



# Fifth National Strategic Plan for HIV and AIDS Response (2024-2028) in Bangladesh



**National AIDS/STD Control**

Directorate General of Health Services

Ministry of Health and Family Welfare

# Fifth National Strategic Plan for HIV and AIDS Response (2024-2028) in Bangladesh

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National AIDS/STD Control  
Directorate General of Health Services  
Ministry of Health and Family Welfare

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## List of Acronyms

AEM	:	AIDS Epidemic Model
ANC	:	Antenatal Care
ART	:	Antiretroviral Therapy
ASP	:	AIDS/STD Programme
BCC	:	Behaviour Change Communication
CBOs	:	Community-Based Organisations
CCM	:	Country Coordinating Mechanism
CD4	:	Clusters of Differentiation 4
DFID	:	Department for International Development
DGHS	:	Directorate General of Health Services
DHIS2	:	District Health Information System 2
DIC	:	Drop-In-Centre
DSD	:	Differentiated Service Delivery
EID	:	Early Infant Diagnosis
EMTCT	:	Elimination of Mother-To-Child Transmission
FDMN	:	Forcibly Displaced Myanmar Nationals
FSW	:	Female Sex Workers
GBV	:	Gender-Based Violence
GDP	:	Gross Domestic Product
HNPSP	:	Health Nutrition and Population Sector Program
HTS	:	HIV Testing Services
IBBS	:	Integrated Biological and Behavioural Survey
IEC	:	Information, Education & Communication
IPT	:	Isoniazid Preventive Therapy
JMM	:	Joint Monitoring Mission
KP	:	Key Populations
LMIC	:	Low- and Middle-Income Countries
MIP	:	Management Implementation Plan
MOHFW	:	Ministry of Health and Family Welfare
MSM	:	Men who have Sex with Men
MSW	:	Male Sex Workers

NAC	:	National AIDS Committee
NASC	:	National AIDS/STD Control
NCD	:	Non-Communicable Diseases
NFM	:	New Funding Model
NGO	:	Nongovernmental Organizations
NSP	:	National Strategic Plan
OP	:	Operational Plan
OST	:	Opioid Substitution Therapy
PCR	:	Polymerase Chain Reaction
PEP	:	Post-Exposure Prophylaxis
PLHIV	:	People Living with HIV
PMTCT	:	preventing mother-to-child transmission of HIV
PrEP	:	pre-exposure prophylaxis
PRs	:	Principal Recipient
PSM	:	Procurement And Supply Chain Management
PUD	:	People Who Use Drugs
PWID	:	People Who Inject Drugs
SDGs	:	Sustainable Development Goals
SOPs	:	Standard Operating Procedures
SRH	:	Sexual and Reproductive Health
SRHR	:	Sexual and Reproductive Health and Rights
SRs	:	Sub-Recipients
STI	:	Sexually Transmitted Infections
TLD	:	Tenofovir-Lamivudine-Dolutegravir
TOT	:	Training of Trainers
UN	:	United Nations
WHO	:	World Health Organization

## Foreword

In the ongoing global endeavour against HIV and AIDS, Bangladesh has emerged as a dedicated participant, aiming to align its efforts with the Sustainable Development Goal of ending AIDS as a public health threat by 2030. The Fifth National Strategic Plan (NSP) for HIV and AIDS Response (2024-2028) is a testament to this dedication, representing a comprehensive and inclusive approach to tackling the epidemic in Bangladesh.

The NSP stands as a guiding light and a strategic roadmap, directing us through the complex landscape of HIV prevention, treatment, and care. It encompasses a multi-sectoral approach, recognizing the crucial role of diverse stakeholders, including healthcare providers, community leaders, policymakers, and, most importantly, the communities affected by HIV. This plan is not merely a document; it is a commitment towards a future free from the burdens of HIV and AIDS.

Significant achievements and challenges have marked our journey over the years. We have seen a commendable expansion in the coverage of HIV prevention services, especially among key populations (KPs) who are at higher risk. The NSP emphasizes the need to enhance these services further, ensuring they are accessible, inclusive, and sensitive to the unique needs of each group. By increasing the reach and effectiveness of our interventions, we aim to reduce new HIV infections and AIDS-related deaths significantly.

The NSP underscores the importance of innovative and ethical HIV testing and case-finding approaches. In pursuing the first 95 of the UNAIDS 95-95-95 target, we aim to expand HIV testing services, making them more accessible and acceptable to diverse groups. Rapid Antiretroviral Therapy (ART) initiation and the management of advanced HIV diseases are central to our strategy, ensuring those diagnosed with HIV receive immediate and effective treatment.

As we look forward, our focus remains unwavering on strengthening health systems and community networks. This strategy is not just about combating a virus; it is about building resilient systems that can endure the challenges posed by HIV and other health emergencies. It empowers communities, particularly those most affected by the epidemic, to take an active role in the response.

In conclusion, the Fifth NSP for HIV and AIDS Response is more than a strategic plan; it is a call to action. It is an invitation to all stakeholders to unite and amplify our efforts to end the HIV epidemic in Bangladesh. We must continue innovating, collaborating, and advocating, ensuring no one is left behind. The road ahead may be long and demanding, but with collective resolve and perseverance, we can achieve our goal of ending AIDS as a public health threat by 2030. With renewed strength and commitment, let us move forward together towards a healthier and more equitable future for all.

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# Executive Summary

## Background

Bangladesh, with a population of 165 million, has seen transformative changes over the decades, including a significant decline in fertility rates and rapid urbanization, with 39% of its population now in urban areas. Recognized as a developing nation by the United Nations in 2018, it continues to make economic and social development strides.

The Fifth National Strategic Plan (2024-2028) for HIV and AIDS Response in Bangladesh addresses the escalating HIV epidemic, particularly among key populations (KPs) like people who inject drugs (PWID), men who have sex with men (MSM), and transgender/hijra individuals. Despite the low national HIV prevalence of below 0.01%, specific groups exhibit much higher rates, with 2020 data showing a prevalence of 4.1% among PWID and 1.5% among MSM. As of October 2022, there were approximately 16,000 PLHIV, with 947 new cases in that year alone, predominantly in the 19-49 age group. Despite high antenatal care coverage, gaps in mother-to-child transmission testing persist, and co-infection with tuberculosis remains a significant challenge.

The strategic plan focuses on interventions tailored to these demographic shifts and behavioural patterns. The 2023 mapping and size estimation study of KPs highlights the changing dynamics within these groups, indicating both stabilization and increases in certain populations. This data suggests a need for reassessment and expansion of current HIV programmes.

Building on the achievements and learning from the fourth National Strategic Plan (2018-2023), the upcoming plan emphasizes reinforcing healthcare infrastructure, enhancing community-based interventions to reduce stigma, and leveraging data-driven strategies to combat the HIV epidemic in Bangladesh effectively.

## The Development Process of the Fifth National Strategic Plan for HIV and AIDS

The development of the Fifth National Strategic Plan for HIV and AIDS Response (2024-2028) for Bangladesh, initiated in March 2023, was led by the AIDS/STD Programme (ASP) with UNAIDS' technical support. This collaborative process involved a wide range of stakeholders, including government, NGOs, international bodies, civil society, and KP community representatives. Guided by experts, the plan is founded on seven principles, focusing on evidence-based interventions to end AIDS by 2030, addressing human rights issues, and advocating for an all-encompassing approach from prevention to care. It aims for integrated services across sectors, quality assurance through monitoring, and involvement of KPs and PLHIV, and aligns with achieving the Sustainable Development Goals, striving for a fair and evidence-based response.

## Challenges and Gaps

Tackling the HIV epidemic in Bangladesh faces critical challenges, notably in delivering services to KPs like PWID, sex workers, and MSM. Coverage for these groups is below global targets, with only 56% for PWID and 25% for MSM, impacting both national and global efforts to eliminate AIDS by 2030. The discontinuation of programs for brothel-based sex workers has also weakened community trust and healthcare access.

Efforts to update the AIDS Epidemic Model (AEM) show that coverage is still below recommended levels. The ASP, reliant on funding sources like the Global Fund, faces challenges such as rising infections and gaps in treatment and stigma management.

The governance of Bangladesh's HIV program shows a mix of strengths and shortcomings. Despite regular updates to the National Strategic Plan and global alignment, resource deficits hinder its execution. There are notable issues with limited endorsement outside the health sector, insufficient human and financial resources, and inadequate engagement of all relevant stakeholders and sectors.

Legal, structural, and policy barriers, such as the criminalization of drug use and homosexuality, hinder effective KP interventions. Health sector human resources are insufficient, with a notable shortage of trained professionals. Funding shortfalls, exceeding \$100 million for NSP implementation, and low condom use among KPs necessitate urgent action. Addressing these through a comprehensive, multi-sectoral strategy is vital for the successful implementation of the Fifth National Strategic Plan for HIV and AIDS Response in Bangladesh.

## **Recommendations and Focus Areas for the Next Five Years**

The Fifth National Strategic Plan for HIV and AIDS in Bangladesh developed through comprehensive reviews, Joint Monitoring Missions, and stakeholder consultations, employs a multi-sectoral approach encompassing medical, social, economic, and legal dimensions. It has identified ten priority areas:

1. **Social and Legal Reforms:** Focuses on advocating anti-discrimination laws, aligning with global standards, creating job opportunities for at-risk youth, and legal reforms concerning homosexuality, drug use, commercial sex work, and integration of KP programmes into government health infrastructure.
2. **Prevention Among KPs:** Aims to reduce stigma, enhance community engagement, use information technology for targeted interventions, increase service coverage, and integrate services with government health systems.
3. **Prevention in Prisons:** Includes staff training, peer education, HIV testing and treatment, and evidence-based treatments for drug dependency.
4. **Prevention Among Migrants:** Involves conducting national studies, policy development, and securing additional funding.
5. **HIV Testing:** Expand testing for KPs, incorporating partner testing, Pre-Exposure Prophylaxis, and condom education.
6. **Treatment and Care:** Enlarges antiretroviral therapy sites, integrates these into government health facilities, and ensures rapid ART enrolment and WHO-aligned viral suppression.
7. **Health System Resilience:** Focuses on scaling up viral load testing, addressing supply chain issues, managing advanced HIV and non-communicable diseases, and promoting universal infection prevention measures.
8. **Data-Driven Monitoring and Evaluation:** Emphasizes robust data collection, real-time monitoring, iterative planning, and national HIV database enhancement.
9. **Laboratory Services:** Involves operational research, setting up specialized facilities, and establishing guidelines for private labs.
10. **Mobilising the Private Sector:** Aims to secure domestic funding and strengthen public-private partnerships.

These priorities collectively aim to address the diverse aspects of the HIV/AIDS response, ensuring a comprehensive and effective approach.

## **Strategy Framework**

The national HIV and AIDS strategy 2024-2028 focuses on evidence-based interventions, health system strengthening, and community engagement to significantly reduce new HIV infections and AIDS-related deaths. This approach aims to improve the quality of life for those affected by HIV and achieve substantial progress by 2030.

### **Goal:**

The strategy's overarching goal is to significantly reduce new HIV infections and AIDS-related deaths, with a long-term aim of ending the HIV epidemic as a public health threat by 2030.

### **Specific Objectives**

1. To prevent new HIV infections by expanding programme coverage by implementing comprehensive, targeted interventions, providing age, gender, and human-rights-sensitive services, and fostering active community involvement in promoting public health.
2. To ensure innovative, effective, differentiated, and ethical HIV testing and case-finding approaches are scaled up across the country.
3. To provide universal access to treatment, care, and support services for PLHIV and AIDS.
4. To establish resilient, sustainable health systems and strengthen community systems for an integrated, people-centric HIV and AIDS response in Bangladesh through the universal health coverage approach.
5. To strengthen strategic information systems and research for an evidence-based response.

### **Strategies and Priority Actions to Achieve the Objectives**

**Objective 1: To prevent new HIV infections by expanding programme coverage by implementing comprehensive, targeted interventions, providing age, gender, and human-rights-sensitive services, and fostering active community involvement in promoting public health.**

#### **Strategies**

- 1.1 Ensure comprehensive HIV prevention services are accessible to key and vulnerable populations, their clients, and other sexual and needle-sharing partners. The strategy aims to broaden HIV prevention services for key groups like PWID, MSM, sex workers, and transgender/hijra individuals, standardize services in prisons, offer prevention for migrant workers, and enhance services for forcibly displaced Myanmar nationals.
- 1.2 Reinforce HIV and STI prevention and other sexual and reproductive health services aiming for the triple elimination of vertical transmission of HIV, hepatitis B, and syphilis.
- 1.3 Reduction of risk behaviours and provision of services for populations at emerging risk and vulnerable groups through awareness raising and evidence-based interventions to link them to integrated STI, HIV, and SRH services under Universal Health Coverage
- 1.4 Promote infection prevention protocols and post-exposure prophylaxis measures for health service providers, laboratory staff, survivors of gender-based violence, etc.

- 1.5 Optimize behaviour change communication strategies to expand case detection and minimize risk behaviours in the general population, emphasising adolescents and youth while connecting them to SRH and HTS.
- 1.6 Strengthen the empowerment of KP communities and eliminate human rights-related barriers to ensure equitable access to health services, including HIV prevention for all KPs.

### **Priority Actions to Achieve the Objective 1:**

Effective expansion of HIV service coverage hinges on precise data collection and epidemiological insights, necessitating capacity building, ongoing training, robust community involvement, and partnerships. A key focus is on data-informed strategies to launch, adjust, or scale interventions. Developing national guidelines for pre-and post-exposure prophylaxis, especially for KPs and gender-based violence survivors, is crucial. Equally important is training healthcare providers and establishing a prophylaxis network.

A comprehensive service package for KPs should encompass HIV prevention, testing, and care, including behavioural health initiatives like condom distribution, needle and syringe programs, and opioid substitution treatment. Enhanced services for often-missed groups such as sex workers' clients and partners are vital, incorporating peer education and HIV testing. Leveraging digital platforms to extend outreach, especially through social media, is essential in today's connected world.

Standardized HIV services in prisons, tailored interventions for migrants and displaced Myanmar nationals, and widespread HIV awareness campaigns targeting the general population are integral parts of this approach. Special programs for adolescents and youth and ensuring all pregnant women receive necessary HIV services are critical. This holistic, rights-based strategy aims for equitable healthcare access for all, including PLHIV and KPs, addressing diverse challenges for effective and fair HIV prevention and treatment in Bangladesh.

<b>Objective 2: To ensure innovative, effective, ethical and differentiated HIV testing and case-finding approaches are scaled up across the country</b>
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### **Strategies:**

- 2.1 Expand facility-based testing for key and general populations and promote provider-initiated testing and counselling in public and private antenatal care, tuberculosis, hepatitis C, hepatitis B, and STI service centres.
- 2.2 Expand community-led testing for KPs by utilizing both trained and supervised lay providers and health professionals to conduct rapid HIV tests.
- 2.3 Expand index testing, online to offline, and social risk network referral testing, complying with the three-test algorithm.
- 2.4 Introduce community-based HIV self-testing among KPs.

### **Priority Actions to Achieve the Objective 2:**

To end HIV by 2030, the government's strategy will include adopting and researching innovative testing technologies like HIV self-testing and combo strip tests. It plans to expand existing HIV counselling and testing services across public and private sectors, incorporating community-led and self-testing methods. Targeted communication campaigns will raise HIV awareness and testing, especially among youth, utilizing both online and offline platforms. The programme will integrate advanced case detection

techniques, like social-network-based and index testing, ensuring ethical standards. Finally, the development of national guidelines and training modules will standardize these innovative HIV testing approaches, contributing to meeting the first 95 of the 95-95-95 targets.

**Objective 3: To provide universal access to treatment, care, and support services for PLHIV and AIDS**

**Strategies**

- 3.1 Reduce mortality and morbidity among PLHIV through early detection and treatment by strengthening government, non-government, and private sector facilities.
- 3.2 Ensure the capacity of service providers in government, non-government, and private sectors to provide age, gender, and human rights-sensitive out-patient and in-patient medical management for PLHIV and KPs.
- 3.3 Ensure functional systems for related policy adoption, linkages, and updates, including for more robust engagement of communities in supporting the treatment and care cascade.
- 3.4 A comprehensive approach to the community support system is adopted to remove barriers to accessing services and strengthen treatment adherence, care, and support for PLHIV, including children affected by HIV and AIDS and orphans and vulnerable children.

**Priority Actions to Achieve the Objective 3:**

To ensure universal access to treatment for PLHIV and AIDS, the strategy includes expanding antiretroviral service sites and maintaining a consistent supply of Tenofovir-Lamivudine-Dolutegravir regimens for quality treatment. Rapid antiretroviral therapy initiation post-diagnosis is prioritized, adhering to WHO guidelines. Enhanced monitoring and community outreach will re-engage those lost to follow-up, and training will be provided for co-infection management and sensitivity towards PLHIV and KPs. Additionally, integrating ART services in all government health facilities, expanding viral load testing capabilities, and establishing standard protocols for treatment monitoring and clinical assessments are critical steps in strengthening the treatment and care cascade.

**Objective 4: To establish resilient, sustainable health systems and strengthen community systems for an integrated, people-centric HIV and AIDS response in Bangladesh through the universal health coverage approach.**

**Strategies:**

- 4.1 Strengthening the capacity of health actors, institutions, and populations to prepare for and effectively respond to HIV and AIDS while maintaining its essential functions.
- 4.2 Strengthen the transition and integration of HIV services into government health systems, especially in public health care settings, by establishing functional links for co-infections (e.g., tuberculosis, hepatitis, cervical cancer) and non-communicable diseases, including mental health.
- 4.3 Strengthen supply chains to ensure medicines, laboratory services, and health products are available when and where needed.
- 4.4 Ensure quality laboratory and diagnostic services are expanded and available at all levels.
- 4.5 Strengthen community systems and community-led HIV programming and help integrate them into national health and social systems.
- 4.6 Adopt mitigation plans for health and other emergencies, including the COVID-19 pandemic and natural and human-made disasters.

#### **Priority Actions to Achieve the Objective 4:**

To establish resilient health systems for a comprehensive HIV response, prioritizing domestic investment in the national HIV and AIDS program is crucial. This involves engaging multiple sectors to align with the global 95-95-95 targets and decentralizing HIV coordination to local levels for better ownership and target achievement. Establishing a national reference laboratory network will standardize HIV identification and management, including viral load testing. Key steps include enhancing quality assurance in partnership with private healthcare and promoting legal literacy for PLHIV and KPs. Additionally, reforming policies that hinder effective HIV responses and developing emergency preparedness plans with community involvement are essential. Strengthening the ASP through capacity building, cross-ministerial coordination, and ensuring the availability of HIV commodities are critical. Empowering community-based organizations for outreach and advocacy will reinforce a people-centric approach to the HIV and AIDS response in Bangladesh.

#### **Objective 5: To strengthen strategic information systems and research for an evidence-based response**

##### **Strategies:**

- 5.1 Conduct comprehensive surveillance to strengthen the capacity to respond considering all population sub-groups, epidemiology, age, sex, and geographical considerations.
- 5.2 Conduct the key population size estimation considering all population sub-groups, epidemiology, age, sex, and geographical considerations.
- 5.3 Conduct the Stigma Index led by the communities.
- 5.4 Strengthen national strategic information, monitoring, and evaluation guidelines to harmonise existing reporting systems, including the HIV database and DHIS2, for alignment and coherence.
- 5.5 Conduct relevant research to inform the national strategic response.
- 5.6 Increase the “granularity” of data, appropriately disaggregated to the district, community, and facility levels by age, sex, population, and location to better understand sub-national epidemics and assess performance along the continuum of HIV services.
- 5.7 Strengthen monitoring and evaluation.
- 5.8 Improve systems for knowledge management.

#### **Priority Actions to Achieve the Objective 5:**

To strengthen strategic information systems and research for HIV and AIDS, the first step is enhancing comprehensive surveillance. This involves dedicated resources for regular HIV behaviour and serology studies, focusing on all population sub-groups and addressing gaps in data collection. KP sizes every three years, with demographic and geographical precision, are crucial. This requires collaboration with community-led organizations, particularly for conducting the Stigma Index and ensuring its effective implementation.

Updating national strategic information and monitoring guidelines is key to harmonizing reporting systems like the HIV database and DHIS2, ensuring their functionality and compatibility. Allocating resources for interdisciplinary HIV/AIDS research will evaluate intervention effectiveness. Refining data collection to provide detailed insights by district, community, facility levels, age, sex, and population demographics, is essential for targeted policy-making. Regularly conducting "Monitoring and Evaluation Strengthening Self-Assessment" will improve the M&E system, integrating the monitoring of other

health concerns like STIs and hepatitis into HIV systems. Continuing and enhancing DHIS2 usage will promote better knowledge management, expanding the scope of surveys and surveillance.

### **Leadership, Coordination, and Accountability**

Leadership and coordination will be spearheaded by the Ministry of Health, with involvement from various other ministries and civil society organizations. A comprehensive monitoring and evaluation framework will be instituted to ensure accountability, with quarterly reviews and annual reports to assess the progress of the implementation.

### **Conclusion**

The fifth National Strategic Plan for HIV and AIDS in Bangladesh is a well-thought-out strategic framework that aims to address the specific challenges of the HIV/AIDS epidemic in the country. It reflects the collaborative inputs of various stakeholders and aligns with national and international commitments. With its focus on prevention, comprehensive treatment, and social reform, the NSP holds promise for halting and reversing the HIV/AIDS epidemic in Bangladesh by 2028.

# Introduction

## A. Background

Bangladesh is among the low- and middle-income countries (LMIC) in South Asia. Most of its terrain consists of a vast delta plain interwoven with numerous large and small rivers that significantly impact the nation's socioeconomic well-being. Mountainous regions can be found in the north and east. Bangladesh has been hit hardest by climate change's direct and indirect effects, with floods, cyclones, and tidal bores being the most common natural disasters.<sup>1</sup>

With a population of around 165 million, Bangladesh ranks as the eighth most populous nation globally. Approximately 91% of its people are Muslim, 8% Hindu, and the remaining 1% practice Buddhism, Christianity, or other religions.<sup>2</sup> The country has experienced a significant demographic shift, as the total fertility rate has decreased from 6.9 births per woman in the early 1970s to just two births per woman in 2020. The annual population growth rate is a mere 1.15% as of 2021.<sup>3</sup> Additionally, rapid urbanization is occurring, with 39% of the population living in urban areas and an annual urban population growth rate of 3.14%.<sup>4</sup> Administratively, Bangladesh is divided into eight divisions (*bibhag*) and 64 districts, although these have a limited role in public policy. For local government, the country is divided into 495 sub-districts (*upazilas*), 330 municipalities (*pourashova*), 12 city corporations, and 4,571 union councils.

Bangladesh has been classified as a least developed country since its independence in 1971. In 2015, the World Bank upgraded Bangladesh to a LMIC, and in 2018, the United Nations (UN) recognized Bangladesh as a developing country. Over the past decade, Bangladesh has achieved the highest economic growth among 26 countries.<sup>5</sup> The nation's gross domestic product (GDP) has grown by 188% since 2009, making it the 33rd largest economy globally, with a 2021 GDP of \$416 billion and a per capita GDP of \$2,458. Over half of the GDP comes from the service sector, particularly agriculture within the rural labour force. Additionally, increased exports of ready-made garments and remittances from migrant workers employed in primarily unskilled overseas positions contribute significantly to economic growth.<sup>6</sup>

Bangladesh has made impressive progress in healthcare and the health-related Millennium Development Goals over the past few decades. Some notable accomplishments include an increase in life expectancy from 52 years in 1972 to 72 years in 2020, a decrease in child mortality for children under five from 133 per thousand in 1993 to 46 in 2014, a reduction in new-born mortality from 52 per 1,000 live births in 1993 to 28 in 2014, and a decline in maternal mortality from 648 per 100,000 live

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<sup>1</sup> World Health Organization. Regional Office for the Western Pacific, "Bangladesh Health System Review," *Health Systems in Transition* 5, no. 3 (2015), <https://apps.who.int/iris/handle/10665/208214>.

<sup>2</sup> "Population-and-Housing-Census - বাংলাদেশে পরিসংখ্যান বৃহত্তম-গণপ্রজাতন্ত্রী বাংলাদেশে সরকার," accessed January 26, 2023, <http://www.bbs.gov.bd/site/page/47856ad0-7e1c-4aab-bd78-892733bc06eb/Population-and-Housing-Census>.

<sup>3</sup> "World Population Prospects - Population Division - United Nations," accessed January 26, 2023, <https://population.un.org/wpp/Download/Standard/Population/>.

<sup>4</sup> Ibid.

<sup>5</sup> Star Business Report, "GDP Growth Tops 26 Countries," *The Daily Star*, September 3, 2019, <https://www.thedailystar.net/business/bangladesh-recorded-the-highest-gdp-growth-1794736>.

<sup>6</sup> "The 50 Largest Economies in the World," *Worlddata.info*, accessed January 26, 2023, <https://www.worlddata.info/largest-economies.php>.

births in 1996 to 181 in 2015. In 2017, 89% of Bangladeshi children aged 12-23 months were fully vaccinated against major vaccine-preventable diseases.<sup>7</sup>

Regarding HIV, Bangladesh has maintained a low national HIV prevalence of 0.01% in the general population since the first case was reported in 1989. However, a concentrated epidemic has emerged among the country's key populations (KP), and the estimated number of new infections is increasing gradually – eg. In 2010, the estimated number of new infections was 1,000. In 2020 it was 1,200, and in 2022, it was 1300. Like other countries with low or concentrated HIV prevalence among key and vulnerable populations, Bangladesh's HIV programme has historically relied heavily on national and international nongovernmental organizations (NGOs) for implementation, with external funding sources providing support. However, the investment of domestic resources in HIV has gradually increased, and the domestic spending on HIV has more than doubled since 2010. The HIV programme for KPs in Bangladesh has been in operation for 28 years, receiving grants from various sources, including traditional government donors, development partners and banks, UN agencies, charities, and global programme partnerships, in addition to the Bangladesh government's HNPSP.

As Bangladesh experiences a significant rise in GDP and a substantial poverty reduction, the country finds itself at a critical juncture. With the anticipated decline in external funding, managing HIV service delivery and prevention efforts must gradually transition to the Government of Bangladesh. The country's HIV programme faces unique challenges, such as maintaining political will and investment, integrating HIV services into the healthcare system, coordinating multisector partnerships, relying on external funding for the HIV health workforce, addressing governance issues, overcoming policy barriers to effective implementation, and combating stigma and discrimination. These challenges demand immediate attention and strategic planning to ensure the long-term sustainability of the HIV programme in Bangladesh.

In this context, the fourth National Strategic Plan (NSP) for HIV and AIDS Response in Bangladesh will end in 2023. Therefore, a new NSP for the next five years is needed. This plan must consider the achievements and challenges of the national HIV programme. To ensure its success, it is crucial to have a well-structured Result-Based Framework and a Costed Implementation Plan involving all stakeholders, including civil society, affected communities, governments, UN agencies, and development partners.

## **B. The Development Process of the Fifth NSP for HIV and AIDS**

The National AIDS/STD Control (NASC) is the Directorate General of Health Services (DGHS) wing responsible for HIV/AIDS and sexually transmitted infections (STI) control and management in the country. Meanwhile, the AIDS/STD Programme (ASP) is a vital component of the Tuberculosis-Leprosy and AIDS/STD Programme Operational Plan (OP), implemented by NASC as part of the HNPSP. ASP led the development of this strategic plan, which received contributions from numerous partners and stakeholders who share the goal of ending AIDS by 2030. The strategy development process captured the expertise, diversity, and innovative mindset of various experts and stakeholders, incorporating their diverse perspectives and experiences. Spearheaded by the ASP and supported by technical assistance

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<sup>7</sup> Center for Research and Information (CRI), "Bangladesh Progress and Development 2019" (Dhaka, Bangladesh, n.d.), <https://cri.org.bd/publication/2019/Sep/Progress-&-Development/files/downloads/Bangladesh-Progress-and-Development-2019.pdf>.

from UNAIDS, the development process began in March 2023. A core group consisting of the Assistant Director of NASC, DGHS, the M&E Expert of ASP, DGHS, the Chief of Party for the HIV programme at Save the Children, the Scientist and Head of HIV and AIDS at icddr,b and the Country Director for UNAIDS Bangladesh was formed to guide the development process.

To further support the ASP, two National Consultants were engaged by UNAIDS. The development process consisted of several steps, which are detailed in subsequent sub-sections.

## Desk Review

The initial stage of the process involved the consultant carefully collecting and reviewing key documents obtained from the ASP, principal recipients (PR) of the global fund-supported programme, and partners of the Operational Plan of the HIV programme. This included grant documents, work plans, recommendations from the technical review panel (TRP), findings of the Joint Monitoring Mission (JMM) for HIV, reports on HIV surveillance and assessments, programme implementation plan, standard operating procedures (SOPs), as well as guidelines, targets, and best practices at the national, regional, and global levels.

## Consultations with Stakeholders

The second step involved conducting key informant interviews and thematic group discussions with pertinent service providers, technical experts, and service recipients. This process ensured active participation from key stakeholders across various organizations, including the DGHS, hospital management, networks for People Living with HIV (PLHIV) and KP, UN agencies, implementing partners, technical experts, and civil society representatives. In March 2023, nine thematic consultations took place, encompassing a variety of important themes as follows:

1. HIV prevention among KP: Men who have sex with men (MSM), Male sex workers (MSW), Transgender people, and their clients
2. HIV prevention among KP: People who use drugs (PUD)
3. HIV prevention in prisons and closed settings
4. HIV prevention among KP: Female Sex Workers (FSW) and their clients
5. HIV prevention among the migrants and general population
6. Universal access to treatment, care, and support
7. Laboratory Services

In addition to the thematic consultation, the following six crosscutting issues were included across all thematic groups:

- Resilient and Sustainable Systems for Health
- Integration of HIV Services into Government Health Facilities under universal health coverage (UHC)
- Sexual and Reproductive Health and Rights (SRHR)
- Governance
- Gender and Human Rights

In addition, in-depth discussions with the key selected experts were conducted further to guide the national strategies for HIV and AIDS response. The fifth NSP for HIV and AIDS Response (2024-2028) in Bangladesh aligns with the following national and global strategies:

- The commitments and targets within the UN General Assembly's 2021 Political Declaration on HIV and AIDS
- End Inequalities, End AIDS: Global AIDS Strategy 2021-2026
- Fighting pandemics and building a healthier and more equitable world; the Global Fund strategy (2023-2028)

## Guiding Principles

The fifth NSP for HIV and AIDS in Bangladesh includes guiding principles to support a high-quality, evidence-based, and equitable response to HIV in Bangladesh. These are included in the HIV prevention, treatment, and care strategies and are drawn from Bangladesh's efforts over time to respond to the challenges, threats, and impacts of HIV, viral hepatitis, and STIs. The most critical is the ongoing and meaningful participation of people with HIV and KPs in all aspects of the response. This is central to the partnership approach and is key to the success of this strategy.

The following seven guiding principles must be adhered to by the national programme in alignment with the End Inequalities, End AIDS: Global AIDS Strategy 2021-2026:

### **A. Evidence-based Interventions for Maximum Impact:**

This principle emphasizes the importance of aligning all funding, interventions, and activities with evidence-based models to achieve the 95-95-95 targets to end AIDS by 2030 in Bangladesh. The NSP has established coverage targets for prevention services in priority districts, HIV testing and treatment for KPs, and care, treatment, and support services for PLHIV. These support services encompass various areas such as addressing stigma and discrimination, economic strengthening, food provision, emotional support, psychosocial counselling or support networks, STI screening and treatment, access to family planning and sexual and reproductive health services, screening and management of mental health disorders and non-communicable diseases (NCDs), community empowerment, and addressing violence etc.

### **B. Addressing Human Rights-related Barriers to Access Services:**

This principle recognizes that human rights violations, including gender inequality and gender-based violence (GBV), contribute to vulnerability to HIV infection and create barriers to accessing HIV and other health services. The NSP emphasizes removing these barriers by addressing stigma, discrimination, and GBV, sensitizing law enforcement, and providing legal services to KPs and PLHIV.

### **C. Prevention to Care Continuum:**

This principle recognizes that a comprehensive response to HIV/AIDS must address the epidemic from prevention to care, treatment, and support. The NSP sets coverage targets for prevention services, HIV testing and treatment, and support services for PLHIV.

### **D. Integration of Services:**

This principle emphasizes the importance of providing integrated services that can be easily navigated, not disjointed for the user. The NSP calls for strengthening coordination and integration within different departments of the government health system, private health care facilities, and NGOs to manage co-infections such as HIV, Tuberculosis, and Hepatitis; to integrate HIV services into antenatal care (ANC) and sexual and reproductive health (SRH) and to address NCDs, including cardiac, renal, mental health concerns, etc.

## **E. Quality Improvement and Quality Assurance:**

This principle emphasizes the importance of quality programmes in generating impact and creating service demand. The NSP calls for regular monitoring, reviewing, and ensuring high-quality service delivery throughout the prevention, treatment, care, and support services continuum.

## **F. Community Involvement and Participation:**

This principle emphasizes the importance of active participation of KPs, PLHIV community groups, and networks in the overall HIV response, including research, development, design, implementation, and monitoring of interventions. The NSP calls for developing social accountability mechanisms, community knowledge, and system strengthening.

## **G. Broad Political Commitment:**

This principle recognizes the critical role of broad-based political will, accountable leadership, and governance in eliminating silos between HIV and mainstream development activities and achieving Sustainable Development Goals (SDGs) by 2030 in the country. The NSP calls for generating political will and leadership through issue briefs, advocacy, and stakeholder engagement.

# HIV/AIDS in Bangladesh

## A. HIV Epidemiological Situation

Bangladesh identified its first HIV case in 1989, and since then, the HIV prevalence has remained below 0.01% among the general population. Despite the low prevalence, Bangladesh is among seven countries in the region experiencing a growing HIV epidemic.<sup>8</sup>

As of 2021, the HIV prevalence among adults aged 15-49 was less than 0.01%.<sup>9</sup> This situation has remained consistent since the first reported case in 1989. The HIV epidemic in Bangladesh is primarily concentrated among KPs, including FSW, MSM, MSW, people who inject drugs (PWID), and transgender people/hijra individuals.

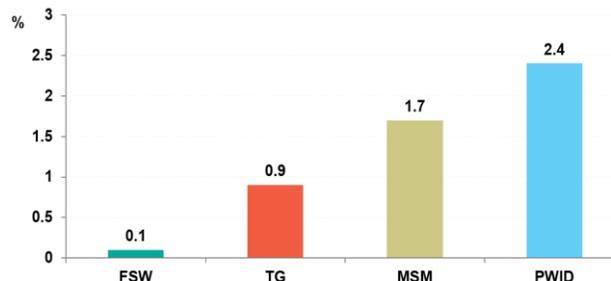


Figure 1: National HIV prevalence among KPs, 2020

The most recent Integrated Biological and Behavioural Survey (IBBS) conducted in 2020 demonstrates an overall HIV prevalence of 2.3% among KPs in Bangladesh. Among PWID, the highest prevalence is observed at 4.1%, with rates of 6.7% in Narayanganj, 6.4% in Dhaka, and 3.8% in Gazipur.<sup>10</sup>

Compared to the 2015 IBBS, the prevalence of HIV among MSM has increased fourfold. MSM exhibits the second-highest HIV prevalence, with an overall rate of 1.5%. Regional rates include 3.4% in Dhaka, 2.5% in Chattogram, 1.6% in Gazipur, and 1.1% in Sylhet.

In contrast, the recorded HIV prevalence among transgender women is relatively lower at 1%. Still, a granular district-based analysis reveals a higher prevalence in Rajshahi (2.6%), Chattogram (1.7%), Khulna (1.5%), and Dhaka (1.2%). FSWs show a marginal HIV prevalence

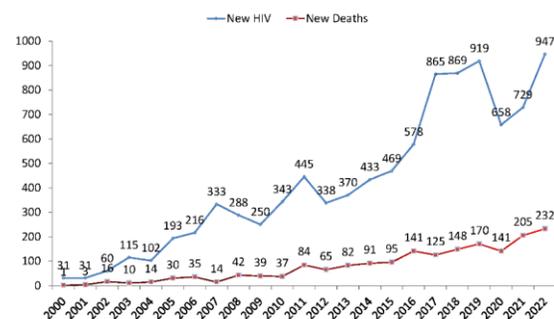


Figure 2: New HIV cases and AIDS-related deaths (2000–2022)

<sup>8</sup> “At a Glance: HIV in Bangladesh,” Be in the KNOW, accessed May 20, 2023, <https://www.beintheknow.org/understanding-hiv-epidemic/data/glance-hiv-bangladesh>.

<sup>9</sup> OECD and World Health Organization, *Health at a Glance: Asia/Pacific 2022: Measuring Progress Towards Universal Health Coverage*, Health at a Glance: Asia/Pacific (OECD, 2022), <https://doi.org/10.1787/c7467f62-en>.

<sup>10</sup> “জাতীয় এইডস/এসটিভি কন্ট্রোল,” 106, accessed January 29, 2023, <http://www.asp.gov.bd/site/publications/27b860e8-5ae7-4250-bfa6-c79c28f20d57/http%3A%2F%2Fwww.asp.gov.bd%2Fsite%2Fpublications%2F27b860e8-5ae7-4250-bfa6-c79c28f20d57%2FIntegrated-Biological-and-Behavioural-Survey-IBBS-among-Key-Populations-at-High-Risk-of-HIV-in-bd-2020>.

of 0.2%. Within this subgroup, HIV cases are found exclusively in Narayanganj (0.4%), Gazipur (0.3%), and Dhaka (0.3%).<sup>11</sup>

Despite the observed differences within groups and regional disparities, the overall HIV prevalence seems to follow a stable pattern compared to data from prior surveys.

According to the most recent ASP data, the estimated number of PLHIV in Bangladesh in 2022 was around 16,000.<sup>12</sup> The total number of reported cases is 9,708, and the number of AIDS-related deaths is 1,820. From the beginning of the epidemic until 2022, the country recorded a cumulative total of 1,811 new HIV cases. The number of new cases has been consistently rising yearly, with 729 cases reported in 2021 and 947 cases reported in 2022. Most of these new cases were among adults aged 19-49 adults aged 19-49, accounting for 83.2% of the total. Adults aged 50 and above represented a smaller proportion at 10.9%, while children aged 0-18 comprised the least at 5.9%. The male-to-female ratio is approximately 5:2. Of these cases, 36% involve KPs, 33% are from the general population, 18% are migrants, and 13% are forcibly displaced Myanmar nationals (FDMN), often called Rohingya.<sup>13</sup>

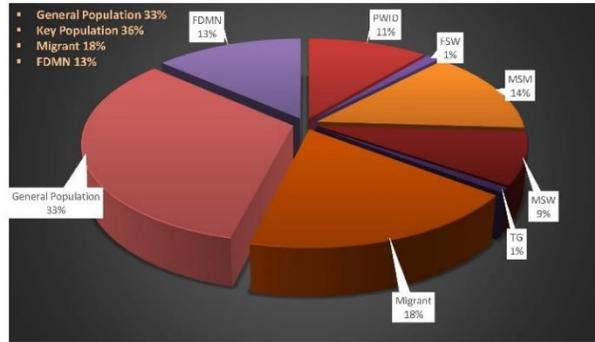


Figure 3: Population category among newly diagnosed PLHIV, 2022

Figure 5a presents data on the reported number of new HIV cases annually, demonstrating a consistent upward trend in the country from 2000 to 2022. Collectively, these data suggest that while the HIV incidence rate remains low, there has been a discernible increase in the trend from 1996 to 2021. This is further supported by the data obtained from modelling HIV incidence rate as shown in 5b, which indicates that in 2021, the estimated HIV incidence rate across all age groups was 0.01 [ $<0.01$ - 0.01] per 1,000 population.

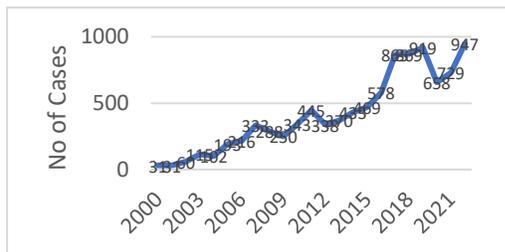


Figure 5a: Trend in reported number of new HIV

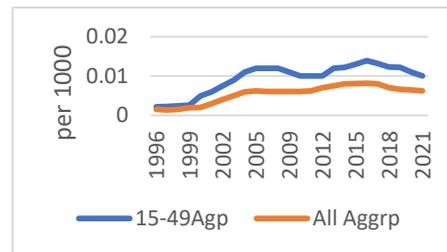


Figure 5b: Trends in estimated HIV incidence

<sup>11</sup> “জাতীয় এইডস/এসটিডি কন্ট্রোল.”

<sup>12</sup> Md. Khurshud Alam, “World AIDS Day 2022: HIV/AIDS Situation in Bangladesh, Presentation by Line Director TB, Leprosy, and ASP, DGHS” (PowerPoint Presentation, World AIDS Day 2022 Celebration, Dhaka, Bangladesh, December 1, 2022).

<sup>13</sup> Ibid.

Data on preventing mother-to-child transmission of HIV (PMTCT) in Bangladesh is limited. The ANC coverage rate, which accounts for at least one visit, was 75.2% in 2019. In 2021, only 109,087 women undergoing ANC, labour and delivery, and postnatal care were tested for HIV, and the HIV positivity rate was 0.02%. All pregnant women living with HIV were reported to receive ART for PMTCT. However, merely 16% of infants born to these women underwent a virologic test within two months of birth (early infant diagnosis: EID). Out of the 53 exposed live births tested for HIV, none tested positive. In 2022, 74,491 women were tested, with a 0.03% HIV positivity rate. Among the 25 HIV-exposed live births tested, one infant was found to be HIV positive, yielding a rate of 4.0%.<sup>14</sup>

The co-infection of tuberculosis and HIV is a significant concern in Bangladesh, one of the top 16 countries with the highest tuberculosis burden.<sup>15</sup> The tuberculosis incidence rate among PLHIV is estimated at 0.43 per 100,000 population.<sup>16</sup> In 2021, an estimated 170 deaths occurred due to tuberculosis among HIV-positive individuals. The incidence of new and relapse tuberculosis cases in this population has been increasing, while the tuberculosis mortality rate among HIV-negative individuals has decreased between 2000 and 2021.<sup>17</sup>

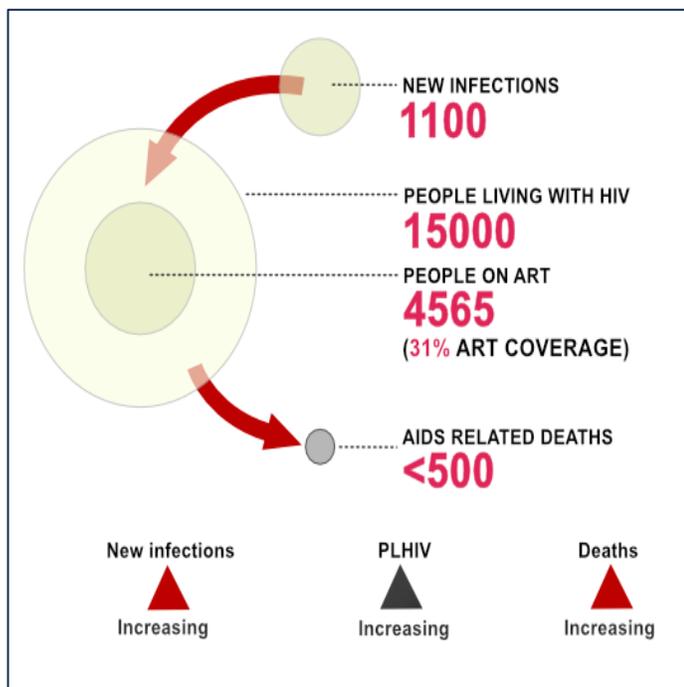


Figure 6: HIV Epidemic Snapshot, Bangladesh

Source: AIDS Data Hub, 2023

HIV infection in Bangladesh is associated with a combination of social, behavioural, and structural factors. Early sexual debut, multiple sexual partnerships, and unsafe practices contribute to increased risk. Migrant work, which often leads to family separation and a higher likelihood of transactional sex, also plays a significant role. High-risk populations include PWID, sex workers, and migrant workers.

<sup>14</sup> Ibid.

<sup>15</sup> “TB Profile,” accessed April 5, 2023, [https://worldhealthorg.shinyapps.io/tb\\_profiles/?\\_inputs\\_&entity\\_type=%22country%22&lan=%22EN%22&iso2=%22BD%22](https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&entity_type=%22country%22&lan=%22EN%22&iso2=%22BD%22).

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

Major risk factors for HIV transmission among these groups are needle sharing, unprotected sex, and STIs.<sup>18</sup>

## B. Estimates of the Size of KPs

The recent "Mapping and Size Estimation of Key Populations and HIV Risk Behaviours" study was conducted by the NASC under the Ministry of Health and Family Welfare, Government of Bangladesh, in 2023. This study was implemented by the Department of Public Health and Informatics at Bangabandhu Sheikh Mujib Medical University and supported by the World Health Organization (WHO) and the United Nations Joint Programme on HIV and AIDS (UNAIDS) in Bangladesh. The mapping encompassed 22 of the 64 districts in Bangladesh, selected based on criteria such as the estimated concentration of KPs, newly reported HIV cases from 2016 to 2021, and proximity to international borders. And statistical extrapolation was conducted through a robust methodology for the remaining districts.

A significant finding from the study is the consistent population sizes of PWID and FSW compared to the previous estimation in 2015-2016. This consistency implies that interventions for these groups may have plateaued, requiring a reassessment of current programme strategies. On the other hand, a marked increase was observed in the populations of MSM, MSW, and transgender women, highlighting an urgent need for targeted measures for these expanding groups. The table below presents the point estimates of the KPs segmented by age groups:

Table 1: Estimated Number of KPs, 2023

KPs	Point Estimates			
	Age Group			Total
	10-19 years	20-24 years	25 years and above	
MSM	24,308	36,347	55,842	116,497
MSW	8,426	21,328	18,940	48,694
Transgender*	-	-	-	12,629
Street-based FSW	4,759	6,021	26,849	37,629
Hotel-based FSW	2,845	3,867	17,455	24,167
Residence-based FSW	4,885	7,652	35,291	47,828
Brothel-based FSW**	-	-	-	3,482
PWID	1,036	1,165	32,169	34,370

\* Age-specific data for the Transgender population are not available.

\*\* Among the 3,482 FSWs in ten brothels, 1,479 are under 25, and 2,003 are 25 or older.

<sup>18</sup> "20 Years of HIV in Bangladesh: Experiences and Way Forward," accessed January 28, 2023, <https://openknowledge.worldbank.org/handle/10986/27592>.

Moreover, the study revealed distinct risk behaviours among KPs. A concerning 27% of FSWs did not use a condom in their most recent sexual intercourse. The rate was particularly low, at 42%, among brothel-based FSWs. This group also reported a notable prevalence of STI symptoms, especially among younger and residence-based FSWs. The MSM and MSW groups displayed specific sexual behaviours, with 33% engaging in sexual activities before age 15 and 70% using condoms during their last anal interaction with a male commercial partner. For PWIDs, 40% acknowledged needle-sharing in the week before the survey. While there is awareness of HIV testing facilities, uptake remains less than ideal, highlighting a disparity between knowledge and action.

This study emphasizes the critical role of data in resource distribution. It lays the foundation for informed resource allocation in formulating effective HIV prevention and treatment strategies. The data present a clear pathway to maximize KP coverage, ensuring the best use of resources and maximizing intervention impact. Robust engagement from all stakeholders, from governmental entities to implementing agencies and the KP communities, is essential for effective planning, target setting, and optimal resource allocation in national HIV programming.

These findings hold significant results for both policy-making and its practical application. It provides a data-centric base to structure the Fifth NSP.

### C. Country's Response Over the Years

Bangladesh has a long history of strong political commitment to combating HIV and a response guided by data on the epidemic. Efforts began even before the first case of HIV was detected. From the beginning, the emphasis was on surveillance to gather evidence on which to base programme decisions, which has focused on preventing HIV in the KPs. During the last three decades, the scope, size, reach, and complexity of the HIV and AIDS programme have significantly grown. Starting from only awareness raising, the programme now encompasses a comprehensive set of policies, guidelines, strategic frameworks, and services targeted at KPs. Currently, the NASC serves as the nodal body, leading and coordinating the HIV response by involving relevant government departments and ministries, UN agencies, international NGOs, Global Fund PRs and sub-recipients (SRs), civil society, and community networks, as well as performing the stewardship role and implementing the HIV programme in Bangladesh under the guidance of the DGHS. It is worth noting that although the NASC implements the HIV programme, it is recognized as the ASP under the sector-wide approach of the 4th HNPS.

Key milestones in the country's response include the following:

- **1985–1990:** The latter half of the 1980s marked the beginning of Bangladesh's experience with the HIV epidemic. The first case of HIV was reported in 1989, leading to the formation of the National AIDS Committee (NAC) in the early 1990s. The NAC was formed with the President of Bangladesh as the Chief Patron and the Minister of Health and Family Welfare as the Chair. The NAC is an advisory body responsible for formulating the main policies and strategies on HIV and AIDS in Bangladesh, supervising programme implementation, and mobilizing resources. During this period, the response focused mainly on raising awareness and educating about HIV and AIDS. The government and other NGOs began to conduct awareness campaigns through the mass media, targeting the general population.
- **1990-2000:** During the 1990s, Bangladesh made significant strides in addressing the HIV epidemic. The government established the Bangladesh AIDS Prevention and Control Programme and

formulated the first NSP for HIV and AIDS in 1997. This decade saw funding from bilateral donors such as the Department for International Development (DFID), USAID, the Australian Agency for International Development, and UN agencies shift the focus of the response towards preventing HIV transmission among KPs, such as sex workers, PWID, MSM, and transgender individuals, as well as starting HIV interventions among bridging populations like transport workers. The government collaborated with NGOs to create community networks involving sex workers, MSM, transgender people, and PLHIV. The country also launched harm reduction programmes, introducing needle and syringe exchange initiatives in Dhaka and Rajshahi.

- **2000–2010:** In the 2000s, Bangladesh made considerable advances in the scale-up of HIV and AIDS interventions among KPs and the general population. The government formulated the second NSP for HIV and AIDS in 2004. Alongside existing USAID/FHI-funded interventions, the ASP initiated the HIV and AIDS Prevention Project in 2004, co-financed by the World Bank and DFID. This project aimed to control and prevent the spread of HIV among high-risk groups, expanding coverage and solidifying targeted interventions. This was further solidified when the government Operational Plan (OP) under the health sector programme started social contracting to engage NGOs in expanding HIV prevention interventions.

Bangladesh committed to the global campaign '3 by 5', striving to be among countries jointly providing ART to at least 3 million HIV-positive people by 2005 and broadening access to HIV prevention, care, and treatment services. The National HIV and AIDS Policy, introduced in 2006, reinforced the country's dedication to preventing transmission and supporting affected individuals. In 2007, Bangladesh established its first voluntary counselling and testing centre. The Government of Bangladesh approved a pilot study on oral substitution treatment with methadone in August 2008.

The Global Fund became a significant player in 2004, contributing substantially to HIV prevention in Bangladesh. Funding supported behaviour change communication programmes for young people and adolescents and improved health systems to offer comprehensive HIV and AIDS services. The grant also supported strengthening the capacity of healthcare providers to deliver HIV and AIDS services, improving service quality, and coordinating the national HIV response. Later, in 2008, the Global Fund grant led to a substantial scale-up of HIV interventions among KPs and expanded care and support programmes for PLHIV throughout the country.

- **2010–2020:** In 2011, the third NSP for HIV and AIDS (2011–2015) was developed, emphasizing a comprehensive approach to HIV and AIDS. The Government of Bangladesh made a significant effort to enhance its health systems and deliver improved HIV and AIDS services to KPs in line with global targets of 90-90-90 by 2020. In 2016, the fourth NSP for HIV and AIDS Response (2018–2023) was introduced, focusing on a continuum of HIV prevention, treatment, and care services. To achieve the ambitious goals outlined in the fourth plan, Bangladesh scaled up various technical components, such as opioid substitution therapy (OST), community-led HIV testing, comprehensive drop-in-centre (DIC) for PWID, and increased access to ART services.
- **2020 onwards:** During this period, the Government of Bangladesh expanded HIV testing services (HTS) to 23 government hospitals and made ART available in 12. Furthermore, the government initiated a prevention, care, and service programme for KPs in five public hospitals. The government, by then, was also purchasing and managing the supply chain for a significant proportion of health products, such as condoms, needles and syringes, methadone, antiretroviral drugs, and HIV testing kits, for the national HIV programme.

During the COVID-19 pandemic, the Government of Bangladesh provided prompt support and collaborated with stakeholders to ensure that essential services to KPs, such as ART, OST, needles and syringes, and condoms, were provided without significant interruption. As a result, there was no major deviation in HIV service delivery in Bangladesh during this period.

## D. Coverage of HIV Prevention Programme among KPs

According to the United Nations 2025 targets aimed at eliminating AIDS as a public health threat by 2030, at least 95% of individuals at high risk of HIV, commonly referred to as KPs, should have access to combination prevention services. Despite these international guidelines, the national programme in Bangladesh shows substantial deficiencies in the coverage among different subsets of KPs, as detailed below.

As of the most recent data available, the estimated population of PWID in Bangladesh is 34,370. Global targets recommend that 32,652 of these individuals should be covered by harm reduction and prevention services, including but not limited to syringe exchange programmes, OST, and behaviour change communication (BCC) initiatives. However, national data up to June 2023 reveals that only 19,343 PWID have been covered. This is a mere 59% of the globally set target. Breaking it down further, the Global Fund’s New Funding Model (NFM) 3 grant covers 17,976 individuals, while the OP supported by the 4th HNPSP accounts for 1,367 PWID.

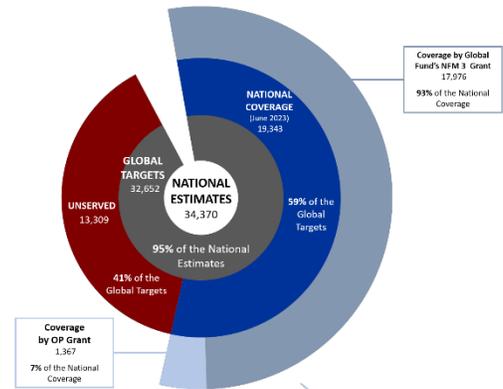


Figure 7: Coverage of the PWID

In the case of FSWs, the total estimated population is 113,106. Within this population, 3,482 are brothel-based. Until December 2022, an OP-supported grant under the 4th HNPSP had covered 3,000 of these brothel-based FSWs. However, the programme closed operations in January 2023, creating a significant service gap. For FSWs operating in other settings—hotels, residences, or streets—the estimated population is 109,624. According to global targets, it is recommended that a total of 104,143 individuals should be provided with combination prevention interventions. Disconcertingly, only 33,317, or 32% of the target, have received such services as of June 2023. This leaves 70,826 FSWs (68% of the target) without essential HIV prevention services.

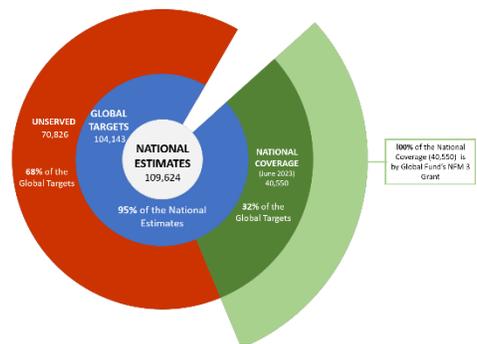


Figure 8: Coverage of the Street, Hotel and Residence based FSW

For MSM and MSW, the situation is even more alarming. The total estimated population is 165,192. However, as of June 2023, only 40,550 individuals, a mere 26% of the global target, are covered. Among these, 36,250 individuals are covered under Global Fund’s NFM 3 grant, and only 4,300 receive services through an OP-supported grant under the 4th HNPSP. Hence, 74% of the MSM and MSW within the global target remain unserved in the country.

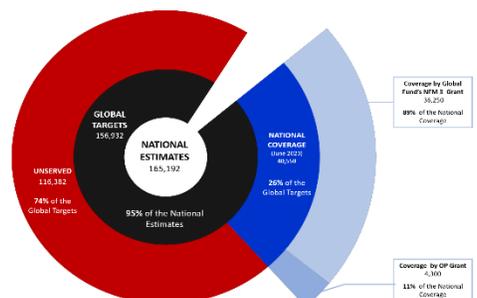


Figure 9: Coverage of the MSM and MSW

Among the transgender community, the estimated population size is 12,629. Global benchmarks set a target of 11,998 individuals through combination HIV prevention services. As of June 2023, Bangladesh has managed to cover only 5,700 transgender individuals, making up just 48% of the globally recommended target. Consequently, 6,298 transgender individuals (52% of the target) remain without HIV prevention services.

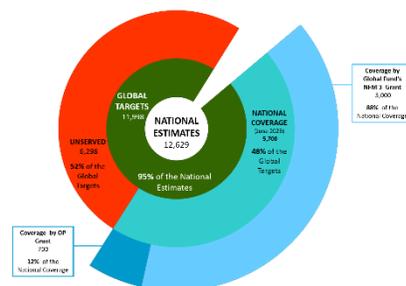


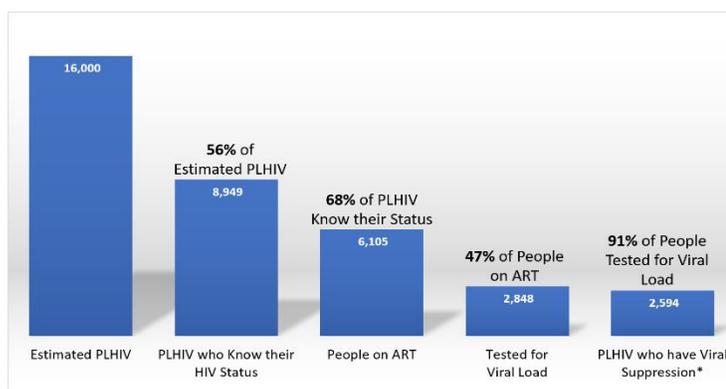
Figure 10: Coverage of the Transgender

In summary, there is a considerable gap in the national coverage of HIV prevention services for KPs in Bangladesh relative to global targets for 2025. This data-driven analysis underscores the pressing need for a strategic realignment of resources and efforts, particularly as Bangladesh faces a growing, though concentrated, HIV epidemic among these vulnerable communities.

### E. Status of the First Track Strategy (95-95-95 Targets) in Bangladesh

The global 95-95-95 targets aim to ensure that by 2025, 95% of all individuals living with HIV know their HIV status, 95% of those infected with the virus are enrolled in treatment, and 95% of those receiving treatment have their viral load suppressed, form a crucial part of the global strategy to end the AIDS epidemic by 2030. Bangladesh's journey towards achieving the ambitious first track strategy, reflects a complex mix of advancements and notable challenges.

Current data reveals that out of an estimated 16,000 PLHIV in Bangladesh, about 68% (or 8,949 individuals) know their HIV status. This represents progress but also underscores a gap in meeting the first diagnosis target. This highlights the need for strengthened HIV testing and awareness initiatives to bridge this gap.



\* Number of people on ART who received a viral load test in the past year and have a viral load of <1000 copies/ml

Figure 11: Status of the First Track Strategy (95-95-95 Targets) in Bangladesh

Regarding the second target of ART linkage, it presents a more significant challenge. Only 47% of those diagnosed, equating to 6,105 individuals, are receiving ART. This signifies a substantial shortfall in linking diagnosed individuals to necessary treatment, underlining a crucial area for strategic intervention and resource allocation.

The third target of viral suppression among those receiving ART shows a complex outlook. However, the test was only 47% - a figure that ideally should reach 100% of people on ART tested for viral load- 91%, with 2,594 out of 2,848 individuals having achieved viral suppression among those tested. This indicates the effectiveness of the treatment programs and adherence support mechanisms. Also, it highlights the further efforts needed to bring all people on ART tested for viral load.

The current scenario underscores the necessity for a multifaceted approach in Bangladesh's healthcare strategies. This approach should encompass a wide range of interventions, including expanding HIV testing, enhancing the linkage to care, improving access to ART, and maintaining treatment adherence

to ensure the health and well-being of PLHIV and to move closer to the goal of ending the HIV epidemic by 2030.

## **F. Institutional Environment**

### **National Policy Environment for HIV Programmes**

The NASC is a wing of the DGHS within the Ministry of Health and Family Welfare (MOHFW). Its primary functions include coordinating, monitoring, planning policies, and executing Bangladesh's HIV/AIDS and STI response program. Financially supported by the government budget, the NASC operates under the guidance of line management and the National Strategy for HIV and AIDS.

Serving as the central body, the NASC leads and coordinates HIV response efforts by involving relevant government departments, ministries, United Nations (UN) agencies, international NGOs, Global Fund's PRs and SRs, civil society, and community networks. Furthermore, it performs stewardship and implements HIV programmes in Bangladesh under the DGHS's supervision. It is important to note that the NASC is recognized as the ASP while implementing the HIV programme.

The NASC also implements the HIV component of the OP under the 4th HNPSP. The full OP is named the National Tuberculosis-Leprosy and ASP and is led by a Line Director. As one of the PRs for HIV grants funded by the Global Fund, known as the NFM 3 grant, the NASC helps manage essential health supplies like condoms, needles and syringes, methadone, antiretroviral medications, and HIV testing kits. These supplies are funded by the HNPSP and, to a lesser extent, the Global Fund.

Bangladesh's overall development plans and sector-wide approach incorporate HIV, as highlighted in the 2009 National Health Policy and the 2014 National Social Security Strategy. Working closely with other ministries on HIV prevention and control activities within their core administrative structures, the NASC ensures the widespread application of the National HIV/AIDS strategy and policies. To this end, the government has designated focal points for HIV/AIDS across 16 ministries and departments. The national response to HIV is guided by various strategies and guidelines. Below is a list of strategies and guidelines developed within the last decade. For strategy and guidelines developed over ten years ago, please refer to Annex 1.

- Pilot Protocol for HIV Services among Key Populations in Government Hospitals of Bangladesh, 2023
- Management Implementation Plan (MIP) for HIV Service Delivery among Key Populations in Government Hospitals of Bangladesh, 2022
- National Guideline on Prevention of Mother-to-Child Transmission (PMTCT) of HIV, Hepatitis and Congenital Syphilis, 2021
- Guidelines on Secondary Channels of Needle and Syringe Distribution in PWID Intervention, 2021
- Revised Guidelines Managing Staff Exposure to COVID-19 in Programme Settings, 2021
- Standard Operating Procedures for Quantitative HIV 1 Viral Load Testing Using GeneXpert Technology, 2021
- Guidelines on Safe Disposal of Needles and Syringes, 2020
- Training Module for Basic Training of Outreach and Needle and Syringe Programme for Effective Prevention and Management of Substance Use and HIV And Viral Hepatitis B&C, 2020

- Training Module for Management Staff on The Effective Implementation of Harm Reduction Interventions, 2020
- National Antiretroviral Therapy Guidelines, Bangladesh, 2019
- National HIV Testing Services (HTS) Guideline, 2019
- National Guideline for Community-Based HIV Testing Services, 2019
- National Antiretroviral Therapy (NRT) Guidelines, Bangladesh, 2019
- Guideline on Selection and Recruitment Procedures of Outreach Staff, 2019
- SOP for DIC Management for Key Population, 2019
- The Investment Case for Fast-Track Strategies: Prioritizing Investment Options in HIV Response in Bangladesh to End AIDS by 2030, 2019
- Framework of Differentiated Care for People Living with HIV and AIDS in Bangladesh,
- SOP for Outreach Service for Effective Needle and Syringe Programme, 2019
- SOP for the Service Center for HIV Prevention among PWID, 2019
- National HIV and AIDS Disclosure Guideline, 2018
- National Guidelines on the Management of tuberculosis-HIV Co-infections, 2018
- 4th National Strategic Plan for HIV/AIDS (2018-2022), 2018
- National AIDS M&E Plan (2018-2022), 2018
- National Guidelines for Management of Sexually Transmitted Infections (Third Edition), 2018
- The National Harm Reduction Strategy for Drug Use and HIV (2017- 2021), 2017
- National HIV Advocacy and Communication Strategy 2017-2022, 2017
- National Strategic Plan to Address Gender-Based Violence for HIV Response in Bangladesh (2017-2021), 2017
- Gender Assessment of the National HIV Response in Bangladesh, 2014
- National Counselling Guidelines for Children and Adolescents Most at Risk of or Affected by HIV and AIDS, 2013
- National Consultation on Punitive Laws Hindering the AIDS Response in Bangladesh, 2013
- National HIV Risk Reduction Strategy for Most at Risk and Especially Vulnerable Adolescents to HIV and AIDS in Bangladesh (2013-2015), 2013

In addition, diverse training resources and protocols for counselling and peer education have been developed following the requirements of projects focused on PWID, FSW, MSM, MSW, transgender people, and PLHIV.

## G. Review of the Fourth NSP for HIV and AIDS Response 2018-2023

The Fourth National Strategic Plan (NSP) for HIV and AIDS Response (2018-2023) in Bangladesh was designed to align with the 4th HNPSP (2017-2022), incorporating both national and global commitments. This comprehensive plan focused on geographical prioritization, optimal resource utilization, and a human rights-based approach for people living with HIV (PLHIV) and key populations (KPs). It strived to meet the global objective of 'Ending AIDS by 2030' and to achieve the '90-90-90' treatment targets by 2020.

### Progress Highlights:

- **Low Prevalence in General and Key Populations:** Bangladesh has maintained a national HIV prevalence below 0.01%. The prevalence among key populations varies, recorded at 0.1% among FSW and 6.8% in PWID.

- **Expansion of ART Centers:** The number of PLHIV receiving ART has risen to 6,105 from an estimated 16,000 PLHIV. This increase and the expansion of ART centres to 12 signifies substantial progress in treatment accessibility and healthcare infrastructure development. The national HIV programme adheres to the national ART guidelines and WHO-recommended strategies, including 'Test and treat' and rapid ART initiation. The ART process, updated in October 2019, involves comprehensive clinical and laboratory follow-up, including opportunistic infection and comorbidity management.
- **Integration with TB Programme:** All ART centres are connected with nearby GeneXpert sites for viral load testing, demonstrating effective collaboration with the TB programme. In 2022, 994 PLHIV enrolled for ART, and each was screened for TB. Of the 817 PLHIV screened, 82 were TB-positive and linked to treatment. Additionally, 71,314 TB patients were tested for HIV, identifying 67 HIV cases.
- **HTC Center Expansion:** The Government of Bangladesh expanded HTS to 23 government hospitals during this period. With this expansion, 8,949 of the estimated 16,000 PLHIV are aware of their HIV status. The country employs WHO standard HIV testing strategies involving three consecutive reactive tests. The HTS is also offered at various service delivery points, with scale-up community-based testing. Furthermore, the government initiated a prevention, care, and service programme for KPs in five public hospitals.
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- **Monitoring and Evaluation:** The development of a comprehensive Monitoring and Evaluation plan and improvements in database management indicate a more robust framework for tracking the efficacy of HIV programs.
- **Responsive and Updated Key Documents:** The program's adaptability is evident in the timely revision of the 4th NSP, its monitoring and evaluation frameworks, update the harm reduction strategies and SOPs for HIV service delivery in response to global policy shifts, and changing contexts demonstrate the program's adaptability and commitment to maintaining international standards. In addition, developing a comprehensive Management Implementation Plan, frameworks for community-based HIV services, and pilot protocols for hospital-based KP services highlight advancements in service standardization.
- **Effective NASC Coordination and Oversight:** The NASC plays a pivotal role in tracking, mapping, and coordinating HIV and AIDS activities. The annual and quarterly review meetings held by NASC ensure a cohesive and responsive approach to the national HIV/AIDS strategy.
- **Innovative Service Delivery Models:** Initiatives to transition from DIC/outlet to district hospital-based service delivery for KPs indicate strategic innovations in service models, aiming to enhance accessibility and effectiveness. The transition to 15 district hospital-based service delivery for KPs represents a strategic innovation to improve service accessibility and integrate HIV and AIDS programmes into the mainstreaming health response. The government also purchases and manages the supply chain for a significant proportion of health products, such as condoms, needles and syringes, methadone, antiretroviral drugs, and HIV testing kits, for the national HIV programme.
- **Consistent National HIV Surveillance:** The establishment of a National HIV Surveillance System in 1998, with regular surveillance rounds, underscores ongoing efforts to monitor the HIV epidemic in Bangladesh.

## Limitations

- **Rising Infections:** Despite the strategic focus, the number of new HIV infections has increased, indicating gaps in the effectiveness of current strategies.<sup>19</sup>
- **Treatment Gap:** Not all PLHIV are receiving antiretroviral therapy, indicating a significant treatment gap that needs to be addressed.<sup>20</sup>
- **Stigma and Discrimination:** The plan did not sufficiently address the issue of stigma and discrimination, which remains a significant barrier to treatment and prevention.<sup>21</sup>
- **Coverage Shortfalls:** The plan fell short in reaching the recommended coverage for KPs such as PWID, FSW, MSM, MSW, and transgender individuals, as evidenced by the "investment case" evaluation conducted by ASP in 2019.<sup>22</sup>

## Recommendations for the Fifth NSP

1. **Enhanced Focus on KPs:** Since the epidemic is primarily concentrated among KPs, targeted interventions are essential.
2. **Strengthening Healthcare Infrastructure:** To close the treatment gap, there is a need to enhance healthcare services, especially in rural areas where the epidemic is growing.
3. **Addressing Stigma:** Community-based interventions can effectively reduce stigma and discrimination related to HIV/AIDS.
4. **Data-Driven Approaches:** Utilize the most recent data for planning and implementation to ensure the strategies align with the current epidemiological landscape.

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<sup>19</sup> “Bangladesh | HIV/AIDS Data Hub for the Asia-Pacific Region,” accessed October 3, 2023, <https://www.aidsdatahub.org/country-profiles/bangladesh>.

<sup>20</sup> “Bangladesh | UNAIDS,” accessed October 3, 2023, <https://www.unaids.org/en/regionscountries/countries/bangladesh>.

<sup>21</sup> “Bangladesh | HIV/AIDS Data Hub for the Asia-Pacific Region.”

<sup>22</sup> AIDS/STD Programme (ASP), “Revised 4th National Strategic Plan for HIV and AIDS Response 2018-2023” (AIDS/STD Programme (ASP), Directorate General of Health Services Ministry of Health and Family Welfare, January 2020), <http://www.asp.gov.bd/site/page/f7690003-c427-46c8-a135-566ae8b16fc0/->.

# Recommendations from Reviews and Consultations

## A. JMM for HIV Programme

The recent JMM conducted in Bangladesh from January to March 2023 was aimed at reviewing the progress of the HIV response, identifying best practices, challenges, and opportunities, and recommending approaches to enhance the national response's performance and impact. The JMM had ten specific objectives, including reviewing the level and trends of the HIV epidemic, progress toward targets, and identifying areas for improvement. The review also assessed data systems and constructed and assessed the HIV prevention and care cascade.

The JMM focused on four major thematic areas; each area and specific recommendations are given below. A detailed JMM report is included in Annex 2.

### Thematic Area 1: Enabling Environment and Human Rights

- Bangladesh's HIV national response faces legal and policy challenges, including difficulties in Naloxone procurement for opioid overdose management among KPs, significant policy gaps, and the need for a Stigma Index assessment to address gender diversity misconceptions.
- Strong advocacy efforts are essential, particularly for introducing anti-discriminatory or transgender protection laws.
- Enhanced coordination and capacity are needed in areas such as global standards, coinfections, NCDs, GBV, human rights, and offering employment opportunities for at-risk youth and unsupported PLHIV.
- Strengthened coordination is required between tuberculosis and HIV programmes for effective co-infections management.
- Addressing ART distribution challenges, such as distance and transportation, is imperative.
- The PLHIV Network demands increased local government, inter-departmental support, and a domestic resource mobilization plan for sustainable funding.

### Thematic Area 2: HIV Prevention

- Expanded and frequent HTS coverage is required for efficient prevention, targeting KPs and other higher-risk groups.
- The focus should be on reaching populations like migrant workers, clients of sex workers, sex partners of KPs and PLHIV, and prisoners.
- Other essential measures include scaling up HIV partner testing, adjusting HTS hours, formulating an evidence-based demand creation strategy, and integrating pre-exposure prophylaxis (PrEP) for HIV prevention among KPs.
- Intensifying condom education, promotion, and distribution efforts is vital, along with strengthening the differentiated service delivery (DSD) model and developing an elimination of mother-to-child transmission (EMTCT) of HIV, syphilis, perinatal hepatitis b, and congenital chagas disease strategic plan.

### Thematic Area 3: Treatment, Care, and Support

- Treatment and care improvements necessitate expanding ART sites, ensuring a steady Tenofovir-Lamivudine-Dolutegravir (TLD) based regimen supply, and integrating ART services into public health facilities following the MIP guidelines.

- Efforts should also be made to incorporate HIV co-infection management, such as viral hepatitis B and C, into ART centres and to enhance viral load testing.
- All government health facilities should be prepared for integrated ART services, including priority and other districts, and more ART refill centres should be established across diverse locations.

#### **Thematic Area 4: Resilient and Sustainable System for Health**

- Laboratory services recommendations include developing a strategic plan for upscaling viral loads and EID and using GeneXpert machines in the National Tuberculosis Programme.
- Procurement plans are necessary for HIV health products, including ART drugs, and strategies to address procurement delays.
- Strengthening the strategic information system is vital, with measures such as real-time data entry, data segregation by demographics, and developing an HIV incidence cohort study protocol for KPs.

## **B. Recommendations from the Group Consultations**

Recommendations were formulated based on day-long consultative workshops held with each of the seven thematic groups. This approach guaranteed the active involvement of essential stakeholders from various institutions. These include the senior officials from DGHS, hospital management, networks of PLHIV and KPs, UN agencies, implementing partners like Global Fund's PRs, SRs, and OP-supported partners, etc. Furthermore, technical experts and civil society representatives were crucial in these discussions. The group-wise recommendations are as follows:

### **Group 1: HIV Prevention among MSM/MSW, Transgender, and Hijra**

In Bangladesh, progress has been achieved in tackling the HIV epidemic among MSM/MSW and transgender groups. Societal perception shifts, legal acknowledgement of the transgender community, and integration of HIV services underscore this advancement. Nonetheless, challenges persist, including criminalized homosexuality, rising HIV rates among MSM, inadequate programme coverage, and restricted comprehensive care access. Tools like virtual interventions, telemedicine, and advocacy can fortify the HIV response. To optimize HIV care for these groups, addressing issues like stigma, punitive legislation, and limited health services is essential. The subsequent recommendations for the upcoming five-year NSP highlight primary areas of focus:

- Extend the programme's reach by integrating mental health interventions and promoting gender diversity in educational curricula. Explore the potential of virtual platforms to serve the affected population's psychosocial needs effectively.
- Strengthen leadership and community involvement in all programme design, development, and service delivery stages. This ensures an inclusive approach and encourages democratic practices and good governance within community-based organisations (CBOs). Advocate for the recognition of fundamental human rights and decriminalization of MSM behaviour. Organize advocacy initiatives at district and upazila levels with key stakeholders. Moreover, leverage virtual platforms and social media for tailored BCC and information, education & communication (IEC) activities to sensitise the general community and the youth.
- Undertake evaluations of current integration models in Bangladesh and strategize based on updated size estimation data from various sources, such as virtual assessments. Ensure consistent conduction

of IBBS alongside studies examining drug resistance, sexual transmission of HIV, barriers in accessing governmental health facilities, innovations, GBV, and human rights issues.

- Prioritize community engagement in participatory monitoring and evaluation at the national level. This approach supports the establishment of a centralized data hub by the ASP, ensuring the availability of high-quality data that informs decision-making and optimizes resource allocation.

## **Group 2: HIV Prevention among PWID**

The harm reduction programme for PWID, initiated in 1998, has shown substantial progress in curbing HIV through a peer-based approach. Initially emphasizing needle syringe programmes, including OST, in 2010 enhanced its scope. Efforts to embed these programmes within government hospitals and train law enforcers about harm reduction have also been initiated. However, challenges persist: the programme heavily relies on external funds, needle syringe and OST coverage falls short of global benchmarks, and the criminalization of drug use remains. Achieving the 95-95-95 targets is still a struggle, and work with prison and law enforcement entities is limited. PUD and their family members confront stigma and discrimination. Multi-sector collaboration, consistent research, and mental health support have room for enhancement.

Despite challenges, there are avenues for improvement. Government funding, standardized guidelines, and active community participation are strengths. Conversely, risks involve the readiness for programme shifts, punitive policies, and the crackdown on drugs. The uprise in HIV cases among PWID in a few districts, rising AIDS fatalities, potential antimicrobial resistance, and gaps in knowledge about viral load suppression are alarming. Supply chain issues for ART and co-infection medications could hamper success. Considering the present scenario, these recommendations are proposed for the harm reduction programme in the NSP 2024-2028:

- Increase coverage of PUD (both injecting and non-injecting) as per the recommendations of epidemiological models, such as AEM.
- Integrate the harm reduction programme with government health services for a unified system addressing HIV, co-infections, NCDs, and mental health. Train and sensitize service providers while upholding ethical standards.
- Adopt internationally approved harm reduction protocols, such as expanding take-home OST doses, backed by relevant government agencies.
- Empower self-help groups and community networks through capacity-building support within the harm reduction programme.
- Design and implement specialized interventions for female drug users, children, and male drug users' partners, addressing their distinct vulnerabilities.
- Test virtual interventions via social media and apps to connect with drug users, especially in remote locations.
- Enhance prisons and law enforcement interventions by introducing packages adhering to international standards, including training and fostering collaboration with harm reduction services.
- Evaluate the programme's direction by comparing the DIC and outreach model to the public hospital approach over five years, focusing on cost, access, and sustainability.
- Regularly update data on KPs with size estimation and integrated surveys every three years, ensuring responsive intervention strategies.

- Implement routine quality assurance measures through periodic surveys conducted by the ASP through community-led monitoring to ensure the programme's effectiveness and efficiency. Collaborate with local government and develop tools for CBOs of PUD engagement.
- Monitor evolving drug scenarios through research with UNAIDS and other entities, studying stigma, discrimination, GBV, human rights barriers, shifting drug use patterns, switching behaviour, and comprehensive studies on amphetamine-type stimulants users.
- Pursue a multi-sectoral approach for drug dependence decriminalization (Triple D) by involving stakeholders, including key ministries, departments, and civil society actors. Reform laws to meet international standards and mobilize national-level advocacy support. Mobilize opinion leaders, members of parliament, politicians, journalists, and community networks through continuous and planned national-level advocacy to build support for these policy changes.

### Group 3: HIV Prevention Services in Prisons

Bangladesh Jail manages 68 prisons, including central, district, and special jails. There's limited data on HIV prevalence among inmates. Between December 2018 and November 2020, 1,110 PWID were jailed, with 114 PLHIV, though actual numbers are likely higher. With a 195.8% occupancy rate, overcrowded prisons may facilitate the spread of HIV, tuberculosis, and hepatitis. Prison healthcare is restricted, with no naloxone for overdoses. Education on HIV, unsafe practices, or drug use is absent, and mental health care is insufficient. Condoms aren't supplied, and female guards supervise healthcare for female inmates and are often delivered by undereducated "writers" unaware of women's health needs. The lesbian, gay, bisexual, transgender, intersex, queer/questioning, and asexual inmates' needs are unaddressed due to officials' lack of expertise.

ASP's initiative aims to improve prison HIV/AIDS services through a global fund-supported project, targeting increased testing and prevention programme coverage. The project operates in nine districts, including Dhaka Central Jail and Keraniganj, with support from district hospitals. Collaborating with prison authorities, ASP has provided counsellors and medical technicians to major jails. By December 2022, ASP targeted reaching 700 inmates across seven prisons, successfully reaching 473. Testing of 1,380 inmates across eight prisons, all tested negative. ASP's initiatives demonstrate dedication to enhancing HIV/AIDS services in prisons, aiming for wide-ranging coverage and support. The group recommended the following to be in the NSP for 2024-2028

- Enhance prison staff's knowledge and skills on drugs, drug dependency, gender, sexuality, sexual orientation, HIV, and other transmissible diseases.
- Conduct a situation and needs assessment in Bangladesh's prisons to understand vulnerabilities, risk factors, and behaviours linked to HIV and other diseases. Include prisoners in the next IBBS to measure HIV and STI prevalence, sexual risk behaviours, and HIV vulnerability.
- Design evidence-based prison interventions aligned with international best practices and cultural relevance.
- Provide services to prevent HIV, including post-exposure prophylaxis (PEP), STI, Tuberculosis, and viral hepatitis B and C for all prisoners and staff.
- Protect staff from workplace risks by ensuring confidential HIV and tuberculosis testing, viral hepatitis B vaccination, protective gear, and PEP access.

- Coordinate and advocate for improving Bangladesh's prison system, engaging diverse stakeholders in reform initiatives.
- Enhance the prison health system to offer HIV testing, overdose management with naloxone, and evidence-based drug treatments, counselling, and rehabilitation.

#### **Group 4: HIV Prevention among FSW**

The HIV prevention efforts for FSWs in Bangladesh display both strengths and shortcomings. Notably, the programme has consistently implemented HIV prevention measures since its inception in 1995. Strengths encompass a reliable supply of essential healthcare products like condoms, proficient field staff, and standard monitoring and evaluation frameworks. Integration with government hospitals and a pilot for virtual interventions are ongoing.

However, several areas need enhancement. The programme reaches only 30% of FSWs, funding constraints impede the broadening of HIV interventions, and no efforts target FSW clients directly. HIV awareness campaigns are confined, and geographically-centred interventions may not cater to mobile FSWs. Condom quality concerns exist, collaboration between agencies is limited, and a top-down design, lack of mental health support, and inadequate research undermine the programme's potential. Moreover, a shift from a solely vertical strategy to one encompassing SRHR and human rights, including safer income options, is necessary.

To enhance the programme's impact, the following are recommended:

- Increase intervention coverage to 60% of FSWs nationally, ensuring comprehensive HIV services like condoms, lubricants, and integrated HIV and SRH services. Deliver these through peer outreach and tailored virtual programmes.
- Prioritize HIV prevention for FSW clients with awareness campaigns and easy access to condoms. Promote safe sexual practices among clients.
- Empower FSW self-help groups with financial resources and training. Ensure FSW participation in programme planning and evaluation.
- Use social media and apps for innovative virtual interventions, especially targeting hard-to-reach FSWs.
- Introduce newer approaches, such as PrEP, self-testing, and condom vending machines. Connect elderly sex workers to income sources less tied to HIV risk.
- Conduct research on FSWs using drugs to develop harm reduction strategies. Integrate these strategies for maximum effectiveness. Undertake action research to monitor the evolving sex trade dynamics, addressing stigma, discrimination, GBV, and human rights challenges. Adapt interventions based on findings. Update surveillance studies every three years, considering the growing virtual sex trade.
- Collaborate with the Ministry of Social Welfare to include FSWs in social safety nets, offering financial support and societal integration.
- Address FSWs' general and reproductive health needs, enhancing access to quality healthcare, including mental health.
- Educate law enforcement on FSW rights and the criticality of HIV prevention to foster a supportive environment.

## Group 5: HIV Prevention among Migrants and General Population

Over the past several decades, Bangladesh has experienced substantial migration, with around 10 million citizens working abroad as of 2021. Remittances from these migrant workers account for over 6% of Bangladesh's GDP, positively impacting poverty reduction, living standards, and investments in education, healthcare, and infrastructure. Major destination countries include Saudi Arabia, the United Arab Emirates, Oman, Qatar, Kuwait, Bahrain, Malaysia, Singapore, and Libya.

Bangladeshi overseas migrants face numerous risk factors for HIV transmission, such as limited access to healthcare and prevention education, social isolation, exploitative working conditions, and stigma and discrimination. These factors hinder HIV identification and treatment and may result in increased vulnerability to infection.

Bangladesh has shown a strong commitment to addressing migrant issues through supportive laws and policies, an independent ministry (the Ministry of Expatriates' Welfare & Overseas Employment), pre-departure training institutes, and investments in infrastructure and administration. Moreover, numerous NGOs and CBOs actively engage in migration-related matters.

Nevertheless, challenges persist in Bangladesh's response to HIV/AIDS among migrants. Key issues include the absence of a comprehensive programme for migrant health, insufficient recognition of migrants as a KP, limited access to support services, and inadequate information-sharing mechanisms. Additionally, challenges such as discrimination in healthcare, lack of HIV testing facilities, understaffed ART centres, limited migrant representation, and internal coordination gaps between relevant ministries and departments must be addressed. To address these challenges, the following priority recommendations are proposed:

- Conduct a national-level study on the nexus between migration and HIV/AIDS, recognizing migrants as a KP group in Bangladesh. Pilot programmes tailored to their unique needs, mainly focusing on female migrants, using national data collected at air, land, and naval ports.
- Develop fair policies for migrant workers living with HIV and AIDS, ensuring non-discrimination at airports, healthcare facilities, and in their communities, including insurance benefits.
- Build capacity by providing training to immigration police and other relevant officials.
- Establish HIV testing and counselling centres in all 64 districts to increase awareness and accessibility for the general population and migrants.
- Implement virtual interventions on migrant health involving foreign missions.
- Enhance online visibility of HIV and AIDS-related news and resources through social media, mass media (TV, newspapers, radio), and over-the-top platforms.
- Promote migrants' health in community and hospital settings, emphasizing the importance of stigma-free and discrimination-free care.
- Allocate increased funding for HIV programmes for migrants and foster collaboration between the MOHFW and the Ministry of Expatriates' Welfare and Overseas Employment to improve migrant health.

## Group 6: HIV Prevention, Treatment, Care and Support

Bangladesh's commitment to combating HIV is evident in its widespread provision of HTS and ART integrated into government facilities, prisons, and hospitals. While challenges such as limited ART and HTS centres and inconsistent supply chain management persist, several opportunities for enhancement exist. These include strengthening community support, integrating services, enhancing healthcare provider training, allocating a portion of the national health budget, bolstering outreach and prognosis monitoring, and addressing NCDs through public-private partnerships. Furthermore, addressing potential threats like difficulties in linking patients to ART, natural disasters, pandemics, political unrest, criminalization, social stigma, and poverty is imperative.

By focusing on strengths and opportunities while addressing weaknesses and threats, Bangladesh can develop a comprehensive and effective HIV care system. Recommendations for the forthcoming five-year NSP further support this effort.

### Recommendations for the 1<sup>st</sup> 95:

- Conduct HIV screening and follow-up testing as necessary, with confirmation of positive results through a secondary test and retesting negative results after six months for accuracy.
- Initiate treatment for confirmed positive cases while providing essential support and resources for patients, including their families and friends.
- Address advanced HIV disease and NCDs by reinforcing clinical services in public, NGO, and private sectors and promoting universal precautions for infection prevention.

### Recommendations for the 2<sup>nd</sup> 95:

- Prioritize rapid ART enrollment and maintain consistent monitoring, proactively addressing any loss to follow up through peer networks and outreach programmes.
- Monitor treatment side effects and conduct regular clinical assessments, especially for clients with co-infections or those receiving Isoniazid preventive therapy (IPT).
- Implement additional protocols to locate and prevent future cases of loss to follow-up.

### Recommendations for the 3<sup>rd</sup> 95:

- Adhere to WHO guidelines for viral suppression monitoring, ensuring the testing frequency aligns with individual patient needs.
- Expand viral load testing to all sites equipped with GeneXpert machines.
- Invest in ongoing capacity building and research, encompassing healthcare professional training, studies on ART drug resistance, and HIV genotype studies to enhance understanding and management of the virus.

### Recommendations for monitoring and reporting:

- Develop a comprehensive PLHIV database managed by ASP to monitor progress, guide targeted interventions, and assess programme outcomes. This database should encompass relevant demographic and health information to facilitate data-driven decision-making.

- All reports need to be segregated by age, gender, other demographical information, population subgroups, etc.
- Engage the PLHIV Network in monitoring, including adherence, viral load tracking, assessment of side effects, identification of signs of resistance, and facilitating referrals, especially in cases of co-infections and NCDs, as well as the provision of counselling and other forms of support.
- By implementing these recommendations, Bangladesh can significantly enhance the lives of individuals affected by HIV and reduce the prevalence of the virus, ushering in a hopeful new era for the nation.

### **Group 7: Thematic area: HIV Laboratory Services**

The HIV laboratory services in Bangladesh demonstrate many strengths, including the presence of an integrated health system, effective implementation of health programmes, policies, and standards, and possessing 11 polymerase chain reaction (PCR) machines by ASP. The presence of adequate infrastructure and a skilled team enables efficient HIV testing and treatment services.

Nonetheless, several challenges hinder the optimisation of these services. These include a lack of diverse testing platforms and a reference laboratory, limited inclusion of KP perspectives, inadequate data standardisation, and inconsistent quality reporting. Additional barriers stem from external factors such as potential future pandemics, political instability, and insufficient supplies and funding for testing. The system also faces challenges integrating the management information system database and the societal stigma associated with HIV.

The following recommendations can improve the country's HIV laboratory services and build a more robust and effective system that serves all populations.

- Undertaking laboratory-based operational research to identify and address drug resistance issues, enhancing treatment outcomes for PLHIV.
- Establishing specialised facilities to investigate opportunistic infections among PLHIV would enable early detection and treatment, improving overall health outcomes.
- Collaboration among various departments of the DGHS can streamline HIV testing and treatment services while adhering to universal precautions for infection control.
- Implementation of an active surveillance system, alongside a web-based supply chain management mechanism, will ensure the consistent availability of ART, viral load, and diagnostic reagents at all service centres.
- Instituting regulatory guidelines for private sector laboratories ensures alignment with national algorithms for HIV testing, improving both quality and coordination.
- Creating a one-point centre for testing facilities for HIV, STIs, and comorbidities offers PLHIV comprehensive care through improved access to a range of services.
- Prioritising biosafety measures in all laboratories is vital for protecting staff and clients.
- Allocating sufficient human resources dedicated to HIV laboratory services and training within the ASP will enable rigorous monitoring, evaluation, quality assurance, and technical support for laboratory tests.

- An alternative testing algorithm incorporating at least three testing methods can mitigate supply chain risks and reduce reliance on specific rapid test kits.
- Incorporating HIV/AIDS testing into the general health system can expand access to essential services for PLHIV.
- Capacity building among CBO members to conduct screening for HIV, syphilis, and hepatitis can also enhance service provision.

## Challenges and Gaps

### A. Scale, Coverage and Closing Gaps

Optimal coverage of KPs is both an ethical obligation and a strategic necessity for controlling the HIV epidemic in Bangladesh. In the global context, KPs comprise 70% of new HIV infections yet receive only a fraction of international HIV funding. Failure to adequately focus on KPs can result in an inefficient use of resources and hinder the opportunity to reduce new infections. Bangladesh is not an exception to this trend. Existing universal guidelines stipulate that HIV programme coverage targets should be ambitious and realistic. Existing guidelines underscore that coverage targets should be both ambitious, aiming for a significant reduction in new HIV infections, and practical, considering available resources and the actual numbers of individuals within KPs.

Current data reveal severe gaps in HIV prevention services for KPs in Bangladesh. National coverage for PWID is currently at 56%, well below the global target of 95%. Similarly, coverage for FSW combined with all typologies stands at 29%, and

Table 2: National Coverage of the KPs (June 2023)

for MSM and MSW, it is merely 25%. Transgender individuals have a coverage rate of 45%. These gaps are not just numerical failures but have ethical and strategic repercussions that jeopardise national and global efforts to eliminate AIDS by 2030.

KP	Total	National Coverage	%
PWID	34,370	19,343	56%
FSW (all typology)	113,106	33,317	29%
MSM and MSW	165,191	40,550	25%
Transgender	12,629	5,700	45%

The discontinuation of HIV prevention programmes for brothel-based FSWs jeopardizes essential healthcare provision and undermines the trust between these communities and service providers. This close is not merely a strategic oversight but constitutes an ethical breach.

Ahead of submitting the Grant Cycle 7 (GC7) grant proposal to the Global Fund in July 2023, Bangladesh conducted a comprehensive modelling exercise using the AEM. The exercise aimed to update AEM workbooks with recent KP size estimates and to produce revised HIV projections. Furthermore, it evaluated future epidemic scenarios based on proposed targets and generated intervention prioritization plans and impact analyses. The study categorised 25 "priority districts" and 39 "remaining districts" based on various factors, including district-wise KP concentration, HIV programme reach, HIV case reports, and ART coverage. To meet the model's best-case scenario criteria, programmes must reach, test, and treat 85% of all KPs in the 25 priority districts and at least 25% in the 39 remaining districts. The current coverage of KPs is still far behind the AEM-recommended coverage threshold.

The HIV programme in Bangladesh relies heavily on external donors such as the Global Fund. Although the government has allocated substantial funding to the OP, bureaucratic procedures often cause delays in the disbursement of funds, leaving a significant portion of the grant unspent. Gaps in the planning and implementation phases of the HNPSP further exacerbate the problem. For instance, the fourth HNPSP phase ended in June 2023, leaving a discontinuation of OP-supported HIV programmes until the fifth phase starts in July 2024.

Given that Bangladesh's HIV epidemic predominantly affects KPs, a comprehensive prevention strategy must focus on these groups to effectively mitigate the overall transmission rate. Failing to achieve the

95% coverage target for KPs would severely compromise Bangladesh's alignment with global AIDS eradication goals. The Fifth NSP for HIV and AIDS Response (2024-2028) must address these coverage gaps. The consequences of strategic and ethical failure are too significant to overlook. Immediate actions, such as resource allocation and community trust restoration, are crucial. Aligning with global best practices and ethical standards is non-negotiable for safeguarding the vulnerable communities most affected by the epidemic. National HIV programmes must prioritize interventions for KPs to reach the 95-95-95 targets for diagnosis, treatment, and viral suppression.

## **B. Governance and Leadership**

Bangladesh has updated its national strategy for HIV and AIDS with a costed plan in place, as are other essential documents, such as the M&E framework, which have been regularly revised, approved by the MOHFW, and made publicly available. However, a significant resource deficit exists for implementing the NSP's recommended interventions. The most recent national strategy (Revised 4th NSP for HIV and AIDS Response 2018–2023) was prepared with the active participation of the stakeholders supporting HIV services in Bangladesh, including the government, civil society, private health sector providers, donors, development partners, and other international organizations. Each round of Global Fund funding proposals requires an updated or revised NSP to be submitted. This requirement catalyses the review and updating of the NSP. The NASC leads the revision process, and senior officials of DGHS, NGOs working in implementing HIV programmes, UN agencies, and community networks participate in the revision process.

The NSP and other key documents, such as the M&E framework, harm reduction strategy, strategy for preventing GBV, SOPs for HIV service delivery and management guidelines, have been updated and adopted on time to accommodate changing contexts and global policy shifts. The ASP developed these documents with relevant stakeholders, including technical experts and community representatives.

A major issue lies in the various authorities' and ministries' endorsement of these documents. Although the documents clearly state the participation of other sectors, these sectors have not been consulted, nor have they endorsed these documents. Moreover, the dissemination of these documents is limited, leaving many people unaware of these strategies and SOPs. As a result, these strategies are primarily being used within the health sector (particularly by the HIV programme implementers), which has access to them. Other departments and stakeholders remain uninvolved in the development and implementation processes. Thus, despite being well-structured and updated, these strategies and SOPs are not being implemented effectively due to these challenges.

Bangladesh's HIV programme is guided by the updated NSP for HIV and AIDS. The document is aligned with the 4th HNPSP, which runs from 2017 to 2022 (with a no-cost extension until June 2024), and other national, regional, and global commitments, most notably the political declaration to eliminate AIDS by 2030. The OP and the Global Fund-supported programme emphasize geographical prioritization based on the "investment case" to maximize resource utilization. Duplication of services, such as multiple entities providing services to the same population, is almost non-existent in Bangladesh's HIV programme. This was extensively evaluated during the planning and negotiating stages of the Global Fund grant.

### **Coordination and Oversight**

The NASC tracks, maps, and coordinates HIV and AIDS activities through a central and district structure. Every year, before World AIDS Day, the NASC reviews all HIV and AIDS activities. A quarterly

coordination meeting is held at the NASC each quarter, during which PRs, SRs of the Global Fund-supported programmes, and other implementers can raise their concerns and discuss solutions. Implementers also share programmatic updates and discuss overlapping challenges and issues. The coordination fosters a formal regulatory process for introducing new products, technologies, and solutions (such as self-testing, PrEP, etc.) to support HIV programming. Coordination structures exist for M&E and strategic information, ART services, procurement and supply chain management (PSM), migrant issues, etc. The NASC leads this coordination.

Although the roles and responsibilities of coordination and oversight are clearly outlined in relevant memos, guidelines and policies, the processes are not functioning smoothly due to insufficient human resources and financial support. The coordination and oversight role primarily depends on human resources and financial support provided by the Global Fund, with efforts mainly focused on interventions for KPs. However, coordination efforts at the district/*upazila* level are weak, and health authorities such as civil surgeons are not held accountable for national HIV and AIDS goals or targets. Tracking and mapping the private sector's HIV and AIDS activities, including those of healthcare providers and other private sector partners, are virtually non-existent.

### Stakeholders' Engagement

Bangladesh has no laws or policies restricting civil society from implementing and overseeing the HIV and AIDS response. However, beyond the Global Fund's Country Coordinating Mechanism's (CCM) civil society engagement requirements, there is no mechanism for civil society oversight. The CCM oversight committee provides regular monitoring, primarily focusing on Global Fund-supported programmes. Other funded programmes involve civil society on an ad hoc basis, taking feedback as needed. During the programme design and planning phase, the engagement of civil society, UN agencies, and community networks is evident. However, the involvement of other relevant ministries or departments and the private sector is nearly non-existent, aside from the Ministry of Health.

Besides Global Fund grants, Bangladesh's primary domestic funding source is the OP under the 4th HNPSP. Under the OP, civil society groups, particularly national and local NGOs, implement the programme. However, no KP community organizations, including CBOs and self-help groups, receive domestic support from the government, private sector, or self-generated funds. The criminalization of drug use and homosexuality and the quasi-legal status of commercial sex create barriers to the legitimate registration of CBOs and self-help groups. Despite these challenges, with a concerted effort, the Sex Workers Network in Bangladesh and a few CBOs for FSW, along with the Network of PLHIV, have successfully attained government registration.

The government can only establish financial partnerships with entities with legal status. As a result, community engagement within interventions funded domestically is in its infancy, characterized by its sporadic nature and a predominance of non-financial involvement. Despite the conclusion of the OP-supported programme under the fourth HNPSP, the government has informally engaged CBOs in brothels, providing them with condoms to distribute among FSWs, indicating a positive move towards community involvement.

The CCM is the only mechanism through which the government involves other relevant ministries, such as the Ministry of Home Affairs; the Ministry of Local Government, Rural Development and Co-operatives; the Ministry of Education; the Ministry of Women and Children Affairs; the Ministry of Finance etc., in HIV prevention, treatment, and support programme. However, the involvement of these other ministries is limited to attending meetings, except for the Ministry of Health. Sometimes, the

involvement is project-based; for instance, the Ministry of Health and Home Affairs signed an agreement providing access and support for implementing the HIV programme inside prisons.

### C. Human Resources for HIV and AIDS

Human resources include service providers delivering HIV prevention, treatment, and care support services. The availability of adequately trained and distributed human resources is vital for programme success and long-term sustainability.

Bangladesh is faced with both a severe lack of human resources for health and unequal distribution. In Bangladesh, the ratio of doctors to the population is 0.6 to 1,000, and the ratio of nurse-midwives to the population is 0.4 to 1,000.<sup>23</sup> This is significantly below the World Health Organization-recommended doctor-to-population ratio of 1:1,000. A health facility study done in 2013 revealed that more than 25% of physician positions and 22% of nurse positions in *upazila* health complexes were vacant.<sup>24</sup> Poor living conditions, work overload, lack of essential equipment, constrained career opportunities, and inadequate compensation and benefits are primary reasons for healthcare professional absenteeism in Bangladesh's rural districts.<sup>25</sup> In addition, the health workforce in Bangladesh often has to work within intense resource constraints, leading to a lack of quality service provision.<sup>26</sup> This contributes to unhealthy working conditions, leading to dissatisfaction with healthcare services.

However, the Government of Bangladesh's Bangladesh Health Workforce Strategy 2015 promotes the determination of service level-specific (i.e., primary, secondary, and tertiary) health workforce demands and estimates until 2030. The strategy also encourages the development of a health workforce production and development plan to identify supply-side bottlenecks and ensure the availability of a competent health workforce.<sup>27</sup>

In NASC, nine positions are employed under the leadership and direction of the NASC Director to ensure that the three NASC tasks are effectively coordinated: a) acting as the nexus for HIV and AIDS responses in Bangladesh by leading and coordinating with various stakeholders, b) managing the HIV component of the OP within the HNPS, and c) serving as one of the PRs for the Global Fund's HIV grants. NASC considers these positions to be core positions. Under the OP of the 4th HNPS, 96 posts have been approved. These individuals are contractual and project-based. Among NGO partners, regardless of whether they receive grants from the OP or the Global Fund, human resource contracts are entirely

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<sup>23</sup> Shangjucta Das Pooja et al., "Working in the Dark": Experiences of Frontline Health Workers in Bangladesh During COVID-19 Pandemic," *Journal of Multidisciplinary Healthcare* 15 (April 25, 2022): 869–81, <https://doi.org/10.2147/JMDH.S357815>.

<sup>24</sup> M. Mahmud Khan et al., "Use of a Balanced Scorecard in Strengthening Health Systems in Developing Countries: An Analysis Based on Nationally Representative Bangladesh Health Facility Survey," *The International Journal of Health Planning and Management* 28, no. 2 (2013): 202–15, <https://doi.org/10.1002/hpm.2136>.

<sup>25</sup> Emmanuel Kwame Darkwa et al., "A Qualitative Study of Factors Influencing Retention of Doctors and Nurses at Rural Healthcare Facilities in Bangladesh," *BMC Health Services Research* 15 (August 27, 2015): 344, <https://doi.org/10.1186/s12913-015-1012-z>.

<sup>26</sup> Md Imran Hasan et al., "Iceberg of Workplace Violence in Health Sector of Bangladesh," *BMC Research Notes* 11 (October 4, 2018): 702, <https://doi.org/10.1186/s13104-018-3795-6>.

<sup>27</sup> "Bangladesh Health Workforce Strategy 2015" (Ministry of Health and Family Welfare, 2015), <http://hospitaldghs.gov.bd/wp-content/uploads/2019/11/Bangladesh-Health-Workforce-Strategy-2015-min.pdf>.

project-based, meaning that after the project ends, the workforce is no longer associated with the HIV programme.

The government needs to update the pre-service training curriculum for health cadres over the last three years to include the most recent HIV-related information. NASC has not yet systematically collected and used health workforce data to plan and manage the HIV and AIDS programme’s health workforce.

## D. Policy and Structural Obstacles to HIV Prevention Services

Bangladesh needs to make extensive efforts to ensure that policies, the legal environment, and human rights aspects are used to improve the lives of people affected and infected with HIV and AIDS. Bangladesh, like many other countries, faces various legal, policy, and human rights barriers that hinder the effectiveness of its HIV programme.

Although Bangladesh has a comprehensive national HIV and AIDS strategy that aligns with global targets, it is not endorsed by relevant ministries, such as the Ministry of Home Affairs. Policies and laws often contradict the strategy. Specifically, the 2018 Narcotics Control Act rejects harm reduction interventions. Also, there was no involvement of the NASC in developing the Anti-discriminatory Act, which has yet to materialize.

In Bangladesh, HIV and AIDS services are free of charge to both KP and the general population. No formal or informal (out-of-pocket or cost without receipts) payments are required for user fees for clinical, testing, prevention, and care services. Non-HIV services in the public sector, such as mother and child healthcare, SRH services, outpatient registration, hospitalizations, etc., may require formal and informal expenditures.

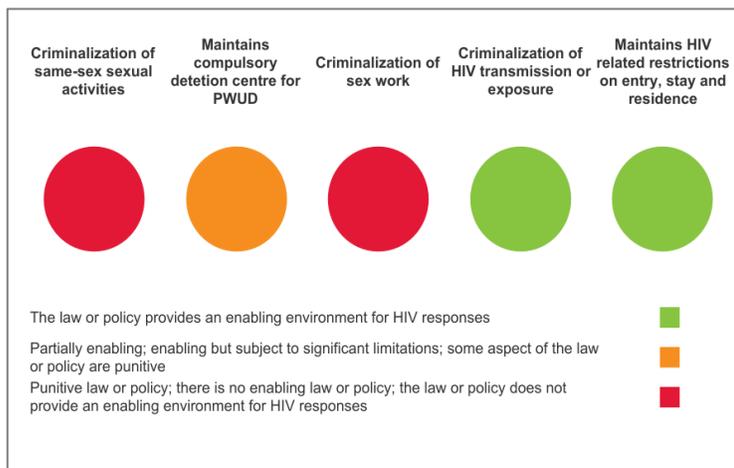


Figure 12: Punitive and Discriminatory Laws, 2021 (AIDS Data Hub, 2023)

The Government of Bangladesh officially recognized transgender / hijra as a separate gender on 26 January 2014,<sup>28</sup> and discrimination based on identification is illegal. However, the most challenging aspects are the continued criminalisation of commercial sex work, homosexuality and drug use.

The Narcotics Control Act 2018, which replaced the Narcotics Control Act of 1990, introduced harsher penalties for drug offences. Using any Class A drug, such as heroin or methamphetamine, is a punishable offence, and the punishments range from three months to two years of imprisonment with a fine. At the

<sup>28</sup> “Gazette notification recognizing the hijra community of Bangladesh as a hijra sex” (Government of Bangladesh, January 26, 2014), [http://www.dpp.gov.bd/upload\\_file/gazettes/6851\\_39605.pdf](http://www.dpp.gov.bd/upload_file/gazettes/6851_39605.pdf).

same time, the sentence for possessing more than 25 mg or 25 ml of any Class A drug can be as severe as life imprisonment with a fine or the death penalty. Other common drug use and possession offences carry harsh punishments.<sup>29</sup>

Sections 21, 23, and 26 of the Narcotics Control Act authorize law enforcement agencies to search and confiscate needles and syringes and arrest PUD if they are “believed to be” injecting or using drugs in the present, past, or future. Sections 21 and 23 authorize law enforcement agency members to suspect proof of drug possession or use in an individual; they reserve the right to search, arrest, and detain individuals who may seem to have taken or intend to take drugs.<sup>30</sup>

According to the “sodomy law,” Section 377 of the Bangladesh Penal Code, “whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal shall be punished with imprisonment for life, or with imprisonment of either description for a term which may be extended to ten years, and shall also be liable to fine.” This section, in particular, criminalizes MSM practices.

FSW commercial sex work is quasi-legal. Laws and ordinances that explicitly refer to prostitution include the Constitution (Article 18, Subsection 2), which says that “The State shall adopt effective measures to prevent prostitution and gambling.” Metropolitan police ordinances in several major cities allow the punishment of anyone who “endeavours to attract attention for the purposes of prostitution, or even solicit or molests any person for the purposes of prostitution,” and the Bengal Suppression of Immoral Traffic Act 1933 refers explicitly to females under age 18 and to any “promiscuous sexual act that is bought, whether for money or for kind.” The Bangladesh Penal Code 290, which refers to ‘public nuisances,’ is also applied to sex workers. Although it does not explicitly refer to sex work, it addresses trades or professions that are hazardous for public health or create uncomfortable situations for common people, and the police use it to harass and punish sex workers.<sup>31</sup>

KPs in all categories often encounter stigma and discrimination, resulting in harassment in public.

In addition, macro and microstructural factors, such as selling sex in public venues, increasing food prices, homelessness, mobility, gender norms in society, violence, etc., increase vulnerability to HIV.<sup>32</sup>

The design of the current intervention programme for sex workers is narrowly focused on HIV and STIs. The broader concerns of health, human and sexual rights, and social and economic development are not adequately incorporated into the overall intervention strategy. As a result, interventions have limited appeal to their target populations.

In summary, Bangladesh faces significant legal, policy, and human rights barriers that hinder the effectiveness of its HIV programme. To address these barriers, the government must adopt a comprehensive approach, including reforming regulations and laws to protect the rights of KP and PLHIV, and increasing knowledge and awareness of HIV among public health personnel is fundamental.

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<sup>29</sup> “মাদকদ্রব্য নিয়ন্ত্রণ আইন, ২০১৮,” accessed February 2, 2023, <http://bdlaws.minlaw.gov.bd/act-1276.html>.

<sup>30</sup> Ibid.

<sup>31</sup> “20 Years of HIV in Bangladesh: Experiences and Way Forward,” accessed January 28, 2023, <https://openknowledge.worldbank.org/handle/10986/27592>.

<sup>32</sup> Ibid.

## E. Limited HIV Prevention Financing

Bangladesh lacks a well-planned, long-term, and comprehensive HIV and AIDS financing strategy. Instead, the country employs ad hoc approaches, which entail developing plans or responses as needed following donor requirements.

The estimated cost for 2021–2023, as outlined in the costed plan of the 4th revised national HIV strategy, is \$170 million.<sup>33</sup> However, only \$23.9 million has been allocated for HIV interventions, treatment, and care in the OP under the 4th HNPSF during this time (the OP is for five years, from January 2017 to June 2022, with a total allocation of \$47 million<sup>34</sup>). For this period, \$23 million came from the Global Fund. Some funds are also allocated from UN agencies. This leaves a shortfall of around over \$100 million for implementing the various components of the NSP over 2021-2023.

The data from 2008 to 2018 show that the government has made efforts to increase domestic funding for the national HIV and AIDS programme. The trend of the total annual funding is declining, with international funding sources accounting for the largest share. Notably, since 2013, there has been a decline in external funding, and the government has progressively increased its domestic funding for HIV and AIDS programmes (see Figure 10). Furthermore, the allocation for the 4th HNPSF is almost double that of the third HNPSF.<sup>35</sup> The execution rate for budgeted domestic HIV and AIDS resources, on the other hand, remains at 0–49% of the budget executed category.

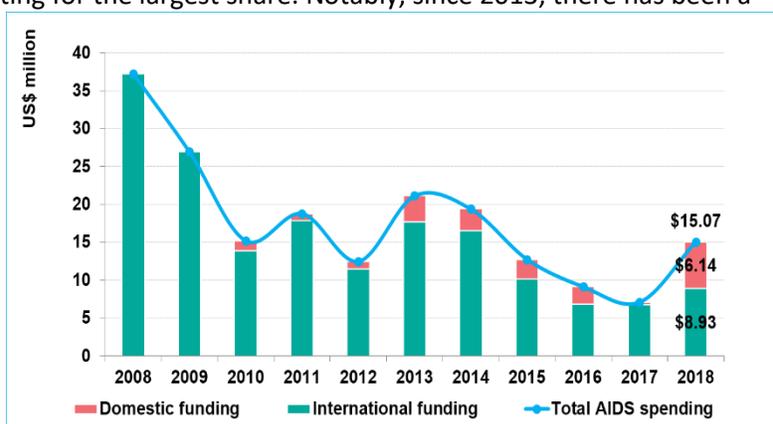


Figure 13: AIDS spending by financing source, 2008–2018 (AIDS Data Hub, 2023)

ASP collects all donors’ AIDS spending for Global AIDS

Monitoring reports. However, a detailed analysis of the spending data is inadequate. Approximately 44% of AIDS spending is directed to KP service delivery, 36% to care and support of PLHIV, 2% to other prevention, and 18% to other HIV expenses.<sup>36</sup>

<sup>33</sup> UNAIDS, “Country Progress Report - Bangladesh, Global AIDS Monitoring 2018” (Dhaka, Bangladesh, n.d.), [https://www.unaids.org/sites/default/files/country/documents/BGD\\_2018\\_countryreport.pdf](https://www.unaids.org/sites/default/files/country/documents/BGD_2018_countryreport.pdf).

<sup>34</sup> DGHS (Directorate General of Health Services), “4th Health, Population and Nutrition Sector Programme (4th HPNSP).”

<sup>35</sup> “HIV/AIDS Asia Pacific Research Statistical Data Information Resources - AIDS Data Hub |,” accessed February 2, 2023, <https://aphub.unaids.org/>.

<sup>36</sup> “HIV/AIDS Data Hub for the Asia Pacific,” HIV/AIDS Data Hub for the Asia Pacific, accessed February 2, 2023, <https://www.aidsdatahub.org>.

## F. A Lack of Differentiation in HIV Prevention Programmes for KPs

DSD presents a person-centered approach to HIV prevention, testing, and treatment, demonstrating its significance in moving away from a one-size-fits-all model. The importance of this approach becomes apparent when assessing the low rate of condom use among KPs such as FSW, MSM, PWID, and transgender people/Hijra in Bangladesh, with a substantial increase in STIs. According to the IBBS conducted in 2020, among FSWs, a mere 42% reported using condoms consistently with their clients within the last four weeks. In MSM, consistent condom use was reported at a low 14% with commercial partners, 23% with casual partners, and 28% with regular partners, a decline from 61% reported in the 2015 IBBS. Among PWID, the condom use rate was also low at 42%, and for the transgender women/hijra population, consistent use of condoms during sex with clients was only 23.3%. A lack of differentiation in service delivery may be significantly contributing to these low rates of condom use.

Comprehensive intervention strategies must integrate a differentiated approach to effectively address the variation in condom usage rates and the associated increase in STIs among these KPs. To do so, interventions should focus on increasing access to condoms and lubricants, providing education on STI transmission and prevention, scaling up HIV intervention programmes, and developing the capacity of healthcare providers for better service delivery to KPs. The ultimate goal is to enhance the accessibility, availability, and coverage of services. For instance, districts such as Chattogram, Gazipur, and Khulna for MSM and transgender women/hijra, Gazipur and Cox's Bazar for FSW, and Narayanganj, Cumilla, and Gazipur for PWID are recommended for an increase in HIV testing coverage. However, the mere availability of services may not suffice without a supportive, discrimination-free environment to encourage KPs to seek services when needed. The current rates of active syphilis, ranging from 4.8% in FSWs to 11.9% in transgender women/hijra, along with the unsatisfactory knowledge of HIV and STI prevention across all KPs, emphasize the urgency of these interventions.

The distribution of condoms and lubricants, particularly in districts such as Chattogram, Cumilla, and Gazipur for MSM and Narayanganj and Gazipur for transgender women/hijra, should be improved. Immediate efforts focusing on raising awareness and the availability of HTS are required, with an emphasis on Cumilla and Chattogram for MSM; Gazipur, Chattogram, and Khulna for transgender women/hijra; Gazipur and Cox's Bazar for FSW, and Narayanganj for PWID, where the uptake of HTS in the past 12 months was lower than other districts.

Differentiated HIV prevention services should be provided for KPs, integrating these into a more comprehensive array of services that KPs need, including social and mental health care support. Virtual access, peer outreach, client approach, community-based organization engagement, and provision of services from multiple accessible sources, including depots or pharmacies, are vital to delivering an effective DSD approach to HIV prevention. With a differentiated approach to HIV prevention service delivery, public health authorities can address different populations' specific needs and barriers, improving outcomes in HIV prevention and overall public health.

# National and International Commitments and Guidance

## A. Sustainable Development Goals:

The SDGs, or Global Goals, are 17 goals established by the UN member states to be achieved by 2030. Each goal consists of several targets aimed at addressing various global challenges.

SDG 3 ensures healthy lives and promotes well-being for all ages, including HIV-related targets.

- Target 3.3 aims to end AIDS as a public health threat by 2030.
- Target 3.8 seeks to achieve universal health coverage, access to quality health care services, and access to essential medicines and vaccines for all, including HIV services, SRH services, and harm reduction services.

Other SDGs related to HIV include:

- SDG 1 (No Poverty) targets eradicating poverty in all its forms (by increasing opportunities for paid work)
- SDG 4 (Quality Education) targets comprehensive SRH education and life skills.
- SDG 5 (Gender Equality) includes targets on SRHR and eliminating violence, harmful gender norms, and practices.
- SDG 10 (Reduced Inequalities) focuses on targets protecting people from discrimination, empowering them to claim their rights, and enhancing access to HIV services.
- SDG 16 (Peace, Justice, and Strong Institutions) features targets to reduce violence against people with HIV and those most at risk of HIV.
- SDG 17 (Partnerships for the Goal) targets Official Development Assistance to encourage growth and trade, which affects safe behaviours and income.

## B. Global AIDS Targets for 2025

UNAIDS has established targets for 2025 to end AIDS as a public health threat by 2030, replacing the 2020 Fast-Track targets. The 2025 targets include the following:

- 95% of people with HIV know their status.
- 95% of people with HIV who know their status are receiving treatment.
- 95% of people with HIV on treatment achieve viral suppression.

These first three targets are similar to the Fast Track 90-90-90 targets but with 95% coverage instead of 90%.

Additional 2025 targets are as follows:

- 95% of individuals at high risk of HIV have access to combination prevention services.
- 95% of women of reproductive age have their sexual reproductive health needs met.
- 95% of people can access services to eliminate parent-to-child transmission of HIV.

- 90% of people with HIV and those most at risk for HIV have access to services for overall health, including support for sexual and GBV, mental health, tuberculosis, and other health conditions.

Moreover, the targets aim for:

- Fewer than 10% of countries have punitive laws and policies that deny people access to justice.
- Fewer than 10% of people with HIV and those at risk of HIV experience stigma and discrimination.
- Fewer than 10% of women, girls, people with HIV, and those most at risk of HIV experience gender inequality or violence.

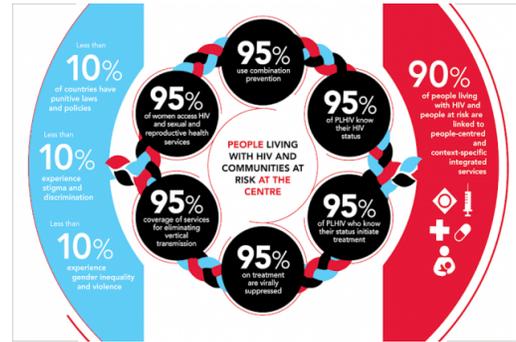


Figure 14: Global AIDS Targets by 2025

UNAIDS’ current strategy (2021-2026) offers a framework to help countries achieve these 2025 targets, emphasizing prioritising at-risk communities and people with HIV. The targets are designed to align with the HIV-related targets in the SDGs.

### C. Community-led Responses:

The UN member states made commitments in 2021, in the 2021 Political Declaration, to ensure that by 2025 community-led organizations will deliver 80% of HIV prevention services; communities will provide 60% of programmes supporting the achievement of societal enablers; and communities will also deliver 30% of testing and treatment services. However, barriers to fulfilling these commitments have been identified, such as a lack of clear definitions and data for monitoring progress. Member States made further commitments on Ending Inequalities and Getting on Track to End AIDS by 2030, including the commitment to the Greater Involvement of PLHIV principle and to ensuring that community-generated data is used to tailor AIDS responses. A Multistakeholder Task Team recommended good practices and improved modalities to provide access to funding for CBOs and constituency-based networks.

### D. UNDETECTABLE = UNTRANSMITTABLE

UNAIDS endorses the concept of undetectable = untransmittable, which means that HIV treatment for PLHIV is in and of itself an essential prevention strategy. Studies have shown that PLHIV on ART with an undetectable level of HIV in their blood have a negligible risk of transmitting HIV sexually. Access to ART not only allows PLHIV to stay healthy and have a lifespan similar to people not living with HIV, but it also provides an opportunity for them to have sex without a condom with effectively no risk of passing HIV on to their partner. However, condoms and other prevention strategies remain essential tools in the HIV response.

Efforts to reduce a person’s viral load to undetectable levels must be tailored to the individual, taking into account factors such as the duration of taking ART, adherence to ART, and the desire to stop using condoms to become pregnant. Regular viral load testing helps PLHIV and their healthcare providers monitor the success of a treatment regimen.

In addition to their primary goal of keeping PLHIV in good health, ART and maintaining an undetectable viral load are essential prevention tools within the combination prevention framework. Other

prevention tools include male and female condoms, PrEP, PEP, harm reduction services for people who inject drugs, and behaviour and structural changes.

- Systemic changes are required to scale up essential health services for all and keep people in care for life. Despite the remarkable scale-up of ART, many PLHIV do not start treatment until they are so ill that they have a low clusters of differentiation 4 (CD4) count and are considered to have AIDS. The UNAIDS endorses the concept of Undetectable = Untransmittable, and efforts should be put in place to ensure that all PLHIV have access to treatment as soon as they are diagnosed so the viral load is suppressed.

## E. Differentiated Service Delivery

The one-size-fits-all model of HIV services does not work for all PLHIV or KPs. DSD is a responsive, client-centred approach that simplifies and adapts HIV services across the cascade to serve individual needs better and reduce unnecessary burdens on the health system. As more countries revise their HIV service delivery models, it is time to deliver differently, recognizing the importance of tailoring services to diverse groups of PLHIV while maintaining the principles of the public health approach to enable high-quality service delivery at scale.

### Key Components of DSD

- Client-centred prevention, testing, treatment and care: DSD prioritizes each individual's unique needs and preferences, ensuring that services are tailored to their specific circumstances. This approach improves client satisfaction, retention in care, and overall health outcomes.
- Decentralized service delivery: By decentralizing HIV services, DSD brings care closer to the communities, reducing travel time and costs for clients. This enhances accessibility, particularly for individuals living in remote areas or facing mobility challenges.
- Task-shifting and task-sharing: DSD promotes the redistribution of tasks among healthcare workers, allowing for better utilization of available resources. By delegating specific tasks to lower cadres of health professionals or community health workers, DSD helps reduce the workload of overburdened healthcare providers.
- Integration of services: DSD aims to integrate HIV services with other health and social services, such as reproductive health, mental health, and support for PUD. This approach ensures a comprehensive and holistic response to the needs of PLHIV and those at risk.
- Flexible service hours and appointment scheduling: DSD recognizes the importance of providing clients with convenient services. The model ensures that clients can access services without compromising their work, education, or family responsibilities by offering flexible hours and appointment options.
- Community engagement and peer support: In the DSD model, communities and PLHIV play an active role in service delivery. Peer support networks and CBOs contribute to improved care retention, treatment adherence, and overall health outcomes.

### Applications of DSD in HIV Prevention, Testing, and Care

#### HIV prevention:

DSD tailors prevention strategies to the specific needs and risk profiles of different populations, such as MSM, transgender individuals, sex workers, and PWIDs. This may include targeted distribution of condoms in different shapes, forms and sizes, distribution of water-based lubricants, PrEP, and PEP, and targeted education and outreach programmes.

**HIV testing:**

DSD promotes diverse testing strategies, such as rapid testing, self-testing, and community-based testing, to increase access and uptake. By providing testing options that cater to individual preferences and needs, DSD helps ensure timely diagnosis and linkage to care. For example, Bangladesh has implemented geographical prioritization community-based testing and piloted HIV self-testing.

**HIV care and treatment:**

DSD offers a range of care models to meet the diverse needs of PLHIV, such as facility-based care, community-based care, and home-based care. These models allow for more flexible appointment schedules, task-shifting to ease healthcare worker burdens, and integration of services to address other health needs.

DSD is a powerful approach to improving the quality, efficiency, and accessibility of HIV prevention, testing, and care services. By tailoring interventions to the unique needs of each individual and engaging communities in service delivery, DSD holds significant potential for enhancing health outcomes and reducing the impact of HIV on individuals and communities. It represents a people-centred approach that increases access to healthcare

## Focusing Areas in the Next Five Years

Firstly, it is crucial to highlight the aspects that remain the same. The main goal of the strategy is to end AIDS by 2030. The Bangladesh government is committed to achieving this goal, and its success will be evaluated against this benchmark. The core philosophy is also unchanging: The government of Bangladesh collaborates with a wide array of partners, encompassing government institutions, civil society organizations, international development partners, UN agencies, and community networks, all working together towards this objective. The government maintains its unwavering focus on outcomes, with performance ultimately assessed by the number of lives saved and HIV infections prevented.

Despite these consistent aspects, there are numerous differences that impact the strategy to accelerate the implementation process. To avoid repeating much of what is outlined in the strategy narrative, here are ten examples of key aspects of the current national HIV and AIDS strategy that will reshape the way the work is carried out in addition to continuing existing strategies:

### A. Optimizing HIV Prevention:

In the development of the National HIV and AIDS Strategy, it is imperative for Bangladesh to adopt bold, ambitious, and innovative measures over the next five years to address the ongoing HIV epidemic. While significant progress has been made in HIV prevention, reducing new infections remains a primary objective. To effectively curtail the epidemic, a substantial decrease in new infections is essential, especially among vulnerable populations and KPs.

In the forthcoming years, Bangladesh should focus on broadening HIV prevention coverage for KPs by diversifying service delivery platforms and augmenting prevention options. By implementing and expanding existing strategies and anticipating the emergence of new technologies, the nation can work toward ensuring that 95% of individuals at risk of HIV utilize appropriate, prioritized, and effective combination prevention packages. This ambitious approach is crucial for achieving meaningful progress in combating HIV and AIDS and ultimately safeguarding the health and well-being of Bangladesh's population. Therefore, in addition to the existing programme, the following aspects should be emphasized:

- i) Strengthen the HIV programme in prisons and other close settings
- ii) HIV prevention among migrants, clients of sex workers, and sex partners of PWID
- iii) PrEP to all people at increased risk of HIV infection and ensure availability for those eligible (e.g., the HIV-negative persons of serodiscordant couples, elderly sex workers with decreasing income and negotiation capacity, MSM and transgender, etc.)
- iv) Strengthen prevention of mother-to-child transmission and pediatric care clinical cascade to eliminate transmission of HIV, hepatitis B and syphilis.
- v) Prioritizing those at higher risk and value for money: rather than general education and information that is not tailored to the context
- vi) Differentiate interventions: according to the unique specificities of each segment within the KPs and within programmes for adolescent girls and young women. Expansion and differentiation of service delivery platforms (esp. SRH/family planning /STI and pharmacies, digital & online).

## **B. Optimising HIV testing:**

Over the next five years, Bangladesh will prioritize expanding HTS to achieve the highest possible coverage. This will include promoting HIV self-testing, ensuring safe and ethical index testing, and implementing social network-based testing. A three-step rapid diagnostic test process will be used to diagnose HIV, emphasising increasing the use of these tests. Trained and supervised lay providers, such as peer outreach workers and supervisors, will conduct the tests alongside healthcare professionals.

## **C. Accelerating ART initiation.**

The National HIV and AIDS Strategy calls for accelerating the pace of rapid ART initiation, given its crucial role in enhancing health outcomes and the quality of life for PLHIV. Universal access to rapid ART, irrespective of age, sex, or gender, should ideally be granted immediately after an HIV diagnosis has been confirmed. However, a notable gap in service delivery exists at present, as ART initiation can take from two days up to an entire week. This delay undermines the core objective of the strategy - initiation of early treatment, which is integral not only to HIV prevention efforts but also to enhance productivity among PLHIV. By adhering to WHO-recommended 'test and treat' regimens and ensuring the management of advanced HIV disease, treatment effectiveness can be improved and complications minimized. Furthermore, comprehensive support should be available to help individuals navigate the treatment cascade, from initiating care to monitoring CD4, viral load levels and side effects, and diagnosing comorbidities and coinfections. By prioritizing the management of HIV in this manner, better health outcomes can be promoted, transmission rates reduced, and progress made toward ending the HIV epidemic.

## **D. Strengthening Integrated, People-Centric Services:**

Break down silos of HIV interventions to build stronger institutions that improve the availability of drugs, equipment, human resources, data, labs, and funding. Strengthen the government's capacity to sustainably deliver high-quality HIV services, increase coverage, enhance service quality, and ensure affordability. Boost HIV and Primary Health Care services to protect vulnerable individuals, address comorbidities, fulfil holistic needs, and promote overall health and well-being. Develop the capacity of the health service providers and recipients so Universal Health Coverage addresses HIV by default government support.

## **E. Enhancing Focus on Programmatic Transition and Financial Sustainability:**

Prioritize programmatic and financial sustainability, ensuring progress can withstand challenges and maintain momentum. Bangladesh has made significant progress in healthcare and health-related millennium development goals, keeping a low national HIV prevalence with a concentrated epidemic among the KPs. Historically, the HIV programme in Bangladesh has relied on external funding from various sources, including government donors, development banks, UN agencies, charities, and global programme partnerships, alongside the Bangladesh government's HNPSP.

With recent GDP growth and substantial poverty reduction, external funding is anticipated to gradually decrease, transferring the responsibility for HIV service delivery and prevention efforts to the Government of Bangladesh. As a lower or middle-income country with a low disease burden,

Bangladesh must prioritize transition preparedness, which entails robust transition planning, addressing challenges in grant and programme design, increasing focus on intervention sustainability for KPs, and accelerating co-financing for all key interventions.

The HIV epidemic presents unique challenges, such as maintaining political will and investment, integrating HIV into the health system, coordinating multi-sector partnerships, relying on external funding for the HIV health workforce, governance challenges, policy barriers to effective implementation, and stigma discrimination. As a result, well-organized transition planning with the highest level of stakeholder engagement is crucial. Any impromptu or abrupt transition might jeopardize long-term sustainability and undermine the success and best practices achieved over time. Therefore, the National HIV and AIDS Strategy 2024-2028 emphasizes an enhanced focus on programmatic transition and financial sustainability to ensure the continued progress and effectiveness of the HIV programme in Bangladesh.

Addressing the challenges of transition and sustainability requires multi-sector political will, engagement of affected communities, and sustainable financing. Key considerations include broadening HIV leadership and ownership, strategically integrating HIV functions into the broader health system, embedding civil society in governance structures, raising attention to public financial management, and advocating for policy changes to reduce service barriers.

## **F. Strengthening the Role of Communities Living with and Affected by HIV:**

Developing a systematic approach to support the growth and integration of community health systems is crucial in combating HIV and AIDS while fostering resilience and sustainability. Strengthening the role and voice of communities impacted by HIV and AIDS and emphasizing community engagement can address barriers to effective participation and leadership, placing the most affected communities at the centre of national HIV programmes.

Prioritizing the empowerment of communities living with and affected by HIV and AIDS is essential for a successful National HIV and AIDS Strategy. By focusing on community-led organizations, meaningful change can be driven through improved health and human rights outcomes for those affected by HIV and AIDS.

Empowering affected communities ensures an inclusive, targeted, and effective response to the epidemic. Community-led organizations, with their unique understanding of constituents' specific needs, can develop tailored strategies and implement culturally sensitive programmes. Furthermore, these organizations can monitor policies, practices, and service delivery while advocating for improved access to healthcare, human rights protection, and social justice.

Emphasizing community involvement and giving a stronger voice to those affected by HIV and AIDS can lead to numerous positive outcomes, such as increased data quality, improved health governance, expanded service reach, and a more just and equitable society. This approach will help accelerate the uptake of HIV prevention, treatment, and support services, ensuring that “no one is left behind” in the fight against HIV and AIDS.

## G. Strengthening Efforts to Tackle Inequities, Human Rights, and Gender-Related Barriers:

Enhancing efforts to address inequities, human rights, and gender-related barriers is a top priority for preventing HIV among KPs in Bangladesh. High-risk behaviour-related criminalization disproportionately affects marginalized groups, including women, and is often applied without considering up-to-date HIV-related science.<sup>37</sup> Fear of prosecution may deter people from seeking testing, treatment, and disclosing their HIV status, undermining prevention efforts.<sup>38</sup> International human rights bodies and experts hold that HIV criminalisation violates human rights, such as the rights to health, privacy, equality, and non-discrimination.

People who use and inject drugs are at the highest risk of acquiring HIV, yet they remain marginalised and unable to access health and social services. Punitive drug control laws, policies, and law enforcement practices have been identified as significant obstacles to healthcare access.<sup>39</sup> Adopting a rights-based approach to drug policy, including decriminalising drug use and possession for personal use, can reduce stigma and discrimination and improve access to health care, harm reduction, and legal services.<sup>40</sup>

In 2019, the risk of acquiring HIV was significantly higher for PWIDs (29 times higher<sup>41</sup>), gay men and other MSM (26 times higher<sup>42</sup>), and transgender and gender-diverse people (13 times higher<sup>43</sup>) compared to the rest of the adult population. These groups experience significant levels of stigma, discrimination, and violence, which hinder the availability, access, and uptake of HIV prevention, testing, treatment, care, and support services. In many cases, these barriers are compounded by criminalisation, such as the criminalisation of homosexuality and drug use in Bangladesh.

FSWs in 2019 had a 30 times greater risk of acquiring HIV than the general female population.<sup>44</sup> The criminalisation of sex work has been proven to impede access to health care services, including effective HIV prevention, treatment, care, and support services. Decriminalising sex work could avert 33% to 46% of HIV infections among sex workers and their clients over ten years.<sup>45</sup>

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<sup>37</sup> UNAIDS, “HIV Criminalization — Human Rights Fact Sheet Series 2021” (UNAIDS, n.d.), 1, [https://www.unaids.org/sites/default/files/media\\_asset/01-hiv-human-rights-factsheet-criminalization\\_en.pdf](https://www.unaids.org/sites/default/files/media_asset/01-hiv-human-rights-factsheet-criminalization_en.pdf).

<sup>38</sup> UNAIDS, “HIV Criminalization — Human Rights Fact Sheet Series 2021.”

<sup>39</sup> UNAIDS, “HIV and People Who Use Drugs — Human Rights Fact Sheet Series 2021” (UNAIDS, 2021), <https://www.unaids.org/en/resources/documents/2021/02-hiv-human-rights-factsheet-people-who-use-drugs>.

<sup>40</sup> Ibid.

<sup>41</sup> Ibid.

<sup>42</sup> UNAIDS, “HIV and Gay Men and Other Men Who Have Sex with Men — Human Rights Fact Sheet Series 2021” (UNAIDS, 2021), [https://www.unaids.org/sites/default/files/media\\_asset/03-hiv-human-rights-factsheet-gay-men\\_en.pdf](https://www.unaids.org/sites/default/files/media_asset/03-hiv-human-rights-factsheet-gay-men_en.pdf).

<sup>43</sup> UNAIDS, “HIV and Transgender and Other Gender-Diverse People — Human Rights Fact Sheet Series 2021” (UNAIDS, n.d.), <https://www.unaids.org/en/resources/documents/2021/04-hiv-human-rights-factsheet-transgender-gender-diverse>.

<sup>44</sup> UNAIDS, “HIV and Sex Work — Human Rights Fact Sheet Series 2021” (UNAIDS, n.d.), <https://www.unaids.org/en/resources/documents/2021/05-hiv-human-rights-factsheet-sex-work>.

<sup>45</sup> Ibid.

To effectively address these challenges, this strategy prioritises protecting human rights and reducing stigma and discrimination. This includes ensuring access to HIV prevention, testing, and treatment services for KPs and creating an enabling social and legal environment that supports safe and voluntary disclosure of HIV, free of stigma and discrimination.

The Infectious Diseases (Prevention, Control, and Eradication) Act of 2018 in Bangladesh is a cornerstone legal initiative in this fight.<sup>46</sup> It not only prioritises the prevention and control of these infectious diseases, but it also aims to eradicate them, including HIV and AIDS, through comprehensive public health strategies and policies. Moreover, the Act emphasises the importance of non-discrimination, respect for human rights, and patient confidentiality, key aspects frequently compromised in HIV and AIDS management.

In addition, efforts should be made to reform policies and laws to protect the rights of KPs and PLHIV and increase knowledge and awareness of HIV among public health personnel.

## **H. Emphasizing Decision-Making:**

HIV responses are frequently hindered by data gaps, such as information about incidence, prevalence of infections, STI surveillance, size estimates of vulnerable populations, disaggregated gender and age data, and qualitative data on social factors influencing HIV vulnerability and access to services. In Bangladesh, these data gaps can limit the effectiveness of HIV and AIDS responses, hindering efforts to limit the spread of the virus and improve the well-being of those affected by it. Therefore, investing in robust data collection and analysis becomes paramount, enabling policy-makers, government officials, development partners, donors, programme implementers, and the community to make informed, data-driven decisions. The forthcoming NSP timeline will seek to address the following prioritized areas.

### **Enhancing Information Flow and Data Interoperability**

Utilizing software like spectrum and AEM, Bangladesh can develop nationally endorsed estimates of PLHIV, which can be disaggregated by age, sex, administrative unit, and risk profile. This information can inform investment priorities and ensure no one is left behind. These data are even more crucial for a densely populated country like Bangladesh, where the risks and effects of the disease can vary dramatically across different populations and regions.

Improvements in programme monitoring and reporting systems aligning with District Health Information System 2 (DHIS2) can enhance the flow of information and initiatives to improve data system interoperability. Routine data systems that enable longitudinal monitoring of individuals can facilitate service delivery and measurement of outcomes, aligning with WHO guidelines.

### **Integration of Monitoring, Reporting, and Evaluating Performance**

Monitoring, reporting, and evaluating performance linked to investments in the national HIV and AIDS response should be integrated into national systems rather than operating in parallel. As community and

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<sup>46</sup> “সংক্রামক রোগ (প্রতিরোধ, নিয়ন্ত্রণ ও নির্মূল) আইন, ২০১৮,” accessed May 22, 2023, <http://bdlaws.minlaw.gov.bd/act-details-1274.html?lang=en>.

national health data systems are integrated, the data privacy needs of priority populations should be emphasized, acknowledging the sensitivity of the data involved.

### **Prioritized Strategic Information**

Strategic information investments can maximize impact and should be prioritized. These investments include periodic cascade data reviews, HIV case surveillance, detailed HIV expenditure analysis, bio-behavioural surveys, population size estimates among key and vulnerable populations, and monitoring HIV prevention programmes. These components provide a comprehensive picture of the state of HIV and AIDS in the country, enabling effective responses and targeted interventions.

### **Data Quality and HIV Drug Resistance Surveillance**

Periodic data quality assessments and HIV drug resistance surveillance are also recommended to ensure data reliability and assess the effectiveness of ART, respectively. Bangladesh, a WHO HIVDR focus country, should pay particular attention to periodic HIVDR surveys.

### **Assessments related to HIV: Stigma Index, Legal, Gender, and Human Rights**

Assessments related to the HIV Stigma Index, as well as legal, gender, and human rights, can provide crucial information about the societal barriers to HIV prevention and treatment. Community-led monitoring can also provide country-level data about the quality, accessibility, acceptability, and affordability of HIV services.

Prioritizing data-driven decision-making in the national strategic plan for HIV and AIDS Response (2024-2028) in Bangladesh can significantly improve the country's HIV response. By leveraging the power of data and strategic information, Bangladesh can better target its interventions, monitor its progress, and ultimately reduce the impact of HIV and AIDS on its population.

## **I. Prioritisation**

The national HIV and AIDS strategy for Bangladesh will adopt a comprehensive and well-defined approach to prioritisation, ensuring that the most urgent needs and challenges are addressed, and resources are allocated efficiently to achieve the goal of ending AIDS as a public health threat by 2030. Several challenges necessitate an emphasis on prioritization in the national strategy, such as the lack of a standard definition and understanding of prioritisation, data gaps, political sensitivities, misalignment between donor and country priorities, and limitations of existing tools and approaches. Moreover, there is a need for improved stakeholder engagement, particularly involving key and vulnerable populations, community groups, and networks.

Prioritisation is vital to ensuring equity in providing services and achieving global and national goals. Without proper prioritisation, we risk failing to deliver services to those who need them the most and, ultimately, not reaching the ambitious target of ending AIDS as a public health threat by 2030. To address these concerns, the national strategy proposes the following evidence-based prioritisation process:

Firstly, the strategy should prioritise investments in high-impact, cost-effective interventions, including new tools and innovations. This maximises the impact of resources and drives progress toward achieving the global and national HIV and AIDS goals.

Geographic prioritisation is another crucial aspect of the strategy. By identifying high-, medium-, and low-priority areas based on disease burden, vulnerability, and access to services, resources can be allocated more effectively to address the most pressing needs.

Furthermore, prioritisation should also target specific populations, focusing on those most at risk of HIV infection or experiencing barriers to accessing care. This approach should be informed by a combination of epidemiological data, geographic prioritisation, behavioural studies, and other relevant factors.

Secondly, the strategy must emphasise equity and focus on addressing the needs of the most vulnerable populations. This includes using robust disaggregated data to ensure that “no one is left behind” and tailoring interventions to different groups' specific needs and contexts.

Thirdly, the strategy must ensure alignment with other donor and country priorities and processes. This will facilitate better coordination and synergies in the HIV and AIDS response and help avoid duplication of efforts.

Lastly, the strategy should prioritise addressing significant gaps in the HIV care cascade, new policy opportunities, and sustainability considerations. This includes focusing resources on different cascade entry points, investing in innovative and DSD models, and ensuring that domestic funding and systems strengthening are prioritized as part of a sustainability approach.

# Strategy Framework

The National HIV and AIDS Strategy for 2024-2028 seeks to address the unique challenges faced by Bangladesh in the previous efforts to end the HIV epidemic. By focusing on targeted, evidence-based interventions and strengthening health systems and community engagement, this strategy aims to significantly reduce new HIV infections and AIDS-related deaths while improving the quality of life for those affected by HIV by 2030.

## A. Goal

The strategy's overarching goal is to significantly reduce new HIV infections and AIDS-related deaths, with a long-term aim of ending the HIV epidemic as a public health threat by 2030.

## B. Specific Objectives

1. To prevent new HIV infections by expanding programme coverage by implementing comprehensive, targeted interventions, providing age, gender, and human-rights-sensitive services, and fostering active community involvement in promoting public health.  
*This objective is linked to Result Areas 1, 4, 5, 6, 7 and 8 of the Global AIDS Strategy, 2021-2026*
2. To ensure innovative, effective, differentiated, and ethical HIV testing and case-finding approaches are scaled up across the country.  
*This objective is linked to Result Areas 2, 3, 4, 5, 6, 7 and 8 of the Global AIDS Strategy, 2021-2026*
3. To provide universal access to treatment, care, and support services for PLHIV and AIDS.  
*This objective is linked to Result Areas 2, 3, 5, 6, 7 and 8 of the Global AIDS Strategy, 2021-2026*
4. To establish resilient, sustainable health systems and strengthen community systems for an integrated, people-centric HIV and AIDS response in Bangladesh through the universal health coverage approach.  
*This objective is linked to Result Areas 8, 9 and 10 of the Global AIDS Strategy, 2021-2026*
5. To strengthen strategic information systems and research for an evidence-based response.  
*This objective is linked to Result Area 9 of the Global AIDS Strategy, 2021-2026*

**All of the objectives have considered the cross-cutting areas of leadership, ownership, advocacy, partnerships, multi-sectorality, collaboration, evidence and innovation, stigma, discrimination, human rights and gender, and geographical setting**

## C. Strategies and Priority Actions to Achieve the Objectives

The strategies against each objective and the priority actions to achieve objectives are listed below:

<p><b>Objective 1:</b>  <b>To prevent new HIV infections by expanding programme coverage by implementing comprehensive, targeted interventions; providing age, gender, and human-rights-sensitive services; and fostering active community involvement in promoting public health.</b></p>	
<p><b>Strategies</b></p>	
<p><b>1.1</b></p>	<p><b>Ensure comprehensive HIV prevention services are accessible to key and vulnerable populations, their clients, and other sexual and needle-sharing partners.</b></p>
1.1.1	Increase access to and uptake of comprehensive HIV prevention services for MSM and MSW and their sexual partners in case of both commercial and non-commercial sex acts.
1.1.2	Increase access to and uptake of comprehensive HIV prevention services for female sex workers, their clients, and other sexual partners.
1.1.3	Increase access to and uptake of comprehensive HIV prevention services for transgender people (who are sex workers), their clients, and other sexual partners.
1.1.4	Increase access to and uptake of comprehensive HIV prevention services for PUD (injecting and non-injecting) and their sexual partners.
1.1.5	Standardize and extend HIV, Tuberculosis, and Hepatitis services in prisons and other closed settings.
1.1.6	Implement a comprehensive prevention HIV service package for migrant workers and sexual partners.
1.1.7	Scale up integrated HIV service package for FDMN.
<p><b>1.2</b></p>	<p><b>Reinforce HIV and STI prevention and other sexual and reproductive health (SRH) services aiming for the triple elimination of vertical transmission of HIV, hepatitis B, and syphilis.</b></p>
1.2.1	Ensure all pregnant women get HIV/Hep B/Hep C/Syphilis testing from ANC clinics, including private health facilities.
1.2.2	Ensure that all pregnant women who are living with HIV are on ART.
1.2.3	Strengthen the EMTCT of HIV, syphilis, perinatal hepatitis b, and congenital chagas disease programme in coordination with the Directorate General of Family Planning.
1.2.4	Strengthen linkage from screening facilities to confirmatory centres and subsequently to treatment centres.
1.2.5	Expand early infant diagnosis (EID) for all HIV-exposed infants.
<p><b>1.3</b></p>	<p><b>Reduction of risk behaviours and provision of services for populations at emerging risk and vulnerable groups through awareness raising and evidence-based interventions to link them to integrated STI, HIV (including PrEP), and SRH services under Universal Health Coverage</b></p>
<p><b>1.4</b></p>	<p><b>Promote infection prevention protocols and post-exposure prophylaxis measures for health service providers, laboratory staff, survivors of gender-based violence, etc.</b></p>
<p><b>1.5</b></p>	<p><b>Optimize behaviour change communication strategies to expand case detection and minimize risk behaviours in the general population, emphasizing adolescents and youth while connecting them to SRH and HTS.</b></p>
<p><b>1.6</b></p>	<p><b>Strengthen the empowerment of KP communities and eliminate human rights-related barriers</b></p>

**and gender based violence to ensure equitable access to health services, including HIV prevention for all KPs.**

### **Priority actions to achieve the objective:**

- a) **Strengthen and update population size estimations and field epidemiological intelligence for coverage expansion and saturation:** Strengthening and updating population size estimations and field epidemiological intelligence at the most granular level is a priority activity for expanding and saturating coverage. This requires enhancing capacity building, facilitating community engagement, strengthening institutional networking, and improving reporting and use of field epidemiological intelligence.

Capacity building involves regular training on new methodologies, tools, and techniques for data collection, analysis, and reporting. Facilitating community engagement consists of involving community members in data collection, analysis, and interpretation. Strengthening institutional networking involves fostering partnerships and collaboration among institutions engaged in programmatic mapping and population size estimation activities.

Improving reporting and use of field epidemiological intelligence involves making informed decisions about initiating, scaling up, and modifying interventions. Data collection, analysis, and reporting quality and timeliness will be improved using modern technology. Programmatic mapping and population size estimation activities will be strengthened by prioritising these activities, leading to more accurate and relevant information. This will help expand and saturate coverage by making informed intervention decisions.

- b) **Develop national operational guidelines to i) initiate PrEP, especially for KPs and serodiscordant couples; ii) enhance PEP among health service providers, laboratory staff, and survivors of GBV:** Bangladesh must implement an effective PrEP programme tailored to the unique needs of MSM, transgender individuals, FSW, and serodiscordant couples. First, learn from icddr,b's pilot study on PrEP among MSM and conduct further assessments for other KPs. Develop national guidelines and protocols for PrEP implementation, considering local health infrastructure, cultural norms, and HIV prevalence. Similarly, the PEP regimen needs to be ensured in health care and laboratory settings and for survivors of gender-based violence based on widely endorsed protocols. In addition, infection prevention protocols among and training of community-, health facility- and lab-based service providers need to be promoted to increase their understanding and address their approaches to managing HIV among PLHIV, KPs and survivors of GBV.

Capacity building is crucial; training healthcare providers on PrEP and PEP prescription, monitoring, counselling, and addressing concerns is needed. Establishing a network of PrEP and PEP providers, including in government hospitals and community-based DICs/outlets, is essential to ensure access for KPs and GBV survivors. Implement targeted campaigns to raise awareness, address stigma, and encourage PrEP and PEP uptake using culturally appropriate messaging.

Continuously monitor and evaluate PrEP programme effectiveness, assessing adherence and identifying areas for improvement or expansion. Prioritize data collection and analysis on PrEP uptake, retention, adherence, and programme impact on HIV incidence. Finally, review experiences

of other countries implementing PrEP programmes and adapt successful strategies to Bangladesh's context, ensuring the programme remains relevant and effective for KPs.

- c) **Ensure minimum service package of KPs:** The minimum service package for KPs focuses on providing comprehensive HIV prevention, testing, and care services tailored to the unique needs of MSM, sex workers, transgender people, and PUD. Common services for all KPs include targeted condom and lubricant programmes, PrEP interventions, HIV prevention communication and demand creation initiatives (including through virtual approaches), community empowerment activities, SRH services, and efforts to remove human rights-related barriers.

In addition to these common services, each KP group should receive specialized support tailored to their specific needs. Services such as needle and syringe programmes, overdose prevention and management, and OST are provided for PUD. These interventions aim to reduce the risk of HIV transmission associated with drug use and address the health needs of this population. Needle and syringe programmes involve procuring and distributing safe injecting equipment, basic healthcare, and referrals to behavioural interventions and HIV testing. Overdose prevention and management include education on minimizing overdose risk and the procurement of naloxone for first responders. OST programmes involve the procurement and distribution of opioid substitutes, the development of protocols and public-health-friendly policies, and the training of service providers.

By employing strategies such as peer outreach, virtual interventions, and targeted distribution methods, the package aims to reach and engage individuals from diverse backgrounds effectively. Through this tailored approach, the Essential Service Package for KPs creates a supportive environment that addresses the distinct challenges these groups face, promoting health equity and reducing the risk of HIV transmission.

Table 3: Minimum Interventions for KPs

Minimum Interventions	*Applicable for			
	MSM	Transgender People	FSW	PUD
<b>a) Behavioural interventions</b>				
Behaviour change communications activities and information, education, and communication activities by peer education	✓	✓	✓	✓
<b>b) Health interventions</b>				
Prevention of HIV, STIs, and viral hepatitis	✓	✓	✓	✓
Condoms and lubricant programming	✓	✓	✓	✓
Needle and syringe programme				✓
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 viral hepatitis B and C	✓	✓	✓	✓
Hepatitis B vaccination	✓	✓	✓	✓
Addressing chemsex	✓	✓	✓	✓

Minimum Interventions	*Applicable for			
	MSM	Transgender People	FSW	PUD
<b>c) Diagnosis and treatment</b>				
HIV testing and counselling (including HIV self-testing)	✓	✓	✓	✓
HIV care and treatment	✓	✓	✓	✓
STI testing and treatment	✓	✓	✓	✓
Prevention, screening, diagnosis, and treatment of Tuberculosis	✓	✓	✓	✓
Hepatitis B and C testing and treatment	✓	✓	✓	✓
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	✓	✓	✓	✓
<b>d) Enabling interventions</b>				
Removing punitive laws, policies, and practices	✓	✓	✓	✓
Reducing stigma and discrimination	✓	✓	✓	✓
Community empowerment	✓	✓	✓	✓
Addressing gender-based violence	✓	✓	✓	✓

\* Note: Inclusive of those who are in prison settings

- d) **Expand and intensify the coverage of KP interventions:** Throughout the five-year timeline of Bangladesh's National HIV Strategy, the country aspires to broaden service delivery platforms for HIV prevention, expand prevention options, scale up existing methods, and anticipate new technologies. The objective is to ensure that 95% of people at risk of HIV use appropriate, prioritized, and effective combination prevention methods. Detailed granular-level HIV prevention targets for KPs are as follows:

Table 4: Coverage Threshold

Variables	KPs				
	Sex workers	MSM	PWID	Transgender people	Prisoners and others in closed settings

Condoms/lubricant use at last sex by those not taking PrEP with a non-regular partner whose HIV viral load status is not known to be undetectable (includes those who are known to be HIV-negative)	--	95%	95%	95%	--
Condom/lubricant use at last sex with a client or non-regular partner	90%	--	--	--	90%
PrEP use (by risk category)					
▪ Very high	80%	50%	15%	50%	15%
▪ High	15%	15%	5%	15%	5%
▪ Moderate and low	0%	0%	0%	0%	0%
Sterile needles and syringes	--	--	90%	--	90%
Opioid substitution therapy among people who are opioid dependent	--	--	50%	--	--
STI screening and treatment	80%	80%	--	80%	--
Regular access to the appropriate health system or community-led services	90%	90%	90%	90%	100%
Access to post-exposure prophylaxis as part of the package of risk assessment and support	90%	90%	90%	90%	90%

- e) **Special effort to expand programme coverage among the clients, spouses and sex partners of sex workers; and spouses and sex partners of PUD and MSM:** Expanding HIV programme coverage among the clients of sex workers (female, male and transgender) and spouses and sex partners of PUD and MSM is crucial; but unfortunately, these groups are often ignored and overlooked in programme design. They are typically grouped with the general population, and their unique needs and characteristics are not considered enough.

To address this issue, it's necessary to assess the vulnerability of these populations within the national HIV and AIDS strategy framework. This means designing a tailored service package that includes peer education, customized HIV awareness, virtual and social media approaches, condom and lubricant distribution, HIV testing, PrEP and enrollment into the ART programme if anyone tests positive.

It's essential to maintain high ethical standards during the implementation of this programme. Confidentiality and anonymity should be guaranteed to protect the privacy and safety of the clients, spouses and sex partners of sex workers, and spouses and sex partners of PUD and MSM. This approach will ensure the programme's success and the target population's safety and well-being.

- f) **Standardize the interventions in prisons and other closed settings through a mix of service delivery models:** HIV prevalence among inmates in some Asian settings is higher than among other KPs. The prevalence is exceptionally high among those awaiting trial compared to convicted inmates. The NASC, in collaboration with UNODC, has conducted a qualitative assessment of the perceived need for interventions, which should be shared widely. The NASC will work to develop standardized interventions based on the assessment findings and lessons learned from nine Bangladeshi prisons. These interventions will include peer education, OST, HIV testing, and combined treatment for HIV, AIDS, hepatitis, and tuberculosis in prisons and closed settings.

To ensure comprehensive coverage, the programme will implement a combination of facility-based and outreach services in prisons nationwide. Facility settings will focus on counselling, testing, and treatment for an integrated HIV, tuberculosis, and hepatitis package while inmates are in prison, utilizing existing health systems whenever possible. The outreach arm of the programme will ensure service provision for released inmates, either directly or through referrals and linkages.

- g) **Redefine and expand coverage among the Migrant and FDMN:** In the global AIDS response, migrants are often identified as a "key population" for HIV prevention activities. However, targeting all migrants may not sufficiently address their needs and could contribute to stigma. To effectively reduce HIV vulnerability among migrants, the NASC must redefine this relationship, focusing on those at increased risk due to mobility, and collaborate with relevant ministries and departments such as the Ministry of Expatriates' Welfare and Overseas Employment and Bureau of Manpower, Employment and Training, as well as NGOs and CBOs.

A standard package of HIV services should include evidence-based pre-departure interventions, such as orientation sessions covering safe sex practices, HIV testing, and healthcare services in host countries. Culturally sensitive IEC campaigns can raise awareness about HIV prevention, transmission, and treatment among migrants and their families. Furthermore, promoting condom use through targeted IEC campaigns is crucial. For returnee migrants, evidence-based and migrant-friendly interventions should be designed.

Post-arrival interventions should provide voluntary, confidential, and accessible HIV testing and counselling services in destination countries. Collaboration with destination country stakeholders is essential for implementing, monitoring, and evaluating the prevention programme. Improving healthcare services for migrant workers includes enhancing access to HIV testing, counselling, and treatment. ART with support networks and psychosocial support services should be established for migrants living with HIV in Bangladesh and destination countries.

A comprehensive HIV prevention programme for overseas migrant workers requires a combination of pre-departure and post-arrival interventions. Prioritizing efforts to address stigma and discrimination associated with HIV among migrants and within host communities is essential. Initiatives encouraging open dialogue and fostering understanding can create a more inclusive environment. Advocacy is crucial to ensure an inclusive environment from the community to the policy level for prevention and treatment.

In the case of FDMN, the current HIV services need to be scaled to include testing and treatment services within their communities using an integrated approach through health and SRHR services.

- h) **Develop and scale up sustainable models of virtual intervention for KP:** In the last decade, Bangladesh experienced a notable rise in internet access, with a 38.9% penetration rate in 2023, fueling a surge in social media usage. As of January 2022, 52 million Bangladeshis, or 30.1% of the population, used Facebook, predominantly young men aged 18-24. The country also ranks among the top three for Facebook user growth. WhatsApp has become the leading communication platform, with 40 million users. This increased access impacts KPs, such as MSM, sex workers, transgender and youth, who use online platforms for socializing, finding partners, and forming communities. However, they often lack risk perception and accurate HIV/STI information.

Virtual interventions can help programmes reach more people, connect with those who prefer online services, promote services through social media and search engines, provide convenient and affordable options, improve service efficiency, and mitigate disruptions caused by health emergencies like COVID-19.

Drawing from a pilot conducted by Save the Children and icddr,<sup>b</sup> and a study conducted by UNAIDS, the current phase of the NSP aims to develop and scale sustainable models that strengthen HIV prevention efforts and improve access to HIV testing among key and vulnerable populations seeking partners on virtual platforms. This includes high-risk groups, at-risk adolescents, and men and women with high-risk behaviours. The National Toll-Free Health Call Centre-16263 can connect virtual platforms with the NASC's services, ensuring target populations benefit from prevention efforts and promoting a healthier, more informed society.

- i) **Maintain and augment the behaviour change communications for the general population:** With over 99.9% of the adult population free of HIV, the NASC efforts will launch a comprehensive HIV awareness campaign to maintain and enhance behaviour change communications for the general population. This campaign will play a pivotal role in reducing stigma and discrimination against KPs and PLHIV, as well as keeping the population HIV-negative. The campaign will incorporate a mix of multimedia and outdoor activities to reach as many people as possible.

Social media will be a cornerstone of this initiative, and the campaign will leverage various social media platforms to maximize outreach in a cost-efficient manner. Moreover, the NASC efforts will explore the possibility of setting up a national toll-free AIDS helpline to provide information and active support to those in need. Community-led initiatives to promote better access to information and services will also be supported by the NASC.

- j) **Sustain focus on adolescent and youth population:** The NASC will prioritize the adolescent and youth population through targeted interventions using both physical and virtual media, such as the adolescence education programme, red ribbon clubs, and out-of-school youth programmes. A focused initiative will promote safe behaviour practices through a peer-led programme, retrieving previous best practices, such as HIV, in the national textbook curriculum and providing youth-friendly health services to enhance access and uptake of prevention, testing, and treatment services in line with national laws, policies, and context.

Tailored age- and gender-appropriate contexts will be mainstreamed at each service delivery point to ensure maximum impact. Investing in the adolescent and youth population is crucial to empower them with the knowledge and tools they need to stay safe and prevent the spread of HIV.

- k) **Support EMTCT of HIV, syphilis, perinatal hepatitis B, and congenital Chagas disease under the leadership of the DGHS:** Through the joint efforts of all relevant departments under the DGHS and collaboration with the directorate general of family planning, all pregnant women can avail HIV, syphilis, perinatal hepatitis B, and congenital Chagas disease testing from ANC clinics, including private health facilities. Collaborative efforts will ensure that all pregnant women who are living with HIV are on ART and HIV-exposed infants are identified early to reduce mortality.
  
- l) **Strengthen KP community empowerment and eliminate human rights-related barriers:** To prevent HIV in a vertical approach is not meaningful as those most at risk face many other problems that take precedence over many issues, including HIV. Thus, only through empowerment and access to services can KP communities attain the confidence to support prevention requirements such as condom use and PrEP. Therefore, equitable access to health and other services, including for all PLHIV and KPs, is vital and directly links to their fundamental human rights.

## Objective 2:

To ensure innovative, effective, ethical and differentiated HIV testing and case-finding approaches are scaled up across the country

### Strategies:

- |     |                                                                                                                                                                                                                             |
|-----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 2.1 | Expand facility-based testing for key and general populations and promote provider-initiated testing and counselling in public and private antenatal care, tuberculosis, hepatitis C, hepatitis B, and STI service centres. |
| 2.2 | Expand community-led testing for KPs by utilizing both trained and supervised lay providers and health professionals to conduct rapid HIV tests.                                                                            |
| 2.3 | Expand index testing, online to offline, and social risk network referral testing, complying with the three-test algorithm.                                                                                                 |
| 2.4 | Introduce community-based HIV self-testing among KPs.                                                                                                                                                                       |

### Priority actions to achieve the objective:

- a) **Appropriately adopt evidence-based, cutting-edge technologies to complement current HIV testing models:** The government will persist in adopting innovative, evidence-based testing technologies and strategies to achieve the global goal of ending HIV by 2030. This includes fostering evidence generation on novel testing methods, such as HIV self-testing and using combo strip tests, in various locations and demographic settings to enable well-informed decision-making and implementation processes.
- b) **Maintain the existing models of HTS and expand through strategic scale-up:** Presently, HIV counselling and testing services are offered through various models, including government hospitals, DICs/outlets, and community-based screenings during outreach programmes. These approaches have significantly increased the accessibility of HTS. Over the next five years, the focus will be on maintaining and strategically scaling these models in public and private sectors, aligning with location and population contexts, and employing facility-integrated, community-led models and self-testing.
- c) **Develop and launch tailored communication campaigns focusing on risk awareness and promoting HIV testing adoption:** The national HIV programme will bolster HIV testing models with customized communication campaigns adapted to the specific epidemiological contexts of districts and populations to increase self-risk perception and demand generation. Particular emphasis will be placed on adolescents and youth, leveraging offline (e.g., adolescent education programmes, youth clubs) and online virtual network platforms.
- d) **Complement the current HIV testing models with efficient methods for active case detection to facilitate early detection:** Over the next five years, the national programme will improve outcomes from current models by focusing on efficient approaches such as social-network-based HIV testing, index testing, and repeat screening/testing among discordant couples to promote early detection of undiagnosed infections. These effective methods for improving case findings and closing the gap in the first 95 will be implemented within a data confidentiality, protection, and sharing ethical framework.

- e) **Develop guidelines, SOPs, training modules, etc.:** National protocols are required (especially in case of various innovations) to ensure quality outputs and standard recording, reporting, monitoring and follow-up.

<b>Objective 3:</b>	
<b>To provide universal access to treatment, care, and support services for PLHIV and AIDS</b>	
<b>Strategies</b>	
<b>3.1</b>	<b>Reduce mortality and morbidity among PLHIV through early detection and treatment by strengthening government, non-government, and private sector facilities.</b>
3.1.1	Maintain existing care, support, and treatment services models and expand further in a sustainable manner.
3.1.2	Continue provisions of high-quality ART drug through differentiated service delivery models, including multi-month dispensing, community-led adherence monitoring, etc., improving access and retention to care.
3.1.3	Focus on rapid ART initiation (the same day after a confirmed HIV diagnosis) for all people irrespective of age, sex or gender and advanced HIV disease management augmenting quality of care.
3.1.4	Address underlying causes of lost-to-follow-up at all levels.
3.1.5	Optimize the uses of public sector laboratories for viral load measurements.
3.1.6	Update the treatment and viral load guidelines periodically, update all service providers, and continue the promotion of U=U.
3.1.7	Bring efficiencies and improve linkages through one-stop service delivery models at public hospitals.
<b>3.2</b>	<b>Ensure the capacity of service providers in government, non-government, and private sectors to provide age, gender, and human rights-sensitive out-patient and in-patient medical management for PLHIV and KPs.</b>
<b>3.3</b>	<b>Ensure functional systems for related policy adoption, linkages, and updates, including for more robust engagement of communities in supporting the treatment and care cascade.</b>
<b>3.4</b>	<b>A comprehensive approach to the community support system is adopted to remove barriers to accessing services and strengthen treatment adherence, care, and support for PLHIV, including children affected by HIV and AIDS and orphans and vulnerable children.</b>

### Priority actions to achieve the objective:

- a) **Expand ART service sites:** increase the number of ART service sites in both priority and other districts to facilitate early detection and treatment.
- b) **Ensure TLD-based regimen supply:** Maintain a continuous supply chain for TLD-based regimen, ensuring sustainable, high-quality treatment options.
- c) **Rapid ART initiation:** Prioritize the same-day initiation of ART post-confirmed HIV diagnosis, irrespective of age, sex, or gender, following WHO guidelines.

- d) **Monitoring and follow-up:** Establish a robust mechanism for monitoring ART adherence, employing peer networks and community outreach to locate and re-engage individuals lost to follow-up proactively.
- e) **Training in co-infection management:** To ensure comprehensive care, incorporate training modules on managing co-infections like TB and viral hepatitis B and C in ART centres.
- f) **Human rights sensitisation:** Conduct training for medical staff in understanding age, gender, and human rights sensitivities, especially while treating PLHIV and KPs.
- g) **Integrated ART services:** Ensure that all government health facilities are equipped and staffed for integrated ART services, including establishing more ART refill centres across varied locations.
- h) **Community engagement:** Strengthen mechanisms for community involvement in policy-making and implementation, particularly concerning treatment and care cascades.
- i) **Viral load testing:** Expand viral load testing capabilities to all healthcare facilities equipped with GeneXpert machines, following WHO guidelines for viral suppression monitoring tailored to individual patient needs.
- j) **Treatment side effects monitoring:** Institute standard protocols for vigilant monitoring of treatment side effects and regular clinical assessments, particularly for patients with co-infections or those receiving IPT.

## Objective 4:

To establish resilient, sustainable health systems and strengthen community systems for an integrated, people-centric HIV and AIDS response in Bangladesh through the universal health coverage approach.

### Strategies

#### **4.1 Strengthening the capacity of health actors, institutions, and populations to prepare for and effectively respond to HIV and AIDS while maintaining its essential functions.**

- 4.1.1 Strengthen NAC and TC-NAC for a more functional role in guiding the national HIV response.
- 4.1.2 Strengthen NASC through capacity building and providing appropriate structure, human resources, and other logistics.
- 4.1.3 Conduct stakeholder meetings to coordinate, review and integrate the HIV response across other ministries and departments and with civil society groups.
- 4.1.4 Facilitate the development and implementation of activities and plans in key sectors for strengthened collaboration on HIV prevention, treatment, care, and support.
- 4.1.5 Strengthen human resource capacity across the health and HIV sector to achieve NSP targets by providing high-quality, rights-sensitive services tailored to the unique needs of KPs and those at emerging risk.

#### **4.2 Strengthen the transition and integration of HIV services into government health systems, especially in public health care settings, by establishing functional links for co-infections (e.g., Tuberculosis, Hepatitis, cervical cancer) and non-communicable diseases, including mental health.**

- 4.2.1 Develop capacities in health institutions and engage relevant programmes for strong referral linkages so co-infections and co-morbidities are detected and treated early.
- 4.2.2 Strengthen Tuberculosis preventive therapy

#### **4.3 Strengthen supply chains to ensure medicines, laboratory services, and health products are available when and where these are needed.**

- 4.3.1 Ensure adequate budgetary allocation to purchase HIV-related commodities
- 4.3.2 Ensure zero stock out of HIV commodities at all levels
- 4.3.3 Strengthen the capacity of district and sub-district level HIV service providers to prepare detailed specifications, quantification and forecasting, and budget planning for procurement of HIV-related commodities.
- 4.3.4 Establish multi-year procurement and supply chain management to ensure supplies are available in all health facilities for the general population and KP.
- 4.3.5 Establish internet-based real-time Logistic Management Information System of HIV commodities (HIV antiretroviral drugs, test kits, reagents, needles, syringes, condoms, methadone, etc.) at HIV service centres.

#### **4.4 Ensure quality laboratory and diagnostic services are expanded and available at all levels**

- 4.4.1 Capacity building of laboratory and diagnostic facilities (human resources, budget, infrastructure, logistics, and supplies) at the district and intervention site levels.
- 4.4.2 Optimization use of GeneXpert and PCR machines for viral load test
- 4.4.3 Ensure quality control of HIV testing through quality assurance from the national reference laboratory
- 4.4.4 Coordination with private health facilities and labs to scale up laboratory services and

	quality assurance of the labs
4.4.5	Enhance partnerships between public and private sector actors so programming and services are sustainable and can reach more people.
<b>4.5</b>	<b>Strengthen community systems and community-led HIV programming and help integrate them into national health and social systems.</b>
4.5.1	Build the capacity of CBOs in scaling up outreach services, community-led monitoring, documentation, and advocacy for domestic resource mobilization.
4.5.2	Enhance formal partnerships between community-led and health facility or private service providers, coordinate joint outreach efforts, and implement bi-directional referral mechanisms between health and community-led service delivery points.
4.5.3	Ensure the involvement of community representatives in high-level health advisory boards, governance bodies, oversight committees (including clinic health committees), and other decision-making forums.
4.5.4	Promote the participation of community representatives in national or regional peer-learning initiatives
<b>4.6</b>	<b>Adopt mitigation plans for health and other emergencies, including the COVID-19 pandemic and natural and human-made disasters.</b>

### Priority actions to achieve the objective:

- a) **Allocate domestic resources independently:** Advocate for and secure the investment of domestic resources that are independent of the AIDS programme to foster a more resilient health system. Engage multiple departments, directorates, and ministries within and outside the health sector for a more holistic approach to HIV response.
- b) **Engage multi-sectoral stakeholders:** Involve district and local level government officials, health service providers from the public, private, and NGO sectors, and community representatives in structured discussions centred on the 95-95-95 strategy. Aim to generate positive support and policy suggestions through these consultations.
- c) **Barrier removal:** Work closely with community representatives to review, design, and implement tailored interventions to remove critical barriers such as stigma, discrimination, and violation of human rights. This would facilitate better access to services for various KPs.
- d) **Decentralised management:** Devolve HIV response coordination and supervision responsibilities to district health managers, hospital superintendents, district commissioners, and civil surgeons. This decentralisation will improve local ownership and create an enabling environment to achieve the 95-95-95 targets.
- e) **National reference laboratory:** Establish a national reference laboratory and a divisional network of laboratories. This will be instrumental in the consistent identification and medical management of HIV and co-morbidities, viral load testing, and drug resistance monitoring.
- f) **Quality assurance:** Partner with private health facilities and labs to extend the scope and quality of laboratory services. Develop a quality assurance mechanism derived from the national reference laboratory's standards.
- g) **Legal Literacy and access to justice:** Coordinate with law-enforcing agencies to conduct workshops to promote legal literacy and access to justice for PLHIV and KPs.

- h) **Policy reforms:** Support community-led initiatives to scrutinize and reform existing criminal laws, policies, and practices that obstruct effective HIV responses.
- i) **Mitigation plans:** Develop and adopt mitigation plans, including action protocols for health and other emergencies, such as the COVID-19 pandemic and natural or human-made disasters. Involve community representatives in the planning and decision-making processes.

## Objective 5:

### To strengthen strategic information systems and research for an evidence-based response

#### Strategies

5.1	Conduct comprehensive surveillance to strengthen the capacity to respond considering all population sub-groups, epidemiology, age, sex, and geographical considerations.
5.2	Conduct the key population size estimation considering all population sub-groups, epidemiology, age, sex, and geographical considerations.
5.3	Conduct the Stigma Index led by the communities
5.4	Strengthen national strategic information as well as monitoring and evaluation guidelines to harmonise existing reporting systems, including the HIV database and DHIS2, for alignment and coherence.
5.5	Conduct relevant research to inform the national strategic response.
5.6	Increase the “granularity” of data, appropriately disaggregated to the district, community, and facility levels by age, sex, population groups, and location to better understand sub-national epidemics and assess performance along the continuum of HIV services.
5.7	Strengthen monitoring and evaluation
5.8	Improve systems for knowledge management

#### Priority actions to achieve the objective:

- a) **Comprehensive surveillance strengthening:** Allocate sufficient resources for regular HIV behavioural and serological surveillance initiatives and initiate early discussions among stakeholders to identify gaps and emerging needs in HIV data collection. Employ an integrated approach that captures information based on age, sex, epidemiology, and geographical considerations, focusing on all population sub-groups, particularly KPs.
- b) **KP size estimation:** Dedicate resources and expertise to periodically (at three-year intervals) estimate the size of KPs, considering the same demographic and geographical considerations as in surveillance. Conduct regular consultative meetings for problem-solving and decision-making regarding the methodologies and tools to be employed in these estimations.
- c) **Community-led stigma index:** Empower community-led organisations to spearhead the Stigma Index and allocate the necessary resources for effective implementation. Generate periodical reports to be incorporated into the national strategic response plan.
- d) **Harmonisation of information systems:** Update national strategic information and monitoring and evaluation guidelines to align existing reporting systems, including the HIV database and DHIS2. Regularly assess the functionality and compatibility of these systems to ensure coherence and operational efficiency.
- e) **Research initiatives:** allocate resources for interdisciplinary research relevant to HIV and AIDS, to be completed within defined timeframes. Engage stakeholders in the evaluation of the effectiveness of current targeted interventions.

- f) **Granular data collection:** Refine data collection systems to offer a high level of granularity, disaggregated to district, community, and facility levels by age, sex, population, and location. Use this data for targeted interventions and policy adjustments to address sub-national epidemics effectively.
- g) **Strengthen Monitoring and Evaluation:** Conduct the “Monitoring and Evaluation Strengthening Self-Assessment” regularly in three-year intervals, using its results to enhance the M&E system.
- h) **Integration of other health concerns:** Incorporate the monitoring of STIs, tuberculosis, and hepatitis into the HIV monitoring systems. Assess and revise guidelines to facilitate the integration of these additional health concerns into the existing surveillance and monitoring mechanisms.
- i) **Knowledge management system:** Continue and improve the utilisation of the DHIS2 to compile, analyse, and disseminate information. Explore the feasibility of including additional populations in surveys and surveillance, extending the database's scope and utility.

By meticulously implementing these priority actions, Bangladesh can strengthen its strategic information systems and research, strengthening its evidence-based response to HIV and AIDS.

## Leadership, Coordination and Accountability

The section further emphasises critical concerns in national HIV and AIDS responses, such as resource shortages and limited involvement of key ministries and stakeholders. Formal endorsement of this NSP by key ministries is imperative to tackle these challenges effectively. Such endorsement is crucial for fostering cross-sectoral commitment to combat HIV and AIDS. The NASC should also establish a comprehensive accountability framework to improve programme governance and oversight. This framework ought to include specific accountability measures and clearly outlined reporting structures.

Moreover, community engagement is currently insufficient, primarily due to the criminalisation of drug use, homosexuality, and commercial sex work. These legal constraints hinder the formal registration of CBOs and self-help groups. Over the next five years, NASC should prioritise policy reforms to decriminalise these activities. Until such reforms are enacted, NASC, in collaboration with the Central Procurement Technical Unit, should facilitate the inclusion of CBOs and self-help groups in public procurement through innovative financial policies. Additionally, national leaders should focus on diminishing stigmatising attitudes and concerns about confidentiality among healthcare professionals. This can be achieved by implementing anti-discrimination policies, providing necessary supplies, adhering to standard infection control practices, and establishing mechanisms for client feedback. The strategy extends beyond traditional healthcare provisions by actively involving communities in planning, implementation, and monitoring. It aims to render HIV and AIDS services more accessible, acceptable, and affordable by reinforcing partnerships with CBOs and prioritising the needs of KPs.

Management, coordination, and capacity development constitute the core of the national response to HIV. Adopting multi-sectoral and decentralised strategies for coordination and management allows for a diverse range of stakeholders to participate. Given the increasing number of stakeholders, coordination has become complex, dynamic, and challenging. This complexity calls for innovative solutions, clearly defined roles, and responsibilities that align with institutional mandates and comparative advantages.

The coordination and management of the national response adhere to the "Three Ones" principle: a single agreed-upon HIV/AIDS Action Framework for coordinating all partners, one national AIDS coordinating authority with a broad-based multi-sector mandate, and one unified country-level Monitoring and Evaluation System.

The specific roles and functions of various key actors involved in the strategy's implementation are detailed in the table below.

Table 5: Key Actors and their Functions

Entity	Role
National AIDS Committee (NAC)	<ul style="list-style-type: none"> <li>Oversight of national strategic plan implementation; strategy revision; national advocacy to government</li> </ul>
National AIDS Committee: Technical Committee (NAC-TC)	<ul style="list-style-type: none"> <li>Strategic guidance to ASP and other stakeholders</li> </ul>
AIDS/ STD Programme	<ul style="list-style-type: none"> <li>Programme management, monitoring,</li> </ul>

Entity	Role
	coordination, advocacy, resource mobilisation, and implementation of HNPS-OP funded interventions
Technical working groups (Prevention; Treatment, care and support; Management and Coordination; Strategic Information, PSM)	<ul style="list-style-type: none"> <li>• Periodic review of epidemic and response; technical advice to ASP</li> </ul>
Other government ministries and sector agencies	<ul style="list-style-type: none"> <li>• Development and implementation of sector plans</li> </ul>
STI/AIDS Network	<ul style="list-style-type: none"> <li>• Representation of implementing agencies in governance structures</li> </ul>
Implementing agencies	<ul style="list-style-type: none"> <li>• Service delivery, research, and development</li> </ul>
Community representative (network of PLHIV, sex worker’s network, network of people who use drugs, other CBOs and self-help groups)	<ul style="list-style-type: none"> <li>• Representation in governance structures; Participation in programme design, implementation, monitoring and evaluation</li> </ul>
Donor agencies and development partners	<ul style="list-style-type: none"> <li>• Provision of funding; harmonisation of funding; technical assistance</li> </ul>
UN agencies	<ul style="list-style-type: none"> <li>• Policy advice; global level reporting; funding; technical support based on global updates and innovations; advocacy</li> </ul>
Private sector	<ul style="list-style-type: none"> <li>• Workplace policy; involvement in sector policy development and implementation; funding mobilisation</li> </ul>
Faith-based Organizations	<ul style="list-style-type: none"> <li>• Involvement in creating an enabling environment; provision and coordination of care and support services</li> </ul>

The above framework aligns with global best practices and recommendations, emphasising the importance of strong leadership, precise accountability mechanisms, and inclusive community engagement in combating the HIV/AIDS epidemic. By adhering to these principles and guidelines, Bangladesh aims to create a cohesive and effective national strategy for HIV and AIDS for 2024–2028, which is both responsive and adaptable to the evolving landscape of the epidemic.

## Conclusion

The Fifth NSP for HIV and AIDS Response in Bangladesh marks a significant step in the nation's ongoing endeavours to limit the transmission of HIV and provide comprehensive care to people affected by the epidemic. It outlines strategic priorities, outlines actionable steps, and serves as a roadmap for all stakeholders, from the government to community organizations. The plan is not just a procedural document; it represents the collective will to address a growing epidemic among KPs.

The main arguments revolve around the need for targeted interventions for KPs, strengthening healthcare infrastructure, and strengthening policy and legislation. The emphasis on KPs is supported by data, reflecting that the HIV epidemic in Bangladesh is not widespread but is growing in these communities. This focus aligns with national and international best practices, serving as a viable model for other nations with similar epidemiological profiles.

Nevertheless, the plan's effectiveness depends on incorporating robust, result-based monitoring and evaluation metrics and inter-sectoral collaborations. While the document outlines the 'what' and the 'how,' the 'how well' remains a gap that needs to be filled with quantifiable objectives, allowing for mid-term review and adjustments. This aligns with the Sustainable Development Goals and provides a parameter for gauging the strategy's success.

In summary, the Fifth NSP for HIV and AIDS Response is more than a guide; it is a commitment to protecting the most vulnerable communities. It calls for immediate and sustained action to prevent the further spread of HIV in Bangladesh. However, to transform from a well-intentioned document into an effective tool, it must be augmented with specific, measurable objectives and open to scrutiny and adaptation. As Bangladesh deals with the complexities of its concentrated HIV epidemic, this plan could serve as a cornerstone of its public health strategy. Hence, this document should be an administrative procedure and a national priority.

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## **Annexes:**

### **Annex 1: Strategies and Guidelines Developed Over Ten Years Ago**

- National Nutrition Guideline for PLHIV, 2012
- HIV/AIDS Stigma and Discrimination Toolkit, 2011
- Training Manual on the Reduction of Stigma and discrimination related to HIV/AIDS, 2010
- Standard Operating Procedures for Services to People Living with HIV and AIDS, 2009
- SOP for Caregivers, Counselors, and Outreach Workers for Supporting PLHIV, 2009
- Management of Opportunistic Infections and Post-Exposure Prophylaxis – Guideline, 2009
- National SOP for PLHIV Interventions, 2009
- Save Blood Transfusion Rules, 2008
- National Policy and Strategy for Blood Safety, 2007
- Safe Blood Transfusion Law, 2002

### **Annex 2: A Detailed Report of the JMM**

Provided in a separate file.

## Annex 3: Summary of Challenges, Gaps, and Proposed Actions in the 5th NSP

The table below summarises the challenges, gaps, proposed actions, and recommendations outlined in the 5th NSP.

**Summary of Challenges, Gaps, and Proposed Actions in the 5th NSP**

Sl#	Challenges and Gaps	Proposed Actions/Recommendations
1	Limited Programme Coverage for Key Populations (KPs)	Expand comprehensive HIV prevention services and customize for MSM, MSW, female sex workers, transgender people, and PUD. Implement peer education, virtual interventions, and community-led monitoring.
2	Inadequate Data on HIV Infection and Transmission	Strengthen surveillance systems; conduct regular KP size estimations and community-led stigma indexes. Increase the granularity of data for targeted interventions.
3	Gaps in HIV Testing and Case-Finding	Expand facility-based and community-led testing. Promote provider-initiated testing in antenatal care and other relevant centres. Introduce HIV self-testing among KPs.
4	Barriers to Treatment Access and Adherence	Ensure rapid ART initiation post-diagnosis. Optimize public sector labs for viral load measurements and monitor treatment side effects. Expand ART service sites.
5	Insufficient Focus on Adolescents and Youth	Implement targeted interventions using physical and virtual media. Include HIV education in the national textbook curriculum and provide youth-friendly health services.
6	Challenges in Addressing Co-Infections and Comorbidities	Integrate HIV services with other health systems, particularly for Tuberculosis, Hepatitis, and cervical cancer. Train healthcare providers in co-infection management.
7	Legal and Policy Barriers for KPs	Advocate for policy reforms to decriminalize activities impacting KPs. Facilitate CBO registration and involvement in public procurement.
8	Resource Limitations and Funding Gaps	Mobilize domestic and international resources. Develop sustainable financial strategies and advocate for increased investment.

<b>Sl#</b>	<b>Challenges and Gaps</b>	<b>Proposed Actions/Recommendations</b>
9	Lack of Comprehensive Care for PLHIV and AIDS	Strengthen one-stop service models in public hospitals for integrated care. Build capacities for providing age, gender, and human rights-sensitive services.
10	Stigma and Discrimination in Healthcare Settings	Implement anti-discrimination policies and training for healthcare professionals. Establish client feedback mechanisms and promote legal literacy.
11	Fragmented Coordination Among Stakeholders	Enhance multi-sectoral stakeholder engagement. Clarify roles and responsibilities and improve mechanisms for collaboration and communication.
12	Inadequate Attention to Mental Health Concerns	Integrate mental health services into HIV care and support. Develop guidelines for mental health assessment and treatment for PLHIV and KPs.
13	Challenges in Health System Resilience	Develop capacities to respond to emergencies, including pandemics. Strengthen supply chains and laboratory services.
14	Lack of Tailored Interventions for Migrants and FDMN	Develop and implement culturally sensitive HIV services for migrants, focusing on pre-departure and post-arrival interventions. Scale up HIV services for FDMN using integrated approaches.
15	Insufficient Community Engagement in Policy Making	Enhance community representation in high-level advisory boards and decision-making forums. Strengthen partnerships between community-led and health facility services.

#### **Annex 4: Results-Based Framework: NSP 2024-2028**

It is provided in a separate file.

#### **Annex 5: Costed Implementation Plan**

It is provided in a separate file.

**Objective:1 To prevent new HIV infections by expanding program coverage through the implementation of comprehensive, targeted interventions, provision of age, gender, and human-rights-sensitive services, and fostering active community involvement in promoting public health.**

Strategy	Indicators	Population/ Unit	2022 Base-line (data source)	2026 target	2028 target	Remarks
1.1.1 HIV prevalence among key population (BD)	Number of estimated annual new infections	General population + KP	1100 ( AEM estimate for 2022)	500 (data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	300 ( The target for 2028 has been set with the assumption that the number of new cases will not exceed 300 per year.)	
		MSM	0.84% (AEM Optimization Report,2022; Figure:5, Page:13)	1.05% The target for 2026 was taken from AEM 2022, Optimization report, Figure-5, Page-13 However,target for 2026 will be revised from upcoming AEM exercise, 2023. However, overall prevalence should remain < 5% to avoid a concentrated epidemic.	1.16% The target for 2028 was taken from AEM 2022, Optimization report, Figure-5, Page-13	NSP Ref: Strategy # 1.1.1
		SW (FSW/MSW/TG)	0.25% (AEM Optimization Report, 2022 Figure:5, Page:13 )	0.24% . The target for 2026 was taken from AEM 2022, Optimization report, Figure-5, Page-13 However,target for 2026 will be revised from upcoming AEM exercise, 2023. However, overall prevalence should remain < 5% to avoid a concentrated epidemic.	0.23% The target for 2028 was taken from AEM 2022, Optimization report, Figure-5, Page-13	NSP Ref: Strategy # 1.1.1, 1.1.2, 1.1.3
		MSW	1.17% (AEM Optimization Report, 2022, Figure:5, Page:13)	1.42% The target for 2026 was taken from AEM 2022, Optimization report, Figure-5, Page-13 However,target for 2026 will be revised from upcoming AEM exercise, 2023. However, overall prevalence should remain < 5% to avoid a concentrated epidemic.	1.56% The target for 2028 was taken from AEM 2022, Optimization report, Figure-5, Page-13	NSP Ref: Strategy # 1.1.1
		FSW (street, hotel and residence)	0.25% (AEM Optimization Report, 2022 Figure:5, Page:13 )	0.24% . The target for 2026 was taken from AEM 2022, Optimization report, Figure-5, Page-13 However,target for 2026 will be revised from upcoming AEM exercise, 2023. However, overall prevalence should remain < 5% to avoid a concentrated epidemic.	0.23% The target for 2028 was taken from AEM 2022, Optimization report, Figure-5, Page-13	NSP Ref: Strategy # 1.1.2
		Hijra (TG)	1.01% (AEM Optimization Report, 2022; Figure:5, Page:13)	1.27% The target for 2026 was taken from AEM 2022, Optimization report, Figure-5, Page-13 However,target for 2026 will be revised from upcoming AEM exercise, 2023. However, overall prevalence should remain < 5% to avoid a concentrated epidemic.	1.41% The target for 2028 was taken from AEM 2022, Optimization report, Figure-5, Page-13	NSP Ref: Strategy # 1.1.3

Strategy	Indicators	Population/ Unit	2022 Base-line (data source)	2026 target	2028 target	Remarks
		Male PWID	4.34% (AEM Optimization Report, 2022; Figure:5, Page:13)	4.27% The target for 2026 was taken from AEM 2022, Optimization report, Figure-5, Page-13 However,target for 2026 will be revised from upcoming AEM exercise, 2023. However, overall prevalence should remain < 5% to avoid a concentrated epidemic.	4.24% The target for 2028 was taken from AEM 2022, Optimization report, Figure-5, Page-13	NSP Ref: Strategy # 1.1.4
		Female PWID	3.15% (AEM Optimization Report, Figure:5, Page:13, 2022)	3.00% The target for 2026 was taken from AEM 2022, Optimization report, Figure-5, Page-13 However,target for 2026 will be revised from upcoming AEM exercise, 2023. However, overall prevalence should remain < 5% to avoid a concentrated epidemic.	2.97% The target for 2028 was taken from AEM 2022, Optimization report, Figure-5, Page-13	NSP Ref: Strategy # 1.1.4
		PWID (Male+Female)	4.31% ( AEM BD Baseline 2022; Average of male and female PWID.)	4.23% The target for 2026 was taken from AEM 2022, Optimization report, Figure-5, Page-13 However,target for 2026 will be revised from upcoming AEM exercise, 2023. However, overall prevalence should remain < 5% to avoid a concentrated epidemic.Average of male and female PWID	4.20% ( The target for 2028 was taken from AEM 2022, Optimization report, Figure-5, Page-13; average of male and female PWID)	NSP Ref: Strategy # 1.1.4
		MSM	2.95 % (AEM Optimization Report,2022; Annex:3, Page:27)	3.72% The target for 2026 was taken from AEM 2022, Optimization report, Annex:3, Page:27 However,target for 2026 will be revised from upcoming AEM exercise, 2023. However, overall prevalence should remain < 5% to avoid a concentrated	4.12% The target for 2028 was taken from AEM 2022, Optimization report, Annex:3, Page:27	NSP Ref: Strategy # 1.1.1
		SW (FSW/MSW/TG)	0.42% (AEM Optimization Report, 2022; Annex:3, Page:27)	0.40% The target for 2026 was taken from AEM 2022, Optimization report, Annex:3, Page:27 However,target for 2026 will be revised from upcoming AEM exercise, 2023. However, overall prevalence should remain < 5% to avoid a concentrated epidemic.	0.39% The target for 2028 was taken from AEM 2022, Optimization report, Annex:3, Page:27	NSP Ref: Strategy # 1.1.1, 1.1.2, 1.1.3
		MSW	3.8 % (AEM Optimization Report,2022; Annex:3, Page:27)	4.58% The target for 2026 was taken from AEM 2022, Optimization report, Annex:3, Page:27 However,target for 2026 will be revised from upcoming AEM exercise, 2023. However, overall prevalence should remain < 5% to avoid a concentrated epidemic.	5.03% The target for 2028 was taken from AEM 2022, Optimization report, Annex:3, Page:27	NSP Ref: Strategy # 1.1.1

Strategy	Indicators	Population/ Unit	2022 Base-line (data source)	2026 target	2028 target	Remarks
	1.1.2.a. HIV prevalence among key population (Dhaka)	FSW (Street, hotel and residence)	0.42% (AEM Optimization Report, 2022; Annex:3, Page:27)	0.40% The target for 2026 was taken from AEM 2022, Optimization report, Annex:3, Page:27 However, target for 2026 will be revised from upcoming AEM exercise, 2023. However, overall prevalence should remain < 5% to avoid a concentrated epidemic.	0.39% The target for 2028 was taken from AEM 2022, Optimization report, Annex:3, Page:27	NSP Ref: Strategy # 1.1.2
		Hijra(TG)	2.27 % (AEM Optimization Report,2022; Annex:3, Page:27)	2.89% The target for 2026 was taken from AEM 2022, Optimization report, Annex:3, Page:27 However, target for 2026 will be revised from upcoming AEM exercise, 2023. However, overall prevalence should remain < 5% to avoid a concentrated epidemic.	3.20% The target for 2028 was taken from AEM 2022, Optimization report, Annex:3, Page:27	NSP Ref: Strategy # 1.1.3
		Male PWID	14.91 % (AEM Optimization Report,2022; Annex:3, Page:27)	14.44% The target for 2026 was taken from AEM 2022, Optimization report, Annex:3, Page:27 However, target for 2026 will be revised from upcoming AEM exercise, 2023. However, overall prevalence should remain < 5% to avoid a concentrated epidemic.	14.28% The target for 2028 was taken from AEM 2022, Optimization report, Annex:3, Page:27	NSP Ref: Strategy # 1.1.4
		Female PWID	4.25 % (AEM Optimization Report,2022; Annex:3, Page:27)	3.95% The target for 2026 was taken from AEM 2022, Optimization report, Annex:3, Page:27 However, target for 2026 will be revised from upcoming AEM exercise, 2023. However, overall prevalence should remain < 5% to avoid a concentrated epidemic.	3.90% The target for 2028 was taken from AEM 2022, Optimization report, Annex:3, Page:27	NSP Ref: Strategy # 1.1.4
		PWID ( male+ female)	13.77% (AEM Optimization Report,2022; Annex:3, Page:27; average of male and female PWID)	13.48% (The target for 2026 was taken from AEM 2022, Optimization report, Annex:3, Page:27 However, target for 2026 will be revised from upcoming AEM exercise, 2023. However, overall prevalence should remain < 5% to avoid a concentrated epidemic; average of male and female PWID)	13.31% (The target for 2028 was taken from AEM 2022, Optimization report, Annex:3, Page:27;average of male and female PWID)	NSP Ref: Strategy # 1.1.4
	1.1.2.b. HIV prevalence among key population (Out side-Dhaka)	PWID ( male+ female)	1.64% (AEM priority 22+ remaining 41 districts)	1.84% (AEM priority 22+ remaining 41 districts)	1.84% (AEM priority 22+ remaining 41 districts)	NSP Ref: Strategy # 1.1.4
		MSM	8.3 % (IBBS,2020, Page:101, Table-4.16.a) This data refers to MSM including MSW in IBBS 2020.	5.19 % ( data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	4.15% (Based on program design , data for 2028 was estimated assuming that the prevalence value will be half of baseline value.)	NSP Ref: Strategy # 1.1.1 and 1.3

Strategy	Indicators	Population/ Unit	2022 Base-line (data source)	2026 target	2028 target	Remarks
	1.1.3 Prevalence of active syphilis among key populations (BD)	SW (FSW/MSW/TG)	4.3% (IBBS,2020, Page:72, Table- 3.11.a) This data is given only for FSW (Hotel+ street+ Residence).Seperate data for MSW and TG sex worker is not available in IBBS 2020.	2.69 % ( data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	2.15% (Based on program design , data for 2028 was estimated assuming that the prevalence value will be half of baseline value.)	NSP Ref: Strategy # 1.1.1, 1.1.2, 1.1.3 and 1.3
		MSW	8.3 % (IBBS,2020, Page:101, Table-4.16.a) This data refers to MSM including MSW in IBBS 2020.	5.19 % ( data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	4.15% (Based on program design , data for 2028 was estimated assuming that the prevalence value will be half of baseline value.)	NSP Ref: Strategy # 1.1.1 and 1.3
		FSW (Street, hotel and residence)	4.3% (IBBS,2020, Page:72, Table- 3.11.a) This data is given only for FSW (Hotel+ street+ Residence) in IBBS 2020.	2.69 % ( data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	2.15% (Based on program design , data for 2028 was estimated assuming that the prevalence value will be half of baseline value.)	NSP Ref: Strategy # 1.1.2 and 1.3
		Hijra(TG)	10.7 % (IBBS,2020, Page:177,Table-6.17.a) This data refers to all Hijra.	6.42% ( data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	<5% (Based on program design , data for 2028 was estimated assuming that the prevalence value will be less than 5%.)	NSP Ref: Strategy # 1.1.3 and 1.3
		Male PWID	3.2 % (IBBS,2020, Page:148,Table-5.12.a). Male and Female PWID are combined in IBBS 2020.	2.00 % ( data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	1.60% (Based on program design , data for 2028 was estimated assuming that the prevalence value will be half of baseline value.)	NSP Ref: Strategy # 1.1.4 and 1.3
		Female PWID	Sex disaggregation is not available in IBBS 2020.	2.0 % ( data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	1.60% (Based on program design , data for 2028 was estimated assuming that the prevalence value will be half of baseline value.)	NSP Ref: Strategy # 1.1.4 and 1.3
		MSM	13.8 % (IBBS,2020, Page:101, Table-4.16.a) This data refers to MSM including MSW in IBBS 2020.	7.20% ( data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	<5% (Based on program design , data for 2028 was estimated assuming that the prevalence value will be less than 5%.)	NSP Ref: Strategy # 1.1.1 and 1.3
	1.1.4 Prevalence of active syphilis among key populations (Dhaka)	SW (FSW/MSW/TG)	5.6% (IBBS,2020, Page:72, Table- 3.11.a) This data is given only for FSW (Hotel+ street+ Residence).Seperate data for MSW and TG sex worker is not available in IBBS 2020.	3.5 % ( data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	2.80% (Based on program design , data for 2028 was estimated assuming that the prevalence value will be half of baseline value.)	NSP Ref: Strategy # 1.1.1, 1.1.2, 1.1.3 and 1.3
		MSW	13.8 % (IBBS,2020, Page:101, Table-4.16.a) This data refers to MSM including MSW in IBBS 2020.	7.19% ( data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	<5% (Based on program design , data for 2028 was estimated assuming that the prevalence value will be half of baseline value.)	NSP Ref: Strategy # 1.1.1 and 1.3
		FSW (Street, hotel and residence)	5.6% (IBBS,2020, Page:72, Table- 3.11.a) This data is given only for FSW (Hotel+ street+ Residence) in IBBS 2020.	3.50 % ( data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	2.80% (Based on program design , data for 2028 was estimated assuming that the prevalence value will be half of baseline value.)	NSP Ref: Strategy # 1.1.2 and 1.3
		Hijra(TG)	12.8 % (IBBS,2020, Page:177,Table-6.17.a) This data refers to all Hijra.	6.94% ( data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	<5% (Based on program design , data for 2028 was estimated assuming that the prevalence value will be less than 5%.)	NSP Ref: Strategy # 1.1.3 and 1.3

Strategy	Indicators	Population/ Unit	2022 Base-line (data source)	2026 target	2028 target	Remarks
1.1 Ensure comprehensive HIV prevention services are accessible to KPs, their client, and other sexual partners.		Male PWID	4.6% (IBBS,2020, Page:148,Table-5.12.a). Male and Female PWID are combined in IBBS 2020.	2.88 % ( data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	2.30 % (Based on program design , data for 2028 was estimated assuming that the prevalence value will be half of baseline value.)	NSP Ref: Strategy # 1.1.4 and 1.3
		Female PWID	4.6% (IBBS,2020, Page:148,Table-5.12.a). Male and Female PWID are combined in IBBS 2020. Same as Male PWID	2.88% ( data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)Same as Male PWID	2.30 % (Based on program design , data for 2028 was estimated assuming that the prevalence value will be half of baseline value.)Same as Male PWID	NSP Ref: Strategy # 1.1.4 and 1.3
	1.1.5 Percentage of key populations reporting condom use at their most recent sexual intercourse (with clients for FSW, MSW, hijra; anal sex with male partners for MSM) (BD)	MSM	46.2 % (Endline Survey 2017; Table-5.8,Page-107).	57.57% (data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	65% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increasing from what is set during 2023.)	NSP Ref: Strategy # 1.1.1 and 1.3
		SW (FSW/MSW/TG)	73.7% (IBBS, 2020; Page 42-43,Table-3.2.h). This data is given only for FSW (Hotel+ street+ Residence).Separate data for MSW and TG sex worker is not available in IBBS 2020.	82.18% ( data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	85% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increasing from what is set during 2023.)	NSP Ref: Strategy # 1.1.1, 1.1.2, 1.1.3 and 1.3
		MSW	46.1%(End Line Survey (Behaviour) on Continuation of the Prioritized HIV Prevention Services among key Population in Bangladesh 2017; Page:.118; Table: 5.22)	57.47% ( data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	60% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increasing from what is set during 2023.)	NSP Ref: Strategy # 1.1.1 and 1.3
		FSW (Street, hotel and residence)	73.7% (IBBS, 2020; Page 42-43,Table-3.2.h). This data is given only for FSW (Hotel+ street+ Residence) in IBBS 2020.	82.18% ( data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	85% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increasing from what is set during 2023.)	NSP Ref: Strategy # 1.1.2 and 1.3
		Hijra(TG)	36.9 % (IBBS,2020, Page:152, Figure 6.2.a) This data refers to all Hijra.	57.98% (data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	65% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increasing from what is set during 2023.)	NSP Ref: Strategy # 1.1.3 and 1.3
		Male PWID	47.7% (IBBS,2020, Page:211, Table-3.6).	56.9% (data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	60% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increasing from what is set during 2023.)	NSP Ref: Strategy # 1.1.4 and 1.3
		Female PWID	76.56% (IBBS,2020, Page:211, Table-3.6).	82.9% (data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	85% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increasing from what is set during 2023.)	NSP Ref: Strategy # 1.1.4 and 1.3
		PWID (Male+Female)	42.2% (IBBS,2020, Page:211, Table-3.6).	69.9% (data for 2026 was estimated by using linear interpolation between the year 2020 and 2028; average of male and female PWID)	72.5% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increasing from what is set during 2023, average of male and female PWID)	NSP Ref: Strategy # 1.1.4 and 1.3

Strategy	Indicators	Population/ Unit	2022 Base-line (data source)	2026 target	2028 target	Remarks
		MSM	57.0 % (IBBS,2020, Page:78, Figure-4.3.b) This data refers to MSM including MSW in IBBS 2020.	63% (data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	65% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increasing from what is set during 2023.)	NSP Ref: Strategy # 1.1.1 and 1.3
		SW (FSW/MSW/TG)	86.7% (IBBS, 2020; Page 42-43,Table-3.2.h). This data is given only for FSW (Hotel+ street+ Residence).Seperate data for MSW and TG sex worker is not available in IBBS 2020.	89.18% (data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	90% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increasing from what is set during 2023.)	NSP Ref: Strategy # 1.1.1, 1.1.2, 1.1.3 and 1.3
		MSW	43.6%(End Line Survey (Behaviour) on Continuation of the Prioritized HIV Prevention Services among key Population in Bangladesh 2017; Page:.118; Table: 5.22)	57.02% ( data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	60% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increase from 2023.)	NSP Ref: Strategy # 1.1.1 and 1.3

Strategy	Indicators	Population/ Unit	2022 Base-line (data source)	2026 target	2028 target	Remarks
	1.1.6 Percentage of key populations reporting condom use at their most recent sexual intercourse (with clients for FSW, MSW, hijra; anal sex with male partners for MSM) (Dhaka)	FSW (Street, hotel and residence)	86.7% (IBBS, 2020; Page 42-43, Table-3.2.h). This data is given only for FSW (Hotel+ street+ Residence) in IBBS 2020.	89.18% (data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	90% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increasing from what is set during 2023.)	NSP Ref: Strategy # 1.1.2 and 1.3
		Hijra (TG)	27.1 % (IBBS,2020, Page:152, Figure 6.2.a) This data refers to all Hijra.	55.53% (data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	65% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increasing from what is set during 2023.)	NSP Ref: Strategy # 1.1.3 and 1.3
		Male PWID	59.4% (IBBS,2020, Page:211, Table-3.6).	67.40% (data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	70% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increasing from what is set during 2023.)	NSP Ref: Strategy # 1.1.4 and 1.3
		Female PWID	87.0% (IBBS,2020, Page:211, Table-3.6).	89.3% (data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	90% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increasing from what is set during 2023.)	NSP Ref: Strategy # 1.1.4 and 1.3
		PWID ( male+ female)	52.35% (IBBS,2020, Male+ female).	78.35% (data for 2026 was estimated by using linear interpolation between the year 2020 and 2028, average of male and female PWID)	80% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increasing from what is set during 2023, average of male and female PWID)	NSP Ref: Strategy # 1.1.4 and 1.3
	1.1.7 Percentage of PWID reporting use of sterile injecting equipment the last time they injected (BD)	Male PWID	73.78% (AEM, April 2022, Baseline value for 2020 was calculated using AEM excel file for Dhaka, 22 Priority and Remaining districts. At first the data value 25.5% that corresponds to percent of Male PWID who shared needles was taken from row 11 and year 2020 (AU11). Then we subtracted this value from 100% and derived at the result that reflects Male PWID reporting use of sterile injecting equipment the last time they injected. We followed similar method for 22 Priority districts and Remaining districts and took the average as country estimate.)	87.93% (data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	95% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increasing from what is set during 2023.)	NSP Ref: Strategy # 1.1.4
		Female PWID	66.50% (AEM, April 2022. Baseline value for 2020 was calculated using AEM excel file for Dhaka, 22 Priority and Remaining districts. At first the data value 25.5% that corresponds to percent of Female PWID who shared needles was taken from row 29 and year 2020 (AU29). Then we subtracted this value from 100% and derived at the result that reflects Female PWID reporting use of sterile injecting equipment the last time they injected. We followed similar method for 22 Priority districts and Remaining districts and took the average as country estimate.)	85.5% (data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	95% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increasing from what is set during 2023.)	NSP Ref: Strategy # 1.1.4

Strategy	Indicators	Population/ Unit	2022 Base-line (data source)	2026 target	2028 target	Remarks
1.1.8 Percentage of PWID reporting use of sterile injecting equipment the last time they injected: Dhaka		PWID (Male+Female)	70.14% (This data is not available in the IBBS 2020 report. Therefore, AEM 2022 Excel files of Dhaka, 22 priority and 41 remaining districts were combined to prepare a single value for Bangladesh. At first, the data value 24.5% from the Dhaka AEM excel file (row#11, year 2020, cell#AU11) was taken that corresponds to the percent of male PWID who shared needles. Then the corresponding estimate for female was taken from the same AEM excel file (row#29, year 2020, cell#AU29) for female. Then we took an average of these to produce male and female. Then we subtracted this value from 100% and derived at the result that reflects male and female PWID reporting use of sterile injecting	86.71% (data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.Average of male and female PWID)	95% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increasing from what is set during 2023.Average of male and female PWID)	NSP Ref: Strategy # 1.1.4
		Male PWID	80.38% (AEM, April 2022, Dhaka. Baseline value for 2020 was calculated using AEM excel file for Dhaka. The data value 25.5% that corresponds to percent of Male PWID who shared needles was taken from row 11 and year 2020 (AU11). Then we subtracted this value from 100% and derived at the result that reflects Male PWID reporting use of sterile injecting equipment the last time they injected.)	90.13% (data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	95% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increasing from what is set during 2023.)	NSP Ref: Strategy # 1.1.4
		Female PWID	80.38% (AEM, April 2022, Dhaka. Baseline value for 2020 was calculated using AEM excel file for Dhaka. The data value 25.5% that corresponds to percent of female PWID who shared needles was taken from row 29 and year 2020 (AU29). Then we subtracted this value from 100% and derived at the result that reflects female PWID reporting use of sterile injecting equipment the last time they injected.)	90.13% (data for 2026 was estimated by using linear interpolation between the year 2020 and 2028.)	95% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increasing from what is set during 2023.)	NSP Ref: Strategy # 1.1.4
		PWID(Male+ Female)	80.38% (This data is not available in the IBBS 2020 report. Therefore, AEM 2022 Excel file of Dhaka was used. At first, the data value 24.5% from the Dhaka AEM excel file (row#11, year 2020, cell#AU11) was taken that corresponds to the percent of male PWID who shared needles. Then the corresponding estimate for female was taken from the same AEM excel file (row#29, year 2020, cell#AU29). Then we took an average of these to produce male and female, 24.5%. Then we subtracted this value from 100% and derived at the result that reflects male and female PWID reporting use of sterile injecting equipment the last time they injected, 75.5%. The targets for 2024-2026 were estimated by using linear	90.13% (data for 2026 was estimated by using linear interpolation between the year 2020 and 2028. average of male and female PWID.)	95% (The target of 2028 has been considered either equal to the current strategic plan (2018-2023) or by slightly increasing from what is set during 2023. average of male and female PWID.)	NSP Ref: Strategy # 1.1.4
		MSM	MSM and MSW-30.51% MSM-22.0% (Program Data, July-December 2022)	85% of the 1st 25 priority ranked districts + 25% of remaining districts	90% of the 1st 25 priority ranked districts + 30% of remaining districts	NSP Ref: Strategy # 1.1.1 and 1.3

Strategy	Indicators	Population/ Unit	2022 Base-line (data source)	2026 target	2028 target	Remarks
	1.1.9 Percentage of key populations reached with core services (condoms, BCC, NSEP) in the past year (2023 targets are set considering 40-90% coverage of 23 priority districts where high impact is needed and 50% of existing coverage in remaining districts and then rounded)	MSW	MSM and MSW-30.51% MSW-59.6% (Program Data, July-December 2022)	85% of the 1st 25 priority ranked districts + 25% of remaining districts	90% of the 1st 25 priority ranked districts + 30% of remaining districts	NSP Ref: Strategy # 1.1.1 and 1.3
		FSW (street, hotel and residence)	32.22% (Program Data, July-December 2022)	85% of the 1st 25 priority ranked districts + 25% of remaining districts	90% of the 1st 25 priority ranked districts + 30% of remaining districts	NSP Ref: Strategy # 1.1.2 and 1.3
		Hijra	64.45% (Program Data, July-December 2022)	85% of the 1st 25 priority ranked districts + 25% of remaining districts	90% of the 1st 25 priority ranked districts + 30% of remaining districts	NSP Ref: Strategy # 1.1.3 and 1.3
		Male PWID	58.93% (Program Data, July-December 2022)	85% of the 1st 25 priority ranked districts + 25% of remaining districts	90% of the 1st 25 priority ranked districts + 30% of remaining districts	NSP Ref: Strategy # 1.1.4 and 1.3
		Female PWID	28.71% (Program Data, July-December 2022)	85% of the 1st 25 priority ranked districts + 25% of remaining districts	90% of the 1st 25 priority ranked districts + 30% of remaining districts	NSP Ref: Strategy # 1.1.4 and 1.3

Strategy	Indicators	Population/ Unit	2022 Base-line (data source)	2026 target	2028 target	Remarks
		Prisoners # of people in prisons and other closed settings reached with HIV program (counseling, testing, STI management, verbal TB screening, group education)	473 (in 9 prisons) (Program Data, July-December 2022)	16223 (The HIV program in 19 selected prisons aims to achieve an 80% reach.)	21735 (The HIV program in selected prisons aims to achieve a 90% reach.)	NSP Ref: Strategy # 1.1.5 and 1.3
	1.1.10 Percentage of key populations who received an HIV test in the past 12 months and know their results	MSM	MSM and MSW-23.22% MSM-16.6% (Program Data Januray -December 2022, Cumulative annual indicator)	95% among those who will be reached	95% among those who will be reached	NSP Ref: Strategy # 1.1.1 and Objective 2
		MSW	MSM and MSW-23.22% MSW-45.7% (Program Data Januray -December 2022, Cumulative annual indicator)	95% among those who will be reached	95% among those who will be reached	NSP Ref: Strategy # 1.1.1 and Objective 2
		FSW	28.45% (Program Data Januray -December 2022, Cumulative annual indicator)	95% among those who will be reached	95% among those who will be reached	NSP Ref: Strategy # 1.1.2 and 1.3
		Hijra(TG)	48.75% (PUDR-July-December2022, data Januray - December 2022, Cumulative annual indicator)	95% among those who will be reached	95% among those who will be reached	NSP Ref: Strategy # 1.1.3 and Objective 2
		Male PWID	53.72% (PUDR-July-December2022, data Januray - December 2022, Cumulative annual indicator)	95% among those who will be reached	95% among those who will be reached	NSP Ref: Strategy # 1.1.4 and Objective 2
		Female PWID	26.41% (PUDR-July-December2022, data Januray - December 2022, Cumulative annual indicator)	95% among those who will be reached	95% among those who will be reached	NSP Ref: Strategy # 1.1.4 and Objective 2
		Prisoner	473 (Number) (Program Data Januray -December 2022, Cumulative annual indicator)	95% among those who will be reached	95% among those who will be reached	NSP Ref: Strategy # 1.1.5 and Objective 2
	1.1.11 Percent of PWID on opioid substitution therapy (OST)	Male and female PWID	10.13% (Program Data, July-December 2022)	22.0 % of the 25 priority districts.	30.0% of the 25 priority districts.	NSP Ref: Strategy # 1.1.4
1.2 Reinforce HIV and STI prevention and other sexual and reproductive health (SRH) services in public health care settings by establishing	1.2.1 Percentage of pregnant women who received an HIV test and know the result	Pregnant women	PMTCT-74,491 74,491 of the total estimated 3.0 million pregnant women (WAD Key note presentation 2022, Slide number 6)	150,000	250,000	NSP Ref: Strategy # 1.2.1
	1.2.2 Screening of hepatitis B and syphilis along with HIV for all pregnant women	Pregnant women	Data not available	150,000 ( Assuming similar number of pregnant women will be screened for syphilis and HBV along with HIV.)	250,000 ( Assuming similar number of pregnant women will be screened for syphilis and HBV along with HIV.)	NSP Ref: Strategy # 1.2.1

Strategy	Indicators	Population/ Unit	2022 Base-line (data source)	2026 target	2028 target	Remarks
functional links for co-infections (e.g., Tuberculosis, Hepatitis) and aiming for the triple elimination of vertical transmission of HIV, hepatitis B, and syphilis.	1.2.3 Strengthen the PMTCT program in coordination with the Directorate General of Family Planning.	Number of PMTCT center	5 ( Program data,2022)	30	64	NSP Ref: Strategy # 1.2.3
	1.2.4 Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	Pregnant PLHIV	100% (WAD Key note presentation, 2022, Slide number 17)	100%	100%	NSP Ref: Strategy # 1.2.2
	1.2.5 Percentage of infants born to HIV infected mothers (under PMTCT program) who are infected	Infants	4.5% (WAD Key note presentation 2022, Slide number 17)	<5%	<5%	NSP Ref: Strategy # 1.2.2
1.3 Reduction of risk behaviours and provision of services for populations at emerging risk and vulnerable groups through awareness raising and evidence-based interventions to link them to integrated STI, HIV (including PrEP), and SRH services under Universal Health Coverage	1.3.1 Percentage of PLHIV and members of key populations who reported denial of health care services (HIV or non-HIV)	PLHIV	5% PLHIV respondents stated denial of health services 2nd National Stigma Index, Bangladesh,2017; Figure-11, Page-39	<5%	<5%	NSP Ref: Strategy # 1.3 and 1.6
		KP	7% KP respondents stated denial of health services 2nd National Stigma Index, Bangladesh,2017; Figure-11, Page-39	<5%	<5%	NSP Ref: Strategy # 1.3 and 1.6
	1.3.2 Percentage of migrants and their spouses initiated ARV drugs on testing positive for HIV in a year	International migrants (departing)	Denominator: 175 migrants and their spouses tested positive in 2022. Numerator: 154 (Program data,2022)	90%	95%	NSP Ref: Strategy # 1.1.6 and 1.3
	1.3.3 Percentage of Key Populations and HIV negative partner of sero-discordant couples using PrEP	KPs and negative partners	200 (Program Data, July-December 2022)	800 Targets also need to be segregated by KP type. 100 partners/spouses of PLHIV who are negative	1000 200 partners/spouses of PLHIV who are negative	NSP Ref: Strategy # 1.3
1.4 Promote infection prevention protocols and post-exposure prophylaxis measures for health service providers, laboratory staff, survivors of gender-based violence, etc.	1.4.1 Number of PEP kits/drugs available to hospitals, laboratories and centers to support rape survivors	Number of centers	Baseline data not available	HTS center: 64 OCC :06	HTS center: 64 OCC :08	NSP Ref: Strategy # 1.4
1.5 Optimize behavior change communication strategies to expand case detection and minimize risk behaviors in the general population, emphasizing adolescents and youth while connecting them to SRH and HTS	1.5.1 Percentage of women and men 15–years old who correctly identify both ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission	Men and Women aged 15-49 years	11.6% (Bangladesh 2019 MICS Report, Page: 147, Table: TM.9.1). In this survey, all respondents were women including young women.	15%	20%	NSP Ref: Strategy # 1.5

Strategy	Indicators	Population/ Unit	2022 Base-line (data source)	2026 target	2028 target	Remarks
1.6 Strengthen the empowerment of KP communities and eliminate human rights-related barriers and gender based violence to ensure equitable access to health services, including HIV prevention for all KPs	1.6.1 Percentage of prevention interventions conducted by KP led Communities. Denominator could be number of intervention sites and numerator could be intervention sites where KP led agency is directly conducting outreach	Number of CBOs	Denominator: Total number of DICs or equivalent needed Numerator: Number of centers directly managed by APOSH, Bandhu, SWN etc.	TBD	TBD	NSP Ref: Strategy # 1.6

**Objective 2: To ensure innovative, effective, ethical and differentiated HIV testing and case-finding approaches are scaled up across the country**

Strategy	Indicators	Population /Unit	2022 Base-line (data source)	2026 target	2028 target	Remarks
2.1 Expand facility-based testing for key and general populations and promote provider-initiated testing and counseling (PITC) in public and private antenatal care, tuberculosis, hepatitis C, hepatitis B, and STI service centers.	2.2.1 Number of public health and other facilities that provide HIV testing and counselling services	Public health or NGO or other facilities	230: 47 GoB set-ups and 183 were private/NGO set ups (50- icddr,b, 60-Save the Children, 24-ASP Treatment Care, 9-ASP Operation Plan, 9-Prison, 5-PMTCT GoB, 6-PMTCT unicef, 67-GAMCA) (Program data 2022)	251: 88 GoB set-ups and 163 were private/NGO set ups (47- icddr,b, 49-Save the Children, 64-ASP Treatment Care, 11-Prison, 13-PMTCT GoB, 67-GAMCA)	>295: >132 GoB set-ups and 163 were private/NGO set ups (47- icddr,b, 49-Save the Children, 64-ASP Treatment Care, 11-Prison, 13-PMTCT GoB, 67-GAMCA)	NSP Ref: Strategy # 2.1
	2.2.2 Number of people counseled and tested for HIV who received their test results	Number of people tested	Total test-2,013,333 (WAD Key note presentation 2022, Slide number 6)	2,337,778 ( data for 2026 was estimated by using linear interpolation between the year 2022 and 2028.)	2,500,000 ( data for 2028 was taken equal to the target of 2023 from the current strategic plan 2018-2023.)	NSP Ref: Strategy # 2.1
2.2 Expand community-led testing for KPs by utilizing both trained and supervised lay providers and health professionals to conduct rapid HIV tests	2.2.1 Percentage of testing services delivered by community led organization	Number of CBOs/ Networks	Denominator: Total number of testing centers at community level Numerator: Number of centers directly managed by APOSH, Bandhu, SWN etc.	30%	40%	NSP Ref: Strategy # 2.2
	2.2.2 Percentage of KPs tested for HIV and Know their result	MSM	Data not available	95%	95%	NSP Ref: Strategy # 2.2
		MSW	Data not available	95%	95%	NSP Ref: Strategy # 2.2
		FSW	54% (Program data, January-December, 2022)	95%	95%	NSP Ref: Strategy # 2.2
		Hijra(TG)	Data not available	95%	95%	NSP Ref: Strategy # 2.2
		PWID ( Male)	61% (Including female PWID) (Program data, January-December, 2022)	95%	95%	NSP Ref: Strategy # 2.2
		PWID ( Female)	Data not available	95%	95%	NSP Ref: Strategy # 2.2
2.3 Expand index testing, online to offline, and social risk network referral testing, complying with the three-test algorithm	2.3.1 Number of people counselled and tested for HIV who received their test results, disaggregated by online and offline	Number of index testing	251: (219-Save the Children; 32-icddr,b); (Program data, January-December, 2022; all KPs are combined)	1000	3000	NSP Ref: Strategy # 2.3
2.4 Introduce community-based HIV self-testing among KPs	2.4.1 Number of key population counselled and self-tested for HIV .	MSM	911 (911-icddr,b; -ASP); (Program data, January-December, 2022)	13,332 (13,065-icddr,b; 267-ASP)	15,000	NSP Ref: Strategy # 2.4  Assuming program coverage is 70% and of the 70% , 80% are tested and of the 80% , 5% are self tested.Rounding was done to the nearest hundred except for PWID.In case of PWID the assumption was that less PWID will be interested in self testing. Coverage assumption are less than targeted considering program data to avoid wastage of test kit as these are expensive)
		MSW	683 (683-icddr,b; -ASP); (Program data, January-December, 2022)	5,711 (5,605-icddr,b; 106-ASP)	7000	
		FSW	1310 (1310-Save the Children; -ASP); (Program data, January-December, 2022)	2500	3000	
		Hijra(TG)	177 (177-icddr,b; -ASP); (Program data, January-December, 2022)	948 (924-icddr,b; 24-ASP)	1500	
		Male PWID	365 (365-Save the Children; -ASP); (Program data, January-December, 2022)	1150	1500	
		Female PWID	10 (10-Save the Children; -ASP); (Program data, January-December, 2022)	50	100	

**Objective 3: To provide universal access to treatment, care, and support services for people living with HIV and AIDS**

Strategies	Indicators	Population /Unit	2022 Base-line (data source)	2026 target	2028 target	Remarks
3.1 Reduce mortality and morbidity among PLHIV through early detection and treatment by strengthening of government, non-government, and private sector facilities.	3.1.1 Percentage of eligible adults and children currently receiving antiretroviral therapy	Adult PLHIV (≥15 years)	39.33% (Program Data, December 2022)	73.1% (program data, interpolation between 2022 to 2028)	90% (program data, interpolation between 2022 to 2028)	NSP Ref: Strategy # 3.1.1, 3.1.2, 3.1.3 and 3.1.4
		Children PLHIV (<15 years)	2.14% (Program Data, December 2022)	60.7% (program data, interpolation between 2022 to 2028)	90% (program data, interpolation between 2022 to 2028)	
	3.1.2 Percentage of viral load testing conducted among those on ART	PLHIV	69.00% (Program Data, December 2022)	86.3% (program data, interpolation between 2022 to 2028)	95% (program data, interpolation between 2022 to 2028)	NSP Ref: Strategy # 3.1.5
	3.1.3 Percent of PLHIV virally suppressed	PLHIV	85.45% (Program Data, December 2022)	91.8% (program data, interpolation between 2022 to 2028)	95% (program data, interpolation between 2022 to 2028)	NSP Ref: Strategy # 3.1.6
3.2 Ensure the capacity of service providers in government, non-government, and private sectors to provide age, gender, and human rights-sensitive out-patient and in-patient medical management for PLHIV and KPs	3.2.1 Number of locations from which HIV ART is available	Number of locations	19 ART Centers : 11 GoB; 8 NGO (CDIC) (Program Data, December 2022)	27 ART Centers : 19 GoB; 8 NGO (CDIC)	33 ART Centers : 25 GoB; 8 NGO (CDIC)	NSP Ref: Strategy # 3.1.7
	3.2.2 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	# of PLHIV who received TB treatment and ART in accordance with the treatment protocol	43.23% (Program data, December 2022)	81.1% (program data, interpolation between 2022 to 2028)	100% (program data, interpolation between 2022 to 2028)	NSP Ref: Strategy # 3.1.1, 3.1.7
	3.2.3 Number of health service providers trained to provide treatment, care and support service sensitive to human rights, age and gender for KP, PLHIV and their families.	Training of Service providers (Including Doctors & Nurse)	1087 (Doctor, nurse, counselor, MT-lab and others)	1250 (15% increase by baseline value)	1375 (10% increase by 2026 target)	NSP Ref: Strategy # 3.2
3.3 Ensure functional systems for related policy adoption, linkages, and updates, including for more robust engagement of communities in supporting the treatment and care cascade	3.3.1 Review of policies and protocols conducted	Number of protocols and policies reviewed	5 protocols, guidelines and plans ( 1. MIP for HIV Service Delivery among Key Populations in Government Hospitals of Bangladesh, 2022; 2. National Guideline on Prevention of Mother to Child Transmission (PMTCT) of HIV, Hepatitis and Congenital Syphilis), 2021; 3. Guidelines on Secondary Channels of Needle and Syringe Distribution in PWID Intervention, 2021;4. Revised Guidelines Managing Staff Exposure to COVID-19 in Program Settings, 2021 ; 5. Standard Operating Procedures for Quantitative HIV 1 Viral Load Testing Using GeneXpert Technology, 2021; 6. National HIV Viral Load Optimization Plan 2022-2026).	6 National guidelines & strategies: 1. National Strategic plan for Human Rights and Gender Rights 2. Mid term review of National Strategic Plan for HIV & AIDS 3.Guidelines and manuals for PrEP. 4..National guideline and / SoP on HIV self-testing 5.National M & E Plan 6. 3rd investment case for HIV	3 guidelines, strategy and protocols: 1. National Management guideline on ART 2. National HTS guideline 3. National guideline for community led HTS	NSP Ref: Strategy # 3.1.6 and 3.3
	3.3.2 Functional linkages between ASP and national technical entities ( e.g. MNCH, NTP/CDC/IDH/ GoB Hospital/DGHS, SRH/DGFP,OGSB, BSMMU)	Number of advocacy and consultative meeting and workshop	10 advocacy meeting (Program data, 2022)	10 advocacy meeting	10 advocacy meeting	NSP Ref: Strategy # 3.3

3.4 A comprehensive approach to the community support system is adopted to remove barriers to accessing services and strengthen treatment adherence, care, and support for PLHIV, including CABA and OVC	3.4.1 Percentage of respondents ( Age 15+) who report receiving a positive HIV test result and experienced verbal insult, harassment or threats	Number of PLHIV	12.4% (2nd National Stigma Index, Bangladesh,2017; Table-22, Page-61)	<10%	<10%	NSP Ref: Strategy # 3.4
	3.4.2 .Percentage of key populations having reported avoiding of healthcare because of stigma and discrimination in the last 12 months Numerator: Number of key populations reported having avoided seeking healthcare because of stigma and discrimination in the last 12 months Denominator: Number of respondent (key population)	MSM	Data not available	<10%	<10%	
		MSW	Data not available	<10%	<10%	
		FSW	Data not available	<10%	<10%	
		Hijra	Data not available	<10%	<10%	
		PWID (Male)	Data not available	<10%	<10%	
		PWID (Female)	Data not available	<10%	<10%	

**Objective 4: To establish resilient, sustainable health systems and strengthen community systems for an integrated, people-centric HIV and AIDS response in Bangladesh.**

Strategy	Indicators	Population/Unit	2022 Base-line (data source)	2026 target	2028 target	Remarks
4.1 Strengthening the capacity of health actors, institutions, and populations to prepare for and effectively respond to HIV and AIDS while maintaining its essential functions.	4.1.1. Strengthen NAC and TC-NAC for a more functional role in guiding the national HIV response.	# of meetings	2	6	4	NSP Ref: Strategy # 4.1.1
	4.1.2 Strengthen NASC through capacity building and providing appropriate structure, human resources, and other logistics to enable NASC to provide high-quality, rights-sensitive services tailored to the unique needs of PLHIV, KPs and those at emerging risk	# of advocacy/training	Need based	Need based	Need based	NSP Ref: Strategy # 4.1.2, 4.1.5
	4.1.3 Conduct stakeholder meetings to coordinate, review and integrate the HIV response across other ministries and departments and with civil society groups.	# of issues discussed and integrated	Data not available	Issues around migrant, TG, PWID and PLHIV	As required	NSP Ref: Strategy # 4.1.3 & 4.1.4
4.2 Strengthen transition and integration of HIV services into government health systems, especially in public health care settings, by establishing functional links for co-infections (e.g., Tuberculosis, Hepatitis, cervical cancer) and non-communicable diseases, including mental health.	4.2.1 Transition Readiness assessment	# of report	2022 (ASP)		One	NSP Ref: Strategy # 4.2
	4.2.2 Number of service centers integrated with Government facility	# of facility	33 (24 Health+9 Home Ministry)	83 (64 Health+19 Home Ministry)	132 (64 Health+68 Home Ministry)	NSP Ref: Strategy # 4.2
	4.2.3 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	Estimated # of incident TB cases in PLHIV	107 (Program data, January-December, 2022)	143 (10% of total HIV positive patient)	173 (10% of total HIV positive patient)	NSP Ref: Strategy # 4.2.1
		# of PLHIV who received TB preventive treatment and ART in accordance with the treatment protocol	74.69% (Program data, January-December, 2022)	100% of Negative cases	100% of Negative cases	NSP Ref: Strategy # 4.2.2
4.3 Strengthen supply chains to ensure medicines, laboratory services, and health products are available when and where these are needed.	4.3.1 Establish internet-based real-time Logistic Management Information System (LMIS) of HIV commodities (HIV antiretroviral drugs, test kits, reagents, needles, syringes, condoms, methadone etc.) at HIV service centers.	# of facility	LMIS yet to start	40	65	NSP Ref: Strategy # 4.3
4.4 Ensure quality laboratory and diagnostic services are expanded and available at all levels	4.4.1 Capacity building of laboratory and diagnostic facilities (human resources, budget, infrastructure, logistics, and supplies) at the district and intervention site levels.	# of advocacy/training	Need based	Need based	Need based	NSP Ref: Strategy # 4.4.1, 4.4.3, 4.4.4 & 4.4.5
	4.4.2 Optimization use of GeneXpert and PCR machines for viral load test	# of facility	11	19	25	NSP Ref: Strategy # 4.4.2
4.5 Strengthen community systems and community-led HIV programming and help integrate them into national health and social systems.	4.5.1 Further build the capacity of CBOs in scaling up outreach services, community-led monitoring, documentation, and advocacy for domestic resource mobilization	Number of CBOs	15 ( 10 CBOs in 10 brothels, SWN, APOSH, NPUD, Bandhu, AAS)	25	25	NSP Ref: Strategy # 4.5.1 and 4.5.4
	4.5.2 Enhance formal partnerships between community-led and health facility or private service providers, coordinate joint outreach efforts, and implement bi-directional referral mechanisms between health and community-led service delivery points.	Number of partnership forms	17 ( ASP-5, NGO-12)	In addition to baseline 11 new ( ASP-7, NGO-4)	5 new	NSP Ref: Strategy # 4.5.2
	4.5.3 Ensure the involvement of community representatives in high-level health advisory boards, governance bodies, oversight committees (including clinic health committees), and other decision-making forums.	community representative	Yes (Oversight committee+BCCM)	Yes (Oversight committee+BCCM)	Yes (Oversight committee+BCCM)	NSP Ref: Strategy # 4.5.3

Strategy	Indicators	Population/Unit	2022 Base-line (data source)	2026 target	2028 target	Remarks
	4.5.4 Percentage of sexual and/or physical violence cases mitigated among KPs through legal support  Numerator: Number of sexual and/or physical violence cases mitigated among KPs through legal support Denominator: Number of sexual and/or physical violence cases among KPs recorded by community lead entity	MSM	Data not available	<10%	<10%	NSP Ref: Strategy # 1.6
		MSW	Data not available	<10%	<10%	
		FSW	Data not available	<10%	<10%	
		Hijra(TG)	Data not available	<10%	<10%	
		Male PWID	Data not available	<10%	<10%	
		Female PWID	Data not available	<10%	<10%	
4.6 Adopt mitigation plans for health and other emergencies, including the COVID-19 pandemic and natural and human-made disasters.						Indicator to be developed based on required emergency response NSP Ref: Strategy # 4.6

Objective 5: To strengthen strategic information systems and research for an evidence -based response						
Strategy	Indicators	Population/ Unit	2022 Base-line (data source)	2026 target	2028 target	Remarks
5.1 Conduct comprehensive surveillance to strengthen the capacity to respond considering all population sub-groups, epidemiology, age, sex, and geographical considerations.	5.1.1 Regular IBBS for KPs	MSM, MSW, Hijra, PWID (male , female), FSW( street, resident, hotel and brothel) , Prisoners	IBBS-2020	One in 2025	One	NSP Ref: Strategy # 5.1
5.2 Conduct the key population size estimation considering all population sub-groups, epidemiology, age, sex, and geographical considerations.	5.2.1 Mapping and size estimation of Key populations	MSM, MSW, Hijra, PWID (male , female), FSW( street, resident, hotel and brothel) , Prisoners	Mapping and size estimation of Key populations and HIV risk behaviors in Bangladesh 2023	--	One	NSP Ref: Strategy # 5.2
5.3 Conduct the Stigma Index led by the communities	5.3.1 National Stigma Index	PLHIV including KPs	Stigma index, 2017, PLHIV Network	One	--	NSP Ref: Strategy # 5.3
5.4 Strengthen national strategic information as well as monitoring and evaluation guidelines to harmonize existing reporting systems, including the HIV database and DHIS2, for alignment and coherence.	5.4.1 Management Information System in place, maintained and improved for prevention interventions among KPs	MIS	MIS in place and routine HIV reporting for GP and KP's is ongoing. This is well maintain by DG-MIS	To integrate HIV related all indicators and developed some data sets for KP's, Migrants, PLHIV and GP.	To integrate HIV related all indicators and developed all relevant data sets for KP's, Migrants, PLHIV and GP.	NSP Ref: Strategy # 5.4
	5.4.2. PLHIV database developed and functional	Database	This is functional	Developed ongoing and create image variable for PLHIV	Produce all kinds of report by PLHIV	NSP Ref: Strategy # 5.4
	5.4.3 National HIV website is maintained and acts as an inventory of all relevant resources	Website	Well maintained and functional	Development ongoing and well maintained	All resource will be available in the website	NSP Ref: Strategy # 5.4
5.5 Conduct relevant research to inform the national strategic response	5.5.2 Conduct relevant research including STI surveillance, stigma index among PLHIV and size estimations of key populations	STI surveillance survey	STI surveillance, 2020, IEDCR, ASP	One	--	NSP Ref: Strategy # 5.5
		CABA Study	CABA study, 2013, ASP	--	--	NSP Ref: Strategy # 5.5
		Operation research/studies based on emerging needs	10 (ASP-4, icddr,b-4, Save The Children-2)	17 (ASP-12, icddr,b-3, Save The Children-2)	8 (ASP-8)	NSP Ref: Strategy # 5.5
5.6 Increase the "granularity" of data, appropriately disaggregated to the district, community, and facility levels by age, sex, population groups, and location to better understand sub-national epidemics and assess performance along the continuum of HIV services	5.6.1 HIV data base functioning and reporting on data disaggregated to the district, community, and facility levels by age, sex, population groups, and location	Functioning HIV database	Started	Reports with granular data generated	Reports with granular data generated	NSP Ref: Strategy # 5.6
5.7 Strengthen monitoring and evaluation	5.7.1 Monitoring and evaluation plan revised and updated	M&E Plan	National M & E Plan revised in 2021 (ASP)	One	-	NSP Ref: Strategy # 5.7
5.8 Improve systems for knowledge management	5.8.1 Number of coordination, knowledge sharing and working group meetings held on information and research agenda	Meetings	2 SI and M&E TWG, 2022	8 (six monthly) SI and M&E TWG meetings; and other need-based meetings for knowledge management	4 (Six monthly) SI and M&E TWG meetings; and other need-based meetings for knowledge management	NSP Ref: Strategy # 5.8

## Assumptions

**Exchange rate:** USD 1 = 101 BDT

**Inflationary adjustment:** 8% per year from 2024

2024	2025	2026	2027	2028
1.00	1.08	1.17	1.26	1.36

## Reference Costing:

1. 4th NSP 2018-2022
2. Costed National Implementation Plan 2018-22
3. Investment Case - Prioritizing Investment Options in HIV Response in Bangladesh to End AIDS by 2030
4. Costing data from GOB budget, 2017-2022
5. National HIV and AIDS M&E Operation Plan 2018-2022 : Roadmap 2016-2017
6. Mapping Study and Size Estimation 2022-2023

**IMPLEMENTATION PLAN OF NATIONAL STRATEGIC PLAN 2024 - 2028**

**Summary Budget**

	2024	2025	2026	2027	2028	Total (USD)	Total (BDT)
Programme Objective 1: To prevent new HIV infections by expanding programme coverage by implementing comprehensive, targeted interventions; providing age, gender, and human-rights-sensitive services; and fostering active community involvement in promoting public health.	19,220,872	21,544,959	30,717,038	26,434,977	28,782,563	126,700,408	12,796,741,250
Programme Objective 2: To ensure innovative, effective, ethical and differentiated HIV testing and case-finding approaches are scaled up across the country	4,910,334	5,817,071	7,821,542	9,200,725	10,139,151	37,888,823	3,826,771,125
Programme Objective 3: To provide universal access to treatment, care, and support services for PLHIV and AIDS	4,387,790	5,200,754	5,982,585	7,006,170	8,111,349	30,688,649	3,099,553,525
Programme Objective 4: To establish resilient, sustainable health systems and strengthen community systems for an integrated, people-centric HIV and AIDS response in Bangladesh through the universal health coverage approach.	8,099,136	3,015,218	3,457,040	3,063,939	3,328,127	20,963,460	2,117,309,410
Programme objective 5: To strengthen strategic information systems and research for an evidence-based response	49,241	688,390	248,756	3,298,124	1,511,050	5,795,561	585,351,679
<b>GRAND TOTAL</b>	<b>36,669,397</b>	<b>36,268,417</b>	<b>48,228,987</b>	<b>49,005,962</b>	<b>51,874,268</b>	<b>222,036,901</b>	<b>22,425,726,989</b>

IMPLEMENTATION PLAN OF NATIONAL STRATEGIC PLAN 2024 - 2028

Programme objective 1: To prevent new HIV infections by expanding programme coverage by implementing comprehensive, targeted interventions; providing age, gender, and human-rights-sensitive services; and fostering active community involvement in promoting public health.

Sl. No.	Specific Activities	Measurement Unit						Comments/Explanation
			2024	2025	2026	2027	2028	
								0
1.1.1	Increase access to and uptake of comprehensive HIV prevention services for MSM and MSW their sexual partners in case of both commercial and non-commercial sex acts.	MSM	71,064	71,064	71,064	76,888	76,888	
		MSW	30,190	30,190	30,190	32,625	32,625	
		PrEP	800	800	800	800	800	
1.1.2	Increase access to and uptake of comprehensive HIV prevention services for female sex workers, their clients, and other sexual partners.	FSW	72,352	72,352	72,352	77,833	77,833	
1.1.3	Increase access to and uptake of comprehensive HIV prevention services for transgender people (who are sex workers), their clients, and other sexual partners.	Hijra	8,335	8,335	8,335	8,967	8,967	
1.1.4	Increase access to and uptake of comprehensive HIV prevention services for PUD (injecting and non-injecting) and their sexual partners.	Male PWID	21,453	21,453	21,453	23,156	23,156	
		Female PWID	200	200	200	216	216	
		PWID	7,458	7,458	7,458	7,458	7,458	
1.1.5	Standardize and extend HIV, Tuberculosis, and Hepatitis services in prisons and other closed settings.	No.of person						
1.1.6	Implement a comprehensive prevention HIV service package for migrant workers and sexual partners.							
1.1.6.1	Conduct national situation assessment to find out the HIV risk among the migrant	No. of assessments	0	1	1	0	0	
1.1.6.2	BCC material development (leaflets, posters, brochures etc.)	No. of BCC packages	20,000	20,000	20,000	20,000	20,000	
1.1.6.3	Interventions for migrants and their families	No. of persons	20,000	25,000	30,000	35,000	40,000	
1.1.6.4	Billboard for General Populations including Migrants	No. of units	0	0	600	0	0	
1.1.7	Scale up integrated HIV service package for FDMN.	Same as Treatment	0	0	0	0	0	Budget ref.: 3.1.2.3 (Provide ART to the PLHIV)
								0
1.2.1	Ensure all pregnant women get HIV/Hep B/Hep C/Syphilis testing from ANC clinics, including private health facilities.	No. of development	150	150	150	150	150	

SI. No.	Specific Activities	Measurement Unit						Comments/Explanation
			2024	2025	2026	2027	2028	
1.2.2	Ensure that all pregnant women who are living with HIV are on ART.	Same as Treatment (3.1.2.3)	0	0	0	0	0	Budget ref.: 3.1.2.3 (Provide ART to the PLHIV)
1.2.3	Strengthen the EMCTC of HIV, syphilis, perinatal hepatitis b, and congenital chagas disease programme in coordination with the Directorate General of Family Planning	No. of Meetings	0	50	50	50	50	
1.2.4	Strengthen linkage from screening facilities to confirmatory centres and subsequently to treatment centres.	No. of Meetings	0	50	50	50	50	
1.2.5	Expand early infant diagnosis (EID) for all HIV-exposed infants.	No. of Centers	0	1	0	0	0	
								0
1.3.1	Interventions for vulnerable populations (Transport, Garments workers, adolescent etc.)	No. of interventions	0	0	1	2	2	Includes age sepcific and sensistive services to MARA (Training of the servie providers, employing MARA Peer Educators)
1.3.2	Training of master trainers and peer educators	# of district	0	0	20	30	14	
1.3.3	Implement basic HIV prevention services for non-injecting drug users	No. of persons	10,000	10,000	10,000	10,000	10,000	
1.3.4	Implement basic HIV prevention services for clients of sex workers	No. of persons	40,000	50,000	50,000	50,000	50,000	
								0

SI. No.	Specific Activities	Measurement Unit						Comments/Explanation
			2024	2025	2026	2027	2028	
1.4.1	Promote awareness among health service providers, laboratory staff, survivors of gender-based violence, etc.	No. of districts (2 batch in 1 district)	0	0	64	64	64	
1.4.2	Provide PEP starter kits	No. of Units	0	286	286	286	286	
								0
1.5.1	Conduct mass media BCC campaigns based on different risk behaviors including STI	No. of campaigns	10	10	10	10	10	
1.5.2	Conduct social media BCC campaign	per year events	1	1	1	1	1	
1.5.3	Training of master trainers and peer educators	per year events	1	1	1	1	1	Inclusive of integrated information on updated STI management guidelines to and promote STI knowledge in general health through BCC strategies
								0
1.6.1	Events to address HIV related human rights issues	No. of year support	1	1	1	1	1	
1.6.2	Sensitize and mobilize the involvement of the media in contributing to the HIV response and Human Rights	No. of year support	2	2	2	2	2	
1.6.3	Capacity building of non-health service providers of relevant ministries, employers federation/trade unions on HIV & AIDS and Human Rights	No of training sessions	4	5	5	5	5	
1.6.4	Provide training for CBOs on policy development, advocacy, legal literacy and Human Rights.	No. of person	0	0	4	4	4	
								0
2.1.1	Revision/adaption and printing of guidelines for HTS	No. of TA	0	0	1	0	1	
2.1.2	Establish HTS in public hospitals at district level	No. of hospital	0	0	16	20	0	
2.1.3	Continue HTS in public hospitals at district level	No. of hospital	23	23	56	64	64	
2.1.4	HIV testing kit (3 test) with other consumables (including for FDMN, for community led testing and for ANC)	No. of kits/ persons	409,360	450,296	450,296	484,753	484,753	
								0
2.2.1	Develop Guideline for Community-led Testing	No of TA	-	1	-	-	-	
2.2.2	Training and refresher training on community-led testing and self testing of representatives from KP communities (FSW, MSM/MSW, TG, PUD)	No. of Batches	-	-	32	32	64	
								0
2.3.1	Conduct court-yard discussion	No of meeting	-	40	100	100	100	

SI. No.	Specific Activities	Measurement Unit						Comments/Explanation
			2024	2025	2026	2027	2028	
2.3.2	Testing Campaign	No of campaign	3	6	6	6	6	
<b>0</b>								
2.4.1	Develop SOP for Community based Self Testing	No of TA	-	1	-	-	-	
2.4.2	HIV Self testing kit with other consumables	No. of kits/ persons	429,828	472,811	472,811	508,990	508,990	
<b>0</b>								
<b>3.1.1</b>	<b>Maintain existing care, support, and treatment services models and expand further in a sustainable manner.</b>							
3.1.1.1	Develop/update protocol for care and support	No. of protocol developed	0	0	1	0	0	
3.1.1.2	Conduct capacity building for care providers	No. of person	0	0	4	4	4	
3.1.1.3	Number of PLHIV enrolled in HIV care	No. of person	4021	4108	4205	4313	4313	
<b>3.1.2</b>	<b>Continue provisions of high-quality ART drug through differentiated service delivery models, including multi-month dispensing, community-led adherence monitoring, etc., improving access and retention to care.</b>							
3.1.2.1	Pocket Manual to support DSD	No. of document	500	-	-	500	-	
3.1.2.2	Training and refresher training Communities on Adherence monitoring	No. of batches	-	6	-	6	-	
3.1.2.3	Provide ART to the PLHIV (all who are identified)	No. of person	8,000	8,680	9,418	10,218	11,087	
3.1.2.4	Follow up for adherence and retention by local service providers	No of visits	360	360	360	360	360	
3.1.2.5	ART Advisory Committee Meeting (15 persons)	No. of Meeting	2	2	2	2	2	
<b>3.1.3</b>	<b>Focus on rapid ART initiation (the same day after a confirmed HIV diagnosis) for all people irrespective of age, sex or gender and advanced HIV disease management augmenting quality of care.</b>							
3.1.3.1	Develop and maintain functional HIV treatment and management task force to ensure rapid ART initiation, advanced HIV disease management, address lost to follow up etc,	No. of meeting	4	4	4	4	4	208.9108911
3.1.4	<b>Address underlying causes of lost-to-follow-up at all levels.</b>	Activity refer to 3.1.2.4	-	-	-	-	-	Budget ref.:3.1.2.4 (Follow up for adherence and retention by local service providers)
<b>3.1.5</b>	<b>Optimize the uses of public sector laboratories for viral load measurements.</b>							
3.1.5.1	Number of PLHIV on ART receive viral load test	No. of person	7,125	7,838	8,621	9,483	10,432	
<b>3.1.6</b>	<b>Update the treatment and viral load guidelines periodically, update all service providers, and continue the promotion of U=U.</b>							
3.1.6.1	Develop comprehensive protocols and procedures		-	1	-	-	-	
3.1.6.2	Review, update and dissemination of treatment protocol - 2 times	No. of review and printing	-	-	1	-	-	
3.1.6.3	Integrate HIV treatment and management in medical curriculum	No. of TA	-	-	-	1	-	
<b>3.1.7</b>	<b>Bring efficiencies and improve linkages through one-stop service delivery models at public hospitals.</b>							
3.1.7.1	Identify and ensure access to training in specialisations identified through human resource functional analysis - out country	No. of person	5	5	5	5	5	Inclusive of training of service providers on STIs as per management guideline
3.1.7.2	SOP for ensuring regulatory frameworks mitigate risk	No. of SOP	-	1	-	-	-	
<b>0</b>								
3.2.1	Basic Clinical Training on HIV/ AIDS for government, non-government, and private sectors to provide age, gender, and human rights-sensitive out-patient and in-patient medical management for PLHIV and KPs.	No. of person	128	128	128	128	128	Inclusive of training of service providers on STIs as per management guideline
<b>0</b>								
3.3.1	Set up support to engage communities in supporting the treatment and care cascade to comply with related policy adoption, linkages, and updates	No. of CBO / Network	1	0	0	0	0	
<b>0</b>								

HTS training/ Dhaka based G-9 25 participants

SI. No.	Specific Activities	Measurement Unit						Comments/Explanation
			2024	2025	2026	2027	2028	
3.4.1	Running Cost to ensure a comprehensive approach to the community support system is adopted and continued to remove barriers to accessing services and strengthen treatment adherence, care, and support for PLHIV, including children affected by HIV and AIDS and orphans and vulnerable children.	No. of person	10	10	10	10	10	
<b>4</b>								<b>0</b>
<b>4.1</b>								<b>0</b>
<b>4.1.1</b>	<b>Strengthen NAC and TC-NAC for a more functional role in guiding the national HIV response.</b>							
4.1.1.1	Conduct annual meeting of NAC	No. of meeting	1	1	1	1	1	
4.1.1.2	Conduct quarterly meetings of TC-NAC	No. of meeting	2	2	2	2	2	
4.1.1.3	Produce annual program report	No. of report	1	1	1	1	1	
<b>4.1.2</b>	<b>Strengthen NASC through capacity building and providing appropriate structure, human resources, and other logistics.</b>							
4.1.2.1	Provide equipment, furniture and logistics	No. of time supported	6	2	2	2	2	
4.1.2.2	Provide utilities and supplies	No. months supported	20	22	22	22	22	
4.1.2.3	ASP HR	No. of year supported	1	1	1	1	1	
4.1.2.4	Conduct advisory committee meetings (half yearly)	No. of meeting	2	2	2	2	2	
<b>4.1.3</b>	<b>Conduct stakeholder meetings to coordinate, review and integrate the HIV response across other ministries and departments and with civil society</b>							
4.1.3.1	Conduct quarterly coordination meetings with stakeholders	No. of meeting	4	4	4	4	4	
4.1.3.2	Develop functional district level coordination under district health authority (CS) to be facilitated by local agency	No. of meeting	64	0	64	0	64	
<b>4.1.4</b>	<b>Facilitate the development and implementation of activities and plans in key sectors for strengthened collaboration on HIV prevention, treatment,</b>							
4.1.4.1	Workshops with multisectoral authorities on relevant HIV Prevention, Treatment, Care and Support issues where collaboration needed.	No. of batches	5	0	0	0	0	
4.1.4.2	Compile and share action plan as per workshop discussion	No. of consultant	1	0	0	0	0	
4.1.4.3	Develop advocacy materials (packages)	No. of material package developed	8000	8000	8000	8000	8000	
4.1.4.4	Conduct national level advocacy	No. of persons attended	2	2	2	2	2	
4.1.4.5	Conduct local level advocacy	No. of persons attended	64	64	64	64	64	
4.1.4.6	Celebration of World AIDS Day	No. of events organized	1	1	1	1	1	
<b>4.1.5</b>	<b>Strengthen human resource capacity across the health and HIV sector to achieve NSP targets by providing high-quality, rights-sensitive services</b>							
4.1.5.1	Develop core curriculum and training resources	No. of TA	1	0	0	0	0	Inclusive of SRHR and Universal Health Coverage
<b>4.2</b>								<b>0</b>
<b>4.2.1</b>	<b>Develop capacities in health institutions and engage relevant programmes for strong referral linkages so co-infections and co-morbidities are detected</b>							
4.2.1.1	Enhance integration of HIV with TB, Hepatitis and SRH services (e.g. strengthening referral mechanism, advocacy with Hospital directors, management, increase community involvement etc.) to support Universal Health Coverage.	No. of Patient Referred	600	600	600	600	600	
<b>4.2.2</b>	<b>Strengthen Tuberculosis preventive therapy</b>							
4.2.2.1	Training to Strengthen Tuberculosis preventive therapy	No. of batches		3		3		
4.2.2.2	Detection of eligible PLHIV for Tuberculosis prevention	No. of Patient	0	0	0	0	0	In Kind Support
4.2.2.3	Management for Tuberculosis prevention	No. of Patient	0	0	0	0	0	In Kind Support link to
4.2.2.4	Follow up for adherence by local service providers	No. of visit	0	0	0	0	0	
<b>4.3</b>								<b>0</b>
<b>4.3.1</b>	<b>Ensure adequate budgetary allocation to purchase HIV-related commodities</b>							
4.3.1.1	Procurement Committing Meetings	No. of meetings	4	4	4	4	4	

30 person doctor, MT, counselor

SI. No.	Specific Activities	Measurement Unit						Comments/Explanation
			2024	2025	2026	2027	2028	
<b>4.3.2</b>	<b>Ensure zero stock out of HIV commodities at all levels</b>							
4.3.2.1	SOP to mitigate risk in alignment with health center regulation	No. of person	1					
4.3.2.2	Training and refresher training on inventory management systems	No. of batches		3		3		
<b>4.3.3</b>	<b>Strengthen the capacity of district and sub-district level HIV service providers to prepare detailed specifications, quantification and forecasting, and</b>							
4.3.3.1	Comprehensive guidelines on procedures to strengthen the capacity	No. of guideline	1					
4.3.3.2	Training and refresher training on inventory management systems	No. of batches		3		3		
<b>4.3.4</b>	<b>Establish multi-year procurement and supply chain management to ensure supplies are available in all health facilities for the general population and</b>							
4.3.4.1	Half yearly Meetings of advisory committee on supply chain	No. of person	2	2	2	2	2	
4.3.4.2	Health Product Chain Management (storage, SCM, Inventories)	No. of Months	12	12	12	12	12	
<b>4.3.5</b>	<b>Establish internet-based real-time Logistic Management Information System of HIV commodities (HIV antiretroviral drugs, test kits, reagents, needles,</b>							
4.3.5.1	Establish internet-based real-time Logistic Management Information System of HIV commodities	No. of person	1					
4.3.5.2	Training and refresher training on establish internet-based real-time Logistic Management Information System of HIV commodities	No. of person		3		3		
4.4								<b>0</b>
<b>4.4.1</b>	<b>Capacity building of laboratory and diagnostic facilities (human resources, budget, infrastructure, logistics, and supplies) at the district and</b>							
4.4.1.1	Develop guidelines and regulatory framework in alignment with	No. of guideline	1					
4.4.1.2	Set up lab requirements	No. of Units	70					
4.4.1.3	Ensure uninterrupted supply chain systems: meetings and pri	No. of Meetings	60	60	60	60	60	
4.4.1.4	Training and refresher training on uninterrupted supply chain	No. of batches		3		3		
<b>4.4.2</b>	<b>Optimization use of GeneXpert and PCR machines for viral load test</b>							
4.4.2.1	Develop guidelines and regulatory framework in alignment with	No. of guideline (Same as 4.4.1.1)						Budget Ref.: 4.4.1 (Capacity building of laboratory and diagnostic facilities (human resources, budget, infrastructure, logistics, and supplies) at the district and intervention site levels.)
4.4.2.2	Set up lab requirements	No. of Units (Same as 4.4.1.2)						
4.4.2.3	Ensure uninterrupted supply chain systems: meetings and pri	No. of Units (Same as 4.4.1.3)						
4.4.2.4	Training	No. of batches (Same as 4.4.1.4)						
<b>4.4.3</b>	<b>Ensure quality control of HIV testing through quality assurance from the national reference laboratory</b>							
4.4.3.1	Establish National Reference Laboratory	No. of year supported	0	1	2	0	0	
4.4.3.2	Develop protocol/guidelines for provision of laboratory services (inclusive of conducting quality assurance for public, private and NGO laboratories)	No. of guideline	0	0	1	0	0	
<b>4.4.4</b>	<b>Coordination with private health facilities and labs to scale up laboratory services and quality assurance of the labs</b>							
4.4.4.1	Coordination workshops with private health facilities and labs	No. of person	35	35			35	
4.4.4.2	Training to scale up laboratory services and quality assurance	No. of person		35		35		
<b>4.4.5</b>	<b>Enhance partnerships between public and private sector actors so programing and services are sustainable and can reach more people.</b>							
4.4.5.1	Meetings for MOUs	No. of person (Same as 4.4.4.1)						Budget Ref.: 4.4.4.1 (Coordination workshops with private health facilities and labs to scale up laboratory services and quality assurance of the labs)
4.5								<b>0</b>
<b>4.5.1</b>	<b>Build the capacity of CBOs in scaling up outreach services, community-led monitoring, documentation, and advocacy for domestic resource mobilization.</b>							
4.5.1.1	Infrastructure of CBOs to contribute HIV program among KPs	No. of CBO / monthly support	48	72	96	120	144	
4.5.1.2	Provide management training for CBOs	No. of person	0	4	4	4	4	

SI. No.	Specific Activities	Measurement Unit						Comments/Explanation
			2024	2025	2026	2027	2028	
4.5.1.3	Provide leadership and accountability training for CBOs	No. of person	0	0	4	4	4	
<b>4.5.2</b>	<b>Enhance formal partnerships between community-led and health facility or private service providers, coordinate joint outreach efforts, and implement bi-directional referral mechanisms between health and community-led service delivery points.</b>							
4.5.2.1	Quarterly meeting with community-led and health facility or p	No. of person	48	120	120	120	120	
4.5.2.2	Transport support to community members to facilitate partici	No. of person (Same as 4.2.2.4)						Budget Ref.: 4.2.2.4 (Follow up for adherence by local service providers) as it will be covered
<b>4.5.3</b>	<b>Ensure the involvement of community representatives in high-level health advisory boards, governance bodies, oversight committees (including clinic health committees), and other decision-making forums.</b>							
4.5.3.1	Transport support to community representatives in different t	No. of person (Same as 4.2.2.4)						Budget Ref.: 4.2.2.4 (Follow up for adherence by local service providers) as it will be covered
4.5.3.2	Meeting / workshop participation of community representativ	No. of meetings (to be covered by organizing entity)						Not budgeted as it should be covered by organizing entity for proper ownership
<b>4.5.4</b>	<b>Promote the participation of community representatives in national or regional peer-learning initiatives</b>							
4.5.4.1	Community representatives in regional peer-learning initiative	No. of person	3	3	3	3	3	
4.6								0
5								0
5.1								0
5.1.1	Conduct regular behavioural surveillance of all key populations with IBBS in some places	No. of surveillance	-	-	-	1	-	
5.1.2	Conduct regular STI surveillance	No. of study	-	-	-	1	-	
5.2								0
5.2	Conduct size estimation studies	No. of study	0	1	0	0	1	
5.3								0
5.3	Conduct Stigma Index Study	No. of study			1			
5.4								0
5.4.1	Maintain HIV Management Information System	No. of time supported	1	1	1	1	1	
5.4.2	Establish HIV reporting and maintain PLHIV database	No. of TA	0	0	1	1	1	
5.5								0
5.5.1	Conduct national workshop to prioritize as well as review existing research /operations research /studies; develop annual national agenda for research	No. of meeting	0	1	1	3	1	

SI. No.	Specific Activities	Measurement Unit						Comments/Explanation
			2024	2025	2026	2027	2028	
5.5.2	Conduct studies based on emerging needs	No. of study	0	0	0	1	0	
								0
5.6								
5.6.1	Produce guidelines and tools	No. of TA	2	0	0	1	1	
5.6.2	Conduct evaluation of design and effectiveness of current targeted interventions	No. of study	0	1	0	1		
								0
5.7								
5.7.1	Conduct mid-term and end-term evaluations	No. of study		0	0	1	1	
5.7.2	Periodic review and updating of the M&E system and its indicators in a participatory manner	No. of review and printing		1			1	
5.7.3	Advocacy workshop and follow up with the stakeholders to ensure regular reporting as well as providing feedback	No. of Workshop	0	0	4	4	4	
5.7.4	M&E training for staff across the sector	No. of person	1	1	6	6	6	
5.7.5	Conduct regular M&E visits to assess quality (third party monitoring may be considered)	No. of visits	24	24	24	24	24	
5.7.6	Conduct ART Adherence Monitoring	No. of year supported		1	1	1	1	
5.7.7	Conduct Client Satisfaction Survey at the public Health facilities integrating KP services	No. of survey		0	1	0	1	
								0
5.8								
5.8.1	Conduct quarterly M&E TWG and coordination Workshop	No. of meeting	4	4	4	4	4	
5.8.2	Develop, print and disseminate different reports	No. of time supported	1	1	1	1	1	

**Costed Implementation Plan**

Sl. No.	Specific Activities	Measure-ment Unit						Unit Rate USD (New)	Inflation Rate						Financial Total (USD)
			2024	2025	2026	2027	2028			2024	2025	2026	2027	2028	
									8.0%	1.00	1.08	1.17	1.26	1.36	
<b>Programme Objective 1: To prevent new HIV infections by expanding programme coverage by implementing comprehensive, targeted interventions; providing age, gender, and human-rights-sensitive services; and fostering active community involvement in promoting public health.</b>															
<b>Strategy 1.1: Ensure comprehensive HIV prevention services are accessible to key and vulnerable populations, their clients, and other sexual and needle-sharing partners.</b>															
1.1.1	Increase access to and uptake of comprehensive HIV prevention services for MSM and MSW their sexual partners in case of both commercial and non-commercial sex acts.	MSM	71,064	71,064	71,064	76,888	76,888	69.06	8.0%	4,907,647	5,300,259	5,724,279	6,688,961	7,224,078	29,845,224
		MSW	30,190	30,190	30,190	32,625	32,625	72.32	8.0%	2,183,370	2,358,040	2,546,683	2,972,225	3,210,003	13,270,321
		MSW	800	800	800	800	800	500.00	8.0%	400,000	432,000	466,560	503,885	544,196	2,346,640
1.1.2	Increase access to and uptake of comprehensive HIV prevention services for female sex workers, their clients, and other sexual partners.	FSW	72,352	72,352	72,352	77,833	77,833	61.66	8.0%	4,461,214	4,818,112	5,203,561	6,045,591	6,529,239	27,057,716
1.1.3	Increase access to and uptake of comprehensive HIV prevention services for transgender people (who are sex workers), their clients, and other sexual partners.	Hijra	8,335	8,335	8,335	8,967	8,967	74.71	8.0%	622,718	672,536	726,339	843,873	911,383	3,776,849
1.1.4	Increase access to and uptake of comprehensive HIV prevention services for PUD (injecting and non-injecting) and their sexual partners.	Male PWID	21,453	21,453	21,453	23,156	23,156	144.82	8.0%	3,106,862	3,355,411	3,623,843	4,224,366	4,562,315	18,872,797
		Female PWID	200	200	200	216	216	144.82	8.0%	28,922	31,236	33,735	39,325	42,471	175,688
		OST Services	3,500	3,500	3,500	3,500	3,500	278.69	8%	975,406	1,053,438	1,137,713	1,228,730	1,327,028	5,722,315
1.1.5	<b>Standardize and extend HIV, Tuberculosis, and Hepatitis services in prisons and other closed settings.</b>	Prison Intervention													
1.1.5.1	Human Resources for selected prisons to deliver HIV prevention and treatment services								8%	90,089	114,457	122,469	128,592	135,022	
1.1.5.2	Operation cost for HIV service delivery center of selected prison								8%	3,213	4,217	4,428	4,649	4,881	
1.1.5.3	Establishment of HIV service delivery (OST/ART) center in selected prison								8%		5,676		6,257	6,570	
1.1.5.4	Satellite session cost for HTS (local)								8%	-	176	176	185	194	
1.1.5.5	Docu Drama for prison								8%	4,995			5,507	5,782	
1.1.5.6	Procurement of Desktop and printer for prison								8%	-	2,131		2,349.94	2,467	
1.1.5.7	PSM Cost for Procurement of Desktop and printer for prison								8%	84			93	97	
1.1.5.8	Group Education Session among Prisoners								8%	2,158	2,769	2,908	3,053	3,206	
1.1.5.9	Higher level Workshop on Prison Staff								8%	1,253	1,258	1,264	1,327	1,394	
1.1.5.10	Orientation on HIV for Prison staffs in collaboration with IG Prisons								8%	5,444	7,568		8,343.51	8,761	
1.1.5.11	3 days training on HIV testing and counseling								8%	6,247	6,327		6,976	7,324	
1.1.5.12	PSM Cost for Procurement of Desktop and printer for prison								8%		8,400		9,261	9,724	
1.1.5.13	Continue interventions for prisoners	No. of persons	12000	12000	12000	12000	12000	70.00	8%	840,000	907,200	979,776	1,058,158	1,142,811	
	<b>Sub-total: 1.1.5</b>									<b>953,483</b>	<b>1,060,179</b>	<b>1,111,020</b>	<b>1,234,751</b>	<b>1,328,233</b>	<b>5,687,666</b>
1.1.6	Implement a comprehensive prevention HIV service package for migrant workers and sexual partners.														
1.1.6.1	Conduct national situation assessment to find out the HIV risk among the migrant	No. of assessments	0	1	1	0	0	525,000.00	8%	-	567,000	612,360	-	-	1,179,360
1.1.6.2	BCC material development (leaflets, posters, brochures etc.)	No. of BCC packages	20000	20000	20000	20000	20000	44.06	8%	881,250	951,750	1,027,890	1,110,121	1,198,931	5,169,942
1.1.6.3	Interventions for migrants and their families	No. of persons	20000	25000	30000	35000	40000	35.00	8%	700,000	945,000	1,224,720	1,543,147	1,904,685	6,317,552
1.1.6.4	Billboard for General Populations including Migrants	No. of units	0	0	600	0	0	10,400.00	8%	-	-	7,278,336	-	-	7,278,336
	<b>Sub-total: 1.1.6</b>									<b>1,581,250</b>	<b>2,463,750</b>	<b>10,143,306</b>	<b>2,653,268</b>	<b>3,103,615</b>	<b>19,945,130</b>
1.1.7	Scale up integrated HIV service package for FDMN.	Same as Treatment (3.1.2.3)	0	0	0	0	0	0	8%	-	-	-	-	-	-
	<b>Total: 1.1</b>									<b>19,220,872</b>	<b>21,544,959</b>	<b>30,717,038</b>	<b>26,434,977</b>	<b>28,782,563</b>	<b>126,700,408</b>
<b>Strategy 1.2: Reinforce HIV and STI prevention and other sexual and reproductive health (SRH) services aiming for the triple elimination of vertical transmission of HIV, hepatitis B, and syphilis.</b>															

SI. No.	Specific Activities	Measurement Unit						Unit Rate USD (New)	Inflation Rate						Financial Total (USD)
			2024	2025	2026	2027	2028			2024	2025	2026	2027	2028	
1.2.1	Ensure all pregnant women get HIV/Hep B/Hep C/Syphilis testing from ANC clinics, including private health facilities.	No. of development	150	150	150	150	150	60.00	8%	9,000	9,720	10,498	11,337	12,244	52,799
1.2.2	Ensure that all pregnant women who are living with HIV are on ART.	Same as Treatment (3.1.2.3)	0	0	0	0	0	0	8%	-	-	-	-	-	-
1.2.3	Strengthen the EMTCT of HIV, syphilis, perinatal hepatitis b, and congenital chagas disease programme in coordination with the Directorate General of Family Planning.	No. of Meetings	0	50	50	50	50	13,938.61	8%	-	752,685	812,900	877,932	948,167	3,391,684
1.2.4	Strengthen linkage from screening facilities to confirmatory centres and subsequently to treatment centres.	No. of Meetings	0	50	50	50	50	13,938.61	8%	-	752,685	812,900	877,932	948,167	3,391,684
1.2.5	Expand early infant diagnosis (EID) for all HIV-exposed infants.	No. of Centers	0	1	0	0	0	13,188.61	8%	-	14,244	-	-	-	14,244
<b>Total: 1.2</b>										<b>9,000</b>	<b>1,529,334</b>	<b>1,636,298</b>	<b>1,767,201</b>	<b>1,908,577</b>	<b>6,850,410</b>
<b>Strategy 1.3: Reduction of risk behaviours and provision of services for populations at emerging risk and vulnerable groups through awareness raising and evidence-based interventions to link them to integrated STI, HIV, and SRH services under Universal Health Coverage</b>															
1.3.1	Interventions for vulnerable populations (Transport, Garments workers, adolescent etc.)	No. of interventions	0	0	1	2	2	100,000.00	8%	-	-	116,640	251,942	272,098	640,680
1.3.2	Training of master trainers and peer educators	# of district	0	0	20	30	14	1,785.75	8%	-	-	41,658	67,486	34,013	143,157
1.3.3	Implement basic HIV prevention services for non-injecting drug users	No. of persons	10000	10000	10000	10000	10000	40.00	8.0%	400,000	432,000	466,560	503,885	544,196	2,346,640
1.3.4	Implement basic HIV prevention services for clients of sex workers	No. of persons	40000	50000	50000	50000	50000	20.00	8.0%	800,000	1,080,000	1,166,400	1,259,712	1,360,489	5,666,601
<b>Total: 1.3</b>										<b>1,200,000</b>	<b>1,512,000</b>	<b>1,791,258</b>	<b>2,083,025</b>	<b>2,210,795</b>	<b>8,797,079</b>
<b>Strategy 1.4: Promote infection prevention protocols and post-exposure prophylaxis measures for health service providers, laboratory staff, survivors of gender-based violence, etc.</b>															
1.4.1	Promote awareness among health service providers, laboratory staff, survivors of gender-based violence, etc.	No. of districts (2 batch in 1 district)	0	0	64	64	64	1,020.19	8%	-	-	76,156	82,249	88,829	247,234
1.4.2	Provide PEP starter kits	No. of Units	0	286	286	286	286	87.50	8%	-	27,027	29,189	31,524	34,046	121,787
<b>Total: 1.4</b>										<b>-</b>	<b>27,027</b>	<b>105,346</b>	<b>113,773</b>	<b>122,875</b>	<b>369,021</b>
<b>Strategy 1.5: Optimize behaviour change communication strategies to expand case detection and minimize risk behaviours in the general population, emphasizing adolescents and youth while connecting them to SRH and HTS.</b>															
1.5.1	Conduct mass media BCC campaigns based on different risk behaviors including STI	No. of campaigns	10	10	10	10	10	238,481.25	8%	2,384,813	2,575,598	2,781,645	3,004,177	3,244,511	13,990,743
1.5.2	Conduct social media BCC campaign	per year events	1	1	1	1	1	118,093.50	8%	118,094	127,541	137,744	148,764	160,665	692,807
1.5.3	Training of master trainers and peer educators	per year events	1	1	1	1	1	8,835.48	8%	8,835	9,542	10,306	11,130	12,021	51,834
<b>Total: 1.5</b>										<b>2,511,741</b>	<b>2,712,681</b>	<b>2,929,695</b>	<b>3,164,071</b>	<b>3,417,197</b>	<b>14,735,385</b>
<b>Strategy 1.6: Strengthen the empowerment of KP communities and eliminate human rights-related barriers to ensure equitable access to health services, including HIV prevention for all KPs.</b>															
1.6.1	Events to address HIV related human rights issues	No. of year support	1	1	1	1	1	983.76	8%	984	1,062	1,147	1,239	1,338	5,771
1.6.2	Sensitize and mobilize the involvement of the media in contributing to the HIV response and Human Rights	No. of year support	2	2	2	2	2	1,535.99	8%	3,072	3,318	3,583	3,870	4,179	18,022
1.6.3	Capacity building of non-health service providers of relevant ministries, employers federation/trade unions on HIV & AIDS and Human Rights	No of training sessions	4	5	5	5	5	1,000.84	8%	4,003	5,405	5,837	6,304	6,808	28,357
1.6.4	Provide training for CBOs on policy development, advocacy, legal literacy and Human Rights.	No. of person	0	0	4	4	4	2,956.98	8%	-	-	13,796	14,900	16,092	44,788
<b>Total: 1.6</b>										<b>8,059</b>	<b>9,785</b>	<b>24,364</b>	<b>26,313</b>	<b>28,418</b>	<b>96,938</b>
<b>Grand Total: Objective-1</b>										<b>22,949,673</b>	<b>27,335,785</b>	<b>37,203,998</b>	<b>33,589,360</b>	<b>36,470,425</b>	<b>157,549,241</b>
<b>Programme Objective 2: To ensure innovative, effective, ethical and differentiated HIV testing and case-finding approaches are scaled up across the country</b>															
<b>Strategy 2.1: Expand facility-based testing for key and general populations and promote provider-initiated testing and counselling in public and private antenatal care, tuberculosis, hepatitis C, hepatitis B, and STI service centres.</b>															
2.1.1	Revision/adaption and printing of guidelines for HTS	No. of TA	-	-	1	-	1	13,824	8%	-	-	16,125	-	18,808	34,932
2.1.2	Establish HTS in public hospitals at district level	No. of hospital	-	-	16	20	-	4,000	8%	-	-	74,650	100,777	-	175,427
2.1.3	Continue HTS in public hospitals at district level	No. of hospital	23	23	56	64	64	30,345	8%	697,935	753,770	1,982,087	2,446,461	2,642,178	8,522,432
2.1.4	HIV testing kit (3 test) with other consumables (including for FDMN, for community led testing and for ANC)	No. of kits/ persons	409,360	450,296	450,296	484,753	484,753	5	8%	2,046,799	2,431,597	2,626,125	3,053,245	3,297,504	13,455,270
<b>Total: 2.1</b>										<b>2,744,734</b>	<b>3,185,367</b>	<b>4,698,986</b>	<b>5,600,483</b>	<b>5,958,490</b>	<b>22,188,061</b>
<b>Strategy 2.2: Expand community-led testing for KPs by utilizing both trained and supervised lay providers and health professionals to conduct rapid HIV tests.</b>															
2.2.1	Develop Guideline for Community-led Testing	No of TA	0	1	0	0	0	30,439	8%	-	32,874	-	-	-	32,874
2.2.2	Training and refresher training on community-led testing and self testing of representatives from KP communities (FSW, MSM/MSW, TG, PUD)	No. of Batches	0	0	32	32	64	6,716	8%	-	-	250,686	270,741	584,800	1,106,227
<b>Total: 2.2</b>										<b>-</b>	<b>32,874</b>	<b>250,686</b>	<b>270,741</b>	<b>584,800</b>	<b>1,139,101</b>
<b>Strategy 2.3: Expand index testing, online to offline, and social risk network referral testing, complying with the three-test algorithm.</b>															
2.3.1	Conduct court-yard discussion	No of meeting	0	40	100	100	100	931	8%	-	40,206	108,556	117,241	126,620	392,622
2.3.2	Testing Campaign	No of campaign	3	6	6	6	6	841	8%	2,522	5,447	5,883	6,353	6,862	27,067
<b>Total: 2.3</b>										<b>2,522</b>	<b>45,653</b>	<b>114,439</b>	<b>123,594</b>	<b>133,481</b>	<b>419,689</b>
<b>Strategy 2.4: Introduce community-based HIV self-testing among KPs.</b>															
2.4.1	Develop SOP for Community based Self Testing	No of TA	1	-	-	-	-	13938.61386	8%	13,939	-	-	-	-	13,939
2.4.2	HIV Self testing kit with other consumables	No. of kits/ persons	429,828	472,811	472,811	508,990	508,990	5.00	8%	2,149,139	2,553,177	2,757,431	3,205,907	3,462,379	14,141,973
<b>Total: 2.4</b>										<b>2,163,078</b>	<b>2,553,177</b>	<b>2,757,431</b>	<b>3,205,907</b>	<b>3,462,379</b>	<b>14,141,973</b>
<b>Grand Total: Objective-2</b>										<b>4,910,334</b>	<b>5,817,071</b>	<b>7,821,542</b>	<b>9,200,725</b>	<b>10,139,151</b>	<b>37,888,823</b>

SI. No.	Specific Activities	Measure-ment Unit	2024	2025	2026	2027	2028	Unit Rate USD (New)	Inflation Rate	2024	2025	2026	2027	2028	Financial Total (USD)
<b>Programme Objective 3: To provide universal access to treatment, care, and support services for PLHIV and AIDS</b>															
<b>Strategy 3.1: Reduce mortality and morbidity among PLHIV through early detection and treatment by strengthening government, non-government, and private sector facilities.</b>															
<b>3.1.1 Maintain existing care, support, and treatment services models and expand further in a sustainable manner.</b>															
3.1.1.1	Develop/update protocol for care and support	No. of protocol developed	-	-	1	-	-	18,485	8%	-	-	21,561	-	-	21,561
3.1.1.2	Conduct capacity building for care providers	No. of person	-	-	4	4	4	2,756	8%	-	-	12,858	13,887	14,998	41,743
3.1.1.3	Number of PLHIV enrolled in HIV care	No. of person	4,021	4,108	4,205	4,313	4,313	12	8%	47,774	52,713	58,274	64,552	69,716	293,029
<b>Total: 3.1.1</b>										<b>47,774</b>	<b>52,713</b>	<b>71,132</b>	<b>78,439</b>	<b>84,714</b>	<b>334,772</b>
<b>3.1.2 Continue provisions of high-quality ART drug through differentiated service delivery models, including multi-month dispensing, community-led adherence monitoring, etc., improving access and retention to care.</b>															
3.1.2.1	Pocket Manual to support DSD	No. of document	500	-	-	500	-	2	8%	1,000	-	-	1,260	-	2,260
3.1.2.2	Training and refreshers training Communities on Adherence monitoring	No. of batches	-	6	-	6	-	1,736	8%	-	11,247	-	13,118	-	24,365
3.1.2.3	Provide ART to the PLHIV (all who are identified)	No. of person	8,000	8,680	9,418	10,218	11,087	496	8%	3,967,143	4,648,698	5,447,345	6,383,198	7,479,832	27,926,216
3.1.2.4	Follow up for adherence and retention by local service providers	No. of visits	360	360	360	360	360	39	8%	13,901	15,013	16,214	17,511	18,912	81,552
3.1.2.5	ART Advisory Committee Meeting (15 persons)	No. of Meeting	2	2	2	2	2	60	8%	120	130	140	151	163	704
<b>Total: 3.1.2</b>										<b>3,982,164</b>	<b>4,675,088</b>	<b>5,463,699</b>	<b>6,415,239</b>	<b>7,498,907</b>	<b>28,035,097</b>
<b>3.1.3 Focus on rapid ART initiation (the same day after a confirmed HIV diagnosis) for all people irrespective of age, sex or gender and advanced HIV disease management augmenting quality of care.</b>															
3.1.3.1	Develop and maintain functional HIV treatment and management task force to ensure rapid ART initiation, advanced HIV disease management, address lost to follow up etc.	No. of meeting	4	4	4	4	4	209	8%	836	902	975	1,053	1,137	4,902
<b>3.1.4 Address underlying causes of lost-to-follow-up at all levels.</b>															
<b>3.1.5 Optimize the uses of public sector laboratories for viral load measurements.</b>															
3.1.5.1	Number of PLHIV on ART receive viral load test	No. of person	7,125	7,838	8,621	9,483	10,432	12	8%	85,500	101,574	120,670	143,356	170,307	621,407
<b>3.1.6 Update the treatment and viral load guidelines periodically, update all service providers, and continue the promotion of U=U.</b>															
3.1.6.1	Develop comprehensive protocols and procedures	0	0	1	0	0	0	61,964	8%	-	66,921	-	-	-	66,921
3.1.6.2	Review, update and dissemination of treatment protocol - 2 times	No. of review and printing	0	0	1	0	0	17,706	8%	-	-	20,653	-	-	20,653
3.1.6.3	Integrate HIV treatment and management in medical curriculum	No. of TA	0	0	0	1	0	30,317	8%	-	-	-	38,191	-	38,191
<b>Total: 3.1.6</b>										<b>-</b>	<b>66,921</b>	<b>20,653</b>	<b>38,191</b>	<b>-</b>	<b>125,764</b>
<b>3.1.7 Bring efficiencies and improve linkages through one-stop service delivery models at public hospitals.</b>															
3.1.7.1	Identify and ensure access to training in specialisations identified through human resource functional analysis - out country	No. of person	5	5	5	5	5	4,738	8%	23,691	25,586	27,633	29,844	32,232	138,987
3.1.7.2	SOP for ensuring regulatory frameworks mitigate risk	No. of SOP	0	1	0	0	0	19,191	8%	-	20,726	-	-	-	20,726
<b>Total: 3.1.7</b>										<b>23,691</b>	<b>46,313</b>	<b>27,633</b>	<b>29,844</b>	<b>32,232</b>	<b>159,713</b>
<b>Sub Total: 3.1</b>										<b>4,139,965</b>	<b>4,943,510</b>	<b>5,704,761</b>	<b>6,706,121</b>	<b>7,787,296</b>	<b>29,281,654</b>
<b>Strategy 3.2: Ensure the capacity of service providers in government, non-government, and private sectors to provide age, gender, and human rights-sensitive out-patient and in-patient medical management for PLHIV and KPs.</b>															
3.2.1	Basic Clinical Training on HIV/ AIDS for government, non-government, and private sectors to provide age, gender, and human rights-sensitive out-patient and in-patient medical management for PLHIV and KPs.	No. of person	128	128	128	128	128	1,842	8%	235,786	254,649	275,021	297,023	320,784	1,383,263
<b>Sub Total: 3.2</b>										<b>235,786</b>	<b>254,649</b>	<b>275,021</b>	<b>297,023</b>	<b>320,784</b>	<b>1,383,263</b>
<b>Strategy 3.3: Ensure functional systems for related policy adoption, linkages, and updates, including for more robust engagement of communities in supporting the treatment and care cascade.</b>															
3.3.1	Set up support to engage communities in supporting the treatment and care cascade to comply with related policy adoption, linkages, and updates	No. of CBO / Network	1	0	0	0	0	9,637	8%	9,637	-	-	-	-	9,637
<b>Sub Total: 3.3</b>										<b>9,637</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>9,637</b>
<b>Strategy 3.4: A comprehensive approach to the community support system is adopted to remove barriers to accessing services and strengthen treatment adherence, care, and support for PLHIV, including children affected by HIV and AIDS and orphans and vulnerable children.</b>															
3.4.1	Running Cost to ensure a comprehensive approach to the community support system is adopted and continued to remove barriers to accessing services and strengthen treatment adherence, care, and support for PLHIV, including children affected by HIV and AIDS and orphans and vulnerable children.	No. of person	10	10	10	10	10	240	8%	2,402	2,595	2,802	3,026	3,269	14,094
<b>Sub Total: 3.4</b>										<b>2,402</b>	<b>2,595</b>	<b>2,802</b>	<b>3,026</b>	<b>3,269</b>	<b>14,094</b>
<b>Grand Total: Objective-3</b>										<b>4,387,790</b>	<b>5,200,754</b>	<b>5,982,585</b>	<b>7,006,170</b>	<b>8,111,349</b>	<b>30,688,649</b>
<b>Programme Objective 4: To establish resilient, sustainable health systems and strengthen community systems for an integrated, people-centric HIV and AIDS response in Bangladesh through the universal health coverage approach.</b>															
<b>Strategy 4.1: Strengthening the capacity of health actors, institutions, and populations to prepare for and effectively respond to HIV and AIDS while maintaining its essential functions.</b>															
<b>4.1.1 Strengthen NAC and TC-NAC for a more functional role in guiding the national HIV response.</b>															
4.1.1.1	Conduct annual meeting of NAC	No. of meeting	1	1	1	1	1	2,554	8%	2,554	2,759	2,980	3,218	3,475	14,986
4.1.1.2	Conduct quarterly meetings of TC-NAC	No. of meeting	2	2	2	2	2	2,182	8%	4,364	4,714	5,091	5,498	5,938	25,604
4.1.1.3	Produce annual program report	No. of report	1	1	1	1	1	5,750	8%	5,750	6,210	6,707	7,243	7,823	33,733
<b>Sub Total: 4.1.1</b>										<b>12,669</b>	<b>13,682</b>	<b>14,777</b>	<b>15,959</b>	<b>17,236</b>	<b>74,323</b>
<b>4.1.2 Strengthen NASC through capacity building and providing appropriate structure, human resources, and other logistics.</b>															
4.1.2.1	Provide equipment, furniture and logistics	No. of time supported	6	2	2	2	2	40,403	8%	242,418	87,270	94,252	101,792	109,936	635,668

SI. No.	Specific Activities	Measure-ment Unit						Unit Rate USD (New)	Inflation Rate						Financial Total (USD)
			2024	2025	2026	2027	2028			2024	2025	2026	2027	2028	
4.1.2.2	Provide utilities and supplies	No. months supported	20	22	22	22	22	59	8%	1,188	1,411	1,524	1,646	1,778	7,548
4.1.2.3	ASP HR	No. of year supported	1	1	1	1	1	1,528,821	8.0%	1,528,821	1,651,126	1,783,217	1,925,874	2,079,944	8,968,982
4.1.2.4	Conduct advisory committee meetings (half yearly)	No. of meeting	2	2	2	2	2	1,267	8%	2,535	2,737	2,956	3,193	3,448	14,870
<b>Sub Total: 4.1.2</b>										<b>1,774,961</b>	<b>1,742,546</b>	<b>1,881,949</b>	<b>2,032,505</b>	<b>2,195,106</b>	<b>9,627,068</b>
<b>4.1.3 Conduct stakeholder meetings to coordinate, review and integrate the HIV response across other ministries and departments and with civil society groups.</b>															
4.1.3.1	Conduct quarterly coordination meetings with stakeholders	No. of meeting	4	4	4	4	4	400	8%	1,600	1,728	1,866	2,016	2,177	9,387
4.1.3.2	Develop functional district level coordination under district health authority (CS) to be facilitated by local agency	No. of meeting	64	0	64	0	64	1,266	8%	81,006	-	94,486	-	110,208	285,700
<b>Sub Total: 4.1.3</b>										<b>82,606</b>	<b>1,728</b>	<b>96,352</b>	<b>2,016</b>	<b>112,385</b>	<b>295,087</b>
<b>4.1.4 Facilitate the development and implementation of activities and plans in key sectors for strengthened collaboration on HIV prevention, treatment, care, and support.</b>															
4.1.4.1	Workshops with multisectoral authorities on relevant HIV Prevention, Treatment, Care and Support issues where collaboration needed.	No. of batches	7	0	0	0	0	737	8%	5,156	-	-	-	-	5,156
4.1.4.2	Compile and share action plan as per workshop discussion	No. of consultant	1	0	0	0	0	4,500	8%	4,500	-	-	-	-	4,500
4.1.4.3	Develop advocacy materials (packages)	No. of material package developed	8000	8000	8000	8000	8000	3	8%	20,672	22,326	24,112	26,041	28,125	121,277
4.1.4.4	Conduct national level advocacy	No. of persons attended	2	2	2	2	2	7,234	8%	14,467	15,624	16,874	18,224	19,682	84,873
4.1.4.5	Conduct local level advocacy	No. of persons attended	64	64	64	64	64	569	8%	36,404	39,316	42,462	45,859	49,527	213,568
4.1.4.6	Celebration of World AIDS Day	No. of events organized	1	1	1	1	1	50,781	8%	50,781	54,844	59,231	63,970	69,088	297,914
<b>Sub Total: 4.1.4</b>										<b>131,981</b>	<b>132,111</b>	<b>142,680</b>	<b>154,094</b>	<b>166,422</b>	<b>727,288</b>
<b>4.1.5 Strengthen human resource capacity across the health and HIV sector to achieve NSP targets by providing high-quality, rights-sensitive services tailored to the unique needs of KPs and those at emerging risk.</b>															
4.1.5.1	Develop core curriculum and training resources	No. of TA	1	0	0	0	0	55,193	8%	55,193	-	-	-	-	55,193
<b>Sub Total: 4.1.5</b>										<b>55,193</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>55,193</b>
<b>Sub Total: 4.1</b>										<b>2,057,411</b>	<b>1,890,067</b>	<b>2,135,758</b>	<b>2,204,574</b>	<b>2,491,148</b>	<b>10,778,958</b>
<b>Strategy 4.2: Strengthen transition and integration of HIV services into government health systems, especially in public health care settings, by establishing functional links for co-infections (e.g., Tuberculosis, Hepatitis, cervical cancer) and non-communicable diseases, including mental health.</b>															
<b>4.2.1 Develop capacities in health institutions and engage relevant programmes for strong referral linkages so co-infections and co-morbidities are detected and treated early.</b>															
4.2.1.1	Enhance integration of HIV with TB, Hepatitis and SRH services (e.g. strengthening referral mechanism, advocacy with Hospital directors, management, increase community involvement etc.) to support Universal Health Coverage.	No. of Patient Referred	600	600	600	600	600	2	8%	1,200	1,296	1,400	1,512	1,633	7,040
<b>Sub Total: 4.2.1</b>										<b>1,200</b>	<b>1,296</b>	<b>1,400</b>	<b>1,512</b>	<b>1,633</b>	<b>7,040</b>
<b>4.2.2 Strengthen Tuberculosis preventive therapy</b>															
4.2.2.1	Training to Strengthen Tuberculosis preventive therapy	No. of batches	0	3	0	3	0	2,746	8%	-	8,896	-	10,376	-	19,271
4.2.2.2	Detection of eligible PLHIV for Tuberculosis prevention	No. of Patient	0	0	0	0	0	-	8%	-	-	-	-	-	-
4.2.2.3	Management for Tuberculosis prevention	No. of Patient	0	0	0	0	0	-	8%	-	-	-	-	-	-
4.2.2.4	Follow up for adherence by local service providers	No. of visit	0	0	0	0	0	39	8%	-	-	-	-	-	-
<b>Sub Total: 4.2.2</b>										<b>-</b>	<b>8,896</b>	<b>-</b>	<b>10,376</b>	<b>-</b>	<b>19,271</b>
<b>Sub Total: 4.2</b>										<b>1,200</b>	<b>10,192</b>	<b>1,400</b>	<b>11,887</b>	<b>1,633</b>	<b>26,311</b>
<b>Strategy 4.3: Strengthen supply chains to ensure medicines, laboratory services, and health products are available when and where they are needed.</b>															
<b>4.3.1 Ensure adequate budgetary allocation to purchase HIV-related commodities</b>															
4.3.1.1	Procurement Committee Meetings	No. of meetings	4	4	4	4	4	313	8%	1,251	1,352	1,460	1,577	1,703	7,342
<b>Sub Total: 4.3.1</b>										<b>1,251</b>	<b>1,352</b>	<b>1,460</b>	<b>1,577</b>	<b>1,703</b>	<b>7,342</b>
<b>4.3.2 Ensure zero stock out of HIV commodities at all levels</b>															
4.3.2.1	SOP to mitigate risk in alignment with health center regulations	No. of person	1	0	0	0	0	8,698	8%	8,698	-	-	-	-	8,698
4.3.2.2	Training and refresher training on inventory management system	No. of batches	0	3	0	3	0	5,054	8%	-	16,376	-	-	19,101	35,478
<b>Sub Total: 4.3.2</b>										<b>8,698</b>	<b>16,376</b>	<b>-</b>	<b>-</b>	<b>19,101</b>	<b>44,176</b>
<b>4.3.3 Strengthen the capacity of district and sub-district level HIV service providers to prepare detailed specifications, quantification and forecasting, and budget planning for procurement of HIV-related commodities.</b>															
4.3.3.1	Comprehensive guidelines on procedures to strengthen the capacity of district and sub-district level HIV service providers to prepare detailed specifications, quantification and forecasting, and budget planning for procurement of HIV-related commodities.	No. of guideline	1	0	0	0	0	8,183.56	8%	8,184	-	-	-	-	8,184
4.3.3.2	Training and refresher training on inventory management system to prepare detailed specifications, quantification and forecasting, and budget planning for procurement of HIV-related commodities.	No. of batches	0	3	0	3	0	6,191.09	8%	-	20,059	-	23,397	-	43,456
<b>Sub Total: 4.3.3</b>										<b>8,184</b>	<b>20,059</b>	<b>-</b>	<b>23,397</b>	<b>-</b>	<b>51,640</b>
<b>4.3.4 Establish multi-year procurement and supply chain management to ensure supplies are available in all health facilities for the general population and KP.</b>															
4.3.4.1	Half yearly Meetings of advisory committee on supply chain	No. of person	2	2	2	2	2	257	8%	515	556	601	649	700	3,020

SI. No.	Specific Activities	Measure-ment Unit						Unit Rate USD (New)	Inflation Rate						Financial Total (USD)
			2024	2025	2026	2027	2028			2024	2025	2026	2027	2028	
4.3.4.2	Health Product Chain Management (storage, SCM, Inventories)	No. of Months	12	12	12	12	12	22,970	8%	275,644	297,695	321,511	347,232	375,010	1,617,091
<b>Sub Total: 4.3.4</b>										276,158	298,251	322,111	347,880	375,710	1,620,111
<b>4.3.5</b>	<b>Establish internet-based real-time Logistic Management Information System of HIV commodities (HIV antiretroviral drugs, test kits, reagents, needles, syringes, condoms, methadone, etc.) at HIV service centres.</b>														
4.3.5.1	Establish internet-based real-time Logistic Management Information System of HIV commodities	No. of person	1	0	0	0	0	129,373	8%	129,373	-	-	-	-	129,373
4.3.5.2	Training and refresher training on establish internet-based real-time Logistic Management Information System of HIV commodities	No. of person	0	3	0	3	0	7,582	8%	-	24,565	-	28,652	-	53,217
<b>Sub Total: 4.3.5</b>										129,373	24,565	-	28,652	-	182,589
<b>Sub Total: 4.3</b>										423,664	360,603	323,571	420,607	377,413	1,905,859
<b>Strategy 4.4: Ensure quality laboratory and diagnostic services are expanded and available at all levels</b>															
<b>4.4.1</b>	<b>Capacity building of laboratory and diagnostic facilities (human resources, budget, infrastructure, logistics, and supplies) at the district and intervention site levels.</b>														
4.4.1.1	Develop guidelines and regulatory framework in alignment with hospital/clinic	No. of guideline	1	0	0	0	0	13,480	8%	13,480	-	-	-	-	13,480
4.4.1.2	Set up lab requirements	No. of Units	70	0	0	0	0	76,835	8%	5,378,450	-	-	-	-	5,378,450
4.4.1.3	Ensure uninterrupted supply chain systems: meetings and print-outs	No. of Meetings	60	60	60	60	60	68	8%	4,099	4,427	4,781	5,164	5,577	24,047
4.4.1.4	Training and refresher training on uninterrupted supply chain systems	No. of batches	0	3	0	3	0	7,582	8%	-	24,565	-	28,652	-	53,217
<b>Sub Total: 4.4.1</b>										5,396,029	28,992	4,781	33,816	5,577	5,469,194
<b>4.4.2</b>	<b>Optimization use of GeneXpert and PCR machines for viral load test</b>														
4.4.2.1	Develop guidelines and regulatory framework in alignment with hospital/clinic	No. of guideline (Same as 4.4.1.1)	0	0	0	0	0		8%	-	-	-	-	-	-
4.4.2.2	Set up lab requirements	No. of Units (Same as 4.4.1.2)	0	0	0	0	0		8%	-	-	-	-	-	-
4.4.2.3	Ensure uninterrupted supply chain systems: meetings and print-outs	No. of Units (Same as 4.4.1.3)	0	0	0	0	0		8%	-	-	-	-	-	-
4.4.2.4	Training	No. of batches (Same as 4.4.1.4)	0	0	0	0	0		8%	-	-	-	-	-	-
<b>Sub Total: 4.4.2</b>										-	-	-	-	-	-
<b>4.4.3</b>	<b>Ensure quality control of HIV testing through quality assurance from the national reference laboratory</b>														
4.4.3.1	Establish National Reference Laboratory	No. of year supported	0	1	2	0	0	300,000	8%	-	324,000	699,840	-	-	1,023,840
4.4.3.2	Develop protocol/guidelines for provision of laboratory services (inclusive of conducting quality assurance for public, private and NGO laboratories)	No. of guideline	0	0	1	0	0	41,183	8%	-	-	48,036	-	-	48,036
<b>Sub Total: 4.4.3</b>										-	324,000	747,876	-	-	1,071,876
<b>4.4.4</b>	<b>Coordination with private health facilities and labs to scale up laboratory services and quality assurance of the labs</b>														
4.4.4.1	Coordination workshops with private health facilities and labs to scale up laboratory services and quality assurance of the labs	No. of person	35	35	0	0	35	2,777	8%	97,203	104,979	-	-	132,244	334,426
4.4.4.2	Training to scale up laboratory services and quality assurance of the private health facilities and labs	No. of person	0	35	0	35	0	2,569	8%	-	97,120	-	113,281	-	210,400
<b>Sub Total: 4.4.4</b>										97,203	202,099	-	113,281	132,244	544,826
<b>4.4.5</b>	<b>Enhance partnerships between public and private sector actors so programing and services are sustainable and can reach more people.</b>														
4.4.5.1	Meetings for MOUs	No. of person (Same as 4.4.4.1)	0	0	0	0	0	0	8%	-	-	-	-	-	-
<b>Sub Total: 4.4.5</b>										-	-	-	-	-	-
<b>Sub Total: 4.4</b>										5,493,232	555,091	752,657	147,096	137,820	7,085,896
<b>Strategy 4.5: Strengthen community systems and community-led HIV programming and help integrate them into national health and social systems.</b>															
<b>4.5.1</b>	<b>Build the capacity of CBOs in scaling up outreach services, community-led monitoring, documentation, and advocacy for domestic resource mobilization.</b>														
4.5.1.1	Infrastructure of CBOs to contribute HIV program among KPs	No. of CBO / monthly support	48	72	96	120	144	550	8%	26,398	42,764	61,580	83,134	107,741	321,617
4.5.1.2	Provide management training for CBOs	No. of person	0	4	4	4	4	2,866	8%	-	12,381	13,371	14,441	15,596	55,789
4.5.1.3	Provide leadership and accountability training for CBOs	No. of person	0	0	4	4	4	2,798	8%	-	-	13,052	14,097	15,224	42,373
<b>Sub Total: 4.5.1</b>										26,398	55,145	88,004	111,671	138,561	419,778
<b>4.5.2</b>	<b>Enhance formal partnerships between community-led and health facility or private service providers, coordinate joint outreach efforts, and implement bi-directional referral mechanisms between health and community-led service delivery points.</b>														
4.5.2.1	Quarterly meeting with community-led and health facility or private service providers	No. of person	48	120	120	120	120	503	8%	24,143	65,187	70,401	76,034	82,116	317,881
4.5.2.2	Transport support to community members to facilitate participation in meetings	No. of person (Same as 4.2.2.4)	0	0	0	0	0		8%	-	-	-	-	-	-
<b>Sub Total: 4.5.2</b>										24,143	65,187	70,401	76,034	82,116	317,881
<b>4.5.3</b>	<b>Ensure the involvement of community representatives in high-level health advisory boards, governance bodies, oversight committees (including clinic health committees), and other decision-making forums.</b>														
4.5.3.1	Transport support to community representatives in different meetings/ workshops	No. of person (Same as 4.2.2.4)	0	0	0	0	0		8%	0	0	0	0	0	0
4.5.3.2	Meeting / workshop participation of community representatives in high-level health advisory boards, governance bodies, oversight committees (including clinic health committees), and other decision-making	No. of meetings (to be covered by organizing entity)	0	0	0	0	0		8%	0	0	0	0	0	0
<b>Sub Total: 4.5.3</b>										-	-	-	-	-	-
<b>4.5.4</b>	<b>Promote the participation of community representatives in national or regional peer-learning initiatives</b>														

SI. No.	Specific Activities	Measure-ment Unit						Unit Rate USD (New)	Inflation Rate						Financial Total (USD)
			2024	2025	2026	2027	2028			2024	2025	2026	2027	2028	
4.5.4.1	Community representatives in regional peer-learning initiatives	No. of person	3	3	3	3	3	24362.52	8%	73,088	78,935	85,249	92,069	99,435	428,776
	<b>Sub Total: 4.5.4</b>									<b>73,088</b>	<b>78,935</b>	<b>85,249</b>	<b>92,069</b>	<b>99,435</b>	<b>428,776</b>
	<b>Sub Total: 4.5</b>									<b>123,628</b>	<b>199,266</b>	<b>243,655</b>	<b>279,774</b>	<b>320,112</b>	<b>1,166,435</b>
<b>Strategy 4.6: Adopt mitigation plans for health and other emergencies, including the COVID-19 pandemic and natural and human-made disasters.</b>															
	Note: -Funding plan to be developed as per need														
	<b>Sub Total: 4.6</b>									-	-	-	-	-	-
	<b>Grand Total: Objective-4</b>									<b>8,099,136</b>	<b>3,015,218</b>	<b>3,457,040</b>	<b>3,063,939</b>	<b>3,328,127</b>	<b>20,963,460</b>
<b>Programme Objective 5: To strengthen strategic information systems and research for an evidence-based response</b>															
<b>Strategy 5.1: Conduct comprehensive surveillance to strengthen the capacity to respond considering all population sub-groups, epidemiology, age, sex, and geographical considerations.</b>															
5.1.1	Conduct regular behavioural surveillance of all key populations with IBBS in some places	No. of surveillance	0	0	0	1	0	632500	8%	-	-	-	796,768	-	796,768
5.1.2	Conduct regular STI surveillance	No. of study	0	0	0	1	0	690000	8%	-	-	-	869,201	-	869,201
	<b>Sub Total: 5.1</b>									-	-	-	<b>1,665,969</b>	-	<b>1,665,969</b>
<b>Strategy 5.2: Conduct the key population size estimation considering all population sub-groups, epidemiology, age, sex, and geographical considerations.</b>															
5.2	Conduct size estimation studies	No. of study	0	1	0	0	1	345,000	8%	-	372,600	-	-	469,369	841,969
	<b>Sub Total: 5.2</b>									-	<b>372,600</b>	-	-	<b>469,369</b>	<b>841,969</b>
<b>Strategy 5.3: Conduct the Stigma Index led by the communities</b>															
5.3	Conduct Stigma Index Study	No. of study	0	0	1	0	0	92,000	8%	-	-	107,309	-	-	107,309
	<b>Sub Total: 5.3</b>									-	-	<b>107,309</b>	-	-	<b>107,309</b>
<b>Strategy 5.4: Strengthen national strategic information as well as monitoring and evaluation guidelines to harmonise existing reporting systems, including the HIV database and DHIS2, for alignment and coherence.</b>															
5.4.1	Maintain HIV Management Information System	No. of time supported	1	1	1	1	1	6,074	8%	6,074	6,560	7,085	7,652	8,264	35,635
5.4.2	Establish HIV reporting and maintain PLHIV database	No. of TA	0	0	1	1	1	4,574	8%	-	-	5,335	5,762	6,223	17,321
	<b>Sub Total: 5.4</b>									<b>6,074</b>	<b>6,560</b>	<b>12,420</b>	<b>13,414</b>	<b>14,487</b>	<b>52,956</b>
<b>Strategy 5.5: Conduct relevant research to inform the national strategic response.</b>															
5.5.1	Conduct national workshop to prioritize as well as review existing research /operations research /studies; develop annual national agenda for research	No. of meeting	0	1	1	3	1	2,870	8%	-	3,100	3,348	10,847	3,905	21,200
5.5.2	Conduct studies based on emerging needs	No. of study	0	0	0	1	0	345,000	8%	-	-	-	434,601	-	434,601
	<b>Sub Total: 5.5</b>									-	<b>3,100</b>	<b>3,348</b>	<b>445,448</b>	<b>3,905</b>	<b>455,801</b>
<b>Strategy 5.6: Increase the "granularity" of data, appropriately disaggregated to the district, community, and facility levels by age, sex, population, and location to better understand sub-national epidemics and assess performance along the continuum of HIV services.</b>															
5.6.1	Produce guidelines and tools	No. of TA	2	0	0	1	1	6,149	8%	12,297	-	-	7,745	8,365	28,407
5.6.2	Conduct evaluation of design and effectiveness of current targeted interventions	No. of study	0	1	0	1	0	235,000	8%	-	253,800	-	296,032	-	549,832
	<b>Sub Total: 5.6</b>									<b>12,297</b>	<b>253,800</b>	-	<b>303,778</b>	<b>8,365</b>	<b>578,240</b>
<b>Strategy 5.7: Strengthen monitoring and evaluation</b>															
5.7.1	Conduct mid-term and end-term evaluations	No. of study	0	0	0	1	1	632,500	8%	-	-	-	796,768	860,509	1,657,277
5.7.2	Periodic review and updating of the M&E system and its indicators in a participatory manner	No. of review and printing	0	1	0	0	1	5,750	8%	-	6,210	-	-	7,823	14,033
5.7.3	Advocacy workshop and follow up with the stakeholders to ensure regular reporting as well as providing feedback	No. of Workshop	0	0	4	4	4	1,519	8%	-	-	7,086	7,653	8,265	23,005
5.7.4	M&E training for staff across the sector	No. of person	1	1	6	6	6	1,794	8%	1,794	1,938	12,556	13,560	14,645	44,492
5.7.5	Conduct regular M&E visits to assess quality (third party monitoring may be considered)	No. of visits	24	24	24	24	24	359	8%	8,624	9,314	10,059	10,864	11,733	50,593
5.7.6	Conduct ART Adherence Monitoring	No. of year supported	0	1	1	1	1	11,834	8%	-	12,781	13,804	14,908	16,101	57,594
5.7.7	Conduct Client Satisfaction Survey at the public Health facilities integrating KP services	No. of survey	0	0	1	0	1	50,000	8%	-	-	58,320	-	68,024	126,344
	<b>Sub Total: 5.7</b>									<b>10,418</b>	<b>30,243</b>	<b>101,824</b>	<b>843,753</b>	<b>987,100</b>	<b>1,973,337</b>
<b>Strategy 5.8: Improve systems for knowledge management</b>															
5.8.1	Conduct quarterly M&E TWG and coordination Workshop	No. of meeting	4	4	4	4	4	2,113	8%	8,451	9,128	9,858	10,646	11,498	49,581
5.8.2	Develop, print and disseminate different reports	No. of time supported	1	1	1	1	1	12,000	8%	12,000	12,960	13,997	15,117	16,326	70,399
	<b>Sub Total: 5.8</b>									<b>20,451</b>	<b>22,088</b>	<b>23,855</b>	<b>25,763</b>	<b>27,824</b>	<b>119,981</b>
	<b>Grand Total: Objective-5</b>									<b>49,241</b>	<b>688,390</b>	<b>248,756</b>	<b>3,298,124</b>	<b>1,511,050</b>	<b>5,795,561</b>

**IMPLEMENTATION PLAN OF NATIONAL STRATEGIC PLAN 2024 - 2028**

**Unit Cost**

Exchange rate	1 USD	101
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Objective-1 1.1.1

MSM					USD	BDT	Remarks
Unit Cost / person / year				69.06		6,975	
<i>Ref: Costed National Implementation Plan 2014-2017</i>							

1.1.1

MSW					USD	BDT	Remarks
Unit Cost / person / year				72.32		7,304	
<i>Ref: Costed National Implementation Plan 2014-2017</i>							

1.1.1

MSW					USD	BDT	Remarks
Unit Cost / person / year				500.00		50,500	
<i>Ref: Costed National Implementation Plan 2014-2017</i>							

1.1.2

Increase access to and uptake of comprehensive HIV prevention services for female sex workers, their clients, and other sexual partners.					USD	BDT	Remarks
FSW					USD	BDT	Remarks
Cost component	Program component			USD	BDT	Remarks	
Behavior change	Peer education						
Training of peer educators	Condom and lubricant promotion						
PE remuneration	Behavior change communication						
Outreach worker	DIC services						
DIC	STI diagnosis and treatment						
IEC Events	VCT						
Commodities	Referral to health and other services						
Condoms	Community mobilization						
Referral HTC and Rapid test							
STI services							
Enabling Environment							
Programme management							
Equipment, furniture DIC							
M+E (5%)							
Unit Cost / person / year				61.66		8,888	
<i>Ref: Costed National Implementation Plan 2014-2017</i>							

1.1.3

Hijra					USD	BDT	Remarks
Unit Cost / person / year				74.71		7,546	
<i>Ref: Costed National Implementation Plan 2014-2017</i>							

1.1.4

Male PWID					USD	BDT	Remarks
Cost Component	Program component			USD	BDT	Remarks	
Behavior change	Peer education						
PE (incl. Training)	Needle syringe exchange						
DIC	Condom and lubricant promotion						
Outreach worker/SV	Behavior change communication						
IEC/events	DIC services						
Commodities & Services	STI diagnosis and treatment						
Syringes/Needles	VCT						
Condoms	Injection related primary health care						
PHC incl. Satellite centers	Referral to health and other services						
Enabling environment	Community mobilization						
Program management							
Equipment, furniture DIC							
M+E (5%)							
Unit Cost / person / year				144.82		14,627	To be reviewed. (Dhaka, Narayangin), Gazipur Unit cost: 268, in other districts: 151.66)
<i>Ref: Costed National Implementation Plan 2014-2017</i>							

1.1.4

Female PWID					USD	BDT	Remarks
Unit Cost / person / year				144.82		14,627	
<i>Ref: Costed National Implementation Plan 2014-2017</i>							

1.1.4

OST Services					USD	BDT	Remarks
Cost Component	Program component			USD	BDT	Remarks	
Behavior change	Peer education						
Staff							
Training of peer educators							
OST Center							
IEC/events							
Commodities & services							
Drugs							
Usables							
Condoms							
Enabling environment							
Program management							
Equipment, furniture DIC							
M+E							
Unit Cost / person / year				279		28,147	

1.1.5.13

Continue interventions for prisoners							Remarks
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks	
20 District jail with 20,000 inmates							

Programme Management						
Training						
Staff remuneration						
Outreach worker/SV						
Investments						
Medicine cost						
IEC/events						
STI, HTC, ART/OI (PMTCT)						
Condoms						
Enabling environment						
M&E (5%)						
Cost/person/year				70.00	7,070	
<b>Ref: Global Fund Grant 2021-2023</b>						

<b>1.1.6.1 Conduct national situation assessment to find out the HIV risk among the migrant</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Study/ Assessment / Research Cost				525,000	53,025,000	
<b>Ref: IBBS 2020</b>						

<b>1.1.6.2 BCC material development (leaflets, posters, brochures etc.)</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Folder	per pcs	1	2.00	2.00	202.00	
Poster		1	0.50	0.50	50.50	
Leaflets		1	0.25	0.25	25.25	
Flip Chart/ Flash Card		1	7.50	7.50	757.50	
Banner		1	25.00	25.00	2,525.00	
Management Cost				8.81	890.06	
Cost/package				44.06	4,450	
<b>Ref: World AIDS Day 2021</b>						

<b>1.1.6.3 Interventions for migrants and their families</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Cost Component						
Program Management						
Training of health workers						
Govt. Health Workers /Field Workers						
Outreach worker						
Equipment, furniture						
Running costs IC/transport						
IEC/events						
STI treatment referral						
Condoms						
Enabling environment						
Referral Cost for HIV testing						
M+E (5%)						
Management Cost						
Unit Cost/person/year				35	3,535	
<b>Ref: Costed National Implementation Plan 2014-2017</b>						

<b>1.1.6.4 Billboard for General Populations including Migrants</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Billboard (Steel Pilar & steel board)		1	10400.00	10,400.00	1,050,400.00	
Cost/package				10,400.00	1,050,400	
<b>Ref: Costed National Implementation Plan 2017-2022</b>						

<b>1.2.1 Ensure all pregnant women get HIV/Hep B/Hep C/Syphilis testing from ANC clinics, including private health facilities.</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
ARV	per patient Cost					
New patients						
Continued patients						
1st line						
2nd line						
Cost of monitoring, 1st year						
Cost of monitoring, cont.						
Training/year						
Adherence/year						
Mgt/coordination/year						
The model do not include mortality or discontinuation among the clients receiving ARV (overestimation)						
Cost/ patient				60	6,060	
<b>Ref: Costed National Implementation Plan 2014-2017</b>						

<b>1.2.3 Strengthen the EMTCT of HIV, syphilis, perinatal hepatitis b, and congenital chagas disease programme in coordination with the Directorate General of Family Planning.</b>						
Development of protocols for PMTCT.						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Local consultant (25 Days)						
Consultancy fee	per day cost	25	400	10,000	1,010,000	
Transportation Cost	lumsum	10	14.85	149	15,000	
Subtotal- Local Consultant				10,149	1,025,000	
Consultant Workshop (2 times)				-	-	
Venue & public address system	Per Day	1	69.31	-	-	
Snacks	Average Cost per workshop	20	37.13	-	-	
Local Participants Allowance	Average Cost per training	10	158.42	-	-	

Non Local Participants Allowance	Average Cost per training	10	495.05			
Travel Cost	Average Cost per training	10	198.02			
Training Materials & Logistics for Orientation & Inf	Average Cost per training	20	39.60			
Printing ( Photograph, documents)	Average Cost per training	20	49.50			
Resource Person Honorarium	Average Cost per training	3	89.11			
Support Staff Allowance	Average Cost per training	2	8.91			
<b>Subtotal- Consultant</b>			<b>1145.049505</b>	<b>2,290</b>	<b>231,300</b>	
Printing of protocol		300	5	<b>1,500</b>	<b>151,500</b>	300 copies
<b>Total cost_ development of protocol</b>				<b>13,939</b>	<b>1,407,800</b>	
<b>Ref: 4th HPNSP</b>						

1.2.4 Strengthen linkage from screening facilities to confirmatory centres and subsequently to treatment centres.

Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>Local consultant (25 Days)</b>						
<i>Consultancy fee</i>	per day cost	25	400	10,000	1,010,000	
<i>Transportation Cost</i>	lumsum	10	14.85	149	15,000	
<b>Subtotal- Local Consultant</b>				<b>10,149</b>	<b>1,025,000</b>	
<b>Consultantation Workshop (2 times)</b>						
<i>Venue &amp; public address system</i>	Per Day	1	69.31			
<i>Snacks</i>	Average Cost per workshop	20	37.13			
<i>Local Participants Allowance</i>	Average Cost per training	10	158.42			
<i>Non Local Participants Allowance</i>	Average Cost per training	10	495.05			
<i>Travel Cost</i>	Average Cost per training	10	198.02			
<i>Training Materials &amp; Logistics for Orientation &amp; Inf</i>	Average Cost per training	20	39.60			
<i>Printing ( Photograph, documents)</i>	Average Cost per training	20	49.50			
<i>Resource Person Honorarium</i>	Average Cost per training	3	89.11			
<i>Support Staff Allowance</i>	Average Cost per training	2	8.91			
<b>Subtotal- Consultant</b>			<b>1145.049505</b>	<b>2,290</b>	<b>231,300</b>	
Printing of protocol		300	5	<b>1,500</b>	<b>151,500</b>	300 copies
<b>Total cost_ development of protocol</b>				<b>13,939</b>	<b>1,407,800</b>	
<b>Ref: 4th HPNSP</b>						

1.2.5 Expand early infant diagnosis (EID) for all HIV-exposed infants.

Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>Local consultant (25 Days)</b>						
<i>Consultancy fee</i>	per day cost	25	400	10,000	1,010,000	
<i>Transportation Cost</i>	lumsum	10	14.85	149	15,000	
<b>Subtotal- Local Consultant</b>				<b>10,149</b>	<b>1,025,000</b>	
<b>Consultantation Workshop (2 times)</b>						
<i>Venue &amp; public address system</i>	Per Day	1	69.31			
<i>Snacks</i>	Average Cost per workshop	20	37.13			
<i>Local Participants Allowance</i>	Average Cost per training	10	158.42			
<i>Non Local Participants Allowance</i>	Average Cost per training	10	495.05			
<i>Travel Cost</i>	Average Cost per training	10	198.02			
<i>Training Materials &amp; Logistics for Orientation &amp; Inf</i>	Average Cost per training	20	39.60			
<i>Printing ( Photograph, documents)</i>	Average Cost per training	20	49.50			
<i>Resource Person Honorarium</i>	Average Cost per training	3	89.11			
<i>Support Staff Allowance</i>	Average Cost per training	2	8.91			
<b>Subtotal- Consultant</b>			<b>1145.049505</b>	<b>2,290</b>	<b>231,300</b>	
Printing of protocol		300	2.5	<b>750</b>	<b>75,750</b>	300 copies
<b>Total cost_ development of protocol</b>				<b>13,189</b>	<b>1,332,050</b>	
<b>Ref: 4th HPNSP</b>						

1.3.1 Interventions for vulnerable populations (Transport, Garments workers, adolescent etc.)

Cost/intervention				100,000	10,100,000	
<b>Ref: Costed National Implementation Plan 2014-2017</b>						

1.3.2 Training of master trainers and peer educators

Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
3 day training for master Trainer for Peer educator on LSE						
<i>Venue &amp; public address system</i>	Per Day	3	207.92			
<i>Snacks</i>	Average Cost per training	75	74.26			
<i>Participants Allowance</i>	Average Cost per training	75	911.39			
<i>Travel Cost</i>	Average Cost per training	25	0.00			
<i>Training Materials &amp; Logistics</i>	Average Cost per training	25	297.03			
<i>Printing ( Photograph, documents)</i>	Average Cost per training	25	49.50			
<i>Resource Person Honorarium</i>	Average Cost per training	9	200.91			
<i>Support Staff Allowance</i>	Average Cost per training	3	26.73			
<i>Banner</i>	Average Cost per training	1	18.00			
TOTAL Cost per training	Average Cost per training	1	1785.75	1,786	180,360.97	
<b>Ref: Costing data from GOB budget, 2017-2022</b>						

1.3.3 Implement basic HIV prevention services for non-injecting drug users

Cost Component	Program component	Total Amount (USD)	Total Amount (BDT)	Remarks
PE (incl. Training)	• Peer education			
IEC/events	• Behavior change communication			
Condoms	• Condom and lubricant promotion			
PHC incl. Satellite centers	• Referral to health and other services			
Program management	• Community mobilization			
M+E (5%)	• Assessment of services			
<b>Cost/person/year</b>		<b>40</b>	<b>4,040</b>	
<b>Ref: Costed National Implementation Plan 2014-2017</b>				

1.3.4 Implement basic HIV prevention services for clients of sex workers

Program Component	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
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Behavior change communication						
Condom and lubricant promotion						
STI services						
Referral to health and other services						
Community mobilization						
Assessment of services						
<b>Cost/person/year</b>				<b>20</b>	<b>2,020</b>	
<b>Ref: Costed National Implementation Plan 2014-2017</b>						

1.4.1 **Promote awareness among health service providers, laboratory staff, survivors of gender-based violence, etc.**

One day awareness session for each districts with 30 participants						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Resource Person	Cost / participants	3	89.11		-	
Per diem	Cost / participants	30	607.60		-	
Workshop Materials	Cost / participants	30	59.41		-	
Venue & public address system	Cost / participants	1	148.51		-	
Snacks	Cost / participants	30	51.98		-	
Banner	Cost / participants	1	15.00		-	
Management Cost				972	98,132	
<b>Cost/workshop/ district</b>				<b>1,020</b>	<b>103,039</b>	
<b>Ref: 4th HPNSP circular</b>						

1.4.2 **Provide PEP starter kits**

572 PEP packages (10 / districts) will be stored across districts. Costing based on 1 month first line ARV provision. US\$ 87.5 / PEP packages for						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
PEP Starter Kits		1	87.5	88	8,838	
<b>Cost/year</b>				<b>88</b>	<b>8,838</b>	
<b>Ref: CMSD procurement 2022</b>						

1.5.1 **Conduct mass media BCC campaigns based on different risk behaviors including STI**

Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>Design workshops with stakeholders</b>						2 workshop with 50 participants- 25 person in each workshop
Technical expert	Cost / participants	0	3.62	-	-	
Per diem	Cost / participants	0	7.24	-	-	
Campaign Materials	Cost / participants	0	1.45	-	-	
Venue & public address system	Cost / participants	0	0.72	-	-	
Food	Cost / participants	0	3.62	-	-	
Banner	Cost / participants	0	0.72	-	-	
Total			17.36	-	-	
Total Cost/ workshop				-	-	
<b>Cost of 2 workshops</b>				-	-	
<b>Develop of TV spots</b>		<b>4</b>	<b>10000</b>	<b>40,000</b>	<b>4,040,000</b>	Unit cost means One script develop, production , Censorship cost
<b>Airing TV spots (12 months airing)</b>		<b>500</b>	<b>315</b>	<b>157,500</b>	<b>15,907,500</b>	Unit cost means One time (with 60 Second duration) each day , 15 day's in a month for 12 months cost
Management Cost				29,625	2,992,125	
<b>Cost/TV spot</b>				<b>238,481</b>	<b>24,086,606</b>	
<b>Ref: Costed National Implementation Plan 2014-2017</b>						

1.5.2 **Conduct social media BCC campaign**

Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>Content Develop</b>		<b>12</b>	<b>5000</b>	<b>60,000</b>	-	Unit cost means One script develop, production , Censorship cost
<b>Dissemination through social media</b>		<b>120</b>	<b>315</b>	<b>37,800</b>	-	Unit cost means One time (with 60 Second duration) each day , 15 day's in a month for 12 months cost
Management Cost				14,670	-	
<b>Cost/TV spot</b>				<b>118,094</b>	-	
<b>Ref: Costed National Implementation Plan 2014-2017</b>						

1.5.3 **Training of master trainers and peer educators**

3 day training for master Trainer and 3 day training for Peer educator on LSE (Total 25 Master Trainer/ district and 30 peer educator/ district). Total 2 batches per districts in 23 district will be						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>3 days Master Trainers' training, 25 person / district</b>						
Venue & public address system	Per Day	3	207.92	-	-	
Snacks	Average Cost per training	75	74.26	-	-	
Participants Allowance	Average Cost per training	75	1013.78	-	-	
Travel Cost	Average Cost per training	25	0.00	-	-	
Training Materials & Logistics	Average Cost per training	25	297.03	-	-	
Printing ( Photograph, documents)	Average Cost per training	25	49.50	-	-	
Resource Person Honorarium	Average Cost per training	9	225.48	-	-	
Support Staff Allowance	Average Cost per training	6	39.91	-	-	
Banner	Average Cost per training	1	18.00	-	-	
Training cost per training	Average Cost per training	1	1925.88	1,926	194,514	
<b>TOTAL training Cost - 1 batch</b>				<b>1,926</b>	<b>194,514</b>	

<b>3 days training for Peer Educator, 30 person / district</b>						
Venue & public address system	Per Day	3	207.92	-	-	-
Snacks	Average Cost per training	1	86.63	-	-	-
Participants Allowance	Average Cost per training	30	751.61	-	-	-
Travel Cost	Average Cost per training	1	217.82	-	-	-
Training Materials & Logistics	Average Cost per training	1	356.44	-	-	-
Printing ( Photograph, documents)	Average Cost per training	1	49.50	-	-	-
Resource Person Honorarium	Average Cost per training	9	225.48	-	-	-
Support Staff Allowance	Average Cost per training	6	39.91	-	-	-
Training cost per training	Average Cost per training	1	1935.32	-	-	-
<b>TOTAL training Cost - 1 batch</b>		<b>1</b>	<b>1727.40</b>	<b>1,727</b>		
<b>Total cost/ District</b>				<b>8,835</b>		<b>892,383</b>
<b>Ref: Costing data from GOB/GF Budget 2017-2022</b>						

1.6.1

<b>Events to address HIV related human rights issues</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	1	69.31	-	-	
Snacks	Average Cost per workshop	30	44.55	-	-	
Participants Allowance	Average Cost per workshop	30	475.25	-	-	
Travel Cost	Average Cost per workshop	30	0.00	-	-	
Workshop Materials & Logistics	Average Cost per workshop	35	69.31	-	-	
Printing ( Photograph, documents)	Average Cost per workshop	35	19.80	-	-	
Resource Person Honorarium	Average Cost per workshop	5	148.51	-	-	
Support Staff Allowance	Average Cost per workshop	2	8.91	-	-	
Banner	Average Cost per workshop	1	19.80	-	-	
Management Cost				128	12,960	
<b>Cost/year</b>				<b>983.76</b>	<b>99,360</b>	
<b>Ref.: Costed National Implementation Plan 2017-2022</b>						

1.6.2

<b>Sensitize and mobilize the involvement of the media in contributing to the HIV response and Human Rights</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	1	148.51	-	-	
Snacks	Average Cost per workshop	60	89.11	-	-	
Participants Allowance	Average Cost per workshop	50	792.08	-	-	
Travel Cost	Average Cost per workshop	50	0.00	-	-	
Workshop Materials & Logistics	Average Cost per workshop	55	108.91	-	-	
Printing ( Photograph, documents)	Average Cost per workshop	55	19.80	-	-	
Resource Person Honorarium	Average Cost per workshop	5	148.51	-	-	
Support Staff Allowance	Average Cost per workshop	2	8.91	-	-	
Banner	Average Cost per workshop	1	19.80	-	-	50 person in each session
Management Cost				200	20,235	
<b>Cost/year</b>				<b>1535.99</b>	<b>155,135</b>	
<b>Ref.: Costed National Implementation Plan 2014-2017</b>						

1.6.3

<b>Capacity building of non-health service providers of relevant ministries, employers federation/trade unions on HIV &amp; AIDS and Human Rights</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	1	69.31	-	-	
Snacks	Average Cost per workshop	40	59.41	-	-	
Participants Allowance	Average Cost per workshop	30	475.25	-	-	
Travel Cost	Average Cost per workshop	30	0.00	-	-	
Workshop Materials & Logistics	Average Cost per workshop	35	69.31	-	-	
Printing ( Photograph, documents)	Average Cost per workshop	35	19.80	-	-	
Resource Person Honorarium	Average Cost per workshop	5	148.51	-	-	
Support Staff Allowance	Average Cost per workshop	2	8.91	-	-	
Banner	Average Cost per workshop	1	19.80	-	-	30 person in each session
Management Cost				131		
<b>Cost/year</b>				<b>1000.84</b>	<b>101,085</b>	
<b>Ref.: Costed National Implementation Plan 2017-2022</b>						

1.6.4

<b>Provide training for CBOs on policy development, advocacy, legal literacy and Human Rights.</b>						
4 person per CBO - 100 CBOs						
Required line items	month	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	3	207.92	-	-	3 days training for 100 CBO members
Snacks	Average Cost per training	30	74.26	-	-	
Local Participants Allowance	Average Cost per training	10	297.03	-	-	
Non Local Participants Allowance	Average Cost per training	15	1039.60	-	-	
Travel Cost	Average Cost per training	15	371.29	-	-	
Training Materials & Logistics	Average Cost per training	20	237.62	-	-	
Printing ( Photograph, documents)	Average Cost per training	1	49.50	-	-	
Resource Person Honorarium	Average Cost per training	9	267.33	-	-	
Support Staff Allowance	Average Cost per training	3	26.73	-	-	
<b>Total Cost/ Training</b>	Average Cost per training			<b>2,571</b>	<b>259,700</b>	
Management Cost				386	38,955	
<b>Cost/ Training</b>				<b>2,957</b>	<b>298,655</b>	
<b>Ref: Costed National Implementation Plan 2014-2017</b>						

Objective-2 2.1.1

<b>Revision/adaption and printing of guidelines for HTS</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Technical assistance						40 day consultancy/year
<b>Local consultant (30 Days)</b>						

Consultancy fee	per day cost	25	400	10,000	1,010,000	
Transportation Cost	lumsun	5	14.85	74	7,500	
Subtotal- Local Consultant				10,074	1,017,500	
Printing Cost		500	7.5	3,750	378,750	
Cost/ Guideline				13,824	1,396,250	
Ref: HTS guideline update 2019						

2.1.2

Establish HTS in public hospitals at district level						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Establishment of physical facilities in hospitals			3000			
Furniture, Equipment, others			1000			
Cost/ center/year				4,000	404,000	
Ref: Costing data from GOB budget, 2017-2022						

2.1.3

Continue HTS in public hospitals at district level						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>Personnel cost</b>						
Counselor	Per Person-Per Month	0	300	-	-	
Medical technologists	Per Person-Per Month	0	250	-	-	
<b>Subtotal - Personnel cost</b>				550	55,550	
<b>Consumables for HTS centre</b>						
Vacationer tube (100/pack), plain	Per Month	100	0.13	13	1,263	
Syringe 5cc	Per Month	100	0.06	6	631	
Masking tape 2"	Per Month	1	0.81	1	82	
Disposable gloves (100/pack)	Per Month	200	0.06	13	1,263	
Sodium Hypochlorite, 4 Liter	Per Month	2	4.00	8	808	
Chlorhexidine Glucunate, 250 ml	Per Month	2	1.88	4	379	
Cotton medium 200 gm	Per Month	1	0.66	1	67	
Liquid soap	Per Month	2	0.79	2	159	
Aluminum foil	Per Month	1	2.19	2	221	
Magic tape with holder	Per Month	1	1.06	1	107	
Permanent marker	Per Month	1	0.70	1	71	
Toilet tissue	Per Month	6	0.25	2	152	
Stationery	Per Month	1	5.25	5	530	
Band-Aid	Per Month	100	0.02	2	202	
<b>Sub total- Consumable</b>				59	5,934	
<b>External quality assessment</b>						
Test Name (ELISA, WB)	per month	192	10.00	1,920	193,920	Assuming per month 3 person from each center will be referred for EQA test both positive and negative each month
<b>Sub total - External quality assessment</b>				1,920	193,920	
<b>Cost/ Center/ month</b>				2,529	255,404	
<b>Cost/ Center/ year</b>				30,345	3,064,845	
Ref: Current intervention of HTS services						

2.1.4

HIV testing kit (3 test) with other consumables (including for FDMN, for community led testing and for ANC)				USD	BDT	Remarks
Unit Cost / person / year				5.00	505	
Ref: Same as HTC for KPs						

2.2.1

Develop Guideline for Community-led Testing						
Development of protocols for PMTCT.						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>Local consultant (25 Days)</b>						
Consultancy fee	per day cost	25	400	10,000	1,010,000	
Transportation Cost	lumsun	10	14.85	149	15,000	
<b>Subtotal- Local Consultant</b>				10,149	1,025,000	

<b>Consultant Workshop (2 times)</b>						
Venue & public address system	Per Day	1	69.31	-	-	
Snacks	Average Cost per workshop	20	37.13	-	-	
Local Participants Allowance	Average Cost per training	10	158.42	-	-	
Non Local Participants Allowance	Average Cost per training	10	495.05	-	-	
Travel Cost	Average Cost per training	10	198.02	-	-	
Training Materials & Logistics for Orientation & Inf	Average Cost per training	20	39.60	-	-	
Printing ( Photograph, documents)	Average Cost per training	20	49.50	-	-	
Resource Person Honorarium	Average Cost per training	3	89.11	-	-	
Support Staff Allowance	Average Cost per training	2	8.91	-	-	
<b>Subtotal- Consultant</b>			<b>1145.049505</b>	<b>2,290</b>	<b>231,300</b>	
Printing of protocol		9000	2	<b>18,000</b>	<b>1,818,000</b>	300 copies
<b>Total cost development of protocol</b>				<b>30,439</b>	<b>3,074,300</b>	
<b>Ref: 4th HPNSP</b>						

2.2.2

<b>Training and refresher training on community-led testing and self testing of representatives from KP communities (FSW, MSM/MSW, TG, PUD)</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	1	69.31			
Snacks	Average Cost per Workshop	30	44.55			
Local Participants Allowance	Average Cost per Workshop	25	173.27			
Non Local Resource Person Allowance	Average Cost per Workshop	6	148.51			
Travel Cost	Average Cost per Workshop	3	118.81			
Training Materials & Logistics	Average Cost per Workshop	20	39.60			
Printing ( Photograph, documents)	Average Cost per Workshop	1	49.50			
Resource Person Honorarium	Average Cost per Workshop	3	89.11			
Support Staff Allowance	Average Cost per Workshop	2	8.91			
<b>Training cost per Workshop</b>		<b>1</b>		<b>2,966</b>	<b>299,600</b>	
<b>Printing Cost</b>		<b>500</b>	<b>7.5</b>	<b>3,750</b>	<b>378,750</b>	
<b>Cost</b>				<b>6,716</b>	<b>678,350</b>	
<b>Ref: Costed National Implementation Plan 2014-2017</b>						

2.3.1

<b>Conduct court-yard discussion</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	1	69.31			
Snacks	Average Cost per Workshop	30	44.55			
Travel Cost	Average Cost per Workshop	3	118.81			
<b>Training cost per Workshop</b>		<b>1</b>		<b>931</b>	<b>94,000</b>	
<b>Ref: Costed National Implementation Plan 2014-2017</b>						

2.3.2

<b>Testing Campaign</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Decoration & Sound System	Per Day	2	69	139		
Volunteer payment	Per Day	10	8	79		
MT Lab Payment	Per Day	2	7	14		
Counselor Per diem	Per Day	2	7	14		
Honorarium for CS office staff	Per Day	2	25	50		
Stationaries, Sheet printing, photocopy and others	Per Day	2	15	30		
Transportation for NASP personel	Per Day	2	79	158		
DA for NASP personel	Per Day	2	178	356		
<b>Per Testing Cost</b>				<b>841</b>	<b>84,900</b>	
<b>Ref: Costed National Implementation Plan 2014-2017</b>						

2.4.1

<b>Develop SOP for Community based Self Testing</b>						
Development of protocols for PMTCT.						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>Local consultant (25 Days)</b>						
<i>Consultancy fee</i>	per day cost	25	400	10,000	1,010,000	
<i>Transportation Cost</i>	lumsum	10	14.85	149	15,000	
<b>Subtotal- Local Consultant</b>				<b>10,149</b>	<b>1,025,000</b>	
<b>Consultant Workshop (2 times)</b>						
Venue & public address system	Per Day	1	69.31			
Snacks	Average Cost per workshop	20	37.13			
Local Participants Allowance	Average Cost per training	10	158.42			
Non Local Participants Allowance	Average Cost per training	10	495.05			
Travel Cost	Average Cost per training	10	198.02			
Training Materials & Logistics for Orientation & Inf	Average Cost per training	20	39.60			
Printing ( Photograph, documents)	Average Cost per training	20	49.50			
Resource Person Honorarium	Average Cost per training	3	89.11			
Support Staff Allowance	Average Cost per training	2	8.91			
<b>Subtotal- Consultant</b>			<b>1145.049505</b>	<b>2,290</b>	<b>231,300</b>	
<b>Printing of SOP (including Pocket info-kit)</b>		<b>300</b>	<b>5</b>	<b>1,500</b>	<b>151,500</b>	300 copies

Total cost of SOP (including Pocket info-kit)					13,939	1,407,800	
<b>Ref: 4th HPNSP</b>							

2.4.2	<b>HIV Self testing kit with other consumables</b>					USD	BDT	Remarks
	Unit Cost / person / year				5.00	505		
	<b>Ref: Same as HTC for KPs</b>							

Objective-3	3.1.1.1	<b>Develop/update protocol for care and support</b>						
		Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
		<b>Local consultant (25 Days)</b>						
		<i>Consultancy fee</i>	per day cost	25	400	10,000	1,010,000	
		<i>Transportation Cost</i>	lumsom	5	18.75	94	9,469	
		<b>Subtotal- Local Consultant</b>				<b>10,094</b>	<b>1,019,469</b>	
		<b>Consultation workshop</b>				-	-	4 workshop with 20 person in each session
		<i>Venue &amp; public address system</i>	Per Day	1	69.31			
		<i>Snacks</i>	Average Cost per Workshop	25	44.55			
		<i>Local Participants Allowance</i>	Average Cost per Workshop	10	158.42			
		<i>Non Local Participants Allowance</i>	Average Cost per Workshop	10	495.05			
		<i>Travel Cost</i>	Average Cost per Workshop	10	198.02			
		<i>Training Materials &amp; Logistics</i>	Average Cost per Workshop	20	39.60			
		<i>Printing ( Photograph, documents)</i>	Average Cost per Workshop	1	49.50			
		<i>Resource Person Honorarium</i>	Average Cost per Workshop	3	89.11			
		<i>Support Staff Allowance</i>	Average Cost per Workshop	6	16.83			
		<b>Training cost per Workshop</b>		1		<b>4,642</b>	<b>468,800</b>	
		<b>Printing Cost</b>		<b>500</b>	<b>7.5</b>	<b>3,750</b>	<b>378,750</b>	
		<b>Cost</b>				<b>18,485</b>	<b>1,867,019</b>	
		<b>Ref: Costed National Implementation Plan 2014-2017</b>						

3.1.1.2	<b>Conduct capacity building for care providers</b>							
	3 days training, 20 person							
		Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
		<i>Venue &amp; public address system</i>	Per Day	3	69.31		-	
		<i>Snacks</i>	Average Cost per training	25	61.88		-	
		<i>Local Participants Allowance</i>	Average Cost per training	5	237.62		-	
		<i>Non Local Participants Allowance</i>	Average Cost per training	15	1485.15		-	
		<i>Travel Cost</i>	Average Cost per training	15	445.54		-	
		<i>Training Materials &amp; Logistics</i>	Average Cost per training	20	237.62		-	
		<i>Printing ( Photograph, documents)</i>	Average Cost per training	1	49.50		-	
		<i>Resource Person Honorarium</i>	Average Cost per training	9	142.57		-	
		<i>Support Staff Allowance</i>	Average Cost per training	3	26.73		-	
		<b>Total Cost/ Training</b>	Average Cost per training			<b>2,756</b>	<b>278,350</b>	
		<b>Ref: Costed National Implementation Plan 2014-2017</b>						

3.1.1.3	<b>Number of PLHIV enrolled in HIV care</b>							
		<i>PLHIV enrolled in HIV care</i>	Average Cost per entolled	1	11.88			
		<b>Cost/person</b>				12	1,200	
		<b>Ref: Costed National Implementation Plan 2014-2017</b>						

3.1.2.1	<b>Pocket Manual to support DSD</b>							
		<i>Pocket Manual printing</i>	Cost per print	1	2.00			
		<b>Cost/person</b>				2	202	
		<b>Ref: Costed National Implementation Plan 2014-2017</b>						

3.1.2.2	<b>Training and refreshers training Communities on Adherence monitoring</b>							
	2 days training, 20 person							
		Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
		<i>Venue &amp; public address system</i>	Per Day	2	138.61		-	
		<i>Snacks</i>	Average Cost per training	25	61.88		-	
		<i>Local Participants Allowance</i>	Average Cost per training	5	99.01		-	
		<i>Non Local Participants Allowance</i>	Average Cost per training	15	779.70		-	
		<i>Travel Cost</i>	Average Cost per training	15	371.29		-	
		<i>Training Materials &amp; Logistics</i>	Average Cost per training	20	39.60		-	
		<i>Printing ( Photograph, documents)</i>	Average Cost per training	1	49.50		-	
		<i>Resource Person Honorarium</i>	Average Cost per training	6	178.22		-	
		<i>Support Staff Allowance</i>	Average Cost per training	2	17.82		-	
		<b>Total Cost/ Training</b>	Average Cost per training			<b>1,736</b>	<b>175,300</b>	
		<b>Ref: Costed National Implementation Plan 2014-2017</b>						

3.1.2.3	<b>Provide ART to the PLHIV (all who are identified)</b>							
		Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
		1st line	per patient Cost			97	-	
		2nd line				199	-	
		<b>TOTAL ART</b>				<b>297</b>	-	
		Cost of monitoring, 1st year				15	-	
		Cost of monitoring, cont.				15	-	
		Training/year				6	-	
		Adherence/year				-	-	
		Coordination/year				98	-	
		Management cost				65	-	
		<b>Cost/patient</b>				<b>496</b>	-	
		<b>Ref: ART guideline &amp; CMSD rates</b>						

3.1.2.4	<b>Follow up for adherence and retention by local service providers</b>						
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Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Mobile bill			4.95		-	
Transportation for follow up			19.80		-	
Perdiem for follow up			13.86		-	
<b>Cost/month</b>				<b>39</b>	<b>3,900</b>	
<b>Ref: 4th Sector Circular rates</b>						

3.1.2.5

<b>ART Advisory Committee Meeting (15 persons)</b>						
Food costs and Logistics				60	-	

3.1.3.1

<b>Develop and maintain functional HIV treatment and management task force to ensure rapid ART initiation, advanced HIV disease management, address lost to follow up etc,</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Quarterly meeting		1	200.0	200	-	
Secretarial support		1	8.91	9	-	
<b>Cost/meeting</b>				<b>209</b>	<b>-</b>	
<b>Ref: Costed National Implementation Plan 2014-2017</b>						

3.1.5.1

<b>Number of PLHIV on ART receive viral load test</b>						
Cost per person				12	-	
<b>Ref: Procurent cost 2023</b>						

3.1.6.1

<b>Develop comprehensive protocols and procedures</b>						
<b>Curriculum development - consultancy (25 days)</b>						
<i>Consultancy fee</i>	per day cost	25	400	10,000	-	
<i>Transportation Cost</i>	lumsun	5	14.85	74	-	
<b>Subtotal- Local Consultant</b>				<b>10,074</b>	<b>-</b>	
<i>Venue &amp; public address system</i>	Per Day	1	69.31			2 workshop with 25 person in each session
<i>Snacks</i>	Average Cost per workshop	25	37.13			
<i>Local Participants Allowance</i>	Average Cost per training	20	316.83			
<i>Training Materials &amp; Logistics</i>	Average Cost per training	20	39.60			
<i>Printing ( Photograph, documents)</i>	Average Cost per training	1	49.50			
<i>Resource Person Honorarium</i>	Average Cost per training	3	89.11			
<i>Support Staff Allowance</i>	Average Cost per training	2	8.91			
<b>Subtotal- Consultation Workshop</b>			<b>610.40</b>	<b>1,221</b>		
<b>Printing Cost</b>		1000	7.5	<b>7,500</b>		
<b>Cost/ Curriculum</b>				<b>18,795</b>	<b>-</b>	
<b>Cost per TA</b>				<b>61,964</b>	<b>6,258,330</b>	
<b>Ref: Costed National Implementation Plan 2014-2017 &amp; Costing data from GOB budget, 2017-2022</b>						

3.1.6.2

<b>Review, update and dissemination of treatment protocol - 2 times</b>						
<b>Development of ART protocol.</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>Local consultant (25 Days)</b>						
<i>Consultancy fee</i>	per day cost	25	400	10,000	-	
<i>Transportation Cost</i>	lumsun	5	14.85	74	-	
<b>Subtotal- Local Consultant</b>				<b>10,074</b>	<b>-</b>	
<b>Consultation Workshop (02 days)</b>						
<i>Venue &amp; public address system</i>	Per Day	2	138.61			
<i>Snacks</i>	Average Cost per workshop	20	61.88			
<i>Local Participants Allowance</i>	Average Cost per training	10	316.83			
<i>Non Local Participants Allowance</i>	Average Cost per training	10	742.57			
<i>Travel Cost</i>	Average Cost per training	10	198.02			
<i>Training Materials &amp; Logistics</i>	Average Cost per training	20	237.62			
<i>Printing ( Photograph, documents)</i>	Average Cost per training	20	49.50			
<i>Resource Person Honorarium</i>	Average Cost per training	3	178.22			
<i>Support Staff Allowance</i>	Average Cost per training	2	17.82			
<b>Subtotal- Consultation Workshop</b>			<b>1,941.09</b>	<b>3,882</b>	<b>-</b>	
<b>Printing Cost</b>		500	7.5	<b>3,750</b>	<b>-</b>	
<b>Cost/ Protocol</b>				<b>17,706</b>	<b>-</b>	
<b>Ref: Costed National Implementation Plan 2014-2017</b>						

3.1.6.3

<b>Integrate HIV treatment and management in medical curriculum</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>Curriculum development - consultancy (30 days)</b>						
<i>Consultancy fee</i>	per day cost	30	400	12,000	-	
<i>Transportation Cost</i>	lumsun	5	18.75	94	-	
<b>Subtotal- Local Consultant</b>				<b>12,094</b>	<b>-</b>	
<i>Venue &amp; public address system</i>	Per Day	2	1089.11			2 workshop with 50 person in each session
<i>Food &amp; Snacks</i>	Average Cost per workshop	55	3811.88			
<i>Local Participants Allowance</i>	Average Cost per training	35	554.46			
<i>Non Local Participants Allowance</i>	Average Cost per training	15	742.57			
<i>Travel Cost</i>	Average Cost per training	15	297.03			
<i>Training Materials &amp; Logistics</i>	Average Cost per training	50	594.06			
<i>Printing ( Photograph, documents)</i>	Average Cost per training	1	49.50			
<i>Resource Person Honorarium</i>	Average Cost per training	3	89.11			
<i>Support Staff Allowance</i>	Average Cost per training	2	8.91			
<b>Subtotal- Consultation Workshop</b>			<b>7,236.63</b>	<b>14,473</b>	<b>-</b>	
<b>Printing Cost</b>		500	7.5	<b>3,750</b>	<b>-</b>	
<b>Cost/ Curriculum</b>				<b>30,317</b>	<b>-</b>	
<b>Ref: Costed National Implementation Plan 2014-2017</b>						

3.1.7.1

<b>Identify and ensure access to training in specialisations identified through human resource functional analysis - out country</b>						

Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Air fare	Cost / participants	5	800	4,000		Out country international (Regional) training - 10 person will be trained
Per diem	Cost / participants	30	280	8,400		
Terminal Fees	Cost / participants	20	11	220		
Visa Processing Fees	Cost / participants	5	200	1,000		
Course Fees	Cost / participants	5	1200	6,000		
Management Cost				2,943	297,243	
<b>Total cost</b>				<b>23,691</b>	<b>2,392,806</b>	
<b>Cost per person</b>				<b>4,738</b>	<b>478,561</b>	

Ref: Costed National Implementation Plan 2014-2017 & Costing data from GOB budget, 2017-2022

3.1.7.2

SOP for ensuring regulatory frameworks mitigate risk						
<b>Curriculum development - consultancy (25 days)</b>						
Consultancy fee	per day cost	25	400	10,000	-	
Transportation Cost	lumsum	5	14.85148515	74	-	
<b>Subtotal- Local Consultant</b>				<b>10,074</b>	<b>-</b>	
Venue & public address system	Per Day	1	69.31			2 workshop with 20 person in each session
Snacks	Average Cost per workshop	25	37.13			
Local Participants Allowance	Average Cost per training	20	316.83			
Training Materials & Logistics	Average Cost per training	20	237.62			
Printing ( Photograph, documents)	Average Cost per training	1	49.50			
Resource Person Honorarium	Average Cost per training	3	89.11			
Support Staff Allowance	Average Cost per training	2	8.91			
<b>Subtotal- Consultation Workshop</b>			<b>808.42</b>	<b>1,617</b>		
Printing Cost		1000	7.5	7,500		
<b>Cost/ Curricularam</b>				<b>19,191</b>	<b>1,938,300</b>	

Ref: Costed National Implementation Plan 2014-2017 & Costing data from GOB budget, 2017-2022

3.2.1

Basic Clinical Training on HIV/ AIDS for government, non-government, and private sectors to provide age, gender, and human rights-sensitive out-patient and in-patient medical 2 days training in batches (25 participants)						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	2	138.61			
Snacks	Average Cost per training	25	74.26			
Participants Allowance	Average Cost per training	25	1014.85			
Non Local Resource Person Allowance	Average Cost per training	9	227.23			
Travel Cost Non Local Resource Person	Average Cost per training	3	118.81			
Training Materials & Logistics	Average Cost per training	25	49.50			
Printing ( Photograph, documents)	Average Cost per training	25	49.50			
Resource Person Honorarium	Average Cost per training	6	151.49			
Support Staff Allowance	Average Cost per training	4	17.82			
<b>Training cost per training</b>		<b>1</b>		<b>1,842</b>	<b>186,050</b>	

Ref: 4th HPNSP

3.3.1

Set up support to engage communities in supporting the treatment and care cascade to comply with related policy adoption, linkages, and updates						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>Office Equipment:</b>						
Computer with UPS	Pcs	1	800	800	80,800	
Printer & cartridge	Pcs	1	150	150	15,150	
Mobile/telephone	Pcs	2	0	-	-	
DVD player	Pcs	1	0	-	-	
Television	Pcs	1	200	200	20,200	
Water filter	Pcs	1	40	40	4,040	
Weight Machine	Pcs	1	30	30	3,030	
<b>Sub Total</b>				<b>1,220</b>	<b>123,220</b>	
<b>Furniture &amp; Fixtures :</b>						
		<b>Unit Required</b>				
File Cabinet steel	Pcs	1	250	250	25,250	
Shelf (wooden)	Pcs	4	200	800	80,800	
Almirah steel	Pcs	1	250	250	25,250	
Conference Table 1	Pcs	1	300	300	30,300	
Executive Table	Pcs	6	180	1,080	109,080	
Revolving chair	Pcs	5	80	400	40,400	
Armless chair	Pcs	50	25	1,250	126,250	
Computer Table & chair	Pcs	1	250	250	25,250	
TV & DVD stand	Pcs	1	0	-	-	
Display Board & Others	Pcs	1	30	30	3,030	
Utensils 1	Pcs	3	0	-	-	
Patient bed	Pcs	1	250	250	25,250	
Spot light	Pcs	1	5	5	505	
BP machine & stethoscope	Pcs	1	25	25	2,525	
Autoclaves	Pcs	1	50	50	5,050	
Medicine Trolley	Pcs	1	0	-	-	
Curtain	Pcs	1	30	30	3,030	
Stares	Pcs	1	0	-	-	
Screen	Pcs	1	0	-	-	
Wall Clock	Pcs	2	5	10	1,010	
Light	Pcs	12	3	36	3,636	
Fan	Pcs	6	35	210	21,210	
<b>Sub Total</b>				<b>5,226</b>	<b>527,826</b>	
Management Cost				967	97,657	
<b>Cost/DIC</b>				<b>9,637</b>	<b>973,314</b>	

Ref: Costed National Implementation Plan 2014-2017

3.4.1

Running Cost to ensure a comprehensive approach to the community support system is adopted and continued to remove barriers to accessing services and strengthen treatment

Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>Rent and utilities cost of DIC</b>						
Office Rent	per month cost	1	0	-	-	
Mobile bill	per month cost	1	15	15	1,500	
Postage	per month cost	1	5	5	500	
Internet/ E-Mail / Dom-in/ Hosting	per month cost	1	15	15	1,500	
Utilities (Electricity, Gas & WASA)	per month cost	1	46	46	4,600	
Photocopy and Printing	per month cost	1	10	10	1,000	
Stationery and Office supplies	per month cost	1	25	25	2,500	
Maintenance / Repairing	per month cost	1	10	10	1,000	
Cleaning supplies	per month cost	1	10	10	1,000	
Library (News paper, magazine & HIV related documents collections.	per month cost	1	10	10	1,000	
Conveyance	per month cost	1	50	50	5,000	
Others	per month cost	1	15	15	1,500	
<b>Subtotal - rent and utilities</b>				<b>209</b>	<b>21,100</b>	
<b>Identify and recruit staff for DIC</b>						
DIC Manager	per person per month	1	-	-	-	
Counselor	per person per month	1	-	-	-	
Program Assistant / Outreach Supervisor	per person per month	2	-	-	-	
Peer educator	per person per month	10	-	-	-	
Peon/Aya	per person per month	1	-	-	-	
Security guard	per person per month	1	-	-	-	
<b>Subtotal- salary of DIC staff</b>						
Management Cost				<b>31</b>	<b>3,165</b>	
<b>Cost/ CBO / Network / month</b>				<b>240</b>	<b>24,265</b>	
<b>Ref: Costed National Implementation Plan 2014-2017</b>						

Objective-4

4.1.1.1

<b>Conduct annual meeting of NAC</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Technical expert	Cost / participants	1	0		-	42 members
Materials	Cost / participants	45	535		-	
Venue & public address system	Cost / participants	1	0		-	
Food	Cost / participants	50	742.57		-	
Perdiem	Cost / participants	42	1247.52		-	
Banner	Number	1	29.70		-	
<b>Cost/meeting</b>				<b>2,554</b>	<b>258,000</b>	
<b>Ref: Costing data from GOB budget, 2017-2022</b>						

4.1.1.2

<b>Conduct quarterly meetings of TC-NAC</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	1	69.31		-	
Snacks	Average Cost per workshop	30	44.55		-	22 members
Local Participatory Resource Person Allowance	Average Cost per workshop	22	1960.40		-	
Training Materials & Logistics	Average Cost per workshop	25	49.50		-	
Printing ( Photograph, documents)	Average Cost per workshop	1	49.50		-	
Support Staff Allowance	Average Cost per workshop	1	8.91		-	
<b>Cost/meeting</b>	Average Cost per workshop			<b>2,182</b>	<b>220,400</b>	
<b>Ref: Costing data from GOB budget, 2017-2022</b>						

4.1.1.3

<b>Produce annual program report</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>Report development 1000 copies</b>						
Printing	Cost / 1000 copies	1000	5.00	5,000	505,000	
Management Cost				<b>750.00</b>	<b>75,750</b>	
<b>Cost/ Report/ year</b>				<b>5,750</b>	<b>580,750.00</b>	
<b>Ref: Costing data from GOB budget, 2017-2022</b>						

4.1.2.1

<b>Provide equipment, furniture and logistics</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>Equipments for NASP</b>						
<b>Office equipment</b>						
Computer		10	900.0	9,000	909,000	
Laptop		3	1100.0	3,300	333,300	
UPS		20	75.0	1,500	151,500	
Printer network		5	300.0	1,500	151,500	
Multimedia		1	1500.0	1,500	151,500	
Scanner		1	300.0	300	30,300	
Intercom		1	2000.0	2,000	202,000	
Sound system		1	2000.0	2,000	202,000	
LAN Set up		0	1500.0			
Photocopier		1	3000.0	3,000	303,000	
IPS		2	2000.0	4,000	404,000	
IPS Battery		8	175.0	1,400	141,400	
<b>Sub Total - Office equipment</b>				<b>29,500</b>	<b>2,979,500</b>	
<b>Furniture :</b>						
Computer Table		2	80.00	160	16,160	
Secretarial Table		0	125.00	-	-	
Air Conditioner		2	1500.00	3,000	303,000	
Book shelf		0	250.00	-	-	
File Cabinet		3	100.00	300	30,300	
Water filter		1	300.00	300	30,300	

	<i>Fan</i>		5	40.00	200	20,200	
<b>Sub Total -Furniture</b>					<b>3,960</b>	<b>399,960</b>	
Management Cost					<b>5,019.00</b>	<b>506,919</b>	
<b>Total Cost</b>					<b>40,403</b>	<b>4,080,698</b>	

*Ref: Costed National Implementation Plan 2014-2017*

4.1.2.2

<b>Provide utilities and supplies</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>Rent, utilities and supplies</b>						
<i>Electricity, water, gas, etc. Bill</i>	Monthly	1	0	-	-	
<i>Office supplies and maintenance</i>	Monthly	1	0	-	-	
<i>Office Rent</i>	Monthly	1	0.0	-	-	
<i>Mobile Bill</i>	Monthly	1	9.90	10	1,000	
<i>Local conveyance</i>	Monthly	1	49.50	50	5,000	
<i>IPS Maintenance cost</i>	Yearly	1.000	0	-	-	
Management Cost						
<b>Cost/ month</b>				<b>59</b>	<b>6,000</b>	

*Ref: Current Global Fund Grant Expenditure*

4.1.2.3

<b>ASP HR</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Senior Manager- Mgt & Co-ordination	Per Person-yearly	1	45552	45,552	4,600,735	
Technical Specialist (HIV)	Per Person-yearly	1	34769	34,769	3,511,709	
M&E Expert	Per Person-yearly	1	25111	25,111	2,536,234	
Manager-IT & Data	Per Person-yearly	1	22991	22,991	2,322,078	
Manager PSM	Per Person-yearly	1	18654	18,654	1,884,032	
Manager - Finance	Per Person-yearly	1	17872	17,872	1,805,084	
Officer PSM	Per Person-yearly	1	12063	12,063	1,218,385	
Support Staff	Per Person-yearly	1	4049	4,049	408,934	
Support Staff	Per Person-yearly	1	4049	4,049	408,934	
Driver	Per Person-yearly	1	4496	4,496	454,094	
Driver	Per Person-yearly	1	4540	4,540	458,513	
HIV Counseling Coordinator	Per Person-yearly	1	4915	4,915	496,400	
M&E Coordinator	Per Person-yearly	1	4915	4,915	496,400	
Coordinator - Communication Documentation	Per Person-yearly	1	4915	4,915	496,400	
DSMO	Per Person-yearly	23	9267	213,149	21,528,000	
Counselor	Per Person-yearly	64	3921	250,931	25,344,000	
MT-Lab	Per Person-yearly	64	3267	209,109	21,120,000	
Accountant	Per Person-yearly	1	2269	2,269	229,129	
<b>Outsourcing</b>						
Cleaner	Per Person-yearly	65	2091	135,921	13,728,000	
Driver	Per Person-yearly	8	2091	16,729	1,689,600	
Peer Educator	Per Person-yearly	192	2091	401,489	40,550,400	
Guard	Per Person-yearly	3	2091	6,273	633,600	
Management Cost				84,062	8,490,240	
<b>Per Year Salary</b>				<b>1,528,821</b>	<b>154,410,900</b>	
<b>ASP Regular HR (Ref: ASP Worksheet)</b>						
<b>Per year salary (All staff)</b>						

*Ref: Costing data from GOB /GF Current Expenditure*

4.1.2.4

<b>Conduct advisory committee meetings (half yearly)</b>						
<i>Venue &amp; public address system</i>	Per Day	1	69.31			
<i>Snacks</i>	Average Cost per workshop	30	44.55			
<i>Local Participatory Resource Person Allowance</i>	Average Cost per workshop	22	1045.54			
<i>Training Materials &amp; Logistics</i>	Average Cost per workshop	25	49.50			
<i>Printing ( Photograph, documents)</i>	Average Cost per workshop	1	49.50			
<i>Support Staff Allowance</i>	Average Cost per workshop	1	8.91			
<b>Cost/meeting</b>	Average Cost per workshop			<b>1,267</b>	<b>128,000</b>	

*Ref: GOB / GF budget, 2017-2022*

4.1.3.1

<b>Conduct quarterly coordination meetings with stakeholders</b>						
<i>Venue &amp; public address system</i>	Per Day	1	69.31			
<i>Food &amp; Snacks</i>	Average Cost per workshop	35	242.57			
<i>Meeting Materials &amp; Logistics</i>	Average Cost per workshop	30	59.41			
<i>Printing ( Photograph, documents)</i>	Average Cost per workshop	1	19.80			
<i>Support Staff Allowance</i>	Average Cost per workshop	1	8.91			

Cost/meeting	Average Cost per workshop			400	40,400	
Ref: GOB / GF budget, 2017-2022						

4.1.3.2

Develop functional district level coordination under district health authority (CS) to be facilitated by local agency						
Local health authority (Civil Surgeon) will organize regular coordination meeting with implementing agency, there will be M&E visit and yearly planning and review workshop with stakeholders.						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>Districty Level Coordination Workshop</b>						
Venue & public address system	Per Day	1	69.31	-		
Snacks	Average Cost per training	30	44.55	-		
Participants Allowance	Average Cost per training	25	303.80			
Training Materials & Logistics	Average Cost per training	25	49.50			
Printing ( Photograph, documents)	Average Cost per training	25	19.80			
Resource Person Honorarium	Average Cost per training	9	186.35			
Support Staff Allowance	Average Cost per training	2	8.91			
Training cost per training	Average Cost per training	1	682.23	682		
<b>Cost/ Meeting</b>				<b>682</b>	<b>68,905</b>	
<b>Cost/year</b>				<b>716</b>	<b>72,351</b>	
<b>M&amp;E visit</b>						
Per diem (2 Days)	Per Person Cost	2	58.14	116	11,744	
travel cost	Per Person Cost	2	79.21	158	16,000	
<b>Total cost /visit</b>				<b>275</b>	<b>27,744</b>	
				<b>549</b>	<b>55,488</b>	
<b>M&amp;E visit Cost / Year (4 visit)</b>						
				<b>1,266</b>	<b>127,838</b>	
Cost / district / year						
Ref: GOB / GF budget, 2017-2022						

4.1.4.1

Workshops with multisectoral authorities on relevant HIV Prevention, Treatment, Care and Support issues where collaboration needed.						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	1	69.31	-		
Snacks	Average Cost per training	30	44.55	-		
Participants Allowance	Average Cost per training	25	396.04			
Training Materials & Logistics	Average Cost per training	25	49.50			
Printing ( Photograph, documents)	Average Cost per training	25	19.80			
Resource Person Honorarium	Average Cost per training	5	148.51			
Support Staff Allowance	Average Cost per training	2	8.91			
<b>Cost per workshop</b>				<b>737</b>	<b>74,400</b>	
Ref: GOB / GF budget, 2017-2022						

4.1.4.2

Compile and share action plan as per workshop discussion						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Consultant Fees (15 days)	per day	15	300.00	4,500	454,500	
<b>Cost per workshop</b>				<b>4,500</b>	<b>454,500</b>	
Ref: GOB / GF budget, 2017-2022						

4.1.4.3

Develop advocacy materials (packages)						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Folders		1	0.84	0.84	85	
Leaflet		1	0.10	0.10	10	
Program Brief		1	1.20	1.20	121	
Management Cost				0.32	32	
<b>Cost / advocacy material package</b>				<b>2.58</b>	<b>261</b>	
Ref: GOB OP Budget, 2017-2022						

4.1.4.4

Conduct national level advocacy						
Ten national advocacy events per year. Fifty participants will attend per advocacy events						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	1	69.31			
Food & Snacks	Average Cost per workshop	60	891.09			
Local Participants Allowance	Average Cost per training	35	554.46			
Non Local Participants Allowance	Average Cost per training	15	742.57			
Travel Cost	Average Cost per training	15	445.54			
Workshop Materials & Logistics	Average Cost per training	50	594.06			
Printing ( Photograph, documents)	Average Cost per training	1	49.50			
Resource Person Honorarium	Average Cost per training	3	89.11			50 participants in each event
Support Staff Allowance	Average Cost per training	2	8.91			
<b>Subtotal- Consultation Workshop</b>			<b>3,444.55</b>	<b>6,889</b>	<b>695,800</b>	
<b>Cost / Workshop</b>				<b>7,234</b>	<b>730,590</b>	
Ref: GOB / GF budget, 2017-2022						

4.1.4.5

Conduct local level advocacy						
Two advocacy events with twenty participants per year per upazilla / DIC (450 Upzilla) @ 20 person per event						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	1	69.31	-	-	

Snacks	Average Cost per workshop	30	44.55	-	-	
Participants Allowance	Average Cost per workshop	25	284.65	-	-	
Travel Cost	Average Cost per workshop	25	0.00	-	-	
Workshop Materials & Logistics	Average Cost per workshop	30	59.41	-	-	
Printing ( Photograph, documents)	Average Cost per workshop	25	19.80	-	-	
Resource Person Honorarium	Average Cost per workshop	3	62.38	-	-	
Support Staff Allowance	Average Cost per workshop	2	8.91	-	-	
Banner	Average Cost per workshop	1	19.80	-	-	
<b>Cost / Workshop</b>				<b>568.81</b>	<b>57,450</b>	
<b>Ref.: Rate as per 4th HPNSP Paripatra</b>						

4.1.4.6

<b>Celebration of World AIDS Day</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>For Central Level</b>						
T-Shirt		1650	3	4,950	499,950	
Rally Sun Cap		3250	1.5	4,875	492,375	
Stall rent		20	80	1,600	161,600	
Printing poster		10000	0.35	3,500	353,500	
Festoon		100	6.25	625	63,125	
Rally banner		1	30	30	3,030	
Stationeries for booth set up		20	30	600	60,600	
Gift items		3000	1.25	3,750	378,750	
Refreshment cost for Preparatory meeting		90	18.75	1,688	170,438	
Communicaion cost		5	12.5	63	6,313	
Refreshment for Rally participants		1000	2	2,000	202,000	
Transportation		10	37.5	375	37,875	
<b>Sub Total</b>				<b>24,055</b>	<b>2,429,555</b>	
<b>Observe World AIDS Day in district and medical college hospital</b>						
Rally, banner, refreshment, discussion meeting , etc		120	150.00	18,000	1,818,000	
		0	0.00	-	-	
		0	0.00	-	-	
		0	0.00	-	-	
		0	0.00	-	-	
		0	0.00	-	-	
		0	0.00	-	-	
<b>Sub Total</b>				<b>18,000</b>	<b>1,818,000</b>	
Management Cost				6,308	637,133	
<b>total Cost/ Event</b>				<b>50,781</b>	<b>5,128,923</b>	
<b>Ref.: Costed National Implementation Plan 2014-2017 &amp; Costing data from GOB budget, 2017-2022</b>						

4.1.5.1

<b>Develop core curriculum and training resources</b>						
This will involve reviewing existing Curriculum and resources in Bangladesh and from overseas and assessing gaps against the functional analysis (3.6.1). Based on this gap analysis curriculum and						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>Curriculum development - consultancy (20 days)</b>						
Consultancy fee	per day cost	20	400	8,000	-	
Transportation Cost	lumsum	5	14.85	74	-	
<b>Subtotal- Local Consultant</b>				<b>8,074</b>	-	
Venue & public address system	Per Day	1	69.31			
Snacks	Average Cost per workshop	25	37.13			
Local Participants Allowance	Average Cost per training	20	316.83			
Training Materials & Logistics	Average Cost per training	20	237.62			
Printing ( Photograph, documents)	Average Cost per training	1	49.50			
Resource Person Honorarium	Average Cost per training	3	89.11			
Support Staff Allowance	Average Cost per training	2	8.91			
<b>Subtotal- Consultation Workshop</b>			<b>808.42</b>	<b>1,617</b>		
Printing Cost		1000	7.5	7,500		
<b>Cost/ Curriculam</b>				<b>17,191</b>	-	
<b>Cost per TA</b>				<b>55,193</b>	-	
<b>Ref.: Costed National Implementation Plan 2014-2017</b>						

4.2.1.1

<b>Enhance integration of HIV with TB, Hepatitis and SRH services (e.g. strengthening referral mechanism , advocacy with Hospital directors, management, increase community involvement</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Patient Reffered	Cost per Patient Reffered	1	2.00	2	202	
<b>Cost per workshop</b>				<b>2</b>	<b>202</b>	
<b>Ref: GOB / GF budget, 2017-2022</b>						

4.2.2.1

<b>Training to Strengthen Tuberculosis preventive therapy</b>						
2 days training in batches (25 participants)						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	2	138.61			
Snacks	Average Cost per training	30	74.26			
Participants Allowance	Average Cost per training	5	158.42			
Non Local Participants Allowance	Average Cost per training	20	1485.15			
Travel Cost Non Local Participants Allowance	Average Cost per training	20	594.06			
Training Materials & Logistics	Average Cost per training	25	49.50			
Printing ( Photograph, documents)	Average Cost per training	25	49.50			
Resource Person Honorarium	Average Cost per training	6	178.22			
Support Staff Allowance	Average Cost per training	4	17.82			
<b>Training cost per training</b>		<b>1</b>		<b>2,746</b>	<b>277,300</b>	
<b>Ref: 4th HPNSP</b>						

4.2.2.4

<b>Follow up for adherence by local service providers</b>						
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Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Mobile bill			4.95		-	
Transportation for follow up			19.80		-	
Perdiem for follow up			13.86		-	
<b>Cost/month</b>				<b>39</b>	<b>3,900</b>	
<b>Ref: 4th Sector Circular rates</b>						

4.3.1.1

<b>Procurement Competing Meetings</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	1	69.31	-	-	
Snacks	Average Cost per workshop	12	17.82	-	-	
Participants Allowance	Average Cost per workshop	8	126.73			
Workshop Materials & Logistics	Average Cost per workshop	10	19.80			
Printing ( Photograph, documents)	Average Cost per workshop	1	19.80			
Resource Person Honorarium	Average Cost per workshop	2	59.41			
<b>Cost / Workshop</b>				<b>312.87</b>	-	
<b>Ref.: Rate as per 4th HPNSP Paripatra</b>						

4.3.2.1

<b>SOP to mitigate risk in alignment with health center regulations</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Curriculum development - consultancy (10 days)						
Consultancy fee	per day cost	10	400	4,000	404,000	
Transportation Cost	lumsum	5	14.85148515	74	7,500	
<b>Subtotal- Local Consultant</b>				<b>4,074</b>	<b>411,500</b>	
Venue & public address system	Per Day	1	69.31			
Snacks	Average Cost per workshop	25	37.13			
Local Participants Allowance	Average Cost per training	20	316.83			
Training Materials & Logistics	Average Cost per training	20	237.62			
Printing ( Photograph, documents)	Average Cost per training	1	49.50			
Resource Person Honorarium	Average Cost per training	3	89.11			
Support Staff Allowance	Average Cost per training	2	8.91			
<b>Subtotal- Consultation Workshop</b>			<b>808.42</b>	<b>1,617</b>		
Printing Cost		200	5	<b>1,000</b>		
<b>Cost/ Curriculam</b>				<b>6,691</b>	<b>675,800</b>	
<b>Cost per TA</b>				<b>8,698</b>	<b>878,540</b>	
<b>Ref.: Costed National Implementation Plan 2014-2017</b>						

4.3.2.2

<b>Training and refresher training on inventory management system</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	2	138.61		-	
Snacks	Average Cost per workshop	25	61.88			
Local Participants Allowance	Average Cost per training	3	71.29			
Non Local Participants Allowance	Average Cost per training	22	1306.93			
Travel Cost	Average Cost per training	22	653.47			
Training Materials & Logistics	Average Cost per training	25	49.50			
Printing ( Photograph, documents)	Average Cost per training	1	49.50			
Resource Person Honorarium	Average Cost per training	3	178.22			
Support Staff Allowance	Average Cost per training	2	17.82			
<b>Total for training</b>			<b>2,527.23</b>	<b>5,054</b>	<b>510,500</b>	
<b>Ref: Costed National Implementation Plan 2014-2017</b>						

4.3.3.1

<b>Comprehensive guidelines on procedures to strengthen the capacity of district and sub-district level HIV service providers to prepare detailed specifications, quantification and forecasting,</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Curriculum development - consultancy (10 days)						
Consultancy fee	per day cost	10	400	4,000	404,000	
Transportation Cost	lumsum	5	14.85148515	74	7,500	
<b>Subtotal- Local Consultant</b>				<b>4,074</b>	<b>411,500</b>	
Venue & public address system	Per Day	1	69.31			
Snacks	Average Cost per workshop	25	37.13			
Local Participants Allowance	Average Cost per training	20	316.83			
Training Materials & Logistics	Average Cost per training	20	39.60			
Printing ( Photograph, documents)	Average Cost per training	1	49.50			
Resource Person Honorarium	Average Cost per training	3	89.11			
Support Staff Allowance	Average Cost per training	2	8.91			
<b>Subtotal- Consultation Workshop</b>			<b>610.40</b>	<b>1,221</b>		
Printing Cost		200	5	<b>1,000</b>		
<b>Cost/ Curriculam</b>				<b>6,295</b>	<b>635,800</b>	
<b>Cost per TA</b>				<b>8,184</b>	<b>826,540</b>	
<b>Ref.: Costed National Implementation Plan 2014-2017</b>						

4.3.3.2

<b>Training and refresher training on inventory management system to prepare detailed specifications, quantification and forecasting, and budget planning for procurement of HIV-related</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	2	138.61		-	
Snacks	Average Cost per workshop	25	61.88			
Local Participants Allowance	Average Cost per training	3	95.05			
Non Local Participants Allowance	Average Cost per training	22	1633.66			
Travel Cost	Average Cost per training	22	871.29			
Training Materials & Logistics	Average Cost per training	25	49.50			
Printing ( Photograph, documents)	Average Cost per training	1	49.50			
Resource Person Honorarium	Average Cost per training	3	178.22			
Support Staff Allowance	Average Cost per training	2	17.82			
<b>Total for training</b>			<b>3,095.54</b>	<b>6,191</b>	<b>625,300</b>	
<b>Ref: Costed National Implementation Plan 2014-2017</b>						

4.3.4.1

<b>Half yearly Meetings of advisory committee on supply chain</b>						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Training Materials & Logistics	per person	15	29.70			
Food and snaks	per person	20	99.01			

Total cost per meeting			128.71	257	26,000	
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Ref: Costed National Implementation Plan 2014-2017

4.3.4.2

Health Product Chain Management (storage, SCM, Inventories)						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Manpower	month	2	19009.90	-		
Carrying Cost		1	3960.40	22,970	2,320,000	
<b>Total Cost</b>				<b>22,970</b>	<b>2,320,000</b>	

Ref: Existing Expenses

4.3.5.1

Establish internet-based real-time Logistic Management Information System of HIV commodities						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>Curriculum development - consultancy (30 days)</b>						
Consultancy fee	per day cost	30	400	12,000	1,212,000	
Transportation Cost	lumsum	20	14.85	297	30,000	
Full Computer with UPS & printer	Pert set	70	1,188.12	83,168	8,400,000	
<b>Subtotal- Local Consultant</b>				<b>95,465</b>	<b>9,642,000</b>	
<b>Venue &amp; public address system</b>						
	Per Day	1	69.31			5 workshop with 20 person in each session
Snacks	Average Cost per workshop	25	37.13			
Local Participants Allowance	Average Cost per training	20	316.83			
Training Materials & Logistics	Average Cost per training	20	39.60			
Printing (Photograph, documents)	Average Cost per training	1	49.50			
Resource Person Honorarium	Average Cost per training	3	89.11			
Support Staff Allowance	Average Cost per training	2	8.91			
<b>Subtotal- Consultation Workshop</b>			<b>610.40</b>	<b>3,052</b>		
Printing Cost		200	5		1,000	
<b>Cost/ Curriculam</b>				<b>99,517</b>	<b>10,051,250</b>	
<b>Cost per TA</b>				<b>129,373</b>	<b>13,066,625</b>	

Ref.: Costed National Implementation Plan 2014-2017

4.3.5.2

Training and refresher training on establish internet-based real-time Logistic Management Information System of HIV commodities						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>Venue &amp; public address system</b>						
	Per Day	2	138.61			3 workshop with 20 person in each session
Snacks	Average Cost per workshop	25	61.88			
Local Participants Allowance	Average Cost per training	3	71.29			
Non Local Participants Allowance	Average Cost per training	22	1306.93			
Travel Cost	Average Cost per training	22	653.47			
Training Materials & Logistics	Average Cost per training	25	49.50			
Printing (Photograph, documents)	Average Cost per training	1	49.50			
Resource Person Honorarium	Average Cost per training	3	178.22			
Support Staff Allowance	Average Cost per training	2	17.82			
<b>Total for training</b>			<b>2,527.23</b>	<b>7,582</b>	<b>765,750</b>	

Ref: Costed National Implementation Plan 2014-2017

4.4.1.1

Develop guidelines and regulatory framework in alignment with hospital/clinic						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>Curriculum development - consultancy (20 days)</b>						
Consultancy fee	per day cost	20	400	8,000	808,000	
Transportation Cost	lumsum	10	14.85	149	15,000	
<b>Subtotal- Local Consultant</b>				<b>8,149</b>	<b>823,000</b>	
<b>Venue &amp; public address system</b>						
	Per Day	1	69.31			2 workshop with 20 person in each session
Snacks	Average Cost per workshop	25	37.13			
Local Participants Allowance	Average Cost per training	20	316.83			
Training Materials & Logistics	Average Cost per training	20	39.60			
Printing (Photograph, documents)	Average Cost per training	1	49.50			
Resource Person Honorarium	Average Cost per training	3	89.11			
Support Staff Allowance	Average Cost per training	2	8.91			
<b>Subtotal- Consultation Workshop</b>			<b>610.40</b>	<b>1,221</b>		
Printing Cost		200	5		1,000	
<b>Cost/ Curriculam</b>				<b>10,369</b>	<b>1,047,300</b>	
<b>Cost per TA</b>				<b>13,480</b>	<b>1,361,490</b>	

Ref.: Costed National Implementation Plan 2014-2017

4.4.1.2

Set up lab requirements						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Gene Expert Matchine	Cost per Matchine	1	0.00			
Chair (Revolving)	Cost per Matchine	1	650.00			
Table SS Steel	Cost per Matchine	2	2000.00			
Celling Fan 56"	Cost per Matchine	1	450.00			
File Cabinet	Cost per Matchine	1	1000.00			
Online UPS With Battery (2 KVA, 3 Hrs Backup)	Cost per Matchine	1	20000.00			
Multi Plug	Cost per Matchine	1	120.00			
Air Condition with installation and Security grill (1.	Cost per Matchine	1	11000.00			
Dial Thermometer	Cost per Matchine	1				
Timer	Cost per Matchine	1	300.00			
Refrigerator	Cost per Matchine	1	9500.00			
Falcon Tube Rack	Cost per Matchine	1	100.00			
Tray (Metal)	Cost per Matchine	2	150.00			
Paddle bin/Dustbin	Cost per Matchine	1	80.00			
Room decoration (Electric wiring, Earthing, Equipm	Cost per Matchine	1	5000.00			
Room Decoration ( Tiles: Floor & Wall)	Cost per Matchine	1	11500.00			

Auto Lockable Sliding Door	Cost per Matchine	1	5000.00			
Windows Replacement and Security Grill	Cost per Matchine	2	2000.00			
Hand wash basin with fitting	Cost per Matchine	1	1000.00			
<b>Management Cost</b>				<b>76,835</b>	<b>7,760,335</b>	

Ref.: Costed National Implementation Plan 2014-2017

4.4.1.3

Ensure uninterrupted supply chain systems: meetings and print-outs						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Food and Snacks		12	59.4			
Secretarial support		1	8.91			
<b>Cost/meeting</b>				<b>68</b>	<b>6,900</b>	

Ref.: Costed National Implementation Plan 2014-2017

4.4.1.4

Training and refresher training on uninterrupted supply chain systems						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	2	138.61		-	3 workshop with 20 person in each session
Snacks	Average Cost per workshop	25	61.88			
Local Participants Allowance	Average Cost per training	3	71.29			
Non Local Participants Allowance	Average Cost per training	22	1306.93			
Travel Cost	Average Cost per training	22	653.47			
Training Materials & Logistics	Average Cost per training	25	49.50			
Printing ( Photograph, documents)	Average Cost per training	1	49.50			
Resource Person Honorarium	Average Cost per training	3	178.22			
Support Staff Allowance	Average Cost per training	2	17.82			
<b>Total for training</b>			<b>2,527.23</b>	<b>7,582</b>	<b>765,750</b>	

Ref.: Costed National Implementation Plan 2014-2017

4.4.3.1

Establish National Reference Laboratory						
Required line items	Measurement Unit	Unit	Unit Cost	Total Amount (USD)	Total Amount (BDT)	Remarks
Establish National Reference Laboratory	No. of year supported			-		
Cost 1st year		1	300,000	300,000	-	
Cost of 2nd & 3rd year		2	300,000	600,000	-	
<b>Total Cost</b>				<b>900,000</b>	<b>-</b>	
Average unit cost			<b>300,000</b>			

Costing Ref: ASP worksheet

4.4.3.2

Develop protocol/guidelines for provision of laboratory services (inclusive of conducting quality assurance for public, private and NGO laboratories)						
Required line items	Measurement Unit	Unit	Unit Cost	Total Amount (USD)	Total Amount (BDT)	Remarks
<b>Curriculum development - consultancy (20 days)</b>						
<i>Consultancy fee</i>	per day cost	20	400	8,000		
<i>Transportation Cost</i>	lumsom	10	14.85	149		
<b>Subtotal- Local Consultant</b>				<b>8,149</b>		
Venue & public address system	Per Day	1	69.31			
Snacks	Average Cost per workshop	25	37.13			
Local Participants Allowance	Average Cost per training	20	316.83			
Training Materials & Logistics	Average Cost per training	20	237.62			
Printing ( Photograph, documents)	Average Cost per training	1	49.50			
Resource Person Honorarium	Average Cost per training	3	89.11			
Support Staff Allowance	Average Cost per training	2	8.91			
<b>Subtotal- Consultation Workshop</b>			<b>808.42</b>	<b>1,617</b>		
Printing Cost		200	10	2,000		
<b>Cost/ Curricular</b>				<b>11,765</b>		
<b>Cost per TA</b>				<b>41,183</b>	<b>4,159,480</b>	

Ref.: Costed National Implementation Plan 2014-2017 & Costing data from GOB budget, 2017-2022

4.4.4.1

Coordination workshops with private health facilities and labs to scale up laboratory services and quality assurance of the labs						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	2	138.61			20 person in each session in 1 meeting
Snacks	Average Cost per workshop	25	61.88			
Local Participants Allowance	Average Cost per training	20	272.28			
Non Local Resource Person Allowance	Average Cost per training	3	151.49			
Travel Cost	Average Cost per training	3	118.81			
Training Materials & Logistics	Average Cost per training	20	39.60			
Printing ( Photograph, documents)	Average Cost per training	1	49.50			
Local Resource Person Honorarium	Average Cost per training	3	75.74			
Support Staff Allowance	Average Cost per training	2	17.82			
<b>Total for training</b>			<b>925.74</b>	<b>2,777</b>	<b>280,500</b>	

Ref.: Costed National Implementation Plan 2014-2017

4.4.4.2

Training to scale up laboratory services and quality assurance of the private health facilities and labs						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	2	138.61		-	20 person in each session, day long training
Snacks	Average Cost per workshop	25	61.88			
Local Participants Allowance	Average Cost per training	20	202.97			
Non Local Resource Person Allowance	Average Cost per training	3	151.49			
Travel Cost	Average Cost per training	3	118.81			
Training Materials & Logistics	Average Cost per training	20	39.60			
Printing ( Photograph, documents)	Average Cost per training	1	49.50			
Local Resource Person Honorarium	Average Cost per training	3	75.74			
Support Staff Allowance	Average Cost per training	2	17.82			
<b>Total for training</b>			<b>856.44</b>	<b>2,569</b>	<b>259,500</b>	

Ref.: Costed National Implementation Plan 2014-2017

4.5.1.1

Infrastructure of CBOs to contribute HIV program among KPs						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Support to CBOs						

CBO Organizer	Salary Support per month	1	178.22	178	-	
Office Rent including utilities	per month	1	148.51	149	-	
Office Supplies, stationery and others	per month	1	49.50	50	-	
Coordination ( meeting ,etc)	per month	1	79.21	79	-	
Management Cost				68.32	-	
<b>cost /CBO per annum</b>				<b>550</b>	-	

Ref: Costed National Implementation Plan 2014-2017

4.5.1.2

Provide management training for CBOs						
2 person per CBO - 100 CBO members						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	1	69.31			
Snacks	Average Cost per training	30	74.26			
Local Participants Allowance	Average Cost per training	10	297.03			
Non Local Participants Allowance	Average Cost per training	15	1039.60			
Travel Cost	Average Cost per training	15	371.29			
Training Materials & Logistics	Average Cost per training	25	297.03			
Printing ( Photograph, documents)	Average Cost per training	1	49.50			
Resource Person Honorarium	Average Cost per training	9	267.33			
Support Staff Allowance	Average Cost per training	3	26.73			
Total Cost/ Training	Average Cost per training			2,492	251,700	
Management Cost				374	37,755	
<b>Cost/ Training</b>				<b>2,866</b>	<b>289,455</b>	

Ref: Costed National Implementation Plan 2014-2017

4.5.1.3

Provide leadership and accountability training for CBOs						
4 person per CBO - 100 CBOs						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	1	69.31			
Snacks	Average Cost per training	30	74.26			
Local Participants Allowance	Average Cost per training	10	297.03			
Non Local Participants Allowance	Average Cost per training	15	1039.60			
Travel Cost	Average Cost per training	15	371.29			
Training Materials & Logistics	Average Cost per training	20	237.62			
Printing ( Photograph, documents)	Average Cost per training	1	49.50			
Resource Person Honorarium	Average Cost per training	9	267.33			
Support Staff Allowance	Average Cost per training	3	26.73			
Total Cost/ Training	Average Cost per training			2,433	245,700	
Management Cost				365	36,855	
<b>Cost/ Training</b>				<b>2,798</b>	<b>282,555</b>	

Ref: Costed National Implementation Plan 2014-2017

4.5.2.1

Quarterly meeting with community-led and health facility or private service providers						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	1	69.31			
Snacks	Average Cost per training	20	29.70			
Local Participants Allowance	Average Cost per training	15	204.21			
Training Materials & Logistics	Average Cost per training	20	39.60			
Printing ( Photograph, documents)	Average Cost per training	1	9.90			
Resource Person Honorarium	Average Cost per training	3	75.74			
Support Staff Allowance	Average Cost per training	2	8.91			
Total Cost/ Training	Average Cost per training			437	44,175	
Management Cost				66	6,626	
<b>Cost/ Training</b>				<b>503</b>	<b>50,801</b>	

Ref: Costed National Implementation Plan 2014-2017

4.5.4.1

Community representatives in regional peer-learning initiatives						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Air fare	Cost / participants	3	1500	4,500		Out country international Conference/ workshop - 3 person will be trained
Per diem	Cost / participants	18	350	6,300		
Terminal Fees	Cost / participants	12	11	132		
Visa Processing Fees	Cost / participants	3	200	600		
Conference Fees/ Course Fees	Cost / participants	3	1200	3,600		
Management Cost				2,270		
<b>Total cost</b>				<b>18,272</b>	<b>1,845,461</b>	
<b>Cost per person</b>				<b>6,091</b>	<b>615,154</b>	
<b>Total Cost</b>				<b>24,363</b>	<b>2,460,615</b>	

Ref: Costed National Implementation Plan 2014-2017 & Costing data from GOB budget, 2017-2022

Objective-5 5.1.1

Conduct regular behavioural surveillance of all key populations with IBBS in some places						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Serological Surveillance				-	-	
IBBS				550,000	55,550,000	
Management Cost				82,500	8,332,500	
<b>Cost/ surveillance</b>				<b>632,500</b>	<b>63,882,500</b>	

Ref: IBBS 2020-2021 (BSMMU)

5.1.2

Conduct regular STI surveillance						
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Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
STI surveillance				600,000	-	
Management Cost				90,000	9,090,000	
<b>Cost/ surveillance</b>				<b>690,000</b>	<b>69,690,000</b>	
<b>Ref: IEDCR-2021</b>						

5.2 Conduct size estimation studies

Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Size estimation studies				300,000	30,300,000	
Management Cost				45,000	4,545,000	
<b>Cost/ study</b>				<b>345,000</b>	<b>34,845,000</b>	
<b>Ref: PSE-2023_BSMMU</b>						

5.3 Conduct Stigma Index Study

Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Study & Data collection and processing		1	80,000	80,000	8,080,000	
Management cost				12,000	1,212,000	
<b>Cost/study</b>				<b>92,000</b>	<b>9,292,000</b>	

5.4.1 Maintain HIV Management Information System

Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Local consultant (20 Days)						
<i>Consultancy fee to DG-MIS</i>	per day cost	20	400	8,000	808,000	
<i>Transportation</i>	per day cost	5	14.85	74	7,500	
<b>Subtotal- Local Consultant</b>				<b>8,074</b>	<b>815,500.00</b>	
<b>Ref: Costed National Implementation Plan 2014-2017</b>						

5.4.2 Establish HIV reporting and maintain PLHIV database

Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Local consultant (15 Days)						
<i>Consultancy fee</i>	per day cost	15	400	6,000	606,000	
<i>Transportation</i>	per day cost	5	14.85	74	7,500	
<b>Subtotal- Local Consultant</b>				<b>6,074</b>	<b>613,500</b>	
<b>Ref: Costed National Implementation Plan 2014-2017</b>						

5.5.1 Conduct national workshop to prioritize as well as review existing research /operations research /studies; develop annual national agenda for research

Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
One national workshop with fifty participants						
<i>Venue &amp; public address system</i>	Per Day	1	297.03			
<i>Snacks</i>	Average Cost per workshop	60	89.11			
<i>Local Participants Allowance</i>	Average Cost per workshop	35	554.46			
<i>Non Local Participants Allowance</i>	Average Cost per workshop	20	990.10			
<i>Travel Cost</i>	Average Cost per workshop	20	693.07			
<i>Workshop Materials &amp; Logistics</i>	Average Cost per workshop	50	99.01			
<i>Printing ( Photograph, documents)</i>	Average Cost per workshop	1	49.50			
<i>Resource Person Honorarium</i>	Average Cost per workshop	3	89.11			
<i>Support Staff Allowance</i>	Average Cost per workshop	2	8.91			
<b>Cost / Workshop</b>				<b>2,870</b>	<b>289,900</b>	
<b>Ref: Costed National Implementation Plan 2014-2017</b>						

5.5.2 Conduct studies based on emerging needs

Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Studies based on emerging needs				300,000		Communication, courier, photocopy, training, training material etc.
Management Cost				45,000		
<b>Cost/ Surveillance</b>				<b>345,000</b>	<b>34,845,000</b>	
<b>Ref: Size estimation Study 4.1.4</b>						

5.6.1 Produce guidelines and tools

Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Local consultant (20 Days)						
<i>Consultancy fee</i>	per day cost	20	400	8,000	-	
<i>Transportation</i>	per day cost	10	14.85	149	-	
<b>Subtotal- Local Consultant</b>				<b>8,149</b>	<b>-</b>	
<b>Ref: Costed National Implementation Plan 2014-2017</b>						

5.6.2 Conduct evaluation of design and effectiveness of current targeted interventions

Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
There is insufficient cost/benefit based evidence to scale up various interventions to achieve sufficient coverage to affect outcomes. Among KPs there is insufficient evidence to support scaling up As per M&E Operation Plan 2011-2017 (11.4 & 11.5)						
<b>Cost/study</b>				<b>235,000</b>	<b>23,735,000</b>	
<b>Ref: National HIV and AIDS M&amp;E Operation Plan 2011-2017 : Roadmap 2016-2017</b>						

5.7.1 Conduct mid-term and end-term evaluations

Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Mid-term and End-term evaluations				550,000		
Management Cost				82,500		
<b>Cost/ surveillance/ Study</b>				<b>632,500</b>	<b>63,882,500</b>	
<b>Ref: Costed National Implementation Plan 2014-2017</b>						

5.7.2 Periodic review and updating of the M&E system and its indicators in a participatory manner						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Consultant fee						
Workshop / meeting						
Printing						
<b>Total</b>				<b>5,000</b>	<b>-</b>	
Management Cost				<b>750</b>	<b>-</b>	
<b>Cost/ Review</b>				<b>5,750</b>	<b>-</b>	

Ref: Costed National Implementation Plan 2014-2017

5.7.3 Advocacy workshop and follow up with the stakeholders to ensure regular reporting as well as providing feedback						
One day workshop @ 25 participant						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	1	69.31			
Food & Snacks	Average Cost per workshop	30	44.55			
Local Participants Allowance	Average Cost per workshop	15	237.62			
Non Local Participants Allowance	Average Cost per workshop	10	495.05			
Travel Cost	Average Cost per workshop	10	297.03		-	
Workshop Materials & Logistics	Average Cost per workshop	25	297.03		-	
Printing ( Photograph, documents)	Average Cost per workshop	1	49.50		-	
Resource Person Honorarium	Average Cost per workshop	3	89.11		-	
Support Staff Allowance	Average Cost per workshop	2	8.91		-	
<b>Cost / Workshop</b>				<b>1,588</b>	<b>160,400</b>	

Ref: Costed National Implementation Plan 2014-2017

5.7.4 M&E training for staff across the sector						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	3	207.92			
Snacks	Average Cost per workshop	30	74.26			
Local Participants Allowance	Average Cost per workshop	15	237.62			
Non Local Participants Allowance	Average Cost per workshop	10	495.05			
Travel Cost	Average Cost per workshop	10	346.53		-	
Workshop Materials & Logistics	Average Cost per workshop	25	297.03		-	
Printing ( Photograph, documents)	Average Cost per workshop	1	49.50		-	
Resource Person Honorarium	Average Cost per workshop	9	267.33		-	
Support Staff Allowance	Average Cost per workshop	3	26.73		-	
<b>Cost / Workshop</b>			<b>2001.98</b>	<b>2,002</b>	<b>202,200</b>	

Ref: Costed National Implementation Plan 2014-2017

5.7.5 Conduct regular M&E visits to assess quality (third party monitoring may be considered)						
Required line items	Measurement unit	Unit/ Days	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Per diem (2 Days)	Per Person Cost	3	200.91			3 person in each team
travel cost	Per Person Cost	4	158.42			
<b>Total cost /visit</b>				<b>359</b>		
<b>Cost/visit</b>				<b>359</b>	<b>36,292.19</b>	

Ref: Costing data from GOB budget, 2017-2022

5.7.6 Conduct ART Adherence Monitoring						
	Measurement Unit	Unit	Unit cost (USD)	Total Amount ( USD)	Total Amount (BDT)	Remarks
Adherence Monitoring	No. of year supported	4	11,834.45	11,834.45	1,195,279	

Ref: ASP Work Sheet

5.7.7 Conduct Client Satisfaction Survey at the public Health facilities integrating KP services						
	Measurement Unit	Unit	Unit cost (USD)	Total Amount ( USD)	Total Amount (BDT)	Remarks
Cost	No. of year supported	1	50,000	50,000	5,050,000	

Ref: ASP Work sheet

5.8.1 Conduct quarterly M&E TWG and coordination Workshop						
Quarterly coordination meeting - 25 participants						
Required line items	Measurement unit	Unit	Unit cost (USD)	Total Amount (USD)	Total Amount (BDT)	Remarks
Venue & public address system	Per Day	1	69.31			
Snacks	Average Cost per workshop	30	44.55			
Local Participatory Resource Person Allowance	Average Cost per workshop	22	1960.40			
Training Materials & Logistics	Average Cost per workshop	25	49.50			
Printing ( Photograph, documents)	Average Cost per workshop	1	49.50			
Support Staff Allowance	Average Cost per workshop	1	8.91			
<b>Cost/ Workshop</b>	Average Cost per workshop			<b>2,182</b>	<b>220,400</b>	

Ref: Costed National Implementation Plan 2014-2017

5.8.2 Develop, print and disseminate different reports						
As per M&E Operation Plan 2011-2017 (12.6 & 12.7)						
<b>Cost / year</b>				<b>12,000</b>	<b>1,212,000</b>	

Ref: National HIV and AIDS M&E Operation Plan 2011-2017 : Roadmap 2016-2017