GOVERNMENT OF THE PEOPLE'S REPUBLIC OF BANGLADESH

# NATIONAL STRATEGIC PLAN FOR HIV/AIDS 2004-2010

NATIONAL AIDS/STD PROGRAMME (NASP)
DIRECTORATE GENERAL OF HEALTH SERVICES
MINISTRY OF HEALTH & FAMILY WELFARE

# ABBREVIATIONS

| | |
|---|---|
| AIDS | Acquired Immune-Deficiency Syndrome |
| ARV | Anti retro virals |
| BCC | Behaviour Change Communication |
| BSS | Behavioural and Serological Surveillance |
| CSW | Commercial Sex Worker |
| DFID | Department for International Development, UK |
| DGHS | Directorate General Health Services |
| DP | Development Partner |
| FHI | Family Health International |
| FSW | Female Sex Worker |
| GFATM | The Global Fund to fight AIDS, Tuberculosis and Malaria |
| GIPA | Greater Involvement of People Living with AIDS |
| GOB | Government of Bangladesh |
| HAPP | HIV/AIDS Prevention Project |
| HIV | Human Immunodeficiency Virus |
| HNPSP | Health Nutrition Population Sector Programme |
| IDU | Injecting Drug User |
| KABP | Knowledge Attitude Behaviour and Practices |
| MDG | Millennium Development Goal |
| M&E | Monitoring and Evaluation |
| MIS | Management Information System |
| MOHFW | Ministry of Health and Family Welfare |
| MSM | Men having Sex with Men |
| MSW | Male Sex Worker |
| NASP | National AIDS/STD Programme |
| NAC | National AIDS Committee |
| NEP | Needle Exchange Programme |
| NGO | Non Governmental Organization |
| NHBS | National HIV & Behavioural Surveillance |
| PPTCT | Prevention of Parents-to-Child Transmission |
| PLWHA | People Living with HIV/AIDS |
| PRSP | Poverty Reduction Strategic Paper |
| RTI | Reproductive Tract Infection |
| SBTP | Safe Blood Transfusion Program |
| STD | Sexually Transmitted Disease |
| STI | Sexually Transmitted Infection |
| SWAP | Sector Wide Approach |
| TC | Technical Committee |
| UNFPA | United Nations Population Fund |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNDP | United Nations Development Programme |
| UNGASS | United Nations General Assembly Special Session |
| UNICEF | United Nations Children's Fund |
| VCT | Voluntary Counselling and Testing |
| WB | World Bank |
| WHO | World Health Organization |

# TABLE OF CONTENTS


| | | |
|---|---|---|
| Abbreviations | ... | **ii** |
| Table of Contents | ... | **iii** |
| Executive Summary | ... | **iv** |
| Vision and Mission Statement | ... | **vi** |
| **CHAPTER-1: SITUATION AND RESPONSE ANALYSIS** | ... | **1** |
| 1.1 | Situation analysis ... | **1** |
| 1.1.1 | Extent of HIV/AIDS ... | **1** |
| 1.1.2 | The Vulnerability Factors for Bangladesh ... | **1** |
| 1.2 | Response analysis ... | **4** |
| 1.2.2 | Programme of action on HIV/AIDS ... | **4** |
| **CHAPTER-2: THE APPROACH AND GUIDNG PRINCIPLES OF THE NSP** | ... | **7** |
| 2.1 | Strategic Plan Developing Process ... | **7** |
| 2.2 | Approach of National Strategic Plan ... | **7** |
| 2.3 | Guiding Principles for the National Strategic Plan ... | **9** |
| **CHAPTER-3: PROGRAMME OBJECTIVES WITH KEY STRATEGIES** | ... | **11** |
| 3.1 | Objective-1: Provide support and services to the priority groups of people ... | **11** |
| 3.2 | Objective-2: Prevent vulnerability to HIV infection in Bangladesh society ... | **15** |
| 3.3 | Objective-3: Promote safe practices in the health care system ... | **18** |
| 3.4 | Objective-4: Provide care and support services to PLWHA ... | **20** |
| 3.5 | Objective-5: Minimize the impact of the HIV/AIDS epidemic ... | **24** |
| **CHAPTER-4: IMPLEMENTATION ARRANGEMENTS FOR THE NSP** | ... | **26** |
| 4.1 | Roles and Responsibility of the National AIDS/STD Programme ... | **26** |
| 4.1.1 | Co-ordination ... | **26** |
| 4.1.2 | Mainstreaming HIV ... | **26** |
| 4.1.3 | Monitoring and Evaluation ... | **27** |
| 4.2 | Operationalising National Strategic Plan ... | **28** |

**APPENDICES**

1. Strategic planning team members and Interim core group members
2. List of people consulted
3. Programme Indicators and targets of first National Strategic Plan 1997- 2002
4. List of documents reviewed
5. Proposed National M&E frame work
6. General Indicators for low prevalence/concentrated epidemic countries

# EXECUTIVE SUMMARY

Faced with the threat of HIV/AIDS, the Bangladesh Government through MOHFW has spearheaded the national response by establishing NAC and NASP, putting in place the HIV/AIDS Policy and initiating HIV/AIDS prevention and control interventions with support and in collaboration with NGOs, the UN and Development Partners. However despite these initiatives it is acknowledged that much more needs to be done to halt further spread of HIV/AIDS and its tragic consequences and ensure desired human and socio-economic development.

The HIV infection rate of 4% among IDUs surveyed in Central Bangladesh in 2002 and 2003 and the myriad of socio-economic factors that increase people's vulnerability to HIV/AIDS, further underscore both the urgency and importance of concerted effort to counter the epidemic by all sectors of society.

It is for this reason and with this background that Bangladesh has prepared the National Strategic Plan for HIV/AIDS (NSP) for the period 2004-2010 under the guidance of NAC and with the involvement of and technical support from different key stakeholders. The NSP recognizes that HIV/AIDS is not just a health problem but that it is largely a development issue that is inextricably linked to cultural, social and economic determinants that demand a wide and accelerated response.

In addition, NSP seeks to fulfil Bangladesh's commitment to UNGASS Declaration and Millennium Development Goals (MDGs) with special reference to MDG6 "Combat HIV/AIDS, Malaria and Other Diseases" with specific target " have halted by 2015 and begun to reverse the spread of HIV/AIDS". Based on analysis of the HIV/AIDS situation and vulnerability factors to the epidemic and assessment of the responses that have been undertaken to date, NSP has prioritised the following five programme objectives:

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

For each objective, relevant strategies and implementing strategies are stated in the strategic plan. Under objective-1, the strategies articulated are to ensure that data and research needed for programme planning and performance monitoring are available in a timely and programme relevant manner; empower priority groups to protect themselves and others; ensure people's access to protective technologies and services, and knowledge of protective practices; improve the capacity of implementing partners for effective participation in the response to the HIV epidemic; generate political, bureaucratic and legal support required for an effective programmatic response at the national level; support civil society to organize for advocacy and policy development, to create partnerships with government and other key players for strengthening the national response; and create linkages with national development and poverty reduction policies.

The strategies for the drug users are to strengthen understanding of drug using patterns and locations, and strengthen and expand research on drug use; strengthen and expand programmes to reduce and eliminate the harm caused by drug injecting practices throughout the country; better understand the ways in which drug use influences sexual behaviour and to ensure access to protection; slow down entry into drug use; and generate political, bureaucratic and legal support required for an effective programmatic response to drug use and HIV.

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 to strengthen 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 education 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.

Under the objective-3, the strategies articulated are to screen the total blood supply in both public and private health sectors; develop a volunteer-based blood supply; develop policies and practices for rational use of blood/blood products and surgical procedures; and safe use of injections in the health sector; and reduce demand on the blood supply.

Under the objective-4, the strategies articulated are to promote rights based approaches to care, support and treatment; ensure universal access to counseling and testing services; create national protocols and guidelines for HIV treatment and care; establish national policy on antiretroviral drug (ARV) production and regulation; build the capacity for team based care starting in selected facilities around the country; maximize treatment effectiveness and ensure equity in access; and promote comprehensive systems of HIV care, support and treatment.

The strategies articulated for prevention of parents to child transmission (PPTCT) of HIV are, to strengthen PPTCT programmes through the involvement of men; build team based capacity for PPTCT in selected facilities; and provide follow up care and support to participating families; provide care and support for children affected by the epidemic.

Under the objective-5, the strategies articulated are to better understand the factors and influences on the emergence of the epidemic; ensure non-discrimination in the world of work; promote protection in the world of work; ensure the support of the legal sector; protect the rights of the infected and affected people, including surviving children; minimize the impact on families; and minimize the impact on the economy.

Cross cutting strategies such as capacity building, involvement of PLWHA and advocacy, social mobilization and communication are covered under the section on “Approach of the Strategic Plan”. Coordination, HIV mainstreaming and monitoring and evaluation are addressed under implementing arrangements for NSP. The urgent and most crucial task is to operationalize NSP through development and implementation of three year rolling operational plans as well as mobilizing financial and logistic support to adequately meet the requirements of the national response to HIV/AIDS.

## Vision Statement

We want HIV/AIDS free society, rights and social justice for all, and tolerance for people living with HIV/AIDS where HIV epidemic has been averted and people live with respect and dignity. Bangladesh will work together with other partners at national, regional and international level within the global movement dedicated to preventing HIV/AIDS.

## Mission Statement

The mission is to improve the quality of life for the members of high-risk and vulnerable groups and general population of Bangladesh by preventing spread of HIV infection and reducing impact of AIDS.

# CHAPTER-1: SITUATION AND RESPONSE ANALYSIS

## 1.1 SITUATION ANALYSIS

**1.1.1 Extent of HIV/AIDS:** The first case of HIV/AIDS in Bangladesh was detected in 1989. Since then a total cumulative of 465 cases of HIV/AIDS have been confirmed and reported as of end of December 2004 (Source: MOHFW-NASP). Of these 87 have developed AIDS out of whom 44 have since died. However, the estimated total number of people living with HIV/AIDS is around 7,500 as of December 2004 (Source: MOHFW-NASP).

As far back as 1998 a sentinel surveillance system was instituted to monitor trends of HIV infection and risk behaviours for HIV transmission among most vulnerable groups (IDUs, SWs and MSM) and some of the bridge population (Riskshaw Pullers and Truckers).

In all the five rounds of National HIV Serological and Behavioural Surveillance (NHBS) that have been carried out to date, the HIV rates have remained below 1% in all groups except in IDUs in Central Bangladesh where HIV positivity reached 1.4% and 1.7% in 2000 and 2001 respectively and increased sharply to 4% in 2002 and 2003/2004. HIV infection of this level and above among IDUs poses serious risk as the epidemic may expand rapidly to sex workers and their clients and eventually to the general population.

The 5$^{th}$ round NHBS (2003/2004) has shown high rates of active syphilis of 9.7% and 12% among FSWs surveyed in Central and South East Bangladesh. Hepatitis C prevalence rates of up to 83% among IDUs (5$^{th}$ round NHBS) are comparable to those in other countries in the region that are experiencing a concentrated and growing HIV epidemic. Active syphilis like other STIs and Hepatitis C are major risk factors for HIV transmission.

In an effort to improve data on the extent of HIV/AIDS plans are under way to strengthen the HIV/AIDS surveillance and reporting system.

**1.1.2 The Vulnerability Factors for Bangladesh:** Current low prevalence situation can possibly mask an increasing prevalence in the general population due to high risk factors in Bangladesh. The factors relating to open borders, sex industry, the link between more vulnerable groups and bridging populations, gaps in healthcare delivery, low levels of HIV/AIDS awareness, heavy labour migration, gender inequities and poverty have been identified as being important factors in the spread of HIV infection.

Geographic Location: Bangladesh is geographically vulnerable to HIV/AIDS due to its close proximity to parts of India and Myanmar with generalized epidemic and Nepal that has a concentrated epidemic among injecting drug users. These borders are porous at several places with legitimate and informal traffic crossing both ways. Trafficking of adults and children across these borders is also significant.

Low Level of HIV/AIDS Awareness: Very high respondents from different groups in the fourth round serological and behavioural surveillance did not know the basic modes of HIV transmission. Of great concern is that most people who engage in high-risk behaviours do not know how HIV is transmitted and are unaware of their behaviour that puts them at risk.

Injecting Drug Users: The highest level of infection ever in Bangladesh was found among IDUs in central part of Bangladesh (4%) in the fifth round national serological surveillance. Sharing of needles and injecting equipment was common among them (77%). The potential is great for HIV to spread in a geometric proportion from IDUs to the bridging population because IDUs are not an isolated group. Rather, they are mobile group, sexually active with married partners, commercial

and non-commercial female partners, and with other males and less than 15% of them using condom consistently. Some of the IDUs sell blood to buy illicit drugs.

Commercial Sex Workers: As elsewhere in the region, commercial sex work exists in Bangladesh. According to NHBS and other sources the clients of Female Sex Workers are men in different categories including Truckers, Rickshaw Pullers, Civil Servants, Students and Businessmen who also put their other partners at risk of HIV infection. Among the countries in the region Bangladesh has reported the lowest condom use among FSWs. Country wide the percentage of consistent condom use with regular clients for brothel sex workers is only 2.8% and with the new clients 5.2%. Among the street sex workers of southeast region it is 3.7% and 3.9% with regular and new clients respectively. Highest number of clients (51) in last week observed among hotel sex workers of southeast region in comparison to central region (32). In brothel the average number of clients in last week was found to be 16 and 10 among street sex workers of central region. MSWs, and Hijra in central region are reported to have an average of 10 to 30 clients per week respectively (5th round NHBS).

Although MSM behaviour is largely hidden, it is however believed that it is more prevalent than previously thought. Many MSM are married and they also visit Hijra, MSW and FSWs. Among the MSM, 73.2% reported to buy sex with male/hijras in past month in central region and 97.2% in southwest region. Mean number of partners of MSM last month observed 4.4 with male, 4.2 with MSW, 2.1 with FSWs in central region (5th NHBS).

External Migrant**:** According to the International Organisation for Migration (IOM), Dhaka, the official number of people who migrate annually from Bangladesh to seek employment in other countries is approximately 250,000. Of the new 102 reported HIV/AIDS cases in 2004, 57 were identified as external migrant.[1]

Transport Workers: Transport workers such as truck drivers, bus drivers, helpers and rickshaw pullers are bridging groups that are known to have high-risk behaviors. Long distance truckers are at higher risk patterns because they ply national highways, go all over the nation often crossing international borders. Only 4.1% of truckers and 2.3% of rickshaw pullers in Central Bangladesh and 1.4% of rickshaw pullers in southeast regions have reported using consistent condom with female commercial partners in the past year (5th NHBS). This is because of the fact that they have low level of knowledge about the modes of transmission of HIV infection.

Gender equity and gender violence**:** Bangladesh is a male-dominated society and violence against girls and women remains a problem. In societies where girls and women are not empowered to develop life skills, such as problem solving, decision making and critical thinking, they lack self-efficacy and are much more susceptible to acquiring HIV. An increasing number of women and girls may be driven into sexual bondage because of poverty and thereby putting themselves and their clients at risk of HIV transmission. Anecdotal evidence point that many women may be sexually exploited by men especially in low paying jobs such as dock work, road work and other forms of employment like the garment industry.

Married women who only have sex with their husbands are at growing risk of HIV and STIs due to the behaviour of men who visit sex workers and sometimes engage in IDU practice. Women do not usually have the power to negotiate safer sex with their partners even if they suspect or know that they are involved in risky behaviour for HIV and STIs.

---

[1] *Number of HIV/AIDS reported cases of Bangladesh as of 2004. NASP, MOHFW, December 2004*

Adolescents and Young Adults: Millions of Bangladeshis reach sexual maturity each year. According to the National Census of 2001, 36.3 million Bangladeshis are adolescents (10-19 years of age) constituting 26.5% of the population. Due to socio-economic hardships reports identify sexual abuse of child domestic workers and adolescents on the street, sexual exploitation through trafficking of adolescents into sex work both internally and to other countries, children growing up in brothels and transition into sex work. There are around 400,000 [1] girls involved in the garment industry in Bangladesh with some reports of sexual exploitation. [2]

There are also an increasing number of anecdotal reports of adolescents patronizing FSWs and a growing body of knowledge that indicates a high level of premarital sexual activity among adolescent boys in Bangladesh. There is growing evidence of MSM exploratory behaviour among boys [3]. There is also evidence of substance abuse among unemployed youth and students in Bangladesh. [4, 5]

Sex education in Bangladeshi schools is an emotionally-charged issue hindered by some policy makers, parental attitudes, or teachers who are poorly-skilled for such a task, adolescents with little access to accurate information about reproductive health, puberty, pregnancy, and STIs including HIV/AIDS.

There is not yet any national representative study conducted on young people's HIV and other sexual health knowledge and behaviour. However, small-scale studies conducted on adolescent boys and girls have found low awareness on STI/HIV/AIDS issues, only 1.3% had effective knowledge about transmission and prevention (Population Council, 2002). In the 3rd round of NHBS, more than 55% of STI patients sampled were below 24 years.

General Population: In fact, evidence suggests that men in many categories of employment access commercial sex services in Bangladesh although little precise information is available about their demographic characteristics, knowledge about HIV/AIDS and STIs or risk perception since they have not been surveyed directly.

Anecdotal evidence suggest that many women may be forced into sex through other lines of employment where they are dependent on men for their supervision and pay, especially in low paying jobs such as road work, dock work and other forms of day labour, but also in more institutionalised forms of employment such as the garment industry. In addition, married women who only have sex with their husbands in Bangladesh are at growing risk of HIV and STIs due to the behaviour of some men having sex with CSWs, and sometimes IDU behaviour.

Other groups that are at greater risk of HIV include internal and external migrants, slum dwellers, factory/garment workers, uniformed personnel, port/dock workers, prison inmates, tea garden workers and street children.

Despite paucity of information on extent of stigma around HIV/AIDS in Bangladesh, there are reports of experiences by some of the most vulnerable groups regarding this negative attitude. HIV/AIDS related stigma and discrimination impedes openness about the epidemic and thereby adversely affecting prevention, care and support efforts.

---

[1] *Federal Bureau of Chamber of Commerce and Industries*

[2] *King MA. Sexual Exploitation of Children and adolescents in Rajshahi: An initial needs assessment and recommendations. UNICEF, 2003*

[3] *Caldwell B et al. sexual regimes and sexual networking: the risk of an HIV/AIDS epidemic in Bangladesh, Social Science & Medicine. 1999; 48:1103-1116*

[4] *Rachel Kabir , Adolescent boys in Bangladesh. UNICEF 2003b*

[5] *Rachel Kabir , Adolescent girls in Bangladesh. UNICEF, 1999.*

## 1.2 RESPONSE ANALYSIS

This section summarizes some of the issues that have characterized the national response to HIV/AIDS and points to some of the challenges that must be addressed.

**1.2.1 Policy, Management and Coordination:** In recognition of the threat of HIV/AIDS, the Government of Bangladesh developed and approved a comprehensive Policy on HIV/AIDS and STD Related Issues in 1997 so as to provide necessary guidance and support to address HIV/AIDS. The National AIDS Committee (NAC) was created in. In 1985 to ensure policy direction and promote multisectoral effort on HIV/AIDS. The President of the country is the Chief Patron of NAC and the Minister of Health and Family Welfare is its Chairperson. The Technical Committee (TC) of NAC that comprises mainly of Health Experts supports it. The NASP that falls under the Directorate General of Health Services within MOHFW is charged with the responsibility to facilitate overall coordination and support for the national response to HIV/AIDS.

To a large extent, NGOs have carried out the major part of HIV/AIDS prevention activities nation wide. In Bangladesh, the NGOs have provided significant contribution in response to HIV/AIDS. To complement Government effort, NGOs working on HIV/AIDS have set up the AIDS/STI Network that seeks to improve coordination among them and enhance their contribution to deal with the epidemic. Similarly two peer support groups for people living with HIV/AIDS (Ashar Alo, and Mukta Akash) are in operation mostly in Dhaka with the aim to provide a support mechanism for PLWHA and promote their greater involvement in HIV/AIDS work.

The UN Theme Group facilitated to establish the Expanded Theme Group (ETG) on HIV/AIDS: a forum that brings together different key stakeholders in order to contribute to strengthen support to the national initiatives on HIV/AIDS.

Coming up with a Policy on HIV/AIDS and STD Related Issues as far back as 1997 has been a significant achievement. However the key challenge is to ensure its effective application and review the need for specific legislation to promote and enforce appropriate care and support for people with and affected by HIV/AIDS based on respect for their rights and dignity. The effectiveness of NAC should be enhanced through revision of its mandate and membership as well as ensuring adequate support for its operation in keeping with the principles of "Three Ones" (One National AIDS Coordinating Authority, One agreed HIV/AIDS Action Framework and One agreed Monitoring and Evaluation System).

The capacity of NASP has improved since the beginning of 2004 following its restructuring and recruitment of 11 consultants. There is need to further strengthen NASP by providing it with requisite policy, logistic and institutional support to enable it to effectively discharge its responsibilities within the framework of the expanded multisectoral and multidimensional response to HIV/AIDS

**1.2.2 Programme of Action on HIV/AIDS:** Prior to the development of the first NSP (1997-2002) the MOHFW with support from the UN established NASP and implemented initiatives that included creating public awareness and sensitising health workers about HIV/AIDS issues. At the same time interventions targeted at the most vulnerable groups were initiated through NGOs with assistance from Development Partners and the UN.

The NSP (1997-2002) that was prepared by Government in consultation with and with support from other stakeholders provided the framework for the national response by defining strategies and priorities for HIV/AIDS prevention and control in accordance with the National Policy on AIDS. Since its (NSP) introduction the work of both Government and NGOs has expanded with at least 385 NGOs currently involved in the field of HIV/AIDS (source: mapping study; Impact-FHI 2003).

Despite that targeted interventions were emphasized in NSP there has been no baseline data available to enable to set targets for accelerated coverage. Furthermore many organizations are implementing these activities in an uncoordinated and overlapping manner. As a result there are wide gaps in coverage of the vulnerable groups and decentralization of programmes that have to be addressed in a comprehensive way.

The Armed Forces HIV/AIDS education and life skills intervention programme for Peacekeepers seems to have been successful in keeping HIV infection low among this cadre despite their deployment to countries with very high HIV prevalence. Out of a total of 55,000 Peacekeepers who have so far been tested for HIV before and after deployment to missions abroad only three (3) were found to be HIV positive[1]. There is need to strengthen this initiative within the Armed Forces and expand it to the entire Uniformed Services.

To promote blood safety Government has established 98 Safe Blood Transfusion Centers throughout the country for screening blood for HIV, Syphilis, Malaria, Hepatitis B and Hepatitis C. Legislation for safe blood transfusion is in place but its implementation countrywide is a challenge, as most of the blood screening centers and private health institutions need to be fully equipped with modern facilities to screen blood. Therefore strengthening and expansion of blood safety to 100% coverage and coordination between NASP and SBTP must be given priority.

As a sign of its commitment to deal with HIV/AIDS and other STIs, Government enlisted and secured a five year (2001-2005) US $ 40 million World Bank Credit and US $ 10 million DFID Grant to support a mix of interventions under the HIV/AIDS Prevention Project (HAPP). However as a result of low implementation rate the project had to be restructured with both its duration and amount reduced by half. The revised project is being implemented with technical and management support from UN Agencies as follows: UNICEF; 5 Large packages for interventions targeted at most vulnerable groups, small grant fund to NGOs of US $ 20 000 each and communication and advocacy strategy: UNFPA; Institutional capacity strengthening of NASP and condom procurement: WHO; Blood safety.

Due to delays as a result of a number of logistic constraints, actual implementation of many aspects of HAPP will only be for one year (July 2004-June 2005). The key challenge is to mobilize resources through future HNPS programme, Development Partners, and the UN so as to sustain and expand interventions beyond the life of HAPP. In addition to HAPP Bangladesh successfully applied for funding from GFATM for an HIV/AIDS intervention project targeting the youths. This US $ 6 million project for the first two years (March 2004 – February 2006) is being implemented through a Management Agency; Save the Children USA on behalf of the Principal Recipient; MOHFW.

Care and support was not emphasized in the first strategic plan 1997-2002. It is only recently that perceptions and practices have changed with WHO/UNAIDS new initiative on care and support and increasing emphasis on Greater Involvement of People Living with AIDS (GIPA). Therefore this should be an area of focus not only to improve and prolong life for PLWHA but also to enhance prevention efforts. Standard precautions for infection control need to be promoted at all healthcare facilities. Hospital hazardous wastes, including used syringes and bloodstained materials are routinely dumped in open public containers, and not incinerated. Therefore, an appropriate mechanism and institution are required to promote to deal with these problems in a systematic and comprehensive manner.

Although there are seven Voluntary Counselling and Testing (VCT) Centers, full VCT facilities are only available at three sites in Dhaka, Chittagong and Sylhet. Better care and support services

[1] *Bangladesh Armed Forces*

for the growing number of people infected and affected with HIV require immediate and focused attention.

As the prevalence of HIV infection is low among the general population and the HIV infection is not screened at the antenatal care centers (ANCs), the scope of Prevention of Parents-to-Child-Transmission (PPTCT) have been limited. Very little attention has been paid to the issue of parents-to-child transmission of HIV. There is paucity of programmes for effective awareness generation for women. Many women have home deliveries therefore clinic-based programmes leave them out. More research is needed in this area but prevention of parent-to-child-transmission (PPTCT) messages can be included in other prevention programmes.

Many NGOs are implementing targeted and other interventions in different geographical areas in uncoordinated and overlapping manner without system wide prioritisation, coordination, or information sharing. Estimates of the extent of coverage and total populations covered are speculative at best. As a result, there are wide gaps in coverage of vulnerable groups. In many districts, many FSWs and IDUs have been identified but no NGOs are working with them and in other cases NGOs have begun working but have no specialised skills for working with these groups. Communities like uniformed personnel, prison inmates, external migrants and street children were not included as vulnerable population in NHBS. The external migrant group has the highest number of recorded cases of HIV [1] but there is no data on risk behaviours and vulnerability among prisons inmates and street children.

Country level coordination mechanism between NASP and developmental/support partners and their implementing NGOs is not adequate to eliminate implementation gaps and overlaps and allocative inefficiencies.

Presently, NASP is not structured with the adequate capacity to promote overall programme planning, coordination, monitoring and evaluation, system wide information sharing and single programme steering. Long-term provision for human resources with sufficient infrastructure is essential for NASP for effectively discharge its mandate and responsibilities.

NHBS has been in operation since 1998 to monitor HIV epidemic; however there is no comprehensive national monitoring and evaluation system in place. Although a number of programme indicators and targets were identified in the first strategic plan (Appendix - 6) very few of them were monitored for performance evaluation. Efforts are therefore required to address this critical component of the national response to HIV/AIDS.

Additionally, significant critical data from studies, including healthcare providers' surveys; KABP or action research of communities like students/external migrants/MSM/prison inmates; need assessment for communication; need assessment for capacity building; cost effectiveness for targeted intervention projects, are not emphasized in ongoing HIV prevention programme.

[1] *Number of HIV/AIDS reported cases of Bangladesh as of 2004. NASP, MOHFW, December 2004*

# CHAPTER-2: THE APPROACH AND GUIDNG PRINCIPLES OF THE NATIONAL STRATEGIC PLAN

## 2.1. STRATEGIC PLAN DEVELOPING PROCESS

The NASP established "Strategic Planning Team" to lead strategic planning process to develop the "National Strategic Plan for HIV/AIDS 2004-2010". The Strategic Planning Team comprised of international and national consultants, UN, and programme personnel of NASP (Appendix-1). The Technical Committee of NAC have provided directions and guidance in the preparation of the strategic plan. Director General of Health Services has provided overall supervision and necessary support in the planning process. Line Director and Programme Manager of NASP facilitated the planning process with support from UNAIDS.

The NASP has formed an "Interim Core Group" that has provided guidance and advice during the strategic planning process exercise (Appendix-1). Strategic Planning Team members reviewed more than 40 documents (Appendix-2) and consulted with about 100 people from wide range of stakeholders including policy makers, developmental partners, support partners, implementing partners, CBOs, community representatives, private sector, focal points of ministries, health care providers, research organizations, etc (Appendix-3).

The purpose of the extensive consultation was to get insight of the HIV programming from the policy makers, learn field situation and experiences from the wide range of stakeholders providing preventive as well as care and support services in the field of HIV/AIDS, and ensure strong basis of developing and designing the "National Strategic Plan for HIV/AIDS 2004-2010" for Bangladesh.

Strategic Planning Team produced first draft and circulated the draft document to the key stakeholders including UN, Expanded Theme Group members, World Bank, networks and developmental partners, and number of NGOs through STI/AIDS Network of Bangladesh. The Strategic Planning Team utilised variety of ways including individual and group consultations, key informants consultative meetings, and written feedback from the key stakeholders to ensure timely response in the development of strategic plan. All these comments and suggestions have been incorporated in the final draft document.

## 2.2 APPROACH OF NATIONAL STRATEGIC PLAN

### Mandate and scope

The National Strategic Plan for HIV and AIDS 2004 - 2010 provides a framework for the national response to the HIV epidemic up to 2010. Its authority is derived from the National Policy on HIV/AIDS and STD Related Issues adopted by Cabinet in 1997. It builds on the first Strategic Plan for The National AIDS Programme of Bangladesh 1997– 2002 and learns from experience gained in its implementation.

The National Strategic Plan for HIV and AIDS 2004–2010 is a plan for the nation. It aims to ensure that Bangladesh protects itself from an encroaching epidemic that will bring in its trail immense personal and social trauma and could eventually undermine the nations' capacity to function and manage its own development.

The National AIDS/STD Programme has stewardship of the response to the epidemic. It exercises this stewardship in partnership with others. The first partnership is with the people of Bangladesh since above all else the epidemic spreads through the practices, norms and inequities of the society. The partnership takes tangible form in its partnership with the national and international

non-governmental organisations and civil society. The stewardship also involves partnerships with the UN and Development Partners.

The plan also builds on and expands the good practices that are already in place. Bangladesh has learnt well from the response elsewhere and thought deeply about how to apply these lessons here.

**Crosscutting strategies**

Rather than separating out the cross cutting strategies, these have been integrated throughout each plan objective. Some cross cutting strategies relate to programme components such as operational research, capacity building, record keeping, advocacy and communication. Others relate to approaches that need to permeate all activities: a sensitivity to address gender issues, emphasis to ensure respect of human rights and dignity and the importance of the involvement of people living with HIV/AIDS.

**Building capacity to understand and respond**

As the national response to the epidemic expands, more and more players will be drawn into the response. These players will include NGOs established for other purposes, academics, journalists, bureaucrats, politicians and many others. Their commitment and engagement will be less effective without a complex understanding of the nature of the epidemic and how to contribute effectively. This capacity needs to be built and strengthened in preparation for their participation.

**The involvement of people living with HIV/AIDS**

There is a particular knowledge that comes from experiencing something. It is a different knowledge than the knowledge that comes from research or activism or implementation. This knowledge is crucial to the development of effective responses and thus necessitates the active involvement of those infected and affected.

This involvement cannot however be taken for granted. It must be organised and respond to the imperatives of representation, participation, accountability, transparency and partnership. This means that the resources necessary to organise and represent, as well as to advocate and participate in policy and programme development must be provided. The rights to privacy and confidentiality must be respected and the forms that this protection may take will need to be decided by those involved on each occasion.

**Advocacy, social mobilisation and communication**

**Advocacy:** Advocacy creates political will for change at national and local levels. It also contributes to deepening peoples' understanding of the nature of the epidemic and its required responses. Although different techniques and tools are available to assist in advocacy it is important to realise that a human face and a human story can make statistics live and create the motivation for effective engagement towards the desired change and action.

**Social mobilisation:** The epidemic requires social mobilisation that involves processes of awareness and understanding creation, which lead to change. Social mobilisation around the HIV epidemic must give rise to social movements based on tolerance, compassion and a respect for human rights and dignity.

**Communication:** The HIV epidemic is a changing phenomenon essentially involving values, emotions, inequities and things normally left unsaid. Communication in such a context is more than the transfer of information and messages or the distribution of pamphlets. It must be interactive, responding to questions as people ask them, in settings where they feel able and

comfortable to ask them. At the heart of HIV communication is discussion, people talking face to face, over time, as other issues arise in their minds. It is people they respect and listen to guiding them and answering their questions. It is an ability to refer people to places where their questions can be answered.

The National Strategic Plan for HIV/AIDS has the following strategy for advocacy, social mobilisation, and communication. The strategy is to integrate effective advocacy, social mobilisation and communication approaches within each component of the Operational Plan of the National Strategic Plan on HIV/AIDS as follows:

***Implementing strategies:***

- To develop social mobilisation, advocacy and communication approaches as an integral component of programme development
- To establish mechanisms for the coordination and rationalisation of social mobilisation, advocacy and communication approaches
- To establish a system of monitoring, evaluating and feedback to ensure effective approaches to social mobilisation, advocacy and communication.

**Linkages to development frameworks**

The National Development Plan including PRSP should provide the overall framework to deal with HIV and AIDS as a social and developmental challenge. The national Strategic Plan on HIV and AIDS needs to inform the PRSP process so that it takes into account the importance and urgency to address the epidemic in a comprehensive way involving all the sectors.

In accordance with the Millennium Development Goals (MDG), Bangladesh is expected to and should do more to attain holistic socio-economic development. MDG 6 "Combat HIV/ AIDS, Malaria and Other Diseases in particular and the UNGASS Declaration of Commitment underscore the need for HIV to be placed on the national agenda of priorities for action and resource allocation.

## 2.3 GUIDING PRINCIPLES FOR THE NATIONAL STRATEGIC PLAN

The NSP and follow up actions are guided by the following principles:

**Multisectoral engagement:** As the epidemic is complex, it affects every aspect of society involving individuals, families, sectors and institutions. It therefore goes beyond the domain of the health sector and as such an effective response to it must be multisectoral in every respect.

**Broad political commitment:** As the UNGASS declaration states "Leadership by Governments in combating HIV and AIDS is essential and their efforts should be complemented by full and active participation of the civil society, business communities and private sector. Leadership involves personal commitment and concrete actions".

**Civil society involvement:** Multisectoral approach and political commitment with meaningful involvement of all the groups representing all segments of the civil society would be able to produce adequate response to HIV and AIDS particularly among the groups infected and affected by HIV/AIDS.

**Stigma reduction:** The adverse impacts of stigma and discrimination are among the key barriers to effective response to HIV and AIDS. All international conventions and the National HIV/AIDS Policy emphasize commitment to stigma reduction.

**Prevention to care continuum:** A keystone of the response to HIV/AIDS is the recognition and adoption of programmes that address the epidemic in a holistic manner from prevention to care, treatment, support and mitigation. Effective care and support do not only improve the quality and length of life of PLWHA and those affected by HIV/AIDS but also greatly enhance prevention of HIV.

**Human rights based approaches:** All international declarations and the National Policy on HIV/AIDS reference the absolute need to make human rights framework and approaches central to the response to HIV/AIDS. Human rights approaches reduce the vulnerabilities to the HIV/AIDS epidemic, and include various rights such as access to health care, information, confidentiality and privacy and gender equity

# CHAPTER-3: PROGRAMME OBJECTIVES WITH KEY STRATEGIES

## 3.1 PROGRAMME OBJECTIVE-1: PROVIDE SUPPORT AND SERVICES TO THE PRIORITY GROUPS OF PEOPLE

By the year 2010, the priority groups of people at risk of HIV infection will have access to the means of protection in ways that respect their human rights and dignity and will be empowered to protect themselves and others. This will help to create a nation in which all those whose livelihood and employment strategies or lifestyles put them and others at risk of infection are protected.

Targeted interventions are effective where people at higher risk of infection and of diffusing infection are geographically or institutionally clustered. The risk of infection is usually produced by people's livelihood or employment strategies, lifestyles, or exploitation. National and international experience makes possible the identification of such groups: sex workers, drug users, prisoners, the uniformed forces, street children, and men who have sex with men, to give some examples among others.

In a relatively well-concentrated epidemic giving programmatic priority to these groups is an effective strategy. Various forms of interventions are possible: empowering the groups themselves to organise, working with the groups to assist them to protect themselves, working with communities formed by people at risk and their social networks, for example.

Since many priority groups are socially marginalized or disadvantaged, there is a need to challenge unconstructive attitudes in the local community and to create understanding and, if possible, acceptance of the interventions. The role and reactions of the police and local government officials can be critical to the achievement of the programme objectives.

The implementation of targeted interventions places critical demands on the implementing partners. As well as the skills and knowledge usually required in development practice, it demands a complex understanding of the epidemic, and human rights based and gender sensitive approach. As more players enter the field there is a continuing and expanding requirement for capacity building and performance monitoring. The priority strategies for providing support and services to the priority groups are as follows:

**Strategy 1: Ensure that data and research needed for programme planning and performance monitoring are available in a timely and programme relevant manner**

*Implementing strategies:*
- To build capacity for record keeping and data analysis in implementing partners and for transmission of data for centralized collation, analysis and feed back
- To strengthen and expand research required to better understanding how to intervene effectively with priority groups and for impact monitoring including surveillance.
- To develop and ensure the funding of a national social research programme

**Strategy 2: Empower priority groups to protect themselves and others**

*Implementing strategies:*
- To support formation of community based organizations and mutual support groups
- To increase involvement of group members in programme development, implementation, and evaluation

- To increase skills required to act on their own behalf and to create a community based social movement

**Strategy 3: Ensure people's access to protective technologies and services, and knowledge of protective practices**

*Implementing strategies:*
- To upgrade and expand services which lessen susceptibility to sexual transmission including services for STI, RTI, VCT and non consensual sex
- To ensure that the means of protection are accessible and affordable to every person who wants to use them
- To develop the social setting at local level within which protective practices are discussed

**Strategy 4: Improve the capacity of implementing partners for effective participation in the response to the HIV epidemic**

*Implementing strategies:*
- To support innovation; to strengthen planning and performance; and to promote mentoring and coaching among implementing partners
- To expand interventions to include the social networks of priority groups
- To increase coordination, collaboration and exchange of experience among implementing partners at the local level
- To ensure community engagement in, and local political support for the initiatives

**Strategy 5: Generate political, bureaucratic and legal support required for an effective programmatic response at the national level**

*Implementing strategies*
- To strengthen national support for scaling up targeted interventions
- To establish supportive partnerships between law and order agencies, local government, and implementing partners
- To ensure an approach based on human rights and dignity

**Strategy 6: Support civil society to organize for advocacy and policy development, and to create partnerships with government and other key players for strengthening the national response**

*Implementing strategies:*
- To create public discussion on ways of organizing civil society's response
- To support creation of effective partnerships in the response to HIV epidemic

**Strategy 7: Create linkages with national development and poverty reduction policies**

*Implementing strategies:*
- To create awareness of the inter-relationships between development and the HIV epidemic, in particular of mobility as a risk factor for HIV infection
- To create local livelihood and employment opportunities to minimize unwanted migration

## SUB COMPONENT OF OBJECTIVE 1: PROVIDE SUPPORT AND SERVICES TO DRUG USERS

The National Policy on HIV and AIDS endorses harm reduction as the key strategy to prevent the spread of the HIV epidemic through drug use. The Ministry of Home Affairs has, as its policy

framework, the reduction of the supply and the demand for illegal substances. At the programme coordination and implementation levels, there has been increasing cooperation in the execution of these two national policy areas with respect to the national response to the HIV epidemic.

Targeted interventions, which respect people's rights and dignity, are an effective programmatic response to drug use and HIV. The strategies in this section highlight specific approaches to working with drug users that differ from the approaches outlined above. Harm reduction is the central programmatic response. Harm reductions consists of a number of interventions all of which need to be available to the injecting community. Some of these interventions minimise the sharing of equipment and some minimise the harm involved in sharing.

Patterns of drug use can change quickly, as can the type of drugs in use. This relates not only to transitions to injecting behaviour but also to the increasing use of drugs that influence the sexual behaviour of drug users and so expanding the sexually driven epidemic. Increasingly in the Asian context drug use is coming to be associated with high-risk patterns of sexual behaviour, particularly among students and young people.

The prevalence of HIV is high as 4 percent among the drug users as revealed in the last five serological surveillances in Bangladesh. In order to prevent spread of HIV infection, we should ensure that the drug users have access to effective support and services throughout the country. The priority strategies to ensure support and services to drug users are as follows:

**Strategy 1: Strengthen understanding of drug using patterns and locations, and strengthen and expand research on drug use.**

*Implementing strategy:*
- To develop and ensure the funding of a national research programme on drug use

**Strategy 2: Strengthen and expand programmes to reduce and eliminate the harm caused by drug injecting practices throughout the country**

*Implementing strategies:*
- To increase local community understanding and acceptance of harm reduction, detoxification and rehabilitation programmes.
- To strengthen and expand the involvement of drug users, former drug users, and organizations of drug users in programme development, implementation and evaluation.
- To ensure access to harm reduction and elimination interventions including access to sterile equipment, drug substitutes, health services, detoxification, rehabilitation programmes, and assist in the development of protective sharing practices.

**Strategy 3: Better understand the ways in which drug use influences sexual behaviour and to ensure access to protection**

*Implementing strategies:*
- To monitor changing patterns of drugs in use and promote research on drug related factors influencing sexual behavior among drug users.
- To ensure that drug users have access to the means of protection in their sexual behavior.

**Strategy 4: Slow down entry into drug use**

*Implementing strategies:*
- To strengthen peer group norms and practices based on awareness of the potential harm of drug use.

- To strengthen interpersonal communication and conflict resolution in the families.

**Strategy 5: Generate political, bureaucratic and legal support required for an effective programmatic response to drug use and HIV**

*Implementing strategies:*
- To strengthen understanding of the need for effective programming, in particular harm reduction strategies.
- To strengthen the role of the legal system in minimising the spread of HIV amongst drug users.

### 3.2 PROGRAMME OBJECTIVE-2: PREVENT VULNERABILITY TO HIV INFECTION IN BANGLADESH SOCIETY

Some societies are more vulnerable to the HIV epidemic than others. The factors, which create vulnerability, are largely social, social values, norms and practices, which place societies at higher risk of HIV infection. This vulnerability takes a number of forms: vulnerability arising from notions of masculinity and femininity; arising from exploitation and abuse; the vulnerability of youth as they make their way to maturity and into the modernising world; and other forms of vulnerability.

The strategy places emphasis on the following factors, which create vulnerability to HIV infection such as (i) Vulnerability of ignorance: Clearly if people are ignorant of the existence of the epidemic, they cannot adopt protective strategies. However, the epidemic also demands an understanding of its nature, its cultural, social and economic causes and consequences, for political will to be mobilised for an effective response.

(ii) Vulnerability arising from gender: Most HIV infected married women are not infected through their own behaviour. There is a vulnerability arising from a lack of autonomy, articulateness and power, which makes women in particular vulnerable to infection. There is also a vulnerability which arises from the social norms and practices associated with masculinity. Experience of the epidemic shows the importance of couple-based programmes.

(iii) Vulnerability arising from exploitation and abuse: Those who endure abuse and exploitation, for example, women who are raped or street children, are usually powerless to protect themselves from infection.

These vulnerabilities affect all members of the society, in and outside of priority groups. Addressing vulnerability will provide greater protection for all. Some societies are able to address social factors more effectively than others. Strategies under this objective are complementary to those under Objective 1. Similarly, strategies under Objective 1 also apply to all members of the society.

By the year 2010, the social norms and practices that protect Bangladesh society will have been identified and strengthened. This will help create a society in which people will have reduced vulnerability to HIV infection. The priority strategies to prevent vulnerability to HIV infection in Bangladesh society are as follows:

**Strategy 1: Reduce vulnerability arising from lack of understanding of HIV epidemic**

*Implementing strategies:*

- To create understanding of the epidemic through the active involvement of those infected and affected
- To create nation-wide awareness through traditional and modern means of interpersonal communication and mass media
- To create awareness among national leaders of personal and national vulnerability
- To develop and ensure the funding of a national social research programme into vulnerability and the HIV epidemic

**Strategy 2: Reduce vulnerability arising from gendered practices**

*Implementing strategies:*

- To increase couple based programme initiatives
- To strongly support national initiatives to strengthen women's empowerment and autonomy

- To encourage men to participate actively in the response to the epidemic including as volunteers and care givers in the community
- To support men to explore protective forms of masculinity

**Strategy 3: Reduce vulnerability arising from exploitation and abuse**

*Implementing strategies:*
- To strengthen social values and practices which minimize rape and other forms of non-consensual sex
- To strengthen access to legal aid services
- To support national initiatives for the protection of children with a particular focus on street children

**SUB COMPONENT OF OBJECTIVE-2: REDUCE THE VULNERABILITY OF YOUTH**

The National Policy on HIV, AIDS and STD Related Issues (1996) stresses the importance of protecting youth. It states that access to correct and relevant information about sexual health and safer sexual practices should be provided to adolescents. Further, it states that sexual and reproductive health services should be provided to adolescents without stigmatization.

Youth women and young men are particularly vulnerable to HIV infection and often vulnerable in different ways. The strategies above apply to youth. The strategies in this section highlight specific vulnerabilities of youth.

Physiological vulnerability: The immaturity of the genital tract of young girls and women places them at serious risk of infection. The face of the global epidemic is increasingly that of young women, whether married or unmarried, poor or affluent. It is critical to protect them from all unwanted and unprotected sexual experiences and to establish protective social norms, for example, on the age of marriage.

The vulnerability of transitions: The transition to adult hood is a particularly fraught time for youth who wish to protect themselves from HIV infection. Social understandings of gender roles, peer pressure, social double standards, and other social factors can heighten vulnerability. At the same time and as elsewhere in the region, Bangladesh is undergoing a transition to modernity and incorporation into the global culture and economy. This transition also renders youth particularly vulnerable to infection.

Supportive social and family environments are needed if youth are to be able to develop the skills, practices and group norms that they will need to reduce their vulnerability. The following strategies will reduce the specific vulnerabilities of youth by developing safer sexual and drug use practices, and by ensuring access to youth friendly health and well-being services. The priority strategies to reduce the vulnerability of youth are as follows:

**Strategy 1: Strengthen family communication and discussion**

*Implementing strategies:*
- To create parental awareness of the importance of establishing the habit of open and respectful discussion.
- To strengthen the role of traditional mentors such as elder-brothers' wives (*Bhabi*) and grandparents.
- To strengthen skills for inter-generational communication and conflict resolution

**Strategy 2: Create safe spaces and occasions for peer discussion and mutual support**

*Implementing strategies:*
- To expand opportunities for youth to develop protective prevention practices and gender identities
- To assist youth to adapt to social change in ways that protect them from infection
- To encourage the development of youth sports and club activities

**Strategy 3: Reduce vulnerability arising from physiological immaturity of young women**

*Implementing strategies:*
- To create awareness of young women's physiological vulnerability
- To support policies and programmes directed at increasing age of marriage, age of sexual initiation, and other protective strategies

**Strategy 4: Integrate a human rights based approach to HIV as a personal and a developmental issue into the curricula for education institutions**

*Implementing strategies:*
- To strengthen discussion forums and research into these issues
- To ensure curriculum development and capacity building for teaching and research
- To encourage young researchers to do research on HIV

**Strategy 5: Establish youth friendly health and well-being services**

*Implementing strategies:*
- To develop and implement guidelines on youth friendly sexual and reproductive health services
- To ensure that the means of protection are accessible and affordable to every young person who wants to use them.

**Strategy 6: Reduce the vulnerability of children and young people living with and affected by HIV**

*Implementing strategies:*
- To protect the human rights and dignity of affected children and youth
- To ensure access to counseling and health services

**Strategy 7: Reduce vulnerability of unemployed youth**

*Implementing strategy:*
- To support national initiatives to increase youth access to livelihood and employment opportunities

### 3.3 PROGRAMME OBJECTIVE-3: PROMOTE SAFE PRACTICES IN THE HEALTH CARE SYSTEM

By the year 2010, the total blood supply will be secured; unsafe practices and unnecessary procedures will be minimized throughout the health sector. Securing total blood supply and minimizing unsafe practices and procedure will help increase the capacity of the health sector to institute safe medical practices and procedures. The success of securing total blood, application of universal infection control procedures, development of volunteer-based blood supply, and development of policies and practices for the rational use of blood/blood products will prevent spread of HIV infection.

The success of securing the health sector will depend on its capacity for changing its norms and practices. Technology alone will not be able to achieve a safe health care environment. Quality assurance is a measure of behaviour change. The application of universal infection control procedures, whether on the ward, in the laboratory, in the morgue or elsewhere, depends on people's motivation to change their practices as well as the availability of the required supplies and equipment.

The success of securing the blood supply will depend as much on changes in the way practitioners use blood, as it will on the capacity to screen. The success of immunization programmes needs to be measured as much by the incidence of unsafe practices as by the number of adults or children immunized. The strategies for securing the health care system take this into account.

Policies, guidelines, training and other approaches to bringing about the required behaviour change are strengthened when there is a community demand for safe services. The transition to a system of voluntary blood collection requires community participation.

Strategies are needed to ensure that equity issues are addressed, whether distributional equity, that is, ensuring the availability of screened blood throughout the country, or gender equity, that is, ensuring women's fair access to safe blood and procedures.

As safe blood donation centres are expanded, policies will be needed to ensure that those wishing to know their HIV infection status do not use these collections sites for their own counselling and testing. This could put the security of the blood supply at risk. Voluntary counselling and testing services will need to be locally available and affordable and people aware of their function. The priority strategies to promote safe practices in the health care system are as follows:

**Strategy 1: Screen the total blood supply in both public and private health sectors**

*Implementing strategies:*
- To expand and upgrade blood transfusion services in public and private health sectors
- To ensure rational use of screened blood in pregnancy, childbirth, and other services for women as a priority
- To establish quality assurance mechanisms throughout the health care system

**Strategy 2: Develop a volunteer-based blood supply**

*Implementing strategies:*
- To develop efficient and user friendly blood donation sites which would include accessible locations, blood donation counselling and follow-up, and the development of local donor inventories
- To develop operational guidelines for programme implementation, clarifying the distinction between a blood donation site and a voluntary counselling and testing site
- To motivate people to donate blood

**Strategy 3: Develop policies and practices for rational use of blood/blood products and surgical procedures; and safe use of injections in the health sector**

*Implementing strategies*:
- To create community demand for safe blood, safe injecting practices and the elimination of unnecessary surgical procedures
- To develop and implement the required polices and guidelines
- To strengthen the capacity for attitudinal and behavioural change in the public and private sectors
- To ensure a consistent supply chain of needed supplies and equipment
- To put in place appropriate waste management systems, including safe needle and syringe disposal

**Strategy 4: Reduce demand on the blood supply**

*Implementing strategies*
- To develop, when necessary, and to strengthen the implementation of strategies to reduce trauma, including national seat belt and motorbike helmet policies and occupational health and safety policies
- To strongly support the implementation of the national safe motherhood policy

### 3.4 PROGRAMME OBJECTIVE-4: PROVIDE CARE AND SUPPORT SERVICES TO PEOPLE LIVING WITH HIV AND AIDS

By the year 2010, people infected and affected by HIV and AIDS will have access to comprehensive systems of care, support and treatment, which respect their rights and dignity. This will indeed enhance the quality and length of life of people infected and affected by HIV and AIDS. The strategy addresses a number of ethical issues such as equity in access to care, support and treatment; couple counselling; and the impact of cost of HIV treatment on families.

The approach to care in a low incidence setting poses particular challenges. All people living with HIV have a right to care and health care but few facilities or providers have the capacity for HIV care. Building capacity across the system leads to wastage of effort and resources as health care workers do not have the caseload to continue their skill development. This necessitates a staged approach to capacity building of interested facilities, clinicians and nurses starting with those near to the organisations and networks of PLWHA.

Such an approach facilitates a team-based approach to capacity building. It also gives priority to the development of skills for clinical diagnosis and management as recommended by World Health Organization. Available laboratory facilities support clinical care. The necessary infection control, treatment, counselling and other protocols and guidelines for HIV care need to be developed as a matter of urgency.

Entry points for HIV care will be through voluntary testing and counselling services or, especially for those who do not know their infection status, through in-patient care. The quality of the counselling is a critical starting point for effective care. The National Policy on HIV/AIDS and STD Related Issues (1997) states that anyone who counsels should care about people.

The care needs of an HIV infected person are life-long. This requires the development of comprehensive systems of care, support and treatment. The strategy supports and seeks to expand the present practice of some counselling and testing services and drop in centres of the provision of integrated care and support services, including the prophylaxis and treatment of opportunistic infections.

It also seeks to promote synergies between related programmes thus providing multiple entry points for HIV counselling, testing, care and referral. Synergies in care lie amongst HIV, TB, malaria, Hepatitis C, and related conditions, as well as amongst HIV, reproductive and sexual health, and trauma services for rape and violence.

The strategy addresses a number of ethical issues: equity in access to care, support and treatment, couple counselling, and the impact on families of the cost of HIV treatment. It seeks to involve families and communities in care and support as a means of increasing social acceptance of PLWHA and treatment effectiveness. It recognises that systems of care, which place the onus of care on families or communities, are not sustainable.

Locally manufactured anti-retrovirals are available. The strategy calls for the urgent regulation of their production, distribution and prescription so that personal harm and widespread drug resistance do not eventuate. Treatment protocols will be developed and the policy developed on access to anti-retrovirals will address the need to develop social as well as clinical criteria for access if universal free access is not adopted.

In a low incidence setting, HIV care can be a particularly effective prevention strategy. It can assist in keeping infection rates low in the health workforce and their families and communities. It also provides an entry point for ensuring family support and acceptance of PLWHA and for building the capacity for home care. The strategy advocates for the involvement of PLWHA in

health sector capacity building and in health care teams as an effective catalyst of attitudinal and behavioural change.

HIV care requires motivated, caring and skilled personnel. The strategy recognises that health settings, which undermine staff morale and dehumanise care are not conducive to quality HIV care. This has human resource and financial implications. The priority strategies to improve the provision of care and support services are as follows:

**Strategy 1: Promote rights based approaches to care, support and treatment**

*Implementing strategies:*
- To promote respect and acceptance of those infected and affected by HIV and AIDS
- To ensure the effective involvement of organizations of PLWHA in care, support and treatment
- To provide access to legal assistance to remedy HIV related discrimination
- To create positive attitudes and language among health care personnel

**Strategy 2: Ensure universal access to counselling and testing services**

*Implementing strategies:*
- To develop and implement guidelines for HIV counselling and testing, including confidentiality and disclosure, and the counselling of children
- To develop standards for recruitment, training and performance monitoring of counsellors including systems for debriefing and support for counsellors
- To ensure the accessibility and affordability of counselling and testing services
- To encourage and support couple based counselling

**Strategy 3: Create national protocols and guidelines for HIV treatment and care**

*Implementing strategies:*
- To develop and ensure the implementation of universal infection control procedures
- To develop and implement guidelines on the prophylaxis and treatment of opportunistic conditions, treatment of co-infection, treatment monitoring, adherence and surveillance for drug resistance
- To develop national policy on antiretroviral treatment access
- To develop and implement national protocols and guidelines on Anti Retroviral Therapy (ART) treatment for adults and children, for prevention of parents to child transmission (PPTCT), and for post exposure prophylaxis for occupational exposure and rape

**Strategy 4: Establish national policy on antiretroviral therapy (ART) production and regulation**

*Implementing strategies:*
- To develop and implement national regulations and guidelines on ART production, quality assurance, procurement and distribution
- To develop and implement national guidelines on eligibility criteria for ART prescription, prescriber training and accreditation, and pharmacist training

**Strategy 5: Build the capacity for team based care starting in selected facilities around the country**

*Implementing strategies:*

- To develop selection criteria for the choice of the facilities in partnerships with local organisations of PLWHA
- To develop and implement a team based capacity building process which includes care as a prevention strategy

**Strategy 6: Maximize treatment effectiveness and ensure equity in access**

*Implementing strategies:*

- To strengthen capacity for clinical diagnosis and management of HIV and AIDS
- To ensure consistent and affordable supply of quality assured drugs for prophylaxis and treatment of opportunistic infections (OIs)
- To ensure access to ART treatment counselling including adherence counselling, nutrition treatment support, and financial planning
- To guarantee equity in access by wealth, gender, age and location

**Strategy 7: Promote comprehensive systems of HIV care, support and treatment**

*Implementing strategies:*

- To develop comprehensive systems of care and facilities which allow for life long patient management at hospitals, hospices and home including palliative care
- To include HIV care in curricula of health training institutions
- To reinforce the integrated delivery of health and social services at local facilities
- To promote synergy and referrals among related programmes/services

**SUB COMPONENT OF OBJECTIVE-4: PROVIDE CARE, SUPPORT AND TREATMENT TO CHILDREN AND THEIR FAMILIES**

HIV transmission from parents to child can be significantly minimized (prevention of parent to child transmission-PPTCT). Experience elsewhere points to two important programming considerations: (i) the need to involve men in decision-making and in programme implementation, and (ii) the need to ensure that participating children receive continuing parental support and guidance.

Children require a particular focus within the response to the epidemic. Children can be deeply traumatised by the knowledge or suspicion that their parents are infected and their lives adversely affected by the demands of home care and support. They have particular counselling and support needs starting from disclosure and lasting long after the death of a parent. This is true whether they are infected or affected.

The priority strategies to provide care, support and treatment to the affected children and their families are as follows:

**Strategy 1: Strengthen PPTCT programmes through the involvement of men**

*Implementing strategies:*

- To provide couple based counselling and encourage couple based decision-making
- To ensure men's understanding and support for the breast feeding option chosen

**Strategy 2: Build team based capacity for PPTCT in selected facilities**

*Implementing strategies:*
- To develop criteria for selection of participating facilities and to involve PLWHA in their selection
- To develop treatment and breastfeeding protocols
- To train health care teams from participating sites for PPTCT
- To develop guidelines, build counselling capacity for pregnancy and HIV with PPTCT

**Strategy 3: Provide follow up care and support to participating families**

*Implementing strategies:*
- To provide ongoing support and counselling on breast-feeding
- To provide ongoing care and support services to the child and the parents including nutrition support, sexual and reproductive health counselling, and family support services

**Strategy 4: Provide care and support for children affected by the epidemic**

*Implementing strategies:*
- To develop the capacity to provide counselling services for parents on disclosure and to children from disclosure onwards
- To develop the capacity of communities and schools for care and support for affected children and to encourage children to continue at school

## 3.5 PROGRAMME OBJECTIVE-5: MINIMIZE THE IMPACT OF THE HIV/AIDS EPIDEMIC

The impact of the HIV epidemic follows certainly from its spread. Hence its extent is determined by a nation's capacity to put in place an effective response. The form the impact takes is determined by who gets infected and how quickly. This in turn is determined by factors such as gender inequity, socio-economic stratification, the structure of the workforce, and the degree of social capital. The impact moves as the epidemic deepens from an impact on individuals and families to encompass the impact on communities, the labour force, the provision of basic services, the capacity to govern, and much else.

Bangladesh's epidemic is emerging. Its future shape is not clear and the factors, which have minimized its spread, are not well understood. Its impact has begun on individuals and families. These micro level impacts can be exceptionally disturbing to those concerned. They may be the result of discrimination or rejection. Or they may result from the use of household savings and assets in the quest for treatment or a cure.

The National Policy on HIV, AIDS and STD Related Issues (1996) endorses the principle of the non-discrimination of PHA and their families and the application of all other fundamental rights and freedoms. Medical ethics imposes a duty of care, requiring that the provision of care without discrimination or prejudice. The honouring of these principles would in themselves reduce the negative impacts of the epidemic.

The strategies under this objective are designed to diminish trauma and disruption. They are also designed to create a more profound understanding of the potential impact of the epidemic if it begins to expand and so generate a national will to respond in a timely and effective manner.

By the year 2010, Bangladesh will continue to have low rates of HIV infection and minimize the impact of HIV epidemic. The priority strategies to reduce the impact of HIV epidemic are as follows:

**Strategy 1: Better understand the factors and influences on the emergence of the epidemic**

*Implementing strategies:*

- To develop and implement research into the factors and influences on the spread of the epidemic
- To encourage public discussion and leadership on these matters

**Strategy 2: Ensure non-discrimination in the world of work**

*Implementing strategies:*

- To ensure non-discrimination of HIV infected and affected people in recruitment and employment
- To support initiatives for awareness creation and for service provision
- To ensure non discriminatory application of benefits and entitlements
- To strengthen the capacity of the senior management

**Strategy 3: Promote protection in the world of work**

*Implementing strategies:*

- To develop and implement HIV protective occupational health and safety practices
- To mobilize workers' associations and employers' associations

**Strategy 4: Ensure the support of the legal sector**

*Implementing strategies:*

- To review and monitor national laws and their implementation to ensure their support of the national response
- To orient and sensitise judicial and law enforcement agencies and personnel

**Strategy 5: Protect the rights of the infected and affected people, including surviving children**

*Implementing strategies:*

- To protect and promote their rights under traditional and formal legal systems
- To develop and implement support services and legal aid for children who are orphans

**Strategy 6: Minimize the impact on families**

*Implementing strategies:*

- To better understand the relationship between health sector financing policies and HIV affected household impoverishment
- To develop sustainable programmes of community and family care
- To provide support services to minimise the emotional and social impact on HIV affected families and support self-help groups

**Strategy 7: Minimize the impact on the economy**

*Implementing strategies:*

- To create awareness in the key sectors of the economy of the potential impact of an expanding epidemic on their workforce and on productivity
- To create awareness in the micro credit sector on the potential impact of an expanding epidemic on their work

# CHAPTER-4: IMPLEMENTATION ARRANGEMENTS FOR THE NATIONAL STRATEGIC PLAN

The National Policy on HIV/AIDS and STD Related Issues (1996) establishes the National AIDS Committee (NAC) as the advisory & policy making body to the Government of the People's Republic of Bangladesh on all aspects related to HIVAIDS and STI. Its membership represents the key players and bodies involved in or which need to be mobilized for a national response. It constitutes an important constituency, which can advocate and mobilise for support, policy development and social mobilisation. The Technical Committee (TC) of the NAC assists NAC in the formulation of guidelines and provides technical guidance.

## 4.1 ROLES AND RESPONSIBILITY OF THE NATIONAL AIDS/STD PROGRAMME

The National AIDS/STD Programme has stewardship of the response to the epidemic. It exercises this stewardship through partnership with other actors. The mandate of the NASP is to provide overall strategic guidance in the formulation of the national response, to coordinate its players, to monitor performance, and to evaluate its effectiveness and impact. Its partners in exercising this mandate come from within and outside the health sector so as to draw on the expertise required to successfully address the HIV/AIDS epidemic.

### 4.1.1. Co-ordination

To carry out this mandate, NASP must have the culture and the capability to be a learning organisation. Its focus should move from programme inputs to the assessment of programme performance and outcomes and to stimulation of research as well as to feedback of the analysis and findings. It will need the organisational and management structure and human and financial resources to carry out this mandate.

Responsibility for coordinating the national response must be exercised in a number of ways. Firstly, NASP is responsible for the coordination and mobilisation of players within the government sector. This responsibility is exercised through inter-ministerial or inter-departmental committees. These may be standing committees or ad hoc committees depending on their purpose. Coordination mechanisms, which enable and ensure the involvement of those whose support is required for an effective response, need to be strengthened.

The coordination of development partners contributing to the national response to HIV/AIDS is a national responsibility. It is important not only to coordinate donor assistance but also to provide a forum for reflection and information sharing on the national response. Assistance can be sought from the UN to facilitate to carry out this responsibility.

A partnership will need to be entered into with the organisations of civil society. For this to happen there needs to be representational structures within the sector to facilitate consultation and accountability within the partnership.

### 4.1.2. Mainstreaming HIV

Integrating or mainstreaming HIV into the work of other Ministries and sectors is essential. Mainstreaming strengthens the capacity to ensure that the workforce remains uninfected and that the sector or Ministry can continue to function in the case of an expanding epidemic. In this respect priority needs to be given to creating awareness in the key sectors about the potential impact of an expanded epidemic on their workforce and productivity. This awareness creation can mobilise these players to be involved in addressing the epidemic by putting in place supportive

policies and programmes on HIV/AIDS specifically targeting their workplaces and providing support to other initiatives of the national response.

### 4.1.3. Monitoring and evaluation

Monitoring and evaluation system is needed for the purpose of learning, of understanding what works and what does not and of improving programme performance and impact. It is also necessary for accountability for financial and programme stewardship. To the extent possible, data should be drawn from existing sources. NASP will manage access to information through ensuring appropriate provisions in contracts with its contractual partners and requesting development partners, support partners and implementing partners in providing minimal but adequate information without any interference. A National M&E Framework has been shown in appendix-4. The following data sources could be used for building a monitoring and evaluation system.

**Existing records:** All implementing partners keep records. The capacity of these implementing partners to analyse this data and use it for programme redesign need to be strengthened. Key data collected should be comparable across all implementing partners and should be transferred to a central data collection facility where it will be collated, analysed and feedback to partners.

**Surveillance system:** The existing system of HIV and behavioural surveillance needs to be strengthened and adapted as understanding of the epidemic in Bangladesh increases.

**Research:** Research projects relevant to HIV should be centrally collated and analysed for their implications for understanding the epidemic and for improving the effectiveness of the response.

**Financial management:** Experience with HIV shows the importance of regular and independent audits for accountability and transparency purposes. At the level of individual implementing partners, the capacity for financial management will be strengthened and procedures for ensuring accountability and transparency developed and implemented. Tools such as CRIS (Country Response Information System) have been developed to assist in resource tracking and accountability.

**Measuring programme performance:** A relatively small number of indicators that are easy to capture and provide a measure of programme performance are needed. These can be supplemented by periodic evaluations. The Millennium Development Goals and UNGASS will form a part of this performance management system. General indicator for low prevalence and/or concentrated epidemic countries is attached in appendix-5 and programme indicators and targets of the first National Strategic Plan 1997-2002 are shown in appendix-6.

**Measuring national competency to respond:** Data exists on progress in achieving national development and social goals, which are relevant to measuring the competency of a nation to respond. There is an interrelationship between certain aspects of development and social change, which can be used to monitor this competency. Thus for example, the extent of socio-economic stratification in a society, its stock of social capital, its educational endowment, its gendered inequities, and the paths it takes to modernisation and incorporation in the global economy can strengthen or constrain its response. A framework for monitoring this competency could be developed from existing data set.

**One agreed National Monitoring and Evaluation System:** Based on the above components a national monitoring and evaluation system will be put in place and this will form the basis for monitoring and evaluating the overall response to HIV/AIDS. A comprehensive M&E system is critical to ensure efficient and effective concerted action on HIV/AIDS.

## 4.2 OPERATIONALISING NATIONAL STRATEGIC PLAN

The Strategic Plan will be operationalized through a three year rolling plan. This plan will be developed through a series of consultations. A task team will be formed for each objective or sub-component consisting of all those who will have a role to play in achieving the objective. This will include implementing partners but it will also include those involved in advocacy, research, capacity building, monitoring and other aspects of implementation. The responsibility of each task team will be to contribute towards the determination of how the objective will be achieved, the allocation of roles and responsibilities, development of mechanisms for cooperation and coordination and assist in the preparation of the Work Plan. The preparation of the Operational Plans could occur in stages.

# APPENDIX: 1

## STRATEGIC PLANNING TEAM MEMBERS

1. Ms Elizabeth Reid, International Consultant, UNICEF
2. Dr. Ivonne Camaroni, Project Officer, UNICEF
3. Mr. Rajendra Jani, International Consultant, UNAIDS
4. Mr. Kwaku Akora, International Consultant, UNAIDS
5. Dr. Evaristo Marowa, UNAIDS Country Coordinator
6. Dr. Md. Mozammel Hoque, Deputy Programme Manager, NASP
7. Dr. Yasmin Jahan, STI Management Specialist, NASP
8. Dr. Md. Golam Mostafa, Programme Implementation Specialist, NASP

## INTERIM CORE GROUP MEMBERS:

1. Dr. Md. Abdus Salim, Programme Manager, NASP
2. Dr. Md. Atiqul Sarwar, Deputy Programme Manager, NASP
3. Dr. Md. Hanif Uddin, Deputy Programme Manager, NASP
4. Dr. Evaristo Marowa, UNAIDS Country Coordinator, Bangladesh
5. Dr. Nazmul Hossein, Acting Programme Coordinator, CARE Bangladesh
6. Dr. Nizam Uddin Ahmed, Director, Health & Nutrition Sector, Save the Children-USA
7. Ms. Shirin Jahangeer, Operations Consultant, World Bank, Dhaka
8. Dr. Noor Mohammad, Programme Coordinator, UNFPA
9. Dr. Mahbubul Islam, National Consultant, Adolescent Health & HIV/AIDS, WHO-Bangladesh
10. Dr. Iyanthi Abeywickreme, Short Term Professional Officer, HIV/AIDS, WHO-Bangladesh
11. Dr. Ivonne Camaroni, Project Officer, UNICEF-Bangladesh
12. Dr. Nazneen Akhter, Executive Director, HASAB
13. Dr. Halida Hanum Khandoker, Executive Director, CAAP
14. Mr. Mohammad Alauddin, Procurement Consultant, NASP
15. Dr. Zaman Ara, Technical Assistance Coordinator, NASP
16. Mr. Mafizur Rahman, M&E Specialist, NASP
17. Dr. Provat Chandra Barua, Epidemiologist, NASP
18. Dr. Mahbubul Hannan, Advocacy/BCC Specialist, NASP
19. Mr. Rehan Uddin Ahmed Raju, Advocacy/BCC Specialist, NASP
20. Dr. Ziya Uddin, IDU Specialist, NASP
21. Dr. Rowshan Ara, STI Management Specialist, NASP

# APPENDIX: 2

## LIST OF DOCUMENTS REVIEWED

1. Advocacy on UNGASS Declaration and Commitment, Report on Dhaka Workshop, 2003. National STI/AIDS Network of Bangladesh.

2. African Development Bank. 2001. HIV/AIDS Strategy Paper for Bank Group Operations.

3. Bangladesh National Women Lawyers Association (BNWLA) Inter-Relation Between Trafficking In Women & Children and HIV/AIDS. July 2003

4. Bangladesh Demographic and Health Survey 1999-2000. National Institute of Population Research and Training (NIPORT). Dhaka.

5. Bangladesh National Women Lawyers Association (BNWLA) Violence Against Women in Bangladesh, 2001.

6. Bangladesh National Women Lawyers Association (BNWLA) Annual Report, 2002.

7. Bangladesh National Women Lawyers Association (BNWLA) Annual Report, 2003.

8. Bhuiya I *et al.* HIV/AIDS Data Base for South Asia Region: Bangladesh Component (Population council Draft Report, 2002).

9. Bollinger L *et al.* 2003. The Effects of HIV prevention interventions on behavior change: Assessment of knowledge and gaps.

10. Brown T *et al.* Effective Prevention Strategies in Low Prevalence Settings. UNAIDS Best Practice Key Materials USAID FHI.

11. Family Health International (FHI) Care and Support Services for PHA in Dhaka, Chittagong and Sylhet. February 2004.

12. GOB. HIV/AIDS Prevention Proje ct: Strategic Implementation Plan 2003-2005. MOHFW. DGHS.NASP June 2003.

13. GOB. Health and Population Statistical Report. Unified Management Information Systems (UMIS) December 2001.

14. GOB. National Policy on HIV/AIDS and STD Related Issues. 1996.

15. GOB. Strategic Plan of The National AIDS Programme of Bangladesh 1997-2002. July 2000.

16. Gopalan S. S. HIV/AIDS Prevention Project (Cr. 3441-BD) Revised Aide Memoire: Joint Review Mission. Prepared for World Bank- Bangladesh. January, 2004.

17. Health, Nutrition and Population Sector Programme (HNPSP). Programme Implementation Plan July 2003-June 2006. Planning Wing, MOHFW. GOB June 2003

18. Health and Population Sector Programme: 1998-2003 Programme Implementation Plan, Part-1, Ministry of Health and Family Welfare. GOB. 1998.

19. HIV/AIDS and Development Planning: An Integrated Approach to National Responses. Guidance Note. UNDP, 2003.

20. HIV in Bangladesh: Is Time Running Out? Background document for the dissemination of the third round of national HIV behavioral surveillance. National Aids/STD Programme. DGHS, MOHFW. Dhaka June 2001.

21. HIV in Bangladesh: Is Time Running Out? Background document for the dissemination of the fourth round (2002) of national HIV behavioral surveillance. National Aids/STD Programme. DGHS, MOHFW. Dhaka June 2003.

22. Inter American Development Bank. Resource Needs for HIV/AIDS: Model for Estimating Resource Needs for Prevention, care, and Mitigation. Washington DC. 2002.

23. Bangladesh Health Bulletin 1997. MOHFW. GOB.

24. JHU/CCP and BCCP. Strategic Communication Plan for the HIV/AIDS Prevention Project (HAPP) Advocacy and Communication Component (ACC) 2004-2005. Developed for UNICEF-Bangladesh and National AIDS/STD Programme, Ministry of Health and Family Welfare, GOB. 2004.

25. Management Systems International Strategic Management Tools to Support HIV/AIDS Policy Change, Produced for USAID Center for Democracy and Governance. Washington DC.

26. Mhatre S *et al.* Third CEIT Service Delivery Survey: Preliminary Key Findings (Draft) Report submitted to Joint Chief, planning (MOHFW). Dhaka. July 2003.

27. Moving for Action with Shared Responsibility. AIDS Conference 2002: National STI/AIDS Network, Bangladesh. October 2002

28. National STI/AIDS Network of Bangladesh. Annual Report 2003

29. Nepal's National HIV/AIDS Strategy Final Draft 2002.

30. Pradham R. 2000. Appreciative Inquiry: The Art of Constructing a Positive Future.

31. Temple F. T. HIV/AIDS Prevention Project (Credit 3442-BD). June 2003 Mid-Term Review Mission. World Bank Office, Dhaka.

32. The Center for Development and Population Activities (CEDPA). Strategic Planning: An Inquiry approach. The CEDA Training Manual Series Vol. X. Washington, DC. CEDPA

33. The Government of Vietnam. Decision of the Prime Minister on Approval of the National Strategy on HIV/AIDS prevention and Control in Vietnam up to 2010 with A Vision to 2020

34. Report on the Second National Expanded HIV Surveillance, 1999-2000. Bangladesh. Aid and STD Control Programme. Directorate General of Health Services, Ministry of Health and Family Welfare. GOB. September, 2000

35. Review of the Problem of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome in all its aspects: A Report of the Secretary-General to A Special Session of the General Assembly on HIV/AIDS. United Nations. New York February 2001.

36. Report on The Serological Surveillance and Behavioral Surveillance on STD and AIDS in Bangladesh 1998-1999.AIDS & STD Programme, DGHS, MOHFW GOB June, 2000.

37. Strategic Framework for the National Response to HIV/AIDS in Ethiopia (2001-2005.

38. UNAIDS. Bangladesh Country Profile. National AIDS/STD Programme. MOHFW. Health and Population Sector Programme (HPSP) May 2001.

39. UNAIDS. Guide to the Strategic Planning for a National Response to HIV/AIDS.UNAIDS Best Practice Collection 2134, 4312, 3241, & 1423.

40. Walford V. Health in Poverty Reduction Strategy Papers (PRSPs): An Introduction and Early Experience, 2002. DFID Health Systems Resource Centre.

41. Weerelt P V.A Human Right-based approach to Development Programming in UNDP-Adding the Missing Link. UNDP 2001.

# APPENDIX: 3

### List of People Consulted/Interviewed

| | Name | Designation | Organization |
|---|---|---|---|
| **Government Officials** | | | |
| 1 | Md. Fazlur Rahman | Secretary, Planning | Ministry of Planning |
| 2 | Prof. (Dr.) Md. Mizanur Rahman | Director General of Health and Line Director NASP | DGHS |
| 3 | Dr. Mir Sayeedul Hoque | Deputy Director Hospital & Programme Manger | Safe Blood Transfusion Programme, DGHS |
| 4 | Prof. Abul Kalam Azad | Director | IEDCR |
| 5 | Dr. Md. Moazzem Hossain | MIS, DGHS | MIS, DGHS |
| 6 | Ms. Lutfa Kabir | Director | MIS, DGFP |
| 7 | Md. Anowarul Isla m Khan | Chief | Bureau of Health Education, DGHS |
| 8 | Ms. Monowara Begum | BCC Specialist | Bureau of Health Education DGHS |
| **Technical Committee (TC) of National AIDS Committee (NAC):** | | | |
| 9 | Maj. General (Dr.) A S M Matiur Rahman | Chairperson, Technical Committee of National AIDS Committee | TC of NAC |
| **National AIDS/STD Programme** | | | |
| 10 | Prof (Dr) Fatima Parveen Chowdhury | Line Director, | NASP |
| 11 | Dr. Md. Abdus Salim | Programme Manager | NASP |
| 12 | Dr. Atiqul Sarwar | Deputy Programme Manger | NASP |
| 13 | Dr. Hanif Uddin | Deputy programme Manger | NASP |
| 14 | Dr. Md. Mozammel Hoque | Deputy Programme Manger | NASP |
| 15 | Dr. Md. Golam Mostafa | Programme Implementation Specialist | NASP |
| 16 | Dr. Yasmin Jahan | STI Management Specialist | NASP |
| 17 | Dr. Zaman Ara | Technical Assistance Coordinator, NASP | NASP |
| 18 | Dr. Rowshan Ara | STI Management Specialist | NASP |
| 19 | Dr. Mahbubul Hannan | Advocacy/BCC Specialist | NASP |
| 20 | Mr. Rehan Uddin Ahmed Raju | Advocacy/BCC Specialist | NASP |
| 21 | Mr. Shamsuddin Chowdhury | Finance & Management Specialist | NASP |
| 22 | Mr. Md. Mafizur Rahman | Monitoring & Evaluation Specialist | NASP |
| 23 | Dr. Provat Chandra Barua | Epidemiologist, NASP | NASP |
| 24 | Mr. Mohammad. Alauddin | Procurement Consultant | NASP |

**AIDS/STI Network of Bangladesh**

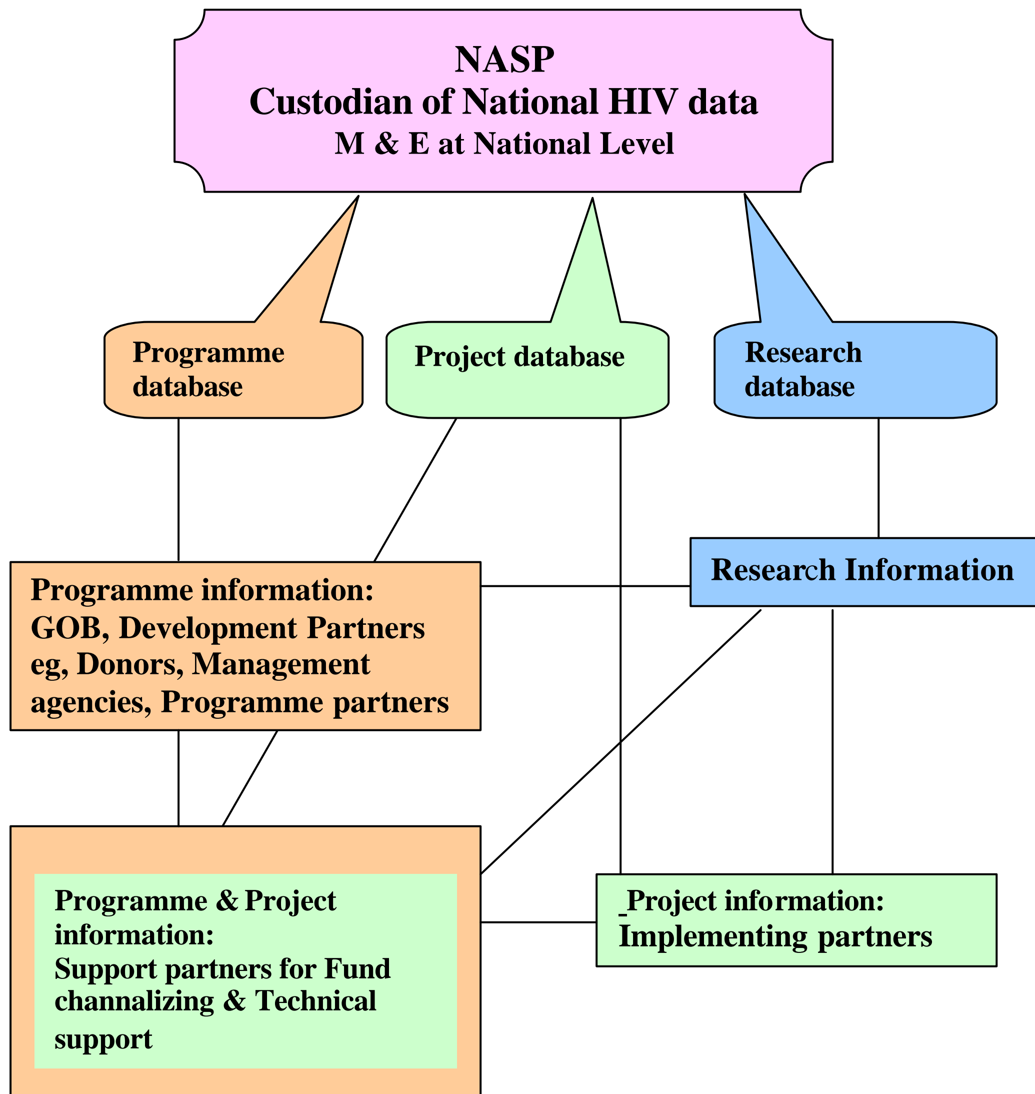
| | | | |
|---|---|---|---|
| 25 | Dr. Yasmin H Ahmed | Managing Director | Marie Stopes Clinic Society (MSCS) |
| 26 | Dr. Shahnewaj Khan | Chairman | STI/AIDS Network |
| 27 | Dr. AZM Zahidur Rahman | Programme Manager | Social Marketing Company (SMC) |
| 28 | Khairuzzaman Kamal | Executive Director | BMSF |
| 29 | Kazi Enayet Hossain | Executive Director | SCOPE |
| 30 | Ms. Afroza Parvin | Executive Director | Nari U. Shakti |
| 31 | Mohd. Alauddin | Executive Director | SEDAP |
| 32 | Mirza Mustafizur Rahman | Program Coordinator | HASAB |
| 33 | Mahfuzul Hoque Chowdhury | Chairman | GREEN Bangladesh, Chittagong |
| 34 | Md. Shah Alam Sarder | Regional Coordinator | BRAC HIV/AIDS Programme |
| 35 | Basudeb Maitra Basu | Project Manager | Aparajeyo Bangladesh, Dhaka |
| 36 | Ms. Shima Dutta | Project Manager | YPSA, Chittagong |
| 37 | Dr. Julia Ahmed | Head of Programme | Bangladesh Women Health Coalition (BWHC) |
| 38 | Ms. Dilrose Hossain | Senior Programme Manager | RDRS |
| 39 | Ms. Shaheen Akhter Dolly | Executive Secretary | Nari Maitree |
| 40 | Dr. Raisul Haque | Project Manager | BRAC Health & Nutrition Program |
| 41 | Dr. AJ Faisal | Country Representative | Engender Health |
| 42 | Dr. Mohammed Zahirul Islam | Programme Coordinator | Plan Bangladesh |
| 43 | Ms. Habiba Akhter | Executive Director | Ashar Alo Society |
| 44 | Badal K Saha | | SWOP |
| 45 | Chitta Ranjan Talukder | | Community Health Care Project CHCP) |
| 46 | Dr. Halida Hanam Khandoker | Executive Director | CAAP |
| 47 | Delruba Karim | Government Liaison Coordinator | CARE Bangladesh |
| 48 | Dr. Munir Ahmed | Programme Coordinator | CARE Bangladesh |
| 49 | TIM Zahid Hossain | | Action Aid Bangladesh |
| 50 | Gazi Matiur Rahman | | Khalifa Foundation (KF), Barguna |
| 51 | Md. Hasibur Rahman | | BUKS, Rajshahi |
| 52 | Mr. Saleh Ahmed | Executive Director | Bandhu Social Welfare Society (BSWC) |
| 53 | Md. Rezaul Karim | | Mukti Nari O Shishu Unnayan Sangstha, Kustia |
| 54 | Md. Anwarul Islam | | PSTC |
| 55 | Ms. Farzana Akhter | Regional Coordinator | CARE Bangladesh |
| 56 | Dr. Kazi Faisal Mahmud | Programme Manager | CONCERN |
| 57 | Dr. Malay Kumar Mridha | Programme Manager | HASAB |

| | | | |
|---|---|---|---|
| 58 | Mr. AB Siddique Tito | Programme Manager | Jugantar Samaj Unnayan Sangstha Chittagong |
| 59 | Mr. AH Farouque Ahmed Khan | Programme Manager | Sylhet Jubo Academy, Sylhet |
| 60 | Prof. Sultan Muhammed Razzak | | Khilgaon, Dhaka |
| 61 | Mr. Tariqul Islam | | ACLAB, Dhaka |
| 62 | Dr. Zahed M Masud | Executive Director | AITAM Welfare Organization |
| 63 | Dr. Nazneen Akhter | Executive Director | HASAB |
| 64 | Dr. Mausumi Amin | Technical Coordinator | HIV program CARE Bangladesh |
| 65 | Ms. Mukti | Secretary | HIV/AIDS Positive Self Help Group Mukto Akash |
| 66 | Rahima Begum Hashi | Secretary | HIV/AIDS Prevention Project Nari Mukti Sangha |
| **UN Agencies** | | | |
| 67 | Dr. Najmus S. Sadiq | Assistant Resident Representative | UNDP |
| 68 | Dr. Evaristo Marowa | Country Coordinator | UNAIDS |
| 69 | Ms. Suneeta Mukherjee | Country Representative | UNFPA |
| 70 | Mr Morten Giersing | Chair Person, UN Theme Group | UNICEF |
| 71 | Rosella Morelli | Senior Programme Coordinator | UNICEF |
| 72 | Dr. Ivonne Camaroni | Project Officer | UNICEF |
| 73 | Dr. Kayode Oyegbite, | Chief, Health and Nutrition | UNICEF |
| 74 | Dr. Noor Mohammad | Programme Manager | Youth and Adolescent Reproductive Health UNFPA |
| 75 | Dr. Suniti Acharya | WHO-Representative Bangladesh | WHO |
| 76 | Dr. Iyanthi Abeyewickreme | Short Term Professional HIV/AIDS | WHO |
| 77 | Dr. Mahbubul Islam | National Consultant, Adolescent Health & HIV/AIDS | WHO |
| **Multilateral development Partners** | | | |
| 78 | Dr. Kees Kostermans | Lead Public Health Specialist, Human Development Group 2 | The World Bank |
| 79 | Bina Valydon | Public Health Specialist | The World Bank |
| 80 | Shirin Jahangeer | Operations Consultant | The World Bank |
| **Bilateral Partners** | | | |
| 81 | Dr. Muhammod Abdus Sabur | Health & Population Sector Manger | DFID |

| | | | |
|---|---|---|---|
| **International NGOs** | | | |
| 82 | Dr. Nizam Uddin Ahmed | Director, Health Population & Nutrition Sector | Save the Children USA |
| 83 | Dr. Amala Ready | National Consultant | FHI |
| 84 | Dr. Tim Brown | International Consultant | FHI |
| 85 | Mr. Robert Kelly | Country Director | FHI |
| 86 | Dr. Enamul Karim | Technical Director | HLSP Consulting |
| 87 | Parveen Rasheed | Managing Director | Social Marketing Company |
| 88 | Dr. Nazmul Hussein | Acting Program Coordinator | CARE Bangladesh |
| 89 | Dr. Yasmin H. Ahmed | Managing Director | Marie Stopes Clinic Society |
| 90 | Dr. Lutfa Ashraf | Program Development Officer | CARE Bangladesh |
| 91 | Dr. Halida Hanum Khandoker | Executive Director | Confidential Approach to AIDS Prevention (CAAP) |
| 92 | Dr. Mausumi Amin | Regional Coordinator, HIV-Program | CARE Bangladesh |
| 93 | Dr. Fatema Zannat | Programme Development Officer, HIV-Positive Support Group | CARE Bangladesh |
| 94 | Dr. Lubana Ahmed | Programme Manager, Adolescent, Reproductive Health. Health Population & Nutrition Sector. | Save the Children USA |
| **Business Sector** | | | |
| 95 | Colonel M. M. Jahangir | Secretary General | The Federation of Bangladesh Chambers of Commerce and Industry |
| **Research Organization** | | | |
| 96 | Dr. Tasnim Azim | Scientist & Head, Virology & HIV Programme, | ICDDR, B |

**APPENDIX-4**

## NATIONAL M&E FRAMEWORK



# APPENDIX-5

**General Indicators for low prevalence/concentrated epidemic countries:**

| AREA | INDICATOR | LEVEL | PRIORITY |
|---|---|---|---|
| 1. Policy | 1. AIDS Programme Effort Index | Context | C |
| | 2. Spending on HIV initiative | Context | |
| 2. Condom accessibility and quality | 1. Condoms available-nation wide | Input | C |
| | 2. Condoms available –retail | Output | A |
| | 3. Condom quality | Input | C |
| 3. Stigma and Discrimination | 1. Accepting attitudes towards HIV infected people | Context | A |
| | 2. Employers not discriminating against those with HIV | Context | A |
| 4. Knowledge | 1. Knowledge of HIV prevention | Output | C |
| | 2. No incorrect belief about HIV | Output | C |
| | 3. Comprehensive knowledge about AIDS | Output | C |
| | 4. Knowledge about HIV prevention among MSM | Output | C |
| | 5. Knowledge about HIV prevention among IDUs | Output | C |
| | 6. Knowledge of PTCT | Output | C |
| | 7. Knowledge that PTCT can be prevented | Output | A |
| 5. Counselling, HIV testing and referral | 1. Population requesting & receiving HIV test results | Output | A |
| | 2. Districts with VCT services | Input | A |
| | 3. Quality- pre and post test counselling and referral | Output | C/A |
| | 4. VCT with conditions for quality service | Input | A |
| 6Parents -to- child transmission | 1. Pregnant women counselled and tested for HIV | Output | A |
| | 2. ANC clinics offering or referring to VCT | Input | C/A |
| | 3. Quality HIV counselling for pregnant women | Output | A |
| | 4. Provision for ARV therapy during pregnancy | Outcome | A |
| 7. Sexual Negotiation | 1. Woman's ability to negotiate safer sex with her husband | Outcome | A |
| 8. Sexual behaviour | 1. Risky sex in the last year | Outcome | C |
| | 2. Condom use during the last risky sex | Outcome | C |
| | 3. Commercial sex during the last year | Outcome | C |
| | 4. Condom use by client during last commercial sex | Outcome | C |
| | 5. Condom use by sex workers with last client | Outcome | A |
| | 6. Condom use at last male-male anal sex | Outcome | C |
| | 7. Risky male-male sex in the last year | Outcome | C |
| 9.Young people's sexual behaviour | 1. Median age at first sex act | Outcome | A |
| | 2. Young people having premarital sex in last year | Outcome | C/A |
| | 3. Condom use at last premarital sex | Outcome | A |
| | 4. Young people with multiple partners in last year | Outcome | C |
| | 5. Condom use in last risky sex | Outcome | C |
| | 6. Age mixing in social relationships | Outcome | A |
| 10.Injecting drug use | 1. Drug injectors sharing needles | Outcome | C |
| | 2. Drug injectors using condom during last sex | Outcome | C |
| 11. Blood safety and healthcare setting | 1. Screening of blood units for transfusion | Outcome | C |
| | 2. Reduction of unnecessary blood transfusion | Outcome | A |
| | 3. Districts with blood bank | Output | C |
| | 4. Accidental transmission in healthcare settings | Output | A |
| 12. STI care and prevention | 1. Appropriate diagnosis and treatment of STIs | Outcome | C |
| | 2. Advice on condom use, partner's notification | Output | C |
| | 3. Drug supply at STI clinic | Input | A |
| | 4. Treatment seeking behaviour for STI | Outcome | C |
| 13. Care and Support for HIV infected and their families | 1. Medical personnel trained in HIV | Output | A |
| | 2. Health facilities with capacity to deliver care | Output | C |
| | 3. Health facilities with drugs in stock | Input | A |
| | 4. Households helped with care of young adult | Output | A |
| | 5. Households helped with care of orphans | Output | A |
| 14. Health and Social Impact | 1. HIV prevalence among pregnant women | Impact | C |
| | 2. Syphilis prevalence among pregnant women | Impact | C |
| | 3. HIV prevalence in sub population at risks | Impact | C |
| | 4. Percentage of households with young adult death | Impact | A |
| | 5. Percentages of children who are orphan | Impact | A |
| | 6. Percentages of orphans who are in schools | Impact | A |

***Note: C=Core, A=Additional, Source:UNAIDS***

# APPENDIX: 6

## NATIONAL STRATEGIC PLAN 1997-2002

### PROGRAMME INDICATORS AND TARGETS

| INDICATORS | EXTENTS OF ACHIEVEMENTS | COMMENTS |
|---|---|---|
| **1. PREVENTION INDICATORS AND TARGETS** | | |
| **1.1 Knowledge of prevention practice:** | | |
| By 2001, 80% of the population between 15-49 years should be able to mention two ways of protection from HIV infection | Not measured through any survey or any study | No Monitoring and Evaluation (M&E) system is in place at NASP. |
| **1.2 Condom availability:** | | |
| By 2001, 150 million condoms will be available for distribution during the preceding 12 months. | Not available | Not available |
| By 2001, all Upazilla Health Complexes will have had 100% uninterrupted supply of condoms in the preceding 12 months. | Not available | Not available |
| By 2001, 80% of the population between 15-49 years will be able to acquire a condom. | Not available | Not available |
| **1.3 Reported condom use:** | | |
| By 2001, 80% of sex workers operating in brothels will report the use of a condom during the most recent act of sexual intercourse. | Only 20% of the brothel sex workers are reported to use condom in their recent sex act. | 3rd Round BSS conducted in 2000-2001. |
| By 2001, 60% of truck drivers will report to have used a condom during the most recent act of sexual intercourse if other than with wife. | Only 8% of the truck drivers were reported to use condom during the most recent sex act. | 3rd Round BSS conducted in 2000-2001. |
| By 2001, 60% of migrant workers will report having used a condom during the most recent act of sexual intercourse. | Between 4% and 6% rickshaw pullers (internal migrant workers) were reported to use condom during the recent sex act. | 3rd Round BSS conducted in 2000-2001. |
| **1.4 STD Clinical Management:** | | |
| By 2001, 90% of Upazilla will have at least on clinician trained in STD case management. | Not available | Not available |
| By 2001, 80% of individuals presenting with STD in health facilities will have been assessed and treated according to national guidelines. | Not available | Not available |
| All ANC clinics will assess and facilitate for clinical management for syphilis. | Not available | Not available |
| **1.5 STD Prevalence:** | | |
| By 2001, the prevalence of urethritis among men aged 15-24 years will decrease by 50% in relation to baseline data available. | Not available | Not available |
| By 2001, the prevalence of positive serology for syphilis in ANC attendees aged 15-24 years will decrease by 50% in relation to baseline values available. | Not available | Not available |

| INDICATORS | EXTENTS OF ACHIEVEMENTS | COMMENTS |
|---|---|---|
| **1.6 HIV Prevalence:** | | |
| By 2001, HIV prevalence among women aged 15-24 years attending ANC will remain below 1%. | Not available | Not available |
| By 2001, HIV prevalence among CSWs will remain below 1%. | HIV Prevalence among CSWs remains <1%. | 3rd Round BSS conducted in 2000-2001. |
| By 2001, HIV prevalence among IDUs will remain below 5%. | HIV Prevalence among IDUs remains <5%. | 3rd Round BSS conducted in 2000-2001. |
| **1.7 Screening blood for transfusion:** | | |
| By 2001, 97 blood centers will have developed blood testing for HIV, syphilis and HVB and HVC. | Not available | Not available |
| 100% of blood donated for transfusion will be routinely screened for HIV antibiotics. | | |
| **2. CARE INDICATORS AND TARGETS** | | |
| **2.1 Counselling services:** | | |
| By 2001, 100% District Hospital will have at least one staff member qualifies as a counsellor. | Not available | Not available |
| By 2002, 100% of HIV infected persons will have received counselling by an adequately trained counsellor. | Not available | Not available |
| **2.2 Clinical management of AIDS:** | | |
| By 2001, 90% of Upazilla will have at least one clinician trained in AIDS clinical management. | Not available | Not available |
| By 2000, 90% of AIDS patients reported in the District Hospitals will receive clinical management according to national guidelines. | Not available | Not available |
| **3. PROGRAMME MANAGEMENT RELATED INDICATORS AND TARGETS** | | |
| **3.1** By 2001, 100% of brothels in the country will be participating in HIV/AIDS prevention activities. | 100% brothels have been brought under HIV/AIDS activities. | HIV/AIDS prevention activities are primarily done by the NGOs. |
| **3.2** By 2001, 90% of relevant ministries of Government will have initiated HIV/AIDS/STD prevention and control activities. | NASP has no such information about the ministries. | No M&E System was in place at NASP. |
| **3.3** By 2001, 80% of NGOs involved in health related areas would have integrated AIDS/STD prevention and control activities into their on-going programme. | NASP has no such information regarding the integration of AIDS/STD is available | No M&E System was in place at NASP. |
| **3.4** By 2001, 100% of Government, NGO and private concerns involved in AIDS/STD related interventions would be regularly sharing their activity reports with the NASP. | Achievement so far was not made. | No M&E System was in place at NASP. |