UNGASS COUNTRY PROGRESS REPORT

Bangladesh

Reporting period: January 2008–December 2009

Prepared by

National **A**IDS/**S**TD **P**rogramme **(NASP)**

Ministry **of H**ealth and **F**amily **W**elfare **(MoHFW)**

Government of the People's Republic of Bangladesh

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I.CONTENTS

ACRONYMS AND ABBREVIATIONS

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

TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	The United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
UPHCP	Urban Primary Health Care project
VCCT	Voluntary and confidential counselling and testing
WB	World Bank
WHO	World Health Organization

II.STATUS AT A GLANCE:

1. THE INCLUSIVENESS OF THE STAKEHOLDERS IN THE REPORT WRITING PROCESS:

National STD/AIDS Programme (NASP) of the Ministry of Health and Family Welfare, Government of Bangladesh, provided coordination and leadership support to the process of preparation of UNGASS 2010 Bangladesh Country report. Report preparation was a joint effort of key stakeholders from government, civil society organizations (particularly organizations working on HIV prevention and care), UN agencies and other development partners. There were several consultations, one on one and in groups, to involve all national key stakeholders in the process of UNGASS report preparation.

In November 2009, a consultative workshop on "Road map to develop UNGASS country report-2010" was held in Dhaka, involving all stakeholder groups to discuss the UNGASS reporting process and to seek the expected cooperation and inputs to complete the report. During this workshop, in a spirit of partnership and inclusion, a course of action for preparation of the report was drawn up. Following were some of the key processes that were followed.

- The National Consultant and the responsible officer for UNGASS reporting from National AIDS and STD Programme attended the UNGASS Report Writers Workshop, a regional meeting to orient the UNGASS writes, organized by TSF-SA in Nepal.
- In January 2010, NCPI data was gathered through a Consultation with representatives of key stakeholder groups, who also provided information on other key sections of this report, including access to relevant research reports
- Interview with individual key informants to collect data on NCPI
- A review meeting on "UNGASS indicators" was held on 1st March at NASP where the Line Director, Program Manager, DPM (M&E), other DPMs, M&E specialist, MARP specialist and financial personnel were present. The UNAIDS Country Coordinator and the national consultant also participated in the meeting.
- The report and data was uploaded in early March on the UNGASS website and was made available for public viewing and review.
- After the initial compilation of data, a validation workshop was organized with PLHIV organizations to verify the data related to VCT, care and support and PPTCT for both UNGASS as well as Universal Access indicator reporting.
- The remaining indicator data sources (such as BSS, HSS, Life Skill Education etc) were verified in a separate meeting with the M&E Technical Working Group (TWG) on 14 March 2010 who provided feedback on the performance of these indicators.
- The report was finalized after gaining consensus from all key stakeholders during a consultation held on 15th March 2010.

2. THE STATUS OF THE EPIDEMIC

The prevalence of HIV in Bangladesh is less than 0.1% in the general population[1] and the estimated number of HIV positive cases in the country is around 7500[2]. The prevalence rate among the MARPs - sex workers (both female and male), male who have sex with male (MSM) and transgender (Hijra)) is below 1% with the exception of Injecting Drug Users (IDUs) which is just above 1% (1.6%)

According to the latest HSS (Round 8, 2007) of Bangladesh, the HIV prevalence among Female Sex Workers, MSW and Hijras was 0.3%. Although HIV prevalence was below 1% in all female sex worker sites, in Hili (a small border town in the northwest part of Bangladesh), prevalence was as high as 2.7% among the casual sex workers[3], all of whom had crossed the border into India to sell sex. In the MSM community the prevalence was reported much low (0% for only MSM in Dhaka and 0.3% in combined MSM and MSW sample in Chittagong). Several surveillance rounds as well as a study conducted in Dhaka using Respondent Driven Sampling (RDS) method[4] in 2006 established very low prevalence of HIV in MSM, along with low rates of active syphilis. Large proportions of MSM and MSW, however, report STI symptoms (MSW more than MSM), as well as multiple sex partners (including women), group sex (often associated with violence and without condoms) and very low condom use with all types of partners. MSMs are highly networked, so if HIV were to emerge, it could spread very rapidly in this population, if prevention efforts are not adequately scaled up[5].

The most recent HSS (Round 8) conducted, in 2007, tested 6,508 drug users (IDU, heroin smokers and the combined group of IDU and heroin smokers) from 28 different cities of Bangladesh. IDUs were sampled from 21 and the combined group of IDU and heroin smokers from seven cities. Overall HIV prevalence was 1.2%, with low rates found in drug users from five cities. However, a rate of 7% was reported in Dhaka (11% in one neighbourhood of Dhaka), where the largest concentration of IDUs is found (7,400 of the estimated 20,000–40,000 IDUs in Bangladesh)[6]. The HSS data over the years is revealing a concentrated epidemic emerging in Bangladesh focusing on the IDUs. There is increasing evidence of a pattern emerging in the country which is - explosive escalation of the epidemic among the IDUs and then spreading into other population sub groups.

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

[2] NASP/ MoHFW, 2004

[3] Those who were selling sex either in the street, residence or hotel during the previous month and had either one or more main sources of income.

[4] It is a method that employed social networks to recruit the sample

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

[6] Ibid (An abbreviation of the Latin ibidem, meaning "in the same place; in the same book; on the same page.")

3. THE POLICY AND PROGRAMMATIC RESPONSE

Even before the first case of HIV was detected in 1989, the Government of Bangladesh (GoB) responded to the HIV epidemic by forming the National AIDS Committee (NAC), way back in 1985. This high-level advisory body has the President as Chief Patron and is chaired by the Minister of Health and Family Welfare. The NAC is responsible for formulating major policies and strategies, supervising program implementation and mobilizing resources. A NAC Technical Committee (TC-NAC) of experts provides technical advice to the NAC and National AIDS/STD Programme (NASP).

The NASP, within the Directorate General of Health Services of the Ministry of Health and Family Welfare (MOHFW), is the main government body responsible for overseeing and coordinating HIV prevention efforts in the country. NASP ensures effective and efficient implementation of the National HIV/AIDS Strategy and national policies. Other ministries carry out HIV prevention and control activities through their core administrative structures. Some of the key ministries that have been involved in the programme are: Finance, Religious Affairs, Home Affairs, Information and Broadcasting, Women and Children Affairs, Youth and Sports, Labour and Manpower, Education, Social Welfare, Posts and Telegraph, and Expatriates Welfare and Overseas Employment. The Government has nominated focal points for HIV/AIDS in 16 ministries and departments, who have been trained on issues related to HIV and HIV response. Key roles of the focal points are to identify best practices for collaboration, develop collaboration mechanisms, and rationalize the roles and responsibilities of the key ministries for prevention and care of HIV.

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

- The Safe Blood Transfusion Act (passed in 2002)
- The National Harm Reduction Strategy for Drug Use and HIV, 2004-2010
- National HIV Advocacy and Communication Strategy 2005-10
- National Anti Retroviral Therapy Guidelines, 2006
- National STI Management Guidelines, 2006
- National Policy and Strategy for Blood Safety, 2007
- Guidelines for VCT
- National Standards for Youth Friendly Health Services (YFHS) 2007
- Standard Operating Procedures for Services to People Living with HIV and AIDS, 2009

Programmatic Response: After extensive consultation and involvement of ministries, NGOs, the private sector and the affected community, the Second National Strategic Plan for HIV-AIDS, 2004-2010 was adopted, with a strong focus on its first strategic objective: to provide support and services for priority groups (those with the highest HIV prevalence and risk). The four other objectives are: 1) to prevent vulnerability to HIV infection; 2) promote safe practices in the health care system; 3) provide care and treatment services to people living with HIV (PLHIV); and 4) minimize the impact of the epidemic. Subsequently, in order to address gaps and to elaborate further on the Second National Strategic Plan, NASP, with the assistance of UNAIDS, developed the 'National AIDS Monitoring and Evaluation Framework and Operational Plan' in 2007.

Currently there are three major HIV programmes being implemented in Bangladesh:

1. **The HIV/AIDS Targeted Intervention (HATI) 2008-2009** supported by World Bank financed Health, Nutrition and Population Sector Program (HNPSP). HATI focuses on intervention packages for six high risk groups: IDUs, brothel based sex workers, street based sex workers, hotel and residence based sex workers, clients of sex workers, and MSM, MSW and *hijra*.

2. **The Bangladesh AIDS Programme (BAP) 2005-2009:** This programme **i**s funded by USAID with about 14 million USD, and implemented through a team comprising FHI, Social Marketing Company (SMC), John Snow Inc Bangladesh (JSI Bangladesh) and Masjid Council for Community Advancement (MACCA), with the support of 18 implementing agencies and numerous collaborating partners. BAP is focused on providing prevention services among the MARPs. BAP ended in October 2009. **Modhumita**, (new cooperative agreement with USAID) starting in October 2009, with about 13 million USD, will continue till 2013. It is a follow-on to the BAP. The program's overarching objective is to support an effective HIV prevention strategy through improved prevention, care, and treatment services for MARPs and a strengthened national response.

3. **Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) supported programmes:** There are three programmes funded by GFATM Round 2 (March 2004-November 2009), Round 6 (Phase-I: May 2007 to April 2009; Phase 2 which started in May, 2009 and supposed to end April, 2012 was merged with RCC from December 2009), and the Rolling Continuing Channel (December 2009 to November 2015; $81 million). Round 2 is a grant project for prevention of HIV among youth and adolescents amounting to 19.7 million USD and was being managed by Save the Children USA. Round 6 GFATM grant ($40 million) aims to limit the spread and impact of HIV in the country by providing prevention services among the MARPs and improving the capacity to deliver high quality intervention. Government of Bangladesh is the principal recipient for both the grants.

4. UNGASS INDICATOR DATA IN AN OVERVIEW TABLE

In 2010 UNGASS report a total of 18 indicators is being reported for Bangladesh as compared to 13 indicators in 2008 UNGASS report. The following table gives the overview status of these indicators.

Indicators	UNGASS guideline recommended		For Bangladesh		Remarks
	Data Collection Frequency	Method of Data Collection	If Data is Available and Reported (Yes or No)	Method of Data Collection	
National Commitment and Action					
Expenditures					
1. Domestic and international AIDS spending by categories and financing sources	Ad hoc based on country request and financing, by calendar or fiscal year.	National AIDS Spending Assessment Financial resource flows	Data is not available either from NASA or National Health Accounts	Expenditure amount collected from key funding sources for 2008 and 2009	GFATM, FHI/USAID, HNPSP (WB, DFID etc) and GTZ
Policy Development and Implementation Status (Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation)					
2. National Composite Policy Index	Every 2 years	Desk review and key informant interviews	Reported	Desk review and Key informant interviews	PART-A is completed by NASP and PART-B by all relevant stakeholders through workshop
Indicators	**UNGASS guideline recommended**		**For Bangladesh**		**Remarks**
	Data Collection Frequency	**Method of Data Collection**	**If Data is Available and Reported (Yes or No)**	**Method of Data Collection**	
National Programmes: blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphans and vulnerable children, and education.					
3. Percentage of donated blood units screened for HIV in a quality assured manner	Annual	Programme monitoring/ special survey	Data not available	Patient records	Reported for Government own centers only

Indicators	UNGASS guideline recommended		For Bangladesh		Remarks
	Data Collection Frequency	Method of Data Collection	If Data is Available and Reported (Yes or No)	Method of Data Collection	
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Annual	Programme monitoring and estimates	Data available	Key informant interviews	Reported
5. Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	Annual	Programme monitoring and estimates	Data not available	Patient records	Not reported
6. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV	Annual	Programme monitoring	Data not available	Patient records	Not reported
7. Percentage of women and men aged15-49 who received an HIV test in the last 12 months and who know the results	Every 4–5 years	Population-based survey	Data not available	Population-based survey	Not reported
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	Every 2 years	Behavioural surveys	Data available	BSS, 2006-7	Reported making correction over previous UNGASS report in 2008
9. Percentage of most-at-risk populations reached with HIV/AIDS prevention programmes	Every 2 years	Behavioural surveys	Data available	BSS, 2006-7	Reported making correction over previous UNGASS report in 2008

Indicators	UNGASS guideline recommended		For Bangladesh		Remarks
	Data Collection Frequency	Method of Data Collection	If Data is Available and Reported (Yes or No)	Method of Data Collection	
10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	Every 4–5 years	Population-based survey	Data not available	Population-based survey	Not reported
11. Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year	Every 2 years	School-based survey	Data not available	School-based survey	Reported
Knowledge and Behaviour					
12. Current school attendance among orphans and among non-orphans aged 10–14*	Every 4–5 years	Population-based survey	Data not available	Population-based survey	Not reported
13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	Every 4–5 years	Population-based survey	Data available	Youth HIV/AIDS End line Survey in Bangladesh, 2008	Reported making correction over previous UNGASS report in 2008

Indicators	UNGASS guideline recommended		For Bangladesh		Remarks
	Data Collection Frequency	Method of Data Collection	If Data is Available and Reported (Yes or No)	Method of Data Collection	
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Every 2 years	Behavioural surveys	Data available	BSS 2006-7	Reported
15. Percentage of young women and men who have had sexual intercourse before the age of 15	Every 4–5 years	Population-based survey	Data available	Youth HIV/AIDS End line Survey in Bangladesh, 2008	Reported making correction over previous UNGASS report in 2008
16. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	Every 4–5 years	Population-based survey	Data available Reported for men only	An assessment of sexual behaviour of men in Bangladesh (ICDDR, B and FHI/USAID) 2006	Reported making correction over previous UNGASS report in 2008
17. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*	Every 4–5 years	Population-based survey	Data available Reported for men only	An assessment of sexual behaviour of men in Bangladesh (ICDDR, B and FHI/USAID) 2006	Reported making correction over previous UNGASS report in 2008

Indicators	UNGASS guideline recommended		For Bangladesh		Remarks
	Data Collection Frequency	Method of Data Collection	If Data is Available and Reported (Yes or No)	Method of Data Collection	
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	Every 2 years	Behavioural surveys	Data available	BSS 2006-7	Reported
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Every 2 years	Behavioural surveys	Data available	BSS 2006-7	Reported
20. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	Every 2 years	Special survey	Data available	BSS 2006-7	Reported
21. Percentage of injecting drug users who report the use of a condom at last sexual intercourse	Every 2 years	Special survey	Data available	BSS 2006-7	Reported

Indicators	UNGASS guideline recommended		For Bangladesh		Remarks
	Data Collection Frequency	Method of Data Collection	If Data is Available and Reported (Yes or No)	Method of Data Collection	
Impact					
22. Percentage of young women and men aged 15–24 who are HIV infected*	Annual	HIV sentinel surveillance and population-based survey	Data not available	HSS /population based survey	Not reported
23. Percentage of most-at-risk populations who are HIV infected	Annual	HIV sentinel surveillance	Data available	HSS 2007	Reported
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Every 2 years	Program monitoring	Data available	Programme monitoring	Reported
25. Percentage of infants born to HIV infected mothers who are infected	Annual	Treatment protocols and efficacy studies	Data not available	Treatment protocols and efficacy studies	Not reported

*Millennium Development Goals indicator

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

Indicator	*Population group(s)*	*Indicator Value (%)*		
		2005	*2007*	2009
1. Domestic and international AIDS spending by categories and financing sources	DETAILS BELOW			

Domestic and international AIDS spending by categories and financing sources

Amount disbursed in STI/HIV related intervention for 2008 and 2009

Area	HNPSP			GFATM Round 2 and Round 6			FHI/USAID		
	2007-2008 (July-June)	2008-2009 (July-June)	Total 2007-2009	2008 (Jan-Dec)	2009 (Jan-Dec)	2008-09 (Jan-Dec)	2008 (Jan-Dec)	2009 (Jan-Dec)	2008-09 (Jan-Dec)
Prevention	14017384	7926861	**21944245**	9,360,278	7,374,649	16,734,927	2,188,358	2,032,223	**4,220,581**
Care and Support				314,485	279,808	594,293	93,136	123,672	**216,808**
Advocacy				2,116,618	822,593	2,939,211			
M&E and management associated costs				2,585,530	1,858,787	4,444,317			
Operational							1,110,193	1,150,062	**2,260,255**
Technical support									
Total $	**14017384**	**7926861**	**21944245**	**14,376,911**	**10,335,837**	**24,712,748**	**3,391,687**	**3,305,957**	**6,697,644**

Area	GTZ			UN Agency (UNAIDS, UNICEF, UNFPA, WHO, UNHCR, UNODC)			ADB (2006-10) HIV prevention integrated into Urban Primary health care including VCT		
	2008 (Jan-Dec)	2009 (Jan-Dec)	2008-09 (Jan-Dec)	2008 (Jan-Dec)	2009 (Jan-Dec)	2008-09 (Jan-Dec)	2008 (Jan-Dec)	2009 (Jan-Dec)	2008-09 (Jan-Dec)
Prevention									
Care and Support							2,000,000	2,000,000	4,000,000
Advocacy									
M&E and management associated costs									
Operational									
Technical support	1,478,799	1369398.8	2848198	2,000,000	2,000,000	4,000,000			
Total $									
	1,478,799	**1,369,399**	**2,848,198**	**2,000,000**	**2,000,000**	**4,000,000**	**2,000,000**	**2,000,000**	**4,000,000**

Total: Sixty four million US$ approximately (US$64202835)

The expenditure data collected from HNPSP, GFATM, FHI/USAID and GTZ are based on the actual expenditure occurred in 2008 and 2009. The data for ADB and UN agency is considered as an estimated figure.

2. National Composite Policy Index	In the Annex

Indicator	*Population group(s)*	*Indicator Value (%)*		
		2005	*2007*	**2009**
3. Percentage of donated blood units screened for HIV in a quality assured manner[7]	All	Not available	Not available	100%[8] Reported for only 116 SBTP centres (including Red crescent) Source: Health Bulletin DGHS, 2009
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	PLHIV	Not available	13.3%	47.7% (353/740) Source: Numerator: AAS, CAAP and MAB Denominator: GTZ supported and IHP conducted projection made in 2008.
5. Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	HIV positive pregnant women	Not available	Not available	Not available
6. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV	Incidence of TB cases in people living with HIV	Not available	Not available	Not available
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results	Women and men aged 15-49	Not available	Not available	Not available

Note: Detail description of indicators are given in annex-5

[7] In 2008, SBTP screened 3, 58, 346 bags of blood and rejected 3,429 bags of blood due to presence of various infectious disease agents including HIV. Source: Health Bulletin 2009 DGHS.

[8] In a study named "Situation of blood supply and transfusion service in Bangladesh" it was found that 48.6% of the centers screen for all five diseases (Hepatitis, C, Syphilis, Malaria and HIV) and 84% of the center screen for HIV. Two-thirds of the centers (out of 42) were under SBTP. More SBTP enlisted centers (20 out of 22) reported screening blood for various TTIs than the non-SBTP ones (13 out of 15).

Indicator	*Population group(s)*	*Indicator Value (%)*		
		2005	***2007***	**2009**
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results[9]	Female sex workers Male sex workers Hijra MSM IDU Heroin smokers Rickshaw pullers Truckers All risk groups	1.6 1.1 0.0 0.0 3.2 0.5 0.0 0.2 1.3 Source: BSS 2003-04	4.1 4.1 14.3 2.5 4.7 1.3 0.0 0.0 3.8 Source: BSS 2006-07	4.1 4.1 14.3 2.5 4.7 1.3 0.0 0.0 3.8 Source: BSS 2006-07
9. Percentage of most-at-risk populations reached with HIV/AIDS prevention programmes[10]	Female sex workers Male sex workers Hijra MSM IDU Heroin smokers Rickshaw pullers Truckers All risk groups	6.9 20.4 1.46 0.66 3.54 0.55 0.0 1.1 5.2 Source: BSS 2003-04	7.4 18.0 22.3 8.1 2.1 2.1 0.2 0.0 7.2 Source: BSS 2006-07	7.4 18.0 22.3 8.1 2.1 2.1 0.2 0.0 7.2 Source: BSS 2006-07
10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	OVC	Not available	Not available	Not available

[9] This Indicator has been corrected for the BSS rounds 2003-2004 and 2006-2007. In the earlier UNGASS report (2008), this indicator was calculated based upon" Percentage of most-at-risk populations that have ever received an HIV test and who know the results". For 2010 UNGASS reporting, the indicator has been correctly calculated based on the indicator definition mentioned in the UNGASS indicator reporting guideline.

[10] In 2005 and 2007 the indicator value was calculated based upon "Have you been in touch with any NGO prevention program in last one year" those who said "yes" the % was reported. But in 2010 reporting, according to the definition of UNGASS indicator "9" this indicator has been calculated. So the percentage is very low as compared to previous report.

Indicator	*Population group(s)*	*Indicator Value (%)*		
		2005	***2007***	**2009**
11. Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year	Schools providing Life Skills Based Education.	Not available	Not available	26/19017 =0.14% Source: Numerator: UNICEF Denominator: Total secondary school in Bangladesh (Statistical pocket book 2008)
12. Current school attendance among orphans and among non-orphans aged10–14	All children aged 10-14	Not available	Not available	Not available
13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission[11]	Males Females All 15-24	Not available Not available Not available	10.4 10.0 10.2 Source: National Baseline HIV/AIDS survey among youth in Bangladesh 2005 NASP, Save-USA, ICDDR,B	22.4 13.4 17.7 Source: National End Line HIV/AIDS Survey among Youth in Bangladesh, 2008, NASP, SC USA, ICDDR,B
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Female sex workers Male sex workers Hijra MSM IDU Heroin smokers Rickshaw pullers Truckers All risk groups	24.0 28.2 3.7 13.2 14.3 4.8 6.0 19.8 17.0 Source: BSS 2003-04	30.8 29.6 55.2 27.3 20.2 19.4 12.1 7.7 25.9 Source: BSS 2006-07	30.8 29.6 55.2 27.3 20.2 19.4 12.1 7.7 25.9 Source: BSS 2006-07

[11] In the last UNGASS report (2008), in baseline, only part of this indicator was reported. i.e. two ways of prevention only. This has been corrected here

Indicator	*Population group(s)*	*Indicator Value (%)*		
		2005	***2007***	**2009**
15. Percentage of young women and men who have had sexual intercourse before the age of 15[12]	Males 15-24 Females 15-24 All 15-24	Not available Not available Not available	11.6 35.7 27.1 Source: National Baseline HIV/AIDS survey among youth in Bangladesh 2005 NASP, Save-USA, ICDDR,B	11.8 30.6 24.3 Source: National End Line HIV/AIDS Survey among Youth in Bangladesh, 2008, NASP, SC USA, ICDDR,B
16. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months[13]	Females Males	Not available Not available	Not available 12.9% Source: Assessment of Sexual behaviour of men in Bangladesh FHI/ICDDRB 2006	Not available 12.9% Source: Assessment of Sexual behaviour of men in Bangladesh FHI/ICDDRB 2006
17. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse[14]	Females Males	Not available Not available	Not available 35.0% Source: Assessment of Sexual behaviour of men in Bangladesh FHI/ICDDRB 2006	Not available 35.0% Source: Assessment of Sexual behaviour of men in Bangladesh FHI/ICDDRB 2006
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client (new clients)	Female sex workers Male sex workers Transgender/Hijra	30.9 44.1 15.6 Source: BSS 2003-04	66.7 43.7 66.5 Source: BSS 2006-2007	66.7 43.7 66.5 Source: BSS 2006-2007

[12] In the last UNGASS report (baseline results 2005), the indicator was calculated based on the "percentage of young women and men aged 15-24 who have had premarital sex before the age of 15. This has been corrected.

[13] This indicator has been corrected

[14] This indicator has been corrected

Indicator	*Population group(s)*	*Indicator Value (%)*		
		2005	*2007*	**2009**
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	MSM Commercial sex Non-commercial sex	 49.2 37.0 Source: BSS 2003-04	 29.5 24.3 Source: BSS 2006-2007	 29.5 24.3 Source: BSS 2006-2007
20. Percentage of injecting drug users who report the use of a condom at last sexual intercourse	**Male IDU:** Commercial Non-comm. sex **Female IDU:** Commercial sex Non-comm. sex	 23.6 18.9 78.9 43.9 Source: BSS, 2003-2004 for male IDUs and Cohort study by ICDDR,B for female IDUs baseline in Dec 2004-May 2005	 44.3 30.5 54.8 42.1 Source: BSS, 2006-2007 for male IDUs and Cohort study by ICDDR,B for female IDUs 3rd round in July-Nov 2006	 44.3 30.5 54.8 42.1 Source: BSS, 2006-2007 for male IDUs and Cohort study by ICDDR,B for female IDUs 3rd round in July-Nov 2006
21. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	Male IDU: Female IDU:	51.8 60.0 Source: BSS, 2003-2004 for male IDUs and Cohort study by ICDDR,B for female IDUs baseline in Dec 2004-May 2005	33.6 73.8 Source: BSS, 2006-2007 for male IDUs and Cohort study by ICDDR,B for female IDUs 3rd round in July-Nov 2006	33.6 73.8 Source: BSS, 2006-2007 for male IDUs and Cohort study by ICDDR,B for female IDUs 3rd round in July-Nov 2006
22. Percentage of young women and men aged 15–24 who are HIV infected	young women and men aged 15–24 who are HIV infected	Not available	Not available	Not available

Indicator	*Population group(s)*	*Indicator Value (%)*		
		2005	*2007*	2009
23. Percentage of most-at-risk populations who are HIV infected	Female sex workers Male sex workers Hijra MSM MSM and MSW combined Male IDU[15] Female IDU Combined IDU and HS Heroin smokers All risk groups	0.3 0.0 0.8 0.0 0.4 1.5[16] (4.9) 0.0 Not sampled 0.5 0.6 Source: National HIV Serological Surveillance, 2004-2005	0.1 0.7 0.6 0.2 Not sampled 1.9[17] (7.0) 0.8 0.0 0.0 0.9 Source: National HIV Serological Surveillance, 2006	0.3 0.3 0.3 0.0 0.3 1.6[18] (7.0) 1.0 0.1 0.2 0.7 Source: National HIV Serological Surveillance, 2007 (unpublished)
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Adult and children with HIV	Not available	Not available	209/232 =90.1% Source: AAS, MAB and CAAP
25. Percentage of infants born to HIV infected mothers who are infected	Infants	Not available	Not available	Not available

[15] In the previous UNGASS report only the prevalence of Dhaka was mentioned. In 2010 UNGASS report the prevalence of IDUs in all sampling sites was mentioned. In the parentheses, to keep the consistency with previous reports, the prevalence of Dhaka is mentioned.

[16] Prevalence in 16 cities

[17] Prevalence in 18 cities

[18] Prevalence in 21 cities

III.OVERVIEW OF THE AIDS EPIDEMIC

Prevention efforts in Bangladesh had been initiated way before the first HIV case was detected in 1989.Though there is no comprehensive national study to measure the prevalence of HIV among the general population, however, the prevalence has been considered at less than 0.1 percent[19]. In all of the eight HIV Serological Surveillance rounds conducted till date (Round 8, 2007) in Bangladesh, the HIV prevalence among the MARPs remained below 1 percent with the exception of Injecting Drug User (IDU) population manly in the capital city of Dhaka.

On December 1, 2009, on the occasion of World AIDS Day, the National AIDS/STD Program (NASP) had confirmed a total of 1745 HIV cases reported in Bangladesh. In 2009 alone, a total of 250 new cases were identified, 143 had developed AIDS and a total of 39 deaths were reported. Total number of HIV infected people developed AIDS until 2009 is 619 and a total of 204 deaths had occurred due to AIDS[20].

Most at Risk Population and HIV

The Most at Risk Population (MARPs) group identified under the national behavioural and serological surveillance in Bangladesh are female sex workers (Street, Hotel, Residence and Brothel based), Male Sex Workers (MSW), Males who have Sex with Males (MSM), transgender or Hijras, Injecting Drug Users (IDU), heroin smokers, clients of sex workers such as rickshaw pullers, truck drivers and their helpers and students. In the last three serological surveillance rounds till 2007, casual female sex workers were included and HIV was found only in one of the four locations included in the surveillance. The casual female sex workers were not included in any of the previous Behavioural Surveillance Survey (BSS). Although the external migrant workers are greater in proportion of reported HIV positive cases in Bangladesh, due to various reasons, this group is still out of the national HIV/AIDS surveillance system.

The following table depicts the overall HIV prevalence among different MARPs over the last eight rounds of HIV serological surveillance in Bangladesh. It is clear from the table that although the overall HIV prevalence remains below one percent but there is an increasing trend from the first to the eighth round.

[19] 20 Years of HIV in Bangladesh: World Bank and UNAIDS, 2009

[20] Bangladesh HIV data 2009, Published in NASP Website

HIV Prevalence over the serological surveillance rounds in Bangladesh among MARPs

Table No 1: Trend in HIV Prevalence of MARPs over the Years

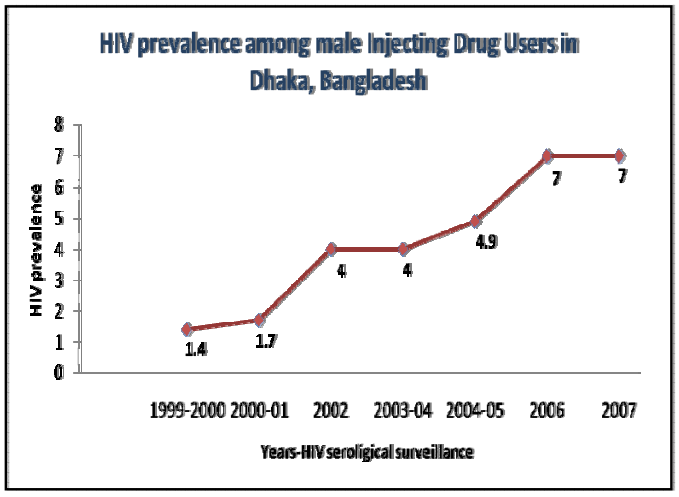
Surveillance Rounds	Year	Total sample	HIV (%)
1st round	1998 – 1999	3871	0.4
2nd round	1999 – 2000	4338	0.2
3rd round	2000 – 2001	7063	0.2
4th round	2002 – 2003	7877	0.3
5th round	2003 – 2004	10445	0.3
6th round	2004 – 2005	11029	0.6
7th round	2006	10368	0.9
8th round	2007	12786	0.7

Source: NASP

Status of the Epidemic among the IDUs – A Major Challenge for National Programme

According to the 8th Serological Surveillance 2007 (NASP), the overall HIV prevalence among the MARPs surveyed in different parts of Bangladesh was 0.7 percent. But the prevalence among IDU population alone was found to be alarmingly high. In Dhaka, overall IDU prevalence was found to be 7 percent and even up to 11 percent in one of the neighbourhoods in the city. The HIV prevalence among IDUs in Dhaka rose up to five times in an interval of seven years (from 1.4 percent in 2nd serological surveillance (1999-2000) to 7 percent in 8th serological surveillance, 2007). Although, the HIV prevalence is still below one percent among the general population in Bangladesh, but the behavioural factors among MARPs, explored from several rounds of Behavioural Surveillance Survey reports, shows a trend that could fuel the spread of HIV from MARPs to the general population if appropriate steps are not taken.

Figure No 1



Sharing of needles has declined in Dhaka, but remained high in three other cities[21]. Half to two thirds of IDUs bought sex from female sex workers, and consistent condom use ranged

[21] BSS (2006-07)

from 14 percent to 42 percent only in different cities[22]. Female drug users are also very vulnerable; most sold sex to support their addiction, and depended on their male partners to buy their drugs and then shared injections with them[23].

Overlapping of Risk among MARPs

There are some overlapping risk between injecting drug users and commercial sex. IDU, female sex workers, MSM, MSW and Hijra – are not mutually exclusive. Injection drug use has been documented among both female and male sex workers. Injecting drug use was reported by 5 percent of MSW in Chittagong in the BSS of 2006-07; in the earlier round of BSS (2003-2004) in Chittagong the highest rates (3.9%) of such overlapping risks were detected. In the study using the RDS (Respondent Driven Sampling) method[24], 13.6 percent of MSM in Dhaka reported taking any illicit drugs in the last year but none injected drugs.

Genetic characterization of HIV subtypes helps to analyze overlapping risks. The extent of similarity in the HIV strains found in different populations points to overlap among those groups. Genetic analysis of HIV strains shows that the IDU and heroin smoker strains are almost identical confirming that spread is occurring within networks of IDUs through sharing of injection equipment. The HIV strains obtained from IDUs are distinct from those obtained from other population groups suggesting that transmission of HIV is still restricted within specific MARPs. HIV subtypes from migrants are genetically diverse and have little or no identity with locally circulating strains in IDUs and female sex workers[25].

HIV Risk in General Population

Approximately 10 percent of men in Bangladesh reported *having ever bought sex* from female sex workers[26]. In the national survey among youth in 2008, almost 20 percent of unmarried males reported having premarital sex and for 28 percent of these respondents, the last sex was with a sex worker. The reporting of consistent condom use amongst this group with FSWs, however, has risen from 14 percent (2005) to 48 percent (2008). About one in three (28%) young people *who have ever had sex* reported one or more symptoms of an STI in the past 12 months, but only a quarter sought treatments from a trained provider. These data point to the need for more concerted prevention efforts also among the general population with specific focus on Men.

Migration and HIV Risk in Bangladesh

Migration may be a factor in HIV transmission in Bangladesh. Migrants, both international and cross border, have generally not been targeted by HIV prevention efforts in the past and there is little understanding as to how such targeted intervention could be implemented[27]. The limited facilities for voluntary counselling and testing, as well as the social stigma and

[22] 20 Years of HIV in Bangladesh: World Bank and UNAIDS, 2009

[23] Azim T., et el. 2006

[24] It is a method that employed social networks to recruit the sample

[25] 20 Years of HIV in Bangladesh: World Bank and UNAIDS, 2009

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

[27] 20 Years of HIV in Bangladesh: World Bank and UNAIDS, 2009

discrimination attached to HIV, remain a major challenge to reach these migrants. There is no official data on overseas migrants living with HIV. However, the majority of passively reported HIV positive cases have been among returned international migrant workers and their families. A recent analysis of existing data on PLHIV showed that of 645 adult PLHIVs who had been employed, 64.3 percent had previously worked abroad[28].

Among the 219 confirmed HIV cases in 2002, returning emigrant workers comprised 50.7 percent of the total. In the period 2002 to 2004, 47 of the 259 (18%) people who tested positive for HIV were either returned migrants or relatives of migrants. Of the 102 new reported HIV/AIDS cases in 2004, 57 were identified as migrants (55.9%). Sometimes, sick migrants return home without money or other social support. In Bangladesh, there is no specific health support system for these migrants. Diagnostic centres conduct pre-migration checkups for potential migrants, but generally none provide treatment or related services. HIV vulnerability is also high particularly among the female migrants some of whom have reported having STI symptoms. Condoms are rarely used in family planning, because they are not preferred by men [HIV vulnerabilities faced by women migrants (OKUP, UNDP, 2009)].

Data suggest that HIV transmission from international migrant workers who have returned and are HIV positive has been mostly restricted to their spouses, although the extent of spousal transmission and couples in which one person is HIV positive and putting the other at high risk has not been assessed systematically in Bangladesh[29].

[28] Ibid

[29] Ibid

IV. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

1. BACKGROUND TO NATIONAL AIDS RESPONSE

There has been no significant change in the national programme over the last two years since the previous UNGASS report was prepared in 2008.

Bangladesh has a long history of strong political commitment in combating HIV and a response that has been 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 detected in the country. The Chief Patron of 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 STI and act as an advisory body responsible for formulating major policies and strategies on HIV/AIDS in Bangladesh. NAC also supervises program implementation and is responsible for mobilizing resources. The National AIDS/STD Program (NASP) is the body established by the Ministry manage 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 STDs (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 key Objectives of the NSP Phase 2 are:

1. Provide support and services for priority groups
2. Prevent vulnerability to HIV infection in Bangladesh
3. Promote safe practices in the health care system
4. Provide care and treatment services to people living with HIV
5. Minimize the impact of the HIV/AIDS epidemic.

Subsequently, in order to address gaps and to elaborate further on the 2nd National Strategic Plan, NASP developed the 'National AIDS Monitoring and Evaluation Framework and Operational Plan' in 2007 with the assistance of UNAIDS. The NASP has also developed several national guidelines, manuals and policies/strategies on specific intervention areas. The revision of current national HIV/AIDS strategic plan (2nd National Strategic Plan of HIV/AIDS for 2004–2010) has already been initiated and will be reviewed and refocused.

2. NATIONAL POLICY ENVIRONMENT AND HIV PROGRAMME

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 nominated focal points for HIV/AIDS in 16 ministries and departments.

Bangladesh has developed the National Multisectoral HIV strategy for the period of 2004-2010. HIV is integrated in its general development plans, Poverty Reduction Strategy, Sector-wide approach. UN Development Assistance Framework also included HIV. In the new National health Policy (Draft-2009), HIV has been emphasized. However, Bangladesh has not evaluated the impact of HIV on its socioeconomic development for planning purposes. HIV-related areas that are included in the national HIV strategic plans are: HIV prevention, treatment for opportunistic infections, antiretroviral treatment, care and support, reduction of gender inequalities, reduction of stigma and discrimination. National strategy addresses HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc) for BCC and HIV testing and counseling. Before departing for UN peace mission, all members of the contingent are provided VCT services and upon return, similar process are followed. Information, education and communication (IEC) on HIV to the general population is included under national strategy. The country also has policy/strategy to promote HIV-related reproductive and sexual health education for young people. National policy allows developing/using generic drugs or parallel importing of drugs for HIV.

National response to HIV is being guided by a number of well developed strategies/guidelines as already outlined in the policy and programmatic response in the "Status at a glance section": Moreover some manuals/modules/guidelines were also developed. TOT manual for School and College teachers and facilitation guide 2007; Training modules for Health Managers on HIV/AIDS (2006); Training of Trainers Manual on Mainstreaming HIV/AIDS for NGOs and Five Key Ministries (2007). The process for the revision of the 2nd National Strategic plan had already been started under the leadership of NASP with technical support from UNAIDS. In support of the national strategic plan, UN system in Bangladesh has formulated a common UN plan to contribute to the formation of a national network and developed the "United Nation Implementation Support Plan (UN-ISP)" that among other issues, seeks to help build the momentum for advocacy and lobbying for enhanced empowerment and recognition of Person Living with HIV. Bangladesh does not have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children and the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009 was poor. Self help groups are working on this issue.

HIV and AIDS related information was incorporated into the National Curriculum from classes 6 to 12 with approval from ministry of health and education. The political support has been continuing, the president, the prime minister and the health minister, on the occasion of World AIDS day" provide speech in the National newspapers. The other high officials also speak publicly about the disease. In the National electronic media HIV transmission and prevention messages are broadcasted.

There exist several laws, acts that are still limiting the access of MARPs to prevention services. The Narcotics Control Act (NCA), under article 18 of national constitution, passed in 1990; made drug use a criminal offense, made drug users criminals, and called for mandatory treatment of drug users. However, the national AIDS policy recognizes harm

reduction approaches and the NASP incorporated harm reduction services for IDUs in its strategic plan 2004-2010. Bangladesh started its NSP for IDUs in the late 1990s, expanded it over the years and has now approved a pilot of OST. However, no initiatives have been taken for the law reform[30] Other similar laws that affect the sex workers are Metropolitan police ordinances, Bengal Suppression of Immoral Traffic Act 1933, The Bangladesh penal code 290 etc.

With the technical assistance from UNAIDS, NASP has developed "Bangladesh technical support plan for HIV and AIDS" for 2008-2015, and a costed plan for 2008 and 2009 has been finalized. The purpose of developing a Technical Support Plan for Bangladesh was to ensure technical support for the HIV/AIDS response is provided in a timely, coordinated and effective manner and addresses Bangladesh's most urgent needs.

3. CURRENT NATIONAL RESPONSE TO AIDS EPIDEMIC

Bangladesh is currently implementing the Second Phase of National Strategic Plan. Though Bangladesh is still in the low prevalence category, there is an increasing evidence of vulnerability to HIV, particularly of the MARP. Therefore focus of the program continues to be on prevention among the priority groups particular among MARPs. Following paragraphs will summarize the performance of the National AIDS Response vis-à-vis the UNGASS indicators.

3.1 PREVENTION:

3.1.1 Prevention among the MARPs

The prevention programs continue to be focused on the MARPs such as IDU, MSM, MSW, Transgender (Hijras), Female Sex Workers and their clients. Three key donors in the country are USAID, World Bank and GFATM that funds major prevention programmes in the country through management agencies.

A new National size estimation exercise of MARPs, under the leadership of NASP, is at the final stage of reporting. UNAIDS is providing coordination support to the process. The new size estimation data is expected to be finalized and approved by NASP in the beginning of 2010. The size estimation exercise will contribute significantly in the process of re-strategizing prevention efforts among MARPs. Currently there are three key prevention intervention programmes being implemented in the country, which are, as discussed earlier, HIV/AIDS Targeted Intervention (HATI) 2008-2009, The Bangladesh AIDS Program (BAP) 2005-2009 and GFATM Supported Programme for Prevention among the Youth and MARPs.

[30] 20 years of HIV in Bangladesh: World Bank and UNAIDS 2009

HATI focuses on intervention packages for six high risk groups: IDUs, brothel based sex workers, street based sex workers, hotel and residence based sex workers, clients of sex workers, MSM, MSW and Hijra. A total of 41 NGOs under the 12 consortia work in 67 Upazilas (sub-districts) of 44 districts. UNICEF has been entrusted to manage the targeted interventions. While prevention programs have been geographically expanded specially with GFATM supported round 6 programmes for the MARPs, the largest targeted Intervention HATI faced an interruption because of the change in its management modality; in March 2009, UNICEF handed it over to the management support agency (MSA) under Ministry of Health; the MSA was not in a position to start its function right then and it also needed new bidding to recruit the implementing agency and this caused a sharp decrease of coverage for MARPs prevention program in the second half of 2009. The HATI ended in June 2009. As a continuation of HATI, from December 2009, under HNPSP, HIV/AIDS intervention services (HAIS) has been started for an initial duration of six months.

Another key programme is the Bangladesh AIDS Programme (BAP) being implemented by FHI, with the funding support of USAID for the period 2005-2009. Some of the key activities/components supported through BAP program are: interventions for MARPs (IDUs, sex workers. MSM, Hijras), support for NGOs, FBOs and groups addressing the needs of PLHIV, National Behavioural and Serological Surveillance surveys, condom promotion, STI studies, support to VCT centres and training for VCT centre staff, advocacy for IDU interventions, Modhumita integrated health centres that provide medical care for sex workers, technical assistance to a PLHIV peer support organization etc. The Modhumita, (new project, after ending BAP in October 2009) with about 13 million USD, will continue the implementation till 2013.

In the Round 2 GFATM supported programme, The Economic Relations Division of the Government of Bangladesh (GoB) is the Principal Recipient (PR) and the Ministry of Health and Family Welfare is the delegated PR while Save the Children USA is the Management Agency. The goal is “to prevent HIV infections in young people, aged 15-24, and thereby help avert a generalized HIV epidemic in Bangladesh”.

Round 6 GFATM grant aims to limit the spread and impact of HIV in the country by (1) improving coverage and quality of essential HIV services for the most vulnerable, high-risk populations, (2) increase coverage and quality of HIV prevention interventions and risk reduction for especially vulnerable young people, and (3) build capacity of government and NGO partners at national and district levels to scale up standardized, high-quality interventions, to monitor and improve coverage and quality, and to improve coordination. Total funding of up to $40 million was approved; phase I ($13 million) started in May 2007 and ended in April 2009, phase II (around $26 million) which started in May, 2009 and supposed to end in April, 2012 was merged with RCC for the period of December 2009 to November 2015.

In 2002, the Country Coordinating Mechanism (CCM) was set up in Bangladesh, in order to coordinate and monitor the GFATM supported programmes and to decide on matters related to projects implementation. The current CCM members represent the government, the private sector, civil society (including NGOs, people living with HIV and TB and young people’s organizations and movements), academicians and development partners. The Secretary under MOHFW is the chair of the CCM.

Analysis of Key UNGASS Indicators Related to MARPs[31]

Number of MARPs Reached: Following table shows percentage of most-at-risk populations reached with HIV/AIDS prevention programmes[32] (UNGASS Indicator no.9) in 2005 (based on 2004 data) and in 2009 (based on 2007 data).

Table No. 2: MARPs Reached with Prevention Programmes

Population Groups	% of Reach 2005	% of Reach 2009	% of Increase
Female Sex Workers	6.9	7.4	0.5
Male Sex Workers	20.4	18	-2.4
Hijra	1.46	22.3	20.84
MSM	0.66	8.1	7.44
IDU	3.54	2.1	-1.44
Heroin smokers	0.55	2.1	1.55
Rickshaw pullers	0	0.2	0.2
Truckers	1.1	0	-1.1
All risk groups	5.2	7.2	2
	Source: BSS 2003-04	**Source: BSS 2006-07**	

Country does not have any other authenticated data on coverage of MARPs and therefore the data presented here are from the BSS study carried out in the country. Overall coverage of all the MARPs is around 7.2 percent and the reported increase from the previous round of BSS is only 2 percent. Achieving scale and coverage is crucial for macro level impact on the status of the epidemic in the country. Therefore this points to the need for a concerted effort to achieve quicker scale and coverage through appropriate strategies and enhancing capacities at all levels.

The data presented in the above also shows that coverage was increased in some groups and decreased in other groups. This is difficult to conclude the specific reasons. The interruption of national program and expansion of coverage for some groups by different funding streams could be some of the reasons.

[31] It is to be noted that, the value reported on behavioural indicators here are same as the previous report (UNGASS 2008), as no BSS study has been carried out after 2007

[32] In 2005 and 2007 the indicator value was calculated based upon "Have you been in touch with any NGO prevention program in last one year" those who said "yes" the % was reported. But in 2010 reporting according to the definition of UNGASS indicator "9" this indicator has been calculated. So the percentage is very low as compared to previous report.

Correct Knowledge of HIV: There is a marked increase in percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (UNGASS Indicator no.14) between the years 2004 and 2007. Significant increase is seen in the case of Hijras (from 3.7 to 55.2), MSM (13.2 to 27.3) and Heroin Smokers (4.8 to 19.4). There is also an improved knowledge reported among the IDUs (14.3 to 20.2) and Female Sex Workers (24 to 30.8). Increase in knowledge among the Male Sex Workers has been minimal (28.2 to 29.6) and in the truckers shows a decrease (19.8 to 7.7). The decrease in knowledge among the truckers might be due to sampling and also the inadequate coverage through intervention programs for them.

Behaviour Change: Percentage of female and male sex workers reporting the use of a condom with their most recent client (new clients) (UNGASS Indicator no.18) as per 2007 BSS is 66.7 and 43.7 percent respectively and among the transgender/Hijra community, it is 66.5 percent. There is a significant increase in condom use reported from previous data (2004 BSS) for female sex workers (35.8 percent increase) and Hijra (50.9 percent increase). But for the male sex workers condom use has reportedly come down by 0.4 percent. This might be due to sampling error, their high mobility, shortage of supply of condoms and lubricants, miss-match of timing with the outreach work etc.

On the indicator, “Percentage of men reporting the use of a condom the last time they had anal sex with a male partner” (UNGASS Indicator no.19), 2007 BSS data shows, 29.5 percent use of condom during commercial sex and 24.3 percent during non-commercial sex. There is a decrease of 19.7 percent and 12.7 respectively from the BSS data of 2004.This might be again due to sampling error and shortage of supply of condoms and lubricants for MSM, as was reported to a data vetting workshop during the 2008 UNGASS report.

The UNGASS indicator - percentage of injecting drug users who report the use of a condom at last sexual intercourse (UNGASS Indicator no.20), 44.3 percent of IDUs reported to have used condom during commercial sex and 30.5 percent used during non-commercial sex. There is an increase of about 20.7 and 11.6 percent respectively from the 2004 BSS finding for the same indicator. Condom use among the female IDUs has shown a decrease according to a cohort study done by ICDDR, B, among the female IDUs. The baseline done in Dec 2004-May 2005, showed 74.4 percent condom use for commercial sex and 43.2 percent in non-commercial sex. 3rd round of this study in July-Nov 2006 showed a decrease of about 19.6 and 1.1 percent respectively.

The indicator - percentage of injecting drug users who reported using sterile injecting equipment the last time they injected (UNGASS Indicator no.21), again reported a decrease in the male IDU from 51.8 percent (BSS 2004) to 33.6 percent (BSS 2007). The most common factor (in three of four cities) associated with needle/syringe sharing was “not being able to assess own risk of HIV infection” which reflects not just knowledge of HIV but internalization of that knowledge. However, even correct knowledge was low among IDUs. Only 12.7-40.8 percent of IDUs in the 2006-07 BSS had comprehensive knowledge[33].Moreover due to drive from law enforcement agencies in northwest part of Bangladesh during the BSS 2006-2007 IDUs were scattered, resulting difficulties for the outreach workers to locate them and distribute needle-syringes[34].

[33] 20 Years of HIV in Bangladesh: World Bank and UNAIDS, 2009

[34] 20 Years of HIV in Bangladesh: World Bank and UNAIDS, 2009

Greater effort had been put in to improve the risk perception of the MARPs through the prevention programmes. Attempts were also made to motivate the MARPs to get HIV testing done as well as to improve their access to the testing facility. On the indicator - Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results[35] (UNGASS Indicator 8), the following table would summarize the key findings for different groups of MARP

Table No. 3: MARPs Received HIV Test and Know the Result

Population group(s)	*Indicator Value (%)*		% of change
	2007	2009	
Female sex workers	1.6	4.1	2.5
Male sex workers	1.1	4.1	3
Hijra	0	14.3	14.3
MSM	0	2.5	2.5
IDU	3.2	4.7	1.5
Heroin smokers	0.5	1.3	0.8
Rickshaw pullers	0	0	0
Truckers	0.2	0	-0.2
All risk groups	1.3	3.8	2.5
	Source: BSS 2003-04	Source: BSS 2006-07	

Table shows an improved access to testing services in the case of almost all the MARPs except for rickshaw pullers and truckers.

[35] This Indicator has been corrected for the BSS rounds 2003-2004 and 2006-2007. In the earlier UNGASS report (2008), this indicator was calculated based upon" Percentage of most-at-risk populations that have ever received an HIV test and who know the results". For 2010 UNGASS reporting, the indicator has been correctly calculated based on the indicator definition mentioned in the UNGASS indicator reporting guideline.

Impact of the Prevention Programme on MARPs: The following table summarizes percentage of most-at-risk populations who are HIV infected:

Table No. 4: MARPs who are HIV Infected

Indicator	*Population group(s)*	*Indicator Value (%)*		
		2005	***2007***	**2009**
Percentage of most-at-risk populations who are HIV infected	Female sex workers	0.3	0.1	0.3[36]
	Male sex workers	0	0.7	0.3[37]
	Hijra	0.8	0.6	0.3[38]
	MSM	0	0.2	0[39]
	MSM and MSW combined	0.4	Not sampled	0.3[40]
	Male IDU[41]	1.5[42] (4.9)	1.9[43] (7.0)	1.6[44] (7.0)
	Female IDU	0	0.8	1[45]
	Combined IDU and HS	Not sampled	0	0.1[46]
	Heroin smokers	0.5	0	0.2[47]
	All risk groups	0.6	0.9	0.7
		Source: National HIV Serological Surveillance, 2004-2005	Source: National HIV Serological Surveillance, 2006	Source: National HIV Serological Surveillance, 2007 (unpublished)

The latest serological surveillance conducted in 2007 shows the overall prevalence among the MARPs is below 1% as was the case for the previous rounds. The major limitation of the serological surveillance is the lack of representation of the geographical areas. Sampling is being done mostly through the NGOs who are providing prevention services to the MARPs and that has been its limitation. Over the several HSS rounds, the sampled geographical area has been expanded. However during the 2007 rounds in the sampling, there were four geographical locations where there were no intervention program for street based female sex workers (1), casual female sex workers (2) and MSM(1). The reasons for low prevalence

[36] Street based female in 4, hotel based in 3, combined hotel and residence based in 5 and casual female sex workers in 5 geographical locations. Brothel based female sex workers were not included in 2007 HSS.

[37] Dhaka only

[38] Two geographic locations (Dhaka and Manikganj) as a combined sample

[39] Dhaka only

[40] In Chittagong only

[41] In the previous UNGASS report only the prevalence of Dhaka was mentioned. In 2010 UNGASS report the prevalence of IDUs in all sampling sites was mentioned. In the parentheses, to keep the consistency with previous reports, the prevalence of Dhaka is mentioned.

[42] Prevalence in 16 cities

[43] Prevalence in 18 cities

[44] Prevalence in 21 cities

[45] In three cities as a combined sample (Dhaka, Narayangonj and Tongi)

[46] In seven geographical areas

[47] Only in Dhaka

might be lack of geographical representation of different MARPs in the HSS, high levels of circumcision among men, existence of prevention program for a long time etc.

3.1.2 Prevention among the General Population:

In the national strategic plan for HIV/AIDS (2004-2010), under the objective-2, the strategies articulated are to reduce vulnerability arising from lack of understanding of HIV epidemic; reduce vulnerability arising from gendered practices; and reduce vulnerability arising from exploitation and abuse. To reduce the vulnerability of youth the strategies are focused on strengthening family communication and discussion; create safe spaces and occasions for peer discussion and mutual support; reduce vulnerability arising from physiological immaturity of young women; integrate a human rights based approach to HIV as a personal and a developmental issue into the curricula for educational institutions; establish youth friendly health and well-being services; reduce the vulnerability of children and young people living with and affected by HIV; and reduce vulnerability of unemployed youth.

The general population has not been brought under any specific intervention. However, there are some interventions that target the clients of sex workers as proxy of general population. There are some programs in the garments workers and youth under the GFATM Round 2. Young people aged 10-24 comprise nearly one third of the population of Bangladesh, and have been the main focus of interventions for the general population. Activities include: HIV prevention information through radio and television shows that have attracted very large audiences, open air concerts and print media (billboards, advertisements, posters, leaflets, stickers, calendars, T-shirts and caps); life skills education through youth organizations and clubs; integration of HIV prevention information into the secondary school curriculum; youth friendly services for sexually transmitted infections and counselling; and outreach activities and peer education to promote safe sex behaviour and encourage more counselling and treatment seeking behaviour. Imams have been provided with information and they disseminate HIV/AIDS information in the Friday sermons for Muslims. Other religious leaders are also disseminating information. NGOs working with micro-credit programs are also now disseminating information on HIV through their regular group discussions with credit beneficiaries[48].

Knowledge and Behaviour: There has been no Behavioural Surveillance Study done in Bangladesh since 2006-2007. As a result the data available in the country for indicators related to behaviour and knowledge is same as 2008 UNGASS report. This is being presented with corrected definition of indicators as per UNGASS guideline due to which, for some indicators, 2010 report will show difference in value. Previous UNGASS indicator table is placed in Annex 4 for reference. In the last two years (2008 and 2009), the National End Line HIV/AIDS Survey among Youth in Bangladesh had been done to measure the impact of GFATM round 2 program for Youth titled “Prevention of HIV/AIDS among Young People in Bangladesh”. From the study it was observed that there is an increase in comprehensive knowledge on HIV compared to the baseline done in 2005, both among male and female respondents. The study reported an overall increase in HIV knowledge level for the male and female in the age of 15-24, from 10.2 percent to 17.7 percent (for males 10.4% to 22.5% and for females 10.0% to 13.4%). The findings from the BDHS 2007 and the recently conducted Multiple Indicator Cluster Survey (PROGOTIR PATHEY-2009) also explored similar level of knowledge among the young population.

[48] 20 years of HIV in Bangladesh: World Bank and UNAIDS

In the BDHS-2007, 17.9 percent of the men and 8 percent of the women of age 15-25 had comprehensive knowledge on AIDS. In the Multiple Indicator Cluster Survey (MICS)[49] conducted in 2009, 14.6 percent of women aged 15-24 years have comprehensive knowledge of HIV prevention.

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

For the indicator – percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse (UNGASS Indicator No 17), according to the study done by FHI/ICDDRB 2006 (Assessment of Sexual behaviour of men in Bangladesh) reported 35.0 percent condom use among the males. Data on the females for this indicator is not available in the country. For the indicator - Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months (UNGASS Indicator No 16), the same study (Assessment of Sexual behaviour of men in Bangladesh) reported 12.9 percent and the data for females is not available for this indicator.

On the indicator - percentage of young women and men who have had sexual intercourse before the age of 15[50] (UNGASS Indicator No 15), - according to the National Baseline and End Line HIV/AIDS Survey among Youth (aged 15 to 24) in Bangladesh, done by NASP, SCUSA and ICDDR,B, reported that, overall there is a decrease from 27.1 percent (baseline, 2005) to 24.3 (End line, 2008). In the male respondents, there is a very minor increase from 11.6 to 11.8 percent and among the female respondents there is a decrease from 35.7 to 24.3 percent.

Impact of HIV program: There has been no population based survey to detect the prevalence among the general population. However a study conducted by IEDCR in 2008 among the anti natal care attendees found that among the 10523 specimens tested for anti HIV antibody by ELISA, 1 (.0001%) was found positive.

Bangladesh is still fortunate to keep the prevalence below 1% among the general population as well as in MARPs. Although the prevalence for IDUs is threatening only for Dhaka (7%), however, in 21 cities sampled in 2007 HSS, the prevalence was 1.6%. Thus among the IDUs, there is movement towards becoming a concentrated epidemic and it is still early enough to strengthen quality and effectiveness of the prevention effort among the IDUs and also focus on preventing the epidemic moving into the general public through this target group.

[49] The MICS-2009 only considered children and women.

[50] In the last UNGASS report (baseline results 2005), the indicator was calculated based on the "percentage of young women and men aged 15-24 who have had premarital sex before the age of 15. This has been corrected.

3.1.3 Blood Safety Programmes for HIV Prevention:

The blood safety programmes have been strengthened in the country through the formulation of Blood Transfusion Acts such as "Safe Blood Transfusion Regulations 2008".

The national strategic plan for HIV/AIDS/STD prevention has incorporated blood transfusion initiatives within the plan. Since 2000, screening of Transfusion Transmitted Infection (WHO recommended) had been introduced in Bangladesh along with judicial act and national policies ruled by the Government of People's Republic of Bangladesh. Safe blood transfusion law 2002 has been approved by the parliament and published with an emphasis towards management and controls for safe collection, processing, preservation and transfusion of blood. The goal was to establish and operationalize private blood transfusion centres and Upazilla blood transfusion centres by 2008. Safe blood Transfusion Programme was sponsored by United Nations Development Programme (UNDP) in 2000-2004 and from 2004 onwards is supported by WORLD BANK, Department for International Development (DFID), World Health Organization (WHO) and Health, Nutrition and Population Sector Programme (HNPSP).

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

Efforts to promote voluntary blood donation and the mandatory screening of transfusion have reduced the practice of professional blood donation remarkably from 70 per cent in 2001 to 16 per cent in 2006. Over the same period, voluntary donation increased from 10 per cent to 24 per cent, and donations from relatives increased from 20 per cent to 27 per cent. Patients' family members, relatives, friends and acquaintances now donate 70% of the blood[51].

For the indicator - Percentage of donated blood units screened for HIV in a quality assured manner[52] (UNGASS Indicator 3), 100%[53] units screened was reported only for 116 SBTP centres (including that of the Red Crescent). Although a recent study done by Population council showed that the more than 50% of sampled blood transfusion centres (under SBTP and non-SBTP) are non compliant to the quality standard. (Ref: Situation of Blood supply and Transfusion services in Bangladesh, Population Council 2009. Table 17, Page 21).

[51] Health Bulletin 2009, DGHS

[52] In 2008, SBTP screened 3, 58, 346 bags of blood and rejected 3,429 bags of blood due to presence of various infectious disease agents including HIV. Source: Health Bulletin 2009 DGHS.

[53] In a study named “Situation of blood supply and transfusion service in Bangladesh” it was found that 48.6% of the centers screen for all five diseases (Hepatitis, C, Syphilis, Malaria and HIV) and 84% of the center screen for HIV. In the study two-thirds of the centers (out of 42) were under SBTP. More SBTP enlisted centers (20 out of 22) reported screening blood for various TTIs than the non-SBTP ones (13 out of 15).

3.1.4 Life Skills Education

Currently UNICEF and Save the Children USA (supported by GFATM) are working on the life skills based HIV/AIDS education programmes in Bangladesh. Under the Global Fund supported HIV prevention program Save the Children USA with the support of NASP and the Implementing partner (namely PIACT, Bangladesh) HIV and AIDS related information was incorporated into the National Curriculum from classes 6 to 12. Approval for the programme has been taken from the Ministry of Health and Family Welfare, Ministry of Education and the National Curriculum and Textbook Board. Through this integration a total of approximately 6.8 million[54] students will be receiving information on HIV and AIDS through class-room education each year. To support this endeavour, teachers training component is also being implemented. Between the year 2008 (3,995) and 2009 (2,551), a total of 6,546 institutions (school, college, Dakhil and Alim Madrasa) had been covered through this programme in 16 districts including city corporations. A total of 46,397 core trainers, master trainers and subject teachers were trained between 2008 (28,282) and 2009 (18,115) on the interactive classroom education methodology for life skill education. All educational institutions/schools in the country are now mandated to teach HIV in the classroom as per National Curriculum and therefore the teachers training will be continued in all the institutions across country.

In addition to the class-room education component, drug resistance education (DRE) has been provided in 70 schools and in 63 non-formal institutions under the same program. Through it 11 components of life-skills based education is fully covered and till date (2008 and 2009) the capacity of 120 Master Trainers, 510 Peer Educators and 109,654 young people have been developed. Supplementary take-home materials are also provided to the students.

Under UNICEF, Life Skills Based Education (LSBE) package containing content materials (lessons), teachers' guide and training manual had been developed in 2007. In 2008, the life skills lessons (which include lessons on HIV/ AIDS, puberty, drugs and personal safety) had been piloted in 26 secondary schools of the country. In each classroom, there were, on average, 65-70 students. Thus, the life skills based lessons reached about 7000 secondary level students in 2008. In 2009, there was only teacher training activities. About 10,000 secondary school teachers including the head teachers were trained up in LSBE. The LSBE package will be getting the approval by the National Curriculum Coordination Committee (NCCC), in the beginning of 2010. Following the approval, Life Skills based HIV/AIDS education will be incorporated into secondary (grades VI to X) textbooks in 2011. It will then cover all the secondary level students which is around 7 million at present.

The indicator - Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year (UNGASS Indicator 11) – currently only 26[55] of the19017 (0.14%) of the educational institutions have provided life skill based education – though close to 6546 institutions are ready to roll out the programme as the teachers have been already trained in these institution. So, it is hoped that in the next couple of years scale up and full coverage will be achieved.

[54] http://www.banbeis.gov.bd

[55] Covered through UNICEF LSBE programme

3.2 TREATMENT, CARE AND SUPPORT FOR THE PLHIV

3.2.1 Prevention of Parent to Child Transmission:

In January 2008, a project on Prevention of Parent to Child Transmission (PPTCT) was started with the technical and financial support of UNICEF for a period of three years (January 2008 to December 2010). JAGORI (ICDDR,B) is project implementing partner. The aim of the project is to provide the full and comprehensive services related to PPTCT in Bangladesh. Through this pilot project ARV medicine is being provided to HIV-positive pregnant women.

The main beneficiaries of this programme include: all pregnant women, newborn and infants under 18 months, spouse/partner of HIV positive pregnant women and HIV infected and affected children of HIV positive pregnant women

Selected health facility staff were trained and equipped to provide antiretroviral prophylaxis, voluntary counselling and testing services, and care and support services for infected women, their spouses and children. Through the PPTCT program in Bangladesh, UNICEF is piloting interventions in three selected health care facilities (one is currently operational and two more to start soon). There is no clear data on how many children could be infected with the HIV virus in the country. In the first year of the PPTCT pilot project, VCT services were provided to 59 pregnant women of whom five were HIV positive while in the second year services were provided to 79 pregnant women of whom 8 were HIV positive and received necessary treatment and care.

In 2009, a technical committee on PPTCT and paediatric HIV care, support and treatment has been formed in order to provide technical assistance to the development of PPTCT services and management of paediatric HIV care, support and treatment (CST) program in Bangladesh. The Director, Primary Health Care and Line Director of Essential Service Delivery under Directorate General of Health Services is the Chairperson of the 32 member committee. They are mandated to meet at least quarterly.

On the Indicator-Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission (UNGASS Indicator 5), currently no data is being captured to measure this indicator in the country.

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

The first VCT centre in Bangladesh was set up in 2002 and by 2009 numbers have gone up to about 105. The quality and range of services vary – only a few centres have professionally trained counsellors, physicians to offer medical examinations when other STIs are suspected, gold-standard HIV test and laboratory procedures, quality assurance and validation of HIV test results etc. Outside Dhaka, to obtain test results can take up to a week in some centres. Post test counselling for people who test positive also includes referral to PLHIV support groups. In recent years, PLHIV peer support groups have expanded to well over 500 members. They provide counselling, home visits, referrals and free treatment for opportunistic infections, advice and information on positive living and advocacy and communication with the general public to reduce stigma and discrimination. On experience of stigma and discrimination, there are numerous reports of denial of treatment to high risk

individuals by the health care providers[56]. Only a few facilities in Bangladesh (mostly in Dhaka) are able to treat HIV-related infections or provide ART.

On the indicator - Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy (UNGASS Indicator 4), the current ART coverage has been increased from 13.3% in 2007 to 47.7% in 2009[57].

3.2.3 Co- management of TB and HIV Treatment

The extent of TB/HIV co-infection is not exactly known in Bangladesh. There is a clear need to keep the trend of TB/HIV co-infection under surveillance. According to three studies carried out in Dhaka city between 1999 and 2007, the figures for HIV prevalence among TB patients have been consistently low. The surveys were conducted between January and June 1999 (first round), between August 2001 and June 2002 (second round), and between August 2006 and July 2007 (third round). The first survey was conducted in two outdoor clinics in Dhaka. The second and third surveys were conducted in the same two outdoor clinics and among indoor patients of National Institute of Diseases of Chest and Hospital (NIDCH), Dhaka

In the first survey, 1 out of 936 new sputum smear-positive patients was found HIV positive. In the second round, out of 959 outdoor patients, no one was infected. While, only 1 out of 887 patients in NIDCH, was found positive. In the last round, 1 from among 1002 outdoor patients and 4 of 879 indoor patients were found positive.

The Strategic Plan for TB Control has identified TB/HIV collaboration as one of the major service delivery areas. The plan envisages four key activities, namely: developing a national policy for TB/HIV; establishing functional linkages between NTP and NASP; increasing awareness among HIV workers for identification and referral of TB suspects, and initiating HIV sero-prevalence studies among TB patients. The DGHS has formed a “Forum for HIV and TB Collaboration” with members from NASP, NTP and WHO. The forum is, however, yet to organize any meetings.

Among the HIV infected persons TB is a common opportunistic infection. TB is a major public health problem in Bangladesh. In 2006, Bangladesh was ranked sixth among the world’s 22 high-burden TB countries by WHO.

In order to measure the UNGAS Indicator - Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV (UNGASS Indicator 6), the numerator figure (29) was received from the GFATM supported programme managed by Save the Children-USA. But the denominator is not known for this indicator in the country. Therefore, it is difficult to calculate a measure for the performance of the indicator. However, according to NASP data, during 2009, 21 cases of TB were reported in new HIV and AIDS cases and among them 17 received TB treatment. It may be mentioned here that in 2009, a total of 250 new cases were identified and 143 had developed AIDS.

[56] United Nations, 2008; UNGASS, 2008; Bondurant et al., 2007

[57] The numerator came from the PLHIV organizations and verified with them in a consultation. The denominator came from a GTZ supported projection model and the denominator was agreed by NASP, M&E TWG and also by the PLHIV organizations.

3.2.4 Services for Orphans and Vulnerable Children

The data on the number of orphans and vulnerable children affected by AIDS is not available in the country. However, in 2007 UNICEF estimated about 5,000,000 Orphan Children (aged 0–17)[58] orphaned due to all causes. Ashar Alo Society (AAS) is serving a total of 360 affected children (age :< 15 years). These 360 children belong to families receiving intervention-support from AAS. Interventions include: provision of ARV, support for lab tests, nutritional support, health education, counselling, income generation training and seed money, care-givers training etc. Total number of children infected as on December 2009 was 36 out of whom 3 were getting ARV support. The total number of children among the members of AAS those who are affected and infected due to HIV/AIDS is 396.

3.2.5 Greater Involvement of People Living with AIDS (GIPA)

Government of Bangladesh through its 2nd National Strategic Plan (NSP) for HIV/AIDS 2004-2010 has specified the need to ensure involvement of Persons Living with HIV in the national response to HIV and AIDS as one of its priorities. In support of the NSP, UN system in Bangladesh has formulated a common UN plan and developed the "United Nation Implementation Support Plan (UN-ISP)". Among other issues that joint UN plan would support, one of the key areas is to build a momentum of advocacy and lobbying for enhanced empowerment and recognition of Person Living with HIV. One of its expected outcomes is that "People who are infected and affected have taken their place in the national response".

In the above context of UN-ISP, UNAIDS Bangladesh has mobilized funds through Project Accelerating Fund (PAF) to facilitate the formation of a network of PLHIV and provide them with required capacity building support. As part of this process, through a sound understanding with the 4 PLHIV groups (Mukta Akash, Ashar Alo, CAAP and Geon Health Foundation) an interim committee has been nominated by the group to work for the national network. A national workshop was held in April 9-11, 2006 at Koitta, Manikganj. An interim committee of 13 volunteers having representation from each of the PLHIV organization from different divisions was formed. The salient terms of reference of this interim committee was to elect the executive committee of national PLHIV network by Dec 2008. The formation of national PLHIV committee is still pending due to various reasons including consensus development among the groups. The terms of reference of this national network was formulated by the interim committee which essentially includes (a) Advocacy for all kind of rights of PLHIVs e.g. health and other citizen rights (b) ensure socio-economic benefits to PLHIVs (c) strengthen relationship between existing PLHIV groups (d) participate in the meetings of country coordination mechanism (CCM) and HIV related bodies headed by government and civil society (e) enhance capacity of PLHIVs in program planning, implementation and (f) to create job opportunity for PLHIVs.

[58] Source: http://www.unicef.org/infobycountry/bangladesh_bangladesh_statistics.html

3.3 TECHNICAL SUPPORT PLAN FOR STRENGTHENING THE NATIONAL PROGRAM

With the technical assistance from UNAIDS, NASP has developed "Bangladesh technical support plan for HIV and AIDS" for 2008-2015, and a costed plan for 2008 and 2009 has been finalized. The purpose of developing a Technical Support Plan for Bangladesh was to ensure technical support for the HIV/AIDS response is provided in a timely, coordinated and effective manner and addresses Bangladesh's most urgent needs. It is not intended to cover every technical support intervention provided to HIV/AIDS programmes over the coming year (much of which is already planned and budgeted), but instead it sets out priority areas of technical support, needed to overcome barriers to achieving the objectives set out in the country's National Strategic Plan. It is hoped that the plan will become a reference document for all development partners in developing their own technical support to Bangladesh HIV programme in the future. It is intended that the document will be reviewed and updated regularly as part of Bangladesh's normal planning and M&E cycles.

3.4 FINANCING AND SPENDING

There has been no National AIDS Spending Assessment (NASA) done yet in the country. Although disease specific data was captured in the third National Health Account done in 2008 but the report is not yet available. In the last two years (2008 and 2009) more than 64 million US$ was spent on the HIV/AIDS prevention program which is more than 20 million US$ as compared to what was spent during the period of 2006 and 2007.

3.5 NATIONAL PRIORITY AND COMMITMENT TO HIV AND AIDS RESPONSE

The national HIV programme has been progressively scaled up in its quality and coverage in the last two years. Government has mobilized loans and grants from development partners, including the World Bank, GFATM, UN agencies, and other multilateral and bilateral donors, to support interventions to prevent and treat HIV particularly among vulnerable populations. NASP has improved its capacity to coordinate TC-NAC, implementing agencies and donors. There is now more consistent recognition by government that HIV is a development issue inextricably linked to cultural, social and economic determinants and, therefore, demands a wider and accelerated response. The inclusion of HIV in national health, nutrition and gender planning and in the government's Poverty Reduction Strategy Paper and in the national health policy 2009 (draft) proves this point.

The third National Health account (NHA) has been completed in 2009 with disease specific account for the first time in Bangladesh. This report will provide data on HIV/AIDS expenditure in Bangladesh for the 2005-07 time period. This is another good initiative of the Government that would provide an understanding of the expenditure pattern of HIV program spending. This report is yet to be published.

Although Bangladesh has taken many positive steps towards preventing and controlling HIV in recent years however, there are still many challenges to be addressed. Policy guidelines, manuals are there and the challenge is to implement them. Some legislative changes are required in order to enable universal access to injecting equipment for IDUs, condoms for sex workers and MSM, and to create an enabling environment for universal access by the

wider population. The technical and organizational capacity of project implementing agencies across Bangladesh needs to be further strengthened, in order to facilitate the scaling up of activities.

V. BEST PRACTICES

Bangladesh has been implementing HIV/AIDS program since 1987 even before the first case of HIV was detected in the country in 1989. Since then, the program has been expanding in its size, quality and coverage. The program has predominantly targeted the MARPs for prevention services, but over the years, other groups are being focused, particularly the young people. In the last two years (2008 and 2009) the national programme has achieved some progress and there are several best practice areas which have contributed to improve program performance in the country which is being shared here.

1. DOCUMENTATION OF 20 YEARS OF HIV IN BANGLADESH: EXPERIENCES AND WAY FORWARD. (THE WORLD BANK, UNAIDS AND ICDDRB-2009)

Periodic and systematic documentation of HIV/AIDS program of a country is a major step to understand the country context, the status of the epidemic, identify the gaps and opportunities. This would provide insights for improving the efficiency and effectiveness of the program. One such effort was made in Bangladesh in 2009 with the support of World Bank, UNAIDS, ICDDR,B and Independent University of Bangladesh (IUB).

This document is a consolidation of the experiences of HIV/AIDS programming in Bangladesh over the past two decades. It synthesizes data from surveillance, behavioural surveys and published and unpublished research to better understand emerging patterns and trends in the HIV epidemic in Bangladesh. Taking stock of 20 years of experience with HIV programming in Bangladesh, this document summarizes the following:

- The scope and the coverage of interventions delivered
- Understanding the process of capacity building and organizational development of the institutions, involved in HIV/AIDS response in Bangladesh.
- Understanding the process involved in knowledge accretion and dissemination, particularly on risk and protective behaviours.
- It also presents an analysis on the trend of the epidemic over the years and impact of the prevention programs.

The document is divided into nine chapters. Chapter I provides a brief introduction and an overview of the methodology used for the documentation. Chapter II discusses the risks and vulnerabilities of the high risk groups including female sex workers, injecting drug users, male who have sex with male, transgender/hijra and overlapping populations, while Chapter III discusses the trend of the infection amongst partners of high risk groups. Bangladesh continues to report low condom use, which is analyzed and discussed in Chapter IV. Structural aspects including macro level and intermediate level factors that affect HIV interventions in Bangladesh are addressed in Chapter V. The national HIV response is discussed in Chapter VI. Chapter VII is a conclusion to the document, with a discussion on the main findings, with recommendations for the future. Chapter VIII and IX are annexes and references.

2. "PEOPLE LIVING WITH HIV (PLHIV) STIGMA INDEX" A STUDY IN BANGLADESH. (JAMES P GRANT SCHOOL OF PUBLIC HEALTH, BRAC UNIVERSITY, BANGLADESH. 2009)

This report focuses on stigma and discrimination faced by people living with HIV/AIDS in Bangladesh. The main aim of the study was to identify actions needed to address HIV related stigma and discrimination. The research investigated the present picture of stigma and discrimination linked to HIV in Bangladesh, identified the barriers to reduce stigma and discrimination existing in the society, and explored future needs to reduce stigma and discrimination which will ultimately benefit the HIV infected community in Bangladesh. The study was conducted by the PLHIV self Help Groups with support from BRAC University, IPPF/FPAB and UNAIDS. The findings opened up options for developing effective HIV/AIDS prevention programs and messaging for Bangladesh, as well as ensuring PLHIV access to testing and care without discriminatory barriers.

The study employed both quantitative and qualitative methods. Stigma Index questionnaire, a quantitative tool, (developed by the International Planned Parenthood Federation (IPPF)) was used to randomly select and interview 238 HIV positive persons in the country. The qualitative tool like In Depth Interview (IDI) was used with 31 selected HIV positive persons for further detailed discussions on their experiences of stigma and discrimination. Profile of PLHIV selected for the qualitative phase included sex workers, sex worker who is IDU, migrant workers, HIV positive people with HIV+ children, IDUs, prisoners, Unmarried HIV+, MSM, Hijra (Transgender) etc. A majority of the 238 participants of this study faced discrimination on revealing their HIV status - from their families, friends, communities, colleagues or at health care settings.

A lack of access to health care services by PLHIV came up as an issue that requires urgent attention. The majority of PLHIV faced some form of discrimination when attempting to get treatment from a government hospital or local clinic, suggesting that adequate training of health care providers (e.g. nurse, doctor and laboratory technicians) is an urgent requirement. Participants indicated that misconceptions with regard to causes and methods of transmission of HIV have lead to intolerance of PLHIV in society and a variety of forms of stigmatization and discrimination. Participants indicated the need for more measures from government to make the public aware of the basic facts of HIV/AIDS. It was also suggested that the government undertake measures to regularly subsidize antiretroviral drugs and other costly medicines which are essential for the well-being of PLHIV. Through these measures, they hope, would reduce the intolerance towards PLHIV in society.

The findings of this report will be useful for the government, NGOs, those working to provide support to PLHIVs; community based organizations and for people living with HIV for any future planning and advocacy to reduce the stigma and discrimination linked to HIV in Bangladesh.

3. FORMATION OF DISTRICT LEVEL LAWYERS GROUPS (DLLGS)- BANDHU SOCIAL WELFARE SOCIETY

Under the existing Bangladeshi law (Bangladesh Penal Code, Section 377 – Of Unnatural Offences) *"Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with imprisonment for life, or with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine".*

BSWS, along with many other organisations working in the sexual health and human rights fields, is keen to see this law reformed. For this reason, BSWS has established a District Level Lawyers Group (DLLG) in their working areas. Each group has 10 – 15 members, most of whom are young and energetic advocates with a strong interest in human rights. Each group is led by a DLLG co-ordinator. Each DLLG is supported by a district advocacy officer, who liaises regularly with the DLLG co-ordinator. The Dhaka-based senior legal officer, the BSWS focal person for legal matters, is also in regular contact with each DLLG. At present, DLLG meetings are funded by Manusher Jonno Foundation and Netherlands Embassy monies under the BSWS human rights and advocacy initiatives. DLLG membership is entirely voluntary and other than reimbursement of transport costs, participants do not receive any remuneration for attending meetings. To date, all DLLG members have received sensitisation training on MSM and Hijra issues including information on HIV and AIDS. BSWS is also planning to organize training on human rights as well as international conventions on legal matters pertaining to sexual minorities and their rights.

The role of the DLLG is three-fold: (i) sensitising local advocates, government officials and other stakeholders, (ii) providing legal support and protection for local MSM and Hijra communities, and (iii) raising a voice on behalf of the community members to advocate for policy reform. DLLGs also help to facilitate other BSWS project activities within their localities, such as commemoration of World AIDS Day and International Human Rights Day. Each DLLG meets once in six months. The first national round table meeting of DLLG members took place in April 2008. Now, if BSWS community members require legal advice or services, they are referred to members of the local DLLG who would advocate on their behalf and provide legal protection.

BSWS looks forward to establishing a DLLG in every district in Bangladesh. One or two representatives from each DLLG would form a national group which would lobby the government on MSM and Hijra issues. Following an initial period of capacity building, it is envisaged that this DLLG network would operate independently of BSWS. BSWS also plans to lead the formation of a national taskforce that would bring together key stakeholders from the health, legal and rights sectors, including government and non-government organizations, international experts and donors, to develop inclusive and supportive policies for the MSM and Hijra communities.

4. TEACHERS TRAINING: TRAINING TEACHERS ON HIV FOR STRONGER IMPLEMENTATION OF THE NATIONAL CURRICULUM.

Under the Global Fund supported HIV prevention programme, which is a collaboration between National AIDS/STD Programme, Save the Children USA, and the Implementing partners (namely PIACT, Bangladesh) HIV and AIDS related information was incorporated into the National Curriculum from classes 6 to 12 through due approvals of the Ministry of Health and Family Welfare, Ministry of Education and the National Curriculum and Textbook Board. Through this integration a total of approximately 6.8 million students will be receiving information on HIV and AIDS through class-room education each year.

In addition to the class-room education component, drug resistance education (DRE) has also been provided in schools and in non-formal institutions under the same program.

The curriculum was developed through a participatory bottom-up approach gathering information and feedback from students, teachers, gatekeepers (including representatives of School and Madrasa Management Committees and Governing Bodies of colleges), religious leaders and national level decision-makers through a needs assessment, a number of

workshops and consultative meetings. The course content for DRE was formulated in a similar manner.

5. HIV/AIDS AWARENESS THROUGH MOSQUES, TEMPLES, PAGODAS AND CHURCHES:

The religious leaders play an important role in moulding the thought process of the general population through influencing socio-religious norms and beliefs. Bearing this in mind, the Global Fund supported HIV/AIDS Project being implemented through the collaborative effort of the NASP and Save the Children USA, sensitized the religious leaders and convinced them of their role in creating awareness on HIV among the young people.

Several consensus building meetings, workshops and activities involving the religious leaders representing the four major religions of Bangladesh; i.e. Islam, Hindu, Buddhist and Christian; were initiated. All representatives at national and local levels have expressed their commitment and jointly declared to fight the epidemic. Four booklets with quotations from the four holy books were developed under this project and have been approved by the IEC technical committee of the MOHFW, Government of Bangladesh. The campaign activities include orientation and planning workshops at divisional, district and upazilla level. Through this process, it is hoped that the four booklets would be distributed among 250,000 religious leaders to disseminate HIV/AIDS prevention, care and support messages through mosques, temples, pagodas and churches. So far, 1,852 participants including representatives of the Ministry of Health and Family Welfare, Ministry of Religious Affairs, Inter-faith groups and organizations, Islamic Foundation, NGOs and other stakeholders have worked together to formulate the full plan for implementation at the local religious institutions across the country. A total of 635,700 religious materials have been distributed so far (Islam: 564,800, Sanaton (Hindu): 46,200, Buddhist: 13,900 and Christian: 10,800) among local religious leaders.

VI.MAJOR CHALLENGES AND REMEDIAL ACTIONS

1. PROGRESS MADE ON KEY CHALLENGES REPORTED IN 2008 UNGASS COUNTRY REPORT

In 2008 UNGASS report, several challenges were mentioned. Good progress has been made on many of those challenges discussed in the report. At the same time, the national programme continues to face some of these challenges. Following paragraphs would briefly capture the progress made.

1.1 POLICY AND PROGRAMMATIC ISSUES

1.1.1 Coordination and Interactive Mechanism of NASP:

This problem still exists as there has been no significant change in terms of resources (personnel, funding, infrastructure, etc.) at NASP. This has been a constraint on the effective planning and coordination of the national response to HIV in Bangladesh. Frequent interruptions in service delivery at the field level as well as inadequate, inappropriate and irregular supplies of materials (condoms, lubricants, sterile injection equipment, and STI drugs) continue to be some of the challenges facing the programme due to issues related to coordination. Efficient coordination among the many donor agencies, hundreds of implementers, multiple ministries is needed to ensure adequate and timely fund flow, right environment for implementation (eg. support of law enforcement agencies to MARPs intervention) and uninterrupted provision of key services. NASP needs to be adequately and appropriately resourced to enhance its capacity to carry out the role of providing strategic direction to the programme, coordination and engaging with various sectors that are important to the success of interventions

1.1.2 Policy Development:

The National Strategic Plan (2004-2010) has still not been reviewed since it was endorsed by the Ministry until April 2009, under the leadership of NASP; the process has been initiated through the first consultative meeting on the review and development of the National Strategic Plan 2010-2015.

There exist several laws, acts that are still limiting the access of MARPs to prevention services. The Narcotics Control Act (NCA), under article 18 of national constitution, passed in 1990; made drug use a criminal offense, made drug users criminals, and called for mandatory treatment of drug users. However, the national AIDS policy recognizes harm reduction approaches and the NASP incorporated harm reduction services for IDUs in its strategic plan 2004-2010. Bangladesh started its NSP for IDUs in the late 1990s, expanded it over the years and has now approved a pilot of OST. However, no initiatives have been taken for the law reform.[59] Other similar laws that affect the sex workers are Metropolitan

[59] 20 Years of HIV in Bangladesh: World Bank and UNAIDS 2009

police ordinances, Bengal Suppression of Immoral Traffic Act 1933, The Bangladesh penal code 290, 377 etc.[60]

These are the areas where legislative changes are needed in order to make sure access of MARPs to HIV/AIDS prevention services in Bangladesh

1.1.3 Prevention

Prevention programs have been geographically expanded specially with GFATM supported round 6 programmes for the MARPs. The GFATM supported round 2 program for the youth also has been contributing in disseminating BCC/IEC information to the young people, religious leaders, school teachers and general population through different mass media.

Absence of an updated size estimation of MARP continues to hamper the target setting process for programme planning and procurement of prevention devices such as condoms, needle-syringes etc.

The number of public and private VCT centres has been increased from 60 to 105 in 2009. The VCT guideline is available to promote comprehensive HIV treatment, care and support. ICDDRB conducted mapping exercise and GTZ supported a projection to identify HIV treatment needs. In addition to these, NASP conducted gap analysis while developing RCC-2 and GFATM R-8 proposal development

1.2 THE PARTICIPATION OF CIVIL SOCIETY:

The civil society has been playing an important role in the HIV/IDS prevention program in Bangladesh. The participation of civil society organization has improved in various forums (CCM, Multi-sectoral AIDS Coordination Body, National M&E Committee etc) since the last UNGASS reporting in 2008. There is an improved financial spending of close to 85% through activities implemented by civil society in the past year. The NASP has been providing support for the implementation of HIV related activities to the civil society organizations in many ways such as: providing information on priority needs, technical guidance, coordination with other implementing partners, capacity building etc.

At the same time, the civil society partners have not been very successful in influencing policies and political commitment especially focusing on legal barriers that prevent easy access to prevention services by MARPs. (NCPI-Part-A, NCPI-Part-B)

1.3 ACCESS TO TREATMENT:

As compared to the last UNGASS report in 2008, a fourfold increase (from 13.3% to 47.7%) has been reported in the estimated number of people receiving ARV treatment. GFATM has started supporting the ARV scale up to the PLHIV through round 6 funding cycle since 2008.

[60] Ibid

1.4 PROTECTION OF HUMAN RIGHTS:

In Bangladesh, there have been no laws and regulations that protect people living with HIV against discrimination. However, there are laws against discrimination in general, but not specifically focusing HIV issues. At the same time there are laws, regulations or policies that are obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations (young people, IDU, SW, MSM, prison inmates). There has been no progress in reforming these laws/regulations.

2. CHALLENGES FACED DURING CURRENT REPORTING PERIOD:

Bangladesh is still fortunate to keep the HIV prevalence below 1% among the general population. This is favourable to achieve the millennium Development Goal-6 “Halting and reversing the spread of HIV by 2015”. At the same time there are several programmatic and implementation related challenges which require immediate attention for successfully achieving this target.

2.1 POLICY ENVIRONMENT

The National Policy on HIV/AIDS and STD related Issues was ratified in 1997 and provides the overarching policy framework for the programme in Bangladesh. The national policy has not been reviewed for more than a decade in the context of the changing situation in the country. As a result, the existing provisions of laws are used haphazardly, often to harass vulnerable population leading to interference and weakening of the program implementation among MARPs. Some of the laws that hamper the program implementation are: a) the Code of Criminal Procedure (section 54: provision of arrest without a warrant); b) Penal Code, (section 377: prohibiting carnal knowledge against the order of nature); c) Dhaka Metropolitan Police Ordinance 1976 (section 86: penalty for being found under suspicious circumstances between sunset and sunrise); d) Bangladesh Penal Code 290: Public Nuisances’. Suppression of Immoral trafficking- act that refers any promiscuous sexual act that is bought, whether for money or for kind. There is a need to review these acts and laws to ensure better policy environment and programme performance.

2.2 LEADERSHIP AND COORDINATION

Leadership and coordination has been a major challenge of the national programme over the years. The existing National AIDS Committee (NAC) needs to be reformed. The NASP is the mandated coordination body for HIV and AIDS program implementation in the country. Inadequate resources in NASP, in terms of personnel, funding, infrastructure, etc., have been a constraint for effective planning and coordination of the national response to HIV in Bangladesh. As a result, there has been interruption in implementation (like delayed procurement of services from NGOs) of national HIV/AIDS program leading to programmatic inadequacies in achieving scale and coverage of MARPs in the field, effective and timely supervisory support, improving quality of services overall etc.. Funding and granting mechanisms are often non-responsive to the need of the community and the field.

There are several stakeholders and development partners involved with the National HIV and AIDS response in Bangladesh. These include multiple donors, multiple implementers, technical support providers (Research, BCC, Procurement etc.) who engage with the program on a regular basis. Absence of mechanism for smooth coordination between different players has been a major hindrance to providing quality services. Within the

government, multiple ministries need to be engaged to ensure the active involvement of key services such as law enforcement; which has not been carried out effectively. Besides, not all services can be provided through the HIV prevention programmes. The needs of MARPs that are beyond the scope of HIV prevention services, such as legal support, alternate income etc need to be provided through linkages with other service providers, which is currently lacking.

2.3 STRATEGIC INFORMATION MANAGEMENT:

Strategic information management system which is crucial for effective generation and management of data following the principle of "one agreed country-level monitoring and evaluation system" has not been operationalized in Bangladesh. There is no coordinated effort to bring together programme related data and information to a central unit. Still the data and information processing is implemented by different programmes independently. Thus, crucial information needed for strategic and policy level decision at the country level is often not accessible (though available) in a form that can be easily consumed. The collection and collation of data through surveillance, surveys and research have been under-resourced. All countries are advised to "know their epidemic". However, in order to have this knowledge it is essential that data are gathered regularly not only through surveillance but also through different sources. The Behavioral and serological surveillance has been absent since 2007.

Research studies have received little priority in Bangladesh. There are major gaps in information in some key areas such as international and cross border migration that needs to be researched much more. Studies piloting innovative prevention designs through operations research are needed. It is also important to introduce system for frequent triangulation of data to determine how the HIV scenario is changing in Bangladesh, including size estimation of MARPs and geographical distribution of risk and vulnerabilities.

2.4 FINANCING TARGETED INTERVENTIONS:

There is no system for comprehensive costing analysis before starting any intervention program in Bangladesh. Bangladesh has not been able to conduct National AIDS Spending Assessment (NASA) yet. One of the major challenges is the absence of a long term funding commitment from the donors, leading to myopic focus only on delivering the input and outputs rather than achieving the outcome or impact. Inadequacy of a robust financial management system and financial resources has led to fund flow issues causing interruptions in program implementation, hampering scale up and coverage and resulting in irregular supply of consumables such as condoms, sterile needles/syringes and STI drugs.

2.5 CAPACITY:

The capacity building initiatives are still not much coordinated in the country due to absence of effective systems for capacity building. This has resulted in duplication of effort and wastage of resources. The technical expertise at individual or institutional level to plan, implement and monitor the responses is still lacking in the country. One of the major challenges is the inadequate resources to enhance the capacity of NASP to carry out strategic planning and coordination and engage the sectors that are important for the success of the National Programme.

There is no coordinated effort to build capacity of the civil society although the National Technical support plan has been developed in participation of the relevant stakeholders.

The civil society partners often lack the technical capacity to understand issues of the target community as well as programme needs. They also lack adequate skill to manage the project efficiently. This has often resulted in poor performance of the project. Therefore the capacity of Civil Society needs to be built which would enable comprehensive and quality delivery of services resulting in better outcomes at the community level.

2.6 PROGRAMMATIC GAPS:

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

- According to the standards laid out in the guidelines of construction of core indicators prepared by UNAIDS for UNGASS reporting, the coverage of MARPs is inadequate in Bangladesh. The BSS data shows high levels of coverage, which is due to the fact that the BSS definition of coverage in Bangladesh differs with that of UNGASS definition. Moreover, under different donor supported programmes, the definition of MARPs also varies. Therefore one of the key requirements is to ensure minimum technical standards are laid out by the national programme and all the donor driven programme should follow the same standards and definition.
- There is great variation in the quality of services delivered in different funded programmes and in different implementing partners. This calls for concerted effort to standardize performance measures and unify strategic information management system
- Last size estimation of MARPs had been carried out in 2004 in the country and the data has not been updated. This has resulted in serious lacunae in defining more realistic denominator while assessing extent of coverage of MARPs.
- Lacks in clear evidence-based focus on priority groups and sometimes the programs are not responsive to the local needs. This is partly due to inadequate involvement of community groups/representatives in the program design phase.
- As the epidemic evolves, there is inadequate mechanism for identification and inclusion of new vulnerable groups (eg. Migrants).
- There exist inadequate access to care and support services for PLHIV and inadequate program to reduce stigmatisation and discrimination. Inadequate Multi-Sectoral Involvement in the program is visible.
- The response to HIV in Bangladesh is provided through multiple funders and multiple implementers. Lack of smooth coordination between players has been a major hindrance to providing quality services.
- Within the government, multiple ministries need to be engaged to ensure the active involvement of key services such as law enforcement; this has not been carried out effectively. The roles and responsibilities of designated focal points in the 16 ministries need to be clarified and activated.

3. REMEDIAL ACTIONS

3.1 INSTITUTIONAL AND STEWARDSHIP ROLE OF NASP:

NASP needs to strengthen its institutional capacity and stewardship role in order to coordinate with diverse community based organization, different parts of government especially within ministries and multiple donors to share lessons, highlight problems and carry out joint problem solving missions. The Three Ones Principle needs to be effectively implemented under the leadership of NASP.

3.2 IMPROVE INTERVENTION COVERAGE, QUALITY AND COMPLEMENTARITIES:

The existing coverage of the MARPS needs to be increased for better impact on reversal of the epidemic. Evidence shows that when the HIV prevention programs were smaller they were more effective. As programmes got scaled up the effectiveness and quality of services have come down. There is a need to build the capacity at all level to facilitate and manage scale up. There is a need for systemic reforms such as – need for gathering better evidence, improve planning and monitoring system, provide adequate resources to manage scale up, improve technical capabilities at all level to effectively manage scale up. Lack of adequate skilled personnel is also a major barrier. In order to improve the quality and complementarities of the core interventions, performance standards need to be developed and the existing monitoring and supervision mechanisms need to be strengthened.

3.3 RESOURCE UTILIZATION:

Resources allocated for HIV prevention to be utilized in a targeted and cost-effective manner, avoiding duplications, increasing synergies to achieve enhanced outcomes. Appropriate resources need to be provided to enhance the capacity of NASP to allow for long term strategic planning, coordination, and engage the sectors that are important to the success of interventions.

3.4 CAPACITY BUILDING:

The National Technical Support Plan (TSP) delineates capacity building needs and technical needs in three key areas: 1. program management; 2. national technical capacity to plan, implement and monitor the response and; 3. implementation and management capacity for NGOs/CBOs. Implementation of TSP needs to be scrutinized as part of the National Strategic plan. In order to enhance understanding and capacity at all level, implementers need enhanced skills in designing, managing and running their interventions. Training on each of these skills needs to be provided by experienced in-country or international technical organizations or individuals.

Policy makers need to understand that situations vary and can change with time, and that they need to keep abreast of the changes and allow flexibility to accommodate variations and changes over time. For this purpose, field or local level knowledge needs to be shared at regular intervals and used to modify interventions if required. Policy makers need to

understand that for an effective program, flexibility is crucial and that a 'one size fits all' policy cannot work. Community based organizations need to be strengthened, new ones need to be created and linkages or networks need to be established. For this, special effort has to be undertaken and if needed regional experience could be brought in.

3.5 STRATEGIC INFORMATION MANAGEMENT:

Monitoring and evaluation system should be streamlined and refocused as Strategic Information Management System within NASP, widening the scope of data management to information management for strategic and programmatic decision making. Need to streamline regular collection of strategic information through behavioural and serological surveillance, build capacity and increase resource allocation for more surveys and research on themes and issues of programmatic interest in the context of Bangladesh and HIV epidemic. The national behavioural and serological surveillance should be started without further delay. Streamline monitoring of and evaluation of projects at the implementation level by defining standard measures. NASP should guide the partners in the collection of priority data required to measure the progress of the national strategic plan. Multi-skilled capacity required for coordinating, guiding and supporting the National Information Management system within NASP and to operationalize National M&E Framework.

3.6 INCREASING PARTNERSHIP:

In order to achieve the MDGs, it is important to mainstreaming HIV into relevant public sectors to develop a comprehensive, right based response at a required scale. It is also important to make sure more Public Private Partnership (PPP) to strengthen the existing responses.

3.7 IMPLEMENTATION OF THE TECHNICAL SUPPORT PLAN (TSP):

NASP, with assistance from UNAIDS Country office in Bangladesh, has prepared "Bangladesh Technical Support Plan (TSP) for HIV/AIDS" for the period 2008 - 2015 and a costed plan prepared for the period 2008-2009. The objective of the plan was "to identify common gaps and bottlenecks in the national response and to ensure that they were addressed through the most appropriate means of technical support in a timely and effective manner". An important goal of the TSP is to create an enabling environment for an effective national response to AIDS. This will be realized by addressing the following cross- cutting issues both in the long and short-run:

- Strengthening coordination among partners (government, donors, management support agencies (MSA), development partners, UN agencies, implementing non-governmental organizations (NGOs) and other relevant ministries).
- A primary focus on building the capacity for NASP and implementing partners (NGOs) to lead a multi-sectoral response.
- Addressing the management of funding channels and ensuring predictable funding.
- Implementing comprehensive M&E systems for tracking and reporting on the epidemic.

SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

Development partners have been playing a significant role in the prevention and control of HIV in Bangladesh, and building the capacity of government to plan, design, implement and monitor the national HIV programme. The development partners are from multilateral bodies such as UN agencies, bilateral donors, international NGOs, and national and international research organizations such as IEDCR and ICDDR,B respectively. IEDCR and ICDDR,B are playing critical role in running the surveillance and other operations research.

The existing HIV interventions are mainly supported by USAID (through FHI), GFATM (through Save the Children-USA) and the World Bank led consortium through HNPSP.

The Bangladesh HIV/AIDS programme has been receiving funding from three major sources. In response to the HIV/AIDS situation in Bangladesh, the HIV/AIDS Prevention Project (HAPP) was conceived and approved in December 2000 by GoB, International Development Association (IDA) and DFID. The project was implemented during 2004-2007 with management support from UNICEF, WHO and UNFPA. The UNICEF Bangladesh Country Office facilitated implementation of Targeted interventions for the Most at Risk Populations through procuring NGO services. The implementation of the HAPP program was seriously affected with repeated funding disruption, which has caused high staff turnover and undermined capacity development interventions. The HAPP project ended in December 2007 and HIV & AIDS Targeted Interventions (HATI) has been initiated under HNPSP through an agreement with MOHFW and UNICEF. HATI was designed utilizing lessons learned from HAPP as the country's largest intervention for high risk populations. The HATI ended in June 2009. As a continuation of HATI, from December 2009, under HNPSP, HIV/AIDS intervention services (HAIS) has been started for an initial duration of six months.

The Global Fund to Fight AIDS, TB & Malaria (GFATM) is another major source of funding for Bangladesh HIV and AIDS program. GFATM Round 2 provided funds to support implementation of HIV and AIDS programs by NGOs "to prevent HIV infections in young people, aged 15-24, and thereby help avert a generalized HIV epidemic in Bangladesh" and to collect data necessary for informing the development of national policy and programmes for the prevention of HIV/AIDS among young people aged 10 to 24 and to strengthen capacity of partners for effective implementation, monitoring and evaluation of the project.

The GFATM Round 6 aims to limit the spread and impact of HIV in the country by improving coverage and quality of essential HIV services for the most vulnerable, high-risk populations, while emphasizing primary prevention and risk reduction especially for vulnerable young people. GFATM Round 6 also proposed to address the identified existing gaps in several priority areas, while building national and district-level capacity to coordinate and strengthen the response. One of the major objectives of GFATM Round 6 is to build capacity of government and NGO partners at national and district levels to scale up standardized, high-quality interventions, to monitor and improve coverage and quality, and to improve coordination. Save the Children USA (SCF) has been managing the GFATM fund as the Management Support Agency (MSA).

GFATM Round 6 has expanded HIV Prevention in Bangladesh project through Rolling Continuation Channel (RCC) for the period 2009 to 2015. The goal of this project is to reduce HIV transmission among most at risk populations in Bangladesh. To achieve the goal the project has the following objectives: (1) To increase the scale of prevention services for key populations at higher risk (IDUs, female sex workers, hijras and MSM) (2) To increase the scale of the most effective activities that would require resources after the expiry of GFATM Round 2 grant (3) To build capacity of partners in order to increase the scale of the national response. The proposal will be managed by three PRs (MOHFW, Save the Children-USA and ICDDR,B), with specific roles and responsibilities by objectives and Service Delivery Areas (SDAs). The implementation will be carried out by SRs and SSRs with experience in identified areas. The total budget is US$ 81.3 million for six years. The proposed activities are in line with the program objectives of the National Strategic Plan for HIV/AIDS 2004–2010 and will contribute to the achievement of Millennium Development Goal (MDG) 6 for Bangladesh.

The other major source of funding for HIV/AIDS program in Bangladesh has been from USAID, with FHI Bangladesh as the MSA which started to support interventions in 2000 for people most vulnerable to HIV. FHI Bangladesh supports a wide variety of community–based and faith-based non-governmental organizations. The USAID funding also addressed the national surveillance system and behaviour change communication to reduce risk and vulnerability to HIV (including condom promotion among high-risk populations), improving management of sexually transmitted infections (STIs), and building capacity of government and NGO partners to plan, implement, and monitor HIV/AIDS interventions. Over time, FHI Bangladesh expanded its activities to include training of health providers in syndromic management of STIs, establishment of voluntary HIV Counselling and Testing (VCT) centres. FHI continues its program and its current phase will end in 2012.

In addition to the targeted interventions being implemented in the country as mentioned above, German Technical Cooperation (GTZ) has been working at four city corporations: Chittagong, Rajshahi, Khulna, and Sylhet in Bangladesh with an aim to improve prevention, counselling, diagnosis and treatment for HIV/AIDS and STI services in these cities through its Multidisciplinary HIV/AIDS programme. Moreover, Asian Development Bank has been contributing in HIV prevention integrated into Urban Primary health care including VCT for 2006-2010.

Long-term planning is required by both government and donors in order to achieve the universal access targets and the MDGs for HIV. In line with the NSP II, Bangladesh has developed a national monitoring and evaluation framework and technical support plan (TSP 2008-2015) that itemizes the resources required to implement the plan and scale up responses to the HIV epidemic.

To address the national priority of prevention and protection against the HIV epidemic, the United Nations Development Agreement Framework (UNDAF), 2006-10 aimed to achieve 'Increased ability of the country to understand and respond to the HIV epidemic.' Accordingly country program action plans of The UN agencies in Bangladesh focused on the following three broad intervention areas during 2008-9 in line with the National Strategic Plan (NSP) for HIV/AIDS 2006-2010.

- A comprehensive national response is in place
- People are able to protect themselves from HIV infection.

- Continued Advocacy on AIDS exceptionality

Under these three focus areas the joint effort of the agencies led to the attainment of

- progress in promoting supportive policy environment, review /development of policies /guidelines,
- mainstreaming of HIV into relevant sectors including strengthening HIV programs within the health sector,
- enhanced human resources and system capacity,
- strengthened public private partnership,
- enhanced coordination-collaboration at all levels, strengthened leadership,
- development and implementation of a UN joint Plan of Action on HIV,
- generation of strategic information,
- implementation of an effective prevention programs for Most At Risk (MARPs) and other Vulnerable Populations,
- increased acceptance and reduced stigma and discrimination for PLHAs and other MARPs,
- women empowerment, reduced violence against women,
- improved knowledge and skill of young people about HIV and how to protect themselves from infection,
- reduction of Parent to Child Transmission of HIV,
- increased participation of persons infected and affected by HIV in the national HIV response.

VIII.MONITORING AND EVALUATION ENVIRONMENT

A landmark agreement promoting universal coordination in the fight against AIDS was adopted at a meeting held by UNAIDS, the UK and the US on 25 April 2004 in Washington D.C. Donors, developing countries and UN agencies agreed to three core principles – known as the "Three Ones" - to better coordinate the scale up of national AIDS responses. The "Three Ones" principles are: 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. The third principle that talks about one agreed M&E system is crucial for more than one reason. Information which is the key to effective policy and program level decision making can be hampered if there is no coordinated effort to bring together data. In most countries, this is still a major challenge, as several donor driven programme related data, do not reach the national program coordinating organization (NASP in the case of Bangladesh). Discussion below would focus on the current M&E efforts in the country, key challenges and remedial action.

1. THE CURRENT MONITORING AND EVALUATION (M&E) SYSTEM:

Under the leadership of NASP and technical support from UNAIDS the National AIDS Monitoring and Evaluation Framework and Operation Plan 2006-2010 has been developed in 2007 and endorsed by key partners including civil society organizations and people living with HIV. Most of the partners have aligned and harmonized their M&E requirements (including indicators) with the national M&E plan. About 11% of the total HIV programme funding is budgeted for M&E activities. But the full funding has not been secured due to lack of adequate mobilization of financial resources and lack of manpower. The M&E expenditures are not being monitored and the M&E priorities are not determined through a national M&E system assessment. The priorities are determined by evaluating the programmatic aspects. There is no functional M&E unit in the NASP yet. The key reasons for not having the functional unit are a). problems in mobilizing funding source, b) lack of existence of permanent organogram of NASP, c) long administrative process and lack of initiative from responsible personnel.

There is a national M&E technical working Group but they meet irregularly mostly need based to coordinate national M&E activities. The M&E TWG consist of members from Government, civil society and UNAIDS. This TWG has limited capacity to influence policies. There is no central national database with HIV related data, although there exists functional health information system at the national level. Different stakeholders are sending their M&E report to NASP but due to lack of database and human resources those are not stored and analysed electronically. Currently, there is no provision for yearly publication of an M&E report on HIV including surveillance data. In developing and revisiting the national AIDS strategy or for resource allocation or for program improvement, M&E data is not used comprehensively.

The DIC data base is being developed. The National HIV MIS Piloting is ongoing. To develop National HIV MIS, CRIS has been customized and the capacity of M&E TWG

members as well as personnel from 16 centers of two pilot sites, were trained to develop capacity to use the Soft ware.

Three training workshops on Country Response Information System (CRIS-3)[61] was organized by UNAIDS in November 2009. The first workshop was a ToT (Training of Trainers) and the remaining two were for the users. The objective of the ToT was to develop the M&E TWG members as trainers, who could help customize the software in order to develop and Pilot national AIDS MIS; An expert supported by UNAIDS guided the whole process. The workshop provided an understanding of CRIS, including its key features, installation, data processing etc. The training also provided information related to reviewing UNGASS data, developing indicators, preparation of reports etc.

2. CHALLENGES FACED IN THE IMPLEMENTATION OF A COMPREHENSIVE M&E SYSTEM

There were few challenges in the implementation of a comprehensive M&E plan. These are: 1. Absence of sustained organizational commitment, 2. Lack of proactive and prompt decisions from all corners, 3. Inadequate technical manpower for forming national M&E unit at NASP.

3. PLANNED REMEDIAL ACTIONS TO OVERCOME THE CHALLENGES

- Mechanisms to be established for advocating with the government so that key management personnel and experts holding the key positions in NASP are retained for longer time period within the organization (at least two to three years)
- Recruitment and appointment of more personnel with M&E expertise and experience at NASP.
- There is a need for adequate funding and logistical support in order to establish functional M&E system at NASP
- Adequate funds for institutional capacity building for M&E and research will be mobilized; improving and strengthening surveillance system; conducting size estimations of MARPs and epidemic projections; and preparing costed M&E plan will be a major focus in the next phase of NSP.

- More local technical expertise need to be developed to implement National HIV MIS nationwide.

- Capacity enhancement of NASP staff through training in research, monitoring and evaluation of the National HIV Programme will be a top priority;
- Publications and regular dissemination of national monitoring and evaluation reports will be streamlined;

[61] CRIS is the generic software and system developed by UNAIDS to promote standardized reporting of the countries. There are provision to customize CRIS to country needs and perspective.

- Use of the information system and research findings for effective programme monitoring, management, implementation, policy decision and sustainability of the programme
- Prioritization of research activities and secondary analysis of available HIV data;
- Coordination of monitoring and evaluation activities, regular meeting of the Monitoring and Evaluation Technical Working Group and other groups working with strategic information will be taken up on priority basis.
- Harmonizing HIV/AIDS M&E with the existing health management information system and other related MIS systems for tracking and supporting the multisectoral response

4. TECHNICAL ASSISTANCE NEEDED

- Setting up of a monitoring and evaluation unit in NASP with adequate staff; and training of those staff for capacity enhancement in research and M&E;
- Identifying and defining priority indicators, and developing information flow, monitoring and evaluation guidelines and tools to track the progress of the national response and to meet needs at national and international level;
- Linkages of national HIV M&E system with National Health Management Information System

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X.ANNEXURE

Annex 1: Consultation and Preparation Process

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

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

1) With inputs from

Ministries:

Education	Yes	√ No
Health	√ Yes	No
Labour	Yes	√ No
Foreign Affairs	Yes	√ No
Others	√ Yes	No
(Information)		

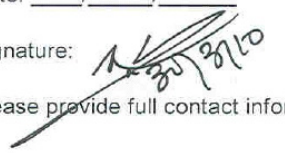
Civil society organizations	√ Yes	No
People living with HIV	√ Yes	No
Private sector	Yes	√ No
United Nations organizations	√ Yes	No
Bilateral	√ Yes	No
International NGOs	√ Yes	No
Others	Yes	√ No
(please specify)		

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

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

Name / title: Dr. Md. Ali Belal, Line Director, National AIDS/STD Program (NASP) and Safe Blood Transfusion Program (SBTP), Directorate General of Health Services, Ministry of Health and Family Welfare, Government of Bangladesh

Date: ____/_____/_____

Signature: 

Please provide full contact information:

Address: House-8/A, Road-8, Gulshan-1, Dhaka-1212

Email: stdaids2008@gmail.com

Telephone: +88-02-8829720

Annex 2: National Composite Policy Index 2010

COUNTRY: BANGLADESH

Name of the National AIDS Committee Officer in charge:

Dr. Md. Ali Belal

Line Director,

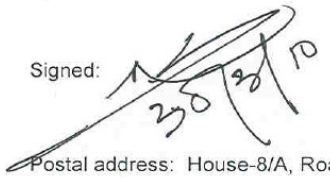
National AIDS/STD Program (NASP) and

Safe Blood Transfusion Program (SBTP)

Directorate General of Health Services (DGHS)

Ministry of Health and Family Welfare, Government of Bangladesh

Signed:



Postal address: House-8/A, Road-8, Gulshan-1, Dhaka-1212

Tel: +88-02-8829720

Fax: +88-02-8829720

E-mail: stdaids2008@gmail.com

Date of submission: -- March 2010

ANNEX-3 BSS Indicators for UNGASS 2010 reporting by age category:

Indicator	Risk groups	Age less than 25 % (n/N)	Age 25 or more % (n/N)	Total % (n/N)
Percentage of most-at-risk populations who have been tested for HIV during the last 12 months and who know the results (Indicator-8)	Female sex workers (FSW):			
	Brothel based	2.0 (8/410)	1.8 (5/273)	1.9 (13/683)
	Street based	3.7 (22/575)	4.4 (22/491)	4.1 (44/1066)
	Hotel based	6.5 (31/487)	8.3 (8/109)	6.8 (39/596)
	All FSW	4.2 (61/1472)	4.1 (35/873)	4.1 (96/2345)
	MSW	2.4 (14/578)	8.7 (20/221)	4.1 (34/799)
	Hijra	12.9 (12/93)	14.7 (49/333)	14.3 (61/426)
	MSM	1.9 (5/257)	2.8 (17/586)	2.5 (22/843)
	IDU	4.3 (4/82)	4.8 (46/1114)	4.7 (50/1196)
	Heroin smokers	2.1 (1/69)	1.1 (2/270)	1.3 (3/339)
	Rickshaw pullers	0 (0/207)	0 (0/539)	0 (0/746)
	Truckers	0 (0/128)	0 (0/345)	0 (0/473)
	All risk groups	3.4 (97/2886)	4.1 (169/4281)	3.8 (266/7167)
	(Source: BSS, 2006-2007)			
Percentage of most-at-risk populations reached with HIV/AIDS prevention programmes	Female sex workers (FSW):			
	Brothel based	2.9 (12/410)	5.1 (14/273)	3.8 (26/683)
	Street based	12.4 (73/575)	11.6 (58/491)	12.0 (131/1066)
	Hotel based	2.8 (13/487)	4.6 (5/109)	3.1 (18/596)

Indicator	Risk groups	Age less than 25 % (n/N)	Age 25 or more % (n/N)	Total % (n/N)
(Indicator-9)	All FSW	6.6 (98/1472)	8.7 (77/873)	7.4 (175/2345)
	MSW	15.7 (92/578)	24.1 (51/221)	18.0 (143/799)
	Hijra	21.5 (20/93)	22.5 (75/333)	22.3 (95/426)
	MSM	14.3 (37/257)	5.4 (30/586)	8.1 (67/843)
	IDU	1.0 (1/82)	2.2 (19/1114)	2.1 (20/1196)
	Heroin smokers	0 (0/69)	2.7 (7/270)	2.1 (7/339)
	Rickshaw pullers	0.6 (2/207)	0 (0/539)	0.2 (2/746)
	Truckers	0 (0/128)	0 (0/345)	0 (0/473)
	All risk groups	8.6 (250/2886)	6.2 (259/4281)	7.2 (509/7167)
	(Source: BSS, 2006-2007)			
Percentage of most-at-risk population who gave the correct answers to all five questions‡	Female sex workers (FSW):			
	Brothel based	24.4 (100/410)	26.0 (71/273)	25.0 (171/683)
	Street based	41.6 (244/575)	34.3 (174/491)	38.2 (418/1066)
	Hotel based	23.8 (117/487)	24.8 (26/109)	24.0 (143/596)
(Indicator-14)	All FSW	30.9 (461/1472)	30.5 (271/873)	30.8 (732/2345)
	MSW	22.1 (129/578)	50.3 (112/221)	29.6 (241/799)
	Hijra	58.1 (54/93)	54.4 (181/333)	55.2 (235/426)
	MSM	23.1 (58/257)	29.1 (174/586)	27.3 (232/843)
	IDU	28.1 (25/82)	19.6 (208/1114)	20.2 (233/1196)
	Heroin smokers	13.7 (11/69)	20.7 (57/270)	19.4 (68/339)

Indicator	Risk groups	Age less than 25 % (n/N)	Age 25 or more % (n/N)	Total % (n/N)
	Rickshaw pullers	17.9 (39/207)	9.8 (56/539)	12.1 (95/746)
	Truckers	7.1 (10/128)	7.9 (27/345)	7.7 (37/473)
	All risk groups	26.8 (787/2886)	25.3 (1086/4281)	25.9 (1873/7167)
	(Source: BSS, 2006-2007)			
Percentage of female and male sex workers reporting the use of a condom with their most recent new client (in last week) (Indicator-18)	Female sex workers (FSW):			
	Brothel based	70.3 (277/394)	70.0 (168/240)	70.2 (445/634)
	Street based	78.9 (419/527)	72.0 (300/420)	75.8 (719/947)
	Hotel based	48.7 (232/472)	42.7 (43/101)	47.7 (275/573)
	All FSW	66.2 (928/1393)	67.6 (511/761)	66.7 (1439/2154)
	MSW	40.6 (144/347)	52.5 (67/130)	43.7 (211/477)
	Hijra	59.8 (55/92)	68.4 (225/329)	66.5 (280/421)
	(Source: BSS, 2006-2007)			
Percentage of men reporting the use of a condom the last time (in last month) they had anal sex with a male/Hijra partner (Indicator-19)	Non-commercial sex			
	With male/Hijra	12.5 (31/249)	30.2 (155/498)	24.3 (186/747)
	With female	7.0 (2/26)	19.5 (56/296)	18.5 (58/322)
	Commercial sex			
	With male	17.2 (26/146)	33.5 (156/447)	29.5 (182/593)
	With female	6.5 (2/28)	44.5 (94/214)	39.7 (96/242)

Indicator	Risk groups	Age less than 25 % (n/N)	Age 25 or more % (n/N)	Total % (n/N)
	(Source: BSS, 2006-2007)			
Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse (Indicator-20)	Male IDU[§]:			
	Non-commercial sex	44.6 (8/19)	30.1 (205/681)	30.5 (213/700)
	Commercial sex	40.9 (23/57)	44.6 (261/608)	44.3 (284/665)
	Female IDU[ɵ]:			
	Non-commercial sex	0 (0/5)	57.1 (8/14)	42.1 (8/19)
	Commercial sex	57.1 (4/7)	54.2 (13/24)	54.8 (17/31)
	(Source: BSS, 2006-2007 for male IDUs and Cohort study by ICDDR,B for female IDUs 3rd round in July-Nov 2006)			
Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected (Indicator-21)	Male IDU[Ø]:	35.3 (25/82)	33.4 (352/1114)	33.6 (377/1196)
	Female IDU[φ]:	71.4 (10/14)	74.5 (35/47)	73.8 (45/61)
	(Source: BSS, 2006-2007 for male IDUs and Cohort study by ICDDR,B for female IDUs 3rd round in July-Nov 2006)			

Indicator	Risk groups	Age less than 25 % (n/N)	Age 25 or more % (n/N)	Total % (n/N)
Percentage of most-at-risk populations who are HIV infected (Indicator-23)	Female sex workers (FSW):			
	Brothel based (not done)	-	-	-
	Street based	0.3 (2/576)	0.1 (1/753)	0.2 (3/1329)
	Hotel	0.2 (1/546)	0 (0/155)	0.1 (1/701)
	Combined residence and hotel based	0 (0/566)	0.3 (3/984)	0.2 (3/1550)
	Casual	0.3 (1/400)	0.5 (4/817)	0.4 (5/1217)
	All	0.2 (4/2088)	0.3 (8/2709)	0.3 (12/4797)
	MSW	0 (0/230)	0.6 (1/170)	0.3 (1/400)
	Hijra	0.4 (1/231)	0 (0/161)	0.3 (1/392)
	MSM	0 (0/242)	0 (0/157)	0 (0/399)
	MSM and MSW combined	0.7 (1/152)	0 (0/138)	0.3 (1/290)
	Male IDU[¶]	0.2 (1/431)	1.7 (76/4461)	1.6 (77/4892)
	Female IDU	0 (0/27)	1.3 (1/76)	1.0 (1/103)
	Combined IDU & Heroin smokers	0 (0/254)	0.1 (1/857)	0.1 (1/1111)
	Heroin smokers	0 (0/46)	0.3 (1/356)	0.2 (1/402)
	All risk groups	0.2 (7/3701)	1.0 (88/9085)	0.7 (95/12786)
	(Source: 8th round National HIV Serological Surveillance, 2007)			

Note: i) 'n' refers to the numerator and 'N' refers to the total number of observations in the corresponding age group that was used as the denominator in calculating the percentage

ii) All percentages that are calculated from BSS 2006-2007 data sets are based on sampling weights

iii) Percentages of street based female sex workers are combined from three sites (Dhaka, Chittagong and Khulna), hotel based female sex workers are combined from three sites (Dhaka, Chittagong and

Sylhet), MSW are combined from two sites (Dhaka and Chittagong), MSM are combined from two sites (Dhaka and Sylhet), IDU are combined from four sites (Dhaka, Chandpur, Rajshahi and Chapai Nawabganj) and rickshaw pullers are combined from two sites (Dhaka and Chittagong).

*Respondents were asked the following questions:

1. Do you know where you can go if you wish to receive an HIV test?
2. In the last twelve months, have you been given condoms (e.g. through an outreach service, drop-in centre or sexual health clinic)?

Injecting drug users should be asked the following additional question:

3. In the last twelve months, have you been given sterile needles and syringes (e.g. by an outreach worker, a peer educator or from a needle exchange programme)?

‡ 1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?
2. Can using condoms reduce the risk of HIV transmission?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV from mosquito bites?
5. Can a person get HIV by sharing a meal with someone who is infected?

§ Last time in the last 12 months (among those who had sex in the last 12 months)
ɵ Last time in the last week (among those who had sex in the last week)
Ø Last time in last 2 months (among those who had injected in the last 2 months)
φ Last time in last 6 months (among those who had injected in the last 6 months)
¶ Data on male IDU is for Central A of Bangladesh that covers mainly Dhaka city and the other areas have been excluded because no HIV positive was detected

ANNEX 4: 2008 UNGASS Indicator Table

Indicator	*Population group(s)*	*Indicator Value (%)*	
		2005	*2007*
3. Percentage of donated blood units screened for HIV in a quality assured manner	All	Not available	Not available
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	PLHIV	Not available	13.3%
5. Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	HIV positive pregnant women	Not available	Not available
6. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV	Incidence of TB cases in people living with HIV	Not available	Not available
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results	Women and men aged 15-49	Not available	Not available
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	Female sex workers Male sex workers MSM IDU All risk groups	1.6 1.1 0.0 3.2 1.3 Source: BSS 2003-04	5.1 7.8 6.4 3.4 4.9 Source: BSS 2006-07

Indicator	*Population group(s)*	*Indicator Value (%)*	
		2005	*2007*
9. Percentage of most-at-risk populations reached with HIV/AIDS prevention programmes	Female sex workers	71.6	56.9
	Male sex workers	76.2	46.6
	MSM	77.0	12.7
	IDU	82.0	81.8
	All risk groups	55.8	43.6
10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	OVC	Not available	Not available
11. Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year	Schools providing Life Skills Based Education.	Not relevant	Not relevant
12. Current school attendance among orphans and among non-orphans aged10–14	All children aged 10-14	Not available	Not available
13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Males	Not available	24.1
	Females	Not available	20.6
	All 15-24	Not available	22.3
			Source: National Baseline HIV/AIDS survey among youth in Bangladesh 2005 NASP, Save-USA, ICDDR,B

Indicator	*Population group(s)*	*Indicator Value (%)*	
		2005	*2007*
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Female sex workers Male sex workers MSM IDU All risk groups	24.0 28.2 13.2 14.3 17.0 Source: BSS 2003-04	30.8 29.6 27.3 20.2 25.9 Source: BSS 2006-07
15. Percentage of young women and men who have had sexual intercourse before the age of 15	Males 15-24 Females 15-24 All 15-24	Not available Not available Not available	4.0 0.8 2.3 Source: National Baseline HIV/AIDS survey among youth in Bangladesh 2005 NASP, Save-USA, ICDDR,B
16. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	Females Males	Not available Not available	Not available 17.5% Source: Assessment of Sexual behavior of men in Bangladesh FHI/ICDDRB 2006
17. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	Females Males	Not available Not available	Not available 35.2% Source: Assessment of Sexual behavior of men in Bangladesh FHI/ICDDRB 2006
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client (new clients)	Female sex workers Male sex workers	30.9 44.1 Source: BSS 2003-04	66.7 43.7 Source: BSS 2006-2007

Indicator	*Population group(s)*	*Indicator Value (%)*	
		2005	*2007*
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	MSM Commercial sex Non-commercial sex	 49.2 37.0 Source: BSS 2003-04	 29.5 24.3 Source: BSS 2006-2007
20. Percentage of injecting drug users who report the use of a condom at last sexual intercourse	**Male IDU:** Commercial Non-comm. sex **Female IDU:** Commercial sex Non-comm. Sex	 23.6 18.9 78.9 43.9 Source: BSS, 2003-2004 for male IDUs and Cohort study by ICDDR,B for female IDUs baseline in Dec 2004-May 2005	 44.3 30.5 54.8 42.1 Source: BSS, 2006-2007 for male IDUs and Cohort study by ICDDR,B for female IDUs 3rd round in July-Nov 2006
21. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	Male IDU: Female IDU:	51.8 60.0 Source: BSS, 2003-2004 for male IDUs and Cohort study by ICDDR,B for female IDUs baseline in Dec 2004-May 2005	33.6 73.8 Source: BSS, 2006-2007 for male IDUs and Cohort study by ICDDR,B for female IDUs 3rd round in July-Nov 2006
22. Percentage of young women and men aged 15–24 who are HIV infected	young women and men aged 15–24 who are HIV infected	Not Relevant	Not Relevant

Indicator	*Population group(s)*	*Indicator Value (%)*	
		2005	*2007*
23. Percentage of most-at-risk populations who are HIV infected	Female sex workers	0.3	0.2
	Male sex workers	0.0	0.7
	MSM	0.4	0.2
	Male IDU	4.9	7.0
	Female IDU	-	0.8
	All risk groups	0.6	0.9
		Source: National HIV Serological Surveillance, 2004-2005	Source: National HIV Serological Surveillance, 2006
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Adult and children with HIV	Not available	Not available
25. Percentage of infants born to HIV infected mothers who are infected	Infants	Not available	Not Relevant

ANNEX-5: Detail description of Indicators for 2010 UNGASS report

Description of Indicators

1. Domestic and international AIDS spending by categories and financing sources

There is no National AIDS Spending Assessment (NASA) has been conducted in Bangladesh. The third National Health Account (NHA) with HIV sub-account that was conducted in 2008 using the 2007 data has not yet been published. In order to report on the HIV/AIDS expenditure for the last two years (2008 and 2009), the financial data on expenditure has been collected from the respective finance department of NASP, GFATM, FHI and GTZ. The ADB funded (2006-10) HIV prevention project for Urban Primary health care including VCT had the allocation of 10 million USD. In order to get a better estimate, the total amount has been divided by five to get the 2008 and 2009 expenditure amount (4 million USD). Around 4 million USD was added for the year 2008 and 2009 by the UN agencies (UNAIDS, UNICEF, UNFPA, WHO, UNHCR, UNODC). Thus altogether 64.2 million USD was allocated in the reporting period. This is about 20 millions more than the expenditure that was made during the 2006-2007 time period.

2. National Composite Policy Index (NCPI)

The national composite policy Index has two parts. Part-A was filled up under the guidance of the Line Director and Program manager of NASP with input from other deputy Program managers and subject specialists. The Part-B was filled up by various stakeholders. The contents of part-B were finalized in the validation workshop through a consensus process.

3. Percentage of donated blood units screened for HIV in a quality assured manner

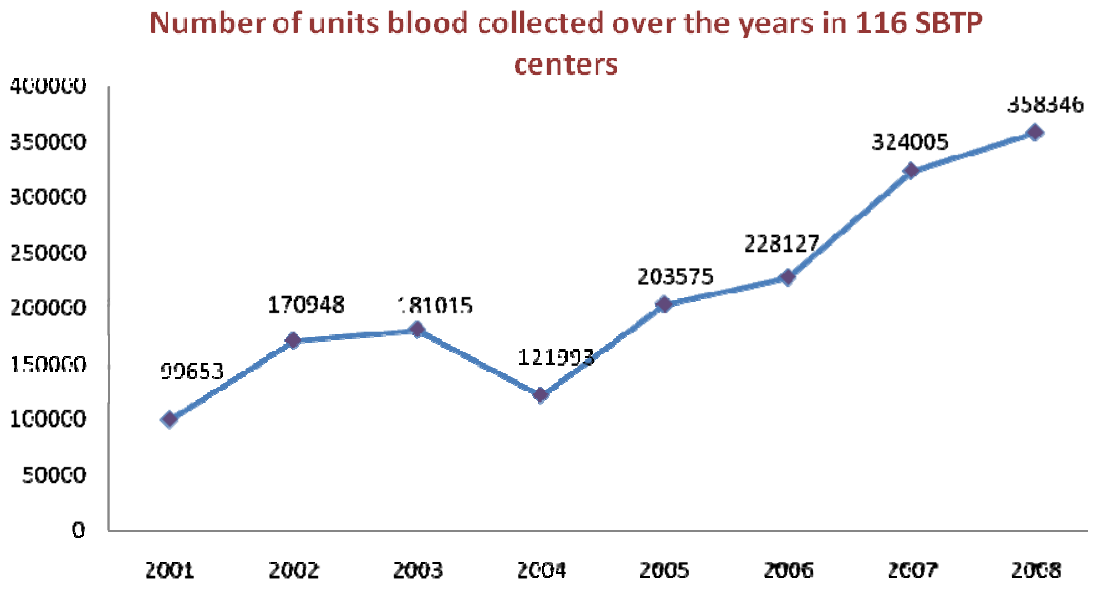
In Bangladesh the annual demand for blood transfusion is estimated to be 3, 00, 000 to 3,50,000 unit per year. But due to lack of voluntary donor and consciousness among people this demand is hardly met. Implementation of Safe Blood transfusion was started in Bangladesh in 2000 with the realization of the need for judicial use and safety of blood and blood products. Key strategies were reduce/stop collection of blood from commercial blood sellers and compulsory screening of blood for 5 blood-borne diseases viz. HIV/AIDS, hepatitis-B, hepatitis-C, syphilis and malaria before transfusion of blood. SBTP has 116 safe blood transfusion centers.

A national strategic plan for HIV/AIDS/STD prevention formulated incorporating blood transfusion sector. Since 2000, screening of Transfusion Transmitted Infection (WHO recommended) has been introduced in Bangladesh along with judicial act and national policies ruled by the Government of People's Republic of Bangladesh. Safe blood transfusion law 2002 has been approved by the parliament and published with an emphasis towards management and services of safe collection, processing, preservation and transfusion. The goal was to establish and operationalize private blood transfusion centers and Upazilla blood transfusion centers by 2008. Official Gazette notification of the law has been published for implementation from 1st august 2004 and safe blood transfusion ruling order has been published on 7th may 2005. Emphasis is given to the outdoor and day care facilities provided by Transfusion Medicine Department. Safe blood Transfusion Programme was sponsored by United Nations Development Programme (UNDP) in 2000-2004 and from

2004-onwards is supporting by WORLD BANK, Development for International Development (DFID), World Health Organization (WHO) and Health, Nutrition and Population Sector Programme (HNPSP).

The National Policy and Strategy on Blood Safety, adopted in 2007, defines minimum standards and requirements for health facilities to qualify and be authorized to screen blood for HIV before transfusion. A Reference Laboratory has been set up in Dhaka Medical College Hospital to conduct HIV confirmatory tests. "Safe blood transfusion regulations 2008" was published in 17 June 2008. The regulations say that without taking license from a licensing authority, no person, organization or institution will be allowed to establish and run a private blood bank. The prerequisites for establishing a blood transfusion center are: physical infrastructure, viz. specialist doctor, medical officer, staff nurse, technical supervisor, counsellor, necessary equipment as per regulations, necessary furniture and reagents. The overall number of blood centers, however, is still inadequate. Efforts to promote voluntary blood donation and the mandatory screening of transfusion has reduced the practice of professional blood donation remarkably from 70 per cent in 2001 to 16 per cent in 2006. Over the same period, voluntary donation increased from 10 per cent to 24 per cent, and donations from relatives increased from 20 per cent to 27 per cent. Patients' family members, relatives, friends and acquaintances now donate 70% of the blood. 25 percent still come from voluntary donors.

In 2008, SBTP through its 116 centers, screened 3, 58, 346 bags of blood and rejected 3,429 bags of blood due to presence of various infectious disease agents. In the SBTP centers 100% of donated blood units screened for HIV (with other 4 diseases) in a quality assured manner



In the UNGASS report 2010, the data has been presented based on the 116 SBTP centers. There are few philanthropic organizations who promote the cause of voluntary blood donation in the country. Sandhani, a well-known medical and dental students' organization in the country pioneered the voluntary blood donation movement in the country in 1978. Since then the organization made significant contributions towards motivating people for voluntary blood donation and safe blood transfusion. Later, other organizations also joined in the

efforts. These organizations are Bangladesh Red Crescent society, Quantum and Badhan. (National Health Bulletin DGHS, 2009)

4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy

The first VCT center in Bangladesh was set up in 2002, with numbers increasing to about 90 by 2008. The quality and range of services vary – only a few centers have professionally trained counselors, physicians to offer medical examinations when other STIs are suspected, gold-standard HIV test and laboratory procedures, quality assurance and validation of HIV test results etc. Outside Dhaka, to obtain test results can take up to a week in some centers. Post test counseling for people who test positive also includes referral to PLHIV support groups. In recent years, PLHIV peer support groups have expanded to well over 500 members. They provide counseling, home visits, referrals and free treatment for opportunistic infections, advice and information on positive living and advocacy and communication with the general public to reduce stigma and discrimination. Many NGOs provide clinical STI services as part of the basic healthcare they offer through fixed clinics or mobile units. The MOHFW trains primary health care workers at District and Thana levels on STI case management, but irregular drug supplies are an issue at all levels of health care services. Moreover, there are numerous reports of denial of treatment to high risk individuals by the health care providers (United Nations, 2008; UNGASS, 2008; Bondurant et al., 2007). Only a few facilities in Bangladesh (mostly in Dhaka) are able to treat HIV-related infections, or provide ART.

In UNGASS report 2010, the numerator has been collected from Save-USA (GFATM) PLHIV consortium service providing organizations (AAS, CAAP, MAB and ICDDR,B) and the denominator is from a ART projection study by GTZ.

5. Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission

The data is not available for Bangladesh. But some numerator values were reported from some of the organizations. UNICEF is piloting the PPTCT project with Jagori /ICDDR,B. The estimated number of HIV-infected pregnant women in the last 12 months is not available.

6. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV

The data is not available for Bangladesh. Although among the HIV infected persons TB is a common opportunistic infection. TB is a major public health problem in Bangladesh. In 2006, WHO ranked Bangladesh sixth among the world's 22 high-burden TB countries. Although the numerator figure (29) was received from Save-USA, who is managing the organizations working with PLHIV consortium under GFATM, since the denominator is not available, it is not possible to measure performance of this indicator. However, according to NASP data, during 2009, 21 cases of TB was reported in new HIV and new AIDS cases and 17 of them received TB treatment. It may be mentioned here that in 2009, a total of 250 new cases were identified and 143 had developed AIDS. In a GTZ supported study "Survey of Conditions, Healthcare Use and Costs of People Living with HIV/AIDS in Bangladesh" (Draft report, data collection period October 2007 to February 2008), 7% of respondents (out of 250 interviewed) reported occurrence of TB in the past year, with most being pulmonary.

7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results

This indicator is not available in Bangladesh due to non availability of nationally representative Population-based survey. Data has been collected from the head quarter of the key funding sources (GFATM, FHI/USAID) and from other service providers such as Jagori/ICDDR,B, FPAB, UPHCP and MSCS. As of 2009, there are few numbers of Voluntary and confidential HIV counselling and testing (VCCT) facilities in Bangladesh. There are only 105 HIV testing centers, private and public, in the country, of which only few facilities truly provide VCCT. These services are mostly targeted for the MARPs and not for general population at large.

8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results

This Indicator has been corrected for the BSS rounds 2003-2004 and 2006-2007. In the earlier UNGASS report (2008), this indicator was calculated based upon" Percentage of most-at-risk populations that have ever received an HIV test and who know the results". For 2010 UNGASS reporting, the indicator has been correctly calculated based on the indicator definition mentioned in the UNGASS indicator reporting guideline.

9. Percentage of most-at-risk populations reached with HIV/AIDS prevention programmes

This indicator has been corrected for both 2003-2004 and 2006-2007 BSS based upon the composite indicator definition of UNGASS 2010 Guideline. Previously, the percentage was reported based only those who reported "YES" for the question "Have you been in touch with any NGO prevention program in the last 12 months".

However, for the sex workers (female, male and hijras), in BSS 2003-2004 the indicator has been calculated based on one of the two criteria to be satisfied for calculating the indicator. The criterion is "Do you know where to go for a confidential HIV test?" Question on "if they received condom in last 12 months" was not asked and hence not considered in calculating the indicator.

10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child

This indicator is not available because of lack of information and study. There is no official statistics on this. The PLHIV service providing NGOs and self help group provide some services for few children. Ashar Alo Society (AAS) is serving a total of 360 affected children (age:<15 years). These 360 children belong to families receiving intervention-support from AAS. Interventions include: - provision of ARV, support for lab tests, nutritional support, health education, counselling, income generation training and seed money, care-givers training. Total number of children infected as of December, 2009 was 36 and 3 were getting ARV support. The total number of children among the members of AAS those who are affected and infected due to HIV/AIDS is 396.

11. Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year

Currently UNICEF and Save the Children USA (supported by GFATM) are working on the life skills based HIV/AIDS education programmes in Bangladesh. Under the Global Fund

supported HIV prevention program Save the Children USA with the support of NASP and the Implementing partners (namely PIACT, Bangladesh) HIV and AIDS related information was incorporated into the National Curriculum from classes 6 to 12. Approval for the programme has been taken from the Ministry of Health and Family Welfare, Ministry of Education and the National Curriculum and Textbook Board. Through this integration a total of approximately 6.8 million students will be receiving information on HIV and AIDS through class-room education each year. To support this endeavour, teachers training component is also being implemented. Between the year 2008 (3,995) and 2009 (2,551), a total of 6,546 institutions (school, college, Dakhil and Alim Madrasa) had been covered through this programme in 16 districts including city corporations. A total of 46,397 core trainers, master trainers and subject teachers were trained between 2008 (28,282) and 2009 (18,115) on the interactive classroom education methodology for life skill education. All educational institutions/schools in the country are now mandated to teach HIV in the classroom as per National Curriculum and therefore the teachers training will be continued in all the institutions across country.

In addition to the class-room education component, drug resistance education (DRE) has been provided in 70 schools and in 63 non-formal institutions under the same program. Through it 11 components of life-skills based education is fully covered and till date (2008 and 2009) the capacity of 120 Master Trainers, 510 Peer Educators and 109,654 young people have been developed. Supplementary take-home materials are also provided to the students.

Under UNICEF, Life Skills Based Education (LSBE) package containing content materials (lessons), teachers' guide and training manual had been developed in 2007. In 2008, the life skills lessons (which include lessons on HIV/ AIDS, puberty, drugs and personal safety) had been piloted in 26 secondary schools of the country. In 4 classrooms (grades VI, VII, VIII, IX / X) of each of the 26 schools (total: 104 classrooms), teachers taught life skills based lessons during the piloting phase (July 2008). In each classroom, there were, on average, 65-70 students. Thus, the life skills based lessons reached about 7000 secondary level students in 2008. In 2009, there was only teacher training activities. About 10,000 secondary school teachers including the head teachers were trained up in LSBE. The LSBE package will be getting the approval by the National Curriculum Coordination Committee (NCCC), in the beginning of 2010. Following the approval, Life Skills based HIV/AIDS education will be incorporated into secondary (grades VI to 10) textbooks in 2011. It will then cover all the secondary level students which is around 7 million at present.

12. Current school attendance among orphans and among non-orphans aged 10–14

According to source The State of the World's Children/UNICEF (UNICEF_SOWC_2009), ratio of school attendance of orphans to school attendance of non-orphans between 2002 and 2007 (UNICEF) was 84. UNICEF estimated in 2007, about 5 million Orphans, children (aged 0-17) orphaned due to all causes. However, lack of information for both numerator and denominator resulted in not reporting this indicator.

(http://www.unicef.org/infobycountry/bangladesh_bangladesh_statistics.html).

13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

An increase in comprehensive knowledge has been observed between the baseline (2005) and endline (2008) survey of Youth both among male and female respondents. Overall for the males and females of age 15-24 years, the knowledge had increased from 10.2% to

17.7% (for males 10.4% to 22.5% and for females 10.0% to 13.4%). The findings from the BDHS 2007 and the recently conducted Multiple indicator cluster survey (PROGOTIR PATHEY-2009) also explored similar level of knowledge among the young population.

In the BDHS-2007, 17.9% of the men and 8% of the women of age 15-25 had comprehensive knowledge on AIDS. In the Multiple Indicator Cluster Survey (MICS) conducted in 2009, 14.6% of women aged 15-24 years have comprehensive knowledge of HIV prevention. The MICS-2009 only considered children and women.

Note: In the last UNGASS report (2008), in baseline, only part of this indicator was reported. i.e. two ways of prevention only. Knowledge on 2 ways of prevention as per endline findings (for comparison with UNGASS reported baseline) is as follows:

Survey name	Male	Female	Overall
National Baseline HIV/AIDS survey among youth in Bangladesh 2005 NASP, Save-USA, ICDDR,B	24.1	20.6	22.3
National End Line HIV/AIDS Survey among Youth in Bangladesh, 2008, NASP, SC USA, ICDDR,B	24.9	24.3	24.6

14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

There has not been any BSS since 2006-2007. So, the same indicator values (as 2008 UNGASS report) have been reported for the UNGASS 2010 report. However, indicator value for some MARPs groups (Hijra, Heroin smoker, Rickshaw pullers and Truckers) was added for both BSS-2003-2003 and BSS 2006-2007.

15. Percentage of young women and men who have had sexual intercourse before the age of 15

In the last UNGASS report (baseline results 2005), the indicator was calculated based on the "percentage of young women and men aged 15-24 who have had premarital sex before the age of 15". Considering the same definition of this indicator, in the endline survey (2008), overall no change was observed (4.8% in baseline vs. 4.4% in endline), among the young women and men (15-24 years) who have had premarital sexual intercourse before the age of 15. For the men, the percentage changes from 11.3 to 11.6 and for the women 1.2 to 0.8.

While in the BDHS 2007, 0.8% percent of men age 20-24 and 0.7 % of men age 25-54 had sexual intercourse by age 15, compared with about 24 percent by age 20 and 39 percent by age 22. By age 25, 58 percent of Bangladeshi men have had first sexual intercourse. The data showed that men in younger age cohorts are likely to initiate sex later than their older counterparts. The median age at first sexual intercourse is 24.1 years for men age 25-29 and 22.1 years for men age 50-54. The proportion of men having first exposure to intercourse by specific ages also increases sharply with age. By age 25, 55 percent of men in the 25-29 age group had initiated sex compared with 68 percent of men in the 50-54 age

group. The median age at first sexual intercourse among men age 25-54 is 23.6 years, which is nearly one year earlier than the median age at first marriage (24.5 years). This indicates that some Bangladeshi men initiate sexual intercourse prior to marriage.

In this reporting episode 2010, the indicator was calculated based on the UNGASS indicator definition for both baseline and endline. As a result, the percentage shows higher. This is due to fact that a higher proportion of female in Bangladesh get married before the age of 15 and in the baseline and endline report it was reflected.

Note: In the last UNGASS report (2008), for baseline, only premarital sex was reported. i.e. % of young women and men aged 15-24 who have had first premarital sex before the age of 15.. As per endline (in order to compare with UNGASS 2008 reported baseline data) findings are as follows:

Percentage of Youth who had first had premarital sex before the age of 15	Male	Female	All
Baseline (reported in 2008 UNGASS report) was Un weighted data.	4.0	0.8	2.3
Baseline value Corrected with weight	11.3	1.2	4.8
Endline value to compare with baseline	11.6	0.8	4.4

16. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months

No updated information on this indicator is available on the population based survey for the adults in Bangladesh. An assessment of sexual behaviour of men in Bangladesh was conducted by ICDDR,B under funding from FHI/USAID in 2006. This survey only considered the male population. The indicator value for only male was reported in last UNGASS report 2008 and is also reported in this 2010 UNGASS report. However, a correction has been made for this indicator. The correct indicator value has been replaced in the 2010 report.

17. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse

No updated information on this indicator is available on the population based survey for the adults in Bangladesh. An assessment of sexual behavior of men in Bangladesh was conducted by ICDDR,B under funding from FHI/USAID in 2006. This survey only considered the male population. The indicator value for only male was reported in last UNGASS report 2008 and is also reported in this 2010 UNGASS report. However, a correction has been made for this indicator. The correct indicator value has been replaced in the 2010 report.

18. Percentage of female and male sex workers reporting the use of a condom with their most recent client

This indicator value has been repeated in the UNGASS 2010 report as no BSS has been conducted after 2006-07. The data were presented for male and female sex workers with their most recent new clients. The indicator value of Hijra has also been added in the 2010 report.

19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

This indicator value has been repeated in the UNGASS 2010 report as no BSS has been conducted after 2006-07.The indicator has been reported for both commercial and non-commercial partners.

20. Percentage of injecting drug users who report the use of a condom at last sexual intercourse

This indicator value has been repeated in the UNGASS 2010 report as no BSS has been conducted after 2006-07.

21. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected

This indicator value has been repeated in the UNGASS 2010 report as no BSS has been conducted after 2006-07.

22. Percentage of young women and men aged 15–24 who are HIV infected

This indicator has not been reported in the UNGASS 2010 report as the data is not available in Bangladesh.

23. Percentage of most-at-risk populations who are HIV infected.

This indicator has been reported based on the latest serological Surveillance round of HIV in Bangladesh (Round-8, 2007). It indicates that the HIV prevalence is still below 1% among the MARPs.

24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

This indicator has been reported for the first time. According to the data received from three organizations (AAS, MAB and CAAP), 91.1% (209/232) of adults and children with HIV known to be on treatment 12 months after initiation of ART.

25. Percentage of infants born to HIV infected mothers who are infected

The required data for calculating this indicator is not available in Bangladesh, hence not reported.