PROTOCOL OF HIV SERVICES FOR KEY POPULATIONS

March 2023

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LIST OF ACRONYMS

ART	antiretroviral therapy
ASP	AIDS/STD Program
BCC	behavior change communication
CMSD	central medical stores depot
DGHS	Directorate General of Health Services
DHIS2	District Health Information Software, version 2
FGD	focus group discussion
FSW	female sex workers
HBV	hepatitis b virus
HCV	hepatitis c virus
HLD	high-level disinfection
HTS	HIV testing services
IBBS	Integrated Biological and Behavioural Surveillance
IEC	information, education, and communication
IPT	isoniazid preventive therapy
KII	key informant interview
KP	key population
LFA	Local Fund Agent
M&E	monitoring and evaluation
MIP	Management Implementation Plan
MIS	management information system
MSM	men who have sex with men
NASP	National AIDS/STD Program
NFM	new funding model
NGO	non-governmental organization
OST	opioid substitution treatment
PEP	post-exposure prophylaxis
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
PR	principal recipient
PrEP	pre-exposure prophylaxis

PU & DR	program update and disbursement request
PWID	people who inject drugs
RSRA	rapid situation and response assessment
SOP	standard operating procedure
SR	sub recipient
SSR	sub-sub recipient
STI	sexually transmitted infection
TB	tuberculosis
TRP	Technical Review Panel
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

GLOSSARY

Defining Key Populations who are at Risk

The definition of the key population in this document focuses on the risk behaviors of the population, which mainly drive most new HIV infections. Behaviors that put people at greater risk of HIV infection include high rates of unprotected sexual partnerships, unprotected anal sex with multiple partners, and unsafe practices for injecting drugs with multi-user equipment and drug paraphernalia. There may be other groups that are at increased risk of infection. Most of these populations are vulnerable because of their partners' risky behaviors. These populations include sexual partners of people who inject drugs, female sexual partners of men who have sex with men, and partners of clients of sex workers are all at increased risk of HIV infection because their partners engage in risky behavior.

The following key partner definitions are derived from the National AIDS Monitoring and Evaluation Plan 2021-2023 and are standardized for reporting at the national level in Bangladesh:

Sl #	Key Population	Definitions
Female sex workers: Women ages 18 years and older reporting having been paid in cash or kind for sex within the past one year		
1.	Street-based female sex workers	Women who were contracted by clients on the street, with the sex act taking place in a public space or other venues
2.	Hotel-based female sex workers	Women who were contracted by clients in a hotel setting, with the sex act taking place in hotels
3.	Residence-based female sex workers	Women who were contracted by clients in a residential setting, with sex acts taking place in residence
4.	Brothel-based female sex workers	Women who were contracted by clients in a brothel setting, with the sex act generally taking place in brothels
5.	Casual female sex workers	Women who have sold sex during the past one year and had either one or more other main sources of income
Men who have sex with men		
6.	Men who have sex with men	Men who have had sex with men (with consent) within the past one year, regardless of whether they have sex with women or have a personal or social gay or bisexual identity, but do not sell sex
7.	Male sex workers	Men who have sold sex to other men in exchange for money or gifts in the last three months
Hijra (transgender or third gender)		
8.	Hijra (transgender or third gender)	Those who identify themselves as belonging to a traditional hijra sub-culture and who maintain the guru-chela hijra hierarchy. They may be sub-categorized as sex worker hijra, Badhai hijra, and Radhuni hijra.
Clients of sex workers		
9.	Client of female sex workers	A man who bought the sexual services of a female sex worker within the past one year
10.	Client of male sex workers	A person who bought the sexual services of a male sex worker within the past one year
People who use drugs (PWUD)		
	Non injecting PWUD – male	Men who consume psychoactive substances by any route except

Sl #	Key Population	Definitions
		injecting within the past one year.
11.	Non injecting PWUD – female	Women who consume psychoactive substances by any route except injecting within the past one year.
12.	People who inject drugs (PWID)—male	Men who injected drugs within the past one year
13.	People who inject drugs (PWID)—female	Women who injected drugs within the past one year
People living with HIV (PLHIV)		
14.	PLHIV	PLHIV are HIV-positive persons (with a confirmatory HIV-positive test result as per national algorithm). PLHIV may continue to live well and productively for many years. The term "people affected by HIV" encompasses family members and dependents who may be involved in caregiving or otherwise affected by the HIV-positive status of a person living with HIV.
Most at Risk Adolescents for HIV		
15.	Most at risk adolescents for HIV	Includes the following: • Female adolescents and youth (ages 10–19 years and ages 20–24 years) who are involved in commercial or transactional sex work, including those who were trafficked or forced for the purpose of sexual exploitation during the past one year • Male adolescents and youth (ages 10–19 years and ages 20–24 years) who injected drugs within the past one year • Female adolescents and youth (ages 10–19 years and ages 20–24 years) who injected drugs within the past one year • Adolescents and youth (ages 10–19 years and ages 20–24 years) who identify themselves as belonging to a traditional hijra sub-culture • Male adolescents and youth (ages 10-–19 years and ages 20–24 years) who had sex with other men within the past one year, regardless of whether they have sex with women or have a personal or social gay or bisexual identity, but do not sell sex • Male adolescents and youth (ages 10–19 years and ages 20–24 years) who had commercial or transactional sex with other males in exchange for money or gift in the past three months

FRAMEWORK AND POLICIES THAT GUIDED THE DEVELOPMENT OF THE DOCUMENT

1. Chapter 2: Addressing Violence Against Sex Workers. Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions. Geneva, World Health Organization, 2013.
2. Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations-2016 update. Geneva, World Health Organization, 2016.
3. Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations Geneva, World Health Organization, 2022.
4. Consolidated Guidelines on HIV Testing Services. Geneva, World Health Organization, 2019.
5. Ensuring Human Rights in the Provision of Contraceptive Information and Services: Guidance and Recommendations. Geneva, World Health Organization, 2014.
6. Guidelines on Safe Disposal of Needle & Syringes. Dhaka, Save the Children, 2020.
7. Guidelines on Secondary Channels of Needle/Syringes Distribution in PWID Intervention
8. Key Population Program Implementation Guide. LINKAGE, FHI 360. 2016.
9. Mental Health Gap Action Programme Intervention Guide for Mental, Neurological, and Substance Use Disorders in Non-specialized Health Settings. Geneva, World Health Organization, 2016.
10. Monitoring, Evaluation, Accountability, and Learning Framework. Dhaka, Save the Children, 2021.
11. National AIDS Monitoring and Evaluation Plan 2021-2023. Dhaka, National AIDS/STD Control, 2021.
12. National Anti-Retroviral Therapy Guidelines, Bangladesh
13. National Guidelines for Management of Sexually Transmitted Infections (Third Edition). Dhaka, National AIDS/STD Control, 2018.
14. National HIV Testing Services Guidelines, Bangladesh
15. National Implementation Guidelines for HIV and STI Programming Among Young Key Populations. Nairobi, National AIDS and STI Control Programme, Kenya, 2018.
16. National Strategy on Addressing Gender-Based Violence for HIV Response in Bangladesh (2017-2021)
17. Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines. Geneva, World Health Organization, 2013.
18. Revised Guidelines Managing Staff Exposure to COVID-19 in Program Settings

19. Standard Operating Procedures: Service Centre for HIV Prevention among People Who Inject Drugs. Dhaka, Save the Children, 2020.

20. Standard Operating Procedures for Implementing HIV Programmes among Key Populations. The Republic of Ghana, 2017.

21. Standard Operating Procedures: Outreach Service for Effective Needle & Syringe Program. Dhaka, Save the Children, 2020.

22. Joint United Nations Programme on HIV/AIDS Guidance for Partnerships with Civil Society, including People Living with HIV and Other Key Populations. Geneva, Joint United Nations Programme on HIV/AIDS, 2011.

23. Joint United Nations Programme on HIV/AIDS Guidance Note: Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses. Geneva, Joint United Nations Programme on HIV/AIDS, 2012.

24. Trainer's Manual Training Program for The Project Staff of Opioid Substitution Treatment Services, Bangladesh. Dhaka, AIDS/STD Programme (ASP), DGHS and Department of Narcotics Control (DNC), 2022.

25. National Standard Operating Procedure for Opioid Substitution Therapy in Bangladesh. Dhaka, AIDS/STD Programme (ASP), DGHS and Department of Narcotics Control (DNC), 2022.

SECTION 1: BACKGROUND

A. What is the document for?

This document (Protocol of HIV Services for Key Populations) outlines the comprehensive HIV intervention program for key populations (KPs) that the Government of Bangladesh implements in public hospitals in five districts: Barisal, Chattogram, Jashore, Pabna, and Sirajganj. It includes guiding principles, rules of thumb, practical steps, tools, and formats to help hospitals train project staff and customize interventions to the district's specific needs.

This document supplements another vital document, the Management Implementation Plan (MIP) for Bangladesh, which was developed by ICF and endorsed by the Global Fund Country Team. The MIP describes how the National AIDS/STD Program (NASP) will manage the new, increased HIV program delivery, coordination, and financial management, and maintain the required accountability mechanisms. This KP service protocol focuses on program technicalities, standards, and monitoring and evaluation (M&E) processes.

B. Who is the document for?

This document is intended for health professionals implementing an HIV program for KPs at five public hospitals in Dhaka, including the NASP team based in Dhaka, hospital directors or superintendents, medical officers cum center managers, outreach supervisors, peer educators, and others. It is also meant to be a valuable resource for other principal recipients (PRs), sub-recipients (SRs), and implementing partners of the government's operation plan (OP) supported implementing partners to learn about the HIV program strategy from public hospitals.

This document is also of indirect benefit to the following:

- **KPs:** through promoting health and well-being through increased access to services
- **Healthcare managers:** by strengthening their technical capacity to provide high-quality, evidence-based HIV interventions to KPs and others
- **Hospitals and health systems:** by enabling hospitals to improve their public health functions, promote universal health coverage, and contribute to the health and well-being of KPs

C. How has this document been developed?

The KP service protocol, like the MIP, is one of the Technical Review Panel (TRP) recommendations for proposed changes to the implementation arrangements in the most current Global Fund grant (new funding model-3 [NFM-3]), which spans from January 2021 to December 2023. ICF, financed by from the Global Fund's Sustainability, Transition and Efficiency (STE) Strategic Initiative, was engaged to provide technical assistance to Global Fund recipients in Bangladesh to meet the TRP requirements. Two national consultants were engaged by ICF to coordinate and design the KP service protocol.

The protocol was developed in three steps, described as follows. [The concept note on developing the protocol for KP services agreed by NASP, the Global Fund Country Team, and ICF, is included in Annex 1.]

Step 1: Gathering and reviewing pertinent documents

The consultants collected and reviewed essential documents from NASP, other PRs, and SRs. The documents included the following.

- NFM-3 grant documents: concept note, NASP's workplan, TRP recommendations, joint M&E framework, procurement and supply chain management plan, etc.
- Information from the Integrated Biological and Behavioural Surveillance (IBBS) survey and previous studies on the readiness of government facilities to integrate KP services
- Existing standard operating procedures (SOPs) that NASP and other PRs use
- Previous workshop reports and meeting minutes with the hospital superintendent
- NASP's quarterly, six-monthly reports
- NASP's field trip reports from the five districts
- International SOPs for KPs services that guide a similar integrated health facility approach

Step 2: Collecting information using the key informant interviews (KIIs) and focus group discussion (FGDs)

The second step was to collect primary data. The data primarily consisted of recommendations and feasible options derived from KIIs and FGDs from three perspectives: (a) service providers, (b) technical experts, and (c) service recipients.

A semi-structured, open-ended interview guide allowed respondents to express their opinions and describe alternative options and strategies for HIV prevention services from district hospitals, as well as gaps, risks, and requirements. It facilitated a discussion to help identify areas of collaboration among district health authorities and other district actors.

Eleven of the 12 KIIs were conducted in person in the districts of Barishal and Jessore. Table 1 specifies the potential respondents for KIIs.

Table 1: List of FGDs and KIIs

Category	Respondent	# of FGD	# of KII
Service providers and government officials	Global Fund-supported team at NASP	1	-
	KP service team, Sher-e-Bangla Medical College and Hospitals, Barishal	1	-
	Deputy director, Sher-e-Bangla Medical College and Hospitals, Barishal	-	1
	KP service team, Jashore 250-bed General Hospital	1	-
	Director, Jashore 250-bed General Hospital	-	1
Technical Experts	Technical team, HIV Program, Save the Children	1	-
	Senior research investigator, Programme for HIV and AIDS, icddr,b	-	1
Outreach team members (who implement the current methodology through non-governmental	Outreach team member of people who inject drugs intervention of CARE Bangladesh	1	-
	Outreach team member of female sex workers intervention of Save the Children	1	-
	Outreach team members of men who have sex with men and transgender intervention of Light House	1	-

Category	Respondent	# of FGD	# of KII
organization PRs and SRs)			
Community representatives	President, Network of People Who Use Drugs, Bangladesh	-	1
	President, Sex Workers Network of Bangladesh	-	1
Total		**7**	**5**

The data were organized into predetermined boundary categories and labeled according to the outline of this document. Finally, the captured data were triangulated with secondary data and background resources and interpreted to develop the narratives for the draft protocol.

Step 3: Validating the protocol

NASP will organize a participatory workshop with all key informants and stakeholders, including hospital directors and superintendents, PRs and SRs of the HIV program supported by the Global Fund, and community representatives, to share the draft protocol. The protocol will be finalized after the incorporation of workshop feedback.

D. Protocol Development Principles

This protocol is developed with the following principles:

i) Human Rights

The protocol development is based on human rights principles reflected in several international agreements, namely, the right to the following:

- The highest attainable standard of physical and mental health for all, without discrimination
- Accessible, acceptable, available, and quality health facilities, goods, and services, including medicines for the treatment of HIV, viral hepatitis, and sexually transmitted infections (STIs), on an equal basis without discrimination, including, but not limited to, based on sex, gender, health status, disability, nationality, sexual orientation, gender identity, race, ethnicity, age, and marital status
- Access to justice and the right to a fair trial
- Freedom from arbitrary arrest and detention
- Freedom from torture and cruel, inhuman, and degrading treatment
- Privacy, bodily autonomy, security of the person, and freedom from violence
- Availability of the same standards of healthcare in prisons and other closed settings as that available in the community

These principles are grounded in underlying core principles of human rights, namely, accountability, equality, and non-discrimination, and participation of all concerned stakeholders.

ii) Gender Equality

The promotion of gender equality is central to the achievement of HIV, viral hepatitis, and STI prevention, diagnosis, and treatment goals. This means recognizing and considering how unequal power in intimate relationships, harmful gender norms, and lack of access to resources and control over them affect access to and experiences with health services.

iii) Equity and Inclusion

Recognizing and addressing the social determinants of health and promoting equity and inclusion are central to achieving health for all.

iv) Medical Ethics

Healthcare providers and institutions must serve people from KPs based on medical ethics, regardless of personal philosophy, politics, religion, moral theory, or opinion. Particularly relevant are those related to provider-patient/client relationships:

- Patient or client autonomy
- Privacy and Confidentiality
- Informed consent
- Voluntary involvement in health services

Also relevant are codes of conduct and etiquette, which require professionalism, quality, high standards, and dedication to "providing competent medical service in full professional and moral independence, with compassion and respect for human dignity (World Health Organization, 2022)"

v) Universal Health Coverage

This protocol must support universal health coverage, which means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential health services, from health promotion to prevention, treatment, ongoing recovery, and palliative care across the life course.

vi) Evidence-based Public Health

This protocol includes recommendations and good practice statements based on an impartial synthesis of evidence guided by national, regional, and international experts.

vii) KP Community-led Response

This protocol upholds the principle of the greater involvement of people living with HIV (PLHIV), applies it to KPs, and commits to supporting the meaningful engagement of KPs in response to HIV, viral hepatitis, and STIs.

viii) Protection from Sexual Exploitation, Abuse and Harassment

The service providers must adhere to the global fund's operational framework on the protection from sexual exploitation and abuse, sexual harassment, and related abuse of power

E. Responding to HIV, Viral Hepatitis, and STIs in KPs: Theory of Change for this Protocol

Sustainable Development Goal 3 and corresponding target 3.3 are: “End epidemics of AIDS, TB, malaria, and neglected tropical diseases by 2030, and combat hepatitis, water-borne infections, and other communicable diseases.” Given epidemiological data, this can only be accomplished by prioritizing infection prevention, diagnosis, and treatment in KPs. Figure 1 depicts a theory of change for achieving these global targets by 2030.

To effectively prevent, diagnose, and treat infections, KPs require equitable access to services on an adequate scale. As part of its global effort to end AIDS, the Joint United Nations Programme on HIV/AIDS (UNAIDS) set up HIV coverage targets for 2025: 95 percent of PLHIV know their HIV status, 95 percent of PLHIV who know their status undertake treatment, 95 percent of people on HIV treatment are virally suppressed, and 95 percent of women have access to HIV and sexual and reproductive health services. By 2030, the global target for viral hepatitis is to have 90 percent of people living with hepatitis C virus (HCV) or hepatitis B virus (HBV) diagnosed and 80 percent treated (HBV) or cured (HCV). By 2030, the target for STIs is for >90 percent of priority populations to be screened for gonorrhea or syphilis and >95 percent to be treated if positive.

Access to services for KPs can only be strengthened if structural barriers, such as stigma and discrimination, criminalization, restrictive policies and violence, and other rights abuses, are eradicated and an enabling environment exists. Women who are members of KPs and partners KP members are at an exceptionally high risk of getting HIV and are less likely to seek treatment. The UNAIDS Global Strategy to End AIDS incorporates structural barriers targets for 2025: less than 10 percent of countries have punitive laws and policies that prohibit or limit access to services, less than 10 percent of people face stigma and discrimination, and less than 10 percent face gender inequality and violence. Community empowerment is also essential to increasing access and coverage.

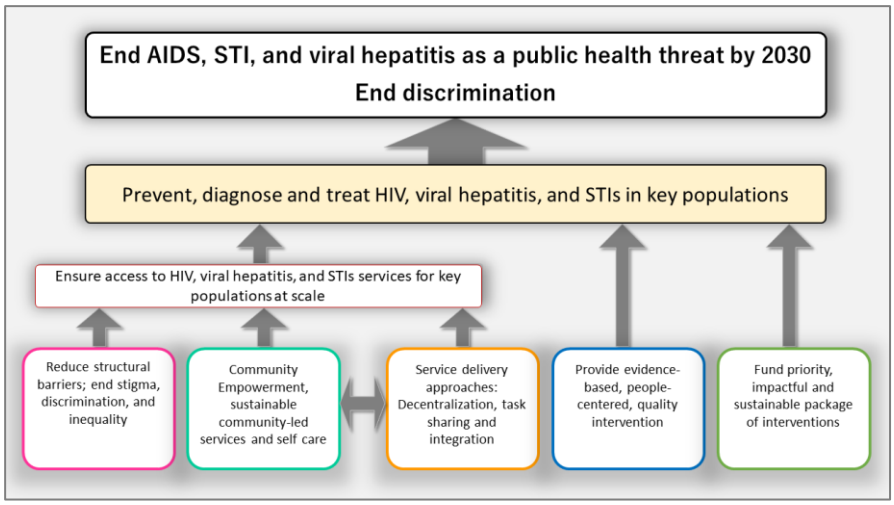


Figure 1: Theory of Change for this Protocol

Putting KPs at the center of healthcare systems—by arranging services around people’s needs rather than diseases and by supporting integrated patient-centered approaches and links with primary healthcare services—is essential to end these epidemics. Different service delivery approaches, such as shifting tasks to KP peers as health workers, decentralizing service provision to KP community-led programs, providing services online, and service integration, are also needed to improve KP access to and availability of HIV, viral hepatitis, and STI services.

Prevention, diagnosis, and treatment of STIs, viral hepatitis, and HIV can only be made if individuals receive appropriate, evidence-based interventions that consider their specific health needs through

person-centered care. Understanding what works to prevent, diagnose, and treat these diseases is required.

Finally, although several effective interventions for preventing and treating HIV, STIs, and viral hepatitis in KPs are cost-effective and cost-saving, their benefit cannot be achieved without adequate funding. Funding must be long-term, consistent, and focused on supporting communities at higher risk.

SECTION 2: PROGRAM STEWARDSHIP

In addition to serving as a nodal body to lead and coordinate national HIV responses, NASP directly implements KP intervention in five public hospitals under the NFM-3 grant that included 3,000 people who inject drugs (PWID) for the needle syringe program and 1,873 female sex workers (FSW). As part of the 4th Health Nutrition Population Sector Programme, NASP delivers HIV prevention services through the non-governmental organization (NGO) service procurement mechanism to 3,600 brothel-based FSW, 5,572 PWID for the needle syringe program, 1,300 PWID for opioid substitution treatment (OST), and about 3,000 men who have sex with men (MSM) and transgender individuals.

The KP service protocol focuses on the five public hospitals that are directly implementing HIV interventions under the Global Fund grant. Upon completion of the pilot, this implementation will be reviewed and updated to enhance its effectiveness. The refined approach can then be adopted by other programs with similar objectives for improved outcomes. Table 2 shows the coverage by district for NASP's direct implementation sites:

Table 2: Coverage by NASP's Direct Implementation Sites under the Global Fund-supported NFM-3 Grant

District Name	No. PWID for Needle Syringe Program	No. FSW
Barisal	971	1,209
Chattogram	700	-
Jashore	298	-
Pabna	550	332
Sirajganj	481	332
Total	**3,000**	**1,873**

The stewardship of this direct implementation component is divided into three key tiers.

Tier 1: NASP's Head Office Level

Under the authority of the director, the government's revenue budget includes a total of nine positions. They are the primary custodians of five district hospitals' KP programs. Supported by the Global Fund, a 10-member project management team headed by the senior manager (management and coordination) at NASP's Dhaka offices is accountable for daily decision-making, problem-solving, and program implementation in the five districts. The senior manager (management and coordination), with assistance from the manager–KP intervention, is the primary point of contact for the overall implementation of the Global Fund grant and serves as an intermediary between NASP's leadership and project management team. Please see Part 1: Program Technical Management of the MIP for a detailed organogram, hierarchy, and job responsibilities of each position (annex 2).

Tier 2: District Level

The director/superintendent of the hospital is responsible for the district's overall stewardship, technical and management leadership, and oversight of all HIV prevention activities. The position engages and coordinates with district-level government officials (civil surgeon, deputy director of the department of narcotics control, deputy jailor, social welfare officer, family planning officer, police super, and others), political and civil society leaders, and other key stakeholders (NGO PRs, SRs, sub-sub recipients (SSRs),

other NGOs working on sexual and reproductive health, journalists and media personnel, community representatives, etc.) to bring a multi-sectoral evidence-based HIV response to the district. The position is critical in ensuring that HIV activities are integrated into routine service delivery at the hospital, resolving obstacles and challenges, and coordinating HIV activities with other departments (such as medicine, gynecology and obstetrics, mental health, surgery, pediatrics, and eye care).

The director/superintendent of the hospital administers and advises on the overall program and provides financial and technical guidance to the project team to maintain internal controls and adherence to government policies and procedures and the Global Fund's rules and regulations. The position functions as the signatory for fund management and financial expenditure. As the final authority for the district team, this individual ensures the timely and quality delivery of project outputs and activities, leads the project team, facilitates review and audit by the Local Fund Agent (LFA), and oversees the timely and accurate submission of reports to NASP as needed.

One medical officer cum center manager, one outreach supervisor, one office attendant, and five to eight peer educators (depending on the KP concentration) are deployed in each of the five district hospitals to carry out NASP's direct implementation program among KPs. The team is also supported by one community peer counselor and a lab technologist in the area in which the antiretroviral therapy (ART) facilities are already established.

medical officers cum center managers collaborate closely with the director/superintendent of the hospital, ART focal person, other hospital departments, and stakeholders, such as narcotics control, social welfare, and law enforcement, to ensure the necessary support for implementing KP interventions. In consultation with the director/superintendent of the hospital, they organize frequent coordination meetings and advocacy workshops with various stakeholders at the hospital, conduct regular field visits to assist peer educators' field activities, and gathers service logistics from NASP and the hospital store.

Tier 3: Community Level

The outreach supervisor is primarily responsible for managing the HIV and AIDS prevention programs at the community level. The position closely coordinates and monitors peer educators' field activities, keeps track of daily update information, and oversees weekly, monthly, and quarterly data compilation and report preparation.

SECTION 3: SUPERVISION MECHANISMS

This section provides a synopsis of five hospitals' supervisory mechanisms for KP services. It is to be noted that the MIP contains a complete organogram; the roles, responsibilities, and reporting lines of each position; and the link between the central and hospital levels.

a. Supervisory Hierarchy at the Central Level

The line director at NASP supervises the senior manager (management and coordination). The line director has signatory authority over all expenditures, regardless of operation plan or Global Fund grants. The senior manager (management and coordination) is obliged to strictly follow the line director's directions and decisions. The deputy director and program manager are responsible for administering operation plan-funded grants and coordinating national HIV responses. Both the director and the line director supervise this position. The assistant director oversees the Global Fund-supported HIV grant at NASP on behalf of the director. The senior manager (management and coordination) relies on the assistant director for day-to-day assistance and guidance.

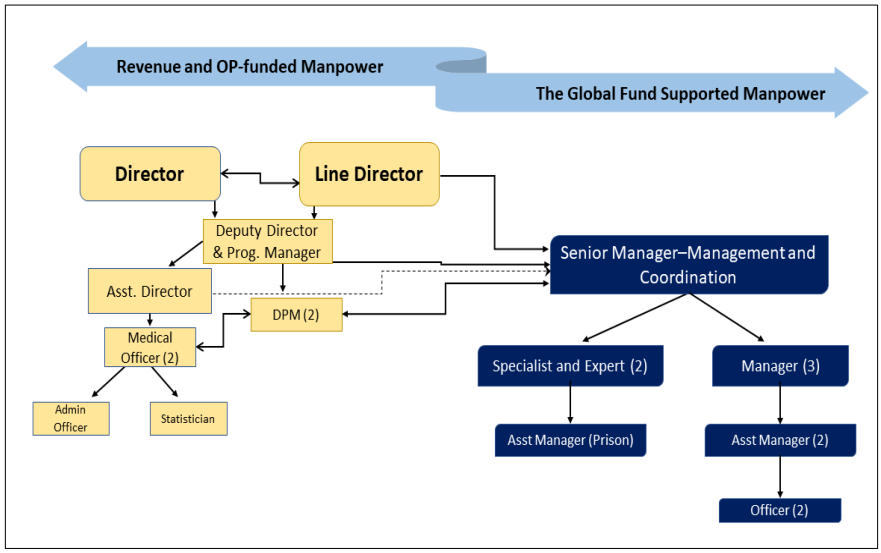


Figure 2: Supervisory Hierarchy at the Central Level

The overall responsibilities of the senior manager (management and coordination) include work plan management, budget management, and reporting. The position is also in charge of program planning, organization, and management, as well as coordinating with various stakeholders to implement NASP's regular programs and events. The position is the supervisor of Global Fund-supported two experts (technical specialist–HIV and M&E expert) and three managers (manager–data and IT, manager–procurement and manager–KP intervention).

In collaboration with the director/superintendent of each hospital, the manager–KP intervention is accountable for planning and implementing high-quality PWID and FSW interventions in five district hospitals. The position is responsible for monitoring and interpreting intervention progress, reporting on project status, supervising the field-based KP intervention implementation team, and providing the necessary guidance to ensure timely and appropriate project expenditures while maintaining compliance and efficient use of project resources. Furthermore, the position conducts extensive field visits for M&E activity and ensures functioning collaborations and coordination with other NGO PRs and community networks. The position is supervised by the senior manager (management and coordination). Figure 2 portrays the central level of the supervisory structure.

b. Supervisory Hierarchy at the District Level

The director/superintendent of the hospital, in conjunction with the ART/HIV Testing Services (HTS) focal persons (as applicable), administers, advises on, and provides financial and technical guidance to the project team based in the hospital to maintain internal controls and adherence to government procedures and guidelines and compliance with the Global Fund's requirements. The position serves as the signatory for financial management and expenditures. As the final authority for the district team, this person is responsible for ensuring the timely and quality delivery of project outputs and activities, leading the project team, facilitating review and audit by the LFA, and overseeing the timely and accurate submission of reports to NASP. The role collaborates with district-level government authorities (such as the Civil Surgeon, Department of Narcotics Control, Prison, Department of Social Welfare, Family Planning, Police, and others), political and civil society leaders, and other stakeholders (NGO PRs, SRs, SSRs, other NGOs working on sexual and reproductive health, journalists and media personnel, community representatives, etc.) to deliver a multi-sectoral evidence-based HIV response to the district.

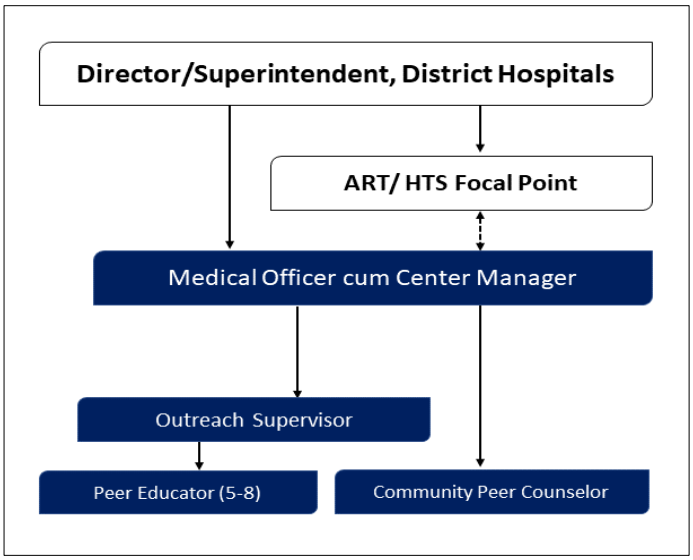


Figure 3: Supervisory Hierarchy at the District Level

The medical officer cum center manager draws the director/superintendent of the hospital's attention to the situation through regular communication, cooperation, and support. This individual is the primary point of contact for the hospital-based KP intervention and works closely with other hospital departments. In consultation with the director/superintendent, this position organizes frequent coordination meetings and advocacy workshops with various stakeholders, performs regular field visits to assist peer educators' field activities, and obtains service logistics from NASP and the hospital store.

The outreach supervisor reports to the medical officer and center manager and oversees the HIV and AIDS prevention program's outreach operations. This position coordinates, monitors, and supervises the peer educators maintains a record of daily update information, and handles the weekly, monthly, and quarterly compilation and preparation of reports.

The primary responsibility of the peer educator is to promote HIV prevention services to KPs, distribute condoms and needle syringes, conduct health education sessions, and accompany potential clients to hospitals for clinical services. This position makes mapping exercises, KP identification, and quarterly/half-yearly *mother list* updates. In addition, the peer educator provides peer counseling, maintains regular contact with KP networks, conduct follow-up, identify causes of lost to follow-up and mitigate them, and improves KP health-seeking behaviors. The peer educators are under the supervision of the outreach supervisor. Figure 3 illustrates the district-level supervisory structure.

SECTION 4: DESIGNING INTERVENTIONS

This section details how to prepare and develop the KP intervention before its full-scale implementation.

A. Ethical Considerations

The RSRA must take into account the ethical issues involved, including the risks of and benefits to the FSW, PWID, and other key stakeholders. The following aspects will be maintained for a high level of ethical consideration.

- **Clearance from the ethical review committee:** Based on the previously indicated methodology, NASP should develop the RSRA conceptual framework and obtain approval from the relevant ethical review committee.
- **Neutrality:** The study team should be non-judgmental in their work. This means respecting the comments and opinions made by the respondents.
- **Confidentiality and comfortability:** All information collected will not be shared with other people, agencies, or third parties. This should be made clear to everybody taking part in the study. Furthermore, privacy will be safeguarded during the data collection. Data that might be used to identify an individual or area will be kept in a secure place.
- **Informed consent:** The RSRA is conducted based on informed consent, meaning that respondents will be sufficiently informed about the study to decide whether or not to participate.

B. District Mapping of KPs and Microplanning

The initial phase of planning for the KP intervention is conducting a rapid situation and response assessment (RSRA), which provides baseline data and information on the HIV prevention services available in the districts for PWID and FSW. The RSRA is a method for identifying and assessing the degree and nature of social and health problems related to drugs and sex work and designing programs to address these problems in a specific location.

For the first implementation of the RSRA in a district, the following steps should be taken:

Step 1: Team formation and training

A district-level RSRA requires a minimum of 7 to 10 team members. At least half of the team members must be from the sex worker and drug user community in the respective districts. The team requires training on the methodologies, data collection instruments, and triangulation techniques.

Step 2: Collection and analysis of secondary information

The major sources of secondary information include official estimates, PWID and FSW arrest data from police and other law enforcement agencies, drug seizure data from the department of narcotics control, previous drug use survey data, hospital admissions and drug treatment statistics, STI-related statistics, IBBS data, size estimation data, and court case data for FSW and vagrant home admission and release data, among others.

One important data source is local media monitoring, which includes gathering, analyzing, and collecting information from local daily newspapers and social media news channels on drug use, sex work, any information related to MSM and TG, hepatitis, STIs etc. At least two team members should examine secondary data sorting, groupings, and analysis and prepare a summary sheet with references or sources. The data categorization could be the following.

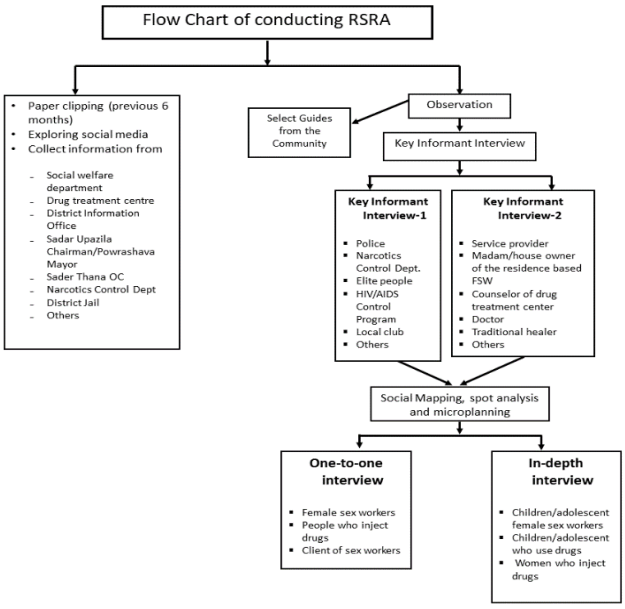


Figure 4: Flow Chart of the RSRA

- Drug use and sex work scenario
- Information related to MSM and TG
- Six-month trends in drug use and sex work
- Locations/spots/congregation places where drug use/sex work/MSM/TG take place
- Those who are injecting/involved with sex work (disaggregated by age, socioeconomic status, gender, occupation, and other sociodemographic characteristics)
- Factors contributing to the spread of injection drug use, such as drug route and any ritualistic/cultural factors, etc.
- HIV, STIs, hepatitis B and C viruses, tuberculosis (TB) information (any published service availability, etc.)
- Information about overdoses and abscesses
- List of key informants

Step 3: Spot observation

After gaining a basic understanding of drug use and sex work spots related details in the district from secondary information, the third step is spot observation.

The initial on-site spot observation should be unstructured and quiet. After gaining a basic grasp of the sites, team members should conduct structured observations employing a checklist. Team members should use time point observations, which entail observing locations during both peak and off-peak hours. The main objective of the observation is to watch, listen, and record the living environment, context, people, power structure, activities in detail, including signs, timing, and any special characteristics of the locations. The secondary goal is to establish rapport with the power structure, which includes pimps, madams, peddlers, neighborhood gatekeepers, such as street store owners, on-duty law enforcement officials, and members of the FSW and PWID communities. The assessment

team also explores potential guides who can assist the team in figuring out the overall estimated number of the FSW and PWID spots.

Step-4: Key informant interviews

Parallel to the spot observation, a list of potential key informants should be prepared. The KII is to be carried out, preferably one-on-one, with the relevant person who already has information due to their position or life experience. These experts provide insight and recommendations with their functional expertise and understanding of sex work and drug use in the districts. Key informants are widely classified into two groups:

- **Key information 1 (person or organization who enforces laws or social norms):** those involved in the sex work or drug use situation for enforcing legislation, policy, or social norms, such as police, narcotics control dept, elite social people, local political leaders, local club members, and others
- **Key informant 2 (service providers):** those who provide any support to PWID or FSW, such as a madam/house owner of a residence-based FSW, a pimp, a government social welfare official, a public leader (Mayor, Chairman, members, etc.), a counselor of a drug treatment center, a public health professional, NGO officials involved in sexual and reproductive health or HIV/AIDS programs, a traditional healer, local officials of the HIV/AIDS control program, and others

The assessment team uses a semi-structured questionnaire tool for KIIs. The main topic of discussion is what behaviors increase HIV risk among PWID and FSW in the district, and what are the policy responses, available programs and services, obstacles, programs needed, and so on. The team will also obtain the key informant's estimate of the number of FSW and PWID by location to triangulate it with the observation data.

The interview length should be between 45 and 60 minutes. The interview should be conducted by two members of the assessment team, one of whom should take notes. If only one member of the assessment team is available, that individual should take short notes. However, if consent is obtained, an audio recording may be used to make a complete transcript for further analysis.

Tips for the KII

a. Before the interview:

- Describe the objective and importance of the RSRA in the context of the respective district.
- Start with thanks to the key informant for their support and time.
- Obtain consent for recording and note taking.

b. During the interview:

- Introduce the questions and the discussion topic in native languages and avoid jargon and acronyms used in the program.

c. After the interview:

- Encourage the respondent to refer other potential key Informants and documents such as reports and guidelines, and collect them from the key informant if they have a copy.
- Summarize and end the conversation with thanks.

Step 5: Social mapping, spot analysis, and microplanning

Social mapping is developing a map of the district's catchment area that shows the PWID and FSW spots, main roads, sub-roads, important landmarks, and other establishments. Following the social mapping exercise, each spot-specific analysis should be plotted on the same map. Spot analytics is a process of exploring the characteristics of drug use and sex work spots using social mapping. For example, the number of FSW/PWID, the number of FSW/PWID visited spots and the time spent there, the kind of drugs sold and used, the number of clients of sex workers at a spot, the number of PWID who share drugs and the types of drugs shared, and so on. The mode and timing of service delivery are determined based on this information.

Prepare a draft mother list on a spot-by-spot basis and conclude with an estimated number of FSW/PWID

After spot analysis, the potential client (FSW/PWID) names and code numbers are recorded in another format ("contact mapping") for further analysis of individual FSW/PWID. The medical officer cum center manager and the director/superintendent or their representative should be engaged in overall assessment and ensure a timely response to spot mapping and analysis.

The mother list is a basic document for the KP intervention. It contains the following variables.

For the FSW intervention:	For PWID intervention:
• Name [using code] • Father's/mother's name [using code] • Spouse/regular sex partner's information [using code] • Year of birth • Where do you live? • If in residence, current address • Permanent address • Mobile number (own/family/friend) [using code] • Typology (street based/residence based/hotel based) • Name/location of the spot/residence/hotel where you peruse the client • The timing of your availability at the spot/residence/hotel • Occupation other than sex work • Education • Marital status • How often do you have commercial sex each week/month? • How long have you been involved in commercial sex? (in years) • How many condoms do you need on a regular basis (weekly/monthly)? • • Have you had any STI symptoms in the last three months? What were the symptoms, if any? • How many times have you used a condom in the previous three sex acts?	• Name [using code] • Father's/mother's name [using code] • Spouse/regular sex partner's information [using code] • Gender • Year of birth • Where do you live? • If in residence, current address • Permanent address • Mobile number (own/family/friend) [using code] • Name of the spot where you inject drugs • The timing of your spot visit (when you are available at the spot) • Occupation • Education • Marital status • How many times a month do you usually have sex (with your regular sex partner/any other partner) • How long have you been injecting drugs? (specify year) • Have you had a cocktail in the last three months? (yes/no) • In which way do you usually take drugs by injection? (vein/muscle) • How many times, on average, do you take drugs by injection? • Have you taken drugs through shared needles/syringes in the past three months?

For the FSW intervention:	For PWID intervention:
• Have you taken drugs in the last three months? If so, what type of drugs are they? (Multiple answers possible) • Have you ever been jailed? (yes/no, comments)	• Apart from the injection, do you take any other drugs? (if yes, write the name) • Have you ever been to jail? (yes/no, comments)

Considering the sensitivity of the information, it is essential to take measures to ensure data security and protect participants' privacy. Such as:

- **Anonymize data:** Remove personally identifiable information immediately and replace it with codes. This helps protect participants' identities and privacy.
- **Secure storage:** Keep physical records, such as questionnaires and interview transcripts, in a locked cabinet or secure location, accessible only to authorized researchers.
- **Controlled access:** Limit access to the data by implementing a system where only authorized researchers can view or use the information. Maintain a log of data access for accountability.
- **Secure disposal:** Establish a policy for securely disposing of data once the study is complete or the retention period has passed. This may involve shredding physical documents and deleting electronic files.

IMPORTANT NOTE

The initial mother list may include duplication of client profiles. It must, however, be revised until it meets the saturation point of listing all FSW/PWID within the catchment area. Each team member should share the mother list with the others so that duplication may be avoided immediately. Notably, the mother list is a living exercise. Drug use and sex in work situations are constantly changing. As a result, this information must be updated regularly (quarterly basis) to reflect changes.

Step-6: One-on-one interviews with PWID and FSW

Step 6 is optional for districts that were included in the most recent IBBS and had the district's most recent FSW and PWID behavioral data. If not, this step must be carried out. A one-on-one interview is conducted using quantitative methodologies to assess demographic, injecting and sexual practices, self-reported STI and other illnesses, HTS information, client exposure to any intervention, and harassment service needs, among other variables. It is strongly suggested that tools from the most recent behavioral surveillance be adapted to compare data. In this case, the M&E professionals should lead the one-on-one interview, which should be supported by the manager-KP intervention.

Step-7: In-depth interviews, especially with vulnerable KPs (children/adolescent FSW, children/adolescents who use drugs, women who inject drugs)

Due to extreme marginalization, lack of information, and access to health services, child and adolescent FSW, child and adolescent drug users, and women who inject drugs are more vulnerable to HIV

infection. Designing interventions for differentiated service delivery for these individuals is crucial. The service requirements of this population also vary. Essential HIV services may not reach them using only a generalized approach. For this reason, in-depth interviews must be done with all accessible children/adolescent FSW, children/adolescents who use drugs, and women who inject drugs on the spot to fully understand the context-specific needs and subsequently design interventions.

C. Dos and Don'ts

Throughout the RSRA, the following dos and don'ts must be adhered to.

Do's	Don'ts
• Build rapport • Use local terms (at least colloquial language) • Show a non-judgmental attitude • Be unbiased • Be careful (the drug scene and sex working spots can be extremely violent) • Express your objective clearly and explain your affiliation • Show respect to the community • Explain clearly the purpose of this activity and its importance in planning and implementing HIV interventions among KPs, as well as how the people of such districts would benefit from the intervention • Keep your credential (ID card, introductory letter, etc.) with you	• Do not engage in drug use or sex acts at these locations • Do not deal drugs • Do not engage in violence • Do not take valuable belongings in to field (gold chain, money, etc.) • Do not move alone to the spot • Do not interfere with the actions of law enforcement personnel • Avoid attracting too much attention from the community (maintain a low profile)

D. Defining the Minimum Service Package for Each Category of KP

After receiving the RSRA outputs—mother list of FSW and PWID, social map, spot analysis, and behavioral data—it is time to define the minimum service package for each KP group. The following list of packages of services is strongly recommended based on decades of HIV interventions in Bangladesh and the most recently published World Health Organization (WHO) consolidated recommendations on HIV, viral hepatitis, and STI prevention, diagnosis, treatment, and care for important populations (2022). The interventions listed here have been categorized as follows:

1. **Behavioral interventions:** This includes health sector interventions that support the delivery of other interventions, such as creating demand and providing information and education.
2. **Health interventions:** This includes health sector interventions that have a demonstrated direct impact on HIV, viral hepatitis, and STIs in KPs.
3. **Essential for broader health:** This includes health sector interventions to which access for KPs should be ensured but do not directly impact HIV, viral hepatitis, or STIs.
4. **Enabling interventions:** This includes all interventions recommended to reduce structural barriers to health services access for KPs.

Table 3 explains the minimum package of interventions in each category for FSW and PWID.

Table 3: Recommended Package for FSW and PWID

Minimum Interventions	Applicable for	
	FSW	PWID
1. Behavioral interventions		
• Behavior change communication activities and information, education, and communication activities by peer education	✓	✓
2. Health interventions		
a. Prevention of HIV, STIs, and viral hepatitis and STIs		
• Condoms and lubricant programming	✓	✓
• Needle and syringe program	-	✓
• Opioid substitution treatment	-	✓
• Naloxone for overdose management	-	✓
• Pre-exposure prophylaxis for HIV	✓	✓
• Post-exposure prophylaxis for HIV and STIs	✓	✓
• Prevention of vertical transmission of HIV, syphilis, and HBV	-	✓
• Hepatitis B vaccination	✓	✓
b. Diagnosis and treatment		
• HIV testing and counseling (including HIV self-testing)	✓	✓
• HIV care and treatment	✓	✓
• STI testing and treatment	✓	✓
• Prevention, screening, diagnosis, and treatment of TB	✓	✓
• Hepatitis B and C testing and treatment	✓	✓
3. Essential for broader health		
• Abscess management	-	✓
• Family planning, conception, antenatal, delivery, and post-natal care	✓	✓
• Mental health	✓	✓
• Prevention, assessment, and treatment of cervical cancer	✓	✓
• Safe abortion	✓	✓
• Screening and treatment for hazardous and harmful alcohol and other substance use	✓	-
4. Enabling interventions		
• Removing punitive laws, policies, and practices	✓	✓
• Reducing stigma and discrimination	✓	✓
• Community empowerment	✓	✓
• Addressing gender-based violence	✓	✓

Section 5 will explain how, when, and with what mode of delivery the minimum service package will be provided.

SECTION 5: PROGRAM IMPLEMENTATION AND SERVICE DELIVERY

A. Outreach Strategy: Strategies to Reach KP

Based on the KP interventions model, outreach work is similar to social work relevant to public health-related interventions. In this work, a "key worker" leaves the office and "hits the street" to meet individuals in their defined location and operate outside the typical office hours paradigm.

There are two levels of outreach work:

- An individual approach aimed at changing one's behavior
- A group-oriented approach aimed at achieving socio-cultural change

Outreach to FSW and PWID has been one of the most frequently conducted interventions because it may reach stigmatized populations of FSW and drug users who are hidden (neither sex work nor drug use is typically done openly in front of strangers).

Outreach is a systematic approach to providing KP intervention services to FSW and PWID in their environments at the street level. These services supplement stationary or permanent service centers, such as district hospitals.

Definitions and Relevance of Outreach

Outreach is defined as follows:

- "… any attempt to take a service to people who need it and would otherwise not use the service." (Thomas, Pierson, 1995)
- "…. Community-oriented activity undertaken to contact individuals/groups from particular target populations who are not effectively contacted or reached by Existing services or through traditional health education channels." (Hartnoll, 1990)
- "…. Providing services to drug users where he or she just is: do not wait for her to come to you." (Save the Children and CARE Bangladesh, 2020)
- "… services could be provided on the streets, in shooting galleries, hospitals, police stations, welfare agencies and treatment centers, etc…" (Save the Children and CARE Bangladesh, 2020)

Outreach is a systematic approach to providing KP intervention services to FSW and PWID in their own environments at the street level. These services supplement stationary or permanent service centers, such as district hospitals.

Recommended Models for KP Intervention Outreach in the Five Districts

Some of the following outreach models have effectively supported Bangladesh's ongoing FSW and PWID interventions:

- **Day and night outreach at the spot with estimated FSW or PWID:** This is a usual method for reaching the FSW or PWID at convenient times. All precautions must be taken to protect client privacy and confidentiality. Peer educators (commonly referred to as outreach workers) meet

FSW and PWID with health supplies (condoms, needles, syringes, HIV test kits, etc.) and pertinent information (information, education, and communication [IEC]/behavior change communication [BCC] materials, dildo for condom demonstration) at distinct times based on peak and off-peak hours of the spots. The outreach team visits hotels and residences using the same strategy for reaching out hotels and residences based FSW. Depending on the requirements of the spot, the team does outreach in one, two, or three shifts. The most common outreach among street-based FSW occurs at night, beginning after dusk and continuing until 10 p.m.

This outreach method is highly recommended for the street-based FSW and PWID in the five districts.

- **Low-threshold (home visit) outreach, only when the client and his or her family or partner are comfortable:** In Bangladesh, home-based outreach is an effective and common strategy for resident-based PWID, FSW, and PWID living with HIV and AIDS. Furthermore, during the COVID-19 pandemic, there has been a need to expand outreach strategies with innovations, and the outreach team adopted this approach instead of outreach at the spots. Health supplies and information were delivered to beneficiaries' homes with their consent. All precautions were taken to avoid taking any action that might enable the neighborhood or any person to spot them. For initial contact with the FSW and PWID, peers were contacted and mobile phone calls were employed.

  The five hospital-based outreach teams will use a similar process for reaching out to the resident-based PWID, FSW, and PWID living with HIV and AIDS.

- **Shooting galleries (highly sensitive), only when the concerned people permit access:** This method is more applicable to PWID intervention, when many PWID are injecting drugs in a group. Such galleries are often located in the city's periphery or suburbs. Shooting galleries should be dealt with delicately if identified. Only a designated outreach worker will pay a visit at the specified time. All precautionary steps must be taken to ensure that such environments or individuals are not harmed.

  If the RSRA discovered such shooting galleries, the five hospital outreach teams would adopt this outreach strategy. The strategy necessitates particular caution. The most competent peer educator on the team and the outreach supervisor should be engaged in these initiatives.

- **Remote outreach:** Because of the geographical location, semi-urban and rural communities sometimes lack access to HIV prevention supplies. A mobile outreach unit best serves such locations, with two to three team members establishing a system to contact FSW and PWID and ensuring regular supply. Motorbikes are used in a few Asian settings to cover two or three locations and return to the reporting station.

  Such remote places have previously been discovered in Jessore and Pabna. Benapole is the remote area for Jessore, and Ishwardi is the remote place for Pabna. The team in the two areas should guarantee that a motorcycle is available for the distant outreach.

Principles of Outreach

Outreach for FSW and PWID is based on several principles that are interlinked and interdependent. The overall outreach objective can be compromised if one principle is not followed. Effective outreach that helps to bring services to the doorstep of FSW/PWID must be based on these principles:

- **Respect:** Service providers should respect and trust FSW and PWID as individuals.
- **Teamwork:** Delivering outreach is teamwork. Efficient teamwork helps ensure greater delivery of services.
- **Non-judgmental:** Service providers should not have preconceived negative notions about the beneficiaries. Such judgmental attitudes act as impediments to successful service delivery, including outreach.
- **Empowerment:** Service providers should empower the FSW and PWID clients to make decisions for their health and welfare. A "client-generated" demand helps in greater acceptability of services provided by the HIV program.
- **Do no harm:** Service providers should ensure that clients/beneficiaries are not harmed in their attempt to provide services.

Outreach Work: What exactly does the outreach team do?

Outreach work is helpful in making and maintaining contact with the following features:

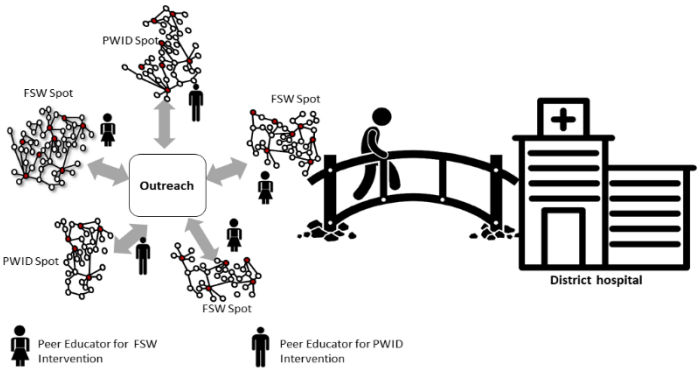


Figure 5: Conceptual Framework of the Outreach

- **Collecting information** on what is going on, what problems of the targeted individuals and groups have priority, how many drug users and FSW are in the spots etc.
- **Providing advice and information (educational sessions)** on where to find client-matching interventions, specific services, and information on safer behaviors (e.g., concisely repeated messages on different occasions and from different angles); sharing information about health, safer sex, drug use, safer drug use, etc.
- **Providing HIV prevention supplies (condoms, needle syringes)** to the FSW and PWID to promote the safer practices; collecting used needle syringes for safe disposal
- **Performing HIV testing in the community** under the community-led HIV testing protocols, training the outreach team to perform HIV testing at the spots/hotels and residences
- **Conducting accompanied referrals** to ensure accompanied referral for STIs, abscesses, and other linked and non-linked services such as therapeutic programs
- **Providing aid and assistance** in case of psychosocial problems, when referrals are impossible
- **Representing the interests of the target groups** by informing other services and organizations about the living situation and needs of the target groups

Planning the Outreach Cycle

Having the estimated number of spots of FSW and PWID, based on the draft mother list, the full outreach team, led by the Medical Officer, needs to plan the outreach cycle so that:

- Every mother-listed PWID should be contacted at least once every other day.
- Every mother-listed FSW should be contacted at least once a week.
- The outreach timing must include each spot's pick-up time.
- Congregation of FSW and PWID during unusual times (such as early morning or late evening) should be considered, and peer educators should be deployed accordingly.
- To ensure accountability, deploy outreach teams consisting of two members each. This pairing approach promotes responsibility, collaboration, and mutual support during the outreach process.
- Although the estimated number of children or adolescent FSWs, children or adolescent drug users, and women who inject drugs is low, these groups should be given special consideration. Based on the travel convenience, deployment of dedicated peer educators for this group is highly recommended.
- One peer educator should serve no more than 50 PWID or FSW.
- No more than one outreach supervisor should supervise six peer educators.
- Outreach activity must be linked with the district hospital-based clinical facilities.

B. Human Resources and Capacity Building (Peer Educator, Supervisor)

Human resources are a critical and necessary component of every program. Successful programs need the involvement of team members with a wide range of skills, such as members of KP communities or persons who have experience with KPs and are "KP competent" (e.g., comfortable working with and delivering programs for these marginalized populations). The team's specific composition (number and kind of skills) in each district is determined by the estimated number of FSW and PWID found in the RSRA, category, service delivery strategy, and intended program coverage. Each intervention should, at a minimum, ensure adequate staffing (appropriate categories, level of effort, and staff numbers) to assume responsibility for service delivery, outreach, and M&E. The recruiting of the outreach team must adhere to the following standards:

- More than 80 percent of the outreach team, particularly the peer educator, must be community members, which means that for the PWID interventions, the team must have drug use (current or previous) experience. For the FSW intervention, the team must be from the FSW community, either currently or previously involved with sex work.
- The remaining 20 percent of team members must be permanent residents of the districts who are knowledgeable about the location and key stakeholders, such as local power structures and government officials.
- Peer educators must have a gender-sensitive approach. FSW and women who inject drugs should be reached by female peer educators, and male peer educators should reach men who inject drugs.
- Involvement of PWID and FSW community-based groups in the outreach team recruiting process provides a significant benefit in identifying qualified peer educators.

- Staff turnover is a common occurrence on the outreach team. To minimize interruptions to field activities, NASP must maintain a candidate pool for each outreach team cadre (particularly peer educators and outreach supervisors).
- Each day, before or after outreach activities, the whole team should sit together and analyze the field situation, making joint decisions to overcome local-level challenges.
- The outreach team must adhere to the operating principles for outreach outlined in the following section.

C. Operating Principles for Outreach

Principle 1: In a hospital, the client tends to be a guest; in street interventions, peer educators are the guests, and therefore, they must behave as such.

REMEMBER

- *Constant stigmatization and discrimination of FSW and PWID have led to mistrust.*
- *Hostility is often the only form of defense available.*
- *Initially, outreach may be seen to be a nuisance, until the outreach team can respect the priorities of FSW and PWID.*
- *The local community, madam, pimp, drug pushers, and police may initially give a hard time.*
- *Things will not change quickly, and there may be resistance to change.*
- *The outreach team will feel strong negative emotions and burnout.*

We will not be welcomed until accepted.

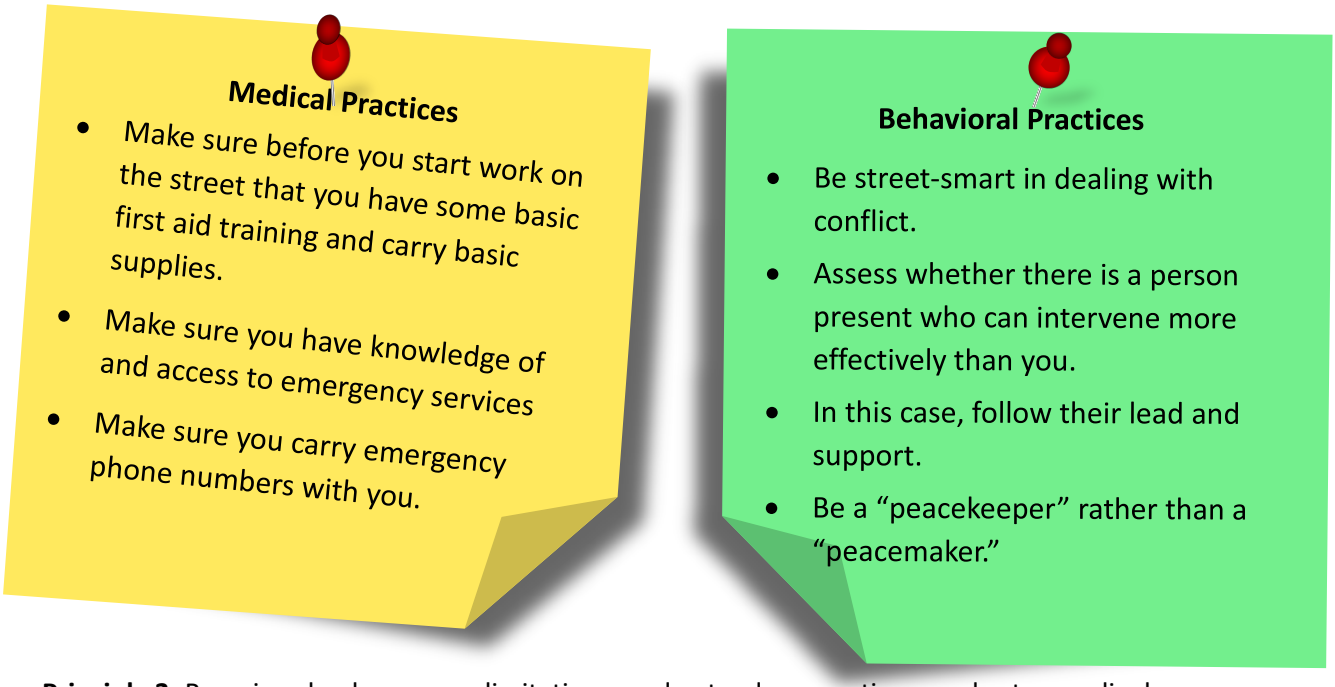
Principle 2: Meet FSW and PWID in their own environment and settings.

Practice

- Talk to:
  - People in the locality
  - Residents about what they observe
  - Any agencies active in the area—such as other NGOs, religious places, general medical practitioners, etc.
  - Organizations or police station
- Most of all, talk to PWID themselves, including drug users currently in treatment

Street scene of drug use and sex work

- Where the KPs:
  - Feel comparatively safe
  - Find resources to buy drugs easily
- These scenes may occur in isolated places.
- KPs may feel that there is less chance of being hassled in these areas.



Principle 3: Remain calm, know your limitations, understand your options, and act accordingly.

Principle 4: It is essential to understand that the first impression sets the tone for establishing a relationship built on mutual trust and understanding. To do so, follow the do's shown in Figure 6.

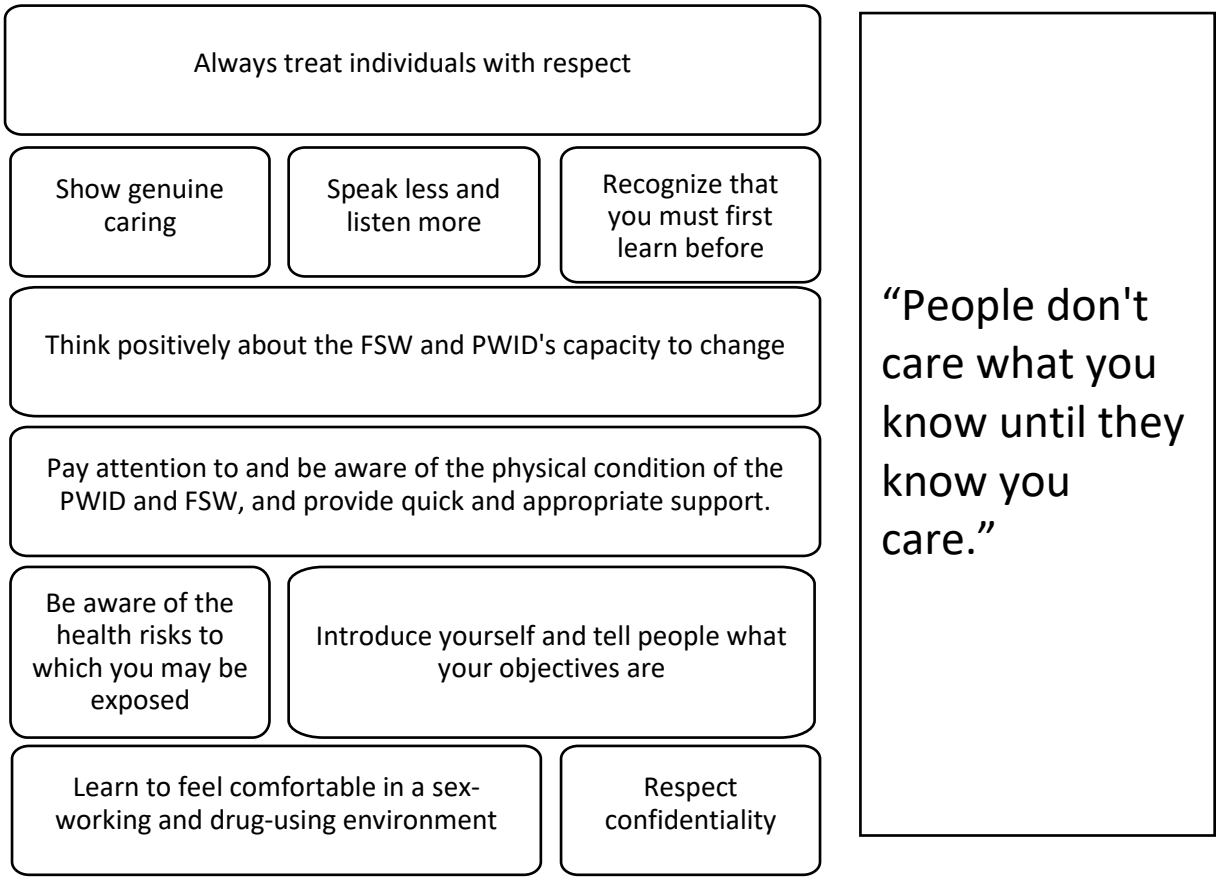


Figure 6: Do's for Creating a Good First Impression

The outreach team, which includes everyone from the medical officer cum center manager to the peer educator, must be able to:

- Gain acceptance by engaging others
- Establish a non-threatening position
- Adapt to changing street dynamic
- Flexible to work as the situation requires—outside of regular office hours
- Have a prejudice-free attitude
- Follow both spot subculture and organizational policies
- Maintain his or her boundaries

Also, the outreach staff should be aware of the following:

- What their organization is all about, and be sure not to oversell
- A thorough understanding of each component specified in the minimum service package, its implementation method, philosophy, and targets, and the standard service delivery model
- Monitoring and reporting mechanism
- Their own job description, tasks, activities, responsibilities, and authority

As a result, the project management team based in the NASP Dhaka office should provide basic training soon after recruitment and refresher training on the skills and knowledge stated above once a year for all cadre of outreach team members. The basic training should last at least four days, and the refresher training should last at least two days.

D. Supplies for the Outreach Activities

The outreach team should have the following supplies:

- Outreach staff credentials (ID card issued by the hospital's director/superintendent)
- Peer educator bags with the following essentials:

For PWID intervention	For FSW intervention
• Sharp object container • Utility safety gloves • Forceps • IEC/BCC materials • Needle syringes • Condoms • Penis model	• IEC/BCC materials • Condoms • Penis model

- Documentation and reporting templates:
  - Mother list of FSW/PWID
  - Daily monitoring format
  - Tracking sheet
  - Harassment reporting form
  - Referral form/format
  - Shift card of a peer educator (if more than one outreach shift exists)

E. KP Service Center Setup at the District Hospital

A KP service center at a hospital is a safe and non-threatening space where FSW and PWID can take a "break" and where a wide range of medical and non-medical services are available in a non-judgmental and user-friendly manner, such as counseling, sexual and reproductive health services such as STI and HIV testing, BCC and IEC activities, condoms, needle and syringe distribution, referrals within and outside the hospitals, etc.

Each of the five district KP service centers at a hospital varies. However, the service center should have the required rooms to facilitate the work of various units. An ideal service center should comprise at least three rooms to ensure seamless functioning and the privacy of service recipients and service providers (the staff). The following describes the general room management of a three-room KP service center inside the hospital.

Room 1: Client Reception and Meeting Room

This space is intended for administrative and reporting work, as well as a reception area where clients initially meet with the Office Attendant. The client would be welcome to access services after registering

basic information (name, age, and location, for example). In addition, all visitors from the government's organizations, NGOs, and hospital management representatives would be received here. This room should include a map of the catchment area, targets, and an infographic showing progress and achievement.

Room 2: Healthcare and Counseling Room

A range of healthcare services would be available here, including screening and diagnosis. A community peer counselor will initiate sessions on many topics, such as STI prevention, safer sex and injecting behavior, sexual and reproductive health, and mental health issues. These services are also available to sexual partners of PWID and FSW. All required equipment should be placed here to enable the medical officer cum center manager and community peer counselor to conduct examinations and take history. This room must provide basic audio and visual privacy.

NASP coordinates with the hospital management to arrange three rooms for the KP service center. If such space is unavailable, a cubicle divider should be installed or adapted according to the services mentioned.

Room 3: Outreach Reporting Room

This room is allocated to staff (outreach supervisor and peer educator). The outreach team sits in this room to prepare and review reports, hold meetings, and undertake orientation. The room should be outfitted with a list of outreach dos and don'ts, names and phone numbers of important stakeholders, key job responsibilities of peer educators and supervisors, etc.

Supplies and Equipment for the KP Service Center at a Hospital

Every service center needs the following supplies:

General Supplies	Equipment Supplies
• Chairs, stool for rest • Chair and table for the outreach team, community peer counselor, and medical officer cum center manager • Emergency lights • Condoms, gloves • IEC and BCC materials • Box for feedback and suggestions • Notice board for distribution of necessary needle syringes • Materials for indoor games • General stationery items • Hand washing facilities	• Speculum, proctoscopies (small, medium, and large) • Stethoscope • BP measurement machine • Thermometer (digital) • Torch and spotlight • Tongue depressor • Weighing scale • Kidney tray • Bin for disposal of gloves and masks • Disinfectant solution • 0.5% chlorhexidine in methylated spirits • Forceps, sterile drums, gauze, and bandages • Proline, silk, autoclave, stacking, and plaster • 2% eloquence without adrenaline

F. Essential Service Delivery Modalities

Service Delivery Principles

Based on the principle of the human right to health, HIV services for the KPs (as for all populations) should be as follows:

- **Available:** There should be a sufficient number of functioning healthcare facilities, goods, and services that can, in coordination, provide a standard package of interventions.
- **Accessible:** Health facilities, goods, and services must be accessible to all KPs. This means that they should be physically accessible, affordable, and non-discriminatory.
- **Acceptable:** Health services must respect medical ethics, be culturally and developmentally appropriate, be sensitive to gender, and be non-judgmental. Acceptability requires that health facilities, goods, services, and programs are people-centered and cater to the specific needs of KPs, following international standards of medical ethics of confidentiality and informed consent.
- **Quality:** Quality health services are evidence-based, safe, effective, people-centered, timely, equitable, integrated, and efficient.

In the five district hospitals, there are five types of service modalities.

1. **Outreach based:** The KP receives services from the peer educator in the spots or convenient locations of the KP. Services include BCC and IEC activities, condom distribution, needle and syringe distribution and collection, and HIV testing.
2. **At the KP service center in the hospital:** Services provided by the KP service center at the district hospital include STI testing (particularly syphilis testing and treatment), abscess management, screening, diagnosis and treatment of TB, hepatitis B and C testing and treatment, HIV treatment (enrollment to the treatment care and support program), post-exposure prophylaxis (PEP) for HIV and STIs, and prevention of vertical transmission of HIV, among others.

   The medical officer cum center manager is the main point of contact for these clinical services. Initially, with the assistance of a community peer counselor and an office assistant, they will perform a health screening and identify a provisional diagnosis. The Medical Officer will treat the client if the case is not severe. Complicated cases are referred to the relevant hospital departments to provide comprehensive care. A KP service center team member accompanies the client to the referral to avoid the risk of missing treatment.

   In addition to outreach, the KP service center staff provides HIV testing, condom and needle syringe distribution, counseling, and IEC and BCC activities.
3. **Within the hospital, through referral:** This modality addresses unmet health needs by navigating FSW and PWID within the hospital and getting access to various health services needed. Each of the five hospitals has an ART corner, where clients who have tested positive for HIV are accompanied and referred for HIV counseling, care, and treatment. Moreover, service is also provided for the etiological management of STIs; screening, diagnosis, and treatment of TB; hepatitis B and C testing and treatment; management of complicated abscesses; conception and pregnancy care; mental health-related support; prevention, assessment, and treatment of cervical cancer; safe abortion; etc.
4. **External referral (outside the hospital):** Above all, external referral ensures that KPs can receive treatments that are still unmet or unavailable at hospitals, such as OST, addiction treatment, etc.

5. **Cross-cutting:** Cross-cutting services include interventions that need concerted efforts and integration with all behavioral and health interventions. This modality primarily advocates for removing punitive laws, policies, and practices; removing stigmatization and discrimination; empowering the community; and eliminating gender-based violence.

Table 4 shows which services are delivered through which modality. The remarks column highlights which of the few essential services at the five hospitals still need to be planned.

Table 4: Service Modalities

Essential Services	Service Delivery Modality					Remarks
	Outreach Based	At the KP Service Center in the Hospital	Within the Hospital, Through Referral	External Referral (Outside the Hospital)	Cross-cutting	
1. Behavioral interventions						
1.1 Peer education for BCC and IEC	✓	✓	-	-	-	
2. Health interventions						
a. Prevention of HIV, STIs, and viral hepatitis						
2.1 Condom distribution	✓	✓				In this grant, the provision of lubricants has not been planned. Nonetheless, ASP will consider incorporating this aspect in future grant applications.
2.2 Needle and syringe program for PWID	✓	✓	-	-	-	
2.3 OST for PWID		✓				
2.4 Naloxone for overdose management	-	-	-	-	-	The use of naloxone is not legal in Bangladesh.
2.5 Pre-exposure prophylaxis (PrEP) for HIV	-	-	-	-	-	PrEP still needs to be approved in Bangladesh. The icddr,b is conducting a PrEP trial among MSM. Following the study's results, the government may approve PrEP.
2.6 Post-exposure prophylaxis for HIV and STIs	-	✓	-	-	-	
2.7 Prevention of vertical transmission of HIV, syphilis, HBV, and HCV	-	✓	✓	-	-	
2.8 Hepatitis B vaccination	✓	✓	✓	✓		NASP has not yet planned the provision of the hepatitis B vaccine to the KP.
b. Diagnosis and treatment						
2.9 HIV testing	✓	✓	-	-	-	
2.10 HIV treatment	-	✓	✓	-	-	
2.11 STI testing and treatment	-	✓	✓	-	-	
2.12 Prevention, screening, diagnosis, and treatment of TB	-	✓	✓	✓	-	
2.13 Hepatitis B and C testing and treatment	-	-	✓	✓	-	

Essential Services	Service Delivery Modality					Remarks
	Outreach Based	At the KP Service Center in the Hospital	Within the Hospital, Through Referral	External Referral (Outside the Hospital)	Cross-cutting	
3. Essential for broader health						
3.1 Abscess management	-	✓	✓	-	-	
3.2 Conception and pregnancy care		✓	✓	-	-	
3.3 Mental health	-	-	✓	✓	-	
3.4 Prevention, assessment, and treatment of cervical cancer	-	-	✓	✓	-	
3.5 Family planning, conception, antenatal, delivery, and post-natal care	-	✓	✓	✓	-	
3.6 Safe abortion			✓	✓		
3.7 Screening and treatment for hazardous and harmful alcohol and other substance use	✓	✓	-	✓	-	
4. Enabling interventions						
4.1 Removing punitive laws, policies, and practices	-	-	-	-	✓	
4.2 Reducing stigma and discrimination	-	-	-	-	✓	
4.3 Community empowerment	-	-	-	-	✓	
4.4 Addressing violence	-	-	-	-	✓	

G. Standard Operating Procedures for Essential Services

This subsection will cover each essential service (except a few that are not yet planned), describing their rationale, SOPs, roles and responsibilities, necessary supplies, and required documentation.

1. Behavioral interventions

1.1 Peer education for BCC and IEC

Introduction:

Peer education is a crucial two-way connection between program staff and FSW or PWID that provides useful information and support in reintegrating vulnerable people into the larger community.

Reaching out to FSW and PWID with HIV prevention and treatment information and linking them to resources is key to reducing their HIV risk and promoting their health. Peer education is an organized, interpersonal method of communication, in which trained KP peers motivate and encourage their peers to maintain positive behaviors or to change their behaviors to improve or protect their health. Peer education is frequently used to effect changes in knowledge, attitudes, beliefs, and behaviors at the individual and community levels, promoting condom distribution, education and use of the condom, community mobilization, HIV, STI, and TB-related education and screening, treatment literacy and adherence, and interventions against gender-based violence, among other things.

Peer educators may be active in protecting their peers' rights and connecting peers to essential health, protection, and psychological services. Peer educators may interact with peers individually or in groups. They are an immediate link between the community and the hospital's KP service center, and they are most effective when they maintain contact with peers over time.

In addition, implementing virtual outreach activities for populations at higher risk for HIV and AIDS is an essential and strategic approach to enhance prevention efforts. Using digital platforms for outreach allows organizations to address traditional barriers such as stigma, discrimination, and geographic limitations, which often prevent vulnerable groups from accessing vital information and services. Virtual outreach assists in delivering timely and accurate information on HIV prevention, risk reduction, and available services, tailored to the specific needs of key populations. Additionally, digital platforms support anonymity and privacy, enabling individuals to engage with outreach workers and access resources without fear of judgment or consequences. With the growing internet penetration and smartphone usage in Bangladesh, virtual outreach provides a cost-effective and efficient way to reach and empower these marginalized communities in their battle against HIV and AIDS.

Rationale:

BCC and IEC activities are at the center of peer education, which strives to address risk behaviors and practices while assisting at-risk groups in making informed decisions about behavior changes. IEC activities deliver valuable information, such as infographic brochures, posters, short videos, and leaflets, to improve the knowledge and abilities of the target population. BCC can also clarify misconceptions around perceived or actual risk.

SOPs:

- The BCC session should promote awareness and understanding of the risks associated with STIs, including HIV, TB, viral hepatitis, and other diseases of FSW and PWID.
- BCC sessions should emphasize safer sexual behaviors and correct and consistent use of condoms for both FSW and PWID.
- An exclusive session should deal with safer injecting practices, vein care, overdose, and safe disposal of injecting equipment among PWID.
- The BCC and IEC activity should be carried out equally at the outreach and hospital's KP service center.
- When carrying out virtual outreach for PWID and FSW, it's essential to prioritize cultural appropriateness and accessibility by creating customized, easy-to-use materials in local languages, keeping in mind the different digital literacy levels. ASP should implement robust privacy and security measures to safeguard participants' information while promoting open communication and building trust. Regular monitoring, evaluation, and capacity building for project staff and stakeholders are vital to continuously refine and enhance the effectiveness of strategies.

Supplies:

- Key message lists:
  - For FSW, at least four sessions: (a) safer sex and condom use, (b) HIV testing, (c) HIV basic information, and (d) STI and sexual and reproductive health
  - For PWID, at least five sessions: (a) sharing of needle and syringe, (b) HIV testing, (c) safer sex and condom use, (d) HIV basic information, and (e) OST and other drug treatment
- IEC materials: flipchart, poster, leaflets, folder, brochure, videos

Documentation:

- Register for session attendance
- Register for the distribution of IEC materials
- Group Education Session Report Form

Responsible:

- Key responsible: Peer educator for outreach-based IEC/BCC
  Community peer counselor for IEC/BCC activity and KP service center in the hospital
- Supervisory responsibility: Outreach supervisor

2. Health interventions

2.1 Condom and lubricant distribution

Introduction:

Correct and consistent condom use is one of the best methods for HIV prevention. Demonstrations and promotion of male condom use are important components of an HIV program for KPs. Condoms should be made available and accessible through KP-focused programs. Peer educators should demonstrate

and encourage the correct and consistent use of condoms and provide FSW and PWID with the skills to negotiate their use with clients and partners.

Incorporating lubricants into HIV prevention programs is crucial for promoting condom use. Lubricants enhance the effectiveness of condoms by reducing friction, minimizing breakage or slippage, and ultimately preventing HIV and STI transmission. They also increase sexual pleasure and alleviate discomfort, making condom use more appealing. Providing lubricants alongside condoms encourages consistent, correct use and strengthens HIV prevention efforts by addressing the practical aspects of condom use and promoting sexual comfort.

Rationale:

The upper skin of the penis can be torn as MSM and heterosexuals have penetrative anal sex. Some people at risk may have sex with many people, including for money, which places them at greater risk of HIV and STIs. Often people have sex without condoms with multiple sexual partners. Due to limited income, condoms are not given any importance. In addition, buying condoms from pharmacy shops imposes a taboo that dissuades people from doing so. The availability of condoms is essential to the national response to HIV and viral hepatitis infection and ensures safer sex practices.

SOPs:

- Condoms and lubricant should be distributed free of cost from the KP service center in the hospital by offering a “Condom Box” and outreach activities.
- All outreach team members, including peer educators, community peer counselors, and the medical officer, must be trained to demonstrate the proper use of a condom.
- Demand creation for condoms can be done by peer educators and community peer counselors through IEC/BCC materials.
- Condom promotion must be done without coercion. Advocacy with law enforcement agencies is important to ensure that the mere possession of condoms is not used as evidence of sex-related criminal activity.
- Peer educators and community peer counselors will distribute condoms according to the need of the KP. There is no rationing or sale of condoms.
- Condom outlets should be available in hotspots. These could include establishing condom depots at shops, hotels, and houses to ensure that condoms are available to FSW and PWID whenever needed.
- Peer outreach worker should monitor the quality of condoms (e.g., expiration dates, reports of breakage) and report problems to NASP.
- The KP service center (medical officer) should take necessary steps and maintain smooth supply chain management of condoms as per the procurement and supply chain management guidelines.

Supplies:

- Uninterrupted supply of condoms and lubricant
- Penis model for demonstration.
- Condom distribution list (for KP service center and outreach staff)
- Outreach staff bags

Documentation:

- Condom distribution guidelines
- SOP for store management
- Condom storage guideline
- Condom distribution book/register
- Supply list, supply management, supply order form/format
- Stock/bin card

Responsible:

- For condom distribution: peer educator, community peer counselor, medical officer cum center manager
- For supply chain management: Officer of Procurement and Supply Management, manager (Procurement)

2.2 Needle and syringe program for PWID

Introduction:

The distribution of free needle syringes is a well-recognized public health intervention for preventing HIV and viral hepatitis transmission among PWID through used and contaminated injection equipment (needle and syringe).

Rationale:

One of the primary objectives of harm reduction approaches and programs is to minimize risk by supplying PWID with fresh needle syringes, promoting safer injection behaviors and stopping the reuse of needles. The needle and syringe program is supplemented with important information about safer injecting practices, breaking the repetitive use of used needles and syringes and preventing needle stick injuries in communities through the collection and proper disposal of used needles and syringes. Providing a consistent supply of needle syringes to clients is a crucial component of an integrated HIV and hepatitis viral infection prevention effort.

SOPs:

- Multiple routes can be used to provide needles and syringes at the KP service center or directly at specified hotspots or sites during peer educators' outreach activity. In addition, there should be a depot and various secondary channels for distributing needles and syringes, which have proven beneficial in Bangladesh, particularly in the older parts of Dhaka, where the number of PWID is higher.
- PWID and their partners are informed about the time and location where they can collect their supplies of needle syringes from the peer educator and return used needles and syringes daily.
- Needle syringes are collected from PWID by the peer educator during the needle syringe exchange at outreach. In addition, there are drop boxes installed at the hotspots/spots where PWID can dispose of their used needles and syringes in the absence of the peer educator.

- The number and type of needles (23g or 27g) and syringes (Ciringe syringes or auto-disable) or size of syringes (3cc or 5cc) should be distributed according to the demand of PWID. No rationing or supply-driven distribution is acceptable.
- The KP service center manager should ensure an adequate and uninterrupted supply of needle syringes to the targeted PWID.

Good practices for a needle and syringe program

Globally among harm reduction practitioners, the following standards are followed:

- Buprenorphine/heroine injectors may need three injections per day.
- Strive to attain the "one syringe—one injection rule."
- Promote the return of used needles and syringes at all times.
- Promote the personal responsibility of the drug user at all times.
- No or low return might jeopardize the whole program→ everybody suffers.
- Return rate should go up over time → 1/1 almost impossible (80% is very good).

Supplies:

- An uninterrupted supply arrangement of needle syringes daily
- Regular monitoring of adequate stock of needles and syringes in the store room substantiated with records
- Risk reduction supplies, including carrying bags, sharp object containers, safety gloves, and forceps
- Carts for collecting returned used needle syringes and a covered drum/large bucket for keeping used syringes
- BCC/IEC materials on the effect of needle syringe sharing

Documentation:

- Stock or bin card, stock register, short expiry register of health products, monthly physical verification report, quarterly requisition format, temperature chart for the store
- Daily outreach service form, distribution and collection sheet of health products for peer educators and secondary channels, track sheet
- SOPs for logistic support and store management

Responsible:

- For distribution: peer educator, community peer counselor manager
- For supply chain management: Officer of Procurement and Supply Management, manager (Procurement)
- Supervisory responsibility: medical officer cum center manager

2.3 OST for PWID

At first, none of the five hospitals had plans to include OST. However, due to a sudden HIV outbreak among PWID in Sirajganj, ASP decided to create an OST center at the Sirajganj district hospital. This decision has been added to the revised budget of the current grant.

To establish the OST center in the hospital, it is recommended to follow "national standard operating procedure for opioid substitution therapy in Bangladesh" and "trainer's manual training program for the project staff of opioid substitution treatment services, Bangladesh" by Save the Children with support from the global fund. These documents are available on ASP's website at this link: http://asp.gov.bd/site/page/f7690003-c427-46c8-a135-566ae8b16fc0/-

For the other four districts, except Sirajganj, if a PWID requires OST services, the medical officer cum center manager will refer them to the nearest OST center. The outreach staff must be aware of the information of the neighboring OST centers..

2.4 Naloxone for overdose management

According to Bangladesh's Narcotics Control Act 2018, naloxone is a controlled substance. Naloxone use is a criminal offense. As a result, no naloxone use has happened in Bangladesh's harm reduction program so far. NASP and other key stakeholders are constantly advocating for making naloxone accessible at the KP service center. Naloxone will not be included in the program until the government approves it.

However, BCC and IEC activities contain overdose prevention messages.

2.5 Pre-exposure prophylaxis (PrEP) for HIV

In Bangladesh, PrEP is not yet recommended for HIV prevention. One of the primary beneficiaries of the Global Fund-supported HIV program, icddr,b, is undertaking a study in Dhaka, Bangladesh, to pilot PrEP among the sexual and gender diverse (MSM and transgender) community. Following the completion of the study, PrEP might be scaled up..

2.6 Post-exposure prophylaxis for HIV and STIs

Introduction:

People can be accidentally exposed to HIV through healthcare work or exposure outside the healthcare setting, such as through unprotected sex or sexual assault among adults and children. Healthcare workers are at increased risk of exposure to HIV through contact with contaminated blood and other body fluids containing HIV through needle stick injuries and injuries by other sharp objects or through non-intact skin and mucous membranes. The National ART Committee has decided to use PEP as a short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure.

To avoid exposure to HIV, precautions should be taken when handling possibly contaminated body fluids, including the use of appropriate barriers such as gloves, gowns, and goggles; care with sharps, including minimizing blind surgical procedures and proper handling and disposal of sharps; safe disposal of contaminated waste; safe handling of soiled linen; and adequate disinfection procedures.

SOPs:

PEP should always be offered as soon as possible, preferably within 2 hours (within a maximum of 72 hours) after a high-risk exposure (as defined in Table 5). Three-drug regimens are preferred for PEP. However, two drugs can be used if a person cannot tolerate a drug (usually the PI/r).

Patients should be counseled and strongly encouraged to complete the full 28-day course of PEP after a decision has been made to initiate PEP. For occupational exposure, immediate care of the exposure site

includes washing the site with soap and water and allowing the wound to bleed freely for several minutes (but do not do anything that will increase tissue damage, such as squeezing, scrubbing, or cutting the site further).

Table 5: Recommendations on PEP

Considerations	Recommendations

Eligibility: Must meet all of the following criteria	• The exposed individual is HIV-negative at baseline.
	• Exposure must have occurred within the past 72 hours.
	• Exposure must be high-risk (high-risk type AND material):
	  ○ Type: mucous membrane, non-intact skin, or percutaneous injury
	  ○ Material: blood or bloody body fluids; breast milk; semen; vaginal secretions; synovial, pleural, pericardial, amniotic fluids; cerebrospinal fluid; or HIV cultures in the lab
	Note: HIV status of the source is no longer part of the risk stratification for PEP because even if the source tests HIV-negative by rapid antibody test, they may still be in the window period of acute HIV infection, so it should be assumed to be positive.
	Note: If a breastfeeding mother starts PEP because of HIV exposure, the infant does **not** require PEP or infant prophylaxis. The infant should continue breastfeeding.

Management at initial contact	• Counsel on risks and benefits of PEP and obtain verbal consent for HIV testing • Voluntary testing for both exposed and source individuals • Offer PEP as soon as high-risk exposure is established and exposed individual tests HIV-negative at baseline (if HIV testing is not available, can provide 1–2 days of PEP to cover until HIV test performed) • Pregnancy testing • Cr (if TDF-containing regimen) and Hb (if AZT-containing regimen); however, PEP should be offered even when lab tests are unavailable. Do not delay the administration of PEP while waiting for lab results. • Hepatitis B vaccination (if not previously immunized and not known HBV positive)

Table 6: Antiretroviral Regimen for PEP

Considerations	Recommendations	
Antiretroviral regimen for PEP	• ≥ 15 years old (or ≥ 35 kg body weight): • TDF + 3TC/(FTC) + PIs or DTG (or TDF + 3TC/(FTC) + ATV/r For women and adolescent girls of childbearing potential	• AZT can be used as an alternative when TDF or ABC cannot be used For children who cannot tolerate LPV/r: RAL or DRV/r can be used instead
	0-14 years and < 35 kg: ABC + 3TC + LPV/r	
Time of initiation	• As soon as possible after exposure, preferably within 2 hours, but no later than after 72 hours	
Duration of PEP	• 28 days (dispense all 28 days of treatment at the first visit)	
Dose of PEP	• Same as indicated for ART, use weight-based dosing for children	
Follow-up	• Follow up with the client at 7 days, 14 days, 28 days, and 12 weeks after starting PEP • Follow-up HIV testing at 12 weeks; if negative, test again at 6 months, after which test as per risk category • Assess for and manage side effects due to PEP	
Counseling	• Adherence, risk reduction, trauma, mental health, social support, safety, safe sex practices	
Other services for sexual assault	• STI prophylactic treatment to all (treat for vaginal/urethral discharge syndrome following the national STI algorithms)	

	• Emergency contraception for non-pregnant women • Tetanus toxoid for any physical injury of the skin or mucous membranes • Documentation of clinical evidence of assault and collection of forensic evidence.

Note: DTG is recommended as the third preferred drug for HIV PEP.

Responsible:

- Medical officer cum center manager
- Supervisory responsibility: HIV specialist, NASP

Supplies:

- Availability of ART
- PEP guidelines and reporting formats

Further readings:

- National Anti-Retroviral Therapy Guidelines (2019), National AIDS /STD Programme, Bangladesh

2.7 Prevention of vertical transmission of HIV, syphilis, and HBV

Introduction:

HIV, syphilis, and HBV can be transmitted from an HIV-positive woman to her child during pregnancy, childbirth, and breastfeeding. Prevention of mother-to-child transmission (PMTCT) of HIV, also known as vertical transmission, accounts for the vast majority of infections in children (0–14 years).

Rationale:

Without interventions, around a third of HIV-positive mothers will pass the virus to their infants through pregnancy, labor and delivery, and after birth through breastfeeding. Without intervention, the risk of transmission is 15–30 percent in non-breastfeeding populations. Breastfeeding by an infected mother adds a 5–20 percent risk, for an overall transmission rate of 20–45 percent.

Prevention of vertical transmission refers to interventions to prevent transmission of HIV from a mother living with HIV to her infant during pregnancy, labor, and delivery or during breastfeeding. PMTCT also focuses on the early initiation of ART in the mother and assuring the mother's health.

There is a four-pronged approach to the comprehensive prevention of vertical transmission:

1. Primary prevention of HIV infection among women of childbearing age
2. Preventing unintended pregnancies among women living with HIV
3. Preventing HIV transmission from women living with HIV to their infants
4. Providing appropriate treatment, care, and support to mothers living with HIV, their children, and their families.

In the third prong, which focuses on the direct interventions to prevent vertical transmission, the preventive interventions consist of a cascade of services, from HIV testing and counseling, ART, safe delivery, safer infant feeding, postpartum interventions in the context of ongoing ART, early infant diagnosis, and final diagnosis for HIV-exposed infants, through linkage of both the mother and child to appropriate care and treatment.

SOPs:

- All pregnant women associated with the KPs (pregnant mothers among the listed FSW, women who inject drugs, and female partners of a male PWID) should have the same access to PMTCT services and follow the same recommendations as women in other populations.
- All pregnant and breastfeeding women living with HIV should initiate triple ART, which should be maintained at least for the duration of the risk of mother-to-child transmission. Women meeting treatment eligibility criteria should continue ART for life (CD4 <500 cells/mm3).
- Each of the five hospitals has a PMTCT focal person (usually the medical officer of the department of gynecology) who has received PMTC training through the UNICEF-supported program.
- The Medical Officer will ensure the accompanying referral of pregnant FSW, women who inject drugs, and female partners to the PMTC focal person, as well as the provision of PMTC services.
- FSW, women who inject drugs, and female partners of men living with HIV and AIDS need specific care and counseling during pregnancy, delivery, and childbearing. The community peer counselor will be trained in this subject and will support them.

Responsible:

- Medical officer cum center manager
- Supervisory responsibility: HIV specialist, NASP

Supplies:

- PMTCT guidelines and reporting formats
- Referral register

Further readings:

- National Guidelines for the Prevention of Vertical Transmission of HIV and Congenital Syphilis, National AIDS /STD Programme, Bangladesh

2.8 Hepatitis B vaccination

NASP does not plan for hepatitis B vaccination for all listed FSW and PWID due to practical challenges such as cost, timing, and availability of hepatitis B vaccine. Vaccination would, however, be provided to peer educators and other outreach team members in coordination with the hospital director/superintendent.

2.9 HIV testing

Introduction:

HTS among people at risk is one of the major activities. It provides an opportunity for individuals to avail of testing and counseling for HIV. HTS is also part of the universal “Test & Treat” campaign to screen for opportunistic infections and establish links with the provision of ART.

Rationale:

People are at risk of contracting HIV and viral hepatitis if there is a history of sharing used needle syringes, having unprotected sex, having multiple sexual partners, and having frequent STIs. The staff should know where to establish linkages to access holistic care and support services. Like many other countries in Asia, Bangladesh has challenges in making HTS available to high-risk people.

SOPs:

- HIV testing will be conducted in both community-based outreach by lay providers and in center-based KP service centers at hospitals. The national HIV testing services guideline should be followed, which is available on ASP's website at this link: http://asp.gov.bd/site/page/f7690003-c427-46c8-a135-566ae8b16fc0/-
- HIV testing kits and reagents should be available at the KP service center. HIV rapid test kits are now used in service centers.
- Self-testing for HIV has not yet been introduced in Bangladesh. ASP is currently in the process of developing the SOP and it is expected that self-testing will be available in 2024. Once it is available, self-testing will be introduced for KPs.
- All relevant staff should undergo intensive training on HTS.
- Service center staff must properly keep documentation of test-seeking persons to ensure no duplications or overcounting.
- Before the blood test, pre-counseling should be completed.
- HIV testing should be conducted in the KP service center and through satellite sessions. Following that, lay providers (e.g., peer educators) should perform HTS in addition to center-based and satellite HTS.
- Post-test counseling should be offered as soon as the test results are available.
- The results should be treated as confidential.
- In the case of a positive or negative test result, each person should be fully informed of the options available to them.
- There should be standard criteria for confidentiality when doing HTS through satellite or outreach.

Supplies:

- National SOP for HTS
- Specific testing rooms/spaces with privacy
- All HTS test kits or reagents and other products and supplies
- Refrigerator for the storage of test kits or reagents (where applicable)
- Uninterruptible power supply for electricity backup (where applicable)
- Running water facilities (basin) and detergent
- Furniture, heat meter timer
- Appropriate arrangements for waste management

Documentation:

- HTS Oath of Confidentiality
- HTS Counseling Form

- HTS Test Result Form
- HTS Service Register
- HTS Track Register

Responsible:

- Lab technician/outreach supervisor and medical officer cum center manager
- Technical supervision: HIV Specialist, NASP

2.10 HIV treatment (ART)

Introduction:

People in KPs may experience discrimination and marginalization that can impede their access to healthcare, including treatment for HIV, and frequently present late for treatment. It is important to ensure that people from KPs have equitable access to HIV treatment and care. KP programs should ensure that missed opportunities are minimized and every encounter with someone from a KP is optimally used. ART service delivery includes decentralization of HIV care and treatment and integration of ART services into other clinical services, such as medically assisted therapy and drop-in centers where appropriate capacity exists.

Rationale:

There is increasing evidence of the potential of ART to reduce HIV transmission by lowering viral load. Viral load is the single greatest determinant of the risk of HIV transmission. When someone is virally suppressed, the risk of HIV transmission is significantly reduced. This evidence supports the early initiation of ART in individuals, irrespective of CD4 count, to prevent HIV transmission.

PWID have complex needs related to drug dependency and psychosocial and medical complications of injection and other substance use. When they require ART, anti-TB, or any other therapy, they are at increased risk of adverse drug reactions, drug interactions, and non-adherence. These patients are best comprehensively managed by providers who have received specific training in managing injection drug users. After they have been identified, PWID should be counseled and linked to programs with the capacity to offer comprehensive care for such patients.

SOPs:

- ART for HIV in KPs, including FSW and PWID, should follow the same general principles and recommendations as for all adults.
- ART should be initiated in all KPs, including FSW and PWID living with HIV, regardless of WHO clinical stage or CD4 cell count.
- Each of the five hospitals has an ART corner on its premises. The medical officer cum center manager accompanies the PWID or FSW living with HIV to the ART corner. The ART corner team must ensure that ART is initiated within 24 hours following national ART guidelines.
- Service center staff must properly keep documentation of ART persons to ensure that no duplications or overcounting happens.

- FSW and PWID on ART need more frequent monitoring and support to maintain treatment adherence, and the KP intervention's outreach team should be trained in ART compliance monitoring through home visits.
- The outreach supervisor and community peer counselor should address adverse drug reactions or drug-drug interactions, especially for PWID on ART.
- Partners with HIV in sero-discordant couples should be offered ART to reduce HIV transmission to uninfected partners.

Responsible:

- Medical officer cum center manager, outreach supervisor
- Technical supervision: HIV Specialist, NASP

Further reading:

- National Anti-Retroviral Therapy Guidelines, Bangladesh

2.11 STI testing and treatment

Introduction:

STIs are caused by microbes that pass from one person to another through sexual contact. The terminology is used to describe the diseases that are acquired through sexual contact. Sexually transmitted organisms may also be sometimes transmitted by non-sexual modes of transmission. The diagnosis and management of STIs are available to the people at risk and their sexual partners (clients, spouses). Under the National Syndromic Treatment and Management for STIs Control strategies, timely treatment and services are available at the KP service center.

Rationale:

These services help reduce STIs and prevent HIV transmission through penetrative and unsafe sex. STI services also provide an opportunity to address the varying needs of KP members, including other services such as HTS, and to promote condom use.

In general, women are not properly examined for diagnosis of STIs at the KP service center, which may be due to a lack of privacy. As a result, STIs commonly remain undetected and unaddressed. Therefore, it is necessary to set up provisions for treating STIs at the service center as an integral part of service provision.

SOPs:

- All precautionary measures should be taken to ensure the privacy of individuals and their sexual partners undergoing any STI treatment.
- A trained doctor (MBBS) and his or her team should manage the treatment of STIs. The treatment should be expanded to cover regular sexual partners and at-risk people at the KP service center.
- STI check-ups should take place at least quarterly. STI service provision should be linked to outreach to help ensure regular STI check-ups.

- New patients who are sex workers should be treated presumptively for gonorrhea and chlamydial infection. The frequency of asymptomatic treatment is based on condom use, the prevalence of STIs, and the availability and accessibility of STI services.
- Diagnosis for STI and testing for HIV should be arranged in the service center.
- All individuals with STIs should be counseled. Based on the field need, community-based STI services (satellite clinics) should organize initially once a week. Evidence shows that community-based STI services (satellite clinics) are more accessible and acceptable to KP members.
- Referrals will be made for chronic or complicated STI cases to avail of further symptomatic or etiological management (if needed).
- Contact tracing methods should be used per the national protocols and guidelines to continue treatment and follow-up.
- Outreach staff and supervisors are authorized to bring sexual partners to service center for follow-up.
- Services, prescriptions, and medicines for STIs will be provided free of charge.

Note: As per procedures at the service center, only STI treatment providers will be able to access information on a regular basis. Medication prescriptions should align with the National Policy for the Treatment of STIs.

Supplies:

- Necessary equipment for diagnosing STIs
- Guidelines for distribution and management of medicines
- Emergency medicines
- Penis model
- Condoms
- Weight measuring instrument
- BP machine
- Patient bed
- Gloves

Documentation:

- Flowchart for the signs and symptoms and treatment of STIs
- National guidelines for the treatment of STIs
- Medications prescribed for the treatment of STIs
- Supply list, supply management documents, supply order
- Register for the distribution of medicines
- Health card
- Referral slip

Services provided with STI treatment
• Promotion of safer sex behavior • Condom programming—encompassing a full range of activities, from condom promotion to the planning and management of supplies and distribution • Promotion of healthcare-seeking behavior • Integration of STI prevention and care into primary healthcare facilities, reproductive healthcare facilities,

private clinics, and others
- Specific services for population at risk—such as female and male sex workers, adolescents, long-distance truck drivers, military personnel, and prisoners
- Comprehensive case management of STIs
- Prevention and care of congenital syphilis and neonatal conjunctivitis
- Early detection of symptomatic and asymptomatic infections

Responsible:

- Medical officer cum center manager, outreach supervisor
- Technical supervision: HIV Specialist, NASP

2.12 Prevention, screening, diagnosis, and treatment of TB

Introduction:

Despite being preventable and curable, TB is the leading cause of HIV-associated mortality, accounting for one of every five HIV-related deaths. The risk of developing TB is 30 times higher among PLHIV than among people who do not have an HIV infection.

Independent of their HIV status, KPs, particularly PWID and prisoners, have an increased risk of TB, including multidrug-resistant TB. Common risk factors and social determinants that put KPs at increased risk of TB include HIV infection, poverty, malnutrition, stress, alcoholism, smoking, diabetes, indoor air pollution, drug use, incarceration, and poor living and working conditions.

Rationale:

Barriers to prevention and care for KPs need to be addressed to ensure access to integrated, client-centered services, preferably at the initial point of care, and to encourage treatment adherence. To address TB among PLHIV, including KPs, WHO recommends a 12-point package of collaborative TB/HIV activities.

Prevention of TB. Isoniazid preventive therapy (IPT) and ART, given together, can reduce the risk of TB among PLHIV by up to 97 percent. Alone, IPT has been shown to reduce the risk of TB among PLHIV by 68 percent. After active TB has been ruled out, PLHIV should be offered at least six months of IPT, and support should be provided to ensure adherence.

In addition, appropriate TB infection control measures and contact tracing are essential to reduce transmission of TB in congregate settings.

Screening and diagnosis of TB. All PLHIV should be screened regularly with the WHO-recommended four TB symptom screening algorithm—a current cough, fever, night sweats, or weight loss—at each contact with a healthcare worker. This screening helps determine eligibility for IPT by ruling out the likelihood of active TB and identifying those who need further evaluation, diagnosis, and treatment for TB as necessary. WHO recommends using Xpert MTB/RIF as the first diagnostic test for TB in all PLHIV and for anyone suspected of having multidrug-resistant TB.

SOPs:

- Key groups should have the same access to TB prevention, screening, and treatment services as other HIV-infected or at-risk populations.

- Each of the five hospitals has a TB corner on its premises. The medical officer cum center manager performs the initial verbal screening for TB at the KP service center, and suspected cases are referred to the hospital's TB corner.
- The IEC/BCC activities must include TB and other co-morbidities, such as viral hepatitis.
- The medical officer cum center manager ensures that referred cases are followed up.
- At each visit to the KP service center, all FSW and PWID living with HIV in the district are screened with the WHO-recommended four TB symptom screening criteria—a current cough, fever, night sweats, or weight loss.

Responsible:

- Medical officer cum center manager, outreach supervisor
- Technical supervision: HIV Specialist, NASP

Supplies:

- HIV-TB Comorbidly Management guidelines
- Referral register
- Reporting template

2.13 Hepatitis B and C testing and treatment

Introduction:

Viral hepatitis B and C disproportionally affect KPs due to sexual transmission and the sharing of needles, syringes, and injecting paraphernalia. It is estimated that, globally, 240 million people are chronically infected with HBV and more than 185 million with HCV. People who inject drugs account for approximately 1.1 million of those with HBV and 10 million of those with HCV.

Rationale:

The major modes of viral hepatitis transmission include using unsterile medical injections, equipment, and other procedures; transfusions of contaminated blood; unprotected sexual intercourse; and unsafe injecting (sharing the needle, syringe, and injecting paraphernalia). HCV is rarely transmitted through heterosexual sex. Because modes of transmission for viral hepatitis overlap those for HIV, many interventions that prevent HIV also prevent HBV and HCV. Examples include correct and consistent condom use, needle and syringe program, OST, etc. It is important to appropriately manage HIV co-infection with HBV or HCV. Co-infection with HIV and HCV accelerates the HCV-related progression of liver fibrosis and leads to a higher rate of end-stage liver disease and mortality.

SOPs:

- KPs should have the same access to hepatitis B and C prevention, screening, and treatment services as other populations at risk of or living with HIV.
- IEC/BCC activities must include a message on prevention, treatment, and care of viral hepatitis.
- The needle and syringe program should also provide low dead-space syringes for PWID. Furthermore, the needle and syringe program should provide all types of syringes (such as 3cc or 5cc), needles (such as 23g or 27g) and other injecting drug preparation equipment, such as alcohol swabs and *Galli* pots, as relevant to local needs.

- The medical officer cum center manager performs the initial counseling on viral hepatitis and refers PWID and FSW to the hospital's relevant department.
- The medical officer cum center manager ensures that referred cases are followed up.

Responsible:

- Medical officer cum center manager
- Technical supervision: HIV Specialist, NASP

Supplies:

- Referral register
- Reporting template

3. Essential for broader health

3.1 Abscess management

Introduction:

People reporting a post-injection abscess or wound at the service center are common among PWID due to missing veins or other reasons. Trained staff will do abscess, boil, or wound management, followed by treatment and referral to a specialist hospital if needed.

Rationale:

Needles cause wounds or sores on the arms and legs of PWID. Such acts destroy soft tissues, veins, and arteries and cause pus formation, known as wounds or sores. Abscesses or wounds can occur due to incorrect injection practices, injection at unsafe body parts, unhygienic injection conditions, dirty needles, and equipment or injection done quickly. Repeated injections at the same body part complicate abscesses or wounds. Many times, a combination of different drugs is injected, which can cause an abscess. These are painful. Proper wound management is very important in this situation.

SOPs:

- Abscesses or wounds should be managed by the medical officer cum center manager.
- Abscess or wound management should be made available free of charge with the necessary medicines.
- If healing of an abscess or wound takes a long time, then the medical officer cum center manager refers such cases to the hospital's relevant department (such as general surgery outdoors department).
- If the treated person refuses to go for further treatment, then he or she should continue treatment at the KP service center.
- All staff should follow the basics of infection control measures as per the standards suggested in the national standards and the service center infection control protocol.
- Regular follow-up of abscess management is an important part of wound management service.
- Staff should teach hygiene, wound healing, and safe injection techniques, etc.

Supplies:

- Disinfectant supplies, tools, and equipment for wound management
- Regular supplies of consumables for abscess management

Documentation:

- Patient record register
- Abscess management records (new and old), with the assurance of privacy and confidentiality
- Equipment, consumables, and materials of the service center

Responsible:

- Medical officer cum center manager
- Technical supervision: HIV Specialist, NASP

3.2 Conception and pregnancy care
3.4 Prevention, assessment, and treatment of cervical cancer
3.6 Safe abortion

Introduction:

Members of KPs, regardless of whether they are living with HIV, should be able to experience full, pleasurable sexual lives and have access to a range of reproductive options. Women from KPs should enjoy the same reproductive health rights as all other women; they must have access to family planning and a range of reproductive health services, including conception and pregnancy care; prevention, assessment, and treatment of cervical cancer; and safe abortion.

Rationale:

For many women from KPs, their main concerns are often not just HIV and STIs but also other reproductive health issues. Healthcare providers, however, often overlook the sexual and reproductive health of PLHIV.

Contraception is a service that is often disregarded for vulnerable populations. It is essential that healthcare providers strongly encourage all people who are at risk of HIV to use condoms in combination with other methods or to use condoms consistently and correctly alone.

SOPs:

- KPs should have access to family planning and reproductive health services, including conception and pregnancy care; prevention, assessment, and treatment of cervical cancer; and safe abortion.
- FSW and women who use drugs should be offered contraceptive counseling to explore pregnancy intention and a range of contraceptive options, including dual protection of condoms.
- The medical officer cum center manager performs the initial counseling on sexual and reproductive health and refers the client to the relevant department (such as obstetrics and gynecology).
- The medical officer cum center manager ensures that referred cases are followed up.

Responsible:

- Medical officer cum center manager
- Technical supervision: HIV Specialist, NASP

3.2 Mental health

Introduction:

PLHIV—including those from KPs—and their families and caregivers may have various mental health needs. Common mental health co-morbidities include depression and anxiety. Dementia and other cognitive disorders are also associated with longer-term HIV infection. HIV care settings can provide an opportunity to detect and manage mental health problems among PLHIV, including pre-existing mental health issues.

Rationale:

Studies suggest that mental health disorders in PLHIV may interfere with treatment initiation and adherence and lead to poor treatment outcomes. The presence of mental health co-morbidities may affect adherence to ART due to forgetfulness or poor organization, motivation, or understanding of treatment plans.

Psychosocial support, counseling, appropriate drug therapies, and interventions such as case management may help to improve adherence to ART and retention in care. The WHO Mental Health Gap Action Programme intervention guide for mental, neurological, and substance use issues in non-specialized health settings makes recommendations related to general mental health care that can be relevant to PLHIV, including those from KPs.

SOPs:

- Routine screening and management for mental health disorders (particularly depression and psychosocial stress) should be provided for people from KPs living with HIV to optimize health outcomes and improve adherence to ART. Management can range from co-counseling for HIV and depression to appropriate medical therapies.
- Integrated and comprehensive services provide the opportunity for patient-centered prevention, care, and treatment for the multiple emotional and mental health issues affecting KPs.
- The community peer counselor conducts a primary screening of the FSW and PWID for mental health disorders and, in consultation with the medical officer cum center manager, refers the client to the hospital's psychiatry department.

Responsible:

- Community peer counselor
- Supervision: Medical officer cum center manager

Supplies:

- Mental health assessment checklist
- Referral register

Further reading:

- WHO Mental Health Gap Action Programme Intervention Guide for Mental, Neurological, and Substance Use Disorders in Non-specialized Health Settings (2016)

3.6 Screening and treatment for hazardous and harmful alcohol and other substance use

Introduction:

In addition to being disproportionately burdened by HIV, KPs have greater rates of depression, anxiety, smoking, harmful alcohol use and alcohol dependency, other substance use, and suicide, as a consequence of chronic stress, social isolation, violence, and disconnection from a spectrum of health and support services.

Rationale:

To end the HIV epidemic, substance use among the KP, PLHIV, should be addressed because it is a barrier to effective engagement in the HIV care continuum. Substance use may raise the likelihood of risk-taking behaviors (e.g., unsafe sexual activities), the risk or severity of substance-related toxicities, and the potential of overdose. Continuous drug use may hinder a person from being tested for HIV, initiating ART, or adhering to ART.

SOPs:

- The community peer counselor and outreach supervisor should be trained in drug counseling and provide counseling support to FSW and PWID.
- If any FSW is revealed to be an injecting drug user, she must be immediately linked to the harm reduction program.

Responsible:

- Community peer counselor and outreach supervisor

Supplies:

- Drug counseling guideline

4. Enabling interventions

4.1 Removing punitive laws, policies, and practices

Introduction:

Laws and regulations can protect the human rights of KPs, including PLHIV and those at risk of acquiring the infection. Legal reforms such as decriminalizing sexual behaviors and drug use and reducing the age of consent are crucial enablers that can transform a hostile environment for KPs into a supportive environment.

Rationale:

Supporting the health and well-being of KPs who are currently criminalized for their sexual behaviors, drug use, gender expression, or perceived sexual orientation may necessitate changing legislation and enacting new policies and protective laws following international human rights standards. Without

protective legislation and legalization of KPs' behavior, barriers to essential health services will persist; many persons from KPs may be fearful that seeking healthcare may expose them to negative legal consequences.

SOPs:

- To facilitate and support increased access to services for KPs, NASP should take the initiative to review laws, legal policies, and practices with the active participation of policymakers and government officials, as well as meaningful engagement of stakeholders from KP groups.
- NASP should endeavor to promote policies and regulations that decriminalize injection and other drug use, lowering incarceration.
- NASP, in collaboration with the Department of Narcotics Control, should work to adopt policies and regulations that decriminalize the use of sterile needles and syringes for PWID.
- Specific IEC/BCC activities that improve KP awareness of their legal and human rights as individuals, including their right to health, can improve their access to healthcare.
- A KP program is particularly needed to ensure that KPs know their legal and human rights, including applicable protective laws and where and how to obtain legal services.
- NASP should strengthen the existing police training initiative so that police get continuous training on how to support or, at least, not limit KPs' access to essential health services.

Responsible:

- Senior manager–management and Coordination, technical specialist–HIV, manager–KP intervention

4.2 Reducing stigma and discrimination

Introduction:

People from KPs are frequently subjected to stigma, discrimination, and unacceptable attitudes relating to their behavior—which is exacerbated if they are also living with HIV—by their families, communities, and health service providers. Such stigma is prevalent in many healthcare facilities and law enforcement agencies. It may appear implicitly supported by the absence of national anti-discrimination laws and practices. HIV-related stigma and discrimination against KPs can result in delayed HIV testing, concealment of positive serostatus, and low HIV service uptake.

Rationale:

Stigma and discrimination in the healthcare system may occur in various ways at both the personnel and system levels. Stigma and discrimination can hinder public health programs' capacity to successfully link individuals to HIV care and engage and keep them in long-term care. The lack of training and educational programs to sensitize health workers about KP's needs, health complications, and strategies and interventions leads to marginalization. It renders healthcare professionals ill-equipped to meet health needs and promotes stigmatizing and discriminatory practices, even to the point of treatment refusal.

SOPs:

- To reduce stigma, discrimination, and harassment against individuals from KPs, NASP should work to adopt and implement anti-discrimination and protective policies based on human rights standards.

- To monitor stigma and address discrimination against KPs in hospital settings, NASP should collaborate with hospital authorities, KP intervention staff members, and district-level civil society organizations.
- NASP should prioritize continuous training, sensitization, and education for all relevant service providers in hospitals, including doctors, nurses, ward boys, *Ayas*, and other hospital staff members, on KP issues, non-discriminatory attitudes and practices, and KP's rights to health, confidentiality, non-coercive care, and informed consent. This ongoing training and discussions are crucial to ensure that the service providers have up-to-date knowledge and skills to provide high-quality care to KPs and maintain a supportive environment for them..

Responsible:

- Manager–KP intervention, assistant manager (training and advocacy)

4.3 Community empowerment

Introduction:

KPs often have little or no control over HIV risk factors driven by the legal, political, and social environment and the context of their lives. For instance, sex workers are frequently exposed to HIV and other STIs, but they may not have the power to negotiate consistent condom use. This lack of control is exacerbated if people are unaware of available HIV-related services and their legal and human rights, specifically their right to health and what to do if these rights are violated. The lack of community empowerment and community-wide awareness and knowledge limit the overall effectiveness of interventions to reduce HIV risk.

Rationale:

Evidence shows that health policies and programs are more effective and have a more positive impact on health outcomes when affected populations participate in their development. Community empowerment is a guiding principle for all HIV programming and activities. Community empowerment is a collective process that enables KPs to address the structural constraints to health, human rights, and well-being; make social, economic, and behavioral changes; and improve access to health services. Community empowerment can foster the wider reach and greater effectiveness of services for KPs. It can take many forms, such as meaningful participation of people from KPs in designing services, peer education, implementation of legal literacy and service programs, and fostering KP-led groups and KP-led programs and service delivery.

SOPs:

- KP interventions must be implemented primarily by the community, which implies that more than 80 percent of outreach staff members must be from the community.
- KP-led organizations and networks may play important roles in training hospital personnel, as well as in facilitating direct interaction between KP communities and service providers.
- Even if KP-led groups are not taking the lead or are not feasible in the setting, meaningful community participation in programming is vital to ensuring the appropriateness and acceptance of services to the target group. It is also essential for establishing trustworthy relationships between the community and service providers.

- KP-led groups will provide para-legal services and support legal aid through the mobilization of human rights organizations and legal rights protection organizations at the district level.

Responsible:

- Manager–KP intervention, assistant manager (training and advocacy)

4.4 Addressing violence

Introduction:

Violence against people from KPs has been shown to be a risk factor for HIV acquisition. Such violence is common. It can take various forms—physical, sexual, or psychological. Violence is fueled by the imbalance in the power dynamics of gender and by prejudice and discrimination against persons perceived to depart from conventional norms and identities of gender and sexuality. In addition, multiple structural factors influence vulnerability to violence, including discriminatory or harsh laws and policing practices and cultural and social norms that legitimize stigma and discrimination.

Women, especially young women, from KPs, including female drug users, FSW, and transgender women, experience particularly high rates of physical, sexual, and psychological abuse. Reported rates of violence against sex workers and transgender women are high but are likely to be underreported where certain behaviors of KPs are illegal.

Rationale:

Efforts to address violence against people from KPs must involve other sectors along with health. Together, they must create an enabling environment to promote physical, sexual, and emotional well-being and safety. Critical enablers include mechanisms for documenting and monitoring violence, training people from KPs and other stakeholders to understand human rights, and fostering the accountability of law enforcement officials to prevent and respond to violence and infringements of human rights.

SOPs:

- Violence against people from KPs should be prevented and addressed in collaboration with KP-led organizations. All violence against people from KP groups should be monitored and reported, and redress mechanisms should be established to provide justice.
- Health and other support services should be provided to all persons from KPs who experience violence. In particular, persons experiencing sexual violence should have timely access to comprehensive post-rape care following WHO guidelines.
- Law enforcement officials and healthcare and social care providers need to be trained to recognize and uphold the human rights of KPs and to be held accountable if they violate these rights, including the perpetration of violence.
- Provide legal support through accompanied referral to human rights organizations and legal rights protection organizations at the district level..

Responsible:

- Manager–KP intervention, assistant manager (training and advocacy)

SECTION 6: PROCUREMENT AND SUPPLY CHAIN MANAGEMENT

To provide uninterrupted service to the KP at the district level, supply chain management of essential pharmaceuticals (such as antiretroviral drugs, medicine, and consumables for STIs, abscesses, and general health management) and health products (such as needles, syringes, condoms, HIV test kits, syphilis testing kits, and and methadone) is essential.

The central medical stores depot (CMSD) is the government's principal procurement and supply management authority. The CMSD has SOPs that address procurement and supply chain management aspects. Any department or directorate within the Ministry of Health and Family Welfare must follow the procurement and supply chain management SOP. The NASP, like the other national programs, adheres to the same SOP. However, given the complexity of the HIV program and its service provision at the district level, a customized, easy-to-understand guideline will be prepared by January 2023 following the CMSD's SOP and relevant compliance.

PR ASP registered on the WAMBO platform and purchased various health items in 2021. At a recent PR coordination meeting, it was decided that PR ASP would obtain HIV test kits for all three PRs. Save the Children and icddr,b have already submitted their requirements to ASP. PR ASP is revising the budget while keeping a sufficient budget for those items from its unspent balance. The re-budgeting is scheduled to be completed by June 2022. After approval of the revised budget, ASP will procure HTS kits from WAMBO using its unspent balance on behalf of three PRs.

The project will adapt the hospitals' existing systems and procedures for site-level storage management, ensuring compliance with the Global Fund's and government's procurement and supply chain management standards.

The following are the overall key elements of procurement and supply chain management and the responsibilities of personnel at various levels:

At the hospital level:

- Complete the supply requisition process at the respective district hospitals quarterly, taking into account minimum and maximum levels of stock, stock in hand, any on-order stock (pipeline stock), buffer stock requirements, and anticipated consumption, to ensure uninterrupted stock availability. Guidance on various parameters (min/max stock levels, buffer, etc.) will be defined for the facilities. In this regard, ASP will seek technical assistance from the Global Fund country team.
- Establish a goods-receiving process that is timely, accurate, and comprehensive. The goods-receiving committee consists of three members and is responsible for the receiving processes. The committee will count the items per work orders and delivery chains and examine quality (expiry) and other specifications during receipt. Following committee approval, the storekeeper will record the items in the stock register and store them according to the storage policy.
- Store health products according to established store management practices, ensuring the quality and security of the stored products.
- Distribute pharmaceuticals and health items to end-users in a timely and efficient manner.

- Establish an effective inventory management system that ensures that adequate stocks are always accessible, including an appropriate safety stock, and that avoids or minimizes product expiration before usage.
- Maintained accurate records and archives of all stock transactions using predefined templates.
- All five hospitals currently use a manual logistical information management system. By June 2023, ASP will have fully established a software-based system that will facilitate inventory management, stock management, and the development of supply management reports, including entry and report preparation.
- Establish the write-off and disposal committee function per January 25, 2018, government directive (Condemnation Guidelines for Use in Health Institutions 2019).
- Establish a local-level formal arrangement for the disposal of health products by adopting the existing waste management system in the hospital.

At the NASP level:

- Compile, analyze, and process demand requests and requisitions to ensure ongoing stock availability to fulfill projected demand for health products and pharmaceuticals. The procurement and supply management coordinating team will conform with and review all requisitions. ASP will provide items at the service delivery level (drop-in center/outlet and hospitals) every quarter.
- During the budget revision, ASP is keeping the provision of budget allocation for HTS kits for 2023. For the item, ASP will act as a procurement agent on behalf of the three HIV PRs.
- Procure pharmaceuticals and health items with Global Fund funds and government policy through WAMBO/Global Drug Facility and other recognized channels.
- Establish an effective follow-up mechanism with suppliers to ensure timely delivery.
- Develop, monitor, and reinforce hospital inventory management systems, including minimum and maximum stock levels and reorder quantity levels, and conduct a performance gap analysis using a set of appropriate key performance indicators. The analysis will be completed in June 2023, and the Global Fund program will cover its costs. The provision is preserved in the budget revision.
- Regularly monitor and analyze performance gaps and enhance hospital-based team members' capacity in all supply chain management elements.
- Coordinate with the hospital's director/superintendent to ensure that supply requisitions are processed on time.
- Compile hospital stock reports to examine and determine adherence to optimal stock level maintenance.
- Generate supply management reports that are timely, accurate, and thorough for submission to the local fund agent and the Global Fund.

Goods and Drugs Receiving and Storage Processes

Receiving Process

Step 1. Drugs, cartridges, or goods come from WAMBO and other sources to Dhaka Airport/Seaport/ Customs House.

Step 2. Collect a No Objection Certificate from the Director General of Drug Administration.

Step 3. The No Objection Certificate, challan/issue, and request letter of the line director, NASP, are submitted to the CMSD with supporting documents from WAMBO or other sources.

Step 4. CMSD appoints the clearing and forwarding agent to clear the drugs, cartridges, or goods.

Step 5. The clearing and forwarding agent clears the items from the customs house/airport.

Step 6. Items are transferred through the clearing and forwarding agent to the national tuberculosis program, Medical Storage at Shyamoli, IDH, or CMSD Dhaka.

Step 7. Items are received by the receiving committee.

Step 8. The medical storage receives the items and registers them.

Storage Process

Step 1. Hospital's authority sends their requisition to the line director, NASP.

Step 2. NASP authorizes a person to prepare the voucher to determine the issuing quantity based on the stock and consumption and sends vouchers to the hospital authority. During delivery, the store considers the first in, first out method.

Step 3. The authorized person of the hospital/DIC/ART/HIV center receives the item, and the item is registered in the hospital store.

Step 4. KP center/ART/HTS center collects required items from the hospital store weekly and when required.

Step 5. KP service center/ART/HTS center dispenses the items according to user demand.

SECTION 7: INFECTION PREVENTION

A. Collection of Needles and Syringes and Medical Waste

Globally it is evident that the designated needle and syringe program deals with a high volume of supply, distribution, collection, and disposal. It is advised that the used needles and syringes be collected in a sharp object container or safety box. A safety box has the following features:

- Needle usually will not penetrate the box wall
- No additional equipment required
- Easy to transport and empty—comes flat
- Assembled at the point of use

Essential Equipment

In Bangladesh, the following equipment is used for collection:

Sharp Object Container

Safety Box

Utility Safety Gloves

Forceps

Line of Responsibilities

To facilitate smooth operation, the following steps are suggested:

The peer educator is primarily responsible for collecting used needles and syringes from designated areas, including outreach areas, spots, hotspots, and sub-spots. While collecting used needles and syringes, the peer educator should ensure strict adherence to using the following:

- Utility safety gloves
- Forceps
- Sharp object container (or safety box)

The peer educator will encourage PWID to put used needles and syringes directly into the container after their use.

In all collection situations, no peer educator is allowed to break, bend, or re-cap any used needle and syringe from the ground and then put it into the sharp object container At least once every week, the outreach supervisor will monitor the peer educators' collection of used needles and syringes. Peer educators would carry collected needle syringes to the KP service center at the district hospital. The office attendant would preserve the items in accordance with the universal precaution procedure

outlined in the subsequent section. According to the hospital's waste management procedure, the medical officer cum center manager would take the necessary steps for the incineration.

Collection Outlet: Drop Box

- The area-specific peer educator will collect the used needles and syringes from drop boxes in the designated sharp object container, following the protocol of using forceps and utility gloves and following all safety measures.
- The outreach supervisor will ensure that these drop boxes are locked properly and the keys are handed over to the respective peer educator.
- After returning from outreach to the KP service center, the peer educator will hand over the used needles and syringes to the office attendant to put them into the selected drums. Respective staff should take charge of used needles and syringes and place them into the drum following all safety measures (e.g., wear utility gloves and mackintosh and use long forceps). The outreach supervisor/community peer counselor will randomly check the process and take necessary measures/guidance in consultation with the medical officer cum center manager.
- The filled drums with used needles and syringes will be locked in a safe place, supervised by the community peer counselor.

Remember

After dropping used needles and syringes into drums, all sharp object containers will be sterilized with 0.5 percent chlorine solution for 30 minutes for their use the next day.

Thematic Campaign Specific to PWID for Safe Disposal

1. A team of at least three members from the outreach staff—preferably peer educators and the outreach supervisor—should be formed for this campaign. The medical officer cum center manager will form this committee.
2. This campaign will be conducted at least once a quarter in a PWID hotspot.
3. The campaign timing should be arranged considering the injecting time of the particular venue because the main aim is to reach as many PWID as possible.
4. Rather than gathering all PWID in one large group, the campaign should be conducted in small groups of 6 to 8 PWID at a time.
5. During a discussion with PWID, the campaign team will discuss the consequences of throwing used needles and syringes on the ground.
6. PWID will be encouraged to hand over the used needles and syringes to the peer educator.
7. All PWID will be familiarized with the placement of the drop box for needles and syringes at the spots.
8. In the absence of the peer educator, PWID will be shown how to safely drop the used needle and syringe into the box safely.
9. A demonstration session will be conducted, during which PWID will be asked to drop the used needle and syringe into the box.
10. PWID will be encouraged to convey these messages to other PWID.

Needle Stick Injuries

First Aid

The following steps should be taken:

- Flush the area with running water.
- Do not force or encourage the wound to bleed.
- Do not lick or suck the wound.
- Wash well with soap and water.
- Apply antiseptic on the wound and cover it with a water-proof Band-Aid.
- Seek medical attention for assessment of the risk of infection and appropriate treatment.
- The medical officer cum center manager must be notified immediately.

Medical Attention and PEP

Seek immediate medical attention (within hours) from the KP service center's medical officer cum center manager. The needle-stick injury will be assessed there. Confidential HIV, hepatitis B, and hepatitis C testing may be recommended. PEP (e.g., immunoglobulin or antiviral therapy for hepatitis B and HIV) may be recommended. Delay or failure to seek medical attention may compromise the effectiveness of post-exposure treatment.

Follow-up Counseling and Evaluation

Periodic testing for hepatitis C antibodies, liver enzyme levels, and HIV antibodies is recommended. Counseling for emotional stress related to the injury and the possibility of infection is recommended. Counseling is also recommended to prevent transmission through sexual contact or blood or organ donation.

Documentation and Surveillance

- Develop a protocol for the prevention and management of needle stick injuries.
- Develop an assessment tool for risk assessment.
- Document all injuries in the sharps injury log register. A sharps injury log includes information such as the date of the injury, the equipment involved, a description of the injury, and an explanation of how the incident occurred.
- This information can be used to help the KP intervention develop further strategies to prevent needle stick injuries.
- Report the incident immediately to the manager—KP intervention.

B. Universal Precautions

This sub-section describes standard precautions recommended for reducing the risk of infection. Effective infection prevention practices can protect healthcare providers, clients, and the community. Standard precautions help break the disease transmission cycle at the "mode of transmission" level. Universal precautions are practices performed to protect healthcare workers from exposure to blood-borne microorganisms.

1. Hand washing

Hand washing is one of the most important infection prevention practices, but it is often overlooked. All team members in the KP intervention should wash hands (a) immediately after arrival at work; (b) before examining each patient; (c) after examining each patient; (d) before putting on gloves for clinical procedures; (e) after touching any instrument or object that might be contaminated with blood or other body fluids or after touching mucous membranes; (f) after handling blood, urine, or other specimens; (g) after removing any kind of gloves (hands can become contaminated if gloves contain tiny tears); (h) after using the toilet or latrine; and (i) before leaving work.

The most appropriate hand washing method is washing with plain soap and running water for 30 seconds, as shown in Figure 7. This will remove transient microorganisms and soil. Remove all jewelry from the hands and wrists before washing, and wet your hands with running water. Rub hands together with soap and then rinse and wipe dry.

Figure 7: Steps of hand washing with plain soap and running water

2. Decontamination

Decontamination, the first step of instrument processing, minimizes the risk of infections to any staff members, including doctors, nurses, and cleaning and housekeeping staff who handle used instruments or other items that may be contaminated with potentially infectious fluids or tissues. To decontaminate items, use 0.5 percent chlorine or a solution from another acceptable disinfectant.

Steps of Decontamination

Step I: Immediately after use, decontaminate instruments and other items in a plastic container of 0.5 percent chlorine solution. Let them soak for 10 minutes.

Step 2: After 10 minutes, remove the items from the chlorine solution and rinse with water immediately. Use utility gloves when removing instruments and other items from a chlorine solution.

Gloves: *Before removing contaminated gloves, dip gloved hands into a 0.5 percent chlorine solution to rinse the outer surfaces and remove blood, other fluids, and tissue. Carefully remove gloves without touching the outer surface with bare hands. If surgical gloves are processed for reuse, place them in a container of 0.5 percent chlorine solution and soak them for 10 minutes before cleaning. Rinse or clean them immediately.*

Storage containers: *Fill containers with a 0.5 percent chlorine solution and soak them for 10 minutes before cleaning. Rinse or clean immediately.*

3. Cleaning

Decontamination makes items safer to handle, but cleaning—the second step in instrument processing—removes organic material, dirt, and foreign matter that can interfere with sterilization or high-level disinfection (HLD). Wear utility gloves, masks, and protective eyewear when cleaning instruments and other items.

Step 1: Using a soft brush, detergent, and water, scrub instruments and other items vigorously to completely remove all blood, body fluids, tissue, and other foreign matter. Hold instruments and other items under the surface of the water while scrubbing and cleaning to avoid splashing. Disassemble instruments and other items with multiple parts, and brush in the grooves, teeth, and joints of items where organic material can collect and stick.

Step 2: Rinse items thoroughly with clean water to remove all detergent. Any detergent left on the items can reduce the effectiveness of further chemical processing.

Step 3: Allow the items to air dry (or dry them with a clean towel).

4. Sterilization

Sterilization, the third step in instrument processing, ensures that instruments and other items are free of all microorganisms (bacteria, viruses, fungi, and parasites), including bacterial endospores. Microorganisms causing infections in patients can be passed during procedures onto the surfaces of items in contact with the bloodstream or tissues under the skin.

Two methods of sterilization are applied here: steam sterilization (also known as autoclaving or “moist heat under pressure”) and dry heat sterilization (hot air oven).

- Steam sterilization (autoclaving): Steam sterilization in an autoclave is one of the most common forms of sterilization used in healthcare facilities.
- Dry heat sterilization (hot air oven): Dry heat sterilization requires high heat for a specific time. Because of the high temperatures, only glass or metal objects can be sterilized by dry heat.

5. HLD

When sterilization is not available or feasible, high-level disinfection (HLD) is the third step in instrument processing. Many facilities use a method of HLD as a backup to their primary sterilization method. Boiling is a main method of HLD that can be performed in any location with access to clean water and a

heat source. Using this method, instruments and other items are placed in a pot or boiler, and the water is heated to boiling for 30 minutes.

Steps of HLD by boiling:

Step l: Decontaminate and clean all items to be placed in a sterilizer/boiler for HLD.

Step 2: Water must touch all surfaces for HLD to be achieved; completely submerge all items in the water in the pot or boiler. Open all hinged items and disassemble those with sliding or multiple parts. Place any bowls and containers upright, not upside-down and filled with water.

Step 3: Cover the pot or close the lid on the boiler and bring the water to a gentle, rolling boil. From this point on, do not add or remove any water, and do not add any items to the pot or boiler. When the water comes to a rolling boil, start timing for 30 minutes. Use a timer or make sure to record the time that boiling begins.

Step 4: After 30 minutes, remove the items using dry HLD pickups (lifters, Cheatle forceps). Place the items on an HID tray or in an HLD container in a low-traffic area away from insects and dust.

Step 5: Allows air-drying before use or storage. Use items immediately or keep them in a covered, sterile, or HLD container for one week.

Steaming: For this method, items are steamed in a steamer containing one to three tiers. Steaming is the best method of HLD for gloves.

6. Waste Disposal

Healthcare activities generate waste, ranging from used needles and syringes to soiled dressings, body parts, diagnostic samples, blood, chemicals, pharmaceuticals, medical devices, and radioactive materials.

Poor management of healthcare waste potentially exposes healthcare workers, waste handlers, patients, and the community at large to infection, toxic effects, and injuries, and risks polluting the environment. It is essential that all medical waste materials are segregated at the point of generation, appropriately treated, and disposed of safely.

Types of Waste

General waste: non-hazardous (e.g., paper, boxes, packing materials, bottles, plastic containers, food-related trash)

Medical waste: materials generated during diagnosis, treatment, or immunization, including the following:

- Blood/blood products, body fluids, used bandages, dressings
- Organic waste: human tissue, body parts, placenta, products of conception
- Sharps: hypodermic needles, suture needles, scalpel blades, blood tubes, pipettes, and other glass items

Hazardous waste: potentially toxic/poisonous waste

Guideline for Waste Disposal

Use washable, leak-proof plastic/galvanized containers for disposal of medical waste in operation theater/procedure rooms.

- Keep waste containers in a place convenient for users.
- Empty containers daily or when three-quarters full.
- Never put your hands into containers with medical waste.
- Always dispose of medical waste correctly, and never simply throw it out.
- Always wear heavy utility gloves and shoes when handling and transporting medical waste.
- Wash both gloves before removing and wash your hands.
- Wash containers with disinfectant cleaning solution and rinse with water daily.
- Sharps, liquid waste, and hazardous chemicals need special procedures for disposal.

Disposal of Sharps

- Dispose of all sharp items in puncture-resistant containers.
- Sharps containers should be kept close to the procedure site.
- Close the sharps container securely when three-quarters full.
- Never bend, break, or remove the needle from the syringe.
- Sharps are not destroyed by burning, except in large industrial incinerators.
- Always wear heavy utility gloves and shoes when handling and transporting medical waste.
- Wash both gloves before removing and wash your hands.

Disposal of Hazardous Waste

- Handle cleaning solutions and disinfectants, such as glutaraldehyde, the same as liquid waste.
- Rinse containers thoroughly with water.
- Wash glass containers with detergent and water, rinse thoroughly and reuse.
- Do not reuse plastic containers.
- Always wear heavy utility gloves and shoes when handling and transporting medical waste.
- Wash both gloves before removing them and wash your hands.
- Disposing of cytotoxic chemicals and radioactive waste requires special considerations.

Clinical Waste Segregation Process

The clinical waste collection involves color-coded containers, which highlight what should be disposed of within each container and how and where they should be transported for treatment or disposal. The colors are organized depending on how hazardous or infectious the contents may be, as shown in Figure 8.

Figure 8: Medical waste segregation with color coding

SECTION 8: MONITORING AND EVALUATION

M&E systems are essential to maintain or improve the quality of any health system intervention and also determine the achievement of the planned changes and results. This provides an understanding of whether the interventions have achieved the planned goals. Furthermore, the health workforce needs to remain on track for monitoring the progress of projects, programs, or policies vis-a-vis the planned goals. For transparency, accountability, and lessons learned, these insights can be used to adjust the existing approach to make it more effective and efficient. An M&E plan linked with the national operational plan is one pillar of any health project.

Under the Global Fund-supported NFM-3 grants, the activities have been clustered into three service packages. The service packages focus on prevention programs for sex workers and their clients, prevention programs for PWID and their partners, and treatment, care, and support for PLHIV.

The activities have been clustered into the following modules based on thematic areas and better program management:

Module 1: Prevention

Module 2: Differentiated HIV testing services

Module 3: Treatment, care, and support

Module 4: Resilient and Sustainable Systems for Health (RSSH): Health management information systems and M&E

Module 5: RSSH: TB/HIV

Module 6: RSSH: Program management

A. Selection of Performance Indicators

PR-ASP responsible for collecting data impact and outcome-level indicators. The project performance indicators were selected from a wide range of standard lists of Global Fund indicators, in consultation and collaboration with the three PRs (NASP, icddr,b, and Save the Children), and are aligned with the National M&E Plan and Global AIDS Response Monitoring Indicators. In case of the absence of appropriate standard indicators, custom indicators were also selected through consultation. Other stakeholders like UNAIDS and UNICEF, and community-based organizations also joined the process of selecting indicators. A consolidated performance framework was formulated through consultation based on impact, outcome, and coverage indicators for this funding request. Impact and outcome-level data will be collected biannually from IBBS/Serological and Behavioral Surveillance Survey.

All the PRs are directly responsible for collecting data for coverage indicators in the performance framework. Data will also be collected for activities mentioned in the work plan. Among eight coverage indicators, seven are divided periodically throughout the project lifecycle, and the eighth is calculated annually.

B. Indicator Definitions and Measurement

According to the combined performance framework of the NFM-3 grant, NASP is contributing to all seven impact-level indicators, seven outcome-level indicators, and 18 coverage indicators. Details of these indicators are provided as follows. The M&E framework template of the Global Fund provides details of each indicator.

Impact indicators:

- HIV I-10$^{(M)}$ Percentage of sex workers who are living with HIV
- HIV I-11$^{(M)}$ Percentage of people who inject drugs who are living with HIV
- HIV I-Other 1 Percentage of people who inject drugs who are living with HIV in Dhaka
- HIV I-Other 2 Percentage of people who inject drugs who are living with HIV outside Dhaka
- HIV I-9a$^{(M)}$ Percentage of men who have sex with men who are living with HIV
- HIV I-9b$^{(M)}$ Percentage of transgender people who are living with HIV
- HIV I-13 Percentage of people living with HIV

Outcome indicators:

- HIV O-5$^{(M)}$ Percentage of sex workers reporting the use of a condom with their most recent client
- HIV O-6$^{(M)}$ Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected
- HIV O-9 Percentage of people who inject drugs reporting condom use at last sex
- HIV O-4.1b$^{(M)}$ Percentage of transgender people reporting using a condom in their last anal sex with a non-regular male partner
- HIV O-4a$^{(M)}$ Percentage of men reporting the use of a condom the last time they had anal sex with a non-regular partner
- HIV O-12 Percentage of people living with HIV and on ART who are virologically suppressed
- HIV O-21 Percentage of people living with HIV not on ART at the end of the reporting period among people living with HIV who were either on ART at the end of the last reporting period or newly initiated on ART during the reporting period

Coverage indicators:

- KP-1a$^{(M)}$ Percentage of men who have sex with men reached with HIV prevention programs - defined package of services
- KP-1b$^{(M)}$ Percentage of transgender people reached with HIV prevention programs - defined package of services
- HTS-3a$^{(M)}$ Percentage of men who have sex with men that have received an HIV test during the reporting period and know their results
- HTS-3b$^{(M)}$ Percentage of transgender people that have received an HIV test during the reporting period and know their results
- M&E-5 Percentage of facilities which record and submit data using the electronic information system

- KP-5 Percentage of individuals receiving Opioid Substitution Therapy who received treatment for at least six months
- KP-1d$^{(M)}$ Percentage of people who inject drugs reached with HIV prevention programs - defined package of services
- KP-4 Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programs
- KP-1c$^{(M)}$ Percentage of sex workers reached with HIV prevention programs - defined package of services
- HTS-3d$^{(M)}$ Percentage of people who inject drugs that have received an HIV test during the reporting period and know their results
- HTS-3c$^{(M)}$ Percentage of sex workers that have received an HIV test during the reporting period and know their results
- M&E-2a Completeness of facility reporting: Percentage of expected facility monthly reports (for the reporting period) that are actually received
- M&E-2b Timeliness of facility reporting: Percentage of submitted facility monthly reports (for the reporting period) that are received on time per the national guidelines
- TCS-1.1$^{(M)}$ Percentage of people on ART among all people living with HIV at the end of the reporting period
- TB/HIV-3.1a Percentage of people living with HIV newly initiated on ART who were screened for TB
- KP-1f$^{(M)}$ Number of people in prisons and other closed settings reached with HIV prevention programs - defined package of services
- HTS-3e Percentage of other vulnerable populations that have received an HIV test during the reporting period and know their results
- TB/HIV-7 Percentage of PLHIV on ART who initiated TB preventive therapy among those eligible during the reporting period

In addition, NASP also has two work plan tracker indicators, which are as follows:

Intervention	Key Activity
Addressing stigma, discrimination, and violence	Advocacy workshops at five district levels with law enforcement, rehab centers, District Chamber of Commerce, Department of Narcotics Control, Directorate of Social Service, Media, DC Office, etc., for KP interventions
Routine reporting	PLHIV/ART database customization, implementation, maintenance, and data visualization (management information system, Directorate General of Health Services)

C. Routine Data Collection

A standard routine data collection process has been established from the hospital to the NASP head office. The KP service center at the hospital is the main hub for generating routine HIV data for the program indicators. The hospital-level data are collected daily or monthly from the outreach KP service center using standardized tools and methods. Under the guidance of the director/superintendent of the hospital, the medical officer cum center manager compiles and analyzes collected data and generates periodic reports for NASP. Data management and record-keeping system at the hospital level have been

standardized, and tools have been incorporated to address different components of the program, such as HTS, HIV case management, ART adherence, management of STI, and referral services within and outside of the hospitals.

NASP receives a soft copy of data from the hospitals quarterly, compiled by the M&E expert, and analyses data quarterly to provide feedback to hospitals and report to the Directorate General of Health Services (DGHS), the Global Fund, LFA, and Bangladesh Country Coordinating Mechanism BCCM to monitor progress and fulfill accountability requirements.

D. Health Management Information System

Data on the selected programmatic areas will be directly entered into the web-based data portal maintained by DGHS. The management information system (MIS) for KP was established in 2013 and integrated into the national health MIS-District Health Information Software, version 2 (DHIS2). DHIS2 is a flexible, web-based open-source information system with essential visualization features, including geographic information systems, charts, and pivot tables. To facilitate and standardize the data entry process, a set of suggested formats were developed and agreed upon by all relevant stakeholders.

Capacity-building efforts are ongoing to facilitate the hospital management teams and project staff directly submitting data to DHIS2. In addition, every month, government ART and HIV testing and counseling centers send information to ASP, and ASP submits the report to DHIS2 after data verification. This is expected to be implemented by the end of 2022.

DHIS2 contains three datasets for the HIV program: (a) HIV testing data, (b) KP coverage/reach data, and (c) training/orientation data. Since 2020, the five hospitals in which ASP is implementing the HIV program among KPs have provided HIV testing data. After the KP intervention is implemented fully, the hospitals will start providing data to the remaining two datasets (KP coverage/reach data and training/orientation data).

E. Reports and Reporting Tools

Reports	Components	Tool	Frequency of reporting	Timeline
Hospital to NASP				
Periodic Progress Report	• Quantitative report • Narrative report • Program finance report	• DHIS2 (KP dataset) • PLHIV database • ASP provided the needed tools	Quarterly	DHIS2 (KP dataset), within 20 calendar days of the following month of each quarter/period PLHIV database, real time
Annual Report	• Formative report/ narrative report	ASP provided the needed tools	Annually	Within 45 calendar days of the completion of the year (January to December)
NASP to the Global Fund and LFA				
Program update	• Formative report—both	According to the	Six monthly	Within 45 calendar

Reports	Components	Tool	Frequency of reporting	Timeline
and disbursement request (PU & DR)	program and finance combined as per the Global Fund format • Narrative report	Global Fund-provided PU & DR template/online submission		days
NASP to DGHS, BCCM, and the Global Fund/LFA				
Dashboard for BCCM Oversight Committee and the Global Fund/LFA	• Periodic PR dashboard	Software-based report	Quarterly	Within 30 calendar days of completion of a period
DGHS report-DHIS2	• Quarterly DGHS reporting in the DHIS2 platform	Online database	Quarterly	Within 30 calendar days of completion of a period

F. Data Flow and Use

The M&E and Strategic Information units of ASP collaborate with all relevant implementing partners to guide and collect M&E data in their respective areas of operation. ASP is primarily responsible for coordinating M&E activities and is the custodian of HIV/AIDS data and reports. As part of the National Health MIS, the DIC/outlet, hospitals, and ART centers enter programmatic output indicators on relevant KP interventions into the DHIS2 system.

Furthermore, ASP leads the process of biological and behavioral surveillance, evaluation studies, assessments, and operational research, all of which provide data for outcome and impact indicators.

ASP analyzes and produces yearly HIV/AIDS reports, biannual progress reports, advocacy briefs, Global AIDS Monitoring (GAM) reports, and other materials based on the data. The reports are used to mobilize resources and advocacy and to provide status updates to the Government of Bangladesh ministries, development partners, the Global Fund, and others.

The ASP website is also being updated and reorganized. All relevant key documents have been uploaded to the website. Figure 9 shows the data flow and subsequent use and sharing to higher levels.

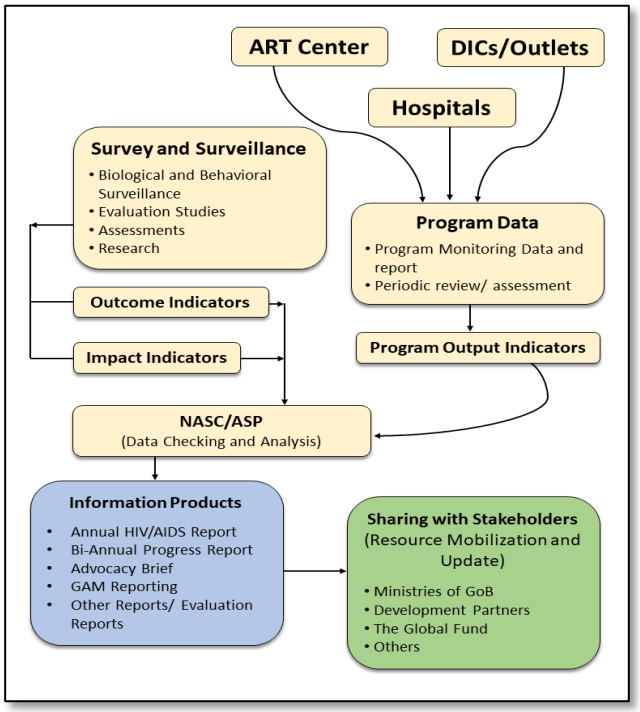


Figure 9: Data Flow

G. Supervisory Visits

Various bodies conduct supervisory visits:

- **ASP:** ASP conducts field visits regularly to monitor program activities, including the national data quality review for ART services. The periodic joint monitoring visits are also planned on a six-monthly basis, with participation from all relevant agencies, including United Nations agencies, other directors of DGHS, technical working groups, PRs/SRs, and networks. The purposes of these visits are to (1) verify achievements against the Performance Framework (PF) indicators, (2) assess the quality of service implementation and operational issues, (3) conduct data verification and audits through data quality assessments, (4) review the documentation, and (5) mitigate implementation barriers. The details of the joint monitoring visits are outlined in Section 10 (Supportive supervision and data auditing) of the national M&E Framework (2018-2023).

  Furthermore, actions deriving from the recommendations of LFA/the Global Fund's Country Team (CT) assurance activities, such as data quality reviews and program quality spot-checks, are given special attention.

  The visit report's findings are shared with PRs/SRs/SSRs. Visitors identify problems and provide suggestions on the spot, jointly with associated PRs, SRs, or SSRs that carry out the programs.

- **BCCM Oversight Committee:** Under the leadership of the Oversight Committee chair, BCCM conducts regular field visits, and other members, including the United Nations team, networks, other ministries, and civil society organizations, participate. A detailed report with suggestions and observations is delivered to the respective implementer for action after each visit.

- **PRs/hospital teams:** These teams conduct cross-learning visits