4th National Strategic Plan

For HIV and AIDS Response

2018-2022

December 2016

National AIDS/STD Programme (NASP)

Directorate General of Health Services

Ministry of Health and Family Welfare

Foreword

Bangladesh is still considered to be a low prevalence country for HIV, but it remains extremely vulnerable given its dire poverty, overpopulation, and gender inequality, high mobility of the population in country and high level of transactional sex. Migration to other countries for employment is also very common, particularly amongst younger people.

It is recognized that HIV and AIDS is beyond the health issues; economic and social challenges for the most productive age range of the society that is infected. Although the estimated total number of HIV infections is below 10,000 the number of people belonging to key populations (sex workers, men who have sex with men and people who inject drugs) is estimated at around 300,000. Other groups at increased vulnerability of infection include especially vulnerable adolescents, migrant workers, clients of sex workers, non-injecting drug users and partners of key populations, and these groups number in the millions. A significant part of all key and vulnerable populations are adolescents and young people who often have limited knowledge about HIV/AIDS because of societal barriers.

Bangladesh has a strong political history and commitment to the HIV response. The country has a unique possibility to succeed where several other developing countries have not, to keep the HIV epidemic from expanding beyond its current level through comprehensive and strategically viable prevention measures, avoiding a gradual spread of HIV from key populations to the general population. To a significant extent, this is probably attributable to the willingness by government to acknowledge the existence of high risk groups and risk behaviours and a willingness to initiate effective interventions earlier rather than later, high quality interventions by NGOs, strong technical support from international agencies as well as local agencies and a clear strategic focus by donor agencies.

The Government of Bangladesh responded to HIV and AIDS from the first case detected in 1989, by forming the National AIDS Committee (NAC) and developing the first AIDS policy. Subsequently, several policy documents have been developed to guide the national HIV and AIDS Program interventions. The National AIDS/STD Control Programme (NASP) is one of the wings of Directorate General of Health Services (DGHS) under the Ministry of Health & Family Welfare (MOHFW) responsible for coordinating with all stakeholders and development partners involved in HIV/AIDS program activities throughout the country.

The goal of the 4th National Strategic Plan for HIV and AIDS Response is to minimize the spread of HIV and minimize the impact of AIDS on the individual, family, community, and society through enhanced prevention linked with testing, treatment, care and support, improved coordination and management, information system strengthening and research based programs.

The 4th NSP has been developed based on the synthesis of evidence and a thorough assessment with several consultations with government departments, civil society, public and private sector partners, NGOs, PLHIV networks and community based organizations. The entire process was based on local knowledge but also gave consideration to neighboring countries' programs and the overall trends of HIV in this region.

Based on the principles of the 4th NSP, the various interventions will continue to provide care, support and treatment to all key populations along with focused prevention and testing services for vulnerable populations. The 4th NSP has adopted an inclusive, participatory and widely consultative approach to ensure quality and coverage, policy and advocacy and to eliminate stigma and discrimination.

Finally, we would like to acknowledge the contribution to the organizations, the individuals and all the different members of the 4th NSP development and revision process. We are thankful to all.

Dr. Md. Anisur Rahman
Director and Line Director
National AIDS/STD Control Programme (NASP)
Directorate General of Health Services
Ministry of Health and Family Welfare

Acknowledgement

The National AIDS/STD Control Programme (NASP) is the focal point of coordination, implementation and monitoring the HIV and AIDS Programs in Bangladesh. The policies, the strategies and the frameworks in this document aim to have wider cooperation and collaboration in HIV and AIDS Responses to engage multiple sectors and we hope for the successful implementation of 4th NSP.

The NASP would like to recognize and acknowledge the different national and international organizations including bilateral organizations, UN agencies, networks and individuals who contributed their time, energy and resources to the development of the 4th National Strategic Plan for HIV and AIDS Response.

Sincere thanks go to Dr. Mohammed Nazmul Huq, Professor, Jahangirnagar University (Consultant) for his technical input in developing this document. Special thanks also go to Mr. Shaikh Masudul Alam, Save the Children in Bangladesh and Ms. Nadira Yasmin for their technical support and assistance.

Finally, NASP would like to thank UNICEF for its financial support in producing this National Strategic Plan for HIV and AIDS Response in Bangladesh and UNAIDS for providing constant technical support.

Programme Manager
National AIDS/STD Programme (NASP)
Directorate General of Health Services
Ministry of Health and Family Welfare
Government of the People's Republic of Bangladesh

Acronyms

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral treatment
BCC	Behavioural change communication
CBO	Community based organization
DGHS	Directorate General of Health Services
EVA	Especially vulnerable adolescents
FSW	Female sex worker
GBV	Gender Based Violence
GF	Global Fund
HIV	Human immunodeficiency virus
HNPSP	Health, Nutrition and Population Sector Program
HTC	HIV testing and counselling
KP	Key populations
MARA	Most at risk adolescents
M&E	Monitoring and Evaluation
MIS	Management information system
MOHFW	Ministry of Health and Family Welfare
MSM	Men who have sex with men
MSW	Male sex worker
NASP	National AIDS/STD Control Programme
NAC	National AIDS Committee
NGO	Non-governmental organization
NSEP	Needle Syringe Exchange Program
NSP	National Strategic Plan
OI	Opportunistic infection
OP	Operational Plan
PEP	Post-exposure prophylaxis
PrEP	Pre-exposure prophylaxis
PMTCT	Prevention of mother-to-child transmission
PLHIV	People living with HIV
PWID	People who inject drugs
RBF	Results-based framework
STI	Sexually transmitted infection
TC-NAC	Technical Committee of National AIDS Committee

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Executive Summary

In the recent years, there has been significant global and national contextual change, and emergence of new evidences and strategies, which have significant bearing on the HIV responses. The existing National Strategic Plan (NSP) for HIV and AIDS Response is revised and updated to adapt strategies based on the recent advances. The National Strategic Plan for HIV and AIDS Response 2018-2022 is developed in alignment with 4th Health, Nutrition and Population Sector Program (HNPSP), 2017-2022 as well as other national, regional and global commitments, mainly the 2016 Political Declaration to end AIDS by 2030.

The National AIDS/STD Program (NASP), Directorate General of Health Services (DGHS) leads the process with financial assistance from UNICEF. The technical aspect of this study was guided by a National Steering Committee formed by DGHS. The key stakeholders from DGHS, PLHIV networks, Key Population (KP) networks, UNAIDS, Save the Children and icddr,b were also involved.

The strategy framework of the strategic plan articulates several strategies under four broad program objectives. In addition, several 'fast track' approaches are set to guide the national response to HIV and AIDS to achieve the global targets on 'Ending AIDS by 2030' and treatment target of '90-90-90' by 2020 focusing on prioritized districts based on proportion of key populations and HIV case detection.

Program objective 1: To implement services to prevent new HIV infections by increasing program coverage and case detection

The first program objective emphasizes implementation of services to prevent new HIV infections among key populations (KPs), emerging populations/vulnerable groups and general population including young people. Four Strategies (1.1 - 1.4) have been developed. While Strategies 1.1 – 1.3 deal with prevention of new HIV infections by increasing program coverage and case detection, Strategy 1.4 is about increased access to HIV, STI prevention and other SRH services in national health care system throughout the country.

Based on the national epidemiological context, interventions among key populations have been attached with the highest priority. Recent program experiences also support expanded interventions among migrant workers especially international migrants and their families. In order to achieve the first program objective, several fast track approaches are identified. These include: geographical prioritization in the HIV response, provision of age specific/sensitive services for MARA, strengthen referral mechanisms and community led approaches in HIV case detection, strengthen mass media campaign, reduce stigma and discrimination and address violence against KPs. The punitive laws that hinder the implementation of the HIV prevention program should be removed.

Program objective 2: To provide universal access to treatment, care and support services for the people living with HIV

While program objective one emphasizes increased HIV case detection, objective two encompasses strategies to reduce mortality and morbidity among PLHIV through ensuring access to treatment, case and support services. Four Strategies (2.1-2.4) have been outlined in the NSP to ensure universal access to treatment, care and support to the PLHIV.

Strategy 2.1 is developed to ensure that 90 percent of the PLHIV who are in need receive ART and viral load test. Since PLHIV and KPs are spread throughout the country, Strategy 2.2 emphasize capacity development of service providers for providing out-patient and in-patient medical management of PLHIV in government, non-government and private. In order to be aligned with the rapidly developing field of HIV treatment and care, Strategy 2.3 emphasises periodical updating of relevant policy documents (e.g. National ART guideline, protocols for STI management, HTC and PMTCT). Moreover, Strategy 2.4 provides a comprehensive approach to treatment adherence, care and support for PLHIV including CABA and OVC and strengthening community support system.

In order to achieve the treatment target, several 'fast track' approaches are identified. These include: increase treatment coverage among PLHIV through effective referral mechanism, health system strengthening, functional supply chain management for drugs and provision of age/gender sensitive services. Furthermore, involving community will ensure more PLHIV to link with treatment and help in reducing the self-stigma and discrimination among them.

Program objective 3: To strengthen the coordination mechanisms and management capacity at different levels to ensure an effective national multi-sector HIV/AIDS response

Effective delivery of prevention services among KPs as well as enhanced treatment coverage among PLHIV, as described under the first and second program objectives, are the major considerations of the NSP 2018-2022. In order to provide prevention services to KPs as well as ensure universal access to treatment by the PLHIV, advocacy for enabling environment, increased capacity of human resource for enhanced response, strengthening health system response to HIV are essential and highlighted under the third program objective.

Eight strategies (3.1-3.8) have been outlined under this program objective to guide smooth management, ensure effective coordination, advocacy, health system strengthening and capacity development plans during 2018-2022.

Program objective 4: Strengthen strategic information systems and research for an evidence based response

A key principle of the National Strategy for HIV and AIDS is that decision making should be evidence based. Under this circumstance, strategic information is needed in the areas of Serological and Behavioural Surveillance; other specific assessments and relevant research; HIV case reporting; STI surveillance; Monitoring and Evaluation. Four strategies (4.1-4.4) have been outlined to ensure effective M&E and guide the national policy through generating strategic information and evidences. Improved systems for knowledge management and sharing is also emphasized through compilation of HIV case reporting data, real-time reporting system for KPs and PLHIV and dissemination of relevant information in World AIDS Day and Global AIDS Report.

This strategic plan has been developed within a results based framework (RBF). The RBF defines a list of core indicators to enable tracking of the national response to HIV and AIDS. It clearly explains the M&E process that will enable systematic collection, collation, processing, analysis, and interpretation of data as well as standardises the data sources to be collected. The framework also illustrates the linkages between program outputs, outcomes and impact under each objective and provides indicators to measure results.

A detailed costed implementation plan for 2018-2022 accompany the revised 4th National Strategic Plan for HIV and AIDS response 2018-2022. This plan provides a framework for harmonizing the efforts of all partners to ensure that low HIV prevalence is ensured and people living with HIV are provided with the best possible treatment, care and support.

1.0 Introduction

Background

The National Strategic Plan (NSP) for HIV and AIDS Response 2018-2022 is developed in alignment with 4th Health, Nutrition and Population Sector Program (HNPSP), 2017-2022 as well as other national, regional and global commitments, specially the 2016 Political Declaration to end AIDS by 2030. The strategic plan is developed with an aim to guide the national response to HIV and AIDS to achieve the global targets on 'Ending AIDS by 2030' and treatment target of '90-90-90' by 2020 focusing on prioritized districts based on proportion of key populations and HIV case detection.

In the recent years, there has been significant global and national contextual change, and emergence of new evidences and strategies, which have significant bearing on the HIV responses and thus the existing approaches need to be revisited in terms of strategic modifications and applications. In view of these circumstances it is required to revise and update the current National Strategic Plan to adapt strategies based on recent global and national contextual and innovative advances in interventions addressing HIV and AIDS. Further, it is intended to provide a framework to follow-up on progress against targets and address issues with more realistic efforts, facilitate future planning among partners from government and non-government sectors by focusing on common goals, a shared commitment to evidence-based programming and role delineation based on strategic planning.

The strategies included in this plan are formulated to guide implementation of services to prevent new HIV infections ensuring universal access to prevention services, 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 and strengthen the strategic information systems and research for an evidence-based response.

The Process

The process of developing National Strategic Plan for HIV and AIDS, 2018-2022 was led by the National AIDS/STD Program (NASP), Directorate General of Health Services (DGHS) starting in November 2016, with financial assistance from UNICEF. The technical aspect of this study was guided by a National Steering Committee formed by DGHS. A National Consultant was engaged by UNICEF to support NASP and implement the development of the NSP for HIV and AIDS. The key stakeholders from DGHS, PLHIV networks, Key Population (KP) networks, UNAIDS, Save the Children and icddr,b were also involved.

In order to support the process, ten thematic consultation group works were conducted at NASP during November 06-22, 2016. The thematic areas covered in the group consultations include: Female Sew Workers (FSW); Males having Sex with Males (MSM) including Male

Sex Workers (MSW); Hijra (TG); People Who Inject Drugs (PWID), Most at Risk Adolescent (MARA), Migration; HIV Testing and Counseling (HTC); Prevention of Mother to Child Transmission (PMTCT); Management & Coordination; Monitoring and Evaluation (M&E) and Strategic Information. The relevant members from program implementing partners and KP representatives participated in the group consultations and contributed to identify the achievements of the programs, gaps and challenges that still persist and also make necessary suggestions for future improvement of the HIV response. Based on the findings of these group consultations, ten Working Papers were developed and are annexed herewith. In addition, in-depth discussions with the key selected experts were conducted to help further guide the national strategies for HIV and AIDS response.

2.0 Epidemic Situation, Response and Challenges

2.1 HIV Epidemic in Bangladesh

Bangladesh has maintained a low national HIV prevalence in the general population[1]. According to the National Surveillance of 2015-16[2,3], a concentrated epidemic has been recorded among the male PWID in a neighbourhood of Dhaka (old Dhaka) where the prevalence was 27.3% and it was 8.9% in the rest of Dhaka. In female PWID in Dhaka the prevalence was 5%. Till now, the prevalence of HIV among FSWs, MSM, MSWs is less than 1%. No HIV was detected among male PWID in Hili (a small border town in the Northwestern part of Bangladesh bordering the Indian State of West Bengal) but of 46 Hijra sampled in Hili two were positive for HIV (4.3%) while 0.9% were positive in Dhaka. Outside of Dhaka, HIV prevalence at or above 1% was documented among male PWID in Narayanganj (1.5%); females who use drugs in Dhaka/Tongi/Narayanganj (1.2%), females who use drugs in Benapole (1.0%); and casual FSW in Hili (1.6%) in the National Surveillance of 2011[4].

Surrogate markers of risk which include hepatitis C (HCV) rates for unsafe injection and active syphilis for unsafe sex are also measured. HCV among PWID was measured in 2011 and the rates varied in different geographical areas: HCV prevalence ≥30% was detected in 10 cities including Dhaka where the rate declined significantly over the years from 66.5% in 2000 to 39.6% in 2011 ($p<0.01$). The prevalence of sexually transmitted infections (STIs) was determined through surveillance where active syphilis rates were measured and through a research study conducted in Dhaka among FSWs, female PWID, MSWs and hijra where active syphilis, gonorrhoea and chlamydia were tested for from different anatomical sites[5,6]. Surveillance data of 2015-16 show that rates were 2.6% and 2.4% in male PWID from old Dhaka and the rest of Dhaka respectively, 5.8% in female PWID in Dhaka, 0.9% in male PWID from Hili, ranging from 0-3.2% in FSWs from different sites in Dhaka , Hili and nationally from brothels. In MSW and MSM the rates around 1% in Dhaka and Hili while in hijra it was 5% in Dhaka and 0 in Hili. When different STIs were considered the overall rates of having

[1] UNAIDS and Govt. of Bangladesh. (2014). HIV Estimates with bounds: 1900-2013. National AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh.

[2] NASP. (2016). Behavioural and Serological Surveillance amongst Key Populations at Risk of HIV in Selected Areas of Bangladesh, 2016. National AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh. (unpublished)

[3] NASP. (2016). Behavioural and Serological Surveillance on males having sex with males, male sex workers and hijra, 2015. National AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh. (unpublished)

[4] NASP. (2011). National HIV Serological Surveillance, 2011. National AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh.

[5] Khanam et al. (2016). Sexually transmitted infections and associated risk factors among street based and residence based female sex workers in Dhaka, Bangladesh. Sexually Transmitted Diseases, 44(1):22-29.

[6] Khanam et al. (2015). Sexually transmitted infections among male and female sex workers, females who inject drugs and Hijra under the Global Fund project in Dhaka. icddr,b (unpublished)

any STI among FSWs from streets and residences in Dhaka were 10% and 12.5% respectively, 20.7% in MSWs, 21.3% in hijra and 7.3% in female PWID. [7,8,9,10]

The key findings from the 2015-16 BSS showed that 53.1% PWID in Dhaka shared used needle/syringes in the last week[11] compared to 60.7% during the last BSS conducted in 2006/07[12]. In 2016 fewer male PWID bought sex from FSWs in the last year since BSS of 2002 (31.2% and 57.2% respectively, $p<0.05$). More FSWs reported using condoms use with clients over the years of BSS since 2002. In 2016, consistent condom use was 39.4%, 36.9% and 42.5% in brothels, streets and hotels of Dhaka respectively. Consistent condom use by MSM also increased over the years since 2002 with 34% and 46.6% reporting this with non-transactional and transactional partners respectively in last month [13]. Similarly for MSWs and hijra in the last week this increased significantly over the years; in 2015 43.7% and 39.9% MSWs used condoms consistently while 24.8% and 22.8% hijra did so with new and regular clients respectively. The prevalence of risk behaviours of HIV positive PWID is of concern as 64.3% lent their used needles/syringes to others in the last week, 33.1% bought sex from FSWs in the last year and 30.4% were married. The low prevalence of HIV among MSM cannot be neglected because MSM in Dhaka city are highly networked[14].

The first case of HIV in Bangladesh was detected in 1989 and up until December 2016 the total number of detected cases was 4,721 of whom 799 have died, leaving 3,922 known people living with HIV[15]. About one third of detected PLHIV are women. Among the 578 new HIV cases reported in 2016, 32.9% were among women, and 5.5% were among children. However, the majority of infections are likely to remain undetected, and the total national estimate is about 9,600 PLHIV[16].

Migrants constituted about 32.7% of annual cases[17]. The risk of HIV associated with migration and mobility is related to the behaviour of individuals and not to migration itself.

[7] Khanam et al. (2016). Sexually transmitted infections and associated risk factors among street based and residence based female sex workers in Dhaka, Bangladesh. Sexually Transmitted Diseases, 44(1):22-29.
[8] Khanam et al. (2015). Sexually transmitted infections among male and female sex workers, females who inject drugs and Hijra under the Global Fund project in Dhaka. icddr,b (unpublished)
[9] NASP. (2016). Behavioural and Serological Surveillance amongst Key Populations at Risk of HIV in Selected Areas of Bangladesh, 2016. National AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh. (unpublished)
[10] Behavioural and Serological Surveillance on males having sex with males, male sex workers and hijra, 2015. National AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh. (unpublished)
[11] Behavioural and Serological Surveillance amongst Key Populations at Risk of HIV in Selected Areas of Bangladesh, 2016.(unpublished)
[12] Behavioral Surveillance Survey 2006-07, Technical Report, NASP, 2009 (page 22)
[13] Behavioural and Serological Surveillance on males having sex with males, male sex workers and hijra, 2015. (unpublished)
[14] Lisa, RDS paper in BD, 2008, page-301; 20 years of HIV, page-xvi
[15] NASP, 2016. Key Note Presentation by NASP, World AIDS Day, 2016
[16] UNAIDS, 2015. Report on the global AIDS epidemic, 2015.
[17] Case reporting data from NASP, 2016

Studies in different settings have shown that migrants practice risky behaviours while living abroad. A study in two rural areas of Bangladesh showed that commercial sex was more common among men who had gone abroad for work compared to those who remained at home. There are many reasons why migrants practice risky behaviours while abroad and understanding those factors in a given context is essential for designing effective programmes. A study conducted in Matlab among 304 returnee migrant workers showed that only one was HIV positive of the 297 returnee migrants sampled (0.3%)[18].

Although the number of infections is still low, the nation remains extremely vulnerable due to its socio-economic and cultural settings[19]. Bangladesh is one of the four countries in the region where the epidemic continues to increase[20].

2.2 Responses

National Response

Bangladesh has a long history of strong political commitment in combating HIV and a response guided by data on the epidemic. Efforts began even before the first case of HIV was detected. From the start, emphasis was given to surveillance, which would provide evidence, on which to base programme decisions.

The National AIDS Committee (NAC) was formed in 1985, four years before the first case of HIV was detected in the country. The Chief Patron of the NAC is the President of Bangladesh, and the Minister of Health and Family Welfare is the Chair. The NAC is the highest decision making body on issues related to AIDS and other sexually transmitted infections (STIs) and acts as an advisory body responsible for formulating major policies and strategies on HIV and AIDS in Bangladesh. NAC also supervises program implementation and is responsible for mobilizing resources when required. The National AIDS/STD Program (NASP) is the body established by the Ministry of Health and Family Welfare to manage and coordinate the National AIDS Programme in the country.

Bangladesh was the first country in the region to adopt a comprehensive national policy on HIV/AIDS and STIs (in 1997), and then also developed the first National Strategic Plan for HIV/AIDS, 1997-2002. This was reviewed in 2005 and the second National Strategic Plan for HIV/AIDS 2004-2010 was adopted. The third National Strategic Plan was developed by NASP in 2011 to provide a framework for the national response to HIV and AIDS up until 2015. Building upon the previous NSPs, as well as the National Policy on HIV/AIDS and STD Related Issues, revised third NSP 2011-2017 was developed in the first half of 2014. This 4th NSP 2018-2022 is developed in alignment with the 4th Health, Nutrition and Population Sector

[18] Alam M S et al. (2016). Point of care HIV testing with oral fluid among returnee migrants in a rural area of Bangladesh. Current Opinion on HIV and AIDS, 11(1):52-58.

[19] NASP. (2015). INVESTMENT CASE: Prioritizing Investment Options in HIV Response in Bangladesh to End AIDS by 2030, with financial and technical assistance from UNAIDS.

[20] UNAIDS. (2012). Report on the global AIDS epidemic, 2012.

Program, 2017-2022 as well as other national, regional and global commitments, namely the 2016 Political Declaration to End AIDS by 2030.

National Policy Environment for HIV Programs

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 prevention and control of HIV/AIDS, and ensuring that the National HIV/AIDS Strategy and national policies are implemented. Other ministries carry out HIV prevention and control activities through their core administrative structures. The Government has nominated focal points for HIV/AIDS in 16 ministries and departments.

HIV is integrated in Bangladesh's general development plans and Sector-wide approach. HIV was emphasized in the National Health Policy from 2009, and is also included in the National Social Security Strategy, 2014. The national response to HIV is being guided by a number of strategies and guidelines. These include:

- The Safe Blood Transfusion Act (2002)
- National HIV Advocacy and Communication Strategy (2005-2010)
- National STI Management Guidelines (2006)
- National Policy and Strategy for Blood Safety (2007)
- Guidelines for VCT (2008)
- National SOP for PLHIV Interventions (2009)
- The National Harm Reduction Strategy for Drug Use and HIV (2010- 2022)
- Training Manual on the reduction of stigma and discrimination related to HIV/AIDS (2010)
- HIV/AIDS stigma and discrimination toolkit (2011)
- National Anti-Retroviral Therapy Guidelines (2011)
- Revised 3rd National Strategic Plan for HIV/AIDS (Revised: 2011-2017)
- Revised National AIDS M&E Plan (2011-2017)
- National Nutrition Guideline for PLHIV (2012)
- National Consultation on Punitive Laws Hindering the AIDS Response in Bangladesh (2013)
- National Guidelines for the Prevention of Vertical Transmission of HIV and Congenital Syphilis (2013)
- National HIV Risk Reduction Strategy for Most at Risk and Especially Vulnerable Adolescents to HIV and AIDS in Bangladesh (2013-2015)
- SOP for Drop-in-Centres for IDU and FSW, and Sexual Minorities (2010 and 2012)
- Gender Assessment of the National HIV Response in Bangladesh (2014)
- Investment case for fast track strategies: Prioritizing investment options in HIV response in Bangladesh to end AIDS by 2030 (2015)
- National strategy on addressing gender based violence for HIV response in Bangladesh (2017-2022)
- National Harm Reduction Strategy for Drug Use and HIV (2017-2021)

- National Strategy on Addressing Gender Based Violence for HIV Response in Bangladesh (2017-2021)
- 4th National Strategic Plan for HIV/AIDS (2018-2022)

In addition, several manuals/modules/guidelines have been developed such as: Training of Trainers (TOT) manual for School and College teachers and facilitation guide, 2007; Training modules for Health Managers on HIV/AIDS, 2006; TOT Manual on Mainstreaming HIV/AIDS for NGOs and Five Key Ministries, 2007.

Programmatic Response

HIV prevention programs for KPs were initiated in Bangladesh in the mid-1990s and since then the services have been massively scaled up[21]. The national response to HIV/AIDS is being guided by a number of well-developed strategies and guidelines. The government, in collaboration with NGOs, development partners and self-help groups, has been instrumental in supporting various prevention, treatment, care, and support activities. Most of the intervention programs are implemented through NGOs under the leadership of NASP. These programs are designed to focus on prevention initiatives among PWID, FSW, MSM, MSW, transgender (hijras), and their intimate partners[22], increase case detection and provide treatment, care and support services to PLHIV.

Response to HIV/AIDS in Bangladesh since the year 2000

Sl. #	Programmatic Response	Year
	NASP/MOHFW and World Bank supported programs:	
1	HIV/AIDS Prevention Project (HAPP) was the first major projects under NASP which was supported by World Bank and DFID. HAPP had four major components: implementing targeted intervention among key populations (PWIDs, FSW, MSM and hijra); advocacy and communication; blood safety; and institutional strengthening and program support. HAPP was implemented through GO-NGOs collaboration with assistance from UNICEF, UNFPA and WHO. More than 100 NGOs were involved in the implementation of HAPP	2004-2007
2	HIV/AIDS Targeted Intervention (HATI) was supported by the World Bank financed Health, Nutrition and Population Sector Program. HATI focused on intervention packages for six high risk groups: PWIDs; brothel based sex workers; street based sex workers, and hotel and residence based sex workers, clients of sex workers, and MSM, MSW and hijra.	2008-2009
3	HIV/AIDS Intervention Services (HAIS) program was supported by World Bank financed Health, Nutrition and Population Sector Program (HNPSP) to implement the intervention packages for (i) brothel based sex workers, (ii) street based sex workers, (iii) hotel and residence based sex workers, (iv) clients of sex workers, MSM, MSW and hijra (v) IDUs	2009-2011
4	The HIV/AIDS Prevention Services (HAPS) program was supported by the Health, Population and Nutrition Sector Development Program (HPNSDP). It implements intervention packages for FSWs, MSW, hijra and PWIDs. The HAPS rolled out interventions among PLHIV and migrants by 2014. Funds were channeled through NASP	2011-2016

[21] Govt. of Bangladesh, 2014. Concept Note on HIV and AIDS for the Global Fund New Funding Model for 2016-2017, Sept 18, 2014.
[22] NASP, 2014. Revised 3rd National Strategic Plan for HIV and AIDS Response 2011-2017.

Sl. #	Programmatic Response	Year
5	HPNSDP funds channeled through NASP via HAPS was rolled out for interventions among PLHIV and supported evidence generating	2011-2016
6	HPNSDP will continue to allocate funds to prevention among key populations and international migrants and care, treatment and support for PLHIV with an aim to minimize the spread of HIV and the impact of AIDS on the individual, family, community, and society, so that HIV is ended in Bangladesh by 2030.	2017-2022
	Bi-lateral agency- supported projects:	
7	Bangladesh AIDS Programme (BAP) was funded by USAID and implemented through a team consisting of FHI, Social Marketing Company (SMC), JSI Bangladesh and Masjid Council for Community Advancement with the assistance of 18 implementing partners. The activities included support to interventions for key populations (PWID, sex workers, MSW, hijras and clients of sex workers), support to NGOs, faith-based organizations and groups addressing the needs of PLHIV, national serological and behavioural surveys, condom promotion, training of health providers in syndromic case management of STI, STI studies, voluntary counselling and testing centres, training of centre staff and advocacy.	2000-2009
8	Modhumita was launched as the follow on to BAP and implemented through FHI, SMC and Bangladesh Centre for Communication Programs. The project is implemented throughout the country with the support of 24 implementing agencies and other collaborating partners	2009-2014
9	Enhancing Mobile Populations' Access to HIV & AIDS Services, Information and Support (EMPHASIS) was aimed to reduce HIV vulnerability of mobile populations across the border areas of Bangladesh, India and Nepal. It focused on women and operated as a pilot intervention is Jessore and Satkhira districts. Care Bangladesh implemented the project in Bangladesh	2009-2014
10	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. In Bangladesh, the project was implemented by Marie Stopes Clinic Society, Population Council and HASAB	2013-2015
11	Over the period 2008 – 2010, the Government of Bangladesh with funding support from UNICEF piloted the first Prevention of Mother to Child Transmission of HIV (PMTCT) programme at the Jagori Clinic of the International Centre for Diarrheal Diseases and Research, Bangladesh (iccdr,b). The pilot has now been scaled up to three medical college / hospitals in Chittagong, Dhaka and Sylhet.	2008-2016
12	Integrate SRH in to HIV program: The project has been implemented by NASP with financial support from UNFPA. The major activities included: training and capacity building of the service providers on SRH and HIV, development of policy guidelines, advocacy and sensitization to the relevant stakeholders, etc.	2011- 2015
	Global Fund (GF) supported programs:	
13	GF Round 2: Prevention of HIV/AIDS among Young People in Bangladesh. Save the Children USA worked as management agency and 16 NGOs implemented the activities across the country	2004-2009
14	GF Round 6: HIV Prevention and control among High-Risk populations and vulnerable Young People in Bangladesh. The Global Fund Round 6 program was merged with Global Fund RCC Program from 2010. A total of 45 NGOs/CBOs and academic organizations through 13 consortiums implemented the activities	2007-2012
15	GF Rolling Continuation Channel (RCC) R2: Expanding HIV prevention in Bangladesh. Reduce HIV transmission among key populations in Bangladesh through increased	2010-2015

Sl. #	Programmatic Response	Year
	coverage of people who inject drugs, female sex workers, hijra and MSM; capacity building of the national response; strengthen capacity of CBOs; expanded high level advocacy for an enabling environment; and strengthening national M&E and operational research. Save the Children USA and icddr,b were the principal recipients of the fund	
16	GF's New Funding Model: Continuation of prioritized activities for the key populations in Bangladesh, with special emphasis on HIV testing and counselling. The principal recipients of the fund include: NASP, Save the Children, icddr,b	Dec 2015-Nov 2017

Sources: (a) NASP, 2014. Revised 3rd National Strategic Plan for HIV and AIDS Response 2011-2017; (b) GARPR report, 2014. (c) GARPR report, 2012. (d) UNGASS report, 2010. (e) Govt. of Bangladesh, 2014. Concept Note on HIV and AIDS for the Global Fund New Funding Model for 2016-2017, Sept 18, 2014. (f)

Several other interventions have been undertaken in Bangladesh targeting clients of sex workers, most at risk adolescents, migrant workers, pregnant mothers, children of sex workers, young people as well as young KPs who maybe/are vulnerable to HIV infections (through their high risk behavior).

UN agencies are supporting the implementation of these HIV/AIDS prevention initiatives and programs in the country which are managed by government and different local and international NGOs. 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 technical support, advocacy, orientation and education.

The scaling up of intervention programs across the country has recently been debated given funding restrictions and impact generation. It has been recognized that the epidemic in most countries is not uniformly distributed across a country[23,24,25], and that impact may be better achieved by concentrating programs in those geographical areas within a country that are more vulnerable to an epidemic. Given this realization, Bangladesh conducted a geographical prioritization exercise in 2015 which is reflected in the Investment Case of 2016[26]. The prioritization was done considering availability of numbers of key populations and numbers of PLHIV detected through case reports which revealed that 23 districts were of high priority where coverage for individual KPs would need to be scaled up to a certain target. The target for each KP was determined by modelling exercises using AEM and Spectrum.

[23] NASP. (2011). National HIV Serological Surveillance, 2011. National AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh.

[24] NASP. (2015). Behavioural and Serological Surveillance on males having sex with males, male sex workers and hijra, 2015. National AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh. (unpublished)

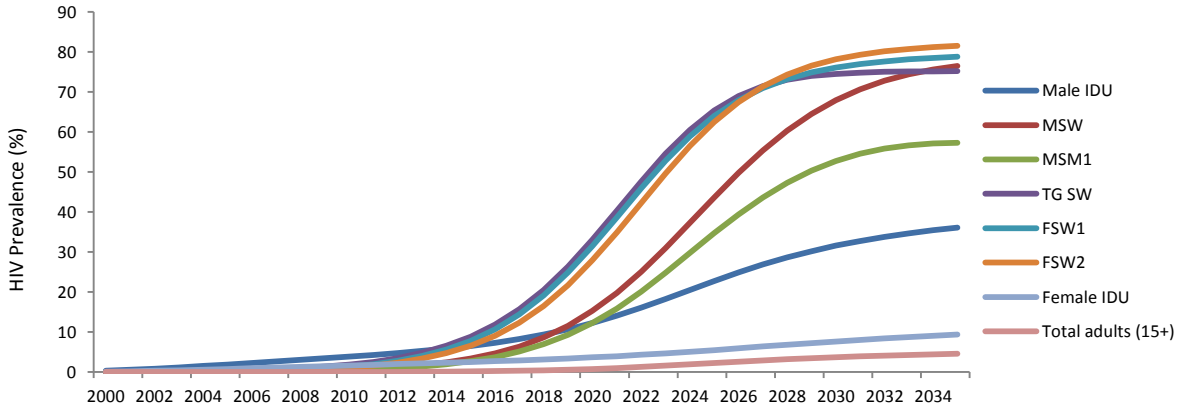
[25] NASP. (2016). Behavioural and Serological Surveillance amongst Key Populations at Risk of HIV in Selected Areas of Bangladesh, 2016. National AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh. (unpublished)

[26] NASP. (2015). INVESTMENT CASE: Prioritizing Investment Options in HIV Response in Bangladesh to End AIDS by 2030, with financial and technical assistance from UNAIDS

2.3 What we have achieved so far and potential future scenarios?

AIDS Epidemic Model (AEM) analysis demonstrates that the recent and ongoing interventions have averted 141,225 HIV infections up to 2014 and the existing interventions have saved 3,841,000 DALYs and 19,545 lives over the past years[27]. However, if these programs would have not materialized since 2000, HIV prevalence would have exceeded 20% in most KPs within the next 20 years and a generalized epidemic would have taken off.

HIV prevalence in Bangladesh if there were no interventions among KP since 2000



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 years; HIV testing and syphilis screening was initiated at the antenatal clinics of three national reference facilities and HIV prevention and treatment coverage for pregnant women has increased. The awareness building programs among young people as well as life skills education has also acted as a change agent in the lives of many young people[28]. Through the school education and upazila level advocacy program, community support was adequately boosted[29].

The AEM was also carried out to demonstrate the potential impact if current interventions were discontinued from 2018. On discontinuation from 2018, the current estimate of about 9,600 PLHIV would become 183,191 by 2030 and the HIV prevalence would rise among all the KPs across the nation with male PWID at more than 12% and FSWs, hijra, female PWID at more than 5%. It is projected that by 2030 without interventions from 2018 in Dhaka almost all KPs will have concentrated epidemics of HIV ranging from about 10% among MSWs to about 50% among male PWID. In priority districts the HIV prevalence for all KPs will go up from 2 to 10% and in the

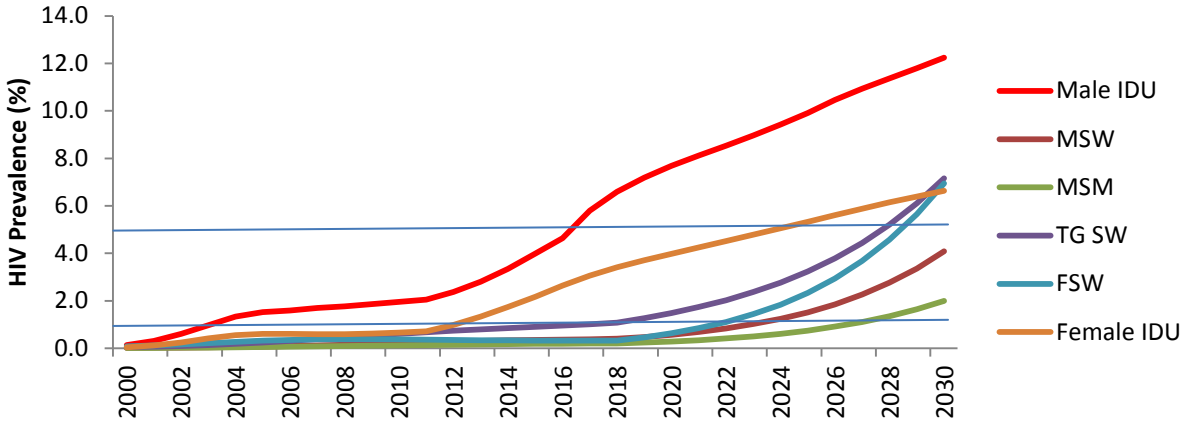
[27] Govt. of Bangladesh, 2014. Concept Note on HIV and AIDS for the Global Fund New Funding Model for 2016-2017, Sept 18, 2014.

[28] Govt. of Bangladesh, 2007. Improving access to life skills based sexual and reproductive health education and condom services for male youth, 2007. National AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh and Save the Children USA.

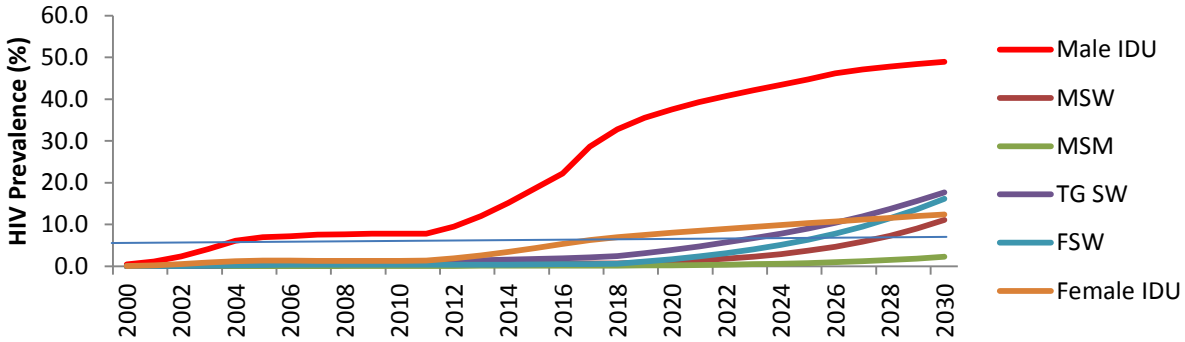
[29] Govt. of Bangladesh, 2008. Endline HIV/AIDS survey among youth in Bangladesh 2008: An assessment of HIVIAIDS related knowledge and attitudes among youth, gatekeepers, community leaders and policy makers. National AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh and Save the Children USA.

remaining districts, although the prevalence will remain within 5%, a rise will be observed in most KPs (graphs below). [30]

HIV prevalence in Bangladesh if there were no interventions among KP from 2018



HIV prevalence in Dhaka if there were no interventions among KP from 2018



2.4 Key Challenges

Although Bangladesh is considered to be a low prevalence country for HIV, it remains extremely vulnerable due to of poverty, overpopulation, gender inequality, high mobility of the population within the country and high levels of transactional sex. Migration to other countries for employment is also very common, particularly amongst younger people[31]. Stigma and discrimination against PLHIV is prevalent in Bangladesh and inhibits both the physical and mental well-being of those carrying the HIV. Stigma and discrimination against PLHIV result in many adverse consequences, such as, delay in HIV testing, the restricted adoption of preventive programs and preventative behaviors like condom use and HIV status disclosure, barriers in a normal socio-economic livelihood, etc. Despite widespread

[30] NASP and UNAIDS, 2017. Draft Report on the AIDS Epidemic Modeling (AEM). National AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh. (unpublished)

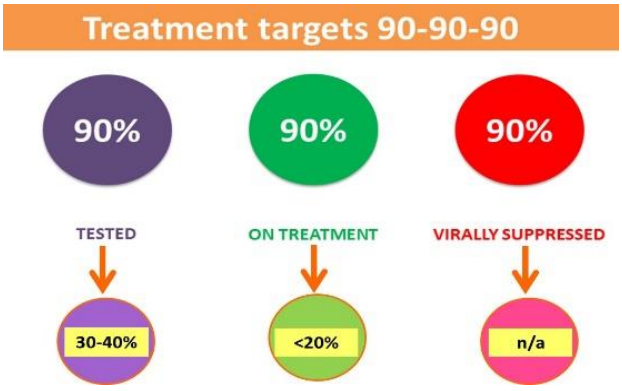
[31] Govt. of Bangladesh, 2014. Concept Note on HIV and AIDS for the Global Fund New Funding Model for 2016-2017, Sept 18, 2014.

recognition of the existence of HIV-related stigma and discrimination, there remains a critical programmatic gap within many national responses to HIV. It is essential to include some effective steps in a cohesive national program to reduce the risk of HIV transmission, to improve the lives and livelihoods of PLHIV and to help families with the issues associated with a lack of knowledge and education of HIV and AIDS in Bangladesh. The analysis of programmatic gaps and existing barriers are summarized below:

Policy and governance: Advocacy issues are considered to be a priority activity to create awareness and mobilize both political commitment and relevant sectors' support for the national response on HIV and AIDS. To facilitate uninterrupted and smooth HIV programs, effective advocacy initiatives need to be planned with key ministries, departments and sectors. Advocacy for integrating SRH with HIV, gender based violence, integrated services with MNCH, TB and hepatitis for increased case detection are also inadequate.

Laws and legal impediments: Sex work in private is legal in Bangladesh, however other aspects are criminalized, including soliciting in public, keeping a brothel or allowing premises to be used as a brothel and living on the earnings of sex work. Also, carrying information and educational material for HIV prevention may also be considered a punishable act under the current laws. These laws hinder effective HIV responses and impede FSW access to justice, especially when they experience violence[32]. A recent study conducted in 2013 found that about 39% of street based FSW faced sexual violence in the last 12 months. PWID also reported facing high levels of violence[33]. This is also true for MSM and hijra, and the legal framework in article/section 377 of the criminal code criminalizes anal sex. Policy reform and continues advocacy with law enforcing agencies to decriminalization of KPs is important to provide essential services.

Treatment, care and support: Treatment, care and support services for PLHIV have been provided through NGOs/SHGs. Until recently, ART was distributed solely through NGOs. Since the end of 2012, the government has taken responsibility for procuring ART and since 2015 started providing ARVs through selected government hospitals through collaboration with NGOs under the HPNSDP. However, problems have been encountered in providing uninterrupted services because of lack of preparedness of the facilities in delivering these services as well as lacking a standard protocol for supply chain management. Only 50% of identified PLHIV are



[32] UNDP, 2012. Sex work and the law in Asia.
[33] Save the Children. (2012). Report on Mid-term survey on expanding HIV/AIDS prevention in Bangladesh, RCC program, funded by the Global Fund. The Nielsen Company (Bangladesh) Limited.

receiving Antiretroviral Therapy (ART) [34], while the ART coverage for the total estimated PLHIV is less than 20%[35]. A comprehensive framework is yet to formulate and needs to define the role of health service delivery and community engagement to ensure treatment adherence and other care & support components for PLHIV. Effective monitoring of treatment adherence needs to be ensured to prevent HIV from multiplying as well as protect the immune system of PLHIV and reduce the risk of both drug resistance and HIV treatment failure.

Further, poor nutritional status of PLHIV speeds up progression from HIV to AIDS and may increase the incidence of AIDS related deaths. The nutritional support to PLHIV need to be integrated into the existing program.

In order to support PLHIV, they need to be involved in the existing social safety net programs. According to the National Social Security Strategy (NSSS), households with HIV affected members have similar eligibility to Social Security programmes as other households. But the Government is yet to make an effort to make its strategy more sensitive and responsive to the needs of HIV/AIDS affected people.

Access to prevention and treatment services: The coverage of the ongoing intervention programs has been reduced significantly. Only 25.4% of the female sex workers are reached by the intervention programs. The program coverage among MSM/MSW is 23.6%, for Hijra it is 39.8% and for PWID it is 34.8%. This very low coverage makes it very difficult to achieve "Ending AIDS by 2030" in the country.

Currently, it is difficult to provide treatment services including ART in timely manner due to the existing procurement process and resource availability. The test and treat modality, which is necessary for achieving treatment target would be difficult under the existing modality.

Many FSW especially those operating through hotels and residences are hidden and difficult to access mainly for reasons of stigma and discrimination[36]. For MSM the main reason behind low coverage is gaining access as they are highly stigmatized. Many MSM hide their identity and are reluctant to visit drop-in centres (DICs) and other HIV specific services. A study on hijra showed that the proximity of DICs as well as their high mobility are key factors affecting uptake of services[37]. For PWID, there are also significant service gaps when it comes to opioid substitution therapy (OST), and services for partners of PWID. Hepatitis C

[34] NASP, 2016.Program data.
[35] UNAIDS estimates 2015.
[36] Govt. of Bangladesh, 2009. Understanding the operational dynamics and possible HIV interventions for residence-based female sex workers in two divisional cities in Bangladesh. Dhaka: National AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh, Save the Children USA and icddr,b, 2008.
[37] icddr,b, 2013. Prevalence of HIV, active syphilis and risk behaviours and factors impinging on HIV prevention service uptake by hijra in Bangladesh-results from a cross-sectional study, 2013 (unpublished).

virus (HCV) is a crucial issue for PWID but currently there are no national guidelines in place to address this, program staff capacity is lacking and diagnosis and treatment is mostly absent.

Women living with HIV (including female KPs) experience barriers to access to maternal and child health services (MCH) and they often experience disproportionately high rates of unintended pregnancy and abortion. For example, a survey of FSW in Bangladesh found that 60% had an unmet need for family planning compared to 16.8% of married women ages 15–49[38]. Effectively addressing unmet contraceptive needs is a key element of preventing mother to child transmission (PMTCT) [39]. This gap stems from the inadequate linkages between SRH and HIV services.

Access to SRH services: In addition to HIV prevention services, FSW and female injecting drug users need access to sexual and reproductive health (SRH) services and child care. The MSM, MSW and Hijra also need SRH services. The KPs and PLHIVs have limited access to the existing health system for SRH services due to stigma and discrimination. Government's initiatives to Universal Health Coverage (UHC) should create enabling environment in the existing health system for providing SRH services to KPs and PLHIVs.

Access to HTC: HTC is accepted as a critical entry point for both HIV prevention and treatment services. In Bangladesh, only 29% of the estimated PLHIV were aware of their HIV status. Most PLHIV only discover their HIV positive status after already developing AIDS. In 2013, 56% of newly diagnosed PLHIV had a CD4 count below 200[40]. Among KPs, the lowest coverage with HTC is observed. Access to HTC by KPs is limited not only because of inadequate numbers of HTC centres but also because of prevailing stigma and discrimination against these groups. A recent study reveals that less than 50% of the KPs are tested for HIV in last 12 months and know the results as against of the target of 90%. HIV testing is even lower among the young KPs aged below 25 years[41].

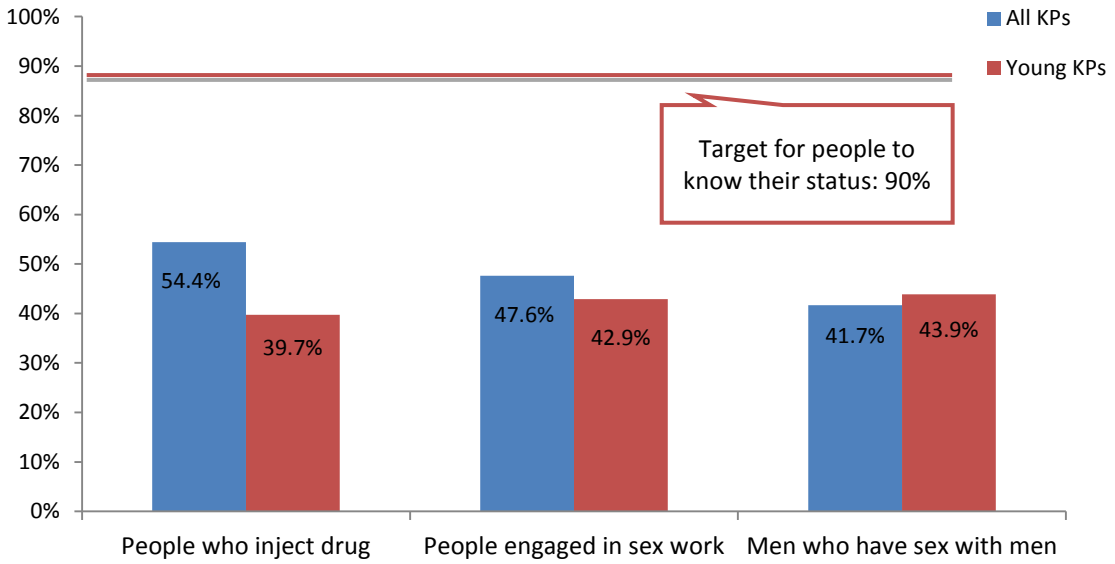
[38] Petruney T, Minichiello S N, McDowell M and Wilcher R, 2012. Meeting the contraceptive needs of key populations affected by HIV in Asia: An Unfinished Agenda. Hindawi Publishing Corporation. AIDS Research and Treatment, Volume 2012, Article ID 792649.

[39] UNFPA, 2011. Preventing HIV and unintended pregnancies: strategic framework 2011–2015.

[40] Govt. of Bangladesh, 2014. HIV case detection in Bangladesh: Summary report, 2007-2013. National AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh (unpublished).

[41] NASP, 2016. Mapping Study and Size Estimation of Key Populations in Bangladesh for HIV Programs. Dhaka, Bangladesh: Directorate General of Health Services, Ministry of Health and Family Welfare.

Percent of KPs and young KPs tested for HIV and know the result



In order to increase the case detection, community led testing and treatment approaches should be adopted. But, there is a lack of operational model for its functionality.

To respond to emerging risk and higher vulnerability: There are population groups among whom higher rates of risk behaviour or vulnerability have been clearly identified in Bangladesh or elsewhere. These groups include international migrant workers, especially vulnerable children and adolescents, prisoners, non-injecting drug users, clients of sex workers and sex partners of people from key populations. Information on and interventions for these groups are inadequate to achieve significant change. Migrants and their spouses comprise a significant portion of all detected cases, and effective interventions for this group are urgently needed.

Approximately 10 percent of men in Bangladesh reported having ever bought sex from female sex workers. 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. 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.

A mapping by the National AIDS/STD Programme (NASP) reported that there were 2,389 Children Infected and Affected by HIV and AIDS (CABA) in Bangladesh. CABA refers to children (up to 18 years) who are infected with HIV or whose parents or other caregivers are HIV-infected or have died of AIDS, even if the children themselves are not HIV positive. Amongst the CABA mapped in Bangladesh, there were 248 children orphaned due to AIDS[42].

[42] National AIDS/STD Programme (NASP), Ministry of Health and Family Welfare Bangladesh, Ashar Alo Society and UNICEF. 2013. Comprehensive Mapping of Children Infected and Affected by HIV and AIDS in Bangladesh.

Special interventions should be taken for Children Infected and Affected by HIV and AIDS (CABA) and Orphans and Vulnerable Children Affected by HIV/AIDS (OVC).

There are other groups among whom higher vulnerability is suspected but supporting evidence is not strong. They include garment workers, transport workers, refugees, displaced persons and some minority ethnic populations.

Low awareness regarding HIV and AIDS among the general population: Data on the general population show that there is widespread lack of knowledge and skills required to protect oneself and others: 30% of ever married women aged 15-49 years had never heard about HIV or AIDS, and only 11 percent have comprehensive knowledge about AIDS[43]. Low awareness regarding HIV and AIDS among the general population is of concern as it may affect behaviours of potential clients of sex workers and of those who migrate abroad for work.

[43] NIPORT, et. al. 2016. Bangladesh Demographic and Health Survey 2014. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT, Mitra and Associates, and ICF International.

3.0 National Strategic Plan 2018-2022

3.1 Guiding Principles

The principles underlying the strategy are intended to provide a framework through which HIV prevention, treatment, care and support programs will be undertaken. The principles are:

Evidence-based interventions for maximum impact
In order to achieve "Ending AIDS by 2030" in Bangladesh, it is imperative that all funding, interventions and activities are aligned with "90-90-90" targets through cost efficient tested models.

Human rights and stigma reduction
The adverse impacts of stigma and discrimination are among the key barriers to an effective response to HIV and AIDS. All international conventions and the National HIV/AIDS Policy emphasize commitment to stigma reduction. Human rights approaches reduce the vulnerabilities to the HIV/AIDS epidemic, and include various rights such as access to health care, information, confidentiality and privacy, legal rights and gender equity.

Prevention to care continuum
A keystone of the response to HIV/AIDS is the recognition and adoption of programs that address the epidemic in a holistic manner from prevention to care, treatment, and support.

Integration of services
Effective coordination and integration between different departments and relevant service provides is essential for management of co-infections such as TB, hepatitis, sexually transmitted infections (STIs) etc. Stronger integration between Sexual and Reproductive Health (SRH) and HIV and AIDS interventions lead to a number of better health outcomes and benefits.

Quality improvement and quality assurance
Quality programs are essential for generating impact as well as creating and ensuring high demand for services. Quality assurance is a continuous process and measurement of quality is therefore of utmost importance.

Community involvement and engagement
Active participation of CBOs, PLHIV and community groups and networks need to be actively engaged in the overall HIV response which will complement the efforts of the public health sector.

Public private partnership

Public-private partnership is necessary for a comprehensive and innovative HIV response.

Gender based approaches

Gender equity is a cornerstone for effective HIV responses as inequity places women and sexual minorities at higher vulnerability.

Multi-sector engagement

As HIV is not just a health issue, engagement of different sectors beyond health is necessary for ensuring an all encompassing response.

Coordinated approach

Harmonization of efforts across programs and between all partners including government and non-government sectors, implementing agencies, donors and technical agencies is fundamental to maximizing the success of this strategy.

Broad political commitment

The 2016 UN Political Declaration on Ending AIDS: on the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030, will guide in addressing the critical linkages between health, development, injustice, inequality, poverty and conflict. The UNGASS declaration 2001 states “Leadership by Governments in combating HIV and AIDS is essential and their efforts should include communities and private sector. Leadership involves personal commitment and concrete actions”.

3.2 Response Approach

The National Strategic Plan identifies priorities and describes the components of specific strategies. The strategies are specific, measurable, attainable, and relevant and time bound in order to guide a coordinated approach. The NSP 2018-2022 will have the following approaches:

- The National Strategic Plan will be used as a framework for a coordinated approach between government, implementing agencies other partners and donors across programs to scale up and improve service delivery;
- Service delivery models could consider using the management support agency approach in case of government funded interventions to gradually strengthen public services through transferring technical knowledge and support and generating ownership, and to adequately track performance based on strong monitoring;
- Geographical targeting and coverage obtained through the Investment Case will be considered for programming;
- Prevention and HTC coverage will be enhanced by ensuring community-led and integrated services are strategically planned and delivered, and that systems are in place

to address emerging challenges and improve quality of services, especially from public service delivery points;

- Evidence will be gathered regularly to monitor the epidemic and to better understand and devise novel methods to provide effective services for different population groups;
- Behaviour change communication strategies will be adapted using innovative technologies suitable for both general and key populations;
- Increased need for treatment, care and support and improved quality will be met by facilitating all relevant actors across multiple sectors, improving coordination and piloting/developing/expanding systems and providing training to service providers across government, non-government and private sectors;
- Laboratory capacity for measuring CD4 counts and viral load and for better diagnosis of OIs will be enhanced. This will be done through provision and maintenance of appropriate equipment, provision of necessary and regular supplies and reagents, ensuring proper store management and instituting quality control mechanisms. Training on all these elements will be provided. These activities will require an integrated approach as part of health systems strengthening;
- 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. Community mobilization will be ensured to address barriers to service access and build self-esteem among key populations;
- Self-help groups and networks for key populations and PLHIV will be involved in all aspects of the national strategy through capacity development in the areas of advocacy and policy development and their inclusion in decision making structures;
- Capacity to implement the national HIV plan will be strengthened through a comprehensive approach to human resource development, health system strengthening and community system strengthening; and
- Capacity of NASP will be strengthened for effective management and coordination among all stakeholders.

3.3 Strategy Framework

Goals:

To minimize the spread of HIV and the impact of AIDS on the individual, family, community, and society, working towards Ending AIDS in Bangladesh by 2030.

Specific objectives:

1. To implement services to prevent new HIV infections by increasing program coverage and case detection;
2. To provide universal access to treatment, care and support services for the people living with HIV;

3. To strengthen the coordination mechanisms and management capacity at different levels to ensure an effective national multi-sector HIV/AIDS response; and
4. To strengthen strategic information systems and research for an evidence based response.

The strategies against each objective are listed below (Section 3.3.1) and the details are provided in section 3.3.2.

3.3.1 Strategies:

Program objective 1: To implement services to prevent new HIV infections by increasing program coverage and case detection
Strategies: 1.1 HIV case detection increased and HIV and STI transmission minimized and risk behavior reduced among key populations through comprehensive targeted interventions and service provision 1.2 Increased case detection and reduction of risk behaviors and provision of services for emerging risk populations and vulnerable groups 1.3 Increased case detection and awareness raising among general population and young people 1.4 Strengthening of HIV and STI prevention and other SRH services in public health care settings and functional linkages for co-infections (e.g. TB, Hepatitis, etc.) ***Fast tracking the response:*** • Geographical prioritization in the HIV response to achieve "Ending AIDS by 2030" • Provision of age specific/sensitive services for MARA • Adoption of community led approaches in testing and treating including innovative technologies • Strengthened referral mechanisms through integrated approaches with TB, hepatitis case management systems and for linking STI and other SRH services to health systems • Community involvement for increased access to SRH and HIV prevention and care services • Quality of care ensured by offering standardized services to KPs • Reducing stigma and discrimination and addressing violence against KPs • Reaching migrants as a priority focus group for HIV prevention • Reaching Especially Vulnerable Adolescents (EVA)

Program objective 2: To provide universal access to treatment, care and support services for the people living with HIV

Strategies:

2.1 Reduce mortality and morbidity among PLHIV through early detection and treatment by system strengthening of government, non-government and private sector facilities

2.2 Ensure capacity of service providers for out-patient and in-patient medical management of PLHIV in government, non-government and private sectors

2.3 Ensure functional systems for related policy adoption, linkages and update

2.4 A comprehensive approach to community support system adopted and implemented to strengthen treatment adherence, care and support for PLHIV including CABA and OVC

Fast tracking the response:

- Link HTC to treatment through effective referral mechanism and health system strengthening, especially public health service sites
- Strengthen health system response and address co-infections with TB, hepatitis and cervical cancer
- Community involvement for treatment, care and support services and to address stigma and discrimination
- Ensure functioning supply chain management for drugs (ARVs and drugs for managing OIs) and reagents
- Provision of age specific/sensitive services
- Interventions for Children Infected and Affected by HIV and AIDS (CABA) and Orphans and Vulnerable Children Affected by HIV/AIDS (OVC)
- Ensure adherence monitoring

Program objective 3: To strengthen the coordination mechanisms and management capacity at different levels to ensure an effective national multi-sector HIV/AIDS response

Strategies:

3.1 Strengthen NAC and TC-NAC for a more functional role in guiding the national HIV response

3.2 Strengthen NASP through providing appropriate structure, human resources and other logistics

3.3 Conduct stakeholder forums to coordinate, review and discuss the HIV response across other ministries and departments and with civil society groups

3.4 Conduct advocacy activities for an enabling environment

3.5 Facilitate development and implementation of activities and plans in key sectors for strengthened collaboration on HIV prevention

3.6 Develop human resource capacity across the HIV sector for enhanced response

3.7 Strengthen the health system response to HIV

3.8 Strengthen the community system response to HIV

Fast tracking the response:

- Engage relevant departments within and outside the health sector through investment of domestic resources independent of the AIDS program
- Involve District and local level GOB officials, health service providers from public, private and NGO sector and community people

Program objective 4: To strengthen strategic information systems and research for an evidence based response

Strategies:

4.1 Conduct comprehensive surveillance to strengthen the capacity to respond
4.2 Conduct relevant research to inform the national strategic response
4.3 Strengthen monitoring and evaluation
4.4 Improve systems for knowledge management

Fast tracking the response:

- Ensure regular surveillances, size estimation of KPs and other relevant research studies in timely manner
- Strengthen STI monitoring and drug resistance monitoring
- Explore feasibility of including additional populations in surveys and surveillance
- Evaluation of design and effectiveness of current targeted interventions
- Continue and improve the use of the DHIS2 for better knowledge management and ownership

3.3.2 Details of each strategy:

Strategy 1: Prevention

Effective prevention of new infections requires tailor-made interventions for different populations at risk of HIV acquisition. For the national response, target populations have been categorized in three broad groups: (i) key populations; (ii) emerging populations and vulnerable groups; and (iii) general population and young people.

Strategy 1.1: HIV case detection increased and HIV and STI transmission minimized and risk behaviour reduced among key populations through comprehensive targeted interventions and service provision

The aim of the strategy is to scale up services for key populations and decrease their risk behaviours through improved knowledge and access to commodities for HTC, safe sex and injections. The desired outcome of these efforts is minimized transmission of HIV and STIs among all KPs.

The KPs are:

- Female sex workers; programmatically divided based on location where they sell sex: brothels (BFSW), hotel (HFSW), residence (RFSW) or street (SFSW);
- Male sex workers (MSW);
- Hijra/Transgender women;
- Males who have sex with males (MSM);
- People who inject drugs (PWID): includes both male and females.

The standard service package defined in the 4th NSP includes:

- Distribution of condoms and lubricants;
- Behaviour change communication and health education;
- STI diagnosis and treatment;
- HIV testing and counselling;
- Referral to other services (PMTCT, health services including ART, hepatitis, TB, social security, legal services etc.);
- Community engagement and empowerment.

In addition, a harm reduction package with needle and syringe distribution (core service for PWID), injection related health care and opioid substitution therapy (OST) is available for PWID.

Fast tracking the response:

Geographical prioritization in the HIV response to achieve "Ending AIDS by 2030":

Geographical prioritization was done based the numbers of cases detected through HTC, numbers of KPs and some factors related to higher vulnerability such as cross border movement. Such categorisation led to identification of 23 priority districts (shown in Annexe). Target setting for each KP in the priority and remaining districts was done through modelling exercises using AEM and has been described in the Investment Case (REF). The scenario reflected in the table below reduces new infections to less than 300 a year by 2020:

Coverage Target by 2020	FSW		MWID		FWID		MSM/hijra			ART
	H&R	Street	NSE	OST	NSE	OST	MSM	MSW	TG	
23 Priority districts	80%	80%	85%	10.5%	70%	10.5%	40%	70%	90%	90%
41 Remaining districts	23.9%	19.5%	41.8%	1.9%	22.3%	0.3%	7.6%	16.4%	24.1%	19%

The key to significantly reducing new HIV infections would be to scale up both the prevention coverage among the KPs in the priority districts, and the ART coverage among PLHIV simultaneously by using strategic approaches through PMTCT, addressing of HIV-TB

and HIV-hepatitis co-infections, focusing on migrants, implementing integrated interventions for the KPs and the clients of sex workers and informing vulnerable adolescents though the existing SRH services. Such prioritized responses will also help in achieving the targets stated in the Health, Population and Nutrition Sector Development Program.

Provision of age specific/sensitive services for MARA: Bangladesh Mapping and Size Estimation revealed 276,997 KPs in 2015 and about 13% of the total KPs are adolescents aged below 20[44]. The HIV prevention program should be designed to serve these adolescents as they are more vulnerable and pose high risk of HIV. The existing service provisions for KPs are not successful in reaching MARA. In order to reach MARA, peer volunteers from this group should be recruited and empowered. It is also important to ensure adolescent friendly service provisions by providing appropriate training to the service providers about the need of the MARA.

Adoption of community led approaches in testing and treating including innovative technologies

As of December, 2016, a total of 4,721 HIV cases have been identified, which is less than half of the total estimated number of PLHIV[45]. In order to increase case detection, new and innovative approaches e.g. HIV testing through oral fluid, quick HIV testing by peer educator/community health workers, etc. should be adopted and implemented. Arrangement should be made to cover pregnant women for HTC during ANC visits in priority districts.

Strengthened referral mechanisms through integrated approaches with TB, hepatitis case management systems and for linking STI and other SRH services to health systems

Many infections including TB, hepatitis, STIs, cervical cancer, etc affect KPs and PLHIV. KPs and PLHIV often require but do not have access to SRH services. Therefore, effective referral mechanism through integrated approaches with systems in place should be ensured and which could also lead to increased case detection. Appropriate training for the service providers would also be required.

Community involvement for increased access to SRH and HIV prevention and care services: Community led SRH and HIV prevention services should be ensured for greater acceptability and accessibility among the KPs. The peer volunteers recruited from the KPs may be empowered to facilitate required linkages and service provision. Community engagement is also key for ensuring treatment adherence with ART.

[44] NASP, 2016. Mapping Study and Size Estimation of Key Populations in Bangladesh for HIV Programs. Dhaka, Bangladesh: Directorate General of Health Services, Ministry of Health and Family Welfare.

[45] NASP, 2016. Key Note Presentation by NASP, World AIDS Day, 2016

Quality of care by offering standardized services to KPs: The minimum set of services identified to deliver under each service package should be implemented, with feasible targets for peer educators and outreach workers as per previous experience and best practice models. Additional services to meet the 90-90-90 targets must be incorporated through standardized community led models after piloting. The focus of the quality improvement efforts will be on improving adherence to clinical practice guidelines; on increasing efficiency, lowering costs, and utilizing staff and health information more efficiently; on improving client flow; and on utilizing existing infrastructures within the health sector.

Reducing stigma and discrimination and addressing violence against KPs: Gender-based violence, stigma and discrimination, certain laws, etc. are hindering the HIV-response by acting as barriers to information, control over life choices and limiting access to health services and information. Human rights, gender equality and an enabling environment are the focus of the national HIV response and strengthened advocacy on these issues will be a key priority. Effective approaches should be adopted to reduce stigma and discrimination among the KPs and service providers. Appropriate training for the service providers and mass media campaign with proper messages are needed. Violence against KPs also needs to be addressed. The violence victims should be linked with the services for legal support and health care services. Punitive laws for protecting rights of the KPs and reduction of stigma and discrimination need to be addressed.

Strategy 1.2: Increased case detection and reduction of risk behaviours and provision of services for emerging risk populations and vulnerable groups

Other than KPs, the following groups have been identified as having higher risk of and vulnerability to HIV:

- **International migrant workers** - can be divided into official and informal international migrant workers as well as cross-border migrants.
- **Especially vulnerable adolescents (EVA)** - refers to adolescents who have an elevated risk but do not belong to any key populations, and are thus not considered MARA. It includes children and adolescents who are likely to develop high risk behaviours, for example those who use (but do not inject) drugs, children of sex workers, street children and others who suffer severe social circumstances.
- **Prisoners –** high prevalence of injecting drug use, high-risk sex and unsafe health services put prisoners at elevated HIV risk.

In addition, garment and tea garden workers, refugees, internally displaced persons and minority ethnic populations may have a heightened vulnerability due to casual sex work.

In all the groups mentioned above, case detection and referral linkages must be increased through integrated efforts with TB DOTS programs, hepatitis case detection, cervical cancer programs, projects supporting NGO services, etc.

Fast tracking the response:

Reaching migrants as a priority focus group for HIV prevention: Migrants constituted about one third of annual cases in 2016, with no clear trend over time. In 2016, 189 out of 578 new cases were migration related. Both the international migrants and cross-border migrants are vulnerable to HIV due to their risk behaviours[46,47]. In addition, spouses of migrants also need attention as an increase was seen among spouses of migrants, who constituted around 10% of detected cases since 2011[48]. A study on a random rural population of returnee migrants showed that of 297 sampled returnees, one was HIV positive using oral fluid[49]. Thus innovative approaches to provide HIV prevention and HTC services are required.

Reaching EVA: According to the Bangladesh Household Census 2011[50], there are 29.44 million adolescents aged 10 – 19 yrs. (20.4% of the total population) in Bangladesh. HIV prevalence and risk behaviors among adolescents have not been measured in Bangladesh. According to BDHS 2011, about 32% of adolescent boys and girls had sex before age 15[51]. All adolescents are vulnerable because sexual risk taking and drug use is often initiated during adolescent years. The street children and the children of sex workers should get focus in EVA interventions.

Strategy 1.3: Increased case detection and awareness raising among general population and young people

The HIV testing and prevalence among the general population is very low in Bangladesh[52]. However, about 8%-11% of Bangladeshi men aged 15-49 years[53] buy sex from female sex workers, occasionally or frequently, making the distinction between "low-risk general population" and "clients of sex workers" difficult to draw. Furthermore, epidemic modelling

[46] Rana et al. (2016). Effects of in country and cross border mobility on condom use among transgender women (hijra) in Bangladesh: A cross sectional study. AIDS and Behavior: 20. Page 2165-2177

[47] Samuels et al. (2014). The effect of an HIV and AIDS project on migrants at source and destination sites in Nepal, Bangladesh and India: Findings from a quasi-experimental study. Shaping Policy for Development. Oversea Decelopment Institute, UK

[48] Govt. of Bangladesh, 2014. HIV case detection summary tables, 2007-2013. National AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh (unpublished).

49 Alam M S et al. (2016). Point of care HIV testing with oral fluid among returnee migrants in a rural area of Bangladesh. Current Opinion on HIV and AIDS, 11(1):52-58.

[50] BBS, 2011.Statistics and Informatics Division (SID), Ministry of Planning.

[51] GOB. (2011). Bangladesh Demographic and Health Survey. 2011. Ministry of Health and Family Welfare, Government of Bangladesh

[52] GOB. (2016). DHIS2. DGMIS, DGHS, Ministry of Health and Family Welfare, Government of Bangladesh

[53] NASP, 2009. Population Size Estimates for Most at Risk Populations for HIV in Bangladesh, 2009.

as well as case reporting data shows that low-risk females account for about one-third of new infections, most likely due to risky behaviours by their partner. Inclusion of the general population in the NSP is important as all people have a basic human right to be informed about HIV prevention; and accurate knowledge can influence people's perceptions. Activities aimed to increasing the knowledge among general population should include mass media campaigns through ICT, FM and Community radio and social networks; development and printing of IEC/ BCC materials and folk media as well as continued HIV education.

Strategy 1.4: Strengthening of HIV and STI prevention and other SRH services in public health care settings and functional linkages for co-infections (e.g. TB, Hepatitis, etc.)

This strategy focuses five main areas:

- HIV testing and counselling (HTC);
- Post-exposure prophylaxis (PEP);
- Pre-exposure prophylaxis (PrEP);
- Management of sexually transmitted infections (STI);
- Prevention of mother-to-child transmission (PMTCT).

Expanding HTC, adopting the test and treat modality and investigating pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) are needed. Currently, there are 128 HTC centers throughout the country, of which 18 are operated in public facilities and 110 are operated in NGO settings. For strengthening of STI service provision, guidelines need to be revised for KPs and general population. Training of service providers and sensitization to the special needs of KPs, PLHIV and young people also need to be undertaken. Complicated case management and integration of STI knowledge in behavioural change communication (BCC) strategies need to be ensured.A massive scale-up is necessary to achieve access to HIV screening during pregnancy for all women from key populations and higher vulnerability groups, and initiation of PMTCT interventions for all who need it. The issues related to co-infections with TB, hepatitis, etc. are discussed under objective 2.

Strategy 2: Treatment, Care and Support

Bangladesh is committed to achieve universal access to HIV treatment, care and support for those in need. Because of limited capacity and competing demands in the government sector, HIV services will continue to be delivered across government, non-government and private sector, but with a gradual shift towards more responsibility shouldered by the government.

The current coverage of treatment, care and support is low and less than one-fifth of the estimated PLHIV are receiving ART. This is far below the threshold set in the treatment

target of “90-90-90”. Under the circumstance, four strategies (2.1-2.4) have been outlined in the NSP to ensure universal access to treatment, care and support to the PLHIV.

Strategy 2.1: Reduce mortality and morbidity among PLHIV through early detection and treatment by system strengthening of government, non-government and private sector facilities

As of 2016 there are 1,964 registered members of PLHIV networks who receive free ART as they fulfil the national eligibility criteria: CD4<350, WHO clinical stage 3 or 4, pregnancy or co-infection with TB. The current ART coverage of HIV patients who are members of PLHIV networks is commendable, but these constitute a little over half of the known PLHIV (1,964/3,922) and only 20% of the estimated total PLHIV. Bangladesh must put a very strong focus on early case detection and treatment initiation in order to achieve the global treatment targets by 2020. In addition, barriers to treatment access must be addressed as almost half of those with detected HIV have opted out of PLHIV network membership and are thereby missing out on life-saving treatment. Currently, membership is a prerequisite for receiving ART as there are no other systems in place for monitoring and follow-up. This must be addressed either by investigating the thresholds for membership and/or provision of treatment, care and support through other channels, which would ensure strict adherence monitoring and follow up to care and support including nutritional support and the control of opportunistic infections (OIs). Treatment adherence and retention is presently not monitored but is essential for ensuring low viral loads and hence to reduce the spread of HIV. This will receive special attention.

Strategy 2.2: Ensure capacity of service providers for out-patient and in-patient medical management of PLHIV in government, non-government and private sectors

The complexity of HIV medicine requires different levels of expertise for different tasks. Given the relatively low number of infections, it is not realistic to provide specialized HIV training across the medical workforce. However, as PLHIV and KPs are spread throughout the country, services need to be geographically accessible and functional referral systems must be in place. The need for establishment of few well-equipped specialist facilities to be able to deal with treatment failures, complicated cases, OIs and paediatric infections have been identified.

The number of locations from which ART is available is currently limited to 10, of which 4 are public hospitals (including the PMTCT sites) and 6 are NGOs. But there is a need for ART access throughout the country, and thus new integrated testing and treatment centres in the government sector need to be established at least covering the priority districts. In addition to managing ART, these centres should be able to deal with a range of communicable and non-communicable co-morbidities and co-infections (particularly TB and

hepatitis), palliative care, nutrition support and inpatient care for both HIV-related and non-HIV-related complications.

To start towards achieving the three 90s Bangladesh needs to integrate testing services, adopt the test and treat modality, strengthen the monitoring mechanism to treatment adherence and ensure viral load testing is established. To achieve these strategies information through social networking, community led interventions, better procurement systems, and integrated approaches especially for case detection and viral load testing need to be either piloted and expanded or strengthened through health systems strengthening.

In Bangladesh, the mother to child transmission rate is estimated to 45.6%. ART coverage among children under 15 is 26%[54]. PMTCT services should be made available at all priority districts and districts having international border.

Strategy 2.3: Ensure functional systems for related policy adoption, linkages and update

Policies and protocols need to be updated frequently in order to be aligned with the rapidly developing field of HIV medicine. The National ART guidelines as well as protocols for STI management, HTC and PMTCT need to be updated periodically.

HIV treatment and management need to be integrated in medical curricula; an HIV treatment and management task force has not been developed although this is partly covered by the ART-PMTCT task force.

Strategy 2.4: A comprehensive approach to community support system adopted and implemented to strengthen treatment adherence, care and support for PLHIV including CABA and OVC

HIV diagnosis is a life changing event for most people and the impact often extends beyond the personal health and can affect their personal as well as social and professional life. Each individual may have different care and support needs, and an assessment against the following service areas should be undertaken for all diagnosed PLHIV:

- Psychological support;
- Social and legal support;
- Peer support;
- Financial support;
- Health education;
- Extended care arrangements for people who are ill;

[54] HIV and SRHR Linkages Infographic Snapshot Bangladesh, 2016 (Draft).

- Support for affected children.

A national protocol on care and support was developed in 2010, and should be updated in line with recent international guidelines. Training should also be arranged for selected groups on relevant and specific areas.

Fast tracking the response:

Link HTC to treatment through effective referral mechanism and health system strengthening, especially public health service sites: An effective referral mechanism needs to be established to reach maximum number of PLHIV under treatment. At the same time, it is important to sensitize the service providers for understanding the need of PLHIV and creating an enabling environment for better access. The providers should have adequate knowledge on HIV management, especially from public service sites. Moreover, laboratory facilities for monitoring of viral load and drug resistance are needed.

Strengthen health system response and address co-infections with TB, hepatitis and cervical cancer

In order to reduce the risk of co-infections with TB, hepatitis and cervical cancer, the existing health system and support services should be strengthened. Advocacy with the different departments of DGHS/MoHFW are need to address co-infections with TB, hepatitis and cervical cancer.

Community involvement for treatment, care and support services

In order to ensure treatment, care and support services among PLHIV, community engagement can play a vital role. Involving community will ensure more PLHIV to link with treatment,ensure adherence and help in reducing the self-stigma and discrimination among them.

Ensure functioning supply chain management for drugs (ARVs and drugs for managing OIs) and reagents: The uninterrupted supply of drugs need to be ensured. In order to do that, public-private partnership could be established. The local renowned drug manufacturing companies could be engaged for manufacturing of drugs at reduced cost with provision of quality assurance testing of required samples if accreditation requirements are not met.

An automated drug management system could be introduced to distribute drugs more efficiently and ensure early notification of stock out in line with the existing LMIS being used by government departments.

Capacity building of service providers and managers are needed on the ARV supply chain, ART, OI management, CD4, viral load and adherence and this may be provided in collaboration with the hepatitis program.

Provision of age specific/sensitive services: In order to enhance access to ART services by adolescent and young PLHIV, age sensitive services should be made available at the ART centers. The providers should be provided with appropriate training and skill to serve these groups. The Adolescent Friendly Health Services may be used through a collaborative process for this.

Interventions for Children Infected and Affected by HIV and AIDS (CABA) and Orphans and Vulnerable Children Affected by HIV/AIDS (OVC)

There were 2,389 CABA and 248 children were orphaned due to AIDS in Bangladesh. Many of these children suffer from various conditions including mental and physical health issues, malnutrition, social and economic deprivation, etc. because of their parent's sickness or death. They are sometimes denied health care. At the individual level internal and external stigma add to their problems.

Strengthened community sensitization efforts, social safety-net mechanisms, access to health care, etc. for ensuring the sustained well-being of the CABA and OVC are needed. More empowering efforts (e.g. leadership training, IG training, etc.) are needed for CABA, OVC, their family members and caregivers. The government initiative of community based child protection committee (CBCPC) needs to be activated.

Ensure adherence monitoring

Communities must be trained on the importance of adherence to ARVs after initiation of therapy. Systems need to be put into place that will monitor and record adherence. Reasons for failure to adhere need to be understood as this can vary for different individuals and appropriate approaches to overcome non-adherence need to be undertaken. Community members who are members of the ART Management Committees in hospitals should report regularly on issues related to adherence.

Strategy 3: Management, coordination and capacity development

Management, coordination and capacity development are the integral part of the national response to HIV. The adoption of the multi-sectoral and decentralised approaches in the coordination and management of the national response create more opportunities and ensure diverse stakeholders' involvement. With increased number of stakeholders, coordination has become increasingly complex, challenging and dynamic. The process demands innovation, clarity of roles and responsibilities linked to institutional mandates and comparative advantages.

The national response coordination and management is premised on the three ones principle - **One** agreed HIV/AIDS Action Framework that provides the basis for coordinating

the work of all partners; **One** National AIDS Coordinating Authority, with a broad based multi-sector mandate and **One** agreed country level Monitoring and Evaluation System.

Eight strategies (3.1-3.8) have been outlined in the NSP to guide smooth management and ensure effective coordination and capacity development plans during 2018-2022.

The roles of different key actors are outlined in the following table:

ORGANIZATION	FUNCTION
National AIDS Committee (NAC)	• Oversight of National Strategic Plan implementation; • Strategy Revision; • National Advocacy to Government
National AIDS Committee: Technical Committee (NAC-TC)	• Strategic guidance to NASP and other stakeholders
National AIDS/ STD Program (NASP)	• Program Management and Coordination
Technical working groups (Prevention; Treatment, care and support; Management and Coordination; Strategic Information)	• Technical advice to NASP
Other government ministries and sector agencies	• Development and implementation of sector plans
STI/AIDS Network	• Representation of implementing agencies in governance structures
Implementing agencies	• Service delivery
Representative bodies of PLHIV and target populations	• Representation of PLHIV and target populations in governance structures;
Donor agencies	• Provision of funding; • Harmonization of funding
UN agencies	• Policy advice; • Technical support; • Advocacy
Private sector	• Workplace policy; • Involvement in sector policy development and implementation; • Funding mobilization
Faith Based Organizations	• Involvement in building enabling environment; • Involvement in provision and coordination of Care and support services

Strategy 3.1: Strengthen NAC and TC-NAC for a more functional role in guiding the national HIV response

The National AIDS Committee and its technical committee should have an active guiding role in the HIV response. In order to improve effectiveness of the national response, coordinated efforts are important. The role and structure of NAC and TC-NAC need to be reviewed. The regular meetings of these committees also need to be ensured.

Strategy 3.2: Strengthen NASP through providing appropriate structure, human resources and other logistics

NASP is responsible for coordination and monitoring of the national response under the overall guidance of a Line Director (LD). In 2009-2010 the institutional structure of NASP was developed. The Operational Plan (OP) of NASP has four components, each headed by a Deputy Program Manager and supported by a Program Manager. These components correspond to the four objectives of the NSP on prevention; treatment, care and support; management, coordination and capacity development; and monitoring, evaluation and strategic information.

Equipment, logistics, utilities and supplies for the establishment and continuous support to NASP is required for its effective functioning. Seven consultants are proposed in the NASP operational plan under HNPSP 2017-2022. For smoothed operations of NASP's activities, relevant consultants for the identified areas including: Program planning and implementation; Procurement Supply Chain Management; Financial Management; Monitoring and Evaluation; Counselling and BCC; Communication and documentation; and HIV / AIDS treatment service.

The current capacity of the NASP also needs to further focus on strengthening intra and inter-ministerial collaboration; for example – further engage with CDC, NCDC, DGDNC, DGFP, etc.

Strategy 3.3: Conduct stakeholder forums to coordinate, review and discuss the HIV response across other ministries and departments and with civil society groups

Although 6-monthly meetings with donor consortium and ministry focal points have been scheduled; usually these are organized on needs basis e.g. before World AIDS Day, HTC and care & support roll out, etc. HIV issues need to be addressed in district level coordination meetings conducted regularly in all 64 districts. More structured approaches are necessary to pursue more engagement of:

- the Ministry of Home Affairs in addressing violence by the law enforcers and OST;

- the DGFP in addressing condom requirements of female sex workers and their clients and in addressing adolescent friendly and SRH services;
- the CDC to address HIV and hepatitis on common grounds;
- the NCDC to address complications related to non-communicable diseases of PLHIV;
- the hospital department to strengthen treatment services;
- the community clinics to work more intricately with community peer educators/ volunteers;
- the MNCH departments to address PMTCT, HIV and cervical cancer, needs of FSW and the partners of PWID;
- Ministry of Social Welfare and Ministry of Women and Children's Affair to link KPs and PLHIV to the NSSS; etc.

Strategy 3.4: Conduct advocacy activities for an enabling environment

The relevant policymakers and other stakeholders need to be reached through sensitization workshops on HIV/ key populations/ stigma & discrimination with an aim to reduce verbal/physical harassment or assault; discrimination against rights, laws and policies; and gender based violence (GBV), etc.

Strategy 3.5: Facilitate development and implementation of activities and plans in key sectors for strengthened collaboration on HIV prevention

HIV strategies and work plans need to be developed for relevant ministries. The OP of NASP under HPNSDP 2017-2022 has identified five other OPs (Hospital, ESD, NTP, CDC and Community Clinic) for integrating HIV activities. Several other ministries (e.g. MoI, MoHA, MoYS, MoE and MoRA) have incorporated HIV activities in their respective strategies. Further efforts need to be pursued to address the requirements outlined in Strategy 3.3.

It is required to continue support for media sensitization and mobilization; support to faith based organizations and to the private sector for work place programs. Moreover, coordination and support to the Human Rights Commission is needed to address HIV related human rights issues resulted in a *National Consultation on punitive laws hindering the HIV response*.

In addition to pursue strongly monitored implementation efforts, the HIV activities and work plan should be managed through a Management Support Agency accountable to the NASP or equivalent work plan, however with full ownership and funds being driven by the NASP or equivalent work plan.

Strategy 3.6: Develop human resource capacity across the HIV sector for enhanced response

The required number of health service providers need to be trained to provide treatment, care and support for PLHIV and their families. A capacity development plan needs to be developed in this regard for sustained and strengthened services. In addition, a human resource assessment should be done in order to review the current situation and be used as the basis for development of a comprehensive training curriculum.

Strategy 3.7: Strengthen the health system response to HIV

HIV screening of donated blood is universal in government facilities; however, no data is available from private hospitals and other non-government actors. In order to strengthen the health system response, it is essential to ensure that no stock-outs of essential drugs, reagents and commodities happen in the NSP implementation period. It is also important to establish systems for drug and essential commodity supplies.

Moreover, guidelines for laboratory services (on program level) need to be updated periodically to include updated technologies; continue HIV training for service providers on laboratory services, ATT and PMTCT ensuring appropriate training materials for ART and PMTCT.

In order to strengthen the existing health system a number of activities need to be conducted:

- Integrate HIV training into capacity development of the health system
- Provide training to service providers across the sector to address HIV specific needs
- Improve management systems and human resource capacity
- Develop protocol/guidelines for provision of laboratory services and strengthen existing laboratory capacity to meet HIV needs
- Ensure availability of appropriate equipment in districts / medical college hospital
- Develop linkages with related service areas
- Development effective referral network

Strategy 3.8: Strengthen the community system response to HIV

Strengthening of community-based organizations need to be ensured during cross-learning visits, management training and M&E training. The CBOs/self-help groups for key populations and PLHIV need to be involved in planning, budgeting, monitoring and evaluation of HIV related activities. The CBOs should also receive capacity building

assistance for ensuring expanded referral systems for treatment and care and improved leadership and accountability by these organizations.

More importantly, community led initiatives need to be piloted with government support. Government supported best practice approaches such as SMS texting for MNCH emergencies and referrals may be explored in case of HIV prevention and treatment, care and support interventions.

Fast tracking the response:

- Engage relevant departments within and outside the health sector through investment of domestic resources independent of the AIDS program
- Involve District and local level GOB officials, health service providers from public, private and NGO sector and community people

Strategy 4: Monitoring, Evaluation and Strategic Information

A key principle of the Bangladesh HIV National Strategy is that decision making should be evidence based. An entire system for strategic information needs to be put in place and information gathered, analysed and disseminated in a systematic manner so that:

- Interventions can be targeted geographically;
- Key populations (KPs) are identified and described (size estimations);
- Disease outbreaks identified;
- Changes in risk behaviours identified;
- Contributing factors identified and monitored (e.g. knowledge, attitudes, structural factors);
- Relevant cultural practices addressed (e.g. use of traditional healers);
- Health service usage monitored;
- Programs can be evaluated;
- Service delivery models and specific interventions can be evaluated, revised and scaled up;
- Assessments may be conducted among certain populations as and when needed (eg. migrants, clients of sex workers, males in general, etc.); and
- Drug resistance may be tracked (e.g. for STIs, HIV, etc.).

To address these needs comprehensive programs in strategic information are needed in the areas of Serological and Behavioural Surveillance; other specific surveys and assessments and relevant research; HIV case reporting; STI surveillance; Monitoring and Evaluation. Four strategies have been outlined in this NSP to ensure effective M&E and guide the national policy through generating strategic information and evidences.

Strategy 4.1: Conduct comprehensive surveillance to strengthen the capacity to respond

A nation-wide serological surveillance was last done in 2011, and before that in 2007. In addition, a combined Sero-and behavioural survey for MSM, MSW and hijra was undertaken in 2013-14. A comprehensive behavioural surveillance has not been done since 2006-07. However, the Mapping and Size Estimation of KPs conducted in 2015-16 includes some key behavioural indicators. STI surveillance beyond the active syphilis testing included in the HIV Sero-surveillance of key populations has not been established.

Strategy 4.2: Conduct relevant research to inform the national strategic response

In addition to the national surveillance and size estimates, other relevant research should be conducted and used to inform the national response. Areas where enhanced information generation is needed include co-infections (TB, Hep C, OIs), situation among migrants and young people, male sexual behaviour, ANC recipients, drug resistance, stigma and discrimination, etc.

Strategy 4.3: Strengthen monitoring and evaluation

The M&E plan should be updated. NASP has a functional M&E unit, and the M&E technical working group conducts regular meetings. M&E training need to be provided across the sector and M&E visits need to be undertaken for quality control. The impact assessment of Harm Reduction Interventions in Dhaka has been conducted in 2014. A comprehensive mechanism for measuring the quality and effectiveness of interventions of key populations would be highly informative for program prioritization based on impact.

Strategy 4.4: Improve systems for knowledge management

A management information system for key populations was established in 2013, and later integrated in the national health MIS. Moreover, an enhanced system for case reporting of HIV, i.e. a real-time reporting system, need to be established. The number of cases detected each year is presented on World AIDS Day and graphs showing distribution by age, gender, occupation and geographical area are usually presented as well.

The PLHIV database with basic information about all cases need to be continuously updated and can be used as a decision-making tool as well as for M&E and research purposes.

Projections and estimates need to be carried out every year and shared among the Technical Working for M&E and Strategic Information and other relevant stakeholders along with information generated for the Global AIDS Report.

NASP has been maintaining a website. All the relevant data, reports, guidelines and policy briefs are available in the website. The website needs to be regularly updated.

Fast tracking the response:

Ensure regular surveillances, size estimation of KPs and other relevant research studies in timely manner: Nationwide serological and behavioural surveillance should be undertaken on a regular basis as it is crucial for assessment of the response and guidance of future directions. It is strongly recommended to secure funding for regular serological and behavioural surveillance as these form the basis of evidence based response.

Strengthen STI monitoring and drug resistance monitoring:
Rising resistance to *Neisseria gonorrhoea* globally is a major concern. In Bangladesh eitiological diagnosis is rarely done, which results in weak monitoring of drug resistance. A similar concern exists for ARVs. To address these issues, laboratories need to be strengthened and linked to regional networks that monitor resistance.

Explore feasibility of including additional populations in surveys and surveillance: Due to the low prevalence outside key populations it may not be feasible to include emerging groups in the HIV serological surveillance due to the large sample size required. However, for behavioural and STI surveillance as well as size estimation additional groups could be included. Moreover, surveillance, size estimation of KPs and other studies should include age-specific data for better understanding of MARA.

The national HIV response should take a holistic approach on the collection, analysis, sharing and evaluation of strategic information. The current situation includes many different compositions of populations, and cross-referencing between different documents is often difficult due to this. It is not obvious which populations should be included, as there are many possible subgroups to each population, but when concordant size estimates, serological and behavioural data are consistently available for the same population groups, decision making based on evidence will become more straight-forward and reliable.

Evaluation of design and effectiveness of current targeted interventions: The quality and effectiveness of interventions must be investigated and assessed regularly in order to achieve as much impact as possible.

Continue and improve the use of the DHIS2 for better knowledge management and ownership: Data on interventions for KPs need to be entered into the DHIS2 software as part of the National Health MIS. Continuation and regular update of DHIS2 is also need to be ensured. An annual or biennial fact sheet with collated information should be developed for program review and updating.

4.0 Results Based Framework: NSP 2018-2022

Program objective 1: Implement services to prevent new HIV infections by increasing program coverage and case detection

Strategy	Indicator	Population/ unit	2014 Base-line	2015-16 Status	Data sources		2022 target
					Baseline (2014)	Status (2015-2016)	
1.1 HIV case detection increased and HIV and STI transmission minimized and risk behaviour reduced among key populations through comprehensive targeted interventions and service provision	1.1.1a HIV prevalence among key populations	FSW (Brothel, street, hotel and residence)	0.3%	0.2%	9th serosurv, 2011 (national)	Behavioural and serological surveillance amongst key populations at risk of HIV in selected areas of Bangladesh, 2016 (unpublished; in case of hotel, residence and street only Dhaka and Hili; in case of brothels-all)	<1% for FSW <1% for MSM/ MSW <5% for TG <10% for male PWID <5% for female PWID
		FSW (Street, hotel and residence)	0.4%	0.3%	9th serosurv, 2011 (national)		
		MSW	0.4%	0.6%	RCC Midline Report 2013, icddrb	Behavioural and serological surveillance on MSM, MSW and hijra, 2015: (unpublished, represents Dhaka and Hilli)	
		Hijra	1.0%	1.4%			
		MSM	0.4%	0.2%			
		Male PWID	1.0%	4.6%	9th serosurv, 2011 (national)	Draft Report on the AEM, 2017, reference year 2016	
		Female PWID	1.1%	2.6%			
	1.1.1b HIV prevalence among key populations: Dhaka	FSW (Street, hotel and residence)	0.4%	0.3%	9th serosurv, 2011 (national)	Behavioural and serological surveillance amongst key populations at risk of HIV in selected areas of Bangladesh, 2016 (unpublished)	<1% for FSW <1% for MSM/ MSW <5% for TG <40% for Male PWID in Dhaka <15% for Female PWID in Dhaka
		MSW	0.6%	0.7%	RCC Midline Report 2013, icddrb	Behavioural and serological surveillance on MSM, MSW and hijra, 2015: (unpublished)	
		Hijra	0.5%	0.9%			
		MSM	0.7%	0.3%			
		Male PWID	5.3%	22%	9th serosurv, 2011 (national)	Behavioural and serological surveillance amongst key populations at risk of HIV in selected areas of Bangladesh, 2016 (unpublished)	
		Female PWID	1.2%	5.0%	9th serosurv, 2011 (national)		
	1.1.2 Prevalence of active syphilis among key populations	FSW (Brothel, street, hotel and residence)	--	2.2%	--	Behavioural and serological surveillance amongst key populations at risk of HIV in selected areas of Bangladesh, 2016 (unpublished; in case of hotel, residence and street only Dhaka and Hili; in case of brothels-	<5%
		FSW (Street, hotel and residence)	3.8%	1.4%	9th serosurv, 2011 (national)		<5%

Strategy	Indicator	Population/ unit	2014 Base-line	2015-16 Status	Data sources		2022 target
					Baseline (2014)	Status (2015-2016)	
						all)	
		MSW	2.4%	1.0%	RCC Midline Report 2013, icddrb (Dhaka only)	Behavioural and serological surveillance on MSM, MSW and hijra, 2015: (unpublished, represents Dhaka and Hilli)	<5%
		Hijra	2.8%	1.8%			<5%
		MSM	1.2%	1.1%			<5%
		Male PWID	2.5%	2.4%	9th serosurv, 2011 (national)	Behavioural and serological surveillance amongst key populations at risk of HIV in selected areas of Bangladesh, 2016 (unpublished, represents Dhaka and Hili for male PWID and for female PWID, Dhaka and Narayanganj)	<5%
		Female PWID	4.2%	5.8%			<10%
	1.1.3a Percentage of key populations reporting condom use at their most recent sexual intercourse (with clients for FSW, MSW, hijra; anal sex with male partners for MSM)	FSW	75.1%	73.7%	SC MTR, 2012 *adjusted*	Mapping Study & Size Estimation of Key Populations in Bangladesh, 2015	80%
		MSW	--	53.6%	--		60%
		Hijra	--	58.3%			65%
		MSM	--	45.8%			55%
		Male PWID	38.5%	32.8%	SC MTR, 2012 *adjusted*		50%
		Female PWID	--	64.2%	-		70%
	1.1.3b Percentage of key populations reporting condom use at their most recent sexual intercourse (with clients for FSW, MSW, hijra; anal sex with male partners for MSM): Dhaka	FSW (Street and hotel)	62.5%	78.7%	Behavioural surveillance and survey (BSS) 2006-2007	Behavioural and serological surveillance amongst key populations at risk of HIV in selected areas of Bangladesh, 2016 (unpublished)	80%
		MSW	54.7%	53.5%	RCC Midline Report 2013, icddrb	Behavioural and serological surveillance on MSM, MSW and hijra, 2015: (unpublished)	60%
		Hijra	45.3%	43.2%			50%
		MSM	49.1%	54.0%			60%
		Male PWID	39.7%	28.7%	Behavioural surveillance and survey (BSS) 2006-2007	Behavioural and serological surveillance amongst key populations at risk of HIV in selected areas of Bangladesh, 2016 (unpublished)	40%
		Female PWID	50.0%	--	FIDU study, icddrb 2006	--	60%
	1.1.4a Percentage of PWID reporting	Male PWID	74.3%	83.9%	SC MTR, 2012 *adjusted*	Mapping Study & Size Estimation of Key	85%

Strategy	Indicator	Population/ unit	2014 Base-line	2015-16 Status	Data sources		2022 target
					Baseline (2014)	Status (2015-2016)	
	use of sterile injecting equipement the last time they injected	Female PWID	--	83.6%	--	Populations in Bangladesh, 2015	85%
	1.1.4b Percentage of PWID reporting use of sterile injecting equipement the last time they injected: Dhaka	Male PWID	--	47.6%	--	Behavioural and serological surveillance amongst key populations at risk of HIV in selected areas of Bangladesh, 2016 (unpublished)	60%
		Female PWID	73.8%	87.1%	FIDU study, icddrb 2006	Mapping Study & Size Estimation of Key Populations in Bangladesh, 2015	85% (maintenance level)
	1.1.5 Percentage of key populations reached with core services (condoms, BCC, NSEP) in the past year *(2022 targets are set considering 40-90% coverage of 23 priority districts where high impact is needed and 50% of existing coverage in remaining districts and then rounded)*	FSW (80% in 23 priority districts)	56.9%	25.4%	Program data	Program data	65%
		MSW & MSM (40% for MSM and 70% for MSW in 23 priority districts)	47.3%, 19.5%	23.6%			65%, 35%
		Hijra (90% in 23 priority districts)	83.3%	39.8%			75%
		Male PWID (85% in 23 priority districts)	84.0%	34.8%			75%
		Female PWID (70% in 23 priority districts)	44.7%				65%
	1.1.6 Percentage of key populations who received an HIV test in the past 12 months and know their results *(2022 targets will be 90% of the targets set in 1.1.5)*	FSW	7.4%	17.8%	HMIS	Program data	58.5%
		MSW & MSM	9.9%, 0.6%	20.5%			58.5%, 31.5%
		Hijra	16.6%	39.8%			67.5%
		Male PWID	11.8%	24.3%			67.5%
		Female PWID	23.5%				58.5%
	1.1.7 Percent of PWID on opioid substitution therapy (OST) *(2022 targets are set considering 10.5% coverage of 23 priority districts and this will be*	Male and female PWID	2.4%	1.9%	Program data	Program data	10.5%

Strategy	Indicator	Population/ unit	2014 Base-line	2015-16 Status	Data sources		2022 target
					Baseline (2014)	Status (2015-2016)	
	considered as the national target)						
1.2 Increased case detection and reduction of risk behaviours and provision of services for emerging risk populations and vulnerable groups	1.2.1 Percentage of migrant workers who received an HIV test in the past 12 months and know the result[55]	Inter-national migrants (departing)	--	3.0%	--	Point of care HIV testing with oral fluid among returnee migrants in a rural area of Bangladesh. icddr,b 2015.	20%
		Cross-border migrants	--	--	--	--	20%
1.3 Increased case detection and awareness raising among general population and young people	1.3.1 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	Males	32.1%	--	Assessment of sexual behavior of men in Bangladesh, a methodological experiment (Male Reproductive Health Survey, 2006) FHI, icddr,b	--	50%
1.4 Strengthening of HIV and STI prevention and other SRH services in public health care settings and functional linkages for co-infections	1.4.1 Number of public health and NGO facilities that provide HIV testing and counselling services	Public health or NGO facitlities	101 (3 were public and 98 were private/ NGO set ups)	128 (18 were public and 110 were private/ NGO set ups)	Program data	Program data	162 (23 will be public and 27 will be NGO set up under the Sector Program; estimated 112 centers to provide HTC for KPs preliminariy with the GF support)
	1.4.2 Number of people voluntarily counselled and tested for HIV who received their test results	Number of people tested	28,961	83,356	HMIS	Wolrd AIDS Day Report	150,000-200,000 per year
	1.4.3 Percentage of pregnant women who received an HIV test and know the result	Pregnant women	0.014% N= 729[56]	0.2% N= 12,208[57]	Program data Projected number of pregnancies	Program data Projected number of pregnancies	10%

[55]GAMCA does testing, but no counselling. No records kept.

[56]729 of the total estimated 5.3 million pregnant women

[57]12,208 of the total estimated 4.9 million pregnant women (The State of Midwifery, 2014, A Universal Pathway. A Woman's Right to Health. Country Brief: Bangladesh, Table: Projected number of pregnancies by year (till 2030), Page 59. UNFPA, International Confedaratoin of Midwives, WHO.)

Strategy	Indicator	Population/ unit	2014 Base-line	2015-16 Status	Data sources		2022 target
					Baseline (2014)	Status (2015-2016)	
	1.4.4 Number and percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	Pregnant PLHIV	13.0% N=18[58]	14.2% N=21[59]	Spectrum estimates and program data, 2013	Spectrum estimates and program data, 2013	50%
	1.4.5 Percentage of infants born to HIV infected mothers (under PMTCT program) who are infected	Infants	0%[60]	0%[61]	Program data and Spectrum estimates	Program data and Spectrum estimates	<5%
	1.4.6 Percentage of PLHIV and members of key populations who avoid going to hospitals when required due to stigma and discrimination	PLHIV	16.8%		Stigma Index report, 2009		10%
		FSW	--				15%
		MSW	--				15%
		Hijra	--				20%
		MSM	--				20%
		Male PWID	--				20%
		Female PWID	--				20%

Program objective 2: Provide universal access to treatment, care and support services for the people living with HIV

Strategy	Indicator	Population/ unit	2014 Base-line	2015-16 Status	Data source		2022 target
					Baseline	2016	
2.1 Reduce the mortality and morbidity among PLHIV through earlier detection and initiation of treatment and care including nutritional support	2.1.1 Percentage of eligible adults and children currently receiving antiretroviral therapy	Adult PLHIV (≥15 years)	18.9%	29.8%	ART patient registers and Spectrum estimates	ART patient registers and Spectrum estimates	81%
		Children PLHIV (<15 years)	32.7%	41.9%			81%
	2.1.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Adult PLHIV (≥15 years)	86.3%	79.4%	ART patient registers	ART patient registers	95%
		Children PLHIV (<15 years)	92.9%	90%			100%
	2.1.3 Percentage of viral load testing conducted among those on ART	PLHIV	0	15% (n=958)	Program data	Program data	90%

[58]The denominator is an estimate of the total number of pregnant PLHIV in Bangladesh (138 in 2013)
[59]The denominator is an estimate of the total number of pregnant PLHIV in Bangladesh (148 in 2015)
[60]Estimate of new child infections for the whole country: 35.5% (N=49/138)
[61]Estimate of new child infections for the whole country: 38.5% (N=57/148)

Strategy	Indicator	Population/ unit	2014 Base-line	2015-16 Status	Data source		2022 target
					Baseline	2016	
	2.1.4 Percent of PLHIV viraly suppresed	PLHIV	-	-	-	-	73%
2.2 Services provided for the out-patient and in-patient medical management of PLHIV in government, non-government and private sectors	2.2.1 Number of locations from which HIV ART is available	Number of locations	11[62]	10[63]	Program data	Program data	30 (23 GOB in priotity districts + 7 NGO)
	2.2.2 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	# of PLHIV who received TB treatment and ART in accordance with the treatment protocol	68	74	Program data	Program data	70%
		Estimated # of incident TB cases in PLHIV	240	630	Global TB Report 2013; Annual TB Report 2014-SEARO	Global TB Report 2016	
2.3 Systems established for ongoing policy development/revision and capacity development and communication	2.3.1 Review of policies and protocols conducted	Number of updated protocols	2 ART and PMTCT	3 Adv/ Comm, GBV and Harm Reduc-tion	Program data	Program data	8 (HTC , STI, ART, Opera-tional Guideline for Care and Support and 3 KP groups, National HIV Policy)
2.4 A comprehensive approach to care and support adopted and implemented for PLHIV including CABA and OVC	2.4.1 Percentage of identified PLHIV who receive care and support	PLHIV	42%[64]	55.8%[65]	Program data	Program data	90%

Program objective 3: Strengthen the coordination mechanisms and management capacity at different levels to ensure an effective national multi-sector HIV/AIDS response

Strategy	Indicator	Popu-lation/ unit	2014 Base-line	2015-16 Status	Data sources		2022 target
					Baseline	2016	
3.1 Strengthen NAC and TC-NAC for a more functional role in guiding the national HIV	3.1.1 Overall directions and guidelines for the national response compiled annually by NAC and shared with relevant stakeholders	Guidance note/ report	--	--	--	--	1 per year

[62]Three public hospitals with PMTCT services and 8 NGO centres (AAS 3, CAAP 1, MAB 3, Hope Care Centre 1)
[63]Four public hospitals (3 with PMTCT services) and 6 NGO centres (AAS 3, CAAP 1, MAB 1, Hope Care Centre 1)
[64]In 2013, 1150 out of 2769 identified PLHIV received care and support
[65]In 2016, 1948 out of 3485 identified PLHIV received care and support

Strategy	Indicator	Popu-lation/ unit	2014 Base-line	2015-16 Status	Data sources		2022 target
					Baseline	2016	
response							
3.2 Strengthen NASC through providing appropriate structure, human resources and other logistics	3.2.1 Four sub-units established & functional: 1. Prevention, treatment, care and support 2. Management, research and M&E	Sub-units	2 M&E and program	4	Approved OP	Approved OP	2
3.3 Conduct stakeholder forums to coordinate, review and discuss the HIV response across other ministries and departments and with civil society groups	3.3.1 Number of stakeholder coordination and / or sensitization meetings at the national level where HIV/ key populations/ stigma & discrimination was discussed	Stake-holder meetings	1 per year	2 per year	Program data	Program data	1 per year
	3.3.2 Number of district level coordination and / or sensitization meetings held where HIV/ key populations/ stigma & discrimination was discussed	Coordi-nation meetings	8	15	Meeting minutes & attendence sheet	Meeting minutes & attendence sheet	128 (2 per district)
3.4 Conduct advocacy activities for an enabling environment	3.4.2 Percentage of PLHIV reporting verbal/physical harassment or assault	PLHIV	24.4%	--	Stigma Index Report, 2009	Stigma Index Report, 2017	15%
	3.4.3 Percentage of PLHIV discriminated against regarding rights, laws and policies	PLHIV	11.3% (fear of verbal insult, harass-ment and threat)	--	Stigma Index Report, 2009	Stigma Index Report, 2017	10%
	3.4.4 Proportion of ever-married or partnered women aged 15-49 years who experienced physical or sexual violence from a male intimate partner in the past 12 months	GBV cases	67.2%	26.9%	Report on Violence Against Women Survey, 2011; Bangladesh Bureau of Statistics (BBS), Statistics and Informatics Division (SID), Ministry of Planning, Government of Bangladesh	Report on Violence Against Women Survey, 2015; BBS, SID, Ministry of Planning, Government of Bangladesh; Page no-22, Table-4.4.1	25%

Strategy	Indicator	Popu-lation/ unit	2014 Base-line	2015-16 Status	Data sources		2022 target
					Baseline	2016	
3.5 Facilitate development and implementation of activities and plans in key sectors and engage management support agency for strengthened transfer of technical and monitoring experience	3.5.1 Number of Ministries and Departments with HIV activities incorporated in and implemented through various strategies	Ministries	5 (MOI, MOHA, MOYS, MOE, MORA)	5	MOHFW, MOI, MOHA, MOYS, MOE, MORA	Relevant Ministries	16 (MOHFW, MOI, MOHA, MOYS, MOE, MORA, MOEWOE, etc. and departments)
3.6 Develop human resource capacity across the HIV sector for enhanced response	3.6.1 Number of health service providers trained to provide care and support for PLHIV and their families	Service providers	500	75	Program data	Program data	6,000
3.7 Strengthen the supply management system for HIV response	3.7.1 Number of stock out situations in a year of essential drugs and commodities as reported at central store level	ARVs	1	1	Program data	Program data	0
		Needles / Syringes	0	0			0
		Condoms	1	0			0
		Other (reagents, etc.)	0	1			0
3.8 Strengthen the community system response to HIV	3.8.1 Numberof CBOs that deliver services for prevention, care or treatment and have a functional referral and feedback system in place	CBOs	PLHIV-4 (AAS, MAB, Jeon Health Founda-tion, Ashar Prodip)	PLHIV-5 (AAS, MAB, Jeon Health Founda-tion, Ashar Prodip, NJ)	Program data	Program data	PLHIV-3
	3.8.2 Numberof CBOs that deliver services for prevention among KPs and have a functional referral system for treatment, care and support in place	CBOs	FSW-11 brothels and 18 street and hotel PWID-2 MSM/MSW/TG- 22	FSW-11 brothels and 18 street and hotel PWID-1 MSM/MSW/TG- 27	Program data	Program data	FSW-29 PWID-2 MSM/MSW/TG- 27

Program objective 4: Strengthen strategic information systems and research for an evidence based response

Strategy	Indicator	Popu-lation/ unit	2014 Base-line	2015-16 Status	Data sources		2022 target
					Baseline	2016	
4.1 Conduct comprehensive surveillance to strengthen the	4.1.1 Regular serological and behavioural surveys of key populations conducted	Serological survey	1	3	NASP, 2011	NASP: focus: Dhaka: 1 for MSM/MSW/TG; 1 for FSW and	2

Strategy	Indicator	Popu-lation/ unit	2014 Base-line	2015-16 Status	Data sources		2022 target
					Baseline	2016	
capacity to respond						PWID icddr,b: PWID POC	
		Behavioural survey	1	1	NASP, 2006-07	NASP (as part of size estimation)	1
4.2 Conduct relevant research to inform the national strategic response	4.2.1 Number of coordination meetings held on research agenda	Meetings	3	3	Meeting minutes of M&E and SI TWG meetings	Meeting minutes of M&E and SI TWG meetings	2 per year
	4.2.2 Conduct relevant research including STI surviellance, stigma index among PLHIV and size estinations of key populations	STI surviellance survey	--	--	--	--	1
		Mapping and Size estimation	1	1	2009 Size Estimation, NASP	NASP	1
		CABA study	1	--	NASP and UNICEF	--	1
		Stigma Index	1	--	2009 Stigma Index, PLHIV Network	--	1
		Operation research/ studies based on emerging needs	--	--	--	--	3
4.3 Strengthen monitoring and evaluation	4.3.1 Monitoring and evaluation plan revised and updated	M&E plan	1	--	Program data	--	1
	4.3.2 Studies to support evaluation	# of studies					5 (mid & end terms, NASA, projections / estimates, etc.)
4.4 Improve systems for knowledge management	4.4.1 Management Infomation System in place, maintained and improved for prevention interventions among KPs	MIS	Done	Maintain ed	NASP and HMIS[66]	--	Main-tained, updated and report-able
	4.4.2 PLHIV database developed and functional	Database	Not done	Almost done	NASP and DG-MIS	NASP and DG-MIS	Main-tained, updated and report-able
	4.4.3 National HIV website is maintained and acts as an inventory of all relevant resources	Website	Partially done[67]	Func-tional	NASP	NASP	Main-tained and updated

[66] MIS was established for KP in 2013 and integrated in the national health MIS that is to be updated regularly.
[67] NASP website is being renovated and restructured (responsibility shifted from SC to NASP). Documents for uploading are being collected

5.0 Costed Implementation Plan of National Strategic Plan 2018 - 2022

Summary Budget	in USD						in BDT
	2018	**2019**	**2020**	**2021**	**2022**	**Total (USD)**	**Total (BDT)**
Programme objective 1: To implement services to prevent new HIV infections by increasing program coverage and case detection							
Strategy 1.1: HIV case detection increased and HIV and STI transmission minimized and risk behaviour reduced among key populations through comprehensive targeted interventions and service provision	29,283,523	31,296,621	33,451,543	35,758,468	38,228,315	168,018,470	12,937,422,227
Strategy 1.2: Increased case detection and reduction of risk behaviours and provision of services for emerging risk populations and vulnerable groups	9,520,084	8,929,118	10,026,353	10,620,554	11,251,431	50,347,539	3,876,760,498
Strategy 1.3: Increased case detection and awareness raising among general population and young people	2,170,790	2,279,329	2,444,760	2,512,961	2,638,609	12,046,449	927,576,564

Summary Budget	in USD						in BDT
	2018	**2019**	**2020**	**2021**	**2022**	**Total (USD)**	**Total (BDT)**
Strategy 1.4: Strengthening of HIV and STI prevention and other SRH services in public health care settings and functional linkages for co-infections (e.g. TB, Hepatitis, etc.)	2,833,080	4,435,958	5,109,984	5,626,443	5,907,765	23,913,230	1,841,318,734
Total	**43,807,477**	**46,941,027**	**51,032,640**	**54,518,425**	**58,026,120**	**254,325,689**	**19,583,078,022**
Program objective 2: To provide universal access to treatment, care and support services for the people living with HIV							
Strategy 2.1: Reduce mortality and morbidity among PLHIV through early detection and treatment by system strengthening of government, non-government and private sector facilities	2,949,796	3,548,974	4,065,188	4,624,151	4,930,057	20,118,165	1,549,098,742
Strategy 2.2:Ensure capacity of service providers for out-patient and in-patient medical management of PLHIV in government, non-government and private sectors	1,759,703	1,847,688	1,940,073	2,037,076	2,138,930	9,723,471	748,707,235

Summary Budget	in USD						in BDT
	2018	**2019**	**2020**	**2021**	**2022**	**Total (USD)**	**Total (BDT)**
Strategy 2.3: Ensure functional systems for related policy adoption, linkages and update	10,384	56,699	11,449	12,021	12,622	103,176	7,944,525
Strategy 2.4: A comprehensive approach to community support system adopted and implemented to strengthen treatment adherence, care and support for PLHIV including CABA and OVC	917,453	2,111,035	1,000,599	1,070,953	1,148,262	6,248,302	481,119,287
Total	**5,637,337**	**7,564,396**	**7,017,308**	**7,744,202**	**8,229,871**	**36,193,114**	**2,786,869,789**
Program objective 3: To strengthen the coordination mechanisms and management capacity at different levels to ensure an effective national multi-sector HIV/AIDS response							
Strategy 3.1: Strengthen NAC and TC-NAC for a more functional role in guiding the national HIV response	11,871	12,465	13,088	13,743	14,430	65,597	5,050,989
Strategy 3.2: Strengthen NASP through providing appropriate structure, human resources and other logistics	449,293	481,058	515,108	551,611	590,745	2,587,814	199,261,664

Summary Budget	in USD						in BDT
	2018	2019	2020	2021	2022	Total (USD)	Total (BDT)
Strategy 3.3: Conduct stakeholder forums to coordinate, review and discuss the HIV response across other ministries and departments and with civil society groups	180,487	82,690	241,451	91,165	219,383	815,176	62,768,524
Strategy 3.4: Conduct advocacy activities for an enabling environment	818,724	859,661	902,644	947,776	995,165	4,523,969	348,345,614
Strategy 3.5: Facilitate development and implementation of activities and plans in key sectors for strengthened collaboration on HIV prevention	454,638	874,533	501,239	526,300	552,616	2,909,325	224,018,041
Strategy 3.6: Develop human resource capacity across the HIV sector for enhanced response	-	388,404	-	-	-	388,404	29,907,117
Strategy 3.7: Strengthen the health system response to HIV	2,396,675	2,467,494	2,590,868	1,027,964	532,385	9,015,386	694,184,737
Strategy 3.8: Strengthen the community system response to HIV	214,202	186,194	195,503	247,966	215,542	1,059,407	81,574,334

Summary Budget	in USD						in BDT
	2018	**2019**	**2020**	**2021**	**2022**	**Total (USD)**	**Total (BDT)**
Total	**4,525,891**	**5,352,497**	**4,959,901**	**3,406,525**	**3,120,264**	**21,365,078**	**1,645,111,021**
Program objective 4: To strengthen strategic information systems and research for an evidence based response							
Strategy 4.1: Conduct comprehensive surveillance to strengthen the capacity to respond	800,742	1,574,383	951,751	978,599	25,212	4,330,687	333,462,918
Strategy 4.2: Conduct relevant research to inform the national strategic response	5,650	1,160,882	6,229	632,847	6,868	1,812,477	139,560,718
Strategy 4.3: Strengthen monitoring and evaluation	141,910	317,346	823,252	349,874	968,103	2,600,485	200,237,351
Strategy 4.4: Improve systems for knowledge management	162,271	211,142	143,073	150,226	197,242	863,954	66,524,491
Total	**1,110,574**	**3,263,754**	**1,924,305**	**2,111,546**	**1,197,424**	**9,607,604**	**739,785,479**
GRAND TOTAL	**55,081,279**	**63,121,674**	**64,934,154**	**67,780,699**	**70,573,679**	**321,491,485**	**24,754,844,310**