

**GOVERNMENT OF THE PEOPLE'S REPUBLIC OF
BANGLADESH**

STRATEGIC PLAN

of

THE NATIONAL AIDS PROGRAMME

OF BANGLADESH

1997-2002

July 2000

**BANGLADESH AIDS PREVENTION AND CONTROL PROGRAMME
PRIMARY HEALTH CARE AND DISEASE CONTROL
DIRECTORATE GENERAL OF HEALTH SERVICES
MINISTRY OF HEALTH AND FAMILY WELFARE**

**DRAFT STRATEGIC PLAN
OF THE
NATIONAL AIDS PROGRAMME OF BANGLADESH
1997-2002**

**Drafted by a TASK FORCE IN April 1997
Appointed by the Ministry of Health and Family Welfare
and modified subsequently in a finalization workshop
In collaboration with
NATIONAL AIDS/STD PROGRAMME, BANGLADESH
in May 2000**

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PROLOGUE

In recognition of HIV as a major multi-dimensional problem, the National AIDS Committee, requested for a National Strategic Plan for AIDS prevention and control. The remit for the Bangladesh AIDS Prevention and Control Programme (BAPCP) included formulating a National Strategic Plan for STD/AIDS (BGD/93/001). The Minister of Health and Family Welfare and the Chairman, National AIDS Committee vide minutes of the 2nd NAC meeting, 1st February 1997, point 2, requested the same to be formulated and finalized through a multisectoral consensus workshop in April 1997. The Minister of Health and Family Welfare and the Health Secretary further endorsed the above, vide minutes of the 3rd NAC meeting, 20th March 1997. A technical Task Force was formed by the Ministry in this regard.

Composition of the Technical Task Force

1. Maj. Gen MR Choudhury (Retd.) -TC/NAC	Convenor
2. Prof Nazrul Islam -BAPCP	Secretary
3. Dr Hasan Mahmud - STD Project	Member
4. Prof Hasan Mahmud Khan (Retd) IPGMR	"
5. Prof Anwarul Haq - SMCH	"
6. Prof AZM Maidul Islam -IPGMR	"
7. Dr. Lisa Messersmith-UNAIDS	"
8. Mr. Ahmed Ilias -Al Falah	"
9. Dr Swarup Sarkar-CARE	"
10. Mr. Maurice Bloem - CCDB	"
11. Mr. Mahmudur Rahman-Anjuman Pharmacy	"
12. Advocate Syed Refaat Ahmed-Supreme Court	"

13. Dr. Tasnim Azim-LSD, ICDDR,B "
14. Dr. Sarah Hawkes-CHD, ICDDR,B "
15. Dr. Aye Aye Thwin-Urban Ext-ICDDR,B "
16. Dr. Shaheeda Rahman-BAPCP "
17. Dr. Md Golam Rasul-BAPCP "
18. Dr. Monsur Ali-BAPCP "
19. Dr. Enamul Karim-IEDCR "
20. Prof. Musharraf Husain-IPGMR "
21. Ms. Perveen Rasheed-SMC "
22. Dr. Parwez Salman Choudhury-Paricharja "
23. Dr. M Anwarul Huq Mian-STD project, "
24. Ms. Lisabeth Fulton-BRAC "
25. Dr. M Ahsanul Kabir-STD Project, IEDCR "
26. Ms. Marianne De Weir-Consultant "
27. Dr. Jai P Narain-WHO/SEARO "
28. Dr Fawzia Rasheed-BAPCP "

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The contribution of the participants of the intersectoral workshop of May 2000 that was organized in Hotel Agrabad, Chittagong, in which the strategy was brushed up thoroughly and modified extensively to fill up some gaps that existed in the first draft prepared in April 1997 viz. injecting drug use, mother to child transmission, facets of empowerment etc. deserves special mention. The draft document could not be submitted to the Ministry of Health and Family Welfare in time mainly because of the changes that ensued as a result of adoption of the now well known reformed infrastructure of the programme under Health and population sector Programme (HPSP). A list of the learned participants of that workshop has been annexed (Annexure - 2).

MISSION STATEMENT

In five year's time, the Bangladesh National AIDS Programme should contribute to:

The understanding by everyone that the HIV epidemic affects everyone and how it is and it is not transmitted.

All sectors of society joining hands to combat the spread and impact of HIV and controlling an epidemic.

People with HIV living and dying with dignity, amongst family and friends, without discrimination and stigma.

Society respecting the equitable right to life, information and health care; working to alleviate conditions which render an individual's health dependent on others; to include promoting economic and social independence for all.

LIST OF ABBREVIATIONS

AI&ACC	AIDS Information and Awareness Campaign Committee
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-natal Clinic
BAPCP	Bangladesh AIDS Prevention and Control Programme
CC	Co-ordination Committee
CHW	Community Health Workers
CPR/CAR	Contraceptive Prevalence Rate/Contraceptive Acceptance Rate
CSW	Commercial Sex Worker
DGHS	Directorate General of Health Services
EC	Executive Committee
EIP	Extended Interim Plan
ESP	Essential Services Package
GOB	Government of Bangladesh
GPA	Global Programme on AIDS
HAPP-5	5 th Health and Population Plan
HIV	Human Immune-deficiency Virus
IEC	Information, Education and Communication
IP	Interim Plan
IDUs	Injecting Drug Users
MCH/FP	Maternal and Child Health/Family Planning
MOHFW	Ministry of Health and Family Welfare
MSM	Men who have sex with men
MTP	Medium Term Plan
NAC	National AIDS Committee
NAP	National AIDS Programme
NBTS	National Blood Transfusion Service
NGO	Non-Government Organisation
PHC	Primary Health Care
PWA	People With AIDS
SMC	Social Marketing Company
SOP	Standard Operating Procedures
STD	Sexually Transmitted Diseases
STP	Short Term Plan
TB	Tuberculosis
TC	Technical Committee
UZHC	Upazila Health Complex
TOT	Training Of Trainers
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
WHO	World Health Organisation

EXECUTIVE SUMMARY

The first patient with Acquired Immunodeficiency Syndrome (AIDS) was diagnosed in Bangladesh in 1989. Until 1999 ten AIDS cases and 126 persons with HIV infection have been reported (17 were reported through 1998-1999 national surveillance). Currently available data show that HIV prevalence is still low. However, the paucity of data calls for a cautious appraisal. Indeed, many factors suggest that HIV may spread rapidly in the near future. These include high rates of sexually transmitted diseases (some studies show, based on syndrome, rate of up to 50-60% among sex workers) and hepatitis B; significant number of commercial sex workers; evidence of high-risk behaviours (pre- and extra marital sex, and low condom use); a large international and national migrant labour force; an essentially unscreened blood supply system derived mostly from professional blood donors, approximately 20% of whom test positive for hepatitis B and syphilis; and rising injecting drug use. The present HIV situation could, therefore, evolve rapidly into an impending and escalating epidemic. This window of opportunity of existing low prevalence should, therefore, not be missed to initiate primary preventive efforts.

The national response has included establishment in 1985 of a National AIDS Committee (NAC), and Technical and Co-ordination Committees at central level and committees at various peripheral levels. A number of activities have been implemented by the NAC, the Ministry of Health and Family Welfare (MOHFW) as well as by the Directorate General Health Services (DGHS). A well-established NGO network carries out various HIV/AIDS related prevention and care interventions. However, in spite of a substantial amount of work already done, the level of response has been neither adequate nor satisfactory. The Government expression of commitment to AIDS prevention has to be translated into action at the ground level.

This Strategic Plan provides a framework for a national response to AIDS and defines Bangladesh's strategies and priorities for STD/AIDS prevention and care for the next five years (1997-2002) in line with National Policy. The plan builds on work already done and emphasizes a multi-sectoral response to the AIDS problem to include enhancing the involvement of various Governmental Ministries, NGOs, the private sector and the community; and outlines programme management aspects including monitoring and evaluation. This strategic plan also provides a guide for further planning and for the development of sector-specific work plans, which will follow.

The broad strategies and interventions included in this strategic plan take into consideration the present epidemiological situation and the likely future scenario. The priority strategies, therefore, include:

- Establishing and keeping a NAP management team effective at central, district and upazila levels.
- Preventing transmission of HIV through expansion of interventions targeted among individuals with high risk behaviours including sex workers and their clients, truck drivers, injecting drug users, etc.; strengthening STD case management to include syndromic approach; increasing availability, accessibility and use of quality condoms; promoting responsible sexual behavior of young people both in and out of school; information, education and communication (IEC) activities targeted at policy makers and the general population; enabling legislation and the use of the media, and above all

creating an enabling environment for people in general and for those afflicted in specific which would include making information and care available to them.

- Improving a safe blood supply through promoting voluntary blood donation and banning professional blood donation;
- Rational use of blood/blood products and a thorough screening of donated blood for HIV and other pathogens;
- Provision of counseling and other support including expansion of voluntary testing facilities targeted at pregnant women or women contemplating pregnancy and breast feeding mothers;
- Provision of care and support systems including counseling services; implementing activities to include legal amendments to counter discrimination against people living with HIV/AIDS and vulnerable groups, towards improving community acceptance;
- Establishing HIV/AIDS and STD surveillance to determine present and future magnitude of the problem and to monitor HIV/AIDS and STD programmatic interventions and their effects;
- Strengthening capacity for diagnosis of STD/HIV/AIDS;
- Mobilising and supporting various Government, private and non-government sectors.

To guide activities related to these strategies and interventions, the NAC recently approved a policy document on STD/HIV/AIDS, which has been accepted by the Government. Moreover, the Government is now fully committed to combat AIDS in Bangladesh and has accorded priority to STD/AIDS prevention and control. This is reflected by the Government commitment to establishing a National AIDS Programme (NAP) in the DGHS with full time staff to co-ordinate the overall national response and to provide technical and operational support to all sectors including NGOs and the private sector. Moreover, Government plans to ensure that all activities are planned and carried out within the framework of this strategic plan. The NAP will assist in coordinating HIV/AIDS prevention activities in various sectors, and facilitate decentralization of activities to upazila and district levels. To do so, the NAP will establish links with upazila, district and division level AIDS committees and focal points in other relevant ministries and assist them in planning and implementing activities. The NAP activities will be monitored by committees established at various levels, through regular reporting from peripheral to central level, and through field visits by the programme staff. External reviews of the NAP will occur every 2-3 years. To assess the progress made, indicators have been identified and targets set.

To carry out various strategies and interventions included in the strategic plan, financial support would be needed. The Government of Bangladesh has committed required number of full-time staff to work at the national level and plans to set aside funds as a part of the 5-year plan. Additional resources would be mobilized from multilateral and bilateral agencies. The total budget requirements for the planning period (1997-2002) are as follows:

**ESTIMATED PRELIMINARY BUDGET FOR
THE 5-YEAR NATIONAL AIDS PROGRAMME**

Broad Programme Area	TK US\$ *	Resource Needs					Total
		Year 1	Year 2	Year 3	Year 4	Year 5	
Programme management							
Mobilizing National International resources,	Tk.	1697.83	884.61	509.12	456.98	487.57	4036.11
Advocacy and Inter-sectoral activities	US \$	4.04	2.11	1.21	1.09	1.16	9.61
Behaviour change	Tk.	1197.76	1279.95	1275.2	1042.75	1012.74	5808.4
intervention, IEC, NGO support and support to PLWHA	US\$	2.85	3.05	3.04	2.48	2.41	13.83
STD Management	Tk.	472.56	573.54	518.34	427.54	162.86	2154.84
	US\$	1.13	1.37	1.23	1.02	0.39	5.13
Condom promotion and harm reduction	Tk.	59.9	55.6	65.5	35.4	54.8	271.2
	US\$	0.14	0.13	0.16	0.08	0.13	0.65
Blood transfusion related activities	Tk.	421.08	426.31	319.72	52.68	28.19	1247.98
	US\$	1.00	1.02	0.76	0.13	0.07	2.97
Care/counseling	Tk.	231	346.5	344.7	221	104.4	1247.6
	US\$	0.55	0.83	0.82	0.53	0.25	2.97
STD/HIV/AIDS surveillance and Laboratory support	Tk.	98.46	126.46	133.21	97.29	72.46	527.88
	US\$	0.23	0.30	0.32	0.23	0.17	1.26
Legislation	Tk.	56.36	61.73	52.65	50.73	51.43	272.9
	US\$	0.13	0.15	0.13	0.12	0.12	0.65
Total	Tk.	4234.95	3754.7	3218.44	2384.37	1974.45	15566.91
	US\$	10.08	8.94	7.66	5.68	4.70	37.06

- Taka – Lakh
US\$ - Million

SECTION I: INTRODUCTION

1.1 Present and Future Situation of HIV/AIDS in Bangladesh

AIDS was first diagnosed in Bangladesh in 1989. Since then, Bangladesh has reported 126 HIV infections (17 of them were reported through 1998-99 National Surveillance) and 10 AIDS cases, 6 of whom have died by 1999. The most common mode of HIV transmission in Bangladesh appears to be through unprotected heterosexual intercourse. Two children acquired infection through perinatal transmission. Unfortunately, the paucity of surveillance data means that HIV prevalence cannot be accurately determined. A protocol of HIV sentinel surveillance in Bangladesh was prepared in May 1994 with the assistance of WHO. Implementation was scheduled for 1995, which was delayed due to several administrative and financial constraints. However, First National Sentinel Surveillance was finally conducted in 1998-1999. The results showed that HIV seropositive cases were present among the sub-populations practicing high-risk behaviour such as injecting drug users (IDUs) (2.5%), commercial sex workers (0.6%), man having sex with man (0.2%), and STD patients (0.1%). In addition, few more studies conducted on people practicing high-risk behaviours have yielded some important findings.

In spite of the low prevalence of HIV in the country, many factors suggest that HIV may spread rapidly in the near future. For example, studies have shown high rates of STD in various populations. In 1989, a syphilis rate of 56% and 39% were found among floating and institutional CSWs respectively. In 1997, 54% of 980 CSWs gave a history of present or past symptomatic STD. Recent reports indicate high levels of STDs amongst various other groups. As with many other Asian countries, condoms are not generally the preferred method of contraception. Furthermore, knowledge of condoms as a means to prevent STDs is very low.

Moreover, sex outside marriage might be more widespread than traditionally acknowledged. Documented practices include premarital, extramarital and male-to-male sex particularly among youth in Bangladesh. For example, some studies indicated a high percentage of youths with experience of sex before marriage and occurrences of induced abortions among women; sixty percent of long distance truck drivers had sex with commercial sex workers about twice a month without knowledge of HIV/AIDS. Extra-marital sex appears to exist in rural societies and in particular where husbands are absent for long periods. Important studies of the sex industry identify large numbers (100,000) of generally non-literate commercial sex workers (CSWs) whose customers represent all segments of society. Female CSWs have an average of 2-5 clients a day, making the number of clients about half a million men a day.

Bangladesh has large numbers of international and national migrant labourers, transport workers and uniformed personnel. These individuals spend extensive periods away from their families that contribute to getting involved in new and different types of sexual relationships. Transborder mobility is high. Bangladesh also hosts large communities of expatriate refugees while itself having nationals with refugee status in bordering countries.

Available data from Client Monitoring System of Department of Narcotics Control and other research reports shows that prevalence of injecting drug use (IDU) is on the rise. Most IDUs in Bangladesh share needles. In some areas the professional injectors use one needle for many IDUs. There are estimated 20,000 IDUs mainly in Dhaka, Rajshahi, and other towns including bordering areas. Prevalence of STDs is quite high among drug users in general. A high proportion of IDUs are clients of sex workers and many IDUs are married putting their family members at a higher risk of disease transmission. The First National Surveillance for HIV and syphilis among population practicing high-risk behaviour showed highest seropositivity for HIV among IDUs that was 2.5%.

The existing blood transfusion system also carries the danger of HIV transmission and therefore needs improvement. Problems include the need for approximately 200,000 units of blood, currently largely (70-75%) provided by professional blood donors of whom approximately 20% are positive for hepatitis B/syphilis. In addition to providing safe (screened) blood, the added risk of transmission caused by medical/surgical/dental procedures needs to be considered in the light of under-practiced universal safety precautions.

Very little attention has so far been paid to the issue of mother to child transmission of HIV at any level. An effective awareness generation for all women, provision for counseling for pregnant women or those contemplating pregnancy, and breast feeding mothers, HIV testing facilities for consenting mothers, training of health personnel related to pregnancy and child birth and research on cost-effectiveness of anti-retroviral therapy are almost nonexistent.

Bangladesh has many special contextual features which are relevant to HIV infection. These include widespread poverty, unequal access to health services, the often subordinate status of women, and low literacy and education levels. All combine to restricting knowledge in relation to health and negotiating power in matters of sex. A multi-sectoral response and policy level support and commitment for empowerment of vulnerable groups to address the issues like stigma and discrimination are yet to be properly visualized.

Research, specially operational research, in the field of HIV and AIDS is very limited in this country. Operational research is an essential component of effective implementation of any programme particularly those related to preventive actions and other cross cutting issues.

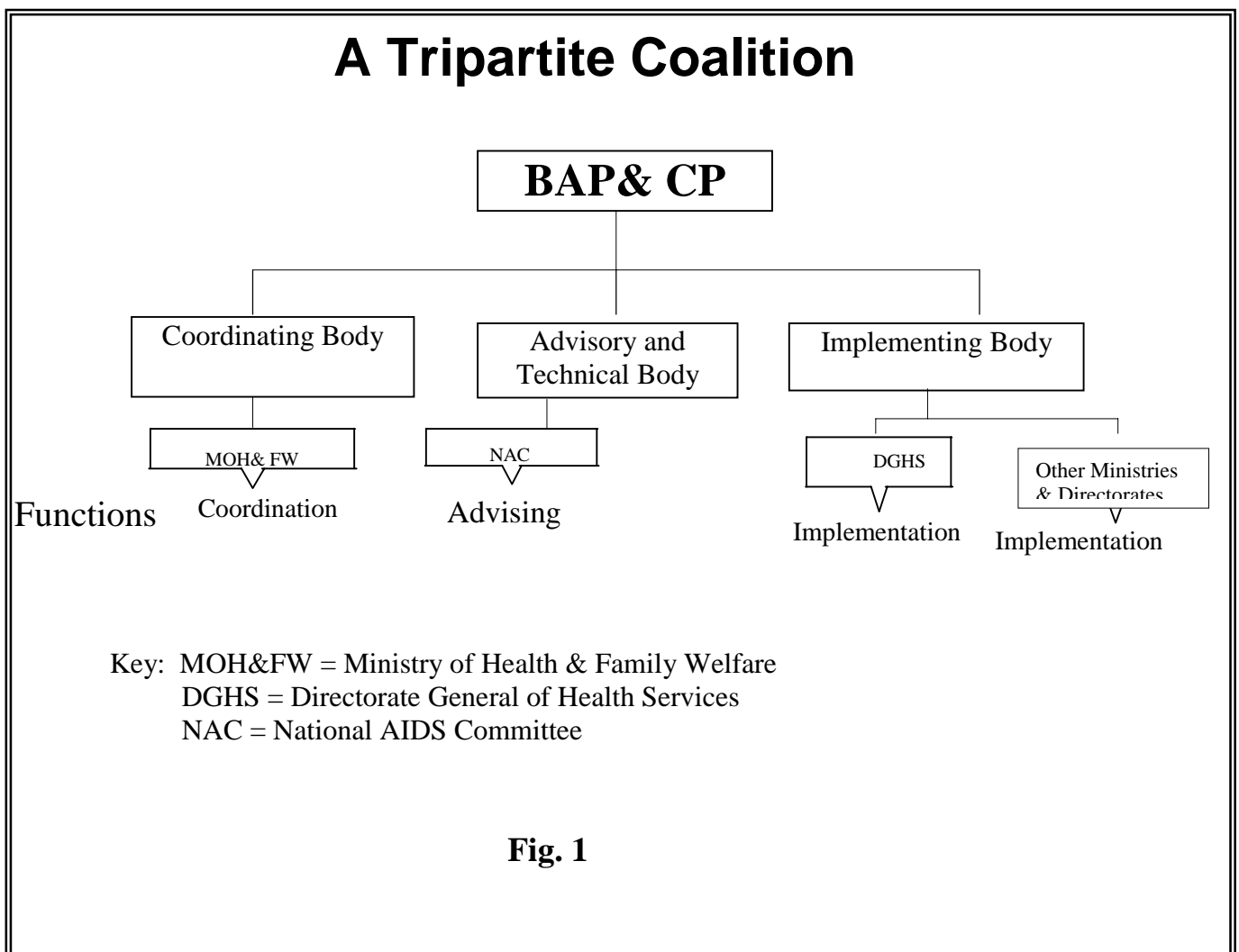
The above mentioned factors indicate that the present HIV situation could evolve rapidly into an impending and escalating epidemic in the country with serious health and socio-economic consequences. The epidemic of AIDS could bring in future needs for major adjustments for individuals and their families, the health system, and within the community and society as a whole. An overburdened health care system both in terms of human and financial resources, disintegration of family structures, problems relating to increased poverty, numbers of orphans and abandoned children, and shortage of manpower in agriculture, industry and other sectors can be apprehended.

1.2 Background of AIDS and STD Control Activities in Bangladesh

- In October 1985, Government of Bangladesh (GOB) appointed a National AIDS Committee (NAC) with representation from different stakeholders. The NAC was defined as an advisory body with responsibility for major policy issues and strategies; co-operation and co-ordination of various sectors including NGOs; supervision of implementation of the programme and mobilization of resources. A Technical Committee (TC) was formed, composed of experts from relevant fields to provide in-depth scientific, medical and technical advice to the NAC and the National AIDS Programme (NAP). By the end of 1990, a Co-ordination Committee (CC) came into being, constituted by key functionaries from institutions already engaged in HIV/AIDS related activities. Responsibilities were assigned to each member as part of a programme building effort.
- In 1987, GOB decided to start AIDS prevention activities with the technical and financial assistance of WHO Global Programme on AIDS (GPA). In 1988, planned prevention activities began under a 'Short Term Plan' (STP) which focused on determining HIV/AIDS prevalence and in developing prevention and control measures, particularly in the health sector. During 1989, a 3-year 'Medium Term Plan' (MTP) was formulated and during the 90's, prevention activities were carried out with WHO support in areas of surveillance, laboratory diagnoses, and strengthening technical, financial, health education and management capabilities.

- Since 1996, UNDP has supported interventions in the country through the 'Bangladesh AIDS Prevention and Control Programme'. The Joint United Nations Programme on HIV/AIDS became operational in 1996 to work with Government, NGOs, the private sector, and donors to support the national response to HIV/AIDS. In appreciation of the complexity and gravity of the HIV/AIDS epidemic, the DGHS formed an 11 member "Task Force" to initiate the process of policy formulation in 1995. The national HIV/AIDS policy document was reviewed by a 19 member Core Group and examined by a multi-sectoral consensus workshop in which ten stakeholder groups participated in October 1996. The resulting final document was approved by the cabinet in 1997.
- The HPSP proposes restructuring of some components of the Health and Family Welfare wings towards unified service delivery. These factors need to be considered in formulating an effective management structure to deliver the health-related aspects of the NAP.
- At present, the government NAP management structure has been outlined in the policy document as follows: Programme activities are to be carried out by three main functionaries, i.e., the NAC, acting as an Advisory Body assisted by its Technical Committee, the MOHFW as the co-ordination body and the DGHS and other ministries, directorates and agencies as the Implementing Bodies.

The relationship between these groups is illustrated in Figure-1.



- Terms of reference for the NAC have been defined and are presented under Annex I. The Technical committee (TC) is comprised of various specialists in fields relevant to the prevention and control of STD/AIDS. The composition is, therefore, continually reviewed to reflect needs as they arise. Important contributions of the TC include assisting the NAC to formulate programme frame-works; guiding programme personnel in the design, development and monitoring/reporting of their activities and review research protocols to be funded by the GOB. For the agreed terms of reference see Annex I. Programme management itself acts to maintain functional links effectively between the tripartite coalition. Terms of reference are being developed to clarify these links and to indicate how this committee can assist inter-ministerial functions.
- Under the leadership of the Secretary, MOHFW, the AIDS Information and Awareness Campaign Committee (AI&ACC), comprising of representatives from several Ministries, WHO, donor agencies, media and NGOs, have conducted many activities in 1993 and 1994. Monthly meetings of the AI&ACC were initially held. Several IEC materials have been produced and distributed by this committee. Other activities have included social mobilization meetings, exhibitions and seminars in cities, towns and villages. Many media activities have focused on contexts in which people get involved in high-risk behaviours, as well as the public at large. However, means to redress religious and cultural sentiments, while still dispensing accurate information on means of transmission and methods for protection, need to be considered. Recent surveys indicate that literate and non-literate populations alike are generally mis- or uninformed about AIDS and are not empowered with sufficient information to protect themselves.
- The availability of a quality condom at an affordable price is an essential component of any HIV/AIDS and STD control programme. At present, GOB provides 37% of condoms while the remaining 63% comes from the Social Marketing Company (SMC) funded by the USAID and the European Union. SMC has recently introduced a new brand with a clear message to link its use to prevent STDs and AIDS. A market has been established for this brand. The STD message should also be considered for all other condoms. For the first time SMC has also been allowed by the government. to use TV for promoting condom for HIV. Condoms are also distributed free by many NGOs.
- Approximately 200,000 units of blood are transfused in Bangladesh every year. Only a small percentage of these units are tested for HIV and other infections. With 70-75% of the blood supply coming from professional blood donors of whom 20% appear to have STDs, there appears to be a real danger for HIV reaching the general public through this route. In March 1997, a protocol for a safe blood transfusion service was submitted to the MOHFW by the Blood Transfusion Technical Sub-Committee of the NAC. At present, a few laboratories have started to provide facilities to test for HIV in the country. Most are in the private sector. However, pre-, post- and follow-up counseling has yet to become an essential part of the process. As HIV/AIDS awareness increases, a rise in the demand for HIV testing is likely. To meet this demand, health facilities which offer voluntary counseling and testing would be required. As it stands now, MOHFW has embarked on establishing 97 blood transfusion centres in the country up to district level, some of which will in the private sector. These centres will screen blood for HIV, trepenoma, malaria, HBsAg and HCV.
- NGOs have set up a STD/AIDS Network. It is broadly recognised that NGOs, given their potential for flexibility and interactive relations with community members, have much to offer towards prevention and behaviour change activities. Relevant to STD/HIV/AIDS, close collaboration between GOB and NGOs is currently being addressed. NGOs are being invited to support the MOHFW with delivery of the Essential Services Package

(ESP); interventions for community behavioural change; training and providing standard guidelines for the programme. Non-Governmental Organizations have been carrying out the major part of HIV/AIDS prevention activities nation-wide. From IEC, targeted interventions, to policy formulation, NGOs have been instrumental at all levels. Indeed, without NGO participation, Bangladesh would undoubtedly have been much further behind than it is at present. Furthermore, there is a network of media people (AIDS and Health Writers Group) and an AIDS and Legal Issues group (ALACAA). A successful consensus workshop was held (November 1995) to agree on the relative roles for GOB and NGOs towards HIV/AIDS prevention and control. In essence, NGOs have been given full support to complement GOB efforts and to take on activities which are beyond government's scope.

- There are specific issues that AIDS brings to women. The disadvantaged and marginalized status of women in Bangladesh deprives them of access to information and intervention programmes on AIDS as well as, most importantly, negotiating power in matters of sexuality. In response, a Women Wing (WW) of the NAC was set up to raise and plan for such issues within the NAC and the programme. In the NGO sector, women are taking part in programmes addressing the wider socio-developmental issues of women as well as providing information and behaviour change support to women. NGOs are also making a start to promote male responsibility in matters of sexuality and family planning. The role of the man as a dominant partner in sexual decision-making is often forgotten, perhaps because of the perceived difficulties. However, this is an area that obviously requires focused attention if a NAP is to be successful.

SECTION II: PRIORITY TARGET POPULATION AND PROGRAMMING STRATEGIES FOR INTERVENTIONS

2.1. Priority Target Population

- Sex workers and their clients
- Injecting drug users (IDUs) and their family members
- Male having sex with male (MSM)
- Migrant workers
- Transport workers
- Young and adolescents

2.2. Vulnerable Sub-population

The whole population structure can be categorized into the following sub-population according to vulnerability and according to the risk behavior practiced:

High risk/core sub-population:

- Sex workers
 - Brothel based (recognized)*
 - Street based*
 - Hotel Based*
 - Home Based (slum/community based)*
- Men who have sex with men
 - Male sex workers and their clients*
 - Non-commercial MSM*
 - Hijras and their clients*
 - Prisoners*
- Injecting Drug users
 - Injecting drug users*
 - Sexual partners*
 - Blood donors*

Bridge population:

- *Truckers (including helpers and cleaner)*
- *Other transport workers*
- *Young people*
- *Military/Uniformed forces*
- *Women in domestic work/workplace setting/garment workers*
- *Male Migrants*
- *International migrants*
- *Slum dwellers*
- *Working children*
- *Tribals*

Low risk:

- *Secondary school boys and girls*
- *Men (15-45)*
- *Women (15-45)*

2.3. Programme Priorities

In Bangladesh, HIV prevalence is still low with few diagnosed AIDS cases. Therefore, the priorities for the NAP under the strategic plan (1997-2002), are to prevent sexual transmission of HIV and reduce the vulnerability of populations with high-risk behaviours like injecting drug use. Immediate priorities, therefore, include implementing interventions targeted at individuals with high-risk behaviour, strengthening STD clinical management at the community level using syndromic approach, improving accessibility of various population groups to good quality condoms, and safe blood transfusion. In the area of care, priorities would include developing counseling services and taking measures to counter discrimination and stigmatization of people with HIV/AIDS, towards enhancing their community acceptance. In addition, advocacy to mobilize political commitment, allocation of adequate resources, and multisectoral response and programme expansion to district and upazila levels will remain as priority areas. The following combinations of strategies and interventions are proposed:

a) Prevention of sexual transmission:

The data available so far suggest that HIV transmission through sexual intercourse is likely to remain the predominant mode of spread. In addition, since HIV is essentially a sexually transmitted disease, most efforts and resources for prevention programme will focus on promoting changes in sexual behaviour which decrease HIV transmission. To that end issues of sexual negotiating power and conditions which render individuals' reproductive health dependent on others, need to be addressed. All interventions will keep the particular vulnerability of women in mind.

Priority areas would, therefore, consist of:

- Expanding interventions targeted among populations engaged in high-risk behaviour such as sex workers and their clients, truck drivers, injecting drug users, groups practicing male-to-male sex, professional blood donors and young people. Interventions will consist behaviour change communication (BCC) which will include peer education, community outreach programmes; enhancing availability of good quality condom, accessibility and its correct use particularly in risk situations; counseling, referral, networking and supportive mass media. The role of community-based NGOs will be crucial. Other approaches would include education of young people both in and out of school.
- Strengthening services for early STD diagnosis and management is now considered both relevant and important to Bangladesh because of the role these play in facilitating HIV transmission. The main thrust of the NAP will be to train primary health care workers (both government and NGO) at district and upazila levels on STD case management including the syndromic approach and supplemented by expansion of laboratory services where necessary and feasible, to provide effective treatment. Resources are required to ensure regular drug supplies at all levels of health care services. Studies on STD treatment seeking behaviour, particularly among women, and to monitor antimicrobial susceptibility patterns will be conducted to support the NAP in policy and strategy formulation. Organized referral system, provision for counseling of the patients and their contacts, and training for all levels of service providers will be the other components of STD management.
- At present, condoms are the only barrier method known to prevent HIV transmission during sexual intercourse with an infected partner. Quality condoms will be made available at affordable prices in as many outlets as is necessary for making the effort

successful. The NAP will complement the social marketing programme to ensure condom availability, accessibility, particularly in all situations of risk and to promote condoms for STD/HIV prevention. In future, when other devices become available programmes on those will also be taken up and will be made known to the population in general.

- Other activities for the planned period include AIDS education in the work places and among general population using IEC approaches such as mass media and other traditional methods. Public opinion makers, lawmakers, law enforcers and policy personnel will be oriented in particular.

b) Prevention of transmission by injecting drug use (IDU):

In many countries, the HIV epidemic has been seeded within and amplified among injecting drug users, leading to spread in the general population. In Bangladesh, injecting drug use is on the increase, therefore, interventions targeted at injecting drug users and their partners are important.

- Interventions for harm reduction should be a priority. Whatever harm reduction interventions are already operational needs to be consolidated and extended to increase coverage. Activities targeted at IDUs need to be consistent with an overall drug abuse prevention strategy.
- Harm reduction strategies should include both safer injecting and sexual behaviour. There should also be treatment provision for STDs and drug addiction itself. The latter is all the more necessary because many IDUs want to leave the habit and receive treatment. Linkages may be established with existing recovery programmes.
- Functional constraints need to be overcome through advocacy and cooperation with relevant agencies including law-enforcing agencies (Department of Narcotics Control, Police). This will in consequence help to reduce stigmatization and harassment of IDUs, and create an enabling environment for harm reduction and recovery programmes.
- Intervention in IDU should encourage self-help and community support groups. Many interventional activities may be transferred to these groups like peer education, outreach, condom promotion and involvement in recovery programmes.
- Adequate resource needs to be allocated for a sustainable programme. Arrangements for monitoring and evaluation need to be agreed between the Government and NGOs working in the field. Operational research specially in the areas of harm reduction component must be an integral part of the strategy, so that the implementing agencies get adequate feedback, training and capacity building are accentuated and there is a wider dissemination of the impact of the programme.

c) Prevention of transmission through blood and blood product:

Theoretically, transmission of HIV through the transfusion of blood/blood products should be easily preventable. The cornerstone of a safe blood supply is voluntary, non-remunerative, regular donations from low-risk populations. However, the existing supply source (70-75%) of professional blood donors and the lack of infrastructure for screening of donated blood at any level are areas of major concern. In order to promote safe blood transfusion, a systematic program of action will be developed including:

- Reorganization of the existing blood transfusion services;
- Expansion of HIV screening facilities at all blood transfusion centres;
- Promotion of voluntary blood donation through education and motivation programmes to dependency on professional blood donation system;

- Acting upon national guidelines and on going in-service training of health care staff on rational use of blood and on promotion of universal precautions at the health care settings; and
- Creating legislative provision to support safe blood transfusion strategies.

d) Prevention of mother to child transmission:

The most effective way of preventing mother to child transmission of HIV infection is prevention of primary infection in mother and her sexual partner(s) through interventions as described in 2.3a and 2.3b. Given the current low level of HIV prevalence in Bangladesh, it is evident that screening during antenatal care will not be adequately sensitive and cost-effective. Therefore, priority for surveillance does not need any deviation from WHO/UNAIDS guidelines at this moment. However, following strategic initiatives should be taken during the plan period:

- Provision should be kept for voluntary counseling and testing of pregnant women and women contemplating pregnancy, and specific protocol should be developed for the purpose, specially for vulnerable and bridge population, and piloted during the plan period. HIV counseling guidelines and related training materials should be reviewed to incorporate the issues of pregnancy and breastfeeding. All voluntary counseling and testing should be consistent with principles of human rights as outlined in the National Policy on HIV/AIDS and STD related issues.
- If HIV status of a pregnant woman is known, supportive counseling should be provided to her and to her family members. Counseling should include factual and accurate information about risks of disease transmission during pregnancy, childbirth and breastfeeding. Information on the benefits and risks of alternative feeding practices should also be made available.
- If a couple decides on termination of pregnancy, safe medical termination should be ensured. HIV-positive women and their families should be referred to available and easily accessible support facilities, if available.
- During all childbirth, a universal safe precaution should be ensured and added measures should be taken during delivery of a seropositive woman. Training facilities should be created for FWVs and FWAs and suitable training modules should be developed for the purpose. Protocol for follow up of children of seropositive mothers may be a part of the training module. There is also a need of adequate efforts to monitor delivery practices.
- Provisions should be made for the use of short course of anti-retroviral treatment to prevent vertical transmission.

e) Enabling social environment:

Working towards the goal of optimally humane and supportive care for people with HIV/AIDS will help reduce personal and social impact of the AIDS epidemic. This is specifically indicated for population with high-risk behaviour and general population with added vulnerability. As there are only a few AIDS cases diagnosed in the country, strengthening counseling services, to be delivered by health care workers and NGOs is an important priority. Moreover, as more HIV infected persons develop AIDS, care will become an ever-increasing part of efforts to limit the impact of the HIV epidemic. In due course, therefore, the need will arise to strengthen clinical management and provide care along the continuum from the institutional to the community and home level. Care will be taken to preserve confidentiality, avoid discrimination and help patients live normal productive lives. The broad strategies and interventions in this area, in order of priority would, therefore, include:

- Further strengthening counseling and support services in relation to STD/AIDS diagnosis to provide psychosocial support including stress and anxiety reduction, and to enable individuals make informed decisions about HIV testing and plan for their future. Development and enhancing of capacity in both government and non-government sectors for the services like counseling and expansion of services and development of a well-organized referral system are essentially important requirement for the purpose. To be able to do so, male and female health care workers and NGOs will be trained in gender-specific counseling skills. Policy guidelines will be followed to ensure that no testing occurs without pre- and post-test counseling and informed consent.
- Expansion of other related services like referral system and service facilities for STD care, detoxification and recovery programmes for drug abusing population, income generation programmes for those who need economic rehabilitation will be part of the activities during the plan period.
- Minimizing discrimination and stigmatization of vulnerable populations as well as those with HIV/AIDS is essential for greater community acceptance as a prerequisite for providing community and home care. Community education and advocacy efforts to counter discrimination will be further strengthened. The media will be used to shape community acceptance of HIV infected people. National legislation will be examined and changed wherever necessary to support relevant behaviour change interventions, human rights, and voice some of the larger societal issues arising with national policy makers.
- HIV/AIDS care will be an integral part of the general health services. Health care workers will have the responsibility of providing care for people with HIV/AIDS and ensuring equitable access to care. Collaboration and coordination with various other health programmes such as tuberculosis, laboratory services, control of diarrhoeal and respiratory diseases etc. will be strengthened.
- Support will be provided to NGOs and community groups in developing and conducting community-based supportive services. It should be emphasized that different population segments like adolescents and young people require different special approaches. Community mobilization on positive health issues like voluntary blood donation and formation of functional self-help community organizations among people who need a supportive environment will support the above strategic efforts. Other activities would include training of health care workers on clinical management of STD and AIDS, strengthening of health care and laboratory systems, and logistic support like provision and promotion of condom, availability of drugs for STD treatment and required test kits. This all should be done for the practice of universal precautions at the health care setting and provision of required services for those who need them.
- Another important aspect of strategic plan for ensuring an enabling environment is information dissemination specially on the issues like adolescent sexual health, mother to child transmission etc.. Documentation of best practices will enhance the effectivity of any effort on information dissemination. It however needs continuous and consistent action research to keep the information up to date.

All such activities will be carried out in order of priority which may evolve with the epidemic in the future. It of course needs relevant guidelines for specific programme implementation so that a standard quality of activities and their outcome is maintained. This all should be done keeping in view the guidelines articulated in the national policy document.

f) Diagnostics, surveillance and research:

Diagnostic facilities will be expanded and maintained. Such provision may be created In NGO and private sectors as well under the supervision and monitoring of the government and

they will report the findings to the designated institution of the government [Institute of Epidemiology, Disease Control and Research (IEDCR)]. Research, specifically operational research on different programme implementation issues will be an important component of strategic plan. Operational research will be an integral part of any implementation effort from its inception. In this component special emphasis should be placed on the following:

- Expansion of diagnostic services in a cost effective manner, monitoring of diagnostic centres and collection of reports from diagnostic units by IEDCR.
- Periodic surveillance, both biological and behavioural, specially of high-risk population and general population with added vulnerability. Nation-wide sample survey may be a long-term strategy.
- Priority areas of research may include study of knowledge, attitude and practice relevant to HIV transmission, condom use, utilization of STD services, and also quality assurance of existing programmes and other similar issues.
- Development of Geographic Information System (GIS) to access to existing information and updates. Development of a Central Information Bank will be another priority.
- Development of a system of dissemination of information to relevant agencies/organizations at regular periodic intervals or as and when necessary. Establishment of a clearinghouse may be an ultimate goal.
- Preparation of a directory of research organizations, specially those involved in health and other development issues.

g) Mobilization of national and international efforts:

Despite diagnosis of AIDS in Bangladesh twelve years ago, a comprehensive national response is yet to be mounted. To be effective, cooperation is needed across various levels of government, central, district and upazila; and between government and non-government including private sector, community and political leaders, as well as people affected by HIV and their families. Advocacy to encourage various key players to contribute to the programme effort is essential. Moreover, the national response needs to be built on existing local and national structures. The various committees established by government, the MOHFW and the DGHS have been very active in carrying out HIV prevention activities. However, these efforts must be planned and implemented in a coordinated manner. Focal points in other relevant ministries have also been identified. NGO networks for STD/AIDS and NGO focal points have been established who are enthusiastic and motivated to work on AIDS-related issues. Various UN agencies and donor organizations have also provided support in various areas.

During the strategic plan period, it is proposed to:

- Further advocate with policy makers at national, district and Upazila levels to mobilize and coordinate resources and to decentralize activities. Support will be provided to committees as well as to the programmes at each level for capacity building and responding to the AIDS epidemic.
- Continue to mobilize various sectors/partners to participate in AIDS prevention and control, and work with focal points in relevant ministries, and representative NGOs and the private sector to plan and implement AIDS prevention/education activities in phased manner.
- Provide training, material and logistical support to various organizations and sectors both within and outside the Government to include establishment of information

resource centres, and advocate for policies as articulated in the national policy document.

- Involve all sectors in consensus building, as well as in the planning, management and evaluation of the NAP. A mechanism will be developed to facilitate dialogue between various partners on progress made and areas where support may be needed.
- Mobilise international support for the multisectoral and comprehensive NAP.
- Monitor the spread and impact of AIDS epidemic in the country by setting up HIV/AIDS and STD surveillance by assessing the current HIV/AIDS situation and monitoring future trends by identifying the determinants of the epidemic spread and forecasting the future scenario. Surveillance data so obtained can then be used more effectively for advocacy as well as planning purposes.

2.4. Summary Strategies of Interventions to Prevent HIV Transmission

a) Prevention of sexual transmission:

- HIV/AIDS education
- Counseling including partner notification and treatment.
- Develop voluntary counseling and testing at upazila/dist. and above
- Strengthen government, private and NGO services
- Appropriate drugs and information, confidentiality, client friendly in dealing people coming for STD treatment
- Develop research
- Promote use of condoms for disease prevention
- Approval of BCC strategy and implementations

b) Injecting drug use (IDU):

- Peer education
- Targeted out reach
- Condom distribution
- Safe needle exchange.
- Substitution of injections with orals for harm reductions
- Health education and counseling
- Support groups
- Recovery programmes

c) Prevention of transmission through blood/blood products:

- Establishment of safe blood transfusion services
- Expansion of screening services
- Encouraging voluntary blood donation

- Capacity building
- Safe blood transfusion regulation bill
- Decentralization of hospital based services with provision of inclusion of VCT

d) Prevention of mother to child transmission of HIV:

- Prevention of primary infection in mothers
- Reviewing and piloting issues and interventions for prevention
- Determination of priority of surveillance
- Expansion of voluntary testing and counseling facilities
- Information dissemination on issues like HIV transmission and breast feeding
- Development of training protocol on care and follow up of HIV infected mothers and their children
- Adoption of safe universal precautions during all child birth
- Anti-retroviral treatment

e) Supportive and enabling social environment and case management:

- Creation of a supportive and enabling social environment
- Expansion and strengthening of STD services and merger of AIDS/HIV intervention into general health care services
- Community mobilization and support for the formation of self help groups for people infected and affected by HIV
- Case management available whenever it is needed
- Collaboration of different sectors
- Research and documentation of best practices

f) Diagnostics, surveillance and research:

- Establishment and strengthening of existing diagnostic laboratories in a cost effective manner
- Conduct or support /commission continuous surveillance and periodic need based surveys
- Clinical research and documentation of best practices
- Operational research on programmes and their implementation

- Conduction of Geographical Information System and central data bank
- Development of directory of research organizations
- Dissemination of information

g) Management mobilization and co-ordination of national and international efforts:

- Establishment and functioning of a programme management structure
- Mobilization and coordination of national and international efforts to control HIV
- Secure high level and effective commitment
- Mobilization and coordination of national and international efforts
- Establishment of focal points and support plan actions of related organizations and ministries
- Mobilization of international support and develop regional initiative
- Exchange of information

SECTION III: POLICY

To address all social, ethical and personal issues related to HIV/AIDS infection, the GOB has accepted policy guidelines for the NAP. These technical policy guidelines refer in particular to the following areas:

- Surveillance and reporting of AIDS cases
- Testing guidelines
- Management of AIDS and HIV infection to include special groups, e.g. TB
- Behaviour change communication
- Counseling of HIV/AIDS patients and confidentiality
- National blood transfusion services
- HIV/AIDS and women, men, children, adolescents, sex workers, IDUs, people staying away from their partners, prisoners, minority populations etc.
- Human rights issues
- HIV/AIDS education in and out of schools
- Maternal and child health
- HIV/AIDS and the workplace
- Relationship of the NAP with other programme areas
- Legal/ethical aspects
- Social/behavioural/clinical research

As programme needs continue to develop, National STD/AIDS policy will be consulted (and possibly amended) to ensure consistency.

Moreover, in the area of political commitment, the GOB recognizes that AIDS is a priority health and development problem in Bangladesh and expresses its commitment to allocate adequate financial and human resources to address effectively the growing HIV/AIDS problem. The Government would urge all its ministries, as well as the NGO and private sectors to get more actively involved in AIDS prevention and control in the country.

SECTION IV: PROGRAMME MANAGEMENT AND MANAGEMENT PROCEDURES

4.1. Policy Advice and National-Level Coordination

The National AIDS Committee (NAC) is a national advisory body that provides policy direction and advice on all matters related to HIV/AIDS. Chaired by the Honorable Health Minister, the NAC is composed of Ministers and Secretaries from all the related ministries and includes three Honourable Members of Parliament and leading experts from related fields. The terms of reference of the Committee and its membership is to be reviewed periodically to make it more effective and efficient. The Technical Committee (TC) is a technical arm of the NAC, comprised of leading experts from a variety of relevant fields including health, finance, media, education, legal issues, psychology, demography, religion, blood/blood products transfusion, academia, NGOs, human rights etc. Besides its policy and advisory capacity, the NAC will also promote, facilitate and co-ordinate a multisectoral response.

The MOHFW acts as the coordinating and supreme Executive Body and the DGHS as the implementing body for health related activities. Similarly, other ministries and their directorates, NGOs and the private sector will act as the implementing agencies for areas related to their respective fields. Each ministry will carry out AIDS prevention and control activities through their existing core administrative structures.

A Coordination Committee consisting of line personnel relevant to various programme activities across different ministries will be formed to assist information and activity coordination. The NAP will provide technical and operational support to relevant ministries, NGOs and private sector in carrying out their specific activities.

An Executive Committee (EC) may be formed in the MOHFW with the Secretary as its Chairman to review implementation progress. A Focal Point (FP) at additional secretary level has been designated in the Ministry to coordinate the activities. Terms of reference have already been developed by GOB and EC membership agreed. The EC will review the recommendations of the NAC and generate executive orders for health-related implementation by the DGHS. The DGHS is to implement the health-related recommendations of the NAC under executive instructions of the EC through the AIDS Programme Manager via the individual Line Directors.

4.2. Programme Management and Collaboration at Central Level

The Government has established an AIDS/STD programme under the DGHS. The AIDS/STD programme will be managed by a Programme Manager and supported by additional full-time staff including deputy and assistant programme managers (four each), and other staff members as appropriate under the leadership of Line Director. Structure of NAP is given below. The Programme Manager will be responsible for the day-to-day implementation and coordination of HIV/AIDS and STD prevention and control activities while Line Director will be responsible for planning, mobilizing as well as facilitating different actions by various actors/organizations. Functions of the NAP would be as follows:

- Providing technical leadership and support
- Facilitating intersectoral collaboration and support, including various Government ministries, NGOs and the private sector

- Mobilising donor support and resources
- Maintaining the inventory of technical and material resources including research
- Ensuring capacity building through training and reorientation of all sectors
- Planning, monitoring and evaluation of the overall national programme
- Quality assurance
- Surveillance

4.3. Programme Decentralization to Division, District and Upazila Levels

a) Division level:

Activities at the district and upazila levels will be coordinated by respective AIDS Committees under the overall chairmanship of the Divisional Commissioner and/or the Divisional Director of Health, and activity co-ordination will be maintained between health services, local bodies, the medical colleges, schools and other relevant agencies on a regular basis.

b) District level:

The existing District Health Development Committee will also act as the District AIDS Committee. Representatives of each ministry/project office staff/NGOs/other agencies, acting in support of AIDS prevention and control activities, will meet as required as members of the District AIDS Committee. Committee will provide an opportunity to share information on the progress and constraints and will coordinate activities at the district level and below. Community members may be co-opted as representatives to advise, support and assist in activity implementation.

A Focal Point within the programme office will plan and facilitate programme activities at the district level in an integrated manner. A quarterly report will be submitted by the district team to the NAP on activities, to alert the NAP to problems and opportunities as they present themselves so that this information can be shared with the relevant authorities to prompt the required response.

c) Upazila level:

The existing Upazila Health Development Committee will also act as the Upazila AIDS Committee. Representatives of each ministry/project office staff/NGOs/other agencies, acting in support of AIDS prevention and control activities, will meet as frequently as necessary as members of this committee. These meetings will be for sharing progress and constraints, available information and to coordinate activities within the upazila. Community members may be co-opted to advise, support and assist the activities planned. Upazila AIDS Committee would share the progress and other information once monthly with the District AIDS Committee.

4.4. Multisectoral Involvement and Collaboration

The National AIDS Committee will be responsible for the promotion and mobilization of a multisectoral response with the following key ministries:

- Prime Ministers' Office
- Ministry of Education
- Ministry of Youth and Sports

Ministry of Finance, Finance Division and ERD
Ministry of Information
Ministry of Home Affairs
Ministry of Law, Justice and Parliamentary Affairs
Ministry of Women Affairs
Ministry of Civil Aviation and Tourism
Ministry of Labour and Manpower
Ministry of Religious Affairs
Ministry of Health and Family Welfare (Line Ministry) and Division
Ministry of Local Government

Other sectors critical for mounting an appropriate multisectoral response in Bangladesh include NGOs, donors, community-based organizations, private sector, academia, community and religious leaders. With assistance from the NAP and following a consensus on the strategic plan, each sector will develop sector-specific workplans and resources will be mobilized for activities included in each work plan. Besides, senior level representation from various sectors in the AIDS committee, focal points have been identified in each sector with responsibility for planning and implementing activities and to work with NAP staff. Attempts will be made to coincide the planning exercise with the 5-year development plans so that resources can be allocated by the Planning Commission for activities planned for by the GOB ministries.

4.5. Collaborating and Facilitating NGO/Private Sector Response

In order to maximise the NGO's response, the NAP will provide technical, material and if possible, financial support and encourage NGOs to focus on areas where they have a comparative advantage, namely, targeted interventions, providing care at the community level and advocacy. Appropriate mechanisms will be developed to deal with specific issues and for clarity on NGO roles in areas such as testing, counseling, care and rehabilitation in collaboration and with guidance from the NAC/TC. The same can be said about active monitoring and reporting of activities by NGOs and the private sector to ensure that their activity areas in voluntary counseling and test (VCT) fall within the priorities articulated in the national strategic plan and in the policy document.

4.6. Direction and Co-ordination of Research Activities

Part of this component of the strategy is dealt with more specifically in the section on programming strategies and intervention (Section: 2.6). The issues mentioned in this section are more generic in nature and more related to aspects of management. It should be mentioned here that it is important to strengthen the national capacity to collect, analyse and use scientific data that increases the understanding of a range of factors which influence patterns of spread and impact for strategy and programme development. Therefore, HIV/AIDS and STD related research would focus on:

- Creation and strengthening of national capacity to undertake studies which can assist in better defining the extent and nature of social and economic causes and consequences of the spread of the virus. Priority areas of research would include operational studies which would guide programme implementation. These types of research will give insight into, for example, the dynamics of sexuality and sexual behaviour within a continuously changing society. Additional research areas would include epidemiological and clinical studies related to AIDS and related opportunistic infections.

- Supporting research proposals which are directly relevant to programme interventions and, if necessary, policy/strategy revision. Such proposals would necessarily involve the participation and use the intelligence of the beneficiary persons themselves.
- Assistance, and/or recommendations for programme implementers, partners and other people involved in interventions to assess and re-design their activities in line with research findings as they become available.

To promote research in priority areas, the NAP will commission research, develop generic protocols and invite institutions/agencies to implement multicentric studies with financial support provided by the programme. Research proposals submitted independently by researchers will be reviewed by the Technical Committee and recommended for financial support.

Co-ordination and general direction of research activities will be implemented using a participatory and partnership approach between GOB, NGOs, community-based organizations, private sector, UN bodies, academic and other types of research organizations.

4.7 Quarterly Progress Reports

In order to avoid duplication of information and reporting existing UMIS format should be carefully reviewed to see if HIV/AIDS issue was adequately addressed. Monitoring the programme will require the development of a management information system designed in collaboration with the Technical Committee. Some issues related to monitoring and evaluation are described in Section VII. Progress reports will be prepared every 3 months by the NAP highlighting the achievements, constraints and remedial actions taken or needed. These reports will be shared with officials of the MOHFW and with the NAC, international agencies and other relevant ministries.

SECTION V: RESOURCES AND SUPPORT SYSTEMS

5.1. Funding Mechanisms

The implementation of the multisectoral activities in the plan will require mobilization of additional national and international resources. An estimate of the budget required over the next 5 years is given in Annex II. This is likely to change as the programme needs become further defined. Mechanisms for fund-raising will be developed by each sector. The NAC and NAP will play a facilitatory role in coordinating these efforts.

The following are possible sources/mechanisms of funding:

a) Local:

- Government may make financial and budgetary allocations to the various ministries and parent ministry/NAP for the prevention and control of HIV/AIDS;
- Community efforts and participation both in cash and kind will be encouraged including introduction of payment systems for certain services provided such as HIV testing keeping provision for the poor.

b) External support:

External resources will still be required to complement Government and community efforts. Donor assistance will, therefore, be mobilized and channeled through one of the following:

- Bilateral funding of the programme should be solicited by the Government. Such support will be administered by the Government to finance priority activities.
- Multilateral funds to be provided by UN agencies for support to various activities planned in collaboration with the NAP and according to the priorities in the described strategic plan.
- NGOs may raise funds and mobilize support directly from donor, Government and other sources for the implementation of AIDS related activities. The amount NGOs raise will have to be reflected along with activities in the Government plan and NAP should be informed by both donor and the concerned NGO about this.

5.2. Sustainment of Staff, Supplies, Maintenance, Activities and Replacement of Capital Investment.

The Government will facilitate or provide full time regular staff to work on the NAP and also provide office space, equipment and furniture etc. However, many programme staff as well as the focal points in various sectors, will need capacity building through training. The NAP will facilitate this training support as a crucial input for effective programme management at the central, district and upazila levels. Efforts to ensure sustainability of the NAP require high-level political commitment, full integration of the Programme, multisectoral participation and diverse national and international funding sources. Sustainability through cost sharing and cost recovery will also be considered keeping provision for poor who cannot afford alternative approaches towards the long-term management of the programme.

5.3. Management of National Fund

The NAP will be responsible for facilitating coordination of administrative procedures related to finances and for prompt implementation of activities. Given the current approved structure for the programme, the management of national resources for AIDS activities shall be the responsibility of the Secretary, Ministry of Health and Family Welfare.

SECTION VI: PROGRAMME INDICATORS AND TARGETS

To evaluate the impact and effectiveness of the programme, targets and indicators have been identified. These include targets in the areas of prevention, care, as well as programme management. Process, output and impact indicators for each strategic area have been enlisted below. Additional specific short-term targets and indicators could also be built into the workplans for monitoring the implementation of NAP activities.

6.1. Prevention Indicators and Targets

a) Knowledge of preventive practices:

- By 2001, 80% of the population between 15-49 should be able to mention two ways of protection from HIV infection.

b) Condom availability:

- By 2001, 150 million condoms will be available for distribution during the preceding 12 months.
- By 2001, all Upazila Health Complexes will have had 100% uninterrupted supply of condoms in the preceding 12 months.
- By 2001, 80% of the population between 15-49 years will be able to acquire a condom.

c) Reported condom use:

- By 2001, 80% of sex workers operating in brothels will report the use of a condom during the most recent act of sexual intercourse.
- By year 2001, 60% of truck drivers will report to have used a condom during the most recent act of sexual intercourse if other than with wife.
- By year 2001, 60% of migrant workers will report having used a condom during the most recent act of sexual intercourse.

d) STD clinical management:

- By 2001, 90% of upazila will have at least one clinician trained in STD case management
- By 2001, 80% of individuals presenting with STD in health facilities will have been assessed and treated according to national guidelines.
- All ANC clinics will assess and facilitate for clinical management for syphilis.

e) STD prevalence:

- By 2001, the prevalence of urethritis among men aged 15-24 years will decrease by 50% in relation to baseline data available.
- By 2001, the prevalence of positive serology for syphilis in ANC attendees aged 15-24 years will decrease by 50% in relation to baseline values available.

f) HIV prevalence:

- By 2001, HIV prevalence among women aged 15-24 years attending ANC will remain below 1%.
- By 2001, HIV prevalence among CSWs will remain below 1%.
- By 2001, HIV prevalence among IDUs will remain below 5%.

g) Screening blood for transfusion:

- By 2001, 97 blood centres will have developed blood testing for HIV, syphilis and HBsAg and HVC.
- 100% of blood donated for transfusion will be routinely screened for HIV antibodies.

6.2. Care Indicators and Targets

a) Counseling services:

- By 2001, 100% district hospitals will have at least one staff member qualified as a counselor.
- By 2002, 100% of HIV infected persons will have received counseling by an adequately trained counselor.

b) Clinical management of AIDS:

- By 2001, 90% of Upazilas will have at least one clinician trained in AIDS clinical management.
- By 2000, 90% of AIDS patients reported in the district hospitals will receive clinical management according to national guidelines.

6.3. Programme Management-related Indicators and Targets

- By 2001, 100% of brothels in the country will be participating in HIV/AIDS prevention activities.
- By 2001, 90% of relevant ministries of Government will have initiated HIV/AIDS/STD prevention and control activities.
- By 2001, 80% of NGOs involved in health related areas will have integrated AIDS/STD prevention and control activities into their on-going programmes.
- By 2001, 100% of government, NGO and private concerns involved in AIDS/STD related interventions will be regularly sharing their activity reports with the NAP.

SECTION VII: MONITORING AND EVALUATION

7.1. Programme Monitoring

Programme activities will be monitored by the AIDS committees established at central, district and upazila levels by quarterly reporting from peripheral to the central levels, and through visits made by programme staff. The NAP will report on the programme activities carried out, deviation if any, from the planned programme and with regard to any specific support required. The NAP staff will regularly make visits to support various actors and to establish close collaborative relationships.

Moreover, the programme will develop a management information system (in collaboration with UMIS) which will permit the tracking and scheduling of activities so as to enable the NAP to monitor the implementation of its work plan. At the same time, this system will provide for reporting on indicators and targets established and hence facilitate strategic planning.

7.2. Co-ordination

Establishment of linkages between various intervention levels including NGOs will facilitate more effective provision of programme support and will ensure better programme monitoring and improvement of programme design. This will promote active participation of the community in these activities.

7.3. Monitoring of the AIDS Epidemic

The progress of the epidemic in Bangladesh will be monitored by expanding and proper homing of the sentinel surveillance system for HIV. This will involve collecting baseline information and monitoring trends of HIV infection in specific population groups. Special studies to monitor gonococcal antimicrobial susceptibility will be carried out and data obtained on screening of donated blood will be monitored. STD prevalence data will also be collected and used for the monitoring of impact of HIV/AIDS prevention activities. The surveillance data will be disseminated to all relevant individual agencies and feedback provided to those collecting and sending data to the national programme.

7.4. Annual Reviews

Internal review of the national programme will be carried out annually by the programme staff themselves to take stock of achievements, constraints and methods for streamlining activities. This review will lead to a comprehensive annual report which will also assess the final implementation of the yearly workplans and the targets achieved. Information on the progress being made to achieve specific targets defined in the workplans will be collected and analysed as appropriate. Additional information from the various sectors and the district and upazila quarterly reports will also be included. The annual report will contain a complete assessment of achievements and constraints in programme implementation, the lessons learnt, financial reporting and recommendations for future plans. The annual review report will be shared and disseminated with NAC and development partners and other stakeholders as a basis for future planning.

7.5. External Programme Review

External programme reviews are necessary to more objectively evaluate the implementation of the NAP. External reviews will be carried out by a team composed of members outside of the national programme. These will include participation of the beneficiaries, various Government and non-government sectors, UNAIDS cosponsors, UNAIDS and representatives of the donors. The external review should occur every 2-3 years. Participation of all interested parties will be encouraged so that repeated separate reviews by different donors can be avoided and discouraged. The review should look not only on the progress made in terms of activities but also assess achievements made on the targets already established in the strategic plan. It is expected that reviews will be undertaken under HPSP system.

ANNEX-I

National AIDS Committee (NAC) - the Advisory Body

NAC will be a multi-sectoral body with a strong political commitment. It is an advisory body to the Government of Bangladesh on all aspects related to HIV/AIDS and STDs, including legal, ethical, managerial, financial, international, regional and technical issues.

The composition of the NAC will be as follows:

- | | | |
|------|---|-------------|
| 1. | Honourable Minister
Ministry of Health and Family Welfare | Chairman |
| 2. | Honourable State Minister
Ministry of Health and Family welfare Ministry | Co-Chairman |
| 3-5. | 3(Three) Members of the National Parliament (MP)
Designated by the Speaker with at least one member
from opposition and one female member | Members |
| 6. | Secretary, Ministry of Health and Family Welfare | Member |
| 7. | Secretary, ERD, Sher-e-Bangla Nagar | " |
| 8. | Secretary, Ministry of Information | " |
| 9. | Secretary, Ministry of Education | " |
| 10. | Secretary, Ministry of Finance, Finance Division | " |
| 11. | Secretary, Ministry of Youth and Sports | " |
| 12. | Secretary, Ministry of Civil Aviation and Tourism | " |
| 13. | Secretary, Ministry of Labour and Employment | " |
| 14. | Secretary, Ministry of Women Affairs | " |
| 15. | Secretary, Ministry of Home Affairs | " |
| 16. | Secretary, Ministry of Religious Affairs | " |
| 17. | Secretary, Ministry of Law, Justice and Parliamentary Affairs | " |
| 18. | Secretary, Ministry of Social Welfare | " |
| 19. | Director General Medical Services, Armed Forces | " |
| 20. | Commandant, Armed Forces Institute of Pathology (AFIP) | " |
| 21. | Consultant Physician, Bangladesh Armed Forces | " |
| 22. | Director General, Health Services | " |
| 23. | Director General, Family Planning | " |
| 24. | Director General, NGO Affairs Bureau | " |
| 25. | Director General, Prime Minister's Office | " |
| 26. | Director General, Bangladesh Television | " |
| 27. | Director General, Bangladesh Betar | " |
| 28. | Director General, Mass Communication | " |
| 29. | Ex-Chairman, National AIDS Committee | " |
| 30. | (A) Vice-Chancellor
Bangabandhu Sheikh Mujib Medical University | " |
| | (B) Vice-Chancellor
Dhaka University, Dhaka | " |
| 31. | President, Bangladesh Medical and Dental Council | " |
| 32. | One Eminent Microbiologist | " |
| 33. | One Eminent Medical Scientist | " |
| 34. | One Eminent physician | " |
| 35. | One Eminent Gynaecologist or Surgeon | " |
| 36. | One Eminent Transfusion Expert | " |
| 37. | One Eminent STD Expert | " |

38.	One Eminent Epidemiologist	"
39.	One Eminent Social Scientist	"
40.	One Eminent Psychologist/Psychiatrist	"
41.	One Eminent Educationist from Universities	"
42.	Divisional Chief, SEI, Planning Commission	"
43.	Chairman, Bangladesh Medical Research Council	"
44.	President/Secretary General, Bangladesh Medical Association	"
45.	President, Bangladesh Private Practitioner's Association	"
46.	President, BFUJ	"
47.	President, FBCCI	"
48.	President, Bangladesh Bar Council	"
49.	President, Mohila Parishad	"
50-54.	Chairpersons of Technical Committee and and Technical Sub-Committees (Members to be adjusted according to representation)	"
55.	Chairperson AIDS Theme Group, UN Agencies, Bangladesh	"
56-57	2 (two) Representatives from NGOs (with at least one from AIDS/STD Network)	"
58.	One Representative from the Human Right Activists	"
59	Additional Secretary and Focal Point, HIV/AIDS Ministry of Health and Family Welfare – Full Time	"
60.	Professor Mosharraf Hossain, Transfusion Expert	"
61	Director, IEDCR	"
62.	Director, Primary Health Care and Disease Control and Line Director, ESP, DGHS	"
63.	Programme Manager, AIDS/STD Programme	Member Secretary

Secretariat of NAC and TC NAC will be located in the programme office till other facilities are made available.

Terms of reference of National AIDS Committee:

- i. To act as an Advisory Body to the Government of Bangladesh on all matters relating to control and prevention of HIV/AIDS & STD,
- ii. To update the National Policy on HIV/AIDS/STD related issues from time to time as required (preferably every two years),
- iii. To provide technical guidelines to the Programme,
- iv. To receive and act upon recommendations from Technical Committee on matters relating HIV/AIDS and STD and to convey those recommendations to the GOB.
- v. To raise and coordinate with donor agencies and international organizations and thus help foster regional and international coordination and cooperation for effective implementation of programmes on HIV/AIDS and STD.
- vi. To co-opt any member as and when necessary,
- vii. To recommend legislation to ensure access to health services for HIV/AIDS infected persons,
- viii. To meet at least three times in a year,
- ix. To be reconstituted every two years,
- x. To ensure gender balance.

Technical Committee of the National AIDS Committee

The Technical Committee is the technical arm of the National AIDS Committee and is composed of several members who are experts in various fields of specialties relevant to the prevention and control of HIV/AIDS/STD. The composition of the committee is as follows:

The Composition of the Technical Committee is as follows:

1.	An Eminent Medical Scientist	Chairman
2.	One Eminent STD Expert	Member
3.	One Eminent Epidemiologist	Member
4.	One Eminent Virologist	Member
5.	One Eminent Demographer	Member
6.	One Eminent Transfusion Expert	Member
7.	One Eminent Psychologist or Psychiatrist or Counseling Expert	Member
8.	One Eminent Anthropologist (Medical)	Member
9.	Health Economist	Member
10.	One Media Expert	Member
11.	One Social Marketing Expert	Member
12.	One Clinician with expertise in AIDS management	Member
13.	Director, Primary Health Care	Member
14.	Director, Maternal Child Health (MCHFP)	Member
15.	Country Programme Advisor, UNAIDS	Member
16.	National Programme Officer, WHO	Member
17.	Director, TB Control Programme	Member
18.	One Eminent Educationist	Member
19.	One Eminent Legal Expert	Member
20.	One Eminent Immunologist	Member
21.	One Eminent Physician	Member
22.	Director, Hospital, DGHS	Member
23.	Chief, Bureau of Health Education	Member
24.	Head, Microbiology Laboratory, IPH	Member
25.	Director, Nursing Services	Member
26.	Focal Point, IEC, MOH&FW	Member
27.	One Eminent Gynaecologist	Member
28.	One Eminent Oncologist	Member
29.	Programme Manager, AIDS/STD Programme	Member Secretary

Terms of reference of Technical Committee

- i. To assist NAC in the formulation of policy guidelines and programme frame-works for the prevention and control of HIV/AIDS/STDs,
- ii. To provide technical guidance to project directors in the design and development of the National HIV/AIDS/STDs Prevention and Control Program and Methodology of its implementation.
- iii. To assist in setting standards of performance for HIV/AIDS related programmes/projects and in identifying measures to ensure quality assurance compliance by all participating agencies in HIV/AIDS/ STDs activities in the country,
- iv. To advise in matters related to design and development of training of personnel and IEC activities in support of the HIV/AIDS/STDs related programmes and projects,

- v. To draft technical guidance for reporting of the HIV/AIDS/STD cases for incorporation in the overall MIS of the programmes/projects.
- vi. To assist in the development of performance indicators for HIV/AIDS/STD activities in their evaluation of various Programs and projects,
- vii. To assist NAC and Project Director in any matter pertaining to HIV/AIDS/STD related relevant programmes as and when NAC or the Project Director requests,
- viii. To form Technical Sub-Committees as and when considered necessary and can co-opt members,
- ix. To form a Research Review Committee that will review research protocols that will be funded by the GOB, and
- x. To 'Undertake scientific publications on HIV/AIDS/STDs related issues'.

Youth Wing, Women Wing and Media Wing of NAC

A Youth Wing (YW), a Women Wing (WW) and a Media Wing (MW), each with a specific TOR may be constituted to complement the activities of NAC. NAC will be working out the composition and the TOR of each as early as possible.

**List of participants of Consensus updating workshop held on May 1 - 3
2000 in Chittagong**

Government

SI No.	Name of Participants	Designation/Dept/Organization
1.	Syed Alamgir Faruque Chowdhury	Secretary, MOHFW
2.	Dhiraj Kumar Nath	Additional Secretary, MOHFW
3.	Prof. A. B. Ahsanullah	Director General of Health Services DGHS
4.	Mr. Shafiuddin Ahmed	Director General Health DGFP, MOHFW
5.	Dr. ASM Mushiur Rahman	Director Planning & Research DGHS
6.	Dr. A M Zakir Hussain	Director, PHC & DC and Line Director, ESP, DGHS
7.	Dr. Ali Jafar	Director Institute of Public Health (IPH), Dhaka
8.	Prof. Subhagata Chowdhury	Principal, Chittagong Medical College
9.	Dr. Nurul Anowar	Director, UMIS DGHS, Dhaka
10.	Dr. Md. Nurul Alam	Director Health, Chittagong Division, Chittagong
11.	Prof. Dr. Abdul Azim	Blood Transfusion Department Chittagong Medical College
12.	Aktari Mamtaz	Sr. Assistant Secretary & DPM, ISMSC Program, MOHFW
13.	Dr. M. A. Rashid	Deputy Director (Hospital) DGHS, Dhaka
14.	Md. Rostam Ali Mia	Director, Family Planning Chittagong & Sylhet Division
15.	Dr. AQM Serajul Islam	Associate Prof. & Head Skin & VD Dept, Chittagong Medical College
16.	Dr. Biswanath Pal	Civil Surgeon, Chittagong
17.	Dr. M A Hashem	Senior Medical Superintendent Narcotics Department Chittagong
18.	M.S. Rahman	Additional Director, DNC Chittagong
19.	Dr. Supriya Barua	Dy. Director, CMCH Chittagong

20.	Mr. Rekha Rani Datta	Deputy Director Family Planning, Chittagong
21.	Dr. Md Shahidullah Sikder	Asst. Prof. Dept of Virology, BSMMU & Representative of BMA
22.	Dr. M A Mannan	Program Manager Reproductive Health DGHS
23.	Md. Mozzamel Hoque	Deputy Chief, MOHFW
24.	Dr. Jafar Ahmed Hakim	PM, ESP-RH, DFP, Dhaka
25.	Md. Abdul Latif	Asstt. Chief (Admin & Training) Bureau of Health Education, DGHS
26.	Dr. A M Nuruzzaman	DPM, BCC, DGHS
27.	Dr. M. A. Baqi	PM (ESP), DGHS
28.	Md. Shamsuddin Chowdhury	Asstt. Director, BCC Family Planning Directorate

DONOR ORGANIZATIONS

29.	Dr. Rowshan Ara	NPPP, UNFPA
30.	Dr. Zareen Khair	Programme Specialist, USAID
31.	Dr. Aslam Zulfiquir Baig	NPPP, UNFPA
32.	Ms. Geeta Sethi	Country Programme Advisor, UNAIDS
33.	Mr. Frank Paulin	Institute of Development Specialist, World Bank
34.	Brad Herbert	Social Sector TL World Bank, Dhaka
35.	Alec Mercer	Program Manager DFID
36.	Dr. Najmus Sahar Sadiq	Sr. Program Officer, UNDP, Dhaka
37.	Brig. QMS Hafiz	National Programme Officer, WHO
38.	Rousselot Armand	Deputy Regional Representative, IOM
39.	A Wazed	District Research Manager ICDDR,B, Dhaka
40.	Morag Humble	Director, CIDA Monitoring & Technical Advisor Unit

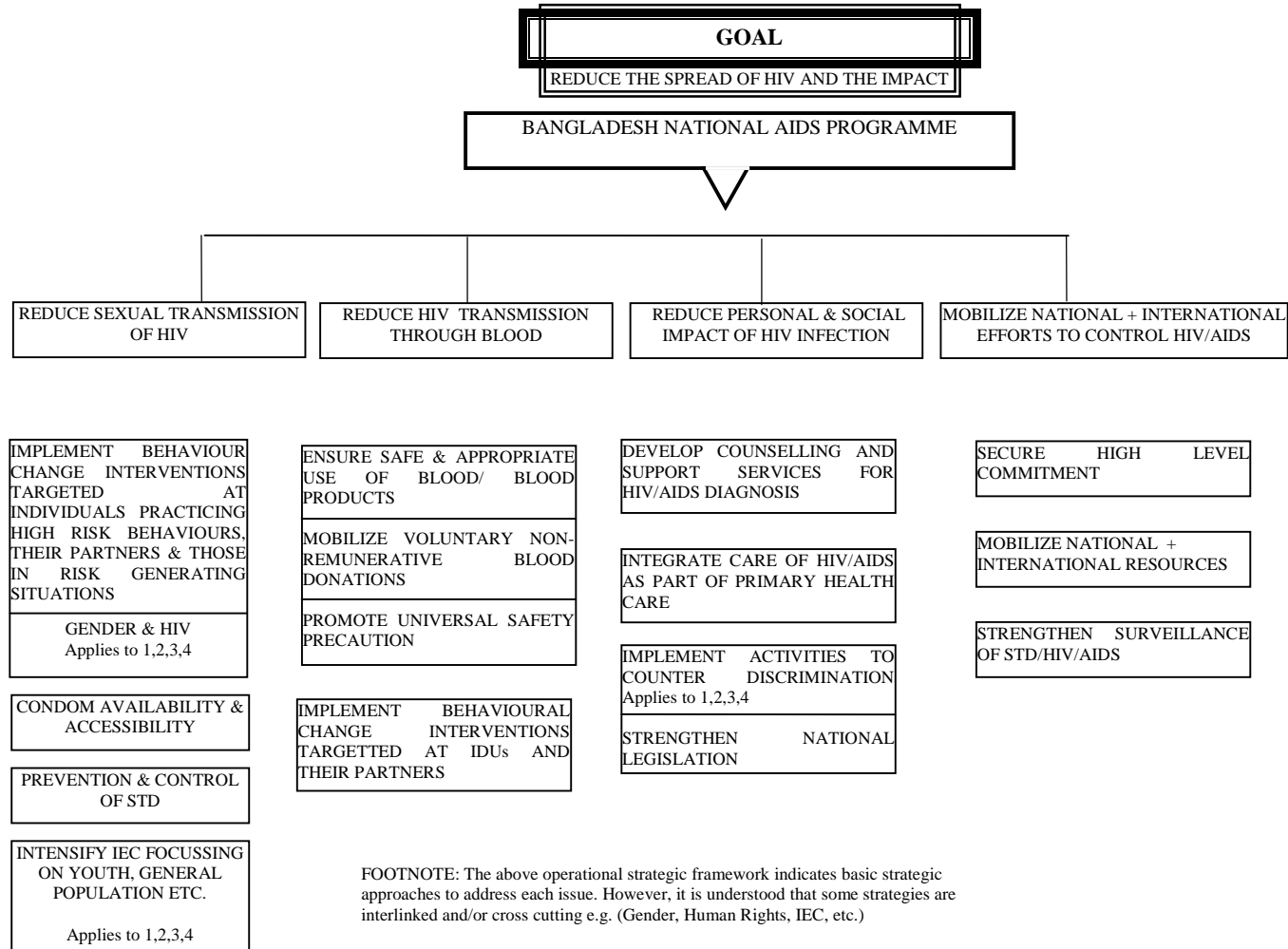
NGOs

41.	Dr. Syeda Nurjahan Bhuiyan	Vice-President Bangladesh Medical Association (Central), Chittagong
42.	Dr. S. Jana	HIV Program Coordinator CARE, Dhanmondi, Dhaka
43.	Habiba Tasneem	Executive Director HASAB
44.	Perveen Rasheed	General Manager, Communication Social Marketing Company (SMC)
45.	Abdul Awal	Executive Director, OSDUY
46.	Md. Alauddin	Executive Director SEDAB
47.	Sultan Mahmud	Country Director Save the Children Australia, Dhaka
48.	Shale Ahmed	ED, BHANDHU Social Welfare Society

AIDS/STD Programme

49.	Dr. Md. Asaduddin	PM, AIDS/STD Program DGHS
50.	Dr. Md Mobarak Hossain	DPM AIDS/STD Programme, DGHS
51.	Dr. Mosaddeque Ahmed	DPM, AIDS/STD Programme, DGHS
52.	Dr. Hasan Mahmud	DPM, AIDS/STD Program, DGHS
53.	Dr. Ashrafuddin Ahmed	Consultant National AIDS/STD Programme
54.	Dr. Nizam Uddin Ahmed	Consultant National AIDS/STD Programme
55.	Dr. Syed Kamaluddin Ahmed	Consultant National AIDS/STD Programme

STRATEGIC FRAMEWORK FOR THE NATIONAL AIDS PROGRAMME



FOOTNOTE: The above operational strategic framework indicates basic strategic approaches to address each issue. However, it is understood that some strategies are interlinked and/or cross cutting e.g. (Gender, Human Rights, IEC, etc.)