

Revised

4th National Strategic Plan

For HIV and AIDS Response

2018-2023

January 2020

AIDS/STD Programme (ASP)
Directorate General of Health Services
Ministry of Health and Family Welfare

Foreword

Acknowledgement

Acronyms

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

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Executive Summary

In the recent years, there have been significant global and national contextual changes and emergence of new evidences and strategies, which have significant bearing on the HIV responses. The existing National Strategic Plan (NSP) for HIV and AIDS Response is revised and updated to adapt strategies based on the recent advances. The revised National Strategic Plan for HIV and AIDS Response 2018-2023 remains aligned with 4th Health, Nutrition and Population Sector Program (HNPPSP), 2017-2022 as well as other national, regional and global commitments, mainly the 2016 Political Declaration to end AIDS by 2030. This updated version of strategic plan aims to accelerate and guide the national response to HIV and AIDS to achieve the global commitment of 'Ending AIDS by 2030' and treatment targets of '90-90-90' by 2020. The document emphasizes on geographical prioritization based on proportion of Key Populations and HIV case load; optimum utilization of resources to enhance HIV case detection, coverage for prevention, treatment and testing for viral loads; integrating prevention, treatment, care and support services for PLHIV and KPs into public health and relevant government systems e.g. Social Safety Net under Ministry of Social Welfare. Another prime focus of the document is ensuring human rights-based prevention, treatment, care and support services for PLHIV, KPs and people at emerging risk and vulnerabilities through strengthening health and community systems involving multi sectoral stakeholders and communities. This strategic plan also emphasizes on reaching vulnerable adolescents, youth and people who are at emerging risk and vulnerabilities through innovative interventions and massive awareness raising among general population.

The AIDS/STD Programme (ASP), Directorate General of Health Services (DGHS) lead the NSP review process with technical and financial assistance support of UNAIDS and ASP through the Global Fund. The technical aspect of this review was guided by a National Steering Committee formed by DGHS. The key stakeholders from DGHS and relevant departments of selected ministries, different hospitals, private sector and media, PLHIV networks, Key Population (KP) networks, Save the Children, icddr,b, UNAIDS and other UN partners were integrally involved in the process.

The strategy framework of the strategic plan articulates several strategies under four broad program objectives. In addition, several 'fast track' approaches are set to guide the national response to HIV and AIDS to achieve the treatment target of '90-90-90' by 2023 and move towards 'Ending AIDS by 2030' and wellbeing of all infected and affected by HIV.

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

The first program objective emphasizes implementation of services to prevent new HIV infections among key populations (KPs), people at emerging risk and vulnerabilities and general population including young people. Four Strategies (1.1 - 1.4) have been developed. While Strategies 1.1 – 1.3 deal with prevention of new HIV infections by increasing program coverage and case detection through comprehensive, targeted and integrated interventions; provision of services sensitive to age, gender and human rights for KPs and people at emerging risks and vulnerabilities and awareness raising for general population. Strategy 1.4 is about increased availability of services for HIV, STI prevention and other SRH services, more functional linkages for managing co-infections (TB, Hepatitis etc.) and elimination of vertical transmission of HIV, syphilis and hepatitis in national health care system throughout the country.

Based on the national epidemiological context, interventions among key populations have been designed with the highest priority. Recent program experiences also support expanded interventions among migrant workers especially international migrants and their families. Reaching especially vulnerable adolescents (EVA) with innovative intervention is also necessary. In order to achieve the first program objective, several fast track approaches are identified. These include: geographical prioritization in the HIV response; provision of age specific/sensitive services for most at risk adolescents(MARA); strengthen referral mechanisms and community led approaches in HIV case detection; reduce stigma and discrimination and address violence against KPs; improve service providers capacity to respond to KP's unique health problems and deliver services sensitive to age, gender and human rights; ensuring quality of care; monitoring implications of punitive laws affecting KP interventions and advocacies with relevant authorities to improve the situation; strengthen mass media campaign for raising awareness among general populations.

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

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

Strategy 2.1 is developed to ensure that 90 percent of the detected PLHIV receive ART and viral load test. Since PLHIV and KPs are spread throughout the country, Strategy 2.2 emphasize capacity development of service providers in government, non-government and private sector facilities for providing out-patient and in-patient medical management, sensitive to age, gender and human rights, for PLHIV. In order to be aligned with the rapidly

developing field of HIV treatment and care, Strategy 2.3 emphasises ensuring functional systems for related policy adoption, linkages and periodical updating of relevant policy documents (e.g. National ART guideline, protocols for STI management, HTS and PMTCT, HIV and Hepatitis). Moreover, Strategy 2.4 emphasises a comprehensive approach to community support system adopted and implemented to remove barrier to access services and strengthen treatment adherence, care and support for PLHIV including children infected and affected by AIDS (CABA) and orphans and vulnerable children (OVC).

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

Program objective 3: To strengthen the coordination mechanisms and management capacity at different levels to ensure a multisectoral, human rights based, effective and sustainable national response

Enhanced prevention and treatment coverage for KP and PLHIV through effective delivery of human right-based services as described under the first and second program objectives, are the major considerations of the NSP 2018-2023. In order to provide prevention services to KPs as well as to ensure universal access to treatment by the PLHIV, advocacy for enabling environment, increased capacity of human resource for enhanced response, strengthening health and community systems response to HIV are essential and highlighted under the third program objective.

Eight strategies (3.1-3.8) have been outlined under this program objective to guide smooth management, ensure effective coordination, advocacy, health and community system strengthening and capacity development plans during 2020-2023.

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

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

management and sharing is also emphasized through compilation of HIV case reporting data, real-time reporting system for KPs and PLHIV and dissemination of relevant information in World AIDS Day, Annual National and Global AIDS Monitoring (GAM) Report.

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

A detailed costed implementation plan for 2020-2023 accompanies the revised 4th National Strategic Plan for HIV and AIDS response 2018-2023. This plan provides a framework for harmonizing the efforts of all partners to ensure that low HIV prevalence is ensured and people living with HIV are provided with the best possible treatment, care and support.

1.0 Introduction

Background

The revised version of 4th National Strategic Plan (NSP) for HIV and AIDS Response 2020-2023 holds the spirit of the original document and is aligned with 4th Health, Nutrition and Population Sector Program (HNPSP), 2017-2022 as well as other national, regional and global commitments, specially the 2016 Political Declaration to end AIDS by 2030. This updated version of strategic plan aims to accelerate and guide the national response to HIV and AIDS to achieve the global targets on 'Ending AIDS by 2030' and treatment target of '90-90-90' by 2023 focusing on geographical prioritization based on proportion of Key Populations and HIV case load; optimum utilization of resources to enhance coverage for prevention; HIV case detection; ART and testing for viral loads; enhancing integration of prevention, treatment, care and support services for PLHIV and KPs into public health system. Another prime focus of the document is ensuring human rights-based prevention, treatment, care and support services for KPs and whoever needs that through strengthening health and community systems involving multi sectoral stakeholders and communities. This strategic plan also emphasizes on reaching vulnerable adolescents, youth and people who are at emerging risk and vulnerabilities through innovative interventions and massive awareness raising among general population.

In the recent years, there has been significant global and national contextual change (Bangladesh is one of the seven countries in Asia and the Pacific region where the new infections continue to increase¹; the country has grown to lower middle income country from a least developed country; inflows of external financing for HIV and AIDS to the region are diminishing² etc.) and emergence of new evidences and strategies, which have significant bearing on the HIV responses and thus the existing approaches need to be revisited periodically in terms of strategic modifications and applications. In view of these circumstances it is required to revise and update the current National Strategic Plan to adapt strategies based on recent global and national contextual and innovative advances in interventions addressing HIV and AIDS. Further, it is intended to provide an updated framework to follow-up on progress against targets and address issues with more realistic efforts, facilitate future planning among partners from government and non-government sectors by focusing on common goals, a shared commitment to evidence-based programming and role delineation based on strategic planning as well as resource mobilization.

The strategies included in this plan are formulated to guide implementation of services to prevent new HIV infections ensuring universal access to prevention services, provide

¹ UNAIDS, 2017. Global AIDS Update. Ending AIDS: Progress towards the 90-90-90 Targets 2017

² Asp, UNAIDS, Bangladesh Investment Case for HIV: Sustainable Investment Options in the National Response, 2019

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

The Process

The process of reviewing the National Strategic Plan for HIV and AIDS, 2018-2022, led by the AIDS/STD Programme (ASP), Directorate General of Health Services (DGHS), started in October 2019, with technical and financial assistance from UNAIDS and ASP through the Global Fund. The technical aspect of this review was guided by a National Steering Committee formed by DGHS. A National Consultant was engaged by UNAIDS to support ASP to review and update the 4th NSP for HIV and AIDS for 2018-2023, so the document can guide the country response for an extended period. The key stakeholders from DGHS and relevant sectors, hospital management, PLHIV networks, Key Population (KP) networks, UNAIDS, Save the Children and icddr,b and other implementing partners: Bandhu Social Welfare Society, Care Bangladesh, Light House among others were integrally involved in the review process.

In order to support the process, eight thematic group consultation meetings were conducted during 4-23 December 2019. The thematic areas covered in the group consultations include:

1. Universal access to treatment, care and support
2. HIV prevention among key population (PWID)
3. HIV prevention among key population (MSM/ MSW and TG)
4. HIV prevention among key population (FSW)
5. Laboratory Services
6. HIV Prevention among General population
7. Advocacy, Communication and human rights
8. M & E and Strategic Information/ Surveillance

In depth interviews were conducted with professionals/experts from ASP and relevant agencies to review Capacity Building, Strengthening Coordination and Integration and Prevention of Mother to Child transmission of HIV (PMTCT) and triple elimination.

The relevant members from program implementing partners, representatives from different departments of relevant ministries, private sector including media and KP representatives participated in the group consultations and contributed to identify the achievements of the programs, gaps and challenges that still persist and also make necessary suggestions for future improvement of the HIV response. Other than these thematic group consultations, five brief meetings were held with KP networks including PLHIV network to learn issues and concerns affecting their lives and how HIV affecting

them as well as their current and potential contribution to enhance response to HIV and overall wellbeing of the populations infected and affected by HIV.

Based on the findings of these consultations, Working Papers and a summary of discussion with KP networks have been developed and are annexed herewith. In addition, in-depth discussions with the key selected experts were conducted to further guide the national strategies for HIV and AIDS response.

2.0 Epidemic Situation, Response and Challenges

2.1 HIV Epidemic in Bangladesh

Bangladesh has maintained a low national HIV prevalence in the general population (<0.01%)⁴ over the years since identification of first case in 1989³. However, a concentrated epidemic has been on rise among populations identified as key populations (KPs) in the country and surveillances conducted in 2015-16, recorded high prevalence (22%) among the male PWID (People who inject drugs) in Dhaka city and 27.3% in a neighbourhood of Dhaka (old Dhaka) and 8.9% in the rest of Dhaka. In female PWID in Dhaka the prevalence was 5%. No HIV was detected among male PWID in Hili (a small border town in the Northwestern part of Bangladesh bordering the Indian State of West Bengal) but of 46 transgenders (Hijra) sampled in Hili two were positive for HIV (4.3%) while 0.9% were positive in Dhaka. Till now, the prevalence of HIV among Female sex workers (FSWs), Men who have sex with men (MSM), Male Sex Worker (MSWs) is less than 1%, while the weighted national average of prevalence among all key populations is 3.9% in 2015-2016, mostly because of high prevalence among PWID^{4, 5, 6}.

Up until December 2019 the total number of detected cases was 7,374 of whom 1,242 have died, leaving 6,132 known people living with HIV. However, the total national estimate is about 14,000 PLHIV. Among the 919 new HIV cases reported in 2019, 11% (105) were among Forcibly Displaced Myanmar National (FDMN) in Cox's Bazar, 33% among key populations, (See table 1 for distribution of new infections among KP), 37% among general populations and migrants constituted 19%. Gender distribution showed, 25% were among women, 1% among TG and the rest were male population. Analysis of age shows, 6.5% were among children (0-18 years) and 74.42 % were among 25-49 years

³ UNAIDS and govt. of Bangladesh (2014). HIV Estimates with with bounds:1900-2013. National AIDS and STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh

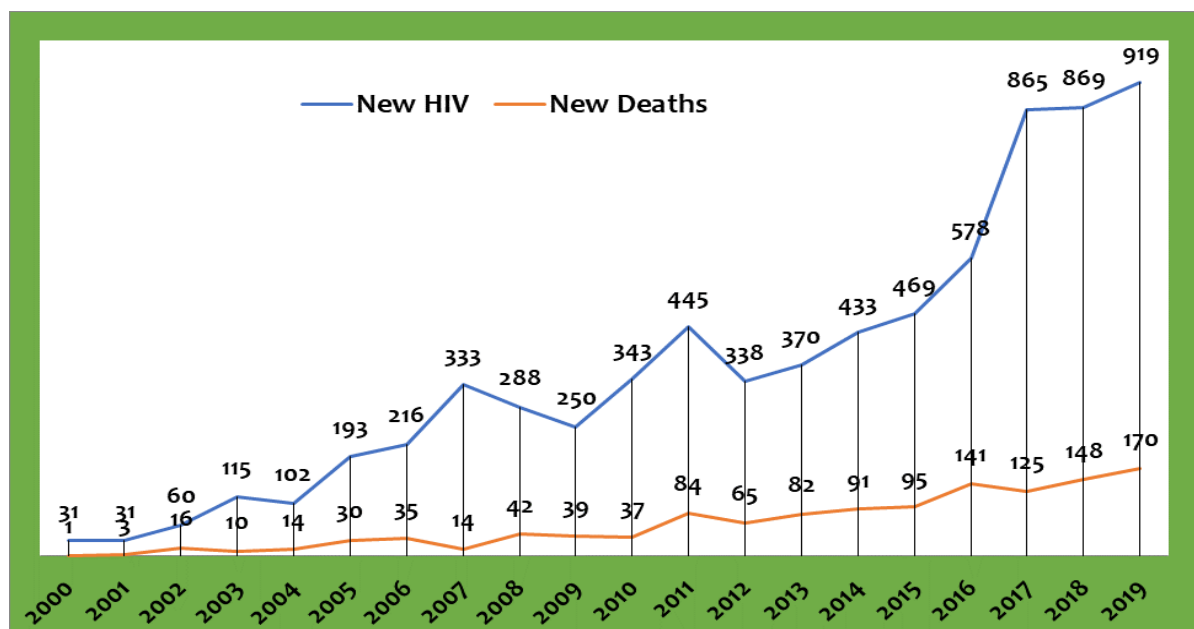
⁴ Behavioural and Serological Surveillance on males having sex with males, male sex workers and hijra, 2015. National AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh.

⁵ Behavioural and Serological Surveillance amongst Key Populations at Risk of HIV in Selected Areas of Bangladesh, 2016

⁶ ASP, 2019, Keynote Presentation by ASP, World AIDS Day, 2019

of age group, who are sexually active. A striking feature is, about 74% of all the cases detected within reproductive age group (793, others are referred as children, infant etc.) in 2019 were married⁷.

Figure 1: New HIV and death cases in Bangladesh, 2000-2019



Source: ASP

Table 1: KP distribution among the new infections; 33% of new infections were from KPs in 2019

PWID	MSM	MSW	FSW	TG
24%	3%	3%	2%	1%

Currently migrants constituted 19% of new cases in 2019⁸. The risk of HIV associated with migration and mobility is related to the behaviour of individuals and not to migration itself. Studies in different settings have shown that migrants practice risky behaviours while living abroad. A study in two rural areas of Bangladesh showed that commercial sex was more common among men who had gone abroad for work compared to those who remained at home⁹. There are many reasons why migrants practice risky behaviours while abroad and understanding those factors in a given context is essential for designing effective programs. A study conducted in Matlab among 304 returnee migrant workers

⁷ Ibid, slide 11-13

⁸ ASP, 2019, Keynote Presentation by ASP, World AIDS Day, 2019

⁹ IOM, icddr,b and UN Women. 2008: Impact of migration on health of male Bangladeshi migrant workers.

found one HIV positive of the 297 returnee migrants sampled (0.3%)¹⁰. While interviewing the Medical Director of a GAMCA allied diagnostic lab, he informed that about 10,000 potential migrants were screened for HIV during November 2018 to October 2019, and 11 cases were found positive. This is a very significant finding as it indicates (0.1%) HIV prevalence among these group, which is higher than the prevalence (<0.01%) among general population estimated so far in the country¹¹.

Apart from FDMN in Cox's Bazar the identified people living with HIV (PLHIV) were concentrated in Dhaka, Chottogram, Sylhet and Khulna divisions; the cumulative total number is 2572 (35.7%) in Dhaka, 2008 (27.9%), in Chottogram, 1219 (16.9%) in Sylhet and 660 (9.2%) in Khulna. Consistently, excluding the FDMN, the newly detected 814 cases in 2019 are highest in Dhaka (381) followed by Chottogram (203), Khulna (90) and Sylhet (59)¹². Out of 64 districts in Bangladesh, HIV was detected in 60 districts. It is reported that, 77% PLHIV were concentrated in 12 districts: Dhaka, Narayanganj, Chattogram, Cumilla, Sylhet, Cox's Bazar, Moulavibazar, Noakhali, Khulna, Brahman Baria (Gazipur), Munshiganj, Chandpur and Cox's Bazar (mainly among FDMN). The heaviest affected districts were Dhaka, Narayanganj, Chattogram, apart from Cox's Bazar¹³. And some districts are strategically vulnerable because of sharing its border with states of India and Myanmar, where high HIV prevalence transcended the boundary of the KPs, e.g Sylhet, Moulavi Bazar, Cumilla, Jessore and Sathkhira, Dinajpur- specially Hili, the hill districts etc.

Surrogate markers of risk which include hepatitis C (HCV) rates for unsafe injection and active syphilis for unsafe sex were measured in 2011. HCV prevalence among PWID varied in different geographical areas: HCV prevalence $\geq 30\%$ was detected in 10 cities including Dhaka where the rate declined significantly over the years from 66.5% in 2000 to 39.6% in 2011 ($p < 0.05$). Surveillance data of 2016 showed that active syphilis rates were 2.6% and 2.4% in male PWID from old Dhaka and the rest of Dhaka respectively, 5.8% in female PWID in Dhaka, 0.9% in male PWID from Hili, ranging from 0-3.2% in FSWs from different sites in Dhaka, Hili and nationally from brothels. In MSW and MSM the rates around 1-2% in Dhaka and Hili while in TG/hijra it was 2.1% in Dhaka and 0% in Hili. When different STIs were considered the overall rates of having any STI among FSWs from streets and residences in Dhaka were 10% and 12.5% respectively, 20.7% in MSWs, 21.3% in TGs and 7.3% in female PWID.^{14,15,16,17}

¹⁰ Alam M S et al. (2016). Point of care HIV testing with oral fluid among returnee migrants in a rural area of Bangladesh. *Current Opinion on HIV and AIDS*, 11(1):52-58.

¹¹ 2019 Data from GAMCA, Allied Diagnostic Ltd, GCC Code NO. 05/01/37)

¹² ASP, 2019, Keynote Presentation by ASP, World AIDS Day, 2019,

¹³ ASP, Annual Report, 2018

¹⁴ Khanam et al. (2016). Sexually transmitted infections and associated risk factors among street based and residence based female sex workers in Dhaka, Bangladesh. *Sexually Transmitted Diseases*, 44(1):22-29.

¹⁵ Khanam et al. (2015). Sexually transmitted infections among male and female sex workers, females who inject drugs and Hijra under the Global Fund project in Dhaka. icddr,b

The key findings from the 2015-16 BSS showed that 53.1% PWID in Dhaka shared used needle/syringes in the last week¹⁸ compared to 60.7% during the last BSS conducted in 2006/07¹⁹. In 2016 fewer male PWID bought sex from FSWs in the last year since BSS of 2002 (31.2% and 57.2% respectively, $p<0.05$). More FSWs reported using condoms use with clients over the years of BSS since 2002. In 2016, consistent condom use was 39.3%, 36.9% and 42.5% in brothels, streets and hotels of Dhaka respectively. Consistent condom use by MSM also increased over the years since 2002 with 34% and 46.6% reporting this with non-transactional and transactional partners respectively in last month in 2015²⁰. Similarly, percentage of MSWs and TGs used condom last week increased significantly over the years; in 2015 43.7% and 39.9% MSWs used condoms consistently while 24.8% and 22.8% TGs did so with new and regular clients respectively. The prevalence of risk behaviours of HIV positive PWID is of concern as 64.3% lent their used needles/syringes to others in the last week, 33.1% bought sex from FSWs in the last year and 30.4% were married²¹. The low prevalence of HIV among MSM cannot be neglected because MSM in Dhaka city are highly networked^{22, 23}.

Among 69,941 pregnant women screened for HIV under PMTCT Program 51 women were found positive in 2019 and all 51 were brought under ART²⁴. Currently identifying and managing HIV and TB coinfections have been emphasised in the country and 45 PLHIV (out of 730 estimated HIV positive TB incidences²⁵) were identified and received TB treatment and ART in 2019²⁶.

¹⁶ ASP (2017). Behavioural and Serological Surveillance amongst Key Populations at Risk of HIV in Selected Areas of Bangladesh, 2016. National AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh.

¹⁷ ASP (2016). Behavioural and Serological Surveillance on males having sex with males, male sex workers and hijra, 2015. National AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh.

¹⁸ ASP (2017) Behavioural and Serological Surveillance amongst Key Populations at Risk of HIV in Selected Areas of Bangladesh, 2016. National AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh

¹⁹ Behavioral Surveillance Survey 2006-07, Technical Report, NASP, 2009 (page 22)

²⁰ Behavioural and Serological Surveillance on males having sex with males, male sex workers and hijra, 2015.

²¹ Behavioural and Serological Surveillance amongst Key Populations at Risk of HIV in Selected Areas of Bangladesh, 2016

²² Huq MN, Khan S, Peerapatanapokin W, Reza M, Hossain Z, Shams Z, Rahman MA. (2017). Modes of HIV transmissions in Dhaka city. HIV & AIDS Review 2017/Volume 16/Number 1, DOI: <https://doi.org/10.5114/hivar.2017.66898>

²³ Lisa, RDS paper in BD, 2008, page-301; 20 years of HIV, page-xvi

²⁴ ASP, Keynote presentation, WAD, 2019

²⁵ Global TB Report, 2019

²⁶ ASP, Program data, 2019

Although the number of HIV infections is still low, the nation remains extremely vulnerable due to its socio-economic and cultural settings²⁷. Bangladesh is one of the seven countries in the region where the epidemic continues to increase²⁸.

2.2 Responses

National Response

Bangladesh has a long history of strong political commitment in combating HIV and a response guided by data on the epidemic. Efforts began even before the first case of HIV was detected 1989. From the start, emphasis was given to HIV surveillance since 1998, which would provide evidence, on which to base programme decisions.

The National AIDS Committee (NAC) was formed in 1985. The Chief Patron of the NAC is the President of Bangladesh, and the Minister of Health and Family Welfare is the Chair. The NAC is the highest decision-making body on issues related to AIDS and other sexually transmitted infections (STIs) and acts as an advisory body responsible for formulating major policies and strategies on HIV and AIDS in Bangladesh. NAC also supervises program implementation and is responsible for mobilizing resources when required. Bangladesh AIDS Prevention and Control Programme (BAPCP) were established in 1997 which was renamed later as National AIDS/STD Control Programme (NASP) as a separate wing of DGHS. In 2013, it became a regular body of DGHS as National AIDS/STD Control (NASC) with approved organogram and was renamed as AIDS/STD Programme (ASP) in 2018²⁹. The AIDS/STD Programme (ASP) is primarily responsible for coordination and management of HIV response in Bangladesh.

Bangladesh was the first country in the region to adopt a comprehensive national policy on HIV/AIDS and STIs (in 1997), and then also developed the first National Strategic Plan for HIV/AIDS, 1997-2002. This was reviewed in 2005 and the second National Strategic Plan for HIV/AIDS 2004-2010 was adopted. The third National Strategic Plan was developed by NASP in 2011 to provide a framework for the national response to HIV and AIDS up until 2015. Building upon the previous NSPs, as well as the National Policy on HIV/AIDS and STD Related Issues, revised third NSP 2011-2017 was developed in the first half of 2014. 4th NSP 2018-2022 was developed in alignment with the 4th Health, Nutrition and Population Sector Program, 2017-2022 as well as other national, regional and global commitments, mainly the 2016 Political Declaration to End AIDS by 2030. 2019 review of 4th NSP 2018-2022 took place to update the document to guide an accelerated national response that ensures achievement of ‘fast track targets: 90-90 -90’ by 2023. Purposes of this review have been:

²⁷ NASP. (2015). INVESTMENT CASE: Prioritizing Investment Options in HIV Response in Bangladesh to End AIDS by 2030, with financial and technical assistance from UNAIDS.

²⁸ Annual Report 2018, ASP, DGHS-MOHFW, Government of the People’s Republic of Bangladesh

²⁹ ASP, Annual Report, 2018

- Follow-up progress against targets and address issues with more effort and attention
- Adapt strategies to recent global and national contextual advances in HIV and AIDS interventions
- Facilitate future planning among partners from government and non-government sectors on next actions
- Update the document to able to provide guidance for coordinated response for an extended period (2023)
- Facilitate resource mobilization
- Facilitate development of ASP Operational Plan under Health, Population and Nutrition Sector Program

National Policy Environment for HIV Programs

The ASP, within the Directorate General of Health Services of the Health Service Division of Ministry of Health and Family Welfare (MOHFW), is the main government body responsible for overseeing and coordinating prevention and control of HIV/AIDS and ensuring that the National HIV/AIDS strategy and national policies are implemented. Other ministries carry out HIV prevention and control activities through their core administrative structures. The Government has nominated focal points for HIV/AIDS in 16 ministries and departments.

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

- The Safe Blood Transfusion Act (2002)
- National STI Management Guidelines (2006) and training manual – being updated currently
- National Policy and Strategy for Blood Safety (2007)
- Guidelines for VCT (2008) – Currently being updated, for both facility and community based
- Standard Operating Procedures for Services to People Living with HIV and AIDS, 2009
- SOP for caregivers, counsellors and outreach workers for supporting PLHIV, 2009
- Management of Opportunistic Infections and Post Exposure Prophylaxis – Guideline-2009
- Clinical Management of HIV and AIDS – Doctors' Handbook-2009
- Standard Operating Procedures for Drop-in-Centres for IDU and FSW, 2010
- Various training manuals and guidelines on counselling and peer education as per project needs for IDU, FSW and PLHIV-2008 to 2011
- National SOP for PLHIV Interventions (2009)- being updated currently

- Training Manual on the reduction of stigma and discrimination related to HIV/AIDS (2010)
- The National Harm Reduction Strategy for Drug Use and HIV (2017- 2021)
- HIV/AIDS stigma and discrimination toolkit (2011)
- National Nutrition Guideline for PLHIV (2012)
- ART Training Module for Doctors, 2013
- National HTC Guidelines, 2013- Updated version drafted, 2019
- National Guidelines for the Prevention of Vertical Transmission of HIV and Congenital Syphilis, 2013
- National Counselling Guidelines for Children and Adolescents Most at Risk of or Affected by HIV and AIDS, June 2013
- National Consultation on Punitive Laws Hindering the AIDS Response in Bangladesh (2013)
- Gender Assessment of the National HIV Response in Bangladesh (2014)
- National HIV Risk Reduction Strategy for Most at Risk and Especially Vulnerable Adolescents to HIV and AIDS in Bangladesh (2013-2015)
- National Anti-Retroviral Therapy Guidelines (2011) – being updated currently
- National HIV Advocacy and Communication Strategy 2017-2022
- National Harm Reduction Strategy for Drug Use and HIV (2017-2021)
- National HIV and AIDS Disclosure Guideline, 2018
- National Guidelines on the Management of TB-HIV Co-infections, 2018
- National Strategic Plan to Address Gender Based Violence for HIV response in Bangladesh (2017-2022)
- Investment case for fast track strategies: Prioritizing investment options in HIV response in Bangladesh to end AIDS by 2030 (2019)
- 4th National Strategic Plan for HIV/AIDS (2018-2022) – being revised currently
- National AIDS M&E Plan (2018-2022)
- Framework of Differentiated Care for People Living with HIV and AIDS in Bangladesh, 2019 – drafted

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

Programmatic Response

HIV prevention programs for KPs were initiated in Bangladesh in the mid-1990s and since then the services have been massively scaled up until 2013³⁰. However, the country program has improved in terms of quality and diversity over the years and from 2017,

³⁰ Govt. of Bangladesh, 2014. Concept Note on HIV and AIDS for the Global Fund New Funding Model for 2016-2017, Sept 18, 2014.

although government funding increased under the sector program, ASP could not utilize that because of wrong placement of line items in OP and that barred ASP to scale up the program coverage as intended. ASP integrated testing and treatment services into government health facilities, strengthened procurement system and improved ARV and laboratory supplies to ensure no stock out situation within 2018 and 2019³¹. The national response to HIV/AIDS is being guided by a number of well-developed strategies and guidelines. The government, in collaboration with NGOs, development partners and self-help groups and CBOs has been instrumental in supporting various prevention, treatment, care, and support activities. Most of the prevention programs are implemented through NGOs under the leadership of ASP. These programs are designed to focus on prevention initiatives among PWID, FSW, MSM, MSW, transgender women (hijras), and their intimate partners³², increase case detection and provide treatment, care and support services to PLHIV by the government.

Response to HIV/AIDS in Bangladesh since the year 2000:

Sl. #	Programmatic Response	Year	Resource (Budget)
<i>NASP/MOHFW and World Bank supported programs:</i>			
1	HIV/AIDS Prevention Project (HAPP) was the first major projects under NASP which was supported by World Bank and DFID. HAPP was implemented through GO-NGOs collaboration with assistance from UNICEF, UNFPA and WHO. More than 100 NGOs were involved in the implementation of HAPP	2004-2007	US\$ 26.3 million
2	HIV/AIDS Targeted Intervention (HATI) was supported by the World Bank financed Health, Nutrition and Population Sector Program	2008-2009	US\$ 7.8 million
3	HIV/AIDS Intervention Services (HAIS) program was supported by World Bank financed Health, Nutrition and Population Sector Program (HNPS) to implement the intervention packages for (i) brothel based sex workers, (ii) street based sex workers, (iii) hotel and residence based sex workers, (iv) clients of sex workers, MSM, MSW and hijra (v) IDUs	2009-2011	US\$ 5.6 million
4	The HIV/AIDS Prevention Services (HAPS) program is supported by the Health, Population and Nutrition Sector Development Program (HPNSDP). It implements intervention packages for FSWs, MSW, hijra and PWIDs. The HAPS will also be rolling out interventions among PLHIV and migrants as well by 2014. Funds are channelled through NASP	2011-2016	US\$ 8 million
5	HPNSDP funds channelled through NASP via HAPS will also be rolling out interventions among PLHIV and migrants and support evidence generating	2011-2016	US\$ 36 million
<i>Bi-lateral agency- supported projects:</i>			
6	Bangladesh AIDS Programme (BAP) was funded by USAID and implemented through a team consisting of FHI, Social Marketing Company (SMC), JSI Bangladesh and Masjid Council for Community Advancement with the assistance of 18 implementing partners	2000-2009	US\$ 14 million

³¹ ASP program report, and KII with Sr. Manager, ASP, Jan 2019.

³² NASP, 2014. Revised 3rd National Strategic Plan for HIV and AIDS Response 2011-2017.

Sl. #	Programmatic Response	Year	Resource (Budget)
7	Modhumita was launched as the follow on to BAP and implemented through FHI, SMC and Bangladesh Centre for Communication Programs. The project is implemented throughout the country with the support of 24 implementing agencies and other collaborating partners	2009-2014	US\$ 12 million
8	Enhancing Mobile Populations' Access to HIV & AIDS Services, Information and Support (EMPHASIS) aims to reduce the HIV vulnerability of mobile populations across the border areas of Bangladesh, India and Nepal. It focuses on women and operates as a pilot intervention in Jashore and Satkhira districts. Care Bangladesh is implementing the project in Bangladesh	2009-2014	US\$ 8.5 million (approx.US\$ 2 million for Bangladesh)
9	The Link Up programme, funded by the Dutch Ministry of Foreign Affairs, aims to improve sexual and reproductive health of young people most affected by HIV and to promote the realization of young people's sexual and reproductive rights. In Bangladesh the project is implemented by Marie Stopes Clinic Society, Population Council and HASAB	2013-2015	US\$ 10 million
10	Over the period 2013 – 2020, the Government of Bangladesh with funding support from UNICEF has been carrying out Prevention of Mother to Child Transmission of HIV (PMTCT) program in five medical college hospitals in Dhaka, Chattogram, Khulna and Sylhet. OMTCT is also supported at district and upazila levels in Sylhet and Cox's Bazar through an integrated approach and a special focus on migrants	2013-2020	US\$ 2.38 million
11	Integrate SRH in to HIV program: The project has been implemented by NASP with financial support from UNFPA. The major activities included: training and capacity building of the service providers on SRH and HIV, development of policy guidelines, advocacy and sensitization to the relevant stakeholders, etc.	2011-2016	US\$ 0.729 million
12	UNFPA current HIV program: UNFPA in Bangladesh working together with national partners to: encourage HIV testing and raise more awareness on safe sexual practices, especially among migrant workers and brothel based sex workers	2017-2019	US\$ 1.18 million
<i>The Global Fund (GF) supported programs:</i>			
13	GF Round 2: Prevention of HIV/AIDS among Young People in Bangladesh. Save the Children USA worked as management agency and 16 NGOs implemented the activities across the country	2004-2009	US\$ 19.9 million
14	GF Round 6: HIV Prevention and control among High-Risk populations and vulnerable Young People in Bangladesh. A total of 45 NGOs/CBOs and academic organizations through 13 consortiums implemented the activities	2007-2009	US\$ 40 million
15	GF Rolling Continuation Channel (RCC) R2: Expanding HIV prevention in Bangladesh	2009-2015	US\$ 59 million
16	GF's New Funding Model: Continuation of prioritized activities for the key populations in Bangladesh, with special emphasis on HIV testing and counselling. The principal recipients of the fund include: NASP, Save the Children, icddr,b	Dec 2015- Nov 2017	US\$ 18 million

Sl. #	Programmatic Response	Year	Resource (Budget)
17	GF's New Funding Request: Continuation of prioritized activities for the key populations in Bangladesh, with special emphasis on HIV testing and counselling. The principal recipients of the fund include: ASP, Save the Children, icddr,b.	Dec 2017- Nov 2020	US\$ 21.50 million
18	GF's New Funding Request: <i>Continuation of prioritized activities for the key populations in Bangladesh, with special emphasis on HIV testing and counselling.</i> The principal recipients of the fund include: ASP, Save the Children, icddr,b.	Dec 2020- Dec 2023	US\$ 23.00 million

Sources: (a) NASP, 2014. Revised 3rd National Strategic Plan for HIV and AIDS Response 2011-2017; (b) GARPR report, 2014. (c) GARPR report, 2012. (d) UNGASS report, 2010. (e) Program budgets (f) Govt. of Bangladesh, 2014. Concept Note on HIV and AIDS for the Global Fund New Funding Model for 2016-2017, Sept 18, 2014 (g) Govt. of Bangladesh, 2017. Concept Note on HIV and AIDS for the Global Fund New Funding Request for 2017-2020, November 2, 2017, **Bangladesh investment Case for HIV: Sustainable Investment Options in the National Response, 2019**

Under the OP fund and the Global fund grant, also with support from HIV PRs and different agencies, ASP put effort to conduct surveys and studies to better understand the epidemic, its context and to evaluate the program. They also tested new modalities for service delivery through piloting, operations research and assessment of current interventions. Many of these innovative interventions showed commendable results in reaching KPs, MARA, engaging and supporting community, increasing uptake of HTS and ART services, reducing non-adherence to treatment and lost to follow. The innovations and best practices include applying ICT based approach to provide IEC/BCC to hidden and hard to reach MSM and hijra, Comprehensive DIC, which is a kind of one stop service centre for PWID; DOT for ART through community case worker; Sex-Workers' community squad to address gender based-violence: this squad attends psychosocial and physical problems, does accompanied referral for psychological counselling at DIC or helps connect legal aids. DIC based micro-planning circle is another innovative approach to involve community for updating number of KP in the catchment area as well as planning how to reach and support each of them. Integrated approach for TB-HIV coinfection management is another innovation. Under the GF grant, icddr,b established/developed 60 community- based organizations (CBOs), worked on building their capacity in financial management, M&E, program management and good governance, and helping CBOs participate in program implementation. Recruiting KP community members as regular staff members to implement program are examples of replicable best practices generated in the country^{33, 34, 35}.

³³ Annual Report 2018, ASP, DGHS-MOHFW, Government of the People's Republic of Bangladesh

³⁴ Save the Children, Bangladesh, Concept Note: Strengthening Case Management of HIV positive PWID, 2018,

³⁵ Save the Children, Bangladesh, Microplanning Guidelines, 2018, Save the Children, Bangladesh

Several other interventions have been undertaken in Bangladesh targeting clients of sex workers, most at risk adolescents, migrant workers, pregnant women, children of sex workers, young people who are vulnerable to HIV infections through their high-risk behaviour. UNICEF and other agencies are supporting the implementation of these HIV/AIDS prevention initiatives and programs in the country which are managed by government and different local and international NGOs. Complementary work by the UN and other partners have focused on PMTCT, integration of STI and HIV into SRH, reducing stigma, discrimination and violence against people living with and affected by HIV through financial and technical support, advocacy, and education.

The scaling up of intervention programs across the country has recently been debated given funding restrictions and impact generation. It has been recognized that the epidemic in most countries is not uniformly distributed across a country^{36,37,38}, and that impact may be better achieved by concentrating programs in those geographical areas within a country that are more vulnerable to an epidemic. Given this realization, Bangladesh conducted a geographical prioritization exercise in 2015 which is reflected in the Investment Case of 2016³⁹. The prioritization was done considering availability of numbers of key populations and numbers of PLHIV detected through case reports which revealed that 23 districts were of high priority where coverage for individual KPs would need to be scaled up to a certain target. The target for each KP was determined by modelling exercises using AIDS Epidemic Model (AEM). Considering these variations, intervention strategies are considered among three subnational model with geographical regions (Dhaka, Priority 22 districts and Remaining 41 districts). Country response have been accordingly guided during 2017-2020 and focused on:

- prevention initiatives among PWID, FSW, MSM, MSW, transgender women (hijra), and their intimate partners;
- increase case detection;
- provide treatment, care and support services to PLHIV; and
- address other cross cutting thematic interventions across all KPs and general populations.

³⁶ NASP. (2011). National HIV Serological Surveillance, 2011. National AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh.

³⁷ NASP. (2015). Behavioural and Serological Surveillance on males having sex with males, male sex workers and hijra, 2015. National AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh. (unpublished)

³⁸ NASP. (2017). Behavioural and Serological Surveillance amongst Key Populations at Risk of HIV in Selected Areas of Bangladesh, 2016. National AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh. (unpublished)

³⁹ NASP. (2015). INVESTMENT CASE: Prioritizing Investment Options in HIV Response in Bangladesh to End AIDS by 2030, with financial and technical assistance from UNAIDS

It is critical to continue effort to determine the most efficient and effective approach to reduce new infections by utilizing limited resources available for response to HIV and AIDS. Investment case analysis is an important tool for understanding the return from investments on HIV prevention and treatment, whether the interventions have some impact on reducing new infections and AIDS deaths, and the return on investment. Bangladesh needs to ensure that the limited resources available are spent where they would have the maximum impact. Under this circumstance, the ASP with support from UNAIDS conducted 'Investment Case' 2019 exercise to identify priorities and solutions to increase the effectiveness, efficiency and sustainability of the national response to HIV.


The process was based on the analysis of country-level evidences to address HIV epidemics effectively, and to ensure that the response to HIV was both efficient and sustainable. It holistically investigated the existing prevention programs, case detection, treatment, care and support programs among different key populations (e.g. FSW, MSW, MSM, hijra, and PWID), people living with HIV (PLHIV), clients of sex workers, young people, etc. to showcase the best possible return on investment against specific interventions⁴⁰.

The Key Messages from 'Investment Case' 2019

Investing in prevention yielded significant savings on treatment costs and made the program affordable over the long period. The key to significantly reducing new HIV infections would be to scale up both the prevention coverage among the KPs, and the ART coverage among PLHIV simultaneously by using strategic approaches through PMTCT, addressing of HIV-TB & Hepatitis co-infection, focusing on migrants, implementing integrated interventions for clients of sex workers and informing vulnerable adolescents through the existing SRH services.

Scale of the current program to reach the "targets as set in the NSP" would be a feasible investment option in terms of sustainability and program effectiveness. It would produce high-impact to achieve new treatment targets (90-90-90) and would come very close to achieving the "Ending AIDS by 2030" target. With an average investment of USD 21.7 million per year to adopt the targets set in the NSP, new HIV infections could be reduced to 338 per year by 2030 and HIV would no longer be a major public health concern. Every single USD spent now could generate a return of approximately 4.5 USD in general.

For implementing the sustainable and cost-effective investment option in HIV, the investment case study recommended implementation of the following strategies:

-  Scale prevention efforts as per the NSP. This would in-turn:
 - Reduce 'high-risk' network among PWID

⁴⁰ ASP, UNAIDS, Bangladesh Investment Case for HIV: Sustainable Investment Options in The National AIDS Response, 2019

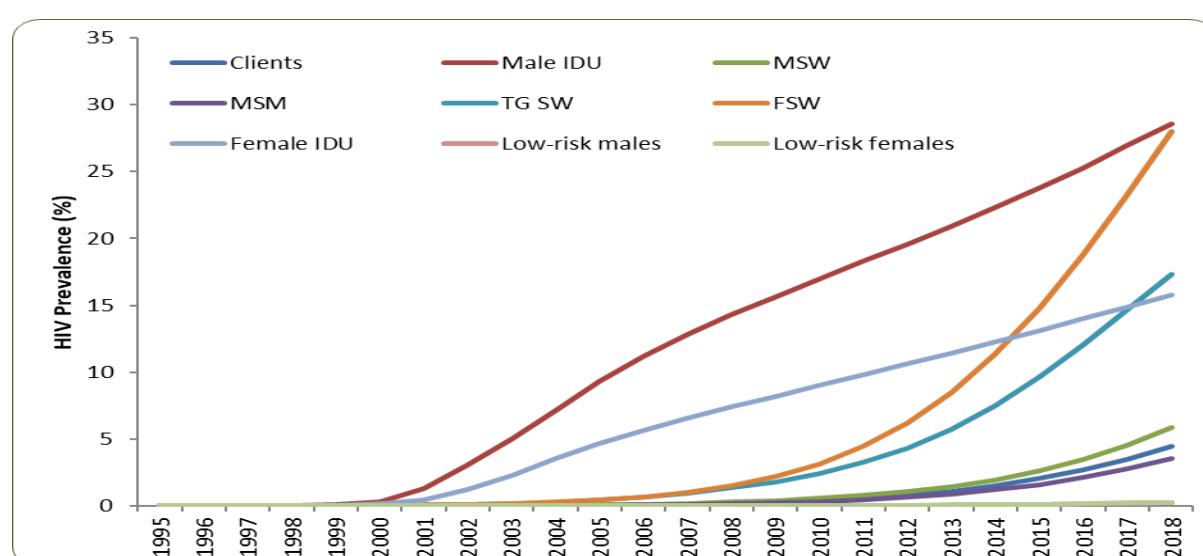
- Intensify OST coverage and link with rehabilitation programs
- Enhance focus on key populations in programmatically prioritized districts
- 🚫 Increase efforts to reach the 90-90-90 targets:
 - Increase case detection
 - Use new technologies and test for triage
 - Scale up treatment, care and support
 - Ensure adequate supply of ARV drugs
- 🚫 Ensure adequate resource mobilization
- 🚫 Build on existing systems and experiences to maximize efficiency
- 🚫 Consideration may also be placed on awareness programs
- 🚫 Continue the perusal towards law and policy reform
- 🚫 Integrate and mainstream HIV agenda in multiple sectors:
 - Universal health coverage: All prevention, treatment, care and support efforts need to be aligned with the broader areas of universal health coverage. HIV MUST BE BROUGHT OUT OF ISOLATION. For instance, integrated services for the prevention of new HIV infections among children could be a part of the IMCI interventions, the Adolescent Corners could be used to reach more adolescents and youth, ANC services should be inclusive of the triple elimination agenda. Moreover, services for STI, SRH, TB and Hepatitis can be integrated with mainstreamed health system and that would reduce all unit costs and increase the cost-benefit ratio. These efforts would add to cost-efficiency, sustainability and would reach more people.
 - Multi-sectoral engagement: The HIV response in Bangladesh should be functionally expanded beyond the health sector to other key ministries including Ministry of Women and Children Affairs (MoCWA); Ministry of Expatriates' Welfare and Overseas Employment (MoEWOE); Ministry of Social Welfare (MoSW); Ministry of Youth and Sports (MoY&S); Ministry of Law, Justice and Parliamentary Affairs (MoLJPA); among others.
- 🚫 Maintain updated strategic information
- 🚫 Engage communities: PLHIV and KP networks and organizations need to be an integral part of all processes that lead up to implementation of interventions. Their needs to be well addressed to ensure maximum gains and to reduce stigma and discrimination.

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

AIDS Epidemic Model (AEM) analysis demonstrated that the ongoing interventions have averted a total of 704,051 HIV infections among adult population since 1995. The interventions also saved 76,861 lives and 4,486,000 DALYs over the past years. In the absence of any HIV intervention programs since 1995, the total number of PLHIV could be 640,859 by the end of 2018. The estimated death among PLHIV was 22,323 in the year 2018.

If there were no HIV interventions since 1995, the prevalence of HIV among male PWID could be 28.6 percent in 2018. Similarly, the HIV prevalence among FSW, in the absence of any intervention, could reach 28.0 percent in 2018 as compared to less than 1 percent, with existing interventions. Moreover, if these programs were discontinued since 1995, HIV prevalence among TG, female PWID, MSW, MSW and clients of sex workers would be on the rise between 1995 and 2018. If the current prevention programs among KPs discontinued after 2020, the estimated PLHIV in Bangladesh would reach 81,154 by 2030 and the most affected group would be the ‘clients’ of sex workers. Out of 16,562 new HIV infections in 2030 nearly 58 percent would be the ‘clients’ of sex workers. In Dhaka, almost all KPs would have a concentrated epidemic.

Figure: 2: HIV prevalence in Bangladesh if there were no HIV interventions since 1995



Prevention of HIV transmission from infected mothers to their unborn children is a global priority area where significant progress has been achieved in Bangladesh through UNICEF support over the past years. PMTCT was introduced at twelve public health facilities including tertiary level reference hospitals and HIV prevention and treatment coverage for pregnant women had increased⁴¹. The awareness building programs among young people as well as life skills education has also acted as a change agent in the lives of many young people⁴². Through the school education and upazila level advocacy program, community support was boosted to a significant extent⁴³.

⁴¹ UNICEF, PMTCT Program Data

⁴² Govof Bangladesh, 2007. Improving access to life skills based sexual and reproductive health education and condom services for male youth, 2007. National AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh and Save the Children USA.

⁴³ Govt. of Bangladesh, 2008. Endline HIV/AIDS survey among youth in Bangladesh 2008: An assessment of HIV/AIDS related knowledge and attitudes among youth, gatekeepers, community leaders and policy makers. National

2.4 Key Challenges

Although Bangladesh is considered to be a low prevalence country for HIV, it remains extremely vulnerable due to overpopulation, gender inequality, high mobility of the population within the country and high levels of transactional sex. Migration to other countries for employment is also very common, particularly amongst younger people⁴⁴. Stigma and discrimination against PLHIV are prevalent in Bangladesh and inhibits both the physical and mental well-being of those carrying the HIV. Stigma and discrimination against PLHIV and key populations result in many adverse consequences, such as, delay in HIV testing, the restricted adoption of preventive programs and preventative behaviours like condom use and HIV status disclosure, barriers to access services from public health facilities and barriers in a normal socio-economic livelihood, among others⁴⁵. A qualitative study conducted in 2017 to understand the willingness of KPs to uptake the STI services of public healthcare facilities found most participants were either resistant or unwilling to visit public healthcare facilities because of their previous first-hand experiences of disrespectful and judgmental attitudes and behaviours and perceived discrimination, anticipatory fear, and lack of privacy⁴⁶. Despite widespread recognition of the existence of stigma and discrimination towards PLHIV and key populations, there remains a critical programmatic gap within many national responses to HIV. It is essential to include some effective steps in a cohesive national program to reduce the risk of HIV transmission, to improve overall well-being of key populations and PLHIV. Major challenges include capacity of service providers to deliver services sensitive to age, gender, human rights and individual needs and issues associated with lack of knowledge and education of HIV and AIDS in Bangladesh. The analysis of programmatic gaps and existing barriers are summarized below:

Policy and governance:

HIV program is still in the silo; it should be brought out of isolation. Although, understanding and effort have been there to make the program multisectoral – much to be done to engage relevant sectors to accelerate response to HIV and AIDS in the country and mobilize resources, that will in turn enhance program coverage for both prevention and treatment as well as universal access to health services and overall

AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh and Save the Children USA.

⁴⁴ Govt. of Bangladesh, 2014. Concept Note on HIV and AIDS for the Global Fund New Funding Model for 2016-2017, Sept 18, 2014.

⁴⁵ PLHIV Network, Nov 2017, Stigma Index

⁴⁶ Gourab G, Khan MNM, Hasan AMR, Sarwar G, Irfan SD, Reza MM, et al. (2019) The willingness to receive sexually transmitted infection services from public healthcare facilities among key populations at risk for human immunodeficiency virus infection in Bangladesh: A qualitative study. PLoS ONE 14(9): e0221637. <https://doi.org/10.1371/journal.pone.0221637>

wellbeing of KPs and PLHIV in Bangladesh. Advocacy issues are considered to be a priority activity to create awareness and mobilize both political commitment and relevant sectors' support for the national response to HIV and AIDS. To facilitate uninterrupted and smooth HIV programs, effective advocacy initiatives need to be planned with key ministries, departments and sectors. Advocacy effort for mainstream HIV is still inadequate⁴⁷.

The AIDS/STD programme is part of an Operational Plan titled 'Tuberculosis-Leprosy and AIDS STD Programme (TB-L & ASP) under 4th Health, Population and Nutrition Sector Programme (4th HPNSP). Currently, government has been procuring and ensuring supplies of ARV to 10 public health facilities as well as 6 other NGO facilities across the country, ASP also managing the treatment programme by the government revenue and OP manpower but the other planned activities under the OP, especially increasing coverage of prevention programs for KPs are yet to be implemented (OP, 4th HPNSP, 2017-2022).

Laws and legal impediments: Sex work in private is legal in Bangladesh, however other aspects are criminalized, including soliciting in public, keeping a brothel or allowing premises to be used as a brothel and living on the earnings of sex work. Also, carrying information and educational material for HIV prevention may also be considered a punishable act under the current laws. These laws hinder effective HIV responses and impede FSW access to justice, especially when they experience violence⁴⁸. A study conducted in 2013 found that about 39% of street based FSW faced sexual violence in the last 12 months. PWID also reported facing high levels of violence⁴⁹. This is also true for MSM and hijra⁵⁰, and the legal framework in section 377 Bangladesh Penal Code criminalizes male to male sex⁵¹. Effort has taken to review the laws which hindering the HIV services for different KPs through forming the high level committee in ministry level. This should be strengthened for policy reform through continuous advocacy with law makers and law enforcing agencies to decriminalization of KPs is important to provide essential services.

Treatment, care and support: Treatment, care and support services for PLHIV had been provided through NGOs/SHGs, until recently. Since the end of 2012, the government has taken responsibility for procuring ART and since 2015 started providing ARVs from selected government hospitals through collaboration with NGOs under the HPNSDP, and currently providing ART services from 10 public health facilities including tertiary level

⁴⁷ Stakeholders Consultation meeting, Thematic Group: Advocacy and Integration, December 2019,

⁴⁸ UNDP, 2012. Sex work and the law in Asia.

⁴⁹ Save the Children. (2012). Report on Mid-term survey on expanding HIV/AIDS prevention in Bangladesh, RCC program, funded by the Global Fund. The Nielsen Company (Bangladesh) Limited.

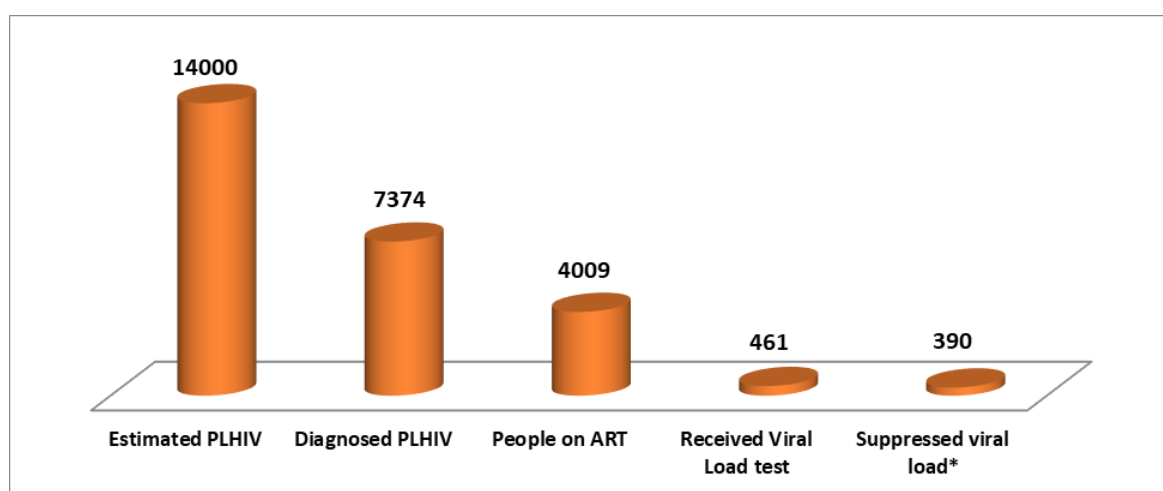
⁵⁰ Khosla N. (2009). HIV/AIDS interventions in Bangladesh: what can application of a social exclusion framework tell us?. Journal of health, population, and nutrition, 27(4), 587–597.

doi:10.3329/jhpn.v27i4.3404

⁵¹The Penal Code, 1860, Bangladesh

hospitals. By 2017, government has taken over full responsibility of procuring and ensuring ARV supplies to the ART centres, although 6 comprehensive drop-in centres are still delivering ART services to the PWID PLHIV under government supplies. As of December 2019, 52.67% of estimated cases of HIV are identified and 65.38% of them are receiving Antiretroviral Therapy (ART) ⁵², recently ASP started viral load testing using GeneXpert machine and found a significant number of patient are suppressed.

Figure: 3 Cumulative cross- sectional cascade for HIV Treatment and Care, Bangladesh, 2019



Source: ASP, WAD 2019

A comprehensive framework for differentiated ART services has been developed to formulate and define the role of health service delivery and community engagement to ensure treatment adherence and other care & support components for PLHIV. Effective monitoring of treatment adherence needs to be ensured to prevent HIV from multiplying as well as protect the immune system of PLHIV and reduce the risk of both drug resistance and HIV treatment failure.

Further, poor nutritional status of PLHIV speeds up progression from HIV to AIDS and may increase the incidence of AIDS related deaths. Evidence shows that, ART initiation with poor nutritional status may increase mortality among PLHIV⁵³. The nutritional support to PLHIV needs to be integrated into the existing program through involving relevant sectors like social welfare. According to the National Social Security Strategy (NSSS), households with HIV affected members have similar eligibility to Social Security programs as other

⁵² ASP, Keynote Presentation, Wad, 2019.

⁵³ Ref: Koethe JR, Lukusa A, Giganti MJ, Chi BH, Nyirenda CK, Limbada MI, et al. Association between weight gain and clinical outcomes among malnourished adults initiating antiretroviral therapy in Lusaka. Zambia J Acquired Immune Deficiency Syndrome. 2010;53:507–13

households⁵⁴. More effort should be put to link PLHIV in the existing social safety net programs. Government is strongly commitment to make its strategy more sensitive and responsive to the needs of HIV/AIDS affected people.

Low coverage of prevention, treatment, care and support services: The coverage of the ongoing intervention programs has been reduced significantly since 2014 when the country lost donors because of its moving into Low Middle Income Country status. Although government commitment increased through OP of the 4th HPNSP 2017-2022, ASP program could not utilize OP funds for KPs intervention because of wrong placement of line items in the OP⁵⁵. As a consequence, prevention program coverage for KP interventions went down. Currently, PWID coverage is 28.7% (9,500/ 33,067), FSW coverage is 21.6% (22,100/ 102,260), MSM coverage 21.3% (28,000/131,472), transgender/Hijra coverage is 39.8% (4,062/10,199) against national size estimation^{56, 57}.

Currently, procurement process and resource availability have been strengthened, however, procurement system must be reviewed to make it quicker and less expensive in order to cope with increased demand resulting from implementing “The test and treat modality” in the country.

Many FSW especially those operating through hotels and residences are hidden and difficult to access mainly for reasons of stigma and discrimination⁵⁸. Reaching MSM is also very difficult as they hide their identity because of stigma attached to the practice and are reluctant to visit drop-in centres (DICs) and other HIV specific services. A study on hijra showed that the proximity of DICs as well as their high mobility are key factors affecting uptake of services⁵⁹. For PWID, there are also significant service gaps when it comes to opioid substitution therapy (OST), and services for partners of PWID. Hepatitis C virus (HCV) is a crucial issue for PWID; national guidelines is being developed by CDC in collaboration with HIV program. Integration within relevant department of health system would be the key to address co-infection among PLHIV and KPs.

Women living with HIV (including female KPs) experience barriers to access to maternal and child health services (MCH) and they often experience disproportionately high rates of unintended pregnancy and abortion. For example, a survey of FSW in Bangladesh

⁵⁴ General Economic Division, Planning Commission, Government of People’s Republic of Bangladesh, March 2015, National Social Security Strategy (NSSS) of Bangladesh

⁵⁵ KII with Sr. Manager, NFM, ASP

⁵⁶ Program data, 2018

⁵⁷ ASP,UNAIDS and SC, Size Estimation of Key Populations in Bangladesh, 2015-16

⁵⁸ Govt. of Bangladesh, 2009. Understanding the operational dynamics and possible HIV interventions for residence-based female sex workers in two divisional cities in Bangladesh. Dhaka: National AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh, Save the Children USA and icddr,b, 2008.

⁵⁹ Rana, A. K. M., Reza, M. M., Alam, M. S., Khatun, M., Khan, S. I., & Azim, T. (2016). Effects of in-country and cross-border mobility on condom use among transgender women (HIJIRAS) in Bangladesh: a cross-sectional study. *AIDS and Behaviour*, 20(10), 2165-2177. <https://doi.org/10.1007/s10461-015-1275-8>.

found that 60% had an unmet need for family planning compared to 16.8% of married women ages 15–49⁶⁰. Effectively addressing unmet contraceptive needs is a key element of preventing mother to child transmission (PMTCT) ⁶¹. This gap stems from the inadequate linkages between SRH and HIV services.

Access to SRH services: In addition to HIV prevention services, FSW and female injecting drug users need access to sexual and reproductive health (SRH) services and childcare. The MSM, MSW and Hijra also need SRH services including their female sex partners. The SRH services of MSM, MSW and hijra are being addressed under the GF grant to some extent, which needs to be further enhanced. The KPs have limited access to the existing health system for SRH services due to stigma and discrimination. Government’s initiatives to Universal Health Coverage (UHC) should create enabling environment, infrastructure and skilled providers in the existing health system for providing SRH services to KPs including MARA and PLHIVs as well as EVA. Integrated HIV, STI and SRH care should also be made available for spouses of KPs, potential and returnee migrants and their spouses.

Access to HTS: HTS is accepted as a critical entry point for both HIV prevention and treatment services. In Bangladesh, only 52% of the estimated PLHIV are aware of their HIV status. Most PLHIV only discover their HIV positive status after already developing AIDS. In 2013, 56% of newly diagnosed PLHIV had a CD4 count below 200 cells/cubic mm⁶². KP’s access to HTS is limited not only because of inadequate numbers of HTS centres but also because of prevailing stigma and discrimination against these groups. ASP taken initiative to established HTS center in all priority district, meanwhile 28 public health facilities already started testing and counselling. The GAMCA under overseas employment ministry testing every yearly about 800,000 potential migrant, which report is receiving by ASP every year. Earlier there were big gap in the information sharing. A recent study reveals that less than 50% of the KPs are tested for HIV in last 12 months and know the results as against of the target of 90%. HIV testing is even lower among the young KPs aged below 25 years⁶³.

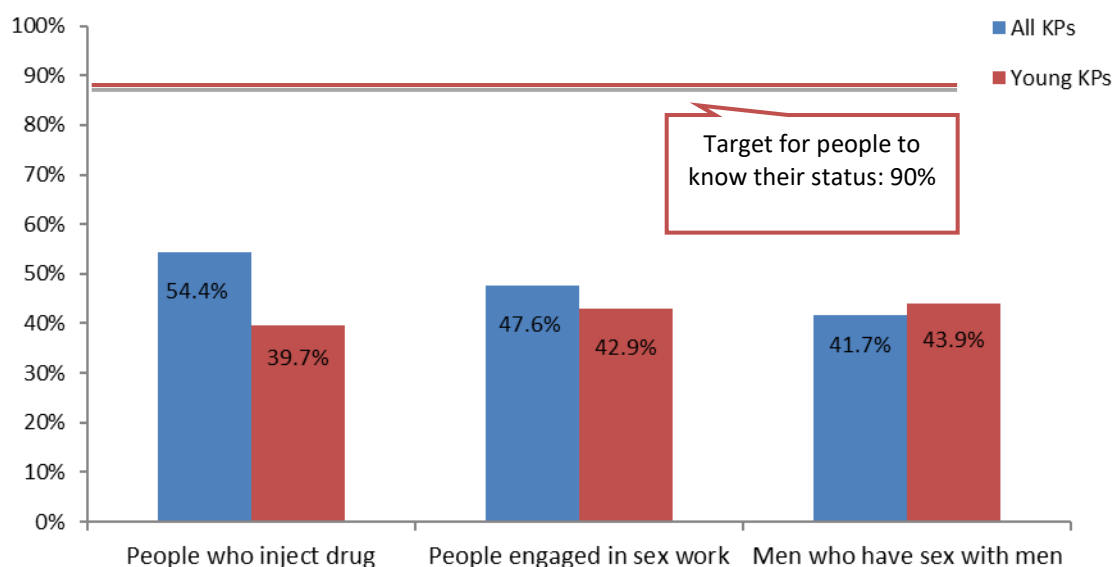
⁶⁰ Petruney T, Minichiello S N, McDowell M and Wilcher R, 2012. Meeting the contraceptive needs of key populations affected by HIV in Asia: An Unfinished Agenda. Hindawi Publishing Corporation. AIDS Research and Treatment, Volume 2012, Article ID 792649.

⁶¹ UNFPA, 2011. Preventing HIV and unintended pregnancies: strategic framework 2011–2015.

⁶² Govt. of Bangladesh, 2014. HIV case detection in Bangladesh: Summary report, 2007-2013. National AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh (unpublished).

⁶³ ASP, 2016. Mapping Study and Size Estimation of Key Populations in Bangladesh for HIV Programs. Dhaka, Bangladesh: Directorate General of Health Services, Ministry of Health and Family Welfare.

Figure: 4 Percent of KPs and young KPs tested for HIV and know the result



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

In order to increase the case detection, community led testing and treatment approaches should be strengthened.

To respond to emerging risk and higher vulnerability: There are population groups among whom higher rates of risk behaviour or vulnerability have been clearly identified in Bangladesh or elsewhere. These groups include international migrant workers, especially vulnerable children and adolescents, prisoners, non-injecting drug users, clients of sex workers and sex partners of people from key populations. Information on and interventions for these groups are inadequate to achieve significant change. Migrants and their spouses comprise a significant proportion of all identified cases and interventions to bring this group under prevention and treatment services piloted in the country⁶⁴. It is important to review and scale up effective interventions for this group urgently. Intimate partners of KPs, especially wives of PWID and MSM are at emerging risk of infection because of their partners' high-risk behaviour including non-disclosure of their infection status because of the fear of stigma and discrimination⁶⁵.

⁶⁴ UNICEF, OKUP, Lesson Learned and Project Completion Report, 2019: Community-based awareness on safe migration and PMTCT reduce migration related risks and HIV infections among migrants, spouses and children

⁶⁵ ASP, HIV and AIDS, Disclosure Guidelines, unpublished

Approximately 10 percent of men in Bangladesh reported having ever bought sex from female sex workers⁶⁶. In the national survey among youth in 2008, almost 20 percent of unmarried males reported having premarital sex and for 28 percent of these respondents, the last sex was with a sex worker. About one in three (28%) young people who have ever had sex reported one or more symptoms of an STI in the past 12 months, but only a quarter sought treatments from a trained provider⁶⁷.

A mapping by the National AIDS/STD Programme (NASP) reported that there were 2,389 Children Infected and Affected by HIV and AIDS (CABA) in Bangladesh. CABA refers to children (up to 18 years) who are infected with HIV or whose parents or other caregivers are HIV-infected or have died of AIDS, even if the children themselves are not HIV positive. Amongst the CABA mapped in Bangladesh, there were 248 children orphaned due to AIDS⁶⁸. Special interventions should be taken for Children Infected and Affected by HIV and AIDS (CABA) and Orphans and Vulnerable Children Affected by HIV/AIDS (OVC).

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

Low awareness regarding HIV and AIDS among the general population: Data on the general population show that there is widespread lack of knowledge and skills required to protect oneself and others: 30% of ever married women aged 15-49 years had never heard about HIV or AIDS, and only 11 percent have comprehensive knowledge about AIDS⁶⁹. Low awareness regarding HIV and AIDS among the general population is of concern as it may affect behaviours of potential clients of sex workers and of those who migrate abroad for work.

Lack of facilities for laboratory services: Achieving first and third 90 of the “90-90-90” fast-track strategy to end AIDS by 2030 depends on laboratory service. HIV Case detection rate is a bit more than 50% and viral load testing has just started in the country⁷⁰. HTS needs to be scaled up to all priority districts as well as to the selected

⁶⁶ National AIDS/STD Programme (NASP), Directorate General of Health Services Ministry of Health and Family Welfare (MOHFW). Baseline HIV/AIDS survey among youth in Bangladesh – 2005 “Project on prevention of HIV/ AIDS among young people in Bangladesh.”, 2005

⁶⁷ NASP, Save the children, 2008, Assessment of HIV/AIDS related knowledge and attitudes among youth, gatekeepers, community leaders and policy makers in Bangladesh, 2008

⁶⁸ National AIDS/STD Programme (NASP), Ministry of Health and Family Welfare Bangladesh, Ashar Alo Society and UNICEF. 2013. Comprehensive Mapping of Children Infected and Affected by HIV and AIDS in Bangladesh.

⁶⁹ NIPOORT, et. al. 2016. Bangladesh Demographic and Health Survey 2014. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPOORT, Mitra and Associates, and ICF International.

⁷⁰ ASP, Keynote presentation, WAD, 2019

public health facilities of remaining districts. There's no facility for testing drug resistance and viral genotype in the country except Bangabandhu Sheikh Mujib Medical University (BSMMU), virology laboratory. Currently BSMMU provides support as a national reference laboratory, conduct external quality assurance, as well as viral load testing and early infant diagnosis. Establishing a national reference laboratory, network of lab facilities, and equipping them properly including developing national policies, plans, protocols and guidelines is a priority, procuring and maintaining necessary equipment also essential. Capacity building of the service providers, proper monitoring, reporting and quality assurance of lab services need to be ensured⁷¹.

3.0 National Strategic Plan 2018-2023

3.1 Guiding Principles

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

Evidence-based interventions for maximum impact

In order to achieve “Ending AIDS by 2030” in Bangladesh, it is imperative that all funding, interventions and activities are aligned with “90-90-90” targets through cost efficient tested models. Scale of the current program to reach the “targets as set in the NSP” would be a feasible investment option in terms of sustainability and program effectiveness.

Addressing human rights related barriers to access services

Ending HIV as a public health problem is possible- through years of experience and greater understanding world has gained that ability now. However, along with implementing targeted interventions for people at highest risk and living with HIV or most affected by HIV, it is extremely important to address the vulnerabilities that lead to HIV infection. Globally key populations and their partners account 54% of new infections and HIV prevalence among young women of 15-24 years is 60% higher than among young men of the same age. Violations of human rights, including gender inequality and gender-based violence, constitute major vulnerabilities to HIV infection, as well as major barriers to HIV and other health services⁷².

⁷¹ Working paper on Laboratory Services, 4th NSP Review, December 2019

⁷² GF , Technical Brief, 2019

“One of the common lessons learned in a diversity of geographic, epidemic and cultural settings is that providing a comprehensive set of services tailored by and for the people in greatest need—and removing gender- and human rights-related barriers to service access—is a winning formula that alters HIV epidemics.” UNAIDS Global AIDS Update, 2019

Human rights are standards that recognize and protect the dignity of all human beings. Basic principles of UN Human Rights Framework include: Universality and inalienability, indivisibility, interdependence and inter-relatedness, equality and non-discrimination, participation and inclusion, accountability and rule of law⁷³.

Bangladesh’s national response included interventions to remove stigma, discrimination against KPs and PLHIV, reduce gender-based violence, provide services sensitive to adolescent and youth, sensitizing law makers and law enforcement agents, legal literacy (know your rights) and legal services⁷⁴. ASP, icddr,b and UNAIDS formed a National Task Force (NTF) in 2019 to address the human rights of the KPs⁷⁵. The country has been progressing towards addressing human rights for marginalized people: on 11 November 2013, Hijras were recognized as a separate gender in a cabinet meeting⁷⁶, In December 2014, the Ministry of Social Welfare invited hijras to apply for government employment⁷⁷ and in April 2019, it was reported that Bangladesh will allow the "hijra" to vote under their proper gender identity, as officials have introduced "hijra" as a third gender option on voting forms for the first time⁷⁸.

This revised NSP further emphasizes expanding existing interventions and inclusion of interventions effective in removing human rights-related barriers to HIV services, such as training for health care providers on human rights and medical ethics, reducing discrimination against women in the context of HIV and monitoring and advocacy for reforming laws, regulations and policies relating to HIV and involving KPs, PLHIV and vulnerable populations at every stage of program development, implementations and monitoring in order to develop a positive response based on human-rights that enables the country to end HIV by 2030.

⁷³ <https://www.unicef.org/child-rights-convention/what-are-human-rights>

⁷⁴ Annual Report, 2018, ASP, DGHS, MOHFW

⁷⁵ ASP, icddr,b, Program report, 2019

⁷⁶ Karim, Mohosinul (25 October 2014). "Hijras Now a Separate Gender". Dhaka Tribune. Archived from the original on 10 September 2017. Retrieved 9 September 2017.

⁷⁷ “Abuses in Bangladesh’s Legal Recognition of Hijras’. Human Rights Watch, 23 December 2016

⁷⁸ 29 April, 2019, "Bangladesh gives voting rights to hijra community". PinkNews- Gaynews, reviews and comment from the world’s most read lesbian, gay, bisexual, and trans news service

Prevention to care continuum

A keystone of the response to HIV/AIDS is the recognition and adoption of programs that address the epidemic in a holistic manner from prevention to care, treatment, and support. This National Strategic Plan has set 40-90% coverage (see detail for each KP in the RBFW) for prevention services in 23 priority districts where high impact is needed and 50% of coverage in remaining districts. 90% of the KPs reached, will receive HTS and 81% of the people identified with HIV will receive ART within the shortest possible time after being detected and 95 to 100% of them will be supported to continue ART and 90 % of them will be tested for viral load. PLHIV and KPs will be linked with support services like psychological counselling, treatment for OIs, STI, screening for TB and hepatitis, nutrition support, shelter, social safety net and legal aid.

Integration of services

“Integration is about a question how to deliver the services to them who need it. The aim is to provide services which are not disjointed for the user and which the user can easily navigate and for specialist care, the issue is how their activities are linked to other services.” Integration may mean a package of preventive and curative health interventions, or a multi-purpose service delivery points for those who need that. It may mean achieving continuity of care over time, or even a well-developed referral mechanism. e.g. a vertical integration can be from upazila to tertiary level hospital. Integration can mean working across the sector⁷⁹.

Stronger integration between Sexual and Reproductive Health (SRH) and HIV interventions lead to a number of better health outcomes as well as make the services cost efficient and sustainable. For our country, strengthening coordination/partnership and integration within different departments of government health system, health care facilities run by private sector and NGOs to manage of co-infections such as HIV,TB, hepatitis, sexually transmitted infections (STIs) and integrated HIV services into ANC and SRH will make these services available and accessible for the KPs and other vulnerable groups. This is also important to remember that KPs’ needs are different and without piloting through implementation science approach, any form of integration for KPs may not work.

Quality improvement and quality assurance

Quality programs are essential for generating impact as well as creating and ensuring high demand for services. Quality assurance is a continuous process and measurement of quality is therefore of utmost importance. Effort should be intensified to regularly

⁷⁹ WHO- making Health System Work, 2008, https://www.who.int/healthsystems/technical_brief_final.pdf

monitor, review and ensure high quality service delivery throughout the continuum of prevention, treatment, care and support services.

Community involvement and engagement

Without active participation of those who are and will be most affected, goal of achieving End of HIV by 2030” is impossible. KPs, CBOs, PLHIV community groups and networks need to be meaningfully engaged in the overall HIV response including research, development, design, implementation and monitoring of prevention, treatment, care and support interventions; Active participation of the community will complement the efforts of the public health sector. Effort should be put on developing social accountability mechanisms, community knowledge and system strengthening⁸⁰.

Public private partnership

Public-private partnership is necessary for a comprehensive and innovative and sustainable HIV response. Opportunities to be explored to mobilize resource and engage private sectors to accelerate country response to HIV and AIDS.

Gender based approaches

Gender equity is a cornerstone for effective HIV responses as inequity places women and transgender people at higher vulnerability. Addressing GVB is essential to contain HIV epidemic. National strategy to address gender-based violence encourages a two prong way to address gender-based discrimination and violence through developing a key population-inclusive gender program and incorporate this agenda into mainstream development activities and institutional governance structure in order to improve GVB awareness, information, support and services. Strengthening reporting system to document the GBV and human rights (already initiated by icddr,b) will help achieve the agenda.

Multi-sector engagement

As HIV is not just a health issue, engagement of different sectors beyond health is necessary for ensuring an all-encompassing response by mobilizing resources, linking and integrating services in order to develop a sustainable response to HIV and AIDS and achieve country commitment to SDGs.

Coordinated approach

Harmonization of efforts across the programs and among all partners including government and non-government sectors, implementing agencies, donors and technical agencies is fundamental to maximizing the success of this strategy. Effort should be continued to strengthen coordinated approach to involve multisectoral stakeholders at

⁸⁰ GF- Technical Brief, 2019

all level of research, development, implementation and monitoring of a high quality, cost effective, and human right -based sustainable national response to end AIDS by 2030.

Broad political commitment

The 2016 UN Political Declaration on Ending AIDS: on the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030, will guide in addressing the critical linkages between health, development, injustice, inequality, poverty and conflict. The UNGASS declaration 2001 states “Leadership by Governments in combating HIV and AIDS is essential and their efforts should include communities and private sector. Leadership involves personal commitment and concrete actions”. Generating broad-based political will, with accountable leadership and governance, will eliminate silos between HIV and mainstream development activities that are being implemented to achieve SDG by 2030 in the country. Developing issue briefs on epidemiology, impact of the effective interventions and tested models both local and global, benefits of integrated approach and sharing through advocacies will help generate political will and leadership.

3.2 Response Approach

The National Strategic Plan identifies priorities and describes the components of specific strategies. The strategies are specific, measurable, attainable, and relevant and time bound in order to guide a coordinated approach. The revised NSP 2018-2023 will have following approaches:

- The National Strategic Plan will be used as a framework for a coordinated approach between government, implementing agencies, other partners and donors across programs to scale up and improve service delivery;
- Service delivery models could consider using the management support agency approach in case of government funded interventions to gradually strengthen public services through transferring technical knowledge and support and generating ownership, and to adequately track performance based on strong monitoring;
- Geographical targeting and coverage obtained through the Investment Case will be considered for programming. Besides, HIV prevention intervention needs to be continued in strategically important districts (e.g., bordering districts, districts where the KPs are concentrated, presence of sex trade in a district, etc.);
- Prevention and HTS coverage will be enhanced by ensuring community-led and community based, self-testing and integrated interventions strategically planned, delivered and monitored to address emerging challenges and improve quality of services;
- Differentiated HTS and ART delivery will be implemented involving community to achieve 90-90-90 targets;

- Evidence will be gathered and analysed regularly to monitor the epidemic and to better understand and devise novel methods to provide effective services for different population groups;
- Behaviour change communication strategies will be adapted using innovative technologies including social media and mobile phone-based apps, print media and national TV and FM suitable for key, vulnerable and general populations;
- Increased need for high quality treatment, care and support will be met by facilitating all relevant actors across multiple sectors, improving coordination and scaling initiatives for building capacity of service providers across government, non-government and private sectors;
- Laboratory capacity for measuring viral load, monitoring ARV drug resistance and for better diagnosis of OIs will be enhanced through developing national reference laboratory and divisional laboratory networks. Laboratory service strengthening will be done as a part of health systems strengthening;
- Conducting needs assessment and resource mapping as necessary steps to design intervention to serve KPs needs and plan advocacy for multisectoral engagement;
- Decentralization and strengthening of local level management and coordination through engaging hospital directors, DCs, Civil surgeons or representatives from their offices;
- Need for pre and post exposure prophylaxis will be assessed and availability will be enhanced accordingly;
- Human-rights based approach will be adopted to remove barriers and maximize service access by marginalized populations through training and sensitizing service providers to deliver services sensitive to age, gender and individual requirement;
- Self-help groups and networks for key populations and PLHIV will be involved in all aspects of the national response through capacity development and their involvement in the areas of advocacy, policy, development and implementation of intervention and inclusion in decision making structures;
- Migrants and their families will be reached in migrant prone areas through UHC and FWC and Community Clinics and public health outreach workers to raise awareness and provide integrated HIV and SRH services;
- Integrating triple elimination of HIV, Syphilis and Hepatitis B with ANC services through public health facilities and networks like Obstetric and Gynaecological Society of Bangladesh;
- Capacity to implement the national HIV plan will be strengthened through a comprehensive approach to develop human resources, M&E system, supply and procurement system, strengthening health and community systems and
- Capacity of ASP will be strengthened for effective management and coordination with all stakeholders for a harmonized and accelerated response to HIV and AIDS

3.3 Strategy Framework

Goals:

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

Specific objectives:

1. To implement services to prevent new HIV infections by increasing program coverage and case detection;
2. To provide universal access to treatment, care and support services for the people living with HIV;
3. To strengthen the coordination mechanisms and management capacity at different levels to ensure an effective national multi-sector HIV/AIDS response; and
4. To strengthen strategic information systems and research for an evidence-based response.

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

3.3.1 Strategies:

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

Strategies:

- 1.1 HIV case detection increased, HIV and STI transmission minimized and risk behaviours reduced among key populations through comprehensive targeted interventions, provision of services sensitive to age, gender and human-rights and effective involvement of communities
- 1.2 Increased case detection, reduction of risk behaviours and provision of services for populations at emerging risk and vulnerable groups through awareness raising and interventions to link them to integrated STI, HIV and SRH service
- 1.3 Increased case detection and reduction of risk behaviours among general population and young people through awareness raising and linking them to SRH and HTS services
- 1.4 Strengthening of HIV and STI prevention and other SRH services in public health care settings and functional linkages for co-infections (e.g. TB, Hepatitis etc.) and triple elimination of mother to child transmission of HIV, Hepatitis B and Syphilis

Fast tracking the response

- Geographical prioritization in the HIV response to achieve “Ending AIDS by 2030”
- Provision of age specific/sensitive services for MARA

- Monitoring implications of punitive laws affecting KP interventions and advocacies with relevant authorities to improve the situation
- Scaling up community led approaches in testing and treating
- Ensuring quality of care by offering standardized services
- Reducing stigma and discrimination against KPs through service providers training and advocacy; developing service providers capacity to deliver services sensitive to age, gender and human rights
- Reaching migrants as a priority focus group for HIV prevention
- Reaching EVA through ICT based awareness program, innovative interventions
- Integrating STI, HIV with SRH services through effective referral mechanism, and health system strengthening

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

Strategies:

- 2.1 Reduce mortality and morbidity among PLHIV through early detection and treatment by system strengthening of government, non-government and private sector facilities
- 2.2 Ensure capacity of service providers in government, non-government and private sectors to provide age, gender and human rights sensitive out-patient and in-patient medical management for PLHIV and KPs
- 2.3 Ensure functional systems for related policy adoption, linkages and update
- 2.4 A comprehensive approach to community support system adopted and implemented to remove barrier to access services and strengthen treatment adherence, care and support for PLHIV including CABA and OVC

Fast tracking the response:

- Increase Link HTS and ART service coverage to treatment through effective referral mechanism and Health system strengthening, especially public health service sites
- Community involvement for increasing access to treatment, adherence monitoring, care and support services and to address stigma and discrimination
- Strengthen health system response and address co-infections with TB, hepatitis and cervical cancer through integration of HIV with MNCH, SRH, TB and Hepatitis-C
- Ensure functioning supply chain management for drugs (ARVs, and drugs for managing OIs, OST for managing OIs) and reagents supplies for labs services (e.g. reagents, test kits)
- Ensure provision of age, gender and human rights specific/sensitive services through training of the service providers
- Implement differentiated service delivery model to increase HIV detection and treatment coverage

Program objective 3: To strengthen the coordination mechanisms and management capacity at different levels to ensure a human right based, multisectoral, effective and sustainable national response

Strategies:

- 3.1 Strengthen NAC and TC-NAC for a more functional role in guiding the national HIV response
- 3.2 Strengthen ASP through capacity building and providing appropriate structure, human resources and other logistics
- 3.3 Conduct stakeholder meetings to coordinate, review and integrate the HIV response across other ministries and departments and with civil society groups
- 3.4 Conduct advocacy and BCC activities for creating an enabling environment
- 3.5 Facilitate development and implementation of activities and plans in key sectors for strengthened collaboration on HIV prevention, treatment, care and support
- 3.6 Develop human resource capacity at different levels across the HIV sector to enhance response and achieve NSP targets through delivering high quality prevention, treatment, care and support services sensitive to human rights, age, gender and unique needs of key populations and people at emerging risk and vulnerabilities
- 3.7 Strengthen the health system response to HIV
- 3.8 Strengthen the community system response to HIV through empowering communities /strengthening existing CBOs by building capacity and involving them at every stage of research, design and implementation, monitoring and evaluation of HIV interventions.

Fast tracking the response:

- Engage relevant departments within and outside the health sector through investment of domestic resources independent of the AIDS program
- Involve district and local level GOB officials, health service providers from public, private and NGO sector and community people in creating enabling environment
- Work with community to review, design and implement specific interventions for different groups of KPs to remove critical barriers (e.g. stigma, discrimination, violation of human rights etc.) to access services
- Decentralize HIV response management coordination and supervision through involving district health manager, hospital superintendent or director of hospitals as well as district commissioners and civil surgeons
- Develop national reference laboratory and divisional network of laboratories to expand and ensure quality of lab services necessary for identification and medical management of HIV and co-morbidities/OIs, testing viral loads and monitoring drug resistance

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

Strategies:

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

Fast tracking the response:

- Proper resource allocation, early initiation of discussion on conducting surveillance, problem solving and decision making to regularize and ensure regular surveillances;
- Ensure regular size estimation of KPs and other relevant research studies encompassing various disciplines and fields in timely manner
- Initiate ART adherence monitoring and ARV drug resistance monitoring
- Initiate/strengthen/integrate STI, TB, Hepatitis monitoring
- Conduct MESSA in 2020 and strengthen M&E system accordingly
- Explore feasibility of including additional populations in surveys and surveillance
- Evaluation of design and effectiveness of current targeted interventions
- Continue and improve the use of the DHIS2 for better knowledge management and ownership

3.3.2 Details of each strategy:

Strategy 1: Prevention

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

Based on the national epidemiological context, interventions among key populations have been and will continue to be the highest priority. Innovative, cost-effective tested interventions should be scaled up to increase coverage of KP prevention programs.

Effective involvement of KP will increase case detection and prevention service coverage by reaching unreachable and linking them to the continuum of care. Prevention program should address critical barriers to access services by KPs. Stigma and discrimination from service providers experienced by the KPs are the major barrier for them to access services from public health facilities. Since country program aims to utilize public health facilities for services to KP, reducing stigma and discrimination and ensuring services sensitive to age, gender and unique needs of KPs will be a major focus of the HIV prevention program.

However, recent program experiences support expanded interventions among migrant workers especially international migrants and their families. Analysis of program data on case reporting points to spouses of key populations as emerging populations at risk and vulnerable groups who should be reached through interventions immediately⁸¹. The HIV prevalence in the general population has been estimated very low, but as case reporting data suggests the HIV is spreading to general population and as our neighbouring countries show beginning of concentrated epidemic among general populations (HIV Prevalence among ANC cases in India, 2017: 0.73% in Meghalaya, 0.47% in Manipur, 0.56 % in Tripura, 1.2% in Mizoram; Myanmar in 2015: 0.8%⁸², this is time for the Bangladesh to act on raising mass awareness to prevent generalized epidemic. Service to general population can also be provided by mainstreaming HIV with STI, SRH, TB and Hepatitis in government, non-government and private health care facilities. Everybody has the basic right to be provided with information and basic services to protect themselves from HIV infection

Strategy 1.1: HIV case detection increased, HIV and STI transmission minimized and risk behaviour reduced among key populations through comprehensive targeted interventions, provision of services sensitive to age, gender and human-rights and effective involvement of communities

The aim of the strategy is to scale up services for key populations and decrease their risk behaviours through improved knowledge, increased access to commodities and respectful services defined under standard service package. The desired outcome of these efforts is minimized transmission of HIV and STIs among all KPs and improvement of their overall well-being.

The KPs are:

- Female sex workers; programmatically divided based on location where they sell sex: brothels (BFSW), hotel (HFSW), residence (RFSW) or street (SFSW);
- Male sex workers (MSW);
- Hijra/Transgender women;

⁸¹ ASP, 2019, Keynote presentation, WAD, 2019

⁸² lcddr,b ppt2019, aidsdatahub

- Males who have sex with males (MSM);
- People who inject drugs (PWID): includes both male and females.

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

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

In addition, a harm reduction package for PWID includes needle and syringe distribution (core service for PWID), injection related health care and opioid substitution therapy (OST). The Comprehensive harm reduction package includes following components as per The National Harm Reduction Strategy for Drug Use and HIV (2017- 2021) :

1. Needle and syringe programs (NSPs)
2. Opioid substitution therapy (OST) and other evidence-based drug dependence treatment
3. Antiretroviral therapy (ART)
4. HIV testing services (HTS)
5. Prevention and treatment of sexually transmitted infections (STIs)
6. Condom distribution for people who inject drugs and their sexual partners
7. Targeted information, education, and communication (IEC) for people who inject drugs and their sexual partners
8. Prevention, vaccination, diagnosis, and treatment for viral hepatitis
9. Prevention, diagnosis, and treatment of tuberculosis (TB)

Fast tracking the response:

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

Geographical prioritization was done based on the numbers of cases detected through HTS, numbers of KPs. Such categorisation led to identification of 23 priority districts (shown in Annexe). Target setting for each KP in the priority and remaining districts was done through modelling exercises using AEM and has been described in the Investment Case Report, 2019. The scenario reflected in the table below reduces new infections to less than **338 per year by 2030 and HIV would no longer be a major public health concern.**

Table: 1

Prevention targets by 2023	FSW		Male PWID		Female PWID		MSM/hijra			ART targets by 2023	
	H&R	Street	NSE	OST	NSE	OST	MSM	MSW	TG	Male	Female
Dhaka	80%	80%	90%	10%	70%	10.5%	40%	78%*	90%	81%	81%
Priority districts	80%	80%	85%	10.5%	70%	10.5%	40%	70%	90%	81%	81%
Remaining districts	12.7%	12.7%	17.4%	1.9%	22.3%	0.3%	11.8%	17.2%	22.9%	81%	81%

The key to significantly reducing new HIV infections would be to scale up both the prevention coverage among the KPs in the priority districts as well as in remaining districts, and the ART coverage among PLHIV simultaneously by using strategic approaches through PMTCT, addressing of HIV-TB and HIV-hepatitis co-infections, focusing on migrants, implementing integrated interventions for the KPs and the clients of sex workers and informing vulnerable adolescents through the existing SRH services. Country response should remain sensitive and flexible to intervene if case reporting shows alarmingly high number of new cases in any geographical area that is not already identified as priority districts/areas. Program should be intensified in this type of areas. Explorative research should be conducted to understand the situation better. However, prioritized responses based on evidences will best utilize the resources and will also help in achieving the targets stated in the Health, Population and Nutrition Sector Program.

Provision of age specific/sensitive services for MARA: Bangladesh Mapping and Size Estimation revealed 276,997 KPs in 2015 and about 13% of the total KPs are adolescents aged below 20⁸³. The HIV prevention program should be designed to serve these adolescents as they are more vulnerable and pose high risk of HIV. Lessons learnt from “Improving health and social well-being of adolescent female sex workers through enhanced access to essential services (MARA Project)”- pilot project implemented by Save the Children, awarded by UNICEF for June 2018 to November 2019, can be utilized to reach MARA. Peer volunteers recruited from this group and empowered through training have been instrumental to reach and make adolescent female sex workers aware on HIV and SRH and overall wellbeing in a sustainable way. It is important to ensure

⁸³ ASP, 2016. Mapping Study and Size Estimation of Key Populations in Bangladesh for HIV Programs. Dhaka, Bangladesh: Directorate General of Health Services, Ministry of Health and Family Welfare.

adolescent friendly service provisions by providing appropriate training to the service providers about the need of the most at risk adolescents.

Adoption of community based, and community led approaches in testing and treating including other innovative technologies:

As of December, 2019, a total of 7374 HIV cases have been identified, which is slightly more than half of the total estimated number (14,000) of PLHIV⁸⁴. In order to increase case detection, new and innovative approaches e.g. quick HIV testing by peer educator/community health workers has been initiated in the country and pilot study on HIV self-testing through oral fluid is ongoing. Evidence based, cost-effective interventions should be scaled up by involving KP communities to increase testing and treatment coverage among KPs.

Integrating HIV into existing health systems for TB, STI, SRH, hepatitis case management through strengthening referral mechanism:

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

Community involvement for increased access to SRH and HIV prevention and care services: Community led SRH and HIV prevention services should be enhanced for greater acceptability and accessibility among the KPs. The peer outreach workers recruited from the PLHIV/KPs can play a major role for accompanied referral for required services and ensuring treatment adherence for ART. PLHIV and KP networks/CBOs can help mainstreaming KP services to public health facilities through reducing fear and self-stigma among KPs and establishing referral linkage.

Quality of care by offering standardized services: The minimum set of services identified to deliver under each service package should be implemented, with feasible targets for peer educators and outreach workers as per previous experience and best practice models. Remuneration and distribution of workload for peer educators outreach workers and peer educators should be encouraging. KP's mental and general health conditions should not be ignored. Psychological counselling through trained peer educators and linking them to support services like social safety net, rehabilitation, facilities to treat NCDs are essential to help them with overall well-being. Additional services to meet 90-90-90 targets must be incorporated with standardized community led models after piloting. The focus of the quality improvement efforts will be on improving adherence to

⁸⁴ ASP, 2019, Key Note Presentation by ASP, World AIDS Day, 2019

clinical practice guidelines; increasing efficiency, lowering costs, and utilizing staff and health information more efficiently; improving client flow; and utilizing existing infrastructures within the health sector.

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

Monitoring implications of punitive laws affecting KP interventions and advocacies with relevant authorities to improve the situation: Efforts should be enhanced to monitor incidences of violation of human rights by the Law enforcing agency or others, and measure should be taken through local and national level advocacies and multisectoral engagement to protect rights of the KPs and reduction of stigma and discrimination against them.

Improve service providers capacity to respond to KP's health need: Advocacies and trainings should be done for service providers at public and private health facilities to sensitize them on KP's needs and rights and to be able to provide standardized prevention, treatment, care and support services. Efforts should be continued to train and sensitize services providers of NGO facilities under HIV program.

Strategy 1.2: Increased case detection, reduction of risk behaviours and provision of services for populations at emerging risk and vulnerable groups through awareness raising and interventions to link them to integrated STI, HIV and SRH services

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

International migrant workers and their families – international migrants can be divided into official and informal international migrant workers as well as cross-border migrants. Potential international migrants, especially the returnee international migrants, their spouses and children must be reached as the number of new infections is continuously

increasing among this group and they comprise about one fourth of total number of PLHIV in the country⁸⁵.

Especially vulnerable adolescents (EVA) - refers to adolescents who have an elevated risk but do not belong to any key populations, and are thus not considered as MARA. It includes children and adolescents who are likely to develop high risk behaviours, for example those who use (but do not inject) drugs, children of sex workers, street children and others who suffer severe social circumstances.

Prisoners – Interventions for prisoners has already been initiated under HIV program, especially for the imprisoned PWID. Since, no study has been conducted on prisoners' risk behaviour in the country, it's highly recommended to conduct HIV risk assessment study among the prisoners, review existing program activities for prisoners and design and expand program as needed.

Spouses of Key Populations: Wives of MSM and PWID were there – within the 25% of new infections that were identified among women in 2019⁸⁶. Partners of HIV positive KPs are at emerging risk for infection as often their husbands do not disclose their status out of the fear of stigma and discrimination⁸⁷. These women should be reached and brought under prevention and treatment service coverage.

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

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

Fast tracking the response:

Reaching migrants as a priority focus group for HIV prevention: Migrants constituted 21% of the total reported cases. In 2019, 19% of the new infections were from migrants. Both the international migrants and cross-border migrants are vulnerable to HIV due to their risk behaviours^{88,89}. In addition, spouses of migrants also need attention as an

⁸⁵ ASP, Program data, 2019

⁸⁶ ASP, Keynote presentation, WAD, 2019

⁸⁷ ASP, National HIV/AIDS Disclosure Guidelines, 2018 (unpublished)

⁸⁸ Rana, A. K. M., Reza, M. M., Alam, M. S., Khatun, M., Khan, S. I., & Azim, T. (2016). Effects of in-country and cross-border mobility on condom use among transgender women (HIJRAS) in Bangladesh: a cross-sectional study. *AIDS and Behaviour*, 20(10), 2165-2177. <https://doi.org/10.1007/s10461-015-1275-8>.

increase was seen among spouses of migrants, who constituted around 10% of detected cases since 2011⁹⁰. A study on a random rural population of returnee migrants showed that of 297 sampled returnees, one was HIV positive using oral fluid⁹¹. A GAMCA allied diagnostic lab informed that about 10,000 potential migrants were screened for HIV during November 2018 to October 2019, and 11 cases were found positive. This is a very significant finding as it indicates (0.1%) HIV prevalence among these group, which is higher than the prevalence (<0.01%) among general population estimated so far in the country⁹². Country program has initiated targeting this group through Bureau of Manpower, Employment and Training (BMET). ASP currently conducting ToT for BMET instructors, has developed TVC and BCC materials as well as employed roaming counselors to link HIV positive cases for confirmatory tests and ART services. Ongoing interventions should be evaluated and strengthened in collaboration with BAIRA, BMET, GAMCA, IOM and Ministry of Labour and Employment strengthened.

A project piloted by OKUP with support from UNICEF in Kanaighat upazila, Sylhet district, the second most international migrant prone area of the country, titled: “Accessible Health, HIV Prevention and Treatment Services for Migrant Workers with special focus to Female Spouses and their Children” during 2017- 2019 period brought huge success to reach, educate, provide HTS and ART/PMTCT services through partnering with government health facilities (Union Health and Family Welfare Centre and Upazila Health complex) and other political representatives and stakeholders working locally. Trained CHCPs and FWVs successfully reached potential migrant, returnee migrants and their families under the project⁹³. Lessons learnt from this project should be considered to design /replicate programs for international migrants and their families.

Reaching EVA: According to the Bangladesh Household Census 2011⁹⁴, there are 29.44 million adolescents aged 10 – 19 yrs. (20.4% of the total population) in Bangladesh. HIV prevalence and risk behaviours among adolescents (other than adolescent KPs under surveillance) have not been measured in Bangladesh. According to BDHS 2011, about 32% of adolescent boys and girls had sex before age 15⁹⁵. All adolescents are vulnerable

⁸⁹ Samuels et al. (2014). The effect of an HIV and AIDS project on migrants at source and destination sites in Nepal, Bangladesh and India: Findings from a quasi-experimental study. Shaping Policy for Development. Oversea Development Institute, UK

⁹⁰ Govt. of Bangladesh, 2014. HIV case detection summary tables, 2007-2013. National AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh (unpublished).

⁹¹ Alam M S et al. (2016). Point of care HIV testing with oral fluid among returnee migrants in a rural area of Bangladesh. Current Opinion on HIV and AIDS, 11(1):52-58.

⁹² 2019 Data from GAMCA, Allied Diagnostic Ltd, GCC Code NO. 05/01/37)

⁹³ OKUP, UNICEF, 2019, Lessons Learned and Project Completion Report: Community-based awareness on safe migration and PMTCT reduce migration related risks and HIV infections among migrants, spouses and children

⁹⁴ BBS, 2011. Statistics and Informatics Division (SID), Ministry of Planning.

⁹⁵ GOB. (2011). Bangladesh Demographic and Health Survey. 2011. Ministry of Health and Family Welfare, Government of Bangladesh

because sexual risk taking and drug use is often initiated during adolescent years. The street children and the children of sex workers should get focus in EVA interventions. Scope for linking EVA with existing adolescent health care initiatives run by government, nongovernment and interventions supported by UN agencies should be explored and utilized.

Strategy 1.3: Increased case detection and reduction of risk behaviours among general population and young people through awareness raising and linking them to SRH and HTS services

The HIV testing and prevalence among the general population is very low in Bangladesh⁹⁶. However, about 8%-11% of Bangladeshi men aged 15-49 years⁹⁷ buy sex from female sex workers, occasionally or frequently, making the distinction between “low-risk general population” and “clients of sex workers” difficult to draw. In a recent WHO report shows that, the HIV epidemiological trend in Asia Pacific is driven by KPs and their intimate partners. The ‘general population’ who are at high risk of HIV are actually the present/past partners of KPs. So reaching to these groups should also be done through KPs and this strategy should be prioritized to stop the epidemic⁹⁸. Furthermore, epidemic modelling as well as case reporting data shows that low-risk females account for about one-third of new infections, most likely due to risky behaviours by their partners. Inclusion of the general population in the NSP is important as all people have a basic human right to be informed about HIV prevention; and accurate knowledge can influence people’s perceptions. Activities aimed to increasing the knowledge among general population should include mass media campaigns through ICT, FMs/community radio and social networks; development and printing of IEC/ BCC materials and folk media as well as continued HIV education through academic curriculum. Studies regarding current knowledge, practice and attitude of youth and general male and female population through anonymous surveys will help designing BCC materials and awareness campaigning. Partnership with academic institutes to conduct studies can be explored. Decentralization of HIV program through developing leadership at the district level engaging Civil surgeons, District Commissioner, Political leaders will help creating multisectoral response at local level for both key and general populations.

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

⁹⁶ GOB. (2016). DHIS2. DGMIS, DGHS, Ministry of Health and Family Welfare, Government of Bangladesh

⁹⁷ Family Health International/icddr,b. Male reproductive health survey. Dhaka: FHI/icddr,b, 2006

⁹⁸ World Health Organization. (2018). Are Key Populations Really the “KEY” to Ending AIDS in Asia? Putting Asia’s HIV response back on track.

Hepatitis) and triple elimination of mother to child transmission of HIV, Hepatitis B and Syphilis

This strategy focuses six main areas:

- HIV testing services (HTS);
- Post-exposure prophylaxis (PEP);
- Pre-exposure prophylaxis (PrEP);
- Management of sexually transmitted infections (STI);
- Integration of HIV, STI, TB, and Hepatitis;
- Triple elimination of mother-to-child transmission of HIV, Hepatitis B and Syphilis

Expanding HTS including counselling, adopting the test and treat modality and assessing needs for pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) in public health facilities are needed. Currently, there are more than 131 HTS facilities throughout the country, of which 28 are being operated in public facilities (government medical college hospitals, districts/ sadars/ general hospitals)⁹⁹. HTS services has been expanded in the government facilities in all priority districts. However, strengthening and further expansion are needed to reach case detection target. For strengthening STI service, service providers should be trained / refresher should be provided on new guidelines. Scaling up interventions to train and sensitize service providers on the special needs of KPs, PLHIV and young people also need to be undertaken.

A massive scale-up is necessary to achieve access to HIV screening during pregnancy for all women from key populations and higher vulnerability groups and initiate of PMTCT interventions for all who need it. Mother to child transmission of HIV, Hepatitis B and Syphilis can be effectively prevented by antenatal screening and treatment for women and her partners, and vaccination for infants through reproductive, maternal, newborn and child health (RMNCH) services. With effective coordination, this global strategy can be implemented in the priority districts to make the service accessible to the vulnerable women, children and their families.

The issues related to co-infections with TB, hepatitis, etc. are discussed under objective 2.

Strategy 2: Treatment, Care and Support

Bangladesh is committed to achieve universal access to HIV treatment, care and support for those in need. NGOs and CBOs had been the major ART service providers in the country since the inception until recently. There has been a gradual shift towards government health system taking more responsibility of providing ART services. ART initiated to the public health facilities through PMTCT in 2012 and by 2019 most of the ART service centres in the country are run under public health facilities. 11 government

⁹⁹ ASP, Program data, 2019

hospitals including tertiary and district level hospitals provided ART and 28 centres delivered HTS in 2019¹⁰⁰. ART services from government hospitals/health facilities will be scaled up to district and upazila level, based on geographical priorities to ensure 90% ART coverage for the PLHIVs by 2023.

The current coverage of treatment, care and support has gone to 62.5% of the detected cases. However, 29%, of the estimated PLHIV are receiving ART ¹⁰¹. This is still far below the threshold set in the treatment target of “90-90-90”. Under the circumstance, country is committed to put more emphasis on strategies (2.1-2.4) already identified in 2017 and added new approaches and activities in the revised NSP to ensure universal access to treatment, care and support to the PLHIV.

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

As early detection and ART initiation is strongly associated with decreased morbidity and mortality, it is emphasised that more active approaches to HIV detection and treatment initiation are explored and scaled up based on evidences. Strategy 2.1 emphasises that 90 percent of the estimated PLHIV will know their status and 90 percent among them receive ART by 2023.

Currently, among the total no 6132 reported cases, who are alive (among 7374, 1242 died) 4060 are reported on ART by the end of 2019¹⁰². Country has revised the national eligibility criteria as “being HIV positive” (Revised ART guidelines, final draft, 2019, ART national eligibility criteria: CD4<350, WHO clinical stage 3 or 4, pregnancy or co-infection with TB, was applicable till 2018. This change has increased the ART coverage to 65% of the reported cases and in 2019, ART coverage for newly identified PLHIV was 85.53%¹⁰³. However, if the estimated number, 14000, of HIV infections are considered as denominator, then ART coverage comes down to 29%. Thus, Country response must continue strong focus on early case detection and treatment initiation in order to achieve the global treatment targets. In addition, barriers to treatment access must be addressed through key populations’ meaningful involvement.

Currently ART is available at 12 public hospitals and 6 are NGO facilities¹⁰⁴. ART services will be expanded to all district hospitals in phases. Integrated testing and treatment centres in the government sector are to be established at least covering the priority

¹⁰⁰ ASP , Program data, 2019

¹⁰¹ ASP, Keynote presentation, WAD, 2019

¹⁰² ASP, Program data, 2019

¹⁰³ ASP, Keynote Presentation, 2019

¹⁰⁴ ASP, Program data, 2019

districts and in addition to managing ART, these centres should be able to deal with a range of communicable and non-communicable co-morbidities and co-infections, palliative care, nutrition support and inpatient care for both HIV-related and non-HIV-related complications.

Newly developed Differential Service Delivery Framework will help increase ART initiation and adherence as well as new modalities of ART distribution/refill centres will bring ART services close to everyone in need in a cost-effective way. Community based HTS and ART delivery are already tested options to increase case detection and ART coverage. Treatment adherence monitoring should receive special attention. However, standardized HTS algorithm and ART delivery framework will ensure high quality service delivery.

Laboratory services should be strengthened to support case detection, disease management and increase coverage for viral load testing. Need for studying drug resistance and viral genotype has been identified in the country; Central reference laboratory should initiate the study. Central accreditation system will ensure both ART and Lab service quality.

Risk of Co-infections with TB, hepatitis, cervical and anal cancer can be screened and managed through integration of HIV services with SRH, MNCH, TB and Hepatitis C. Integration of KP health services should be promoted in government, private and NGO health facilities.

Toll free helpline service will create better linkage with the ART centres. Scope of sharing information through social networking on availability of HTS/ART should be explored and integrated into program.

Online registration, reporting, ICT based data management system will reduce burden of documentation and improve data quality. Private hospitals should be brought under reporting system.

Reducing mother to child transmission has been a significant success of Bangladesh HIV country program. PMTCT has been implemented in the country through public health facilities since 2012 and currently 12 government hospitals provide HTS and ART services to pregnant mothers. In 2019, Mother to child transmission was reduced to less than 2%¹⁰⁵, which is exemplary compared to global success documented as 5%. PMTCT services will be made available at all priority districts and districts having the international border. Establishment of paediatric HIV management and complex

¹⁰⁵ ASP, UNICEF, Program Data, 2019

treatment referral centres in public hospitals is also important, apart from capacity for management of infections in new-born children in the PMTCT sites.

When it's important to increase the availability of services, it's equally important to make them accessible to the target population. Thus, services should be taken close to the target populations and provided in a sensitive manner to fulfil individual's unique need and respect their rights. Proper training and orientation of service providers and key populations' participation in the program will play vital role to increase usage of services by the community.

Strategy 2.2: Ensure capacity of service providers in government, non-government and private sectors to provide age, gender and human rights sensitive out-patient and in-patient medical management, for PLHIV and KPs

The complexity of HIV medicine requires different levels of expertise for different tasks. Although it's not a big number yet, PLHIV and KPs are spread throughout the country, and services need to be geographically accessible. The need for establishment of well-equipped specialized facilities, able to manage treatment failures, complicated cases, opportunistic infections and paediatric infections has been identified in the country. Regional referral centres should be developed to fulfil this requirement. Infectious Disease hospitals equipped as one stop service centres for PLHIV will be very helpful. Some specialized centres (e. g select hospitals /health care facilities for heart and kidney diseases and other NCD management) also need to be identified and motivated to manage PLHIV present with NCDs. Post exposure prophylaxis (PEP) and universal precaution should be in place in the health facilities managing HIV. To ensure KP friendly environment and quality of service for both out-patient and in-patient management, service providers training should be planned based on a needs assessment. Training will be a core activity to strengthen health system and expanding integrated services for HIV, STI, TB and Hepatitis C.

Awareness raising on HIV and KPs among health care service providers of all priority districts should be done urgently. Service Providers and support staff should be oriented on HIV and maintenance of universal precaution. Hospital management should be involved to introduce and maintain universal precaution.

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

Country program has achieved success in developing and reviewing policies and protocols periodically in order to be aligned with the rapidly developing field of HIV medicine. This

effort should be continued; the National ART guidelines as well as protocols for STI management, HTS and PMTCT need to be updated periodically and disseminated timely. Human rights and gender issues should be addressed while updating or developing new strategies, policy documents, protocols/guidelines.

HIV treatment and management need to be integrated in medical curricula; HIV treatment and management task force has not been developed yet. This is partly covered by the ART-PMTCT task force but there is still no professional society of ART providers. This is extremely important that a Task Force developed and that stays vigilant to address issues related to medical management of HIV and OIs

Coordination with the relevant departments of DGHS like CDC, and specialized centres dealing with hepatitis need to be strengthened for addressing HIV and hepatitis based on the harmonized strategic plans and guidelines.

A TB -HIV guidelines is being developed in collaboration with ASP and TB programs under DGHS; ASP should strengthen coordination with TB program to ensure implementation of the strategies so the integration of TB- HIV management can be scaled up at all possible service outlets.

Although, HIV is an integral part of SRH, it's still being managed in isolation. All possible opportunities to integrate HIV with STI and overall SRH services should be explored and utilized. Relevant guidelines should be reviewed to integrate HIV in them.

To accelerate achievement towards “90-90-90” targets, Bangladesh has adopted test and treat modality and integration of testing services through different departments of health system like TB and Hepatitis. Along with expansion of HTS and ART services, strengthening monitoring mechanism to treatment adherence and to ensure viral load testing is also necessary.

Most importantly annual reviews should be held with the relevant stakeholders to have an overview of integration of services and further scope for improvement. Integration of services will reduce the program cost significantly. Annual scientific conference, experience sharing will be very helpful to identify and address any issues and updating treatment, support and care policies and protocols to ensure continued improvement of service quality, availability and accessibility.

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

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

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

A national protocol on care and support was developed in 2010, that should be updated in alignment with recent international guidelines. Training should be arranged for selected groups on relevant and specific areas according to the new guidelines.

Country as well as global evidences indicate that community involvement increases case detection and ART coverage to a significant extent¹⁰⁶. Thus, it's extremely important to strengthen community system, involve communities meaningfully to develop a better response to HIV and AIDS. Community network can contribute increasing community based HTS coverage, linking PLHIV to ART centres, providing psychosocial counselling through trained peers as well as linking PLHIVs to other support services like social safety net, shelter home, nutrition support, income generating activities, drug rehabilitation etc. Communities can play important role in reducing barriers to access services through advocacies, networking, participatory monitoring and accompanied referral. Currently health system is not fully ready to provide services to the PLHIV and KPs. They are denied health care even at tertiary level hospitals for their general health problems including conditions need surgeries¹⁰⁷. This situation leads PLHIV to non-disclosure of their status. It is very important to involve community to promote compliance to HIV disclosure guidelines.

Fast tracking the response:

Link HTS to treatment through effective referral mechanism and health system strengthening, especially public health service sites: Referral mechanism needs to be strengthened to bring maximum number of people identified as HIV positive under treatment. At the same time, it is important to sensitize the service providers for understanding the need of PLHIV and creating an enabling environment for better access.

¹⁰⁶ GF Technical Brief, 2019

¹⁰⁷ Consultation with PLHIV and KP networks, 26 December 2019

The providers should be trained be on HIV management, especially from public service sites.

Lab service strengthening: Laboratory facilities for EQA for HTS, monitoring of viral load and ARV drug resistance are needed. Development of central reference laboratory and network of divisional facilities are essential to maintain and improve quality of medical management of HIV and coinfections. Policies, protocols/guidelines are to be developed and staff members engaged in lab services should be trained accordingly.

Community involvement for treatment, care and support services, In order to ensure treatment, care and support services like nutrition, social safety net, shelter for the homeless, legal support, drug rehabilitation, income generating activities etc for PLHIV, community engagement can play a vital role. Involving community will ensure more PLHIV to link with treatment, ensure treatment adherence and help reducing self- stigma among them.

Develop PLHIV data base: A central digitalized **PLHIV** database with unique ID code should be developed in order to monitor ART adherence and detect 'lost to follow up' early.

Strengthen systems to address co-infections with TB, STIs, hepatitis and cervical cancer Co-infections with TB, STIs, hepatitis and cervical cancer should be managed through strengthening ongoing effort for integrating HIV with TB, SRH and Hepatitis programs through further advocacies and collaboration with relevant departments of DGHS/MoHFW, like CDC, TB program, Gynae/Obs department of Public hospitals, UN agencies like WHO, UNFPA.

Ensure functioning supply chain management for drugs (ARVs and drugs for managing OIs) and reagents: Effort to ensure uninterrupted supply of drugs need to be continued and more options like public-private partnership should be explored. The local renowned drug manufacturing companies could be engaged for manufacturing of drugs at reduced cost with provision of quality assurance testing of required samples if accreditation requirements are not met.

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

Capacity building of service providers and managers, laboratory staff are needed on the ARV supply chain, drugs for OI management and lab supplies and this may be conducted in collaboration with other programs like hepatitis and TB program.

Provision of age specific/sensitive services: In order to enhance access to ART services by adolescent and young PLHIV, age sensitive services should be made available at the ART centres. Service providers should be provided with appropriate training and skill to serve these groups. Existing Adolescent Friendly Health Services may be used and HTS and ART services can be integrated through developing a collaborative process and Community involvement.

Interventions for Children Infected and Affected by HIV and AIDS (CABA) and Orphans and Vulnerable Children Affected by HIV/AIDS (OVC): There were 2389 CABA and 248 children were orphaned due to AIDS in Bangladesh. Many of these children suffer from various conditions including mental and physical health issues, malnutrition, social and economic deprivation, etc. because of their parents' sickness and death. They are sometimes denied health care. At the individual level internal and external stigma add to their problems¹⁰⁸.

Strengthened community sensitization efforts, with social safety net mechanisms, access to health care, linking with education, nutrition, providing mental and emotional support for ensuring sustained wellbeing of CABA and OVC are needed. More empowering efforts (e.g. leadership training, IG training etc.) are needed for CABA, OVC and their family members and care givers. The government initiative of community-based child protection committee (CBCPC) needed to be activated.

Ensure adherence monitoring: Both global and country evidences show community involvement in ensuring ART adherence is very effective. Thus, community involvement should be further intensified and they must be trained on the importance of adherence to ARVs after initiation of therapy. Systems need to be in place to monitor and record adherence. Reasons for failure need to be understood as this can vary for different individuals and appropriate approaches to overcome non-adherence need to be undertaken. Community members who are members of ART Management committees in hospitals should report regularly on issues related to adherence.

Reduce stigma and discrimination by training service providers on human rights-based service provision: Stigma and discrimination are the major barriers for the PLHIV to access health services. Effective approaches should be adopted to reduce stigma and discrimination exerted by the service providers. Appropriate training for the service providers, advocacies involving community and BCC with proper messages would help in reducing the stigma and discrimination and make service providers sensitive to PLHIV's unique needs and rights.

¹⁰⁸ National AIDS and STD Programme, MOHFW, Bangladesh, Ashar Alo Society, UNICEF, 2013, Comprehensive Mapping of Children, Infected and Affected by HIV and AIDS in Bangladesh

Strategy 3: Management, coordination and capacity development

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

The national response coordination and management is premised on the three ones principle - **One** agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; **One** National AIDS Coordinating Authority, with a broad based multi-sector mandate and **One** agreed country level Monitoring and Evaluation System.

Eight strategies (3.1-3.8) have been outlined in the NSP to guide smooth management and ensure effective coordination and capacity development plans during 2020-2023.

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

ORGANIZATION	FUNCTION
National AIDS Committee (NAC)	<ul style="list-style-type: none">• Oversight of National Strategic Plan implementation.• Strategy Revision;• National Advocacy to Government
National AIDS Committee: Technical Committee (NAC-TC)	<ul style="list-style-type: none">• Strategic guidance to ASP and other stakeholders
AIDS/ STD Program (ASP)	<ul style="list-style-type: none">• Program Management, Monitoring, Coordination, Advocacy, Resource Mobilization, Implementation of HNPS-OP Interventions
Technical working groups (Prevention; Treatment, care and support; Management and Coordination; Strategic Information)	<ul style="list-style-type: none">• Periodic review of epidemic and response and Technical advice to ASP
Other government ministries and sector agencies	<ul style="list-style-type: none">• Development and implementation of sector plans
STI/AIDS Network	<ul style="list-style-type: none">• Representation of implementing agencies in governance structures
Implementing agencies	<ul style="list-style-type: none">• Service delivery, research and development
Representative bodies of PLHIV and key populations	<ul style="list-style-type: none">• Representation of PLHIV and key populations in governance structures; participation in program implementation

ORGANIZATION	FUNCTION
Donor agencies	<ul style="list-style-type: none"> • Provision of funding; • Harmonization of funding • Technical Assistance
UN agencies	<ul style="list-style-type: none"> • Policy advice; • Funding • Technical support; • Advocacy
Private sector	<ul style="list-style-type: none"> • Workplace policy; • Involvement in sector policy development and implementation; • Funding mobilization
Faith Based Organizations	<ul style="list-style-type: none"> • Involvement in building enabling environment; • Involvement in provision and coordination of Care and support services

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

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

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

AIDS/STD Programme is responsible for coordination and monitoring of the national response under the overall guidance of a Line Director (LD). In 2009-2010 the institutional structure of National AIDS/STD Programme was developed. The Operational Plan (OP) of NASP had four components, each headed by a Deputy Program Manager and supervised by a Program Manager. These components corresponded to the four objectives of the NSP on prevention; treatment, care and support; management, coordination and capacity development; and monitoring, evaluation and strategic information. Currently NASP renamed as ASP and has two functional units as Treatment, Care and Support (TCS) and Management. Prevention, M&E and SI are included under TCS units. Both units have adequate human resources including, coordination, advocacy, M&E and SI professionals. ASP has recently recruited 56 doctors, counsellors, lab technicians and accountants to work at HTS and ART centres in 23 priority districts and several roaming counsellors to provide immediate counselling service and link HIV positive potential international

migrants from GAMCA laboratories to HTS and ART centres. The Programme has provision for recruiting more specialists as needed to render its responsibility.

A functional task analysis is essential for ASP human resources in order to plan for strengthening capacity of ASP as the management and coordination body for national response. Equipment, logistics, utilities and supplies for the establishment and continuous support to ASP is required for its effective functioning.

The current capacity of the ASP also needs to further focus on strengthening intra and inter-ministerial collaboration; for example – further engage with CDC, NCDC, DGDNC, MACAH-DGHS of MNCH-DGFP, MOEAEW MOHFW, MOSW, MOE, MOHA, MOWCA, MOL, MOYS, MOF and MOI among others.

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

Although 6-monthly meetings with donor consortium and ministry focal points have been scheduled; usually these are organized on needs basis e.g. before World AIDS Day, HTS and care & support roll out, etc. HIV issues need to be addressed in district level coordination meetings conducted regularly in all 23 priority districts. Structured approaches are necessary to pursue more engagement of:

- the Ministry of Home Affairs in addressing violence by the law enforcers and OST;
- the DGFP in addressing condom requirements of female sex workers and their clients and in addressing adolescent friendly and SRH services and integrating HIV into MNCH;
- the CDC to address HIV and hepatitis on common grounds;
- NTP for strengthening the coordinating body for collaborative TB/HIV activities at all levels including joint planning to integrate the delivery of TB and HIV services, laboratory support, joint monitoring and supervision;
- the NCDC to address complications related to non-communicable diseases of PLHIV;
- the hospital department/authorities to strengthen HIV testing, treatment, support and care services;
- the community clinics/ART centres/UHC/FWC/DICs to work more intricately with community peer navigators/ volunteers;
- the MNCH departments and professional bodies like OGSB to address, integration of triple elimination of HIV, Syphilis and Hepatitis into ANC, HIV and cervical cancer in SRH care, needs of FSW and the partners of PWID and young women;
- Ministry of Social Welfare and Ministry of Women and Children's Affair to link KPs and PLHIV to the NSSS.

Strategy 3.4: Conduct advocacy and BCC activities for creating an enabling environment

The relevant policymakers and other stakeholders need to be reached through sensitization workshops on HIV/ key populations/ stigma & discrimination with an aim to reduce verbal/physical harassment or assault; discrimination against rights, laws and policies; and gender based violence (GBV), etc. It is important to ensure a coordinated and collaborated approach to act upon creating an enabling environment. Relevant stakeholder including UN agencies and key populations' participation is necessary. Most importantly, data should be collected regularly on incidences of GBV and violation of human rights, laws and policy impediments, and analysed to develop evidence-based advocacy and follow up plan. Local bodies including government and community networks should coordinate to link the victim with support services, e.g psychological counselling, legal aid, accompanied referral to hospital or one stop crisis centre. Local level advocacies will be supported from ASP and decentralized HIV management body. BCC activities involving social and print media is also important to bring changes in the environment.

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

HIV strategies and work plans need to be developed for relevant ministries. The OP of NASP under HPNSDP 2017-2022 has identified five other OPs (Hospital, ESD, NTP, CDC and Community Clinic) for integrating HIV activities. Several other ministries (e.g. MoI, MoHA, MoYS, MoE and MoRA) have incorporated HIV activities in their respective strategies. Further efforts need to be pursued to address the requirements outlined in Strategy 3.3 and work with ministries and departments identified under strategy 3.2.

It is required to continue, strengthen coordination and support for media sensitization and mobilization through organizing training and involving them for BCC and advocacy activities; support to faith-based organizations for raising awareness on HIV and human rights and to the private sector for work place programs and resource mobilization. Moreover, coordination and support to the Human Rights Commission should be strengthened to promote rights and respects of KPs and integrating them with social safety net. A *“National Consultation on punitive laws hindering the HIV response”* also be conducted in coordination with Human Rights commission to properly address the law and punitive impediments hindering the KP interventions.

It is imperative that the “National Task Force NTF” proposed in a joint advocacy meeting held in 2018, is activated to deal human rights issues affecting country response to HIV. The NTF will sit semi-annually to review the human rights situation, legal and other barriers of HIV intervention and it also will combine all the previous efforts of NGOs regarding human rights.

Strategy 3.6: Develop human resource capacity at different levels across the HIV sector to enhance response and achieve NSP targets through delivering high quality prevention, treatment, care and support services sensitive to human rights, age, gender and unique needs of key populations and people at emerging risk and vulnerabilities

The required number of health service providers need to be trained to provide prevention, treatment, care and support services for KP, PLHIV and their families as well as people at emerging risk and vulnerabilities. A capacity development plan needs to be developed in this regard for sustained and strengthened services. In addition, a human resource assessment should be done in order to review the current situation and be used as the basis for development of a comprehensive training plan and curricula. Effort should be continued for HIV training for service providers on laboratory services, STI, HIV and Co-infection eg. TB, Hepatitis, ensuring appropriate training materials that address both science and ethics. Service Providers should learn about KP/PLHIV, their unique needs and be sensitive to human rights, gender and age. It's Important to include HIV in community medicine and create opportunity for medical students and trainee doctors to interact with PLHIV through their network. HIV awareness can be raised among new doctors joining hospitals by making HIV certificate course mandatory for them.

Strategy 3.7: Strengthen the health system response to HIV

HIV screening of donated blood is universal in government facilities; however, no data is available from private hospitals and other non-government actors except GAMCA approved laboratory network. All relevant facilities should be brought under HMIS for routine reporting. Overall reporting system should be reviewed and simplified in order to enhance compliance to routine reporting and improve data quality.

In order to strengthen the health system response, it is essential to ensure that no stock-outs of essential drugs, reagents and commodities happen in the NSP implementation

period. It is also important to establish systems for drug and essential commodity supplies.

Moreover, establishment of national reference laboratory, divisional laboratory network and functional mechanism of EQA and IQA for all HTS and ART centres is imperative to ensure detection, medical management of HIV and co-infections, viral load testing as well as monitoring drug resistance. Development of comprehensive national laboratory policies and protocols is also essential. Guidelines for laboratory services (on program level) need to be updated periodically to include updated technologies.

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

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

Strategy 3.8: Strengthen the community system response to HIV through empowering communities/strengthening existing CBOs, by building capacity and involving them at every stage of research, design, implementation, monitoring and evaluations of HIV interventions

Strengthening of community-based organizations need to be ensured through cross-learning visits, management training and M&E training. It is important to support them to get a registered organization status. The CBOs/self-help groups for key populations and PLHIV need to be involved in planning, budgeting, monitoring and evaluation of HIV related activities. The CBOs should also receive capacity building assistance for to better organize, improve leadership and accountability and be able to contribute expanding referral systems for treatment, care and support services. They can support implementation of differentiated delivery for HTS and ART. They can also address GBV, violation of human rights, stigma and discrimination through educating community

members about their rights and participating in advocacies with service providers as community level leaderships. Peer Counsellors and navigators already playing a significant role in providing psychological support to PLHIV and KPs and reaching the unreachable and reducing treatment nonadherence.

More importantly, community led initiatives need to be piloted with government support. ICT based intervention such as Voice SMS, text SMS, online risk assessment for HIV through web and mobile app for MSM and hijra initiated by icddr,b are praised by users. These interventions should be reviewed and replicated. Government supported best practice approaches such as SMS texting for MNCH emergencies and referrals may be explored in case of HIV prevention and treatment, care and support interventions. FSW Community squad, developed and supported by Save the Children is another example of best practice of using hotlines to identify and attend female sex workers experience GBV or any other violation of human rights.

Fast tracking the response:

- Engage relevant departments within and outside the health sector through investment of domestic resources independent of the AIDS program
- Involve District and local level GOB officials, health service providers from public, private and NGO sector and community people in creating enabling environment
- Work with community to review, design and implement specific interventions for different groups of KPs to remove critical barriers (e.g. stigma, discrimination, violation of human rights etc.) to access services
- Decentralize HIV response management coordination and supervision through involving district health manager, hospital superintendent or director of hospitals as well as district commissioner and civil surgeon office
- Establish national reference laboratory and divisional network of laboratories to expand and ensure quality of lab services necessary for identification and medical management of HIV and co-morbidities, testing viral loads and monitoring drug resistance. Develop national laboratory policies and plans, upgrade infrastructure/equipment train relevant staff members, ensure functional procurement system for lab supplies.

Strategy 4: Monitoring, Evaluation and Strategic Information

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

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

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

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

A nation-wide surveillance system was established in the country in 1998. The last nation-wide serological surveillance was last done in 2011, and before that in 2007. In addition, a combined Sero-and behavioural survey for MSM, MSW and hijra was undertaken in 2013-14. A comprehensive behavioural surveillance has not been done since 2006-07. However, the Mapping and Size Estimation of KPs conducted in 2015-16 included some key behavioural indicators. Cross sectional surveys were conducted as a

part of the surveillance system among MSM, MSW and TG in 2015 and among PWID and female sex workers (street, hotel, residence and brothel) in 2016 to assess changes in risk behaviours and prevalence of HIV and syphilis in selected geographical sites of the country. 2015-16 surveillance was limited to only three districts and 11 brothels. Decision has been taken for conducting IBBS in 2020. STI should also be brought under surveillance system. Irregularities in conducting surveillance is a big issue for improving country's capacity to respond. Proper resource allocation, early initiation of discussion on conducting surveillance, problem solving and decision making will help to regularise the conduction of surveillance. Regular meetings of M&E TWG could address issues related to barriers in conducting surveillance and other studies.

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

In addition to the national surveillance and size estimates for KPs and other vulnerable populations, other relevant research should be conducted and used to inform the national response. Areas where strategic information is needed include co-infections (TB, Hep C, OIs), situation among migrants and young people, male sexual behaviour, ANC recipients, drug resistance, and stigma and discrimination. For example a serological survey has been carried out among pregnant women in the Sylhet area¹⁰⁹. When extensive screening of pregnant women becomes a reality, it is important to ensure that all data is collected and analysed properly to understand the prevalence and risk factors in different geographic areas. M&E TWG should analyse program data and triangulate available information in order to develop research agenda annually and coordinate and collaborate with relevant authorities to conduct studies.

Strategy 4.3: Strengthen monitoring and evaluation

M&E plan should be updated regularly and the ASP M&E unit should be further strengthened to be able to implement M&E plan, organize M&E Technical Working Group meetings regularly to conduct periodic analysis and review of program data and strategic information from all relevant sources. M&E training need to be provided across the sector and M&E visits need to be undertaken for quality control. The impact assessment of Harm Reduction Interventions in Dhaka has been conducted in 2014. A comprehensive mechanism for measuring the quality and effectiveness of interventions of key populations would be highly informative for program prioritization based on impact. M&E System Strengthening Assessment (MESSA) should be conducted immediately, and measures should be taken to strengthen M&E system accordingly.

¹⁰⁹ Institute of Epidemiology and Disease Control (IEDCR), Ministry of Health and Family Welfare, Bangladesh and UNICEF, 2013. HIV, Syphilis and Hepatitis B Survey among pregnant women in Selected Health Facilities of Greater Sylhet Area of Bangladesh

Strategy 4.4: Improve systems for knowledge management

A management information system for key populations was established in 2013, and later integrated in the national health MIS. Although MIS is in place, it needs improvement to cope with increasing demand of strategic information. The system should be reviewed and adjusted in order to include reporting scope for all stakeholders' response (e.g. WHO, UNICEF, UNFPA, GAMCA, private sector data). An enhanced system for case reporting of HIV, i.e. a real-time reporting system has been established. Program data shared on World AIDS Day on new HIV infection, as well as graphs showing distribution by age, gender, occupation and geographical area are usually presented well and helpful. However, maintenance is still a challenge. To ensure data quality, staff involved in keeping records and entering data need training.

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

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

ASP has been maintaining a website; currently it's functional after a period of non-functional state. An inventory for all the relevant data, program and study reports, strategies, guidelines and policy briefs should be available in the website and all resources can be made available through adding an-archive (DGHS archive can also be utilized). The website needs to be regularly updated.

A national congress maybe organized annually to review epidemic situation and program response involving all stakeholders including KP communities and networks, professional societies and representatives from relevant sectors.

Fast tracking the response:

M&E TWG coordination meetings: Regular M&E -TWG meetings should be held to review, triangulate updated information on the epidemic and response to it in order to provide strategic direction to the program to take appropriate measure based on evidences.

Strengthening M&E system: M&E Plan should be reviewed periodically and M&E System Strengthening Assessment (MESSA) should be conducted immediately to take necessary measure to strengthen and maintain a strong M&E /SI system in the country.

Strengthen Program Monitoring: Program monitoring should be strengthened through field monitoring and supervision visits, service users' exit interviews, and continued capacity building of field level staff through hands on training, mentoring on data quality and triangulation.

Ensure regular surveillances, size estimation of KPs and other relevant research studies in timely manner: Nationwide serological and behavioural surveillance should be undertaken on a biannual basis as it is crucial for assessment of the response and guidance of future directions. It is strongly recommended to secure funding for regular serological and behavioural surveillance as these form the basis of evidence-based response. Proper resource allocation, early initiation of discussion on surveillance, can identify and address issues and help decision making to regularize and ensure regular surveillances, size estimation of KPs and other relevant research studies encompassing various disciplines and fields (e.g. social, behavioral, clinical, epidemiological, community and laboratory based etc.) in timely manner. Research agenda should be developed by the M&E -TWG and reviewed annually to make the country response more evidence based and effective.

Initiate ART adherence and drug resistance monitoring: ART adherence and ARV drug resistance should be monitored through program data as well as periodic surveys. It's also important to look for viral genotypes while studying ARV drug resistance.

Feasibility of including additional populations in surveys and surveillance should be explored: Due to the very low prevalence outside key populations it may not be feasible to include emerging groups in the HIV serological surveillance. However, to explore behavioural risk surveys a FGDs, In-depth interviews can be conducted with potential migrants, their spouses and returnee migrants as well as other groups like students, transport workers (drivers, helpers of bus/truck, water transport workers, rikshaw pullers, dock workers etc.) STI prevalence can be surveyed in different vulnerable groups, anonymous surveys among general male populations can be conducted. Moreover, surveillance, size estimation of KPs and other studies should include age-specific data for better understanding of MARA.

The national HIV response should take a holistic approach on the collection, analysis, sharing and evaluation of strategic information. To reduce confusion, and difficulties of cross referencing, concordant size estimates, serological and behavioural data should be consistently available for the same population groups to make the decision-making more straight-forward and reliable.

Evaluation of design and effectiveness of current targeted interventions: The quality and effectiveness of interventions must be investigated and assessed regularly in order to

achieve as much impact as possible. Cost-effectiveness and cost-benefit studies should be conducted with DIC modalities of targeted interventions.

Continue and improve the use of the dhis2 for better knowledge management and ownership: Data from entities (UNFPA, UNICEF etc.) other than GF Principal Recipients and implementing partners, need to be entered into the dhis2 software as part of the National Health MIS. Continuation and regular update of dhis2 should also be ensured. An annual or biennial fact sheet with collated information should be developed for program review and updating.

Maintain National HIV website and archive: Maintain national website and develop or link it with an existing archive (e.g. DGHS Archive) for all relevant resources to support increase use of SI.

4.0 Results Based Framework: NSP 2018-2023

5.0: Costed Implementation Plan