



BANGLADESH TECHNICAL SUPPORT PLAN FOR HIV AND AIDS

2008-2015



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Acronyms

AAS	Ashar Alo Society
ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
BSS	Behavioural and Serological Surveillance
CAAP	Confidential Approach to AIDS Prevention
CBO	Community Based Organisation
CSW	Commercial Sex Worker
DFID	Department for International Development, UK
DGHS	Director General of Health Services
DIC	Drop-In Centre
FBO	Faith Based Organisation
FHI	Family Health International
FSW	Female Sex Worker
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
GOB	Government of Bangladesh
HAPP	HIV/AIDS Prevention Project
HATI	HIV & AIDS Targeted Interventions
HIV	Human Immunodeficiency Virus
HNPSP	Health Nutrition Population Sector Programme
ICDDR,B	International Centre for Diarrhoeal Disease Research Bangladesh
IDU	Injecting Drug User
IEC	Information Education Communication
M&E	Monitoring and Evaluation
MAB	Mukto Akash Bangladesh
MARP	Most At Risk Population
MDG	Millennium Development Goal
MIS	Management Information System
MoHA	Ministry of Home Affairs
MoHFW	Ministry of Health and Family Welfare
Mol	Ministry of Information
MoLE	Ministry of Labor and Employment
MoSW	Ministry of Social Welfare
MoWCA	Ministry of Women and Children Affairs
MSA	Management Support Agency

MSM	Men who have Sex with Men
MSW	Male Sex Worker
NAC	National AIDS Committee
NASP	National AIDS/STD Programme
NGO	Non Government Organisation
NOP	National Operational Plan for HIV/AIDS 2006 - 2010
NSP	National Strategic Plan for HIV/AIDS 2004 - 2010
OI	Opportunistic Infection
OST	Oral Substitution Therapy
PAF	Project Acceleration Funds
PEP	Post Exposure Prophylaxis
PLHA	People Living with HIV/AIDS
PPTCT	Prevention of Parent-to-Child Transmission
RTI	Reproductive Tract Infection
SBTP	Safe Blood Transfusion Program
SCF	Save the Children USA
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TA	Technical Assistance
TSF	Technical Support Facility
TSNA	Technical Support Needs Assessment
TSP	Technical Support Plan
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	US Agency for International Development
VCT	Voluntary Counseling and Testing
WB	World Bank
WHO	World Health Organization

Executive Summary

The National Technical Support Plan (TSP) for HIV and AIDS

In 2004, the Ministry of Health and Family Welfare through the National AIDS/STD Program (NASP) approved the second *National Strategic Plan for HIV/AIDS, 2004 – 2010*. The plan identifies five programme objectives and several strategies to achieve these objectives. They are:

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

In the years following the release of this document, the nature of the epidemic in Bangladesh changed greatly, calling for a more effective management of the response and inclusion of key factors in an affective response. Urgent challenges that arose include, among other things; rapid increases in available funding, expanded demands for services and implications for a more effective response emanating from better understandings of the behaviours and needs of those most at risk.

In response to the above, NASP, with assistance from UNAIDS Secretariat Bangladesh, commissioned this *Technical Support Plan 2008 - 2015* (TSP) development exercise **to identify common gaps and bottlenecks in the national response and to ensure that they were addressed through the most appropriate means of technical support in a timely and effective manner.**

The process of developing the Technical Support Plan was overseen by a Technical Working Group chaired by NASP, with representatives invited from all major stakeholder groups. Through reviewing programme reports and documents, interviewing key stakeholders and from feedback gathered at consultation meetings, priority technical support needs were identified and the following plan (including a costed plan for 2008-2009) was developed in line with the existing framework of the NSP.

The significant long and short term cross-cutting issues emerging through this TSP development exercise include; strengthening coordination between partners to develop an effective multi-sectoral response; ensuring predictable uninterrupted funding; sustainable programme management and implementation of a comprehensive M&E system, including improved surveillance and epidemiology. These long term issues will need different types of technical support over the plan period.

For the immediate programmatic needs, the issues needing technical support interventions include:

1. **Retaining clear evidence-based focus on priority groups.** Program areas to be supported are: scaling up access to high quality interventions for priority groups; ensuring consistent and adequate availability of commodities; and reducing the stigmatization of most at risk populations (MARPs).
2. **Strengthening support for the reduction of vulnerability to HIV infection.** Program areas of support will include street children and vulnerable women; reducing vulnerability associated with cross-border travel and undocumented migration; reducing vulnerability to HIV infection in prisons; reducing vulnerability among ethnic groups; and increasing access to reproductive tract infections (RTI) and sexual tract infection (STI) prevention and treatment services.
3. **Ensuring that universal precautions are adopted within the healthcare system;** specifically, ensure blood safety and implementation of 2002 blood safety act.
4. **Increasing access to care and support services for people living with HIV and AIDS (PLHA).**
5. **Reducing stigmatisation and discrimination of people living with HIV and AIDS (PLHA).**

An important goal of the TSP is to create an enabling environment by strengthening coordination among partners (government, donors, management support agencies (MSA), development partners, UN agencies, implementing non-governmental organizations (NGOs) and other relevant ministries). Primarily this focuses on building the capacity for NASP, implementing partners (NGOs) to lead a multisectoral response. The support will also address the improvement of the management of funding channels (ensuring predictable funding) and the implementation of a comprehensive M&E systems for tracking and reporting on the epidemic.

The management of the TSP will primarily lie with NASP; however, given the lack of human resources at the unit, support will be needed to help build their capacity to manage technical support. Even though the NASP will have an over-arching coordinating and monitoring role for the plan, as well as being direct recipient of some of the individual technical support interventions, they will not be expected to assume all the responsibilities for directly managing every assignment outlined in the plan.

Different organisations will be responsible for managing specific technical support assignments where they are the ultimate 'client'. Where appropriate, the Technical Support Plan 2008-9 will indicate which organisation will be responsible for managing the technical support.

The immediate steps envisaged to expedite action on this plan are:

- The secondment of a technical officer to work with the NASP for the first year to ensure that the plan is implemented effectively.
- The placement of a procurement specialist to assist NASP in procuring needed services within HNPSP and build in-house capacity.
- A stakeholders meeting to discuss the TSP and enlist the commitment of donors to the different aspects of the plan.

The required budget for the Technical Support Plan activities 2008-09 is as follows:

Technical Support Interventions	Estimated Costs (\$US)
Cross cutting issues	137,310
1. Provide support and services to priority groups of people	56,225
2. Prevent vulnerability to HIV infection in Bangladesh society	75,900
3. Promote safe practices in the healthcare system	45,025
4. Provide care and support services to PLHA	92,050
5. Minimize the impact of the HIV/AIDS epidemic	41,875
6 Management and implementation of the TSP	6,600
Total	\$454,985

1. INTRODUCTION

1.1 Overview of the Epidemic .

The first case of HIV in Bangladesh was detected in 1989. Until December 2007, there were 1,207 reported cases of HIV and 365 cases of AIDS, of which 123 deaths were officially recorded. Although Bangladesh is perceived to have low prevalence rates of HIV/AIDS, almost all of the factors that facilitate rapid transmission of the disease, such as a large, hidden sex industry, low levels of condom use, increasing injecting drug use and persistent sharing practices, the porous border with India and Myanmar, and the neighboring high risk countries of Thailand and Nepal are present.

In spite of these risk factors Bangladesh has been successful so far in maintaining a low level of HIV epidemic (below 1%) among the general population. The epidemic is also low within vulnerable populations at present, with the notable exception of injecting drug users (IDUs) for whom it has entered a concentrated phase with the rise of prevalence from 1.4% in 1999 to 7% according to the 7th round of serological surveillance in 2007 (NASP, 2007). In one neighbourhood of Dhaka city the prevalence of the epidemic among the IDUs has risen to 10.8%.

Serious action is needed to check this increasing trend. Experts observe that Bangladesh is one of the pattern III countries for the HIV/AIDS epidemic, and as such is in an early phase of the epidemic. The national Behavioural Surveillance Survey (BSS) 2006 -07 covered 10 categories of high risk population that included IDU, heroine smokers, brothel -based female sex workers, hotel based female sex workers, street based female sex workers, male having sex with male, male sex workers, transgender or hijra, truckers and rickshaw pullers.

BSS 2006-07 reports high needle sharing behaviour of IDUs, increased average number of clients of hotel based sex workers, low condom use among sex workers and MSM, significant proportion of high risk population reporting STI and a large number of bridging population truckers and rickshaw pullers the greater proportion of whom had sex with commercial sex workers in the year preceding the survey (NASP 2007). These findings and the increasing number of high risk populations call for better national coordination, sustained effort and better targeted intervention to prevent the epidemic.

The latest size estimation of the various high risk populations have been developed by a specially-convened Working Group on Size Estimation of HIV/AIDS Infection in Bangladesh. Members of the Working Group included NASP, ICDDR, FHI, UNICEF, WHO and UNAIDS. This size estimation shows that the number of brothel, hotel and street based female sex workers ranged from 54,000 – 90,000, and number of male sex workers and MSM from 40,000 – 150,000, number of hijras are from 10,000 -15,000 and that of the injecting drug users from 20,000 - 40,000. The other groups of high risk population such as clients of female sex workers range from 1,882,080 - 3,136,800 while that of the returned external migrants from 268,000 - 536,000 (NASP, 2004). The number of two major bridging high risk groups of population, rickshaw pullers and truckers, would exceed millions, with clearly no harmonized and coordinated intervention programmes for them. There are other vulnerable population groups such as unofficial cross border migrants, extremely marginalized tea garden labourers, street children and women, and dock labourers.

1.2 History of the National Response .

The government of Bangladesh's commitment to tackling HIV has been reflected in its preparation for the national response to HIV and AIDS as early as 1985, with the formation of a multi-sectoral National AIDS Committee (NAC) to decide upon policy and strategy issues, cooperation and resource mobilization. A Technical Committee (TC) comprising various specialists in fields relevant to the prevention and control of AIDS/STDs was also formed to assist the NAC. By the end of 1990, a Coordination Committee (CC) came into being, constituted by key functionaries from institutions already engaged in HIV/AIDS related activities.

The National STD/AIDS Network was formed in 1993 as a forum of NGOs in Bangladesh working on different aspects of HIV and AIDS to respond to the national needs. Bangladesh AIDS Prevention and Control Programme (BAPCP) was established in 1996 and continued till June 1998. In the same year BAPCP finally changed over to the establishment of National AIDS/STD Programme (NASP) under the Director General of Health Services (DGHS) to ensure greater stake of the NGOs, community-based organizations (CBOs), private organizations and civil societies and to facilitate programme implementation. The NASP is responsible for coordinating with all stakeholders in implementing all HIV/AIDS programme activities throughout the country. It has been mandated as an oversight and stewardship body to address the national response to HIV/AIDS.

The first Strategic Plan of the National AIDS/STD Programme was developed for the period 1997-2002. The second National Strategic Plan for HIV/AIDS (2004–2010) prioritizes five programme objectives and proposed strategies to achieve these goals.

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

The country has a National Policy on HIV and AIDS and STD Related Issues' approved by the Cabinet. This policy emphasized four cross cutting themes and priority issues namely; human rights, gender equity, information, education and communication, and behavior change. NASP has also developed a National Harm Reduction Strategy (NHRS, 2004 - 2010), National Guidelines for ART (2007), and National STI Management Guidelines (2006). A National AIDS Monitoring and Evaluation Framework and Operation Plan 2006-2010 has also been developed . The Government of Bangladesh set up a national HIV surveillance system in 1998 following the UNAIDS/WHO guidelines for a revised 'second generation ' surveillance in a low prevalence situation. During 1998 – 2007 periods, seven rounds of serological surveillance and six rounds of behavioral surveillances were conducted (NASP/MOHFW , 2007).

The Bangladesh HIV/AIDS programme has been receiving funding from three major sources. In response to the HIV/AIDS situation in Bangladesh, the HIV/AIDS Prevention Project (HAPP) was conceived and approved in December 2000 by GoB and IDA/DFID. The project was implemented during 2004-2007 with management support from UNICEF, WHO and UNFPA. The UNICEF Bangladesh Country Office facilitated implementation of Targeted interventions for the Most at Risk Populations through procuring NGO services. The implementation of the HAPP program was seriously affected with repeated funding disruption, which has caused high staff turnover and undermined capacity development interventions. The HAPP

project ended in December 2007 and HIV & AIDS Targeted Interventions (HATI) has been initiated under HNPSP through an agreement with MOHFW and UNICEF. HATI was designed utilizing lessons learned from HAPP as the country's largest intervention for high risk populations.

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

The GFATM R6 aims to limit the spread and impact of HIV in the country by improving coverage and quality of essential HIV services for the most vulnerable, high-risk populations, while emphasizing primary prevention and risk reduction for especially vulnerable young people. GFATM R6 also proposed to address the identified existing gaps in several priority areas, while building national and district-level capacity to coordinate and strengthen the response. One of the major objectives of GFATM R6 is to build capacity of government and NGO partners at national and district levels to scale up standardized, high-quality interventions, to monitor and improve coverage and quality, and to improve coordination. Save the Children USA (SCF) has been managing the GFATM fund as the Management Support Agency (MSA).

The other major source of funding for HIV/AIDS program in Bangladesh has been from USAID, with FHI Bangladesh as the MSA which started to

support interventions in 2000 for people most vulnerable to HIV. FHI Bangladesh supports a wide variety of community-based and faith-based non-governmental organizations. The USAID funding also addressed the national surveillance system and behaviour change communication to reduce risk and vulnerability to HIV (including condom promotion among high-risk populations), improving management of sexually transmitted infections (STIs), and building capacity of government and NGO partners to plan, implement, and monitor HIV/AIDS interventions. Over time, FHI Bangladesh expanded its activities to include training of health providers in syndromic management of STIs, establishment of voluntary HIV Counseling and Testing (VCT) centers.

In addition to the targeted interventions being implemented in the country as mentioned above, German Technical Cooperation, GTZ has been working at four city corporations: Chittagong, Rajshahi, Khulna, and Sylhet in Bangladesh with an aim to improve prevention, counselling, diagnosis and treatment for HIV/AIDS and STI services in these cities through its Multidisciplinary HIV/AIDS programme. GTZ – programme's core activities include capacity building of local authorities (both GO and NGO and private sectors) for coordination, strengthening leadership, Health System Strengthening (with a focus on surveillance and STI services), sensitization on HIV/AIDS, STI and Gender and demand creation on tertiary level students and garment workers for HIV and STI related services.

For providing support to people living with HIV and AIDS a number of local NGOs, Self Help Groups/Community Based Organizations have been established; they are – Confidential Approach to AIDS Patients (CAAP), Ashar Alo Society (AAS), Mukto Akash Bangladesh (MAB) and Geon Health Foundation. Another long-standing health NGO, Associates in Training and Management (AITAM), has extended its services to PLHA. These NGOs

provide the greatest proportion of available HIV/AIDS care and support services for people living with HIV/AIDS – the only specialized hospital of Government of Bangladesh providing services to PLHA is the Infectious Disease Hospital (10 beds reserved for PLHA) situated in Mohakhali, Dhaka.

A decade ago WHO was the first UN agency to begin work in the field of HIV and AIDS in Bangladesh, followed by UNDP and other agencies. UNAIDS operates in developing countries mainly through the country-based staff of its nine co-sponsors that form the host country's UN Theme Group on HIV and AIDS. UNAIDS has been working in Bangladesh since 1996. Under the current situation of the HIV and AIDS programme to encounter many challenges, to overcome the existing gaps and bottle necks and strengthen the government efforts in streamlining the programme, UNAIDS has lot of opportunity to extend its services by providing technical support in required areas.

1.3 Background to developing Bangladesh's Technical Support Plan.

The provision of sustained technical support to develop national capacity is critical to ensure that national capacity to manage and implement its HIV programme grows at the same rate as funding and programme expansion, and to help Bangladesh meet its Universal Access targets. The NASP, in collaboration with UNAIDS, has therefore taken the initiative of commissioning a technical needs assessment and developing a long term vision for Technical Support required in the country for 2008-2015 and a costed technical support plan for 2008 -2009.

The technical support plan will help the government and key development partners to address constraints in implementing the National Strategic Plan (NSP) 2004-2010, and will also help the process of updating the Strategic Plan. The NSP will be reviewed and extended within September -October

2008 to cover the period up to 2015. The data gathered in the process of the technical needs assessment will be used as an input to the situation analysis of the NSP review. The technical support plan itself will be incorporated as an element of the updated NSP.

1.4 Objectives of the Technical Support Plan .

The purpose of developing a Technical Support Plan for Bangladesh is to ensure that technical support for the HIV/AIDS response is provided in a timely, coordinated and effective manner and addresses Bangladesh's most urgent needs. It is not intended to cover every technical support intervention provided to HIV/AIDS programmes over the coming year (much of which is already planned and budgeted), but instead it sets out *priority* areas of technical support needed to overcome barriers to achieving the objectives set out in the country's National Strategic Plan . It is hoped that the plan will become a reference document for all development partners in planning technical support to Bangladesh in the future. It is intended that the document will be reviewed and updated regularly as part of Bangladesh's normal planning and M&E cycles. Specific next steps to support this are detailed in Section 4. The terms of reference for the consultancy are included in Appendix 5.

1.5 Definitions and principles.

Technical 'capacity' and 'support' can mean different things to different people. For the purposes of this plan, technical capacity is defined as ***the knowledge capabilities and processes which organisations or individuals require to design manage or implement effective programmes.*** Technical capacity does not describe the overall level of resources (e.g., drugs, clinics, doctors) available in a country

Technical support describes time-bound, short-to-medium term (i.e., maximum 3-5 years) interventions to:

- § Build technical capacity through the transfer of knowledge and capabilities (e.g., through training or mentoring); or
- § Provide external expertise or capabilities to address a particular problem related to a lack of technical capacity (e.g. consultancy to redesign a process or conduct a needs assessment).

Three key principles underpin the content of the Technical Support Plan, as well as the process followed to develop it (these are based on principles identified by the UN General Assembly Special Session on HIV/AIDS (UNGASS) and UNDP's Good Practice on Technical Cooperation):

1. Technical support should be aligned behind nationally owned HIV/AIDS strategies and plans, in line with the Three Ones principles.
2. Technical support should be demand-led and driven by the priorities and timetables of the end-user rather than funding organisations or technical support providers
3. Technical support should focus on collaboration to solve practical local problems, rather than providing top-down, standardised external expertise in situations that have a very specific socio-economic, epidemiological and institutional context

2. Methodology for the development of the Technical Support Plan.

This plan was developed by a team of consultants led by UNAIDS Bangladesh office in collaboration with NASP and the UNAIDS National Capacity Support Team. Building on the UNAIDS Guidance Note, the team followed a systematic five-step methodology to develop the Technical Support Plan.

1. Identify major constraints to scaling up the HIV response and implementing the National Strategic Plan.
2. Identify the technical capacity needs which underlie each bottleneck and potential technical support interventions to address these
3. Map existing and planned technical support interventions against the constraints identified
4. Prioritise the constraints to be addressed, and the corresponding technical support activities
5. Develop a costed 12-month Technical Support Plan

This methodology was designed to ensure a bottom-up assessment of Bangladesh's technical support needs, based on a clear understanding of the existing context and the priorities of those people directly involved in the implementation of HIV/AIDS programmes in the country. Findings were based on existing reports and documents, as well as regular input from NASP and interviews and consultative meetings with key stakeholders including representatives from NASP, the Ministry of Health and Family

Welfare (MoHFW) and other key ministries, bilateral donors, UN agencies, NGOs, CBOs / Self Help Groups of people living with HIV , sex workers, IDUs, and MSM/Hijras. A full list of the documents reviewed and individuals consulted is included in Appendices 4 and 5.

The process of developing the Technical Support Plan was overseen by a Technical Working Group chaired by NASP, with representatives invited from all major stakeholder groups. All inputs received have been incorporated into this version of the plan. Consistent with the principles laid out in the section above, the constraints and technical support interventions identified were structured around the thematic areas of the NSP.

2.1 Technical Capacity Needs Assessment .

The first stage of the process was to identify the major constraints that hinder the effectiveness of Bangladesh's efforts to tackle HIV and to assess what, if any, technical capacity issues underlay each of the bottlenecks . The team sought to be as comprehensive as possible in identifying constraints, based upon:

- A literature review of previous reports and planning exercises .
- Interviews with key stakeholders from government, development partners, UN agencies and NGOs and CBOs .
- A series of consultative meetings to discuss the results of the literature review and interviews, and to develop recommendations on priority areas for technical support.

A full list of reports reviewed, interviews conducted and attendees of the consultation meetings are attached as annexes 4, 5 and 6 . This process enabled the team to generate a comprehensive picture of Bangladesh's technical capacity needs and, therefore, a set of technical support interventions to address each constraint. The full technical capacity needs assessment, including proposed technical support interventions is contained in Appendix 1.

2.2 Mapping of existing technical support interventions.

The third step in the technical support planning methodology was to map existing technical support being provided or planned in Bangladesh so as to ensure the interventions proposed in the Technical Support Plan complement rather than duplicate these activities . In addition to reviewing Programme Reports, the team requested interviewees to provide a brief summary of technical support activities planned or underway within their programmes. This information was then matched to the constraints and technical capacity needs identified. This mapping is attached in Appendix 3.

2.3 Prioritising interventions.

The fourth step in the methodology is to prioritise technical support interventions. While most of the constraints and technical capacity needs identified should be addressed in the course of the next seven years, there is a limit to the amount of technical support development partners can provide and that Bangladesh can absorb at any one time. It is important to be realistic in assessing what can be achieved and to identify a manageable subset of constraints to be addressed in the first years of this Technical Support Plan. The team therefore focused on developing an actionable plan for the first twelve months . While this plan contains our recommended set of

priority interventions based on the literature review, interviews and consultations, the plan should be a 'living document' and may need be further developed and refined, particularly after the National Strategic Plan is revised. The constraints were prioritised based on three criteria:

- § Constraints that were **highlighted most frequently** and as most significant in programme reports, performance reviews and studies, as well as in the interviews and consultation meetings that were conducted as part of the process of preparing this plan.

- § Constraints that relate to developing **sustainable systems** underlying the HIV response (such as streamlining financial and management systems, monitoring and evaluation etc).

- § **'Underlying'** constraints that have the biggest impact – for example improving the flow of financial resources will have an impact on service provision, staff retention, build trust between service users and providers etc.

Based on these criteria, the team developed a list of technical interventions to be prioritised during the budget cycle July 2008 to June 2009.

2.4 Developing and costing an implementation plan .

The last step in the methodology is to create a practical, achievable 12 month Technical Support Plan . Each priority intervention was developed into practical inputs (number of consultant's days, workshops, deliverables etc with an estimated overall costing. Though these inputs were discussed as fully as possible within the timeframe available, the final amounts may

change as the activities are planned in more detail. The cost estimates are therefore indicative only. The total cost of these interventions is estimated at approximately \$ 450,000.

3. Technical Support Plan 2008/2009

This section provides an overview of the major challenges and constraints to achieve the objectives outlined in Bangladesh's National strategic plan, with proposed technical support interventions that could be provided in 2008/2009 to address these constraints. A more detailed table, with specific activities is provided in annex 2. The interventions in the first section are considered cross cutting issues that, if successfully addressed, will create a more enabling environment to achieve the National Strategic Plan's five objectives. All other issues are described and outlined under the relevant National Strategic Plan (NSP) objective.

3.1 Enabling Environment (Cross cutting issues) .

Under this section, four main cross cutting issues were identified as critical in creating the enabling environment for an effective response to HIV and AIDS. These were:

1. Strengthening coordination between partners to develop an effective multi-sectoral response
2. Ensuring predictable uninterrupted funding
3. Ensuring sustainable programme management
4. Implementing a comprehensive M&E system

Each of these is explained in detail below .

3.1.1. Strengthening coordination between partners to develop an effective multi-sectoral response

Strengthening coordination among government, donors, management support agencies (MSA), development partners, UN agencies, implementing NGOs and other relevant ministries is a major challenge in achieving the programme goals. Institutional coordination mechanisms between partners are not fully functional and donors and MSAs and other ministries have been working vertically, causing duplication of efforts and unharmonised programme activities. The National Strategic Plan strongly recommended providing the NASP with adequate capacities to promote overall programme planning, coordination, monitoring and evaluation and system-wide information sharing. Priority technical interventions needed for the year 2008-09 for strengthening coordination are as follows:

Support NASP to establish and convene functional partner's forum and technical working groups with clear terms of reference and participation of senior policy makers

Provide consultancy support to establish regular inter-ministerial forum to co-ordinate a more multi-sectoral response to HIV/AIDS.

Support an assessment of the capacity and human resource needs of NASP in relation to its mandate (based on previous reviews) including multi-sectoral coordination, leadership, evidence-based programming and M&E.

3.1.2 Ensuring predictable uninterrupted funding

Bangladesh HIV/AIDS programme has suffered from repeated funding interruption. This disruption of funding was most frequent within the HAPP programme. The Global Fund programme has experienced similar funding delays to a lesser extent initially. This issue was probably the most common complaint that the various implementing partners raised during interviews and consultations. Delays in funding were associated with complex government and donor procedures that need review and revision.

Implementing agencies also find the current grant management system difficult to use and further orientation and training on the systems was felt necessary. Funding delays also have a negative impact on staff morale and contributed to high turnover of skilled staff. Bondurant et al (2007). strongly recommended exploring the possibility of bridge funding and to increase flexibility in terms of allocation of budgets and material within reasonable parameters to make the service programs effective. Priority technical support interventions that could be provided during 2008 -09 were:

Support high level Technical Working Group (donor and government) to harmonise funding systems and tools.

Provide guidance, support and training from donors on financial systems and procedures.

3.1.3 Ensuring sustainable programme management .

Difficulty in recruiting and retaining qualified staff to work in HIV and AIDS program has been a persistent challenge for many implementing partners.

This resulted from the short duration of most projects, short term contracts, uncertainty over continuation of funding and lack of adequate incentives and benefits. Inconsistent capacity within NGOs and CBOs to design, manage and monitor high quality targeted interventions was another constraint to ensuring sustainable programme management. In addition to supporting improved coordination of vertical projects and improving funding flow as outlined above, the following priority technical support intervention may be provided during 2008-09 to improve the situation:

- NGO/CBO capacity assessment and review of existing networking /capacity building opportunities, including MARP networks. Design coordinated mechanism to roll out capacity building programme.

3.1.4. Implementing a comprehensive M&E system .

In line with the 'Three Ones' principle to establish a single monitoring and evaluation system for HIV/AIDS programme, a national AIDS Monitoring and Evaluation Framework together with an Operational Plan (2006-10) has been developed. The Operational Plan of the M&E Framework prioritizes the establishment of a functional M&E within NASP with appropriate skilled and technical human resources and logistic support. The NSP also articulated the need for strengthening the M&E system:

- Strengthening the role of the Technical Working Group on M&E through convening and supporting regular meetings (this may be aligned with technical support interventions proposed under A. aimed at assessing capacity and human resource needs of NASP).

In the following section, the technical support needs are presented under the relevant NASP objective under which they were discussed .

3.2 NSP Objective 1: Provide support and services to priority groups of people

Under this objective four key technical support needs were identified

Retaining clear evidence -based focus on priority groups

Scaling up access to high quality interventions for priority groups as defined in the NSP

Ensuring consistent and adequate availability of commodities to priority group

Reducing the stigmatization of MARP to create an enabling environment for interventions

3.2.1 Retaining clear evidence -based focus on priority groups

A serious constraint to targeting interventions to those most at risk is that current programming does not fully reflect factors that cause vulnerability and key drivers of the epidemic. The dynamics of the epidemiology and its changing pattern means that the definition of priority groups needs revisiting and updating. Support that may be provided in the current year is the updating of NSP priorities and targets using most recent surveillance data in order to ensure that emerging demands e.g. services for MARP such as MSM, OST services, prison inmates and are addressed.

3.2.2. Scaling up access to high quality interventions for priority groups as defined in the NSP .

Scaling up access to high quality services was constrained by disproportionate distribution of coverage, overlapping or duplication of services, limited access to high quality RTI and STI services, limited and centralized VCT facilities, lack of Oral Substitution Therapy (OST) services and limited access to services for MSM and transgenders.

Scaling up access to interventions will require expansion of services at various levels from primary to tertiary facilities both at public and private health care systems along with institutional capacity building at those levels for HIV mainstreaming.

Although strengthening coordination and NASP capacity building as proposed above will minimize the problem of coverage and distribution, decentralized quality RTI and STI and VCT services will require strengthening and expanding counseling, testing, and care and treatment facilities by providing:

- Support for capacity building to district level hospitals by providing roll out training in VCT/treatment (planned and applied for GF Round 8 proposal).
- NGO/CBO capacity assessment and review of existing networking /capacity building opportunities, including MARP networks. Design coordinated mechanism to roll out capacity building programme (as proposed above).

3.2.3. Ensuring consistent and adequate availability of commodities to priority groups

Inconsistent and irregular supply of commodities especially condoms, needles/syringes and medicines has been a major operational constraint. This challenge has emerged not only because of the complicated procurement systems, but also lack of capacity to make accurate projections and forecasts and preparing and sending timely indent to avoid stock outs and shortages. The situation is unlikely to improve unless STI and HIV/AIDS procurement is mainstreamed into the government procurement systems, a process that is currently underway. However, capacity building of the service delivery organizations and strengthening commodity management may be considered for which the immediate feasible intervention would be to:

- Review existing training curricula and design training curricula and strategy for rolling out capacity building in strengthening commodity management of service delivery organizations.

3.2.4 Reducing the stigmatization of MARP to create an enabling environment for interventions

The most common complaint by MARPs at the field level is regular harassment by the members of the law enforcement agencies, the officials of the narcotics department and even by the members of the community. This insensitivity arising out of the lack of awareness among the community and key ministerial staff and lack of support from key ministries aggravates the situation of the already stigmatized vulnerable populations.

BSS 2006-07 also recorded evidence of violence and harassment mostly reported by the IDUs, heroin smokers and street based sex workers. Lack of alternative livelihood strategies for some MARPs also undermined the effectiveness of the interventions. MARP networks are not well established enough to conduct effective advocacy to reduce stigma. In addition to the support to develop MARP networks proposed above, the priority technical intervention in 2008-09 to reduce stigma would be to:

- Impact assessment of the existing interventions with Ministry of Home Affairs (UNFPA).

3.3. NSP Objective 2. Prevent Vulnerability to HIV Infection in Bangladesh Society

Under this objective five key areas for technical support were identified. These include;

1. Strengthening support for street children and vulnerable women.
2. Reducing vulnerability associated with border travel and unofficial migration.
3. Reducing vulnerability to HIV infection in prisons
4. Reducing vulnerability among ethnic groups
5. Increase access to RTI and STI services

3.3.1. Strengthening support for street children and vulnerable women.

Data in Bangladesh on HIV has focused on previously defined most-at-risk persons (MARPs), injecting drug users, sex workers and external migrants, however, available evidence suggests that other groups (including day labourers, domestic workers, partners of external migrants, partners of sex worker clients and partners of IDUs) may also be exposed to risk, increasing

their vulnerability to HIV infection. This study should feed into the situation analysis of the NSP by providing an evidence base for strategising the national response to AIDS.

- Conduct desk research to identify vulnerable groups , their behaviours and best practices to feed into the revision of the NSP

3.3.2 Reducing vulnerability associated with cross-border travel and unofficial migration.

The Ministry of Women and Children’s Affairs has developed a pilot project in three districts on the border with India to support HIV prevention particularly amongst migrant populations. This initiative should be scaled up requiring financial and technical support . Scaling up has been included into the GFATM round 8 proposal, which is awaiting approval at the time of writing.

- Support development of HIV prevention programme in border areas (as per GFATM Round 8 proposal) incorporating lessons learned from MoWCA three pilot districts

3.3.3 Reducing vulnerability to HIV infection in prisons

Prisoners are, in most countries, considered to be highly at risk to HIV due to behaviours such as sharing needles for injecting drug use and unprotected anal sex and the low access to prevention, care and treatment services. In Bangladesh, there is evidence to show a considerable problem of intravenous drug use, however there is no data on HIV/AIDS per se in prisons. Therefore, there is a need to build an evidence base to guide future

programming. This risk assessment will be conducted according to the UNODC project proposal submitted to UNAIDS.

- Conduct risk assessment study in prisons (according to UNODC proposal) to be funded under UNAIDS PAF

3.3.4 Reducing vulnerability among ethnic groups.

With assistance from UNFPA, the Ministry of Labor and Employment is implementing a project for workers in tea gardens and the local population in Sylhet region to provide information and services on sexual and reproductive health and HIV/AIDS. This intervention needs to be reviewed and documented to consider and guide scale up to other regions is appropriate. If the report recommends scale up, lessons learned from the project will be incorporated in to future programming in tea producing areas.

- Document lessons learned from MoLE/UNFPA project in Sylhet region to support scale up to other regions

3.3.5 Increase access to RTI and STI services

Currently programmes for HIV are not well integrated into RTI and STI programmes due to a lack of consensus within the MoHFW. There is a clear need to have a more integrated client-focused approach. In order to explore opportunities for increased integration and to learn from good practices a consultant will be recruited to produce a policy paper and a series of three workshops will be held to ensure key policy makers make their inputs.

- Consultations with MoHFW and other stakeholders re giving greater prioritisation to RTIs and STIs, linked to HIV prevention,

and policy paper developed to highlight opportunities for integration of programmes

RTI/STI services have not been given a high priority in public health communication in Bangladesh. However with global fund finance, the country has increased the provision of youth -friendly services. The lessons learned from this process need to be documented to enhance the impact of future programming and to guide scaling up to increase coverage. To this end a consultant will be recruited to guide the process and workshops will be held at implementation and national level to gather data and the views of different stakeholders.

- Document lessons learned from GFATM R2&6 programme on providing youth friendly RTI/STI services & Support scale up of evidence-based advocacy efforts

3.4 NSP Objective three: Promote safe practices in the healthcare system

Two issues identified under this objective were:

1. Ensuring that universal precautions are adopted within the healthcare system
2. Ensure blood safety and implementation of 2002 blood safety act .

3.4.1 Ensuring that universal precautions are adopted within the healthcare system .

At present, there is no systematic documentation or monitoring of safe practices provision , and there is a lack of clear policy directives from the

MoHFW regarding safe practices (including private hospitals and the NGO sector). Proposed year one technical support would be:

- Baseline situation analysis of current level of safe practice provision, and support to develop longer term strategy for scaling up implementation and monitoring and evaluation .

3.4.2 Ensure blood safety and implementation of 2002 blood safety act.

Promoting safe practices through screening of total blood supply in both public and private sector remains a challenge, even in the presence of appropriate law, and the number of public facilities is limited compared with the size of Bangladesh' population . Currently one hundred and fifteen blood transfusion centers have been made functional as per claim of SBTP. Unscrupulous blood selling and buying without screening of quality has been reported in private facilities.

In the longer term, this will require a capacity needs assessment (as proposed in the recent Global Fund Round 8 proposal), followed up by on-going capacity development programme of relevant staff. One of the more immediate problems is insufficient voluntary donation of blood to blood banks, exacerbated by the lack of integration of blood safety messages into public health campaigns. Proposed first year technical support intervention is:

- Consultative meeting between responsible government agencies and stakeholders to develop an action plan and collaborating mechanisms to ensure that blood transfusion messaging is integrated into other public health campaigns.

3.5. NSP Objective four: Provide care and support services to PLHA

3.5.1 The main issue identified in this area was, the ***increasing of access to care and support services***

One of the most significant challenges in providing services for PLHA is that ARV drugs are not reliably available, and there are no child doses available. In spite of the National Policy on Anti-retroviral Drugs, Production and Regulation, pharmaceutical companies are not willing to apply for WHO certification (necessary for compliance to UN and other donor's procurement regulation) for their locally produced ARVs, therefore drug and treatment and care depends on imports for uninterrupted supply. In addition to the procurement review proposed under 'Enabling Environment – Cross-cutting issues, the following intervention is proposed in the first year:

- Advocacy to and technical support for local pharmaceutical producers to apply for WHO certification for ARV.

Another problem is that treatment for common opportunistic infections (OI) is not adequately available, compounded by a lack of understanding, awareness and capacity among health service providers on treatment of OI. Proposed technical support to address this:

- Support to develop training curriculum, based on the National Opportunistic Infection guidelines, and building on work already done by CAAP.

At present measures to prevent transmission to family members, including PPTC, are limited and there is a lack of routine training and professional development on HIV. Proposed technical support in the first year:

- Support to scale up dissemination and implementation of new national guidelines for PPTCT (as developed by UNICEF).

3.6. NSP Objective five: Minimise the impact of the HIV/AIDS epidemic.

One key issue was identified in this area and that is ***reducing stigmatisation and discrimination of PLHA.***

At present, there is limited legal support to protect and promote the rights of PLHA. The strong stigmatisation and discrimination surrounding HIV means that PLHA are frequently targeted with abuse by members of their communities, and even relatives. UNAIDS is supporting the development of guidelines and roll-out training to the media, to deepen their understanding of HIV/AIDS and thus report more accurately on the issue. Two further interventions are recommended.

- Review of legislative provision for the rights of people living with HIV in Bangladesh and other countries, building on previous review of human rights.
- Support Ministry of Information to integrate HIV into their existing mass communication programme.

The capacity of PLHA networks to lobby for and protect the rights of people living with or vulnerable to HIV is still relatively weak. In addition to the general capacity building programme for NGOs /CBOs described in 'Cross-cutting Issues', targeted technical support is needed to develop advocacy networks.

- Support NGOs and CBOs (that includes Self Help Groups in the context of Bangladesh) to develop advocacy strategies and materials and link with national advocacy technical working group

Implementation Milestones

	Specific activities to be conducted	Client organisation (+ key stakeholders).	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Key implementation milestones (including dates by which activity should be completed)
Enabling environment														
A1	Consultant to: i. Design coordination mechanism (using recommendations from previous reports) (40 days, over four months) ii. Support preparation, facilitation of meetings (NASP coordination officer)	NASP			X	X	X	X						October 1, consultant contracted. Meetings held October, November, December. Report complete, Jan 15.
A2	Bi-monthly meetings (3 meetings) for 20 people.	NASP		X		X		X		X		X		On-going
A3	i. Two consultants to review previous capacity assessments and reports and update, including job analysis (15 days each) ii. Develop funding proposals where necessary. (One consultant for 20 days)	NASP						X	X	X				Consultants contracted by Jan 1, to commence work Jan, Feb, March. March 30, Review complete. Proposals on-going dependent on funding sources.

B1	i. One national (25 days) and one international (15 days) consultant to review existing financial management systems, facilitate dialogue between donors and national plans, develop recommendations for harmonizing systems, compile harmonized tools etc. ii. Three half-day consultative meeting to share and discuss reports (30 participants)	NASP						X	X	X				Consultants contracted by Jan 1, to commence work Jan, Feb, March. March 30, Review complete.
B2	i. Sub-contract capacity development organisation to design and facilitate three two-day training workshop(s) for 60 NGOs (3 representative per workshop) <i>link activity to C2</i>	SCF/NASP/management organisation of HNPSP (TBD)									X	X		Client organisation (manager of TA) agreed by November 2008. Consultant contracted by April 1 2008. Workshops completed by May 30th.
C2	i. 2 national consultants. (25 days each) ii. 3 full-day consultative meetings to develop and disseminate capacity development plan. (30 participants per meeting)	SCF/NASP/management organisation of HNPSP (TBD)							X	X	X			Consultants contracted by Jan 29. Meetings held Feb - April. Plan developed and agreed by April 30.
D2	i. Monthly meetings of M&E TWG (13 members), from October	NASP/UNAIDS			X	X	X	X	X	X	X	X	X	On-going
Objective one														

1.1	<p>i. Recruit epidemiologist to review existing data on MARPS for presentation to NSP review (15 days)</p> <p>ii. Consultancy support to multisectoral forum (A.1) to update NSP and make evidenced based revisions.</p> <p>iii. Facilitate participatory review and planning meetings (government, partners, and NGO/CBOs. (3 one-day meetings for 30 participants)</p>	NASP	X	X										Epidemiologist recruited by August 22. Meetings held August and September. New priorities and targets set by September 30.
1.6	<p>i. Recruit consultant for 30 days</p> <p>ii. Three one-day workshops for ministries and stakeholders (including IDUs)</p> <p>iii. Submit and present report as part of NSP review</p>	NASP/UNODC	X	X	X									Consultant recruited by August 29. 3 meetings held by October 23. Report submitted by October 30.
1.9	<p>i. Recruit consultant for 45 days to conduct impact assessment of work with MoHA</p> <p>ii. One day consultation meeting for 35 people.</p>	MoHA (NASP)						X	X	X				Consultant recruited by December 31st. Impact assessment and consultation by end February. Report finalized by March 12.
Objective two														

2.1	I Recruit two consultants to conduct desk research on vulnerability and vulnerable groups, for 20 days each ii. Consultative meetings to build consensus on vulnerability and vulnerable groups in Bangladesh iii. Present findings of research to NSP review meetings	NASP	X	X	X										Recruit two consultants by August 22. Review by end October.
2.3	<i>(If regional GFATM R8 proposal accepted, then activities are already covered and funded)</i>	GF Round 8 PR.													As per final agreement with GF.
2.4	<i>Risk assessment to be undertaken, funded by UNAIDS.</i>	MoHA (UNODC)			X	X	X	X	X	X	X	X	X		Agency hired by December 30.
2.5	i. Recruit consultant for 25 days ii. Field visit to Sylhet for NASP and MoLE iii. 4 one-day workshops for 20 people. iv. Printing and dissemination of report 1000 copies	MoLE (UNFPA)			X	X	X								Consultant recruited by October 1. Field visit October. Workshop by November 12. Report finalized and disseminated by December 30.
2.6	i. Three consensus building workshops (30 people) with key policy makers and stakeholders ii. 10-day consultancy to review and document international best practices and country level experiences in STI/RTI and HIV management with recommendations for policy change	MoHFW							X	X	X				Workshops held by end April . Consultants report on STI/RTI management with recommendations by end April.

2.7	i. Recruit consultant for 30 days to documents lesson learned ii. 5 one-day workshops at district level for 20 persons iii. One half-day national workshop for 50 persons	NASP/SCF/ICD DRB					X	X	X					Consultant recruited by Dec 1. District level workshops held in end January. National workshop by Feb 15.
Objective three														
3.1	i. Two one-day consultative meetings with policy makers and other key stakeholders ii. Recruit consultant to conduct situation analysis of capacity, implementation of safe practices and capacity development plan for 60 days iii. One day validation meeting to approve report and capacity development plan iv. printing and dissemination 1000 copies v. Consultant to adapt international guidelines for PEP to Bangladesh (15 days)	DG Health (SBTP/WHO)						(X)	(X)	(X)				For discussion.
3.4	i. Conduct three one-day consultative meeting for responsible agencies for 25 persons to develop action plan	SBTP						(X)	(X)	(X)				For discussion
Objective four														
4.2	i. one one-day national workshop, 25-30 people.	NASP (WHO)				X								Advocacy meeting held by November 27th.

4.5	i. Recruit consultant for 15 days to develop training curriculum	MoHFW (AAS/MAB/CAAP)						X	X				Consultant recruited by Feb 1. Curricular developed by March 29.
4.6	i. Print and disseminate 1,000 copies, 40-50 pages.	UNICEF					X	X					Reports printed and disseminated by Feb 15.
Objective five													
5.1	i. Recruit lawyer to conduct review of legislative provisions in relation to HIV for 35 days ii Multi-stakeholder workshop to discuss and validate findings of report on law and HIV in Bangladesh for one day for 40 persons	AAS/MAB/CAAP/GEON (NASP, UNDP, SCF, UNAIDS) - to be discussed.						X	X				Client organisation agreed by November 27. Lawyer recruited by Feb 1. Legislative review submitted by March 29.
5.2	See C.2 above.												
5.4	i. Convene one-day round table meeting (30 participants). ii. Consultant to help Ministry of Information to develop a strategy for HIV.	Mol.						X	X				Meeting held by Feb 15. Consultant recruited by Feb 1. Strategy developed by March 29.
5.6	i. Recruit advocacy specialist to support NGOs/PLHA groups/CBOs to develop strategies and materials for 40 days, over six months ii Three two-day capacity building workshop for 35 people to train and support development of action and monitoring plans iii. Result from on-going stigma index research (UNAIDS) has to be incorporated	Advocacy forum (UNAIDS).					X	X	X	X			Strategy and tools developed by March 29.

Management and implementation of the TSP														
Link person with NASP to coordinate TA and oversee implementation.	NASP	X	X	X	X	X	X	X	X	X	X	X	X	On-going
Request secondment of procurement specialist from development partner or specialist agency for six months	NASP		X	X	X	X	X	X					On-going	

4. Management and Oversight of the Technical Support Plan

4.1 Technical Working Group

The development of the technical support plan was overseen by a high-level technical working group chaired by the NASP and comprised of representatives from government, development partners and NGOs. This Technical Working Group will also oversee implementation of the plan.

4.2 Day-to-day management and implementation of the TSP

Ensuring that the first year plan is implemented effectively will require careful planning, as well time and resources to develop terms of references, brief and support consultants, and review consultant's reports and arrange meetings and workshops.

As coordinating national body, the NASP will have overall responsibility for overseeing that activities are being implemented and monitoring the plan's progress against key milestones. Given their lack of human resources, support will be given to help build their capacity to manage technical support. This support has also been planned and costed within the Technical Support Plan.

- ***Resource person to support the NASP .***

A resource person will be seconded to work with the NASP for the first year to ensure that the plan is implemented effectively. They will work with NASP to liaise with partners, help to develop terms of reference, and provide administrative support.

- ***Procurement specialist***

At present, NASP have limited time or capacity to procure consultancy services – including contract development and management. Though funds to provide technical support and build NASP capacity are available within

the major programmes, they have not been utilised because NASP have not had the time or capacity to access the funds. To help overcome this constraint, a procurement specialist will be contracted to support the NASP to help access available resources and to build NASP capacity to procure consultancy services in the future.

Though the NASP will have an over-arching coordinating and monitoring role for the plan, as well as being direct recipient of some of the individual technical support interventions, they will not be responsible for directly managing every assignment outlined in the plan. Different organisations will be responsible for managing specific technical support assignments where they are the ultimate 'client'. Where appropriate, the Technical Support Plan 2008-9 (Annexe 2) indicates which organisation will be responsible for managing the technical support in the 'Client Organisation' column.

DRAFT Bangladesh Technical Support Plan (2008 - 2015) for consultation				
	Challenge	Constraints	Related capacity issues	Potential Technical Support Interventions, 2008-2015
	Cross cutting issues			
A.1	Strengthened coordination between partners to develop an effective multi-sectoral response.	Partners (government, UN and donors and NGOs) working relatively independently, with limited joint planning leading to duplication, programme gaps and activities that are unaligned.	Institutional coordination mechanisms between partners are not fully functional.	Strengthening institutional coordination mechanisms at all levels.
A2			Institutional coordination between ministries is weak.	Support improved interministerial coordination.
A.3		Despite on-going improvements, NASP is still not sufficiently equipped with human and technical resources to deliver its mandate.	New staff have been recruited, though numbers still small compared to mandate. Need for further capacity building to consolidate skills.	Sustained programme of capacity development for NASP, using current funding opportunities.
B.1	Ensuring predictable, uninterrupted funding to enable longer term strategic programming.	Frequent delays in funding due to complex government and donor financial procedures .	Complex, inflexible systems, that are geared towards donor reporting priorities. Pooled funding systems have many conditions. Protracted negotiation process to	Support to develop harmonised and simplified systems and mainstream HIV/AIDS into national budget.

			release funds.	
B.2			Implementing agencies find grant management systems difficult to use.	Capacity building of implementing agencies, supported by orientation and training.
C1	Ensuring sustainable programme management.	Difficult to recruit and retain qualified staff to work in HIV and AIDS.	Lack of incentives and short term contracts, due to short term funding of projects, means staff miss out on benefits. Uncertain funding.	Support development of strategies to create better incentives to retain skilled workers, including situation analysis, salary surveys.
C2		Inconsistent capacity within NGOs and CBOs to design, manage and monitor high quality targeted interventions.	Gaps in management and technical capacity at all levels and in different sectors.	Technical support to develop mechanism for providing a rolled out capacity building programme for NGOs and CBOs. Develop capacity building curriculum and tools.
C.3			Lack of harmonised tools to manage programmes.	Support increased standardisation and harmonisation of good quality management tools. <i>Follow up activity from C2</i>
D.1	Implementing comprehensive M&E system.	Insufficient alignment and harmonisation of M&E systems	Increased institutional capacity within NASP required, to manage harmonised national M&E and use data to improve programmes.	Capacity development in M&E within NASP. Support to strengthen District level M&E Systems (HMIS), and integrate HIV M&E into

			Lack of capacity in NASP to procure resources (equipment and human resources) to support M&E system.	routine health monitoring systems.
D.2			Develop capacity of national TWG on HIV M&E to ensure operationalisation of M&E framework	
1	Management and implementation of the TSP			
	Objective 1: Provide support and services to priority groups of people			
	Bangladesh's 2010 Universal Access Targets			
	<i>80 % of most-at-risk populations reached by prevention programmes (eg: outreach services, condom promotion, drug substitution treatment, needle exchange, etc).</i>			
	<i>60 % of most-at-risk populations who both correctly identify ways of preventing the transmission of HIV and reject major misconceptions about HIV transmission</i>			
	<i>60 % of female and male sex workers reporting the use of a condom with their most recent client</i>			
	<i>60% of men reporting the use of a condom the last time they had anal sex with a male partner</i>			
	<i>60% of injecting drug users who have adopted behaviours that reduce transmission of HIV, i.e., who avoid using non-sterile injecting equipment or use methadone substitution treatment and use condoms, in the last 12 months.</i>			
1.1	Retaining clear, evidenced-based focus on priority groups, as defined in the NSP.	Current programming does not reflect current epidemiology of priority groups.	Revised NSP will require updated definitions of priority groups to reflect current epidemiology. Research findings not	Support to develop better links between research, surveys and programming.

			sufficiently used to inform programming.	
1.2	Scaling up access to high quality interventions for priority groups, as defined in NSP.	Coverage of most at risk populations is not distributed according to need, with some duplication and other gaps.	Insufficient coordination between partners in the past (see A1).	Capacity development within NASP. Improve coordination at all levels.
1.3		Limited access to good quality RTI and STI services for high risk groups.	Some limited support provided, but tends to be project-specific. Other than at primary level, HIV not mainstreamed into existing public, NGO and private services. Existing interventions of inconsistent quality.	Support to expand mainstreaming of HIV into public and private health systems (from primary to secondary and tertiary level), as part of the sectoral development strategies.
1.4		Limited, centralised VCT facilities means that travelling to get tested is prohibitively expensive for many vulnerable people.	Lack of capacity and facilities at district level to provide VCT services	Support to roll out training in VCT/treatment to district level doctors and establish CD4 testing facilities at district level. Support to provide VCT services in prisons.
1.5		Limited access to services for MSM and transgenders.	Existing MSM groups do not have human resources/capacity to provide services sufficient to meet current levels of demand.	Support to strengthen MSM and transgender non-government organisations and networks.

1.6		No Oral Substitution Therapy (OST) services available for IDUs.	No system to provide OST services at present. Limited capacity to implement comprehensive services (see C2)	Support to develop enabling legislation for OST, support to ensure that lessons learned from pilot OST Projects are disseminated and used to develop policy. Build capacity to provide services.
1.7	Ensuring consistent and adequate availability of commodities to priority groups.	Complicated procurement systems, with heavy dependence on UN systems.	STI and HIV/AIDS procurement is not currently integrated into government procurement services. Changes to the system are underway, and capacity building needs will become clearer then.	Support to establish and strengthen revised system once in place.
1.8		Inaccurate projections lead to stock-outs and shortages.	Insufficient capacity to develop projections by service delivery organisations.	Improve guidance on how to develop projections.
1.9	Reducing the stigmatisation of MARP to create an enabling environment for interventions with MARP	Lack of support from key ministries to implement programmes for MARP (eg harassment of service users by law enforcement agencies and communities).	Low awareness of HIV and lack of clarity on what could be done by different ministries, which has led to limited engagement by ministries.	On-going support to develop and implement multi-sectoral strategies for reducing stigmatisation of MARPs.
1.10			MARP networks are currently weak, making it difficult for them to	Support to strengthen MARP networks.

			conduct effective advocacy.	
1.11		Lack of alternative livelihood strategies for some MARP undermines effectiveness of interventions.	Inconsistent capacity among government and CBOs to link livelihood/development interventions with prevention interventions.	Capacity development for government (including health staff) and CBOs in mainstreaming HIV/AIDS in development interventions.
2	Prevent vulnerability to HIV infection in Bangladesh society			
2.1	Strengthening support for street children and vulnerable women.	Insufficient awareness and understanding of vulnerability of street children and vulnerable women to design and implement effective programmes.	Insufficient information/knowledge about vulnerability of street children and vulnerable women (including day labourers, domestic workers, partners of external migrants, partners of sex worker clients, partners of IDUs)	Targeted research regarding behaviours/risks/vulnerabilities to inform revised NSP. Document best practices on work with vulnerable groups. Based on this support to design and implement effective programmes.
2.2		Lack of institutionalised protection, for example access to legal aid	Limited engagement of sectoral ministries to reduce vulnerability to HIV/AIDS due to weak understanding of the legal aspects of HIV/AIDS by both service providers and the general public	Provide support to advocate for legal reform, and subsequently to review and update legal instruments as part of development of sectoral strategies.
2.3	Reducing vulnerability associated with	Lack of evidence base on HIV aspects of vulnerable	HIV not mainstreamed into existing research and	Technical support to promote mainstreaming

	border travel and unofficial migration	migrant populations to support effective programming (eg. On trafficking of women).	programmes.	and develop, implement and monitor evidence-based programmes as part of development of multi-sectoral strategies.
2.4	Reducing vulnerability to HIV infection in prisons.	Risk reduction in prisons is not part of the national response to HIV.	Low awareness of vulnerability among prison service.	Support to promote risk reduction programmes and develop, implement and monitor evidence-based programmes.
2.5	Reducing vulnerability among ethnic groups	Targeted risk reduction interventions among vulnerable ethnic groups not part of the national response to HIV.	Limited understanding of vulnerability associated with vulnerable ethnic groups.	Support to promote risk reduction programmes and develop, implement and monitor evidence-based programmes. Support to improve coordination between Ministries, eg. Health and Labour.
2.6	Increase access to RTI and STI services.	Lack of consensus within MoHFW on approach to prevention of RTIs and STIs.	i. Lack of awareness of links between RTIs/STIs and HIV ii. Lack of data regarding STI/RTI prevalence	i. Advocacy to high level policy makers in MoHFW to link HIV prevention aspect into RTIs/STIs treatment at secondary and tertiary level hospitals ii. Support collection and analysis of data on RTIs and STIs iii. Training for relevant department and stakeholders to deal with

				prevention of RTI/STI
2.7		Public awareness about RTI and STI limited.	RTI/STI services not considered a high priority, so limited IEC has been conducted.	Support to public IEC campaigns and community based responses targeting youth to RTIs/STIs and HIV (building on lessons learned from GFATM R2&6 grants)
2.8	Reduce vulnerability among youth.	Lack of youth friendly services.	Lack of data on what influences young people's usage of preventive services Lack of plans for scaling up youth friendly services	1. Conduct participatory action research into young people and HIV services to understand current knowledge, attitudes and behaviour 2. Support advocacy initiatives and support scaling up of youth friendly services based on understandings from research
3	Promote safe practices in the healthcare system			
3.1	Ensuring that universal precautions are adopted within the healthcare system	No systematic documentation/monitoring on current level of safe practices provision, including PEP.	Lack of policy/directives from MoHFW regarding ensuring safe practice in all hospitals (including private and NGO sector)	Support to introduce system for sustained capacity building and monitoring safe practices/universal precaution within the healthcare system.
3.2		NGO/CSO supplies of equipment (gloves etc)	see 1.4	See 1.4.

		affected by problems in procurement systems (See 1.4)		
3.3	Ensure blood safety and implementation of 2002 blood safety act	Lack of human and physical capacity to screen blood systematically at public and private health centres	Lack of training for all staff involved	Capacity needs assessment for staff involved (as per GF Round 8 proposal) Design a capacity development programme for staff involved. Implement and monitor capacity development programme
3.4		Insufficient voluntary donation of blood to blood banks	Lack of integration of blood safety messages into other public health campaigns	Improve coordination of blood transfusion messages with other public health information campaigns
3.5			Insufficient capacity to scale up public information campaigns by government and NGOs	Capacity needs assessment for SBTP and SBTCs in hospitals Design a capacity development programme for staff involved Implement and monitor capacity development programme
4	Provide care and support services to PLHA			
4.1	Increasing access to HIV+ people's care	ARV drugs are not reliably	No long term procurement agreement for ARVs.	Support improved procurement mechanisms

	and support facilities	available. No child doses.	Children doses of ARV not available.	for ARV.
4.2			Locally produced ARVs are not certified by WHO so therefore most ARVs are imported	Support local pharmaceutical producers to obtain WHO certification for locally produced ARVs
4.3		Insufficient follow up and monitoring of patients on ART. No reference laboratory.	Lack of capacity within medical system and families are not well informed to support proper adherence	Capacity development of existing ART centres. Support to decentralise ART services to divisional level
4.4		TB/HIV services are not integrated.	No policy or system in place for integrating services.	Support to integrate HIV and TB programmes as part of multi-sectoral strategy.
4.5		Treatment for common opportunistic infections not adequately available	lack of understanding, awareness and capacity of health service providers on treatment of HIV OIs	Capacity development of health service providers in public and private sectors
4.6		Inadequate measures to prevent transmission to family members, including PPTCT.	Lack of routine training/professional development on HIV.	Capacity development of relevant staff
4.7	Strengthen culture of seeking care, treatment and support among PHLA and their families	Limited sense of entitlement means that PLHA do not come forward for treatment and services.	PLHA groups have limited capacity to provide information and support to PLHA and do not have strong networks.	Strengthen PLHA networks and support them to mobilise communities to address HIV

5	Minimise the impact of the HIV/AIDS epidemic			
	\$70m Resource mobilized by Government (both from domestic and international sources).			
	20 % of members in National AIDS Coordinating body who represent sectors of civil society			
	National legislation to address stigma, discrimination, rights of infected and affected population.			
	<1 % of most-at-risk populations who are HIV infected			
5.1	Reduce stigmatisation and discrimination of people living with or affected by HIV/AIDS.	Limited legal support to protect and promote the rights of PLHA.	PLHA groups do not have capacity to support member to take advantage of and test existing legislation to protect their rights.	Training and capacity development of PLHA groups capacity development in view of existing legislation. Review legislative provisions for the rights of PLHA. Strengthening of PLHA networks
5.2				
5.3		Workplace discrimination against PLHA by employers and co-workers	Lack of basic understanding of HIV and how it is transmitted Lack of work place policies on HIV	Support to national guidelines for work place programmes Support to organisations to develop specific work place programmes in public and private sectors Supportive advocacy strategies for implementation of WPPs
5.4		Open discrimination against PLHA at	HIV is not prioritised in government as a public	Support key ministries and other stakeholders to

		community level.	health issue and therefore community leaders have not been adequately sensitised on AIDS.	develop clear sectoral strategies to reduce stigmatisation within the community.
5.5			Media has not been adequately sensitised on HIV and therefore do not report comprehensively on HIV.	Capacity development for media to report accurately on HIV/AIDS
5.6			Limited capacity of PLHA/NGO/CBO networks to represent the interests of PLHA.	Support advocacy capacity of NGOs/CBO and strengthen leadership skills and advocacy networks.
5.7	Increase support services available for families of people affected by HIV/AIDS.	Limited care and support services available for family's of PHLA.	HIV/AIDS not fully mainstreamed into standard development (education, social welfare, nutrition etc) programmes.	Support integration of family's of PHLA into vulnerable groups of NSP. Support capacity building of development NGOs/CBOs/FBOs and private sector organisations.
	Management and implementation of the TSP			
	Ensure resources are in place to manage and implement TSP effectively.	Limited capacity to manage and absorb technical support	NASP human resources over stretched compared with mandate (see A3)	Support to build capacity of national programme to manage technical support effectively.

TECHNICAL SUPPORT MAPPING 2008- 2009

Annex - 3

Approach to technical support mapping	<p>1. focus on activities of largest technical support providers</p> <ul style="list-style-type: none"> - UN system - GFATM - USAID - GTZ <p>2. identifying ongoing technical support activities and future commitment</p>			
Organization	Ongoing and planned Technical support	Amount	Linked Challenges in TSP	Relevant Proposed activities in TSP 2008-09
To address cross cutting issues:				
WHO, UNAIDS	Provide and coordinate technical assistance for multisectoral response	\$83,000	A-1 A-2 1.9	<ul style="list-style-type: none"> – Support to NASP to establish and convene functional partner's forum and technical working groups with clear terms of reference and participation of senior policy makers (TWGs on: finance, human resources...) – Provide consultancy support to establish regular ministerial meetings Support meetings – Support to develop multisectoral strategies in NASP (see 1.1) Impact assessment of the existing interventions with Ministry of Home Affairs (UNFPA).

WHO, UNAIDS	Strengthen current M&E and surveillance system for generating strategic information	\$133,000	D-1	– Strengthen role of TWG on M&E through convening regular meetings
UNAIDS	Strengthen current M&E and surveillance system for generating strategic information	\$125,000	D-1	– Strengthen role of TWG on M&E through convening regular meetings
	Provide leadership support in policy and programme implementation	\$258,000		
WHO, UNAIDS	Strengthen civil society including PLHIV organizations to intensify prevention of HIV	\$268,000	C-2	NGO/CBO capacity assessment and review of existing networking/capacity building opportunities, including MARP networks. Stock taking and review of previous capacity building efforts. Design coordinated mechanism to roll out capacity building programme.
WFP, UNAIDS	Support the inclusion of HIV and AIDS education in various curricula at various levels of learning, provide management and technical support to the partner NGOs and WFP Sub-Offices in implementation of the training activities	\$300,000	C-2	- As above
GTZ	Increased Coordination of implementing partners at local level- - Development of City Corporation Multidisciplinary HIV/AIDS coordination committees and technical working groups in Chittagong, Sylhet, Rajshahi, Khulna, - Development of city level monitoring and evaluation systems in the above 4 cities		A-1 D-1	– Support to NASP to establish and convene functional partner's forum and technical working groups with clear terms of reference and participation of senior policy makers (TWGs on: finance, human resources...) – Strengthen role of TWG on M&E through convening regular meetings

	Advocacy meetings to promote better understanding of the epidemic at both city and national level		A-1 A-2	– As above – Provide consultancy support to establish regular ministerial meetings Support meetings
	Provide technical support to NASP in developing national multisectoral HIV/AIDS strategy for urban areas (as suggested by NASP)		1.9	– Support to develop multisectoral strategies in NASP (see 1.1) Impact assessment of the existing interventions with Ministry of Home Affairs (UNFPA).
Goal 1: Provide support and services to the priority groups and people				
UNFPA, WHO	Number of orientation, workshop / meeting conducted to improve awareness of HIV prevention among young and at-risk population including female sex workers and transgenders.		C-2 1.1 2.7	NGO/CBO capacity assessment and review of existing networking/capacity building opportunities, including MARP networks. Stock taking and review of previous capacity building efforts. Design coordinated mechanism to roll out capacity building programme. Support to update NSP priorities, targets and scaling up mechanisms for MARP using most recent surveillance data and literature reviews. Ensure that emerging demands are addressed. Document lessons learned from GFATM R2&6 programmes on providing youth friendly RTI/STI services. Support scale up of evidence-based advocacy efforts
UNFPA	Number of orientation and training programs conducted with various population groups to implement HIV awareness and integration of HIV and RH issues with	\$226,525	A-2	– Provide consultancy support to establish regular ministerial meetings (linked to A1 in TSP). Support meetings.

	various ministries and departments.			
IOM	Training course for Police, Prison and Ansar & VDP personnel	\$47,000	1.9 2.4	<ul style="list-style-type: none"> – Support to develop multisectoral strategies in NASP (see 1.1) Impact assessment of the existing interventions with Ministry of Home Affairs (UNFPA). – Conduct risk assessment study in prisons (according to UNODC proposal) to be funded under UNAIDS PAF
UNODC	Develop minimum standards on OST and conduct training, trials and advocacy for IDUs and their partners through an established UNODC Country Support Unit	\$5,835		
UNODC	Provide technical support for orientation training in HIV/AIDS, safer drug use and safer practices to prison officials and prisoners	\$350,000	1.1 1.9	<ul style="list-style-type: none"> – Support to update NSP priorities, targets and scaling up mechanisms for MARP using most recent surveillance data and literature reviews. Ensure that emerging demands (eg. services for MARPS (MSM, OST) are addressed. – Conduct risk assessment study in prisons (according to UNODC proposal) to be funded under UNAIDS PAF
UNODC	Inter country study tour(s) to learn and share best practices on OST in prisons		1.9	– As above
Save the Children/ GFATM Round-6	Overall TA	\$350,236		
USAID /FHI	Capacity building of Self Help Groups and NGOS	\$248,946	C-2	– NGO/CBO capacity assessment and review of existing networking/capacity building opportunities, including MARP

				networks. Stock taking and review of previous capacity building efforts. Design coordinated mechanism to roll out capacity building programme.
FHI/RTM International	Manual / guidelines developed under the BAP program		C-2	- As above
Bondhu	Capacity building from FHI training on field staff		C-2	- As above
VARD	Training provided on STI management, counselor training, local level advocacy, peer education.		C-2	- As above
Durjoy Nari Shangha	Training on condom use		C-2	- As Above
KMSS	Staff training on STIs and Risk Reduction , counseling		C-2	- As above
GTZ	Support and services to drug users - - Training on standard detoxification management to DNC staff and other service providers (NGOs), Chittagong - community-based Drug Action Team to improve services, coordinate local activities,		C-2	- As above

	identify and facilitate filling of gaps			
	Research on interventions amongst priority groups- - Conduct vulnerability assessments amongst high risk groups in the Chittagong, Rajshahi, Sylhet and Khulna		1.1	– Support to update NSP priorities, targets and scaling up mechanisms for MARP using most recent surveillance data and literature reviews. Ensure that emerging demands (eg. services for MARPS (MSM, OST) are addressed.
Goal 2 : Prevent vulnerability to HIV infection in Bangladesh society				
UNICEF	Adaptation and printing of existing life skills based education materials developed focusing on prevention of HIV and Drug abuse in Children at Risk Project	\$3,000	2.1	– Conduct desk research to identify vulnerable groups, their behaviors and best practice interventions to feed into the revision of the NSP
UNHCR, UNFPA	Volunteers trained to improve awareness and access to HIV related information and services among the refugee population		2.1	– As above
UNICEF	Training of peer educators	\$5,000	C-2	– NGO/CBO capacity assessment and review of existing networking/capacity building opportunities, including MARP networks. Stock taking and review of previous capacity building efforts. Design coordinated mechanism to roll out capacity building programme.
UNESCO, UNICEF, UNAIDS	Mainstreaming HIV prevention within formal and non-formal education in Bangladesh and providing care and support for vulnerable children in selected districts	\$67,880	2.1	– Conduct desk research to identify vulnerable groups, their behaviors and best practice interventions to feed into the revision of the NSP
UNICEF	Print and distribute 5000 copies of Bangla reader friendly version report on "Assessment of risk and vulnerability of children and women to HIV in Bangladesh". Distribute 5000 copies of the report among	\$20,000		

	GO/NGO stakeholders.			
UNICEF	Organize 1 national and 6 sub-national dissemination workshops on the HIV/Study with GO/NGO stakeholders	\$15,000		
Goal 3 : promote safe practices in the health care system				
USAID/FHI	Needs Assessment and Policy development and Capacity development of safe blood transfusion centers		3.1 3.4	<ul style="list-style-type: none"> – Baseline situation analysis of current level of capacity and safe practices provision, and support to develop longer term strategy for scaling up implementation of universal precautions and monitoring and evaluation. Support to develop monitoring tools. – Consultative meeting between responsible government agencies and stakeholders. Establishing action plan and collaborating mechanisms to ensure that blood transfusion messaging is integrated into other public health campaigns
UNHCR	Antenatal staff trained in VCT for wet nurses		3.1	– As above
GTZ	<ul style="list-style-type: none"> - Training on universal precautions to HCP (doctors, nurses, paramedics) in Chittagong - Capacity development of City Corporation Health staff on ART Promote comprehensive systems of HIV care, support, treatment- <ul style="list-style-type: none"> - Training on STI case management, and STI counseling in health facilities - Facilitation of city wide HIV/AIDS and STI referral network with public and private partners 		3.1 2.6	<ul style="list-style-type: none"> – As – Consultations with MoHFW and other stakeholders re giving greater prioritisation to RTIs and STIs, linked to HIV prevention, and policy paper developed to highlight opportunities for integration of programmes above.

Goal 4: Provide care and support to PLHA				
UNICEF	Capacity building of health workers in the selected facilities on key areas related to PPTCT (VCCT, standard infection precaution, primary prevention of HIV for all service providers, HIV testing and blood safety).	\$10,000	1.4 3.1 3.4 4.6	<ul style="list-style-type: none"> – Support for capacity building to district level hospitals planned and applied for (covered in GF Round 8 Proposal). – Baseline situation analysis of current level of capacity and safe practices provision, and support to develop longer term strategy for scaling up implementation of universal precautions and monitoring and evaluation. Support to develop monitoring tools. – Consultative meeting between responsible government agencies and stakeholders. Establishing action plan and collaborating mechanisms to ensure that blood transfusion messaging is integrated into other public health campaigns – Support to scale up dissemination and implementation of new national guidelines for PPTCT (as developed by UNICEF).
UNICEF	Approval and dissemination of national strategic guideline on PPTCT	\$5,000		
	Develop training modules for various areas of PPTCT (UNICEF)	\$10,000	4.6 C-2	<ul style="list-style-type: none"> – Support to scale up dissemination and implementation of new national guidelines for PPTCT (as developed by UNICEF – NGO/CBO capacity assessment and review of existing networking/capacity building opportunities, including MARP networks. Stock taking and review of previous capacity building efforts. Design coordinated mechanism to roll out capacity building programme.
WFP	Provide technical and financial support to the NASP to develop Nutrition Guidelines for PLHA			
USAID/FHI /RTM International	Protocol and guidelines development			

USAID/FHI	Capacity building of care and support service provider			
AAS (Ashar Alo society)	Information dissemination on about VCT BCC/IEC materials			
GTZ	Stigma reduction and improvement of healthcare services; - Develop master trainers on the above subject in each of the 4 cities			
	HIV treatment and care- - ART demand projection for Bangladesh for 2008-2011 (submitted to NASP) - Studies conducted on the costs of treatment amongst PLHA			
Goal 5: Minimize the impact of the HIV epidemic				
USAID/FHI	Sect oral impact assessment ; Legislation development		5.1	– Review of legislative provision for the rights of people living with HIV in Bangladesh and other countries, building on the review of human rights situation of PLHA conducted already.
				–
USAID/FHI/MAC CA	Advocacy and training on stigma and discrimination ,	\$220,800	5.4	– Support Ministry of Information to integrate HIV into their existing mass communication programme.
			5.5.	– Develop guidelines and roll out training for the media to deepen their expertise in HIV/AIDS and thus accurately report on the issue (Activities underway, funded by UNAIDS).
			5.6	– Support NGOs to develop advocacy strategies and materials and link with national advocacy technical working group

Annex-4: Reports and documents reviewed

	Documents
1.	National Strategic Plan -II (2004-2010)
2.	Operational Plan of NSP-II
3.	National policy on HIV/AIDS and STD related Issues
4.	National HIV M&E Framework and Operational Plan
5.	National Harm Reduction Strategy
6.	National BSS and Sero Surveillance reports (2007)
7.	National Communication strategy
8.	Cambodia & Tanzania models of TSNA and TSP
9.	UN Development Assistance Framework in Bangladesh 2006 -2010
10.	Practical guidelines for intensifying HIV prevention towards Universal access, UNAIDS
11.	GFATM PPs (Rounds -2,6,8)
12.	GFATM Baseline survey document / TNA Report
13.	Towards a coordinated national response for targeted national response in Bangladesh; Tony Bondurant, Nov 2007
14.	Capacity Development Plan, NASP 2005
15.	UNGASS country progress report 2008
16.	AIDE Memoir, 2007, 2008
17.	Country harmonization and Alignment Tool, UNAIDS
18.	MDGs, A mid-term Bangladesh report, Draft 2007
19.	Consolidated lessons learned on AIDS in Bangladesh (Draft), IUB, ICDDR,B
20.	Review of Policy Environment, Ain -O-Salish Kendra (ASK)
21.	Redefining AIDS in Asia: Commission on AIDS in Asia
22.	The Asian Epidemic model for Dhaka city 2006, Technical Report, Amla

	Reddy
23.	Assessment of Sexual Behavior of Men: A Methodological experiment in Bangladesh, FHI, ICDDR,B
24.	HAAP Review report, WB, 2008
25.	HATI Participatory M& E framework and guidelines, 2008
26	NASP, Functional Task Analysis, MoHFW, March 2007
27	Bangladesh UA, 2006

Annex 5: Individuals interviewed

NSP Objective-1: Provide support and services to the priority groups of people		
	Name and designation	Organization
1.	Mr. A K Nazmuzzaman, Joint Secretary	Ministry of Labor & Employment
2.	Mr. Humayun Kabir, Senior Assistant Chief	Ministry of Labor & Employment
3.	Dr. Md. Mozammel Hoque HIV/AIDS Advisor	UNODC
4.	Bridget Job-Johnson HIV Specialist	UNICEF
5.	Md. Ehsanul Haque HIV Specialist, Health & Nutrition Section	UNICEF
6.	Mr. A H Towfique Ahmed Divisional Coordinator	UNICEF, Barisal
7.	Dr. Nizam Uddin Ahmed Director, HIV/AIDS Sector and South Asia Program Advisor	Save the Children, USA
8.	Mr. Avra Saha Program Manager	FHI
9.	Mr. Munir Ahmed, Team Leader, Operations,	CARE Bangladesh

	HIV Prog.	
10.	Mr. Shamim Rabbani Team Leader, GFATM-907	Padakhep Manobik Unnayan Kendra
11.	Mr. Forkan Hossain Technical Coordinator (M&E)	Padakhep Manobik Unnayan Kendra
12.	Ms. Sajeda Begum Technical Coordinator (Advocacy & Training)	Padakhep Manobik Unnayan Kendra
13.	Mr. Iqbal Masud HIV Focal Person	Ahsania Mission
14.	Mr. Md. Abul Bashar Poltu Executive Director	APOSH, Rajshahi
15.	Mr. Shale Ahmed Executive Director	BONDHU Social Welfare Society
16.	Mr. Md. Belayet Hossain Assistant Director	VARD, Sylhet
17.	Pinky Sikder Executive Director	BADHAN
18.	Mr. A K M Sakwat Hossain Project Officer	Setu Bandhan, Mymensingh
19.	Mr. Noyon Mahmud Cashier	Setu Bandhan, Mymensingh
20.	Ms. Shahnaz Begum President	Durjoy Nari Sangha
21.	Mr. Dipak Kumar Biswas Director	HASAB
22.	Mr. Md. Siddiqur Rahman Director (Capacity Building & Partnership Management)	HASAB
23.	Dr. Akhtar Iqbal Begum Team Leader (Interim Management Team)	BWHC
24.	Dr. Dil Afroz Director (Clinical Services)	BWHC
25.	Mr. Md. Masudul Haque Director (Community Based Program)	BWHC
26.	Mr. Aktaruzzaman Team Leader (HATI)	BWHC
27.	Mr. Babul Adhikary Team Leader	DORP
28.	Dr. Md. Mostafa Kamal, President	Khulna Mukti Seba Sangha

29.	Ms. Afroja Akter Monjur Executive Director	Khulna Mukti Seba Sangha
30.	Mr. Nasimul Haque Roni Project Officer (HATI)	Khulna Mukti Seba Sangha
31.	Ms Parveen Ara Sheuly Project Coordinator	Khulna Mukti Seba Sangha
32.	Mr. Sohrab Hossain Injecting Drug User	DIC CARE, Mirpur -1, Dhaka
33.	Mr. Wasim Reza Karim Injecting Drug User	DIC CARE, Mirpur -1, Dhaka
34.	Mr. Shahjahan Mia Ex - Drug user	DIC CARE, Mirpur -1, Dhaka
35.	Mr. Md. Hanif Drug user	DIC CARE, Mirpur -1, Dhaka
36.	Ms. Tuli FSW	DIC Durjoy Nari Sangha (Iqbal Road, Mohammadpur, Dhaka)
37.	Ms. Asma FSW	DIC Durjoy Nari Sangha (Iqbal Road, Mohammadpur, Dhaka)
38.	Ms. Tara FSW	DIC Durjoy Nari Sangha (Iqbal Road, Mohammadpur, Dhaka)
39.	Ms. Shilpi FSW	DIC Durjoy Nari Sangha (Iqbal Road, Mohammadpur, Dhaka)
40.	Mr. Afzal Hossain DIC Manager	DIC Durjoy Nari Sangha (Iqbal Road, Mohammadpur, Dhaka)

NSP Objective-2: Prevent vulnerability to HIV infection in Bangladesh society

	Name and designation	Organization
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1.	Mr. Md. Abdul Jalil Mian, Deputy Secretary	Ministry of Women and Children Affairs
2.	Dr. Nizam Uddin Ahmed, Director, HIV/AIDS Sector and South Asia Program Advisor	Save the Children, USA
3.	Ms. Bridget Job-Johnson, HIV Specialist	UNICEF
4.	Mr. Md. Ehsanul Haque, HIV Specialist, Health & Nutrition Section	UNICEF
5.	Mr. Avra Saha, Program Manager	FHI
6.	Mr. Iqbal Masud, HIV Focal Person	Ahsania Mission
7.	Dr. Nazneen Akhter, Executive Director	HASAB
8.	Dr. Ahmed Al Kabir, Chief Executive	RTM International

NSP Objective-3: Promote safe practices in the health care systems

	Name and designation	Organization
1.	Dr. Mozammel Hoque HIV/AIDS Advisor	UNODC
2.	Mr. Avra Saha Program Manager	FHI
3.	Dr. Nahid Ahmed Chowdhury Technical Manager (HIV/AIDS)	Concern Worldwide

NSP Objective-4: Provide care and support to PLWHA

	Name and designation	Organization
1.	Dr. Nizam Uddin Ahmed Director, HIV/AIDS Sector and South Asia Program Advisor	Save the Children USA
2.	Dr. Monira Parveen, HIV Specialist, Health & Nutrition Section	UNICEF
3.	Ms. Asma Deputy Director	Ashar Alo Society (SHG)
4.	Mr. Sayeed Humaun Kabir Executive Director	Geon Health Foundation, Khulna

NSP Objective-5: Minimize the impact of the HIV/AIDS epidemic		
	Name and designation	Organization
1.	Mr. A K Nazmuzzaman, Joint Secretary	Ministry of Labor and Employment
2.	Dr. Abdul Jalil Mian, Deputy Secretary	Ministry of Women and Children Affairs
3.	Mr. Shudhakar Dutta, Deputy Secretary	Ministry of Expatriates Welfare & Overseas Employment
4.	Mr. Humayun Kabir, Senior Assistant Chief	Ministry of Labor and Employment
5.	Dr. Abul Bashar Poltu, Executive Director	APOSH
6.	Mr. Sayeed Humaun Kabir, Executive Director	Geon Health Foundation, Khulna

Annex - 7

(Draft)

Terms of Reference

for

Technical needs assessment and technical support plan for HIV and AIDS in Bangladesh 2008 -2010

Background and Justification:

Bangladesh, one of the few countries in the South Asia region with a low HIV prevalence, has a considerable opportunity to contain the AIDS epidemic. Recent accelerations in HIV/AIDS funding have further heightened this opportunity, yet also emphasized the need for strong and effective capacity to implement a comprehensive, full -scaled and sustained response.

In the 2008 UNGASS Country Progress Report and other recent national reviewsⁱ, a number of significant implementation gaps were identified that present major obstacles to achieving programme goals in Bangladesh. These gaps included (but were not limited to), targeted prevention with MARPs; provision of treatment, care and support services for PLHA; impact mitigation programming; and the capacity of the NASP to coordinate and manage the national response.

Since national capacity is not growing at the same rate as funding, particularly with regards to Bangladesh's Universal Access targets, the provision of technical support is critical. In response, the National AIDS/STD Programme (NASP) in collaboration with UNAIDS, Dhaka will conduct a Technical Needs Assessment for Bangladesh, and to develop a Technical Support Plan for 2008 -2010. The Assessment and Plan will benefit the government and key development partners in Bangladesh to implement the National Strategic Plan 2004 -2010 (and adjoining National Operational Plan 2006 -2010).

In February 2007 UNAIDS Secretariat, in coordination with WHO, WB, Global Fund and PEPFAR convened a workshop in response to the increasing demand for quality-assured, technical support and for more coordinated and harmonized provision of technical support by partners to help countries meet performance-based funding criteria, and commitments to scale up towards Universal Access and the Millennium Development Goals. As a follow-up to this, and based on country experience, National Capacity Support Team, UNAIDS HQ, Geneva will support conducting Technical Support Needs Assessment exercise and developing a comprehensive technical support plan for Bangladesh 2008 -2010.

The Assessment and a Technical Support Plan for 2008 -2010 will benefit the government and key development and implementing partners in Bangladesh to implement the National Strategic Plan 2004 -2010 and adjoining National Operational Plan 2006 -2010.

Goals:

The goals of conducting TSNA and developing TSP are:

- Increase the country capacity in achieving the Universal Access targets and Millennium Development Goals
- Accelerate provision of technical support by improving coherence and coordination

Objectives

The objectives of the exercise are:

- To identify the gaps in terms of technical skills and capacity building requirements among key partners (government and non -government) fighting HIV infection and AIDS in Bangladesh in line with NSP: II (2004 -2010) priorities.
- To develop a costed Technical Support Plan that reflects the requirements of key implementing partners in Bangladesh.

The expected outputs:

- A technical needs assessment carried out;
- A costed technical support plan developed and approved;
- Technical support monitoring and evaluation system developed and integrated into the national M&E system;
- Report disseminated widely among the stakeholders.

Guiding Principles:

- Aim to scale-up the response towards Universal Access
- Remove bottlenecks in the implementation of the National Response hampering the achievements of scaling –up efforts
- Ensure availability of a technical support plan, based on identified obstacles and on a comprehensive technical need assessment.
- The Technical Support Plan will constitute for all national and international partners, the reference document for the provision technical support to the country.

Available approved budget for the activity: US\$ 35,000.00

Duration of the exercise: 15 June to 15 September 2008

TSNA & TSP Development Process and Plan:
