%**
Reduction of Stigma and Discrimination	<25%	25-50%	51–75%	**>75%**
Clinical services (ART/OI)*	<25%	25-50%	51–75%	**>75%**
Home-based care	<25%	25-50%	51–75%	**>75%**
Programmes for OVC**	<25%	25-50%	51–75%	**>75%**

*Not in place

8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2013?

Low										**High**
0	1	2	3	4	5	6	7	8	9	10

***Since 2011*, what have been key achievements in this area**

- HPNSDP has mobilized funds for intervention packages including interventions among sex workers, injecting drug users (NSE and OST), MSM and Hijra. Currently efforts are ongoing to mobilize funds for migration and care and support as well. All of these interventions are being implemented through civil society. In addition to HPSNDP, the Global Fund, USAID and the Government of Netherlands' support is also rolled out through civil society. Civil Society is leading interventions among SWs, PWID, MSM, etc. to create awareness about HIV/AIDS., STI, VCT, etc and to ensure safer sex and other practices. SHG of PLHV and SHG group of FSW are leading two separate intervention packages in national-level programs.

- The national MIS report is generated from civil society implementers, whilst it is being maintained by Government.
- Civil Society is leading advocacy efforts with Government for continuing support towards marginalized groups.
- The current CCM has over 40% of representatives from civil society.
- The development and review of different guidelines, strategic papers, training modules, etc. such as the PMTCT guidelines, ART training modules, the strategic document on migration and MARA, the mid-term review of the national strategic plan have heavily engaged civil society inputs.

What challenges remain in this area:

- Capacity of civil society in terms of generating funds must be based on a plan, or be more strategic, about systematically building capacity and accessing technical assistance.
- Civil society organizations recognize that there is not a gender balance in representation.
- Civil society networks, which are composed of people who are often stigmatized and discriminated against, face significant barriers in health and advocacy arenas which are not directly related to HIV.
- Nationally undocumented mobile populations existence is not recognized thus the national level advocacy to address HIV and migration related vulnerabilities of cross border mobile population
- Despite appropriate forums and mechanisms being in place, there are still gaps and duplications in coordination of funding and priorities.

II. POLITICAL SUPPORT AND LEADERSHIP

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?

Yes	No

***IF YES*, describe some examples of when and how this has happened:**

CS members were (and are) actively involved in:

- The mid-term review of the National Strategic Plan on HIV/AIDS
- Updating / implementing the National M&E Plan
- CCM and technical subcommittee restructuring
- The people living with HIV are involved with all types of policy level activities, policy formulations, guideline preparations, etc.
- Government has taken initiative to extend care, support and treatment through HPNSDP
- Department of Narcotics Control collaborated with CS to expand OST.
- Relevant civil society agencies regularly take part in HIV/TB coordination forums and SRH coordination forums.
- Civil society organizations were represented and consulted during the National AIDS Spending Assessment (NASA) process.
- Consultations with civil society are ongoing regarding the integration of sexual and reproductive health (SRH) with HIV services.
- Civil society organizations were the drivers behind Government approval and recognition of the 3rd gender; Hijra.
- National consultations for HIV and the Law and the Gender Assessment, and the subsequent publication of the report, involved civil society organizations and inputs.
- The development and review of different guidelines, strategic papers, training modules, etc. such as the PMTCT guidelines, ART training modules, the strategic document on migration and MARA, the mid-term review of the national strategic plan have heavily engaged civil society inputs.
- Civil society was also engaged in conducting the impact assessment on interventions for PWID in Dhaka.
- Workshops were held with civil society for the Post-2015 agenda and National Social Protection Strategy (NSPS).

III. HUMAN RIGHTS

1.1 Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle yes if the policy specifies any of the following key populations:

KEY POPULATIONS AND OTHER VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	**No**
Men who have sex with men	Yes	**No**
Migrants/mobile populations	Yes	**No**
Orphans and other vulnerable children[3]	**Yes**	No
People with disabilities	**Yes**	No
People who inject drugs	Yes	**No**
Prison inmates	Yes	**No**
Sex workers	Yes	**No**
Transgender people (approved by cabinet)	**Yes**	No
Women and girls	**Yes**	No
Young women/young men	**Yes**	No
Other specific vulnerable subpopulations[4]	Yes	No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on nondiscrimination?

Yes	No

***IF YES* to Question 1.1 or 1.2, briefly describe the contents of these laws:**

- National Women's Policy was developed in 2011, which stresses non-discrimination
- Recognition of Hijra as the 3rd Gender in Government policy
- The National Social Protection Strategy, which is currently being developed, also stresses non-discrimination particularly against marginalized groups
- The National Youth Policy stresses to ensure the protection of child rights, basic human rights including social security, sexual and reproductive health rights, employment rights, and all other types of services irrespective of social status
- Constitution of Bangladesh, Women and Children Protection Law (2003) strongly mentioned non discrimination in terms of color, sex, religion
- NASP has developed 'National Harm Reduction Strategy for Drug Users 2004- 2010' that was endorsed by Ministry of Health and Family Welfare of Bangladesh
- Bangladesh has developed following policies for General Population: 'National Health Policy', 'National Population Policy' and also 'National Nutrition Policy'

Briefly explain what mechanisms are in place to ensure that these laws are implemented:

- Law Commission
- Human Rights Commission
- Legal support and rights based agencies (for example Bangladesh Legal Aid Services Trust)
- Newspapers and media playing an important role
- Regular meeting of National assembly, Meeting of Parliamentary standing committee,
- Advocacy with different Ministries and Departments, such as the Ministry of Women and Children Affairs
- Judiciary

Briefly comment to the degree which they are being implemented:

Advocacy work is continuing with different levels of Government, however, the Judiciary continues to play an important role in resolving cases of discrimination.

2. Does the country have laws, regulations or policies that present obstacles[16] to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?

Yes	No

2.1. IF YES, for which sub-populations?

KEY POPULATIONS AND OTHER VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	**No**
Men who have sex with men	**Yes**	No
Migrants/mobile populations	Yes	**No**
Orphans and other vulnerable children[3]	Yes	**No**
People with disabilities	Yes	**No**
People who inject drugs	**Yes**	No
Prison inmates	**Yes**	No
Sex workers	**Yes**	No
Transgender people	**Yes**	No
Women and girls	Yes	**No**
Young women/young men	Yes	**No**
Other specific vulnerable subpopulations[4] Specifically for under 18, the age of consent is problematic, as this prevents access to services.	**Yes**	No
Adolescents and youth	**Yes**	
Drug user	**Yes**	No
Partners of returning migrants	**Yes**	
Other *[write in]:* Adolescents and youth, Drug users, Partners of returning migrants. Other vulnerable people involved in the drug trade	**Yes**	

Briefly describe the content of these laws, regulations or policies

1. Vagrants and Shelterless Persons Act are reportedly used to discriminatorily harass and detain Female Sex Workers and MSM
2. Existing punitive laws (Section 19, 21, 25 of Narcotics Control Act, 1990) are detrimental to harm reduction programs, such as needle exchange initiatives which are not supported by law enforcers.
3. Laws that criminalise sex work by adults (eg. Sections of Human Traffic Act 2012; Penal Code, 1860; Cantonment Act, 1924; Dhaka Metropolitan Police Ordinance, 1976) are used arbitrarily to harass sex workers, including peer educators by filing false cases, etc.
4. Laws that criminalize certain sexual practices as ‘unnatural offences’.

Briefly comment on how they pose barriers

1. Vagrants and Shelterless Persons Act are reportedly used to discriminatorily harass and detain Female Sex Workers and MSM 2 Existing punitive laws (Section 19, 21, 25 of Narcotics Control Act, 1990) are detrimental to harm reduction programs, such as needle exchange initiatives which are not supported by law enforcers.
2. Lack of protective laws on People Who Inject Drugs (PWID) result in many PWID facing harassment, threat of or actual arrest due to possession of drug paraphernalia.
3. Laws that criminalise sex work by adults (eg. Sections of Human Traffic Act 2012; Penal Code, 1860; Cantonment Act, 1924; Dhaka Metropolitan Police Ordinance, 1976) are used arbitrarily to harass sex workers, including peer educators by filing false cases, etc. Obstacles within the legal system such as difficulty in securing bail, long and protracted trials, etc. mean that law becomes a medium of harassment.
4. Laws that criminalize certain sexual practices as 'unnatural offences'. Although no reported cases of prosecutions under this legal provision have been found, its continued existence contributes to a culture of silence, exclusion and marginalisation for Men Who Have Sex with Men , who may be threatened with prosecution and extortion.

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?

Yes	No

Briefly describe the content of the policy, law or regulation and the populations included.

There is no specific laws for protection of women living in HIV but law is available to protect women from any forms of violence; Women and children protection law-2003 (amendment 2007, 2011)

National action plan was developed in 2013 specifically to protect women against violence.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes	No

***IF YES*, briefly describe how human rights are mentioned in this HIV policy or strategy:**
The National Policy on HIV and AIDS has upheld human rights issue in terms of Universal Declaration of Human Rights (UDHR); media prejudices and judgments; behavioral changes; other government sectors, international agencies, public and private authorities, institutions, corporations, organizations, professional associations and other groups and individuals; research; schooling; health services; stigma and discrimination.

The NSP mentions, “A human rights approach will be adopted to maximize service access by marginalized populations and empower them to be involved in all aspects of the national response.” It also recommends the involvement of the Human Rights Commission and to consider human rights issues in all interventions alongside capacity development and advocacy in the same regard.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and other vulnerable populations?

Yes	No

***IF YES*, briefly describe this mechanism:**

- Hotline for everyone
- Implementing organizations and funding agencies require such documentation. The recording and reporting of discrimination, exploitation and harassment of the target population aids strategic decision-making and the understanding of required actions.
- Local level and higher level advocacy initiatives aim to reduce stigma, discrimination. Research has also been carried out to measure any changes through these advocacy activities.
- Sexual minority communities (MSM & TG) in Bangladesh face myriad of difficulties in accessing citizen services in general, and sexual and reproductive health services in particular. Often time they are discriminated, stigmatized and harassed by the dominant society or individual on the basis their gender identity, behaviors and sexual practices. The largest MSM CBO has established Human Right Cell (HRC) and a set of activities, ranging from human right abuse case documentation to policy advocacy. The cell is closely work with Human Right Commission of Bangladesh, UN agencies, NGOs and Media working on human rights issues.
- Flying squad: This is an inimitable idea that will explore more areas to create a supportive platform for the execution of innovative high risk interventions involving the different level of people. Scope of work as a response to crisis management is to (1) Create a supportive platform for HIV and STI prevention through social mobilization (2) To increase interaction, cooperation and strengthen collaboration among the likeminded NGOs, professional bodies and GOB (3) To share program updates and thus get a clear idea on HIV/AIDS/STI condition in implementing areas. (4) To have a detail discussion during crisis period.

6. Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle "yes" or "no" as applicable).

	Provided free-ofcharge to all people in the country		**Provided free-of-charge to some people in thecountry**		**Provided, but only at a cost**	
Antiretroviral treatment	Yes	No	Yes	No	Yes	No
HIV prevention services	Yes	No	Yes	No	Yes	No
HIV-related care and support interventions	Yes*	No	Yes	No	Yes	No

*Full hospital care is provided for care, support and treatment, but for nutritional requirements, there is only partial support (requiring partial payment by patient).

If applicable, which populations have been identified as priority, and for which services?

- PLHIV receive ART, VCT, etc. free of charge
- FSW (street, hotel and residence based), PWID, MSM, MSW, Hijra and intimate partners receive condoms, BCC, STI and abscess management and general health services, needle and syringes and health education and counseling including family planning counseling
- Some laboratory services are also free of charge via different programs and projects – eg. syphilis testing, CD4 count, screening suspected TB
- Capacity building of project staff and health service providers and advocacy also support such services for PLHIV, KAP and cross border mobile population
- KP SRH services free
- Garment factory workers and street children and key populations are receiving SRH services
- PMTCT clients
- Clients of sex workers

7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes	No

7.1. In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

Yes	No

8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?

Yes	No

***IF YES*, Briefly describe the content of this policy/strategy and the populations included:**

Key vulnerable and affected population are reached through decentralized health centers, DICs and outreach services. Social mobilization and BCC campaigns provide further support.

Key and vulnerable populations are receiving services from HTC centers, and two primary level health care centers in the Government setting also provide HTC services.

Regarding policy, the National Strategic Plan includes universal access for all populations. The country has developed national HIV/AIDS policy in 1997 which supports equal access for key affected populations.

There is no separate law for positive men and women but country has common law on equal rights

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?

Yes	No

***IF YES*, briefly explain the different types of approaches to ensure equal access for different populations:**

Different type of interventions were designed according to the actual need of specific group people. Some approaches have already been mentioned above – eg. ART centers, DIC, social mobilization, multi-media/multi-channel BCC, counseling including family planning counseling, TB screening, SRH, etc.

9. Does the country have a policy or law prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes	No

***IF YES*, briefly describe the content of the policy or law:**

The National Policy on HIV and AIDS states under, "General Guidelines for HIV Testing":

"Screening for HIV infection or other STDs will not be mandatory for travelers or migrants into or out of the country. As an HIV infected person does not necessarily affect the state of health or performance of an individual, it is not by itself grounds for refusal of employment. HIV screening will not be mandatory for those seeking employment in any public or private organisation or enterprise."

It also recommends the right for security in case of livelihood caused by employment, sickness

10. Does the country have the following human rights monitoring and enforcement mechanisms?

a. Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

Yes	No

b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

Yes	No

***IF YES* on any of the above questions, describe some examples:**
There is an independent Human Rights Commission which is protecting rights of the people include HIV positive (no separate commission for HIV positive). The main mandate of the NHRC is advocacy toward legal and policy reform.

11. In the last 2 years, have there been the following training and/or capacity-building activities:

a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)?

Yes	No

b. Programmes for members of the judiciary and law enforcement on HIV and human rights issues that may come up in the context of their work?

Yes	No

12. Are the following legal support services available in the country?

a. Legal aid systems for HIV casework

Yes	No

b. Private sector law firms or university-based centers to provide free or reduced-cost legal services to people living with HIV

Yes	No

13. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes	No

IF YES, what types of programmes?		
Programmes for health care workers	Yes	No
Programmes for the media	Yes	No
Programmes in the work place	Yes	No
Other (write in)	Yes	No

14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2013?

Low										**High**
0	1	2	3	**4**	5	6	7	8	9	10

***Since 2011,* what have been key achievements in this area:**

- Anti-discriminatory laws, not only for Hijra, but overall.
- Revision of the National Social Protection Strategy (ongoing)
- National Legal consultation and publishing of the subsequent report
- Maridpur brothel eviction has been stayed by high court
- 150 children have been enrolled in social welfare department in Sylhet
- Members of Parliament are strong advocates who led the successful campaign to recognize the third gender.
- The Law Commission and National Human Rights Commission are actively working together on non-discriminatory laws as per recommendations from the legal consultation. Both entities have mandated rights for marginalized and vulnerable groups, but key populations are not directly mentioned.
- The national AIDS policy addresses the role of media

What challenges remain in this area:

- Priority of HIV within the government institutions
- Existing discriminatory laws
- Political and administrative commitment
- Associated stigma and discrimination
- Capacity for policy advocacy, needs rewording as it's not much of a challenge now. Has been addressed
- Absence of strong policy
- Attitude and mind-set

15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2013?

Low										High
0	1	2	3	**4**	5	6	7	8	9	10

***Since 2011,* what have been key achievements in this area:**

- Law commission is also now involved, along with the Human Rights Commission
- Media involvement has strengthened
- Ministry of Law now more involved, especially legal consultation
- Policy advocacy done at the highest level of political authority, which is ongoing

What challenges remain in this area:

- Denial by law enforcers and policy makers of human rights abuses of key populations
- Changing of law/decriminalizing sex work
- Associated stigma and discrimination
- Sensitization of local administration and law enforcing agencies
- Capacity building of service providers for "Key Population friendly services"
- Absence of strong policy
- Resource limitation to continue advocacy
- Attitude and mind-set

IV. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

Yes	No

***IF YES*, how were these specific needs determined?**

- Specific needs are identified for specific target population through 'Rapid Situation and Response Assessment'
- Size estimation of Key Population
- Analysis of findings of Behavioral Surveillance Survey
- Analysis of National HIV Serological Surveillance
- Analysis of other research findings
- Baseline surveys
- Bangladesh Demographic Health Survey (BDHS)
- Different studies conducted on key affected populations and other vulnerable groups.
- Need identified for key strategies/activities for implementation through workshops, FGD etc.
- AEM and other modeling tools
- Midterm term reviews: eg. Save the Children, icddrb, NASP
- Hijra mobility survey
- SRH needs assessments among young key populations
- Gender assessment
- National strategic plan of action on HIV for migrant populations
- HIV testing guidelines
- MARA and CABA mapping and assessment
- Analysis of regular MIS reports

***IF YES*, what are these specific needs?**

- Some specific service needs for Hijra were identified such as satellite services to to access DIC services
- HIV is controlled among all key populations, however, constant monitoring is required as sometimes there are some increases noted in some areas
- FSW need MCH services
- Modeling and estimations clearly show that there is need for increased testing and detection.
- Programs for families of migrants are needed
- Among 1881 migrant workers, 32 were found to be HIV positive, so we must upgrade detection
- Children affected by AIDS (CABA) need support in livelihoods, food, education, discrimination, and treatment
- Currently there is no CABA specific strategy and interventions are negligible

- As many CABA are lost stronger tracking mechanisms need to be in place and the numbers are now known for better planning
- Among PLHIV treatment literacy less, however adherence is maintained
- Hepatitis C and TB issues need stronger intervention support, which should be based on baseline data (yet to be conducted)
- CD4 cell count is delayed due to logistic constraints and thus treatment is delayed among PLHIV
- Sailors working in the Bangladesh and India river routes need specific prevention interventions
- Sailors have reported suffering from STI and there is inadequate understanding on HIV and AIDS issues

1.1 To what extent has HIV prevention been implemented?

The majority of people in need have access to…	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**	**N/A**
Blood safety	1	**2**	3	4	N/A
Condom promotion Provided free by government are only for married couples (eligible couple)	1	2	**3**	4	N/A
Harm reduction for people who inject drugs	1	2	3	**4**	N/A
HIV prevention for out-of-school young people	1	**2**	3	4	N/A
HIV prevention in the workplace (Link Up?)	**1**	2	3	4	N/A
HIV testing and counseling	1	**2**	3	4	N/A
IEC[11] on risk reduction	1	**2**	3	4	N/A
IEC on stigma and discrimination reduction	1	**2**	3	4	N/A

Prevention of mother-to-child transmission of HIV (3 engaged, more needs to be done)	1	**2**	3	4	N/A
Prevention for people living with HIV[12]	1	2	**3**	4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	**3**	4	N/A
Risk reduction for intimate partners of key populations	1	**2**	3	4	N/A
Risk reduction for men who have sex with men	1	**2**	3	4	N/A
Risk reduction for sex workers	1	2	**3**	4	N/A
School-based HIV education for young people	1	**2**	3	4	N/A
Universal precautions in health care settings	1	**2**	3	4	N/A
Other*[write in]*:	1	2	3	4	N/A

2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2013?

Low										**High**
0	1	2	3	4	5	6	7	**8**	9	10

***Since 2011*, what have been key achievements in this area:**

- The low HIV prevalence rate among key populations are well sustained
- National level programs since 2008 and 2009 are smoothly ongoing (without interruption) for PWID, FSWs, young people, PLHIV, MSW, MSM, and Hijra through evidence based programming
- New interventions were introduced for young people, including garment factory workers, to

promote sexual and reproductive health services
- STI rate is either unchanged or decreased in certain sites
- Condom use rate has increased.
- OST has been expanded
- Asia-Pacific regional-level interventions for MSM is ongoing
- Policy makers and administrators are sensitized on HIV prevention issues

What challenges remain in this area:

- Reimbursement mechanism of the HPNSDP
- Mechanism of integration of SRH programs with existing programs, due to program design
- Case finding; testing and treating
- Continuation of fund: Some HTC interventions are phasing-out from June 2014
- Central and local level political commitments, although improved, needs to be further strengthened.
- Violence and trafficking issues
- Social stigma and discrimination
- Service overlapping in some area and low coverage in others – better mapping of services needed.

V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

Yes	No

IF YES, **Briefly identify the elements and what has been prioritized:**

- Government / NGO collaboration and transition
- An SOP on PLHIV was developed through multiple stakeholder participation. The SOP includes prevention, treatment, and nursing care (VCT, management of opportunistic infections and STIs, TB, ART, PEP, universal precaution, home-based care, family planning, PPTCT, nutrition, OVC), psychosocial support, legal and human rights support, socio-economic support, etc.
- TB/HIV collaboration
- Nutritional guidelines highlight special nutritional requirements for PLHIV
- Members day orientation is also conducted by self-help groups

Briefly identify how HIV treatment, care and support services are being scaled-up?

- PMTCT and ART procurement:

PMTCT is introduced in three tertiary hospitals (one semi-autonomous and 2 government) and ART procurement is being based on projections and demand addressing updated WHO guidelines.

1.1. To what extent have the following HIV treatment, care and support services been implemented?

The majority of people in need have access to…	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Antiretroviral therapy	1	2	**3**	4	N/A
ART for TB patients	1	2	**3**	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	**3**	4	N/A
Early infant diagnosis	1	**2**	3	4	N/A
HIV care and support in the workplace (including alternative working	**1**	2	3	4	N/A

arrangements)					
HIV testing and counselling for people with TB	1	2	**3**	4	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	1	2	3	4	**N/A**
Nutritional care	**1**	2	3	4	N/A
Paediatric AIDS treatment	1	2	**3**	4	N/A
Palliative care for children and adults	1	**2**	3	4	N/A
Post-delivery ART provision to women	1	2	**3**	4	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault) (changed? Double check)	1	2	3	**4**	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	**2**	3	4	N/A
Psychosocial support for people living with HIV and their families	1	**2**	3	4	N/A
Sexually transmitted infection management (note only syndromic)	1	2	**3**	4	N/A
TB infection control in HIV treatment and care facilities	1	2	**3**	4	N/A
*TB preventive therapy for people living with HIV	1	2	**3**	4	N/A
TB screening for people living with HIV	1	2	**3**	4	N/A
Treatment of common HIV-related infections	1	2	**3**	4	N/A
Other*[write in]*:	1	2	3	4	N/A

* INH prevention therapy has been introduced for children

1.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	**7**	8	9	10

***Since 2011*, what have been key achievements in this area:**

- Around 1000 identified PLHIVs are getting ARV through government and donor support.
- HTC guidelines and ART guidelines, and ART service monitoring guidelines are in place
- PMTCT guidelines are in place
- National ART advisory committee is now the national ART and PMTCT advisory committee
- Identified PLHIV are reached with care and support services
- Availability of fund for ART ensured
- National guideline on TB-HIV co-infection is being updated
- TB and HIV co-infection issues addressed through National TB Control Program, NASP and CS organizations working on TB treatment and prevention interventions
- Service Providers are aware of HIV treatment, care and support

What challenges remain in this area:

- Rolling out and executing a comprehensive care and support package, which should includes interventions with family members and the community.
- Training and capacity building on ART and VCT (nurses, counselors, etc.)
- Sustaining and expanding HTC services.
- The treatment, care & support costs, human resources cost and CD-4 testing cost are not in health sector program
- Political commitment
- Associated stigma and discrimination
- Continuation of fund
- Prevention of drug resistance
- Social and family support
- Coordination and integration
- Sustaining mainstreaming efforts including vertical transmission

2. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?

Yes	No

2.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

2.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No