Prepared Under HNPSP of the Ministry of Health and Family Welfare

HIV/AIDS EXPENDITURE IN BANGLADESH (2005-07)

Bangladesh National Health Accounts (NHA)

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HIV/AIDS Expenditure in Bangladesh 2005-2007 - National Health Accounts

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In collaboration with:

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
BAP	Bangladesh AIDS Project
BBS	Bangladesh Bureau of Statistics
BNHA	Bangladesh National Health Accounts
CGA	Controller General of Accounts
CSW	Commercial Sex Workers
DFID	Department for International Development
DI	Data International
DP	Development Partners
GDP	Gross Domestic Product
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GOB	Government of Bangladesh
GTZ	German Technical Cooperation
HAPP	HIV/AIDS Prevention Project
HIV	Human Immunodeficiency Virus
HNPSP	Health Nutrition and Population Sector Programme
HPSP	Health and Population Sector Program
ICDDR,B	International Centre for Diarrhoeal Diseases Research
ICHA	International Classification for Health Accounts
IDA	International Development Agency
IDU	Injection Drug Users
MOF	Ministry of Finance
MOHFW	Ministry of Health and Family Welfare
MSM	Men having Sex with Men
NAC	National AIDS Committee
NASA	National AIDS Spending Assessments
NASP	National AIDS/STD Programme
NGO	Non Government Organization
NHA	National Health Accounts
NHA3	Third National Health Accounts
NPISH	Non-Profit Institutions Serving Households
OECD	Organization of Economic Cooperation and Development
OOP	Out of Pocket
PLWHA	People Living with HIV/AIDS

PRSP	Poverty Reduction Strategy Paper
ROW	Rest of the World
THE	Total Health Expenditure
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations International Children Emergency Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Notes:

Taka = Bangladeshi currency unit

US$ 1 = Taka 69 (approx. in July 2007) [All $ referred to in the text indicates US$]

Taka values converted into dollar ($) using exchange rates (below) for corresponding years.

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
1US $=Taka	42.70	45.46	48.06	50.31	53.96	57.44	57.90	58.94	61.39	67.08	69.03
GDP at current price (in billion Taka)	1,807	2,002	2,197	2,371	2,535	2,732	3,006	3,330	3,707	4,157	4,725
GDP in US$ (in billion)	42.32	44.03	45.71	47.12	46.99	47.56	51.91	56.49	60.39	61.97	68.45
Population (Million)	124.0	125.9	127.7	129.5	130.0	132.9	134.8	137.7	138.6	140.6	143.9

HIV/AIDS EXPENDITURE IN BANGLADESH (2005-07)

Executive Summary

This report provides data on HIV/AIDS expenditure in Bangladesh for the 2005-07 period. It primarily uses the Bangladesh National Health Accounts (BNHA) framework in describing and comparing the expenditure flows for each of the three years. An HIV/AIDS expenditure estimate hence has been created within the context of BNHA framework. Expenditure estimates have also been presented by the classification defined in the National AIDS Spending Assessments (NASA) indicators, a detailed HIV/AIDS related expenditure tracking model termed developed by UNAIDS.

The HIV/AIDS subaccount shows the amount of funds provided by major sources (e.g. government, NGOs, and development partners), organized according to the institutional entities providing the services (e.g. health ministry, NGOs) and type of service (e.g. prevention and awareness creation, treatment).

Total expenditure on HIV/AIDS intervention activities was Taka 892 million (US$12.9 million) in 2007, Taka 1,427 million (US$21.3 million) in 2006 and Taka 1.127 million (US$18.4 million) in 2005. In 2007, based on the government's actual audited spending data from the Controller General and Accounts (CGA) data, there was a significant drop in the HIV/AIDS expenditure by the Ministry of Health and Family Welfare (MOHFW) – from Taka 668 million in 2006 to a meagre Taka 10 million the following year. The average total expenditure on HIV/AIDS during 2005-07 is Taka 144.7 million ($17.5 million). At approximately 76 percent, donor funding is overwhelmingly the major source of financing for all HIV/AIDS related expenditures. Government expenditure accounts for only 1 percent.

Prevention and promotion related activities are the major component in HIV/AIDS programming in Bangladesh. In 2007, Taka 882.4 million was spent on prevention strategies and interventions, which is around 98.9% of the total HIV/AIDS expenditure. Taka 7.2 million was spent on program management and administration, while Taka 2.2 million was disbursed care and treatment. Unlike African countries the amount spent on treatment is small – Taka 19.1 million which is 2 percent of the total HIV/AIDS expenditure.

Broadly speaking, Bangladesh's HIV/AIDS prevention and treatment activities are being supported by three major multi-year programs. These are: (HIV/AIDS Prevention Project) HAPP, (Bangladesh AIDS Project) BAP and (Global Fund to fight AIDS, Tuberculosis and Malaria) GFTAM. In addition, the government, several development partners, international and national NGOs are implementing their own programs.

GFATM is the largest program accounting for almost Taka 316 million in 2007, which is close to one-third of the total outlay on HIV/AIDS related expenditure. GFATM is closely followed by HAPP, with Taka 313.3 million expended in 2007. GTZ spent Taka 62.9 million in 2007, a figure that increased considerably over GTZ HIV/AIDS expenditure in previous years (Taka 7 million in 2005 and Taka 14.4 million in 2006).

NGO programmes are funded from both external sources (GOB, donors) as well as from their own resources. As expected, through the years, the larger share of NGO funding has derived from external sources. In 2007, Taka 679.3 million (77%) of the total of Taka 881.2 million that comprises NGO funding came from foreign development partners. Households accounted for a mere 1%.

HIV/AIDS patients' out-of-pocket treatment expenditure is reproduced in this report from a recent GTZ supported study (Rannan-Eliya et al., 2008). Total Out of Pocket (OOP) HIV/AIDS expenditure for households for 2007 was Taka 2.95 million, while it was Taka 1.96 million and Taka 1.24 million for the two preceding years. In all three years, households spent the highest amount in NGO hospitals; constituting almost 70 percent of total OOP in 2007.

For outpatient care, People Living with HIV/AIDS (PLWHA) reported a per capita rate of 10.1 visits annually to NGO providers. For inpatient care, public providers accounted for the most care – 32 percent in medical college hospitals and 39 percent in upper tier government hospitals.

Per capita outpatient expenditure on HIV/AIDS is Taka 1,977 and inpatient per capita expenditure is Taka 1,717, higher than national per capita expenditures on these health functions of Taka 156 and Taka 160.

For household outpatient costs, related travel expenses account for the highest share – almost twice the amount required for medical costs (Taka 4,408 versus Taka 1,977 respectively). Among medical expenses, two thirds were expended on purchasing drugs. Medical fees accounted for the bulk of inpatient expenditure (Taka 1,032) at both public and private hospitals. The overwhelming majority of PLWHA who undergo Antiretroviral Therapy (ART) receive free services.

The HIV/AIDS subaccounts aimed to present its estimates in accordance with the BNHA framework. However, some effort was also expended in an attempt to disaggregate expenditures based on the NASA boundaries. Further effort and resources are warranted to present comprehensive estimations in accordance with the NASA classifications.

HIV/AIDS EXPENDITURE IN BANGLADESH (2005-07)

I. Introduction

1.1 National Health Accounts (NHA)

Bangladesh has conducted two rounds of National Health Accounts (NHA) to date. Under the third round (NHA3), it adds another dimension to the usual round of activities by developing an HIV/AIDS Health Accounts for 2004-2005 to 2006-2007. This report documents the findings on HIV/AIDS related expenditures in Bangladesh.

National Health Accounts (NHA) presents the expenditure flows – both public and private – within the health sector of a country. They describe, in an integrated way, the sources, uses and channels for all funds utilized in the whole health system. NHA shows the amount of funds provided by major financing agents (e.g. government, firms, households), and how these funds are used in the provision of final services, organized according to the institutional entities providing the services (e.g. hospitals, outpatient clinics, pharmacies, traditional medicine providers) and types of service (e.g. inpatient and outpatient care, dental services, medical research, etc.).

1.2 HIV/AIDS Subaccounts

The HIV/AIDS subaccounts have been created within the context of NHA. The HIV/AIDS subaccounts are aimed at mapping all expenditures made within the health system relating to HIV/AIDS. Broadly speaking, the activities undertaken for HIV/AIDS can be classified under the following categories: treatment, prevention and awareness creation. The HIV/AIDS activities have been adapted to the International Classification of Health Accounts (ICHA) that provides the functional classification of NHA. The tables presented in the report are classified in accordance with the BNHA coding or classification. (Detailed discussion of the ICHA and BNHA mapping and classification is available in the report Bangladesh *National Health Accounts 1997-2007*.)

1.3 NASA Indicators

Based on the NHA framework, UNAIDS has developed a detailed HIV/AIDS related expenditure tracking model termed the National AIDS Spending Assessments (NASA). The NASA boundaries are inclusive of health and non-health activities. "The functions are no longer limited to health expenditures, following the framework of the NHA, but emphasize the tracking of social mitigation, education, labour, justice and other sectors for an expanded response to HIV/AIDS."
(http://data.unaids.org/pub/Presentation/2007/20080116_5_nasa_framework_en.pdf).

In addition to tracking expenditures based on sources and financing agents, providers and functions, NASA suggests identification of target groups (e.g. beneficiaries; vulnerable and at-risk epidemiologically defined populations). Spending has been classified into the following eight groups:

1. Prevention
2. Treatment and care
3. Orphan and vulnerable children
4. Programme management
5. Human resources for AIDS
6. Social protection
7. Enabling environment and community development
8. Research: AIDS related

The NASA indicators have been developed to define highly disaggregated functional activities relating to HIV/AIDS expenditure. Whilst many of the listed functions may not be germane for a particular country, considerable data collection effort would be required to fill in the subaggregated categories relevant for Bangladesh. Thus, for the purposes of this report, expenditures have been classified for the key eight categories defined by NASA.

1.4 Organization of the Report

The report is organised in five sections. Section I provides a brief background to this report and discusses the role of HIV/AIDS subaccounts and the NASA indicators. Section II presents an overview of HIV/AIDS and its prevalence in Bangladesh.

Section III details the key findings, i.e. the expenditure estimates related to HIV/AIDS in Bangladesh. The estimations are presented along the NHA framework – by financing agent (Section 3.2), provider (Section 3.3) and function (Section 3.4). Section 3.5 attempts a cross classification of these expenditures. The expenditure burden borne by households is presented in 3.6. HIV/AIDS expenditures classified according to the eight NASA categories are documented in 3.7.

Three multi-year HIV/AIDS prevention and treatment programmes are in operation. A brief overview of the activities and outlays of these programmes is attempted in Section IV as it would be of interest to policy makers and other stakeholders associated with the health sector of Bangladesh (a more detailed summary is provided in Annex III). Section V summarizes the implications of the findings.

The report has three annexure. Annex I presents companion tables to the data presented Sections 3.2, 3.3 and 3.4. While the tables presented in the main text provide figures for the reporting years (2005-2007), the annex tables include estimates for prior years covering 2000-2007. A narrative on secondary and primary data collated and collected to derive the HIV/AIDS expenditure estimates appears in Annex II. Annex III describes the three key HIV/AIDS programs functioning in Bangladesh in more detail.

II. An Overview of HIV/AIDS Incidence in Bangladesh

Globally almost 40 million adults and 2.3 million children are living with HIV/AIDS (World AIDS Day Report, National AIDS/STD Program). The vast majority of this population are located in the developing countries. In the past few years, Asia has emerged as a region where the AIDS epidemic is spreading quickly, with approximately 1 million in China and 6 million in India. Indonesia and Nepal have been declared countries experiencing concentrated epidemics. Unsafe sexual contact and Injecting Drug Use (IDU) behaviour have been identified as the main routes of transmission in South Asian regions (http://data.unaids.org/Publications/Fact-Sheets01/Bangladesh_EN.pdf).

Table 2.1: Health in Bangladesh: An Overview (provisional)

Indicators	2000	2005	2006	2007
Population of Bangladesh (in millions)	129.47	138.60	140.60	143.91
Life expectancy at birth, total (years)	63.6	65.2	65.4	
Total Health Expenditure (in million Taka)	69,580	122,877	144,859	166,274
Per Capita Health Expenditure (in Taka)	537	887	1030	1155
Per Capita Health Expenditure (in US$)	11	14	15	17
Health Expenditure as percent of GDP	2.9%	3.3%	3.5%	3.6%

Source: Statistical Year book of Bangladesh 2007, BBS; Bangladesh Economic Review 2007; NHA3

In Bangladesh, the first identified case of HIV was documented in 1989. By 2005, the number of (reproductive age) adults who were HIV positive or suffering from AIDS was 11,000 (Table 2.2). However, the pandemic of HIV/AIDS has had less of an impact on Bangladesh with an HIV/AIDS prevalence rate of less than 1 percent, compared to a number of other developing nations (especially the Sub-Saharan nations where one of the hardest hit countries estimate that 40% of the total population have contracted HIV). In Bangladesh, the most at-risk populations have been identified as Commercial Sex Workers (CSW), Men having Sex with Men (MSM), migrant workers (both internal and external migrants) and Injecting Drug Users (IDU).

Table 2.2: HIV/AIDS in Bangladesh: An Overview, 2005

Adults age 15-49 with HIV/AIDS	11,000
Adult HIV prevalence (%)	<0.1
Women age 15-49 with HIV/AIDS	1,400
Children with HIV/AIDS	No data
AIDS orphans (ages 0-17)	No data
AIDS deaths	<500

Source: UNAIDS (http://data.unaids.org/Publications/Fact-Sheets01/Bangladesh_EN.pdf)

However, despite being termed a “low prevalence country”, Bangladesh is currently at a critical juncture in relation to the AIDS epidemic. A number of factors are extant that render the country vulnerable to a massive upsurge in HIV/AIDS infected population. Poverty, low perceptions of risk, risky behaviour (these include increasing injecting drug use, growing sex work, ignorance regarding “safe sex” practices) rising levels of internal and external migration, trafficking, borders with countries suffering higher rates of HIV prevalence, gender

inequalities, inadequate supply and access-issues of safe blood and blood products, etc. are strong contributing factors in the spread of HIV/AIDS among both the general and the vulnerable populations.

Women (due to social and cultural traditions that limit their powers of decision making, economic and cultural independence and critical thought) are more vulnerable to the risk of HIV. Young people – adolescents and teenagers – are vulnerable as well. It is estimated that as much as half of the new HIV infections contracted are among young people 15-24 years of age (http://data.unaids.org/Publications/Fact-Sheets01/Bangladesh_EN.pdf). A population-based survey among adolescents and young people of 15-24 years of age indicates that only one out of three males in urban and one out of four in rural areas have correct knowledge of HIV and AIDS (Save the Children, USA and NASP 2005).

One of the key sources of information regarding the spread of HIV/AIDS in Bangladesh is a periodic surveillance, which is conducted by ICDDR,B in accordance with guidelines espoused by UNAIDS/WHO. This surveillance focuses on sample groups selected from high-risk populations (such as CSWs, MSMs, drug users and the transgender community).

Key challenges in the prevention initiatives to stem a possible HIV/AIDS epidemic have been identified thus:

- Lack of openness in discussion related to sexuality and HIV/AIDS;
- Condom Promotion among the population at risk and general population;
- Essential policy review and legal/law reform to enhance enabling environment for HIV/AIDS prevention;
- Effective multi-sectoral responses based on respect for human rights and dignity;
- Reaching out to the community with the right message;
- Reaching out to young people with information and providing them access to HIV and STI prevention services;
- Link HIV/AIDS control and preventive activities to national development framework such as the Poverty Reduction Strategy Paper (PRSP) and HNPSP.

2.1 Policy Level Response to HIV/AIDS

Government initiatives focus on high-risk populations as well as the general populace in raising levels of awareness regarding the spread of HIV/AIDS. The National AIDS Committee (NAC) of the Government of Bangladesh (GOB) was established in 1985, four years before the first reported case of HIV/AIDS in Bangladesh. The HIV/AIDS National Policy was drafted in 1996 and finally received endorsement in 1997.

Following the National Policy, a plan of action was formulated (within the framework of the Health and Population Sector Program (HPSP)) to address the issue of HIV/AIDS in Bangladesh. In 2003, legislation was enacted for safe blood transfusion to provide the much needed support and effective policy direction to ensure blood safety.

The First National Strategic Plan was envisaged for the period of 1997-2002. This plan focused on the significance of active involvement of community and religious leaders as well as students and young people in HIV/AIDS prevention initiatives.

In 2004, a Second NSP for HIV/AIDS (2004-2010) was developed. This NSP drew on guidance from the NAC and technical support from various stakeholders. Through the endorsement of the government's commitment to the "Three Ones"[1] principles, NSP urges the application of these principles with an aim of strengthening multi-sectoral action. In addition, the current NSP focuses on ensuring effective involvement of People Living with HIV/AIDS (PLWHA) as well as other at-risk populations in policy dialogue and formulation as well as programming. The five program objectives of the NSP are to:

1. provide support and services for priority groups;
2. prevent vulnerability to HIV throughout society;
3. promote safe practices within the healthcare system;
4. provide care and support services for people living with HIV;
5. minimize the impact of the epidemic.

HIV/AIDS: Basic Information

AIDS (Acquired Immune Deficiency Syndrome) is the fatal condition resulting from long-term infection with HIV (Human Immunodeficiency Virus). HIV progressively weakens the body's immune defense system until it is no longer able to fight off a wide range of infections, such as tuberculosis or persistent diarrhoea. These are called opportunistic infections. AIDS is defined as infection with HIV and the presence of such opportunistic infections. Eventually the immune system can no longer defeat these infections and the individual dies.

HIV infection is permanent and cannot be cured. It is believed that virtually all those who contract HIV will eventually develop AIDS, although some of them may not do so for 20 or more years. During this time, they have no symptoms of the disease and are able to continue working and living normally. Some drugs appear to slow down the rate at which HIV attacks the body's immune system. However, such drugs are expensive and their effect is only temporary.

HIV is transmitted through:

1. unprotected sexual intercourse where one partner has HIV;
2. transfusion of HIV-infected blood or blood products;
3. HIV-infected blood in needles, syringes and skin- piercing instruments;
4. from an infected mother to her child before or during birth. Also during breastfeeding.

- PANOS 1995

[1] In 2004, UNAIDS, the United Kingdom and the United States co-hosted a meeting where key donors reaffirmed their commitment to strengthening national AIDS responses led by the affected countries
- One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.
- One National AIDS Coordinating Authority, with a broad-based multi-sectoral mandate.
- One agreed country-level Monitoring and Evaluation System.

(http://www.unaids.org/en/CountryResponses/MakingTheMoneyWork/ThreeOnes)

III. Expenditure Estimates

3.1 Total Health Expenditure (THE)

Most countries, under the NHA framework, disaggregate sources of health financing into two categories – public and private. In Bangladesh, NGOs and external development partners (donors) are active players in the health sector in the provision of financing and/or services. Hence, outlays of these two entities have been explicitly identified in many instances in this report. Rest of the World (ROW) expenditure includes all foreign development partners' expenditure excluding funding directly provided to the Government of Bangladesh (GOB) by them.

Total Health Expenditure (THE) measures the final use of resident units of health care goods and services, gross capital formation in health care provider industries plus education and research expenditures of all healthcare providers. For Bangladesh, THE is estimated at Taka 159.91 billion ($2.32 billion) in 2007 (Table 3.1) which constitutes 3.4% of GDP. Per capita spending on health was Taka 1,111 ($16.1) in 2007.

Household remains the main source of financing for healthcare in Bangladesh, comprising 64.7% of THE in 2007. The government is the second largest financing agent making up for 25.8% of THE in 2007. The share of NGO financing from own source was between 1.1% to 1.7% over the 1997-2007 period. Development partners (identified as Rest of World (ROW) in this report) contribute a sizeable amount of their assistance through the government or through NGOs.

For public sector financing, primarily the Ministry of Health and Family Welfare (MOHFW) serves as a financial intermediary of the Government of Bangladesh (GOB) receiving funds from the Ministry of Finance (MOF). Of the total amount of public sector health financing, MOHFW's share was Taka 40.1 billion ($581 million) which is 97% of the total public financing in 2007.

3.2 Financing Agent

The financing agents typically have programmatic control over the funds, whereby they decide what to spend on and through which providers. Examples include the Ministry of Health and Family Welfare (MOHFW), international and local NGOs.

Total expenditure on HIV/AIDS intervention activities was Taka 945.2 million ($13.7 million) in 2007, Taka 1,314.6 million ($19.6 million) in 2006 and Taka 1,124.8 million ($18.3 million) in 2005 (Table 3.1).
In 2007, based on the government's actual audited spending data from the Controller General of Accounts (CGA) data, there was a significant drop in HIV/AIDS expenditure by the public sector, channelled primarily through MOHFW. Public expenditure declined from Taka 668 million ($10 million) in 2006 to a meagre Taka 10.4 million ($0.2 million) the following year.

NGOs spent Taka 195.1 million ($2.8 million) of their own funds on HIV/AIDS related activities in 2007, a considerable increase from Taka 138.6 million ($2.3) in 2005. ROW's contributions have been steady over the 2005-2007 period, Taka 502 million ($8.2 million) in

2005 to Taka 737.6 million ($10.7 million) in 2007. It is reiterated that funds provided by development partners to the government are captured in public sector data.

Table 3.1: Total Health and HIV/AIDS Expenditure (in million Taka)

BNHA Code	Financing Agent	2005	2006	2007
	Health Expenditure			
BF1	Public Sector	**29,918**	**38,696**	**41,318**
BF2	**Private Sector**	**76,720**	**88,903**	**106,203**
BF2.4	Households	74,506	86,419	103,459
BF2.5	Non-profit institutions/NGOs	1,765	1,954	2,092
BF2.6	Private Firm	449	530	652
BF3	**Rest of the World (ROW)**	**9,734**	**10,530**	**12,391**
	Total Health Expenditure	**116,372**	**138,129**	**159,912**
	HIV/AIDS Expenditure			
BF1	**Public Sector**	**483.3**	**667.9**	**10.4**
BF2	**Private Sector**	**139.5**	**134.2**	**197.2**
BF2.4	Households	0.9	1.4	2.2
BF2.5	Non-profit institutions/NGOs	138.6	132.8	195.1
BF3	**Rest of the World (ROW)**	**502.0**	**512.4**	**737.6**
	Total HIV/AIDS Expenditure	**1,124.8**	**1,314.6**	**945.2**
	HIV/AIDS Expenditure as percent of Total Health Expenditure	1%	1%	0.6%

Source: CGA data, NHA3

At approximately 78 percent, donor funding is overwhelmingly the major source of financing for all HIV/AIDS related expenditures in 2007, followed by NGOs (21%) (Table 3.2). Government and household expenditure for HIV/AIDS are only 1 percent and 0.2% respectively. In the preceding two years, public expenditure amounted to a significant share of total HIV/AIDS expenditure – 43% in 2005 and 51% in 2006. Table A1 (Annex I) presents HIV/AIDS expenditure estimates by financing agent for the years spanning 2000-2007.

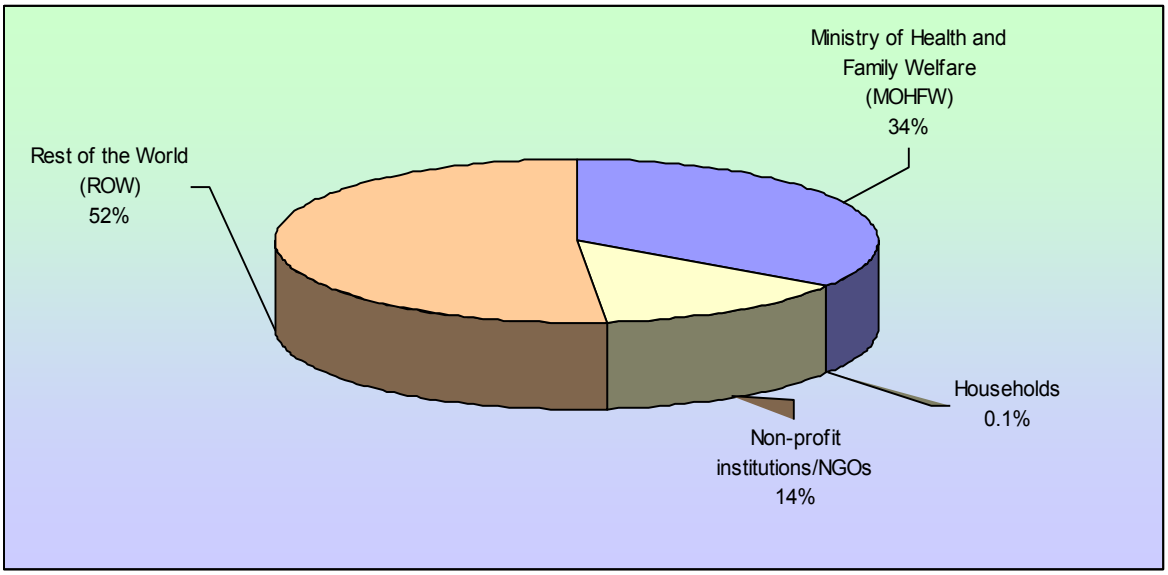
Table 3.2: HIV/AIDS Expenditure by Financing Agent

BNHA Code	Financing Agent	2005	2006	2007	2005-2007 (Average
BF1	**Ministry of Health and Family Welfare (MOHFW)**	**43**	**51**	**1**	**32**
BF2	**Private Sector**	**12**	**10**	**21**	**14**
BF2.4	Households	0.1	0.1	0.2	0.1
BF2.5	Non-profit institutions/NGOs	12	10	21	14
BF3	**Rest of the World (ROW)**	**45**	**39**	**78**	**54**
	Total HIV/AIDS Expenditure	**100**	**100**	**100**	**100**

Source: CGA data, NHA3

This sudden drop in public expenditure in 2007 warrants a look at a wider time period of respective expenditures of the various financing agents. The average figures show that while the development partners account for over half (52%) of HIV/AIDS expenditure, the public sector accounts for 34% and the NGOs account for 14% (Figure 3.1).

Figure 3.1: HIV/AIDS Expenditure Share by Financing Agent, 2005-2007 (Average)



Source: CGA data, NHA3

HIV/AIDS expenditure constitutes less than one percent of Total Health Expenditure (THE) for Bangladesh. A breakdown of expenditures of key financing agents is presented in Table 3.3. The table also compares share of HIV/AIDS expenditure to THE for each financing agent.

Foreign development partners (identified as ROW or Rest of the World) spent 6 percent of their total health expenditure on HIV/AIDS in 2007 (which was 5 percent in the preceding two years). NGOs spent slightly more than the donors – 7.1 percent in 2007, 5.3 percent in 2006 and 6.3 percent in 2005. In 2005 and 2006, HIV/AIDS expenditures incurred by MOHFW comprised a mere 1.7% and 1.8% of the ministry's total healthcare expenditure; in 2007, this dropped to an even lower 0.02%.

Table 3.3: HIV/AIDS Expenditure (in million Taka)

Expenditure	2005	2006	2007
MOHFW			
Total Expenditure on Healthcare	29,012	37,690	40,096
Total expenditure on HIV/AIDS	483.3	667.9	10.4
HIV/AIDS Expenditure as % of Total	1.7	1.8	0.02
Households			
Total Expenditure on Healthcare	74,506	86,419	103,459
Total Expenditure on HIV/AIDS	0.9	1.4	2.2
HIV/AIDS Expenditure as % of Total	0.001	0.002	0.002
NGOs			
Total Expenditure on Healthcare	2,214	2,484	2,744

Expenditure	2005	2006	2007
Total Expenditure on HIV/AIDS	138.6	132.8	195.1
HIV/AIDS Expenditure as % of Total	6.3	5.3	7.1
Rest of the World (ROW)			
Total Expenditure on Healthcare	9,734	10,530	12,391
Total expenditure on HIV/AIDS	502.0	512.4	737.6
HIV/AIDS Expenditure as % of Total	5	5	6
National			
Total Expenditure on Healthcare	116,372	138,129	159,912
Total expenditure on HIV/AIDS	1,124.8	1,314.6	945.2
HIV/AIDS Expenditure as % of Total	1	1	0.6

3.3 Providers

There exist a wide range and type of healthcare providers in Bangladesh. The three broad categories of providers are: (a) public providers, (b) private providers, and (c) Non-Profit Institutions Serving Households (NPISH) popularly known as Non Government Organization (NGO) providers.

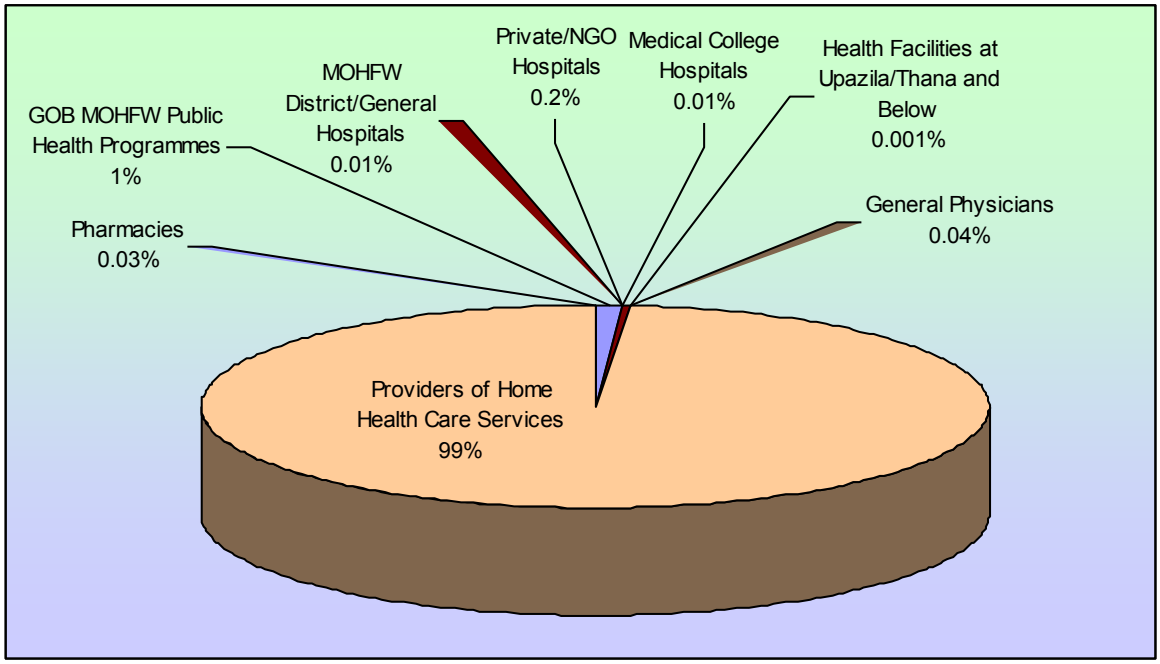
According to Table 4.4, during 2007, the NGO providers of HIV/AIDS services constitute the largest component. NGO service provision primarily covers home healthcare providers which include NGOs day care services such as awareness creation, counselling, etc., provided at facilities or through home visits. This amounts to Taka 932 million ($13.5 million) in 2007 and Taka 640.3 million ($10.4 million) in 2005. In 2007, this accounted for 99 percent of total HIV/AIDS expenditure. Table A2 (Annex I) presents HIV/AIDS expenditure estimates by provider for the years 2000-2007.

Table 3.4: HIV/AIDS Expenditure by Provider (in million Taka)

BNHA Code	Provider	2005	2006	2007
BP2.1	GOB MOHFW Public Health Programmes	483.3	667.9	10.3
BP3.2	Medical College Hospitals	0.0	0.1	0.1
BP3.3.1	MOHFW District/General Hospitals	0.0	0.0	0.1
BP3.3.3	Private/NGO Hospitals	0.9	1.4	2.1
BP3.4	Health Facilities at Upazila/Thana and Below	0.0	0.0	0.01
BP5.1	General Physicians	0.2	0.3	0.4
BP5.8	Providers of Home Health Care Services	640.3	644.7	931.9
BP7.1	Pharmacies	0.1	0.2	0.3
			-	-
	Total Expenditure	**1,124.8**	**1,314.6**	**945.2**

Source: CGA data, NHA3

Figure 3.2: HIV/AIDS Expenditure Share by Provider, 2007



3.4 Functions

Services and activities that are delivered on health related issues are called functions. Examples include curative and preventive care, management of programs, capital formation, research and development relating to the health sector.

Table 3.5 shows that prevention and health awareness creation are the categories where the lion's share of HIV/AIDS expenditure is spent – over 98% during the 2005-2007 period. Of the resources expended on these activities, resource distribution underwent a significant change in 2007: while health awareness creation on HIV/AIDS accounted for 56.5 percent in 2005 and 48.55 percent in 2006, in 2007, this component constituted 97.8 percent of total funds. (A detailed discussion on programmatic expenditures and activities appear in Section IV and Annex III.) Table A3 (Annex I) presents HIV/AIDS expenditure estimates by function for the years spanning 2000-2007.

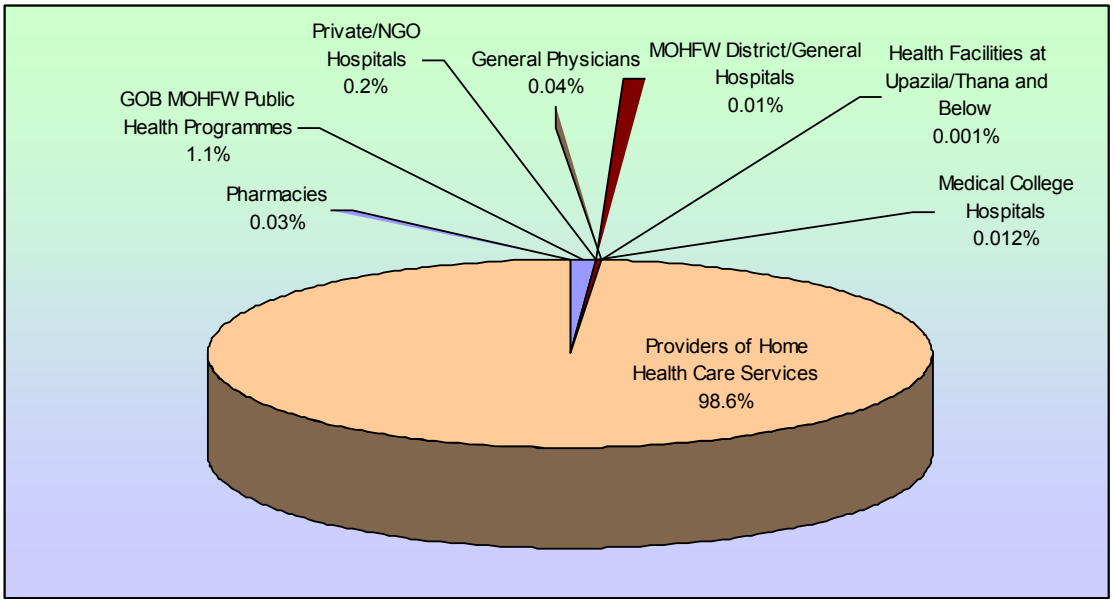
Table 3.5: HIV/AIDS Expenditure by Function (in million Taka and in %)

BNHA Code	Function	2005	2006	2007
BC.1.1.0.1	Inpatient care	0.16 (0.01%)	0.25 (0.02%)	0.37 (0.04%)
BC.1.3.0.1	Outpatient care	0.03 (0.00%)	0.05 (0.00%)	0.08 (0.01%)
BC.1.3.1.1	Provider initiated testing of HIV/AIDS	0.03 (0.00%)	0.04 (0.00%)	0.07 (0.01%)
BC.5.1.1	Medicines	9.06 (0.81%)	1.04 (0.08%)	0.35 (0.04%)
BC.6.3.2	Prevention of HIV/AIDS	470.09 (41.79%)	653.05 (49.68%)	3.19 (0.34%)
BC.6.3.2.1.99	Others / Not-elsewhere classified	0.87 (0.08%)	1.38 (0.10%)	2.08 (0.22%)

BNHA Code	Function	2005	2006	2007
BC.6.9.0	Health Awareness creation of HIV/AIDS	635.46 (56.50%)	638.22 (48.55%)	924.55 (97.82%)
BCR.1	Capital formation	4.26 (0.38%)	14.08 (1.07%)	7.15 (0.76%)
BCR.3.1.4	Social science research	4.82 (0.43%)	6.44 (0.49%)	7.32 (0.77%)
			-	-
Total	**Total**	**1,124.8 (100%)**	**1,314.6 (100%)**	**945.2 (100%)**

Source: CGA data, NHA3

Figure 3.3: HIV/AIDS Expenditure Share by Function, 2007)



3.5 Cross Classification

As discussed in an earlier section, NGOs are the key providers of HIV/AIDS services (primarily preventive) in Bangladesh. Table 3.6 to 3.8 provides a cross classification of expenditures by provider and financing agent for 2005-2007. NGOs rely primarily on foreign development partners (ROW) to implement these activities. They also use their own funds to support such programmes. In 2007, Taka 194.3 million ($2.8 million) accounted for NGOs' own funds and Taka 737.6 million ($10.7 million) from ROW. In percentage terms, NGOs own funds amounted to 20.8 percent and ROW 79.2 percent. In the preceding years, ROW's contributions were 79.5 percent in 2006 and 78.4 percent in 2005. MOHFW's expenditures on HIV/AIDS is channeled primarily through its own programmes.

Table 3.6: HIV/AIDS Expenditure by Provider and Financing Agent, 2007 (in million Taka)

		Financing Agent				
BNHA Code	**Provider**	**Ministry of Health and Family Welfare (MOHFW)**	**Households**	**Non-profit institutions/ NGOs**	**Rest of the World (ROW)**	**Total**
BP2.1	GOB MOHFW Public Health Programmes	10.35	-	-		10.35
BP3.2	Medical College Hospitals	-	0.08	0.03		0.12
BP3.3.1	MOHFW District/ General Hospitals	-	0.02	0.04		0.06
BP3.3.3	Private/NGO Hospitals	-	1.54	0.52		2.06
BP3.4	Health Facilities at Upazila/Thana and Below	-	0.00	0.00		0.01
BP5.1	General Physicians	-	0.30	0.11		0.41
BP5.8	Providers of Home Health Care Services	-	-	194.27	737.60	931.87
BP7.1	Pharmacies	-	0.21	0.09		0.30
			-	-	-	-
	Total	10.3	2.2	195.1	737.6	945.2

Source: CGA data, NHA3

Table 3.7: HIV/AIDS Expenditure by Provider and Financing Agent, 2006 (in million Taka)

		Financing Agent				
BNHA Code	**Provider**	**Ministry of Health and Family Welfare (MOHFW)**	**Households**	**Non-profit institutions/ NGOs**	**Rest of the World (ROW)**	**Total**
BP2.1	GOB MOHFW Public Health Programmes	667.94	-	-		667.94
BP3.2	Medical College Hospitals	-	0.05	0.02		0.08
BP3.3.1	MOHFW District/ General Hospitals	-	0.01	0.02		0.04
BP3.3.3	Private/NGO Hospitals	-	1.02	0.35		1.37
BP3.4	Health Facilities at Upazila/Thana and Below	-	0.00	0.00		0.00
BP5.1	General Physicians	-	0.20	0.07		0.27
BP5.8	Providers of Home Health Care Services	-	-	132.26	512.40	644.66
BP7.1	Pharmacies	-	0.14	0.06		0.20
		-	-	-	-	-
	Total	667.9	1.4	132.8	512.4	1,314.6

Source: CGA data, NHA3

Table 3.8: HIV/AIDS Expenditure by Provider and Financing Agent, 2005 (in million Taka)

		Financing Agent				
BNHA Code	**Provider**	**Ministry of Health and Family Welfare (MOHFW)**	**Households**	**Non-profit institutions/ NGOs**	**Rest of the World (ROW)**	**Total**
BP2.1	GOB MOHFW Public Health Programmes	483.26	-	-	-	483.26
BP3.2	Medical College Hospitals	-	0.03	0.01	-	0.05
BP3.3.1	MOHFW District/ General Hospitals	-	0.01	0.01	-	0.02
BP3.3.3	Private/NGO Hospitals	-	0.65	0.22	-	0.86
BP3.4	Health Facilities at Upazila/Thana and Below	-	0.00	0.00	-	0.00
BP5.1	General Physicians	-	0.12	0.05	-	0.17
BP5.8	Providers of Home Health Care Services	-	-	138.31	501.97	640.28
BP7.1	Pharmacies	-	0.09	0.04	-	0.13
			-	-	-	-
	Total	**483.3**	**0.9**	**138.6**	**502.0**	**1,124.8**

Source: CGA data, NHA3

Tables 3.9 to 3.11 present HIV/AIDS expenditures by function and financing agent for 2005-2007. The major functional activity in 2007 is the awareness creation component – Taka 924.55 million ($13.5 million). Financing agents for this component in 2007 were ROW, accounting for 79 percent of financing while NGOs accounted for the remainder. MOHFW financing for HIV/AIDS in 2007 (Taka 10.3 million) was expended in capital formation (69.4 percent) and prevention of HIV/AIDS (30.9 percent).

In the two preceding years, public sector expenditure on prevention (Taka 653 million in 2006 and Taka 470 million in 2005) constituted total expenditure on this component, while ROW and NGOs financed health awareness creation on HIV/AIDS. In 2006 and 2005, ROW amounted to 79.3 percent and 78.2 percent respectively, while NGOs were 20.6 percent and 21.8 percent.

The function entitled “Others/Not elsewhere classified” comprises the highest share of household expenditure – constituting 58 percent. This function covers cash benefits received by People Living with HIV/AIDS (PLWHA) from NGOs and related Out of Pocket (OOP) travel expenses.

Table 3.9: HIV/AIDS Expenditure by Function and Financing Agent, 2007 (in million Taka)

BNHA Code	Function	Financing Agent				
		MOHFW	Households	Non-profit institutions/ NGOs	ROW	Total
BC.1.1.0.1	Inpatient care	-	0.37	-		0.37
BC.1.3.0.1	Outpatient care	-	0.08	-		0.08
BC.1.3.1.1	Provider initiated testing of HIV/AIDS	-	0.07	-		0.07
BC.5.1.1	Medicines	-	0.35	-		0.35
BC.6.3.2	Prevention of HIV/AIDS	3.19	-	-		3.19
BC.6.9.0	Health Awareness creation of HIV/AIDS	-	-	193.95	730.60	924.55
BC.6.3.2.1.99	Others / Not-elsewhere classified	-	1.28	0.80		2.08
BCR.1	Capital formation	7.15	-	-		7.15
BCR.3.1.4	Social science research	-	-	0.32	7.00	7.32
	Total	**10.3**	**2.2**	**195.1**	**737.6**	**945.2**

Source: CGA data, NHA3

Table 3.10: HIV/AIDS Expenditure by Function and Financing Agent, 2006 (in million Taka)

BNHA Code	Function	Financing Agent				
		MOHFW	Households	Non-profit institutions/ NGOs	ROW	Total
BC.1.1.0.1	Inpatient care	-	0.25	-		0.25
BC.1.3.0.1	Outpatient care	-	0.05	-		0.05
BC.1.3.1.1	Provider initiated testing of HIV/AIDS	-	0.04	-		0.04
BC.5.1.1	Medicines	0.81	0.23	-		1.04
BC.6.3.2	Prevention of HIV/AIDS	653.05	-	-		653.05
BC.6.9.0	Health Awareness creation of HIV/AIDS	-	-	131.92	506.30	638.22
BC.6.3.2.1.99	Others / Not-elsewhere classified	-	0.85	0.53		1.38
BCR.1	Capital formation	14.08	-	-		14.08
BCR.3.1.4	Social science research	-	-	0.34	6.10	6.44
	Total	**667.9**	**1.4**	**132.8**	**512.4**	**1,314.6**

Source: CGA data, NHA3

Table 3.11: HIV/AIDS Expenditure by Function and Financing Agent, 2005 (in million Taka)

BNHA Code	Function	Financing Agent				
		MOHFW	Households	Non-profit institutions/ NGOs	ROW	Total
BC.1.1.0.1	Inpatient care	-	0.16	-	-	0.16
BC.1.3.0.1	Outpatient care	-	0.03	-	-	0.03
BC.1.3.1.1	Provider initiated testing of HIV/AIDS	-	0.03	-	-	0.03
BC.5.1.1	Medicines	8.91	0.15	-	-	9.06
BC.6.3.2	Prevention of HIV/AIDS	470.09	-	-	-	470.09
BC.6.9.0	Health Awareness creation of HIV/AIDS	-	-	138.06	497.40	635.46
BC.6.3.2.1.99	Others / Not-elsewhere classified	-	0.54	0.33	-	0.87
BCR.1	Capital formation	4.26	-	-	-	4.26
BCR.3.1.4	Social science research	-	-	0.25	4.57	4.82
Total		483.3	0.9	138.6	502.0	1,124.8

Source: CGA data, NHA3

Tables 3.12 to 3.14 provides a cross classification of HIV/AIDS expenditures by provider and function for 2007, 2006 and 2005. Although the prevention and health awareness creation components are by far the largest, the MOHFW expenditure under this category does not utilize district and below level health facilities.

As discussed earlier, the public expenditure on the prevention component of HIV/AIDS took a considerable dip in 2007 – from Taka 653 million ($9.7 million) in 2006 and Taka 470 million ($6.8 million) in 2005 to a mere Taka 3.19 million ($0.05 million) in 2007. In 2005 and 2006, the MOHFW provided medicines comprising Taka 0.81 million and Taka 8.91 million respectively, while no such outlay from the ministry occurred in 2007.

Table 3.12: HIV/AIDS Expenditure by Provider and Function, 2007 (in million Taka)

BNHA Code	Provider	Function									
		Inpatient care	Outpatient care	Provider initiated testing of HIV/AIDS	Medicines	Prevention of HIV/AIDS	Health Awareness creation of HIV/AIDS	Others / Not-elsewhere classified	Capital formation	Social science research	Total
BP2.1	GOB MOHFW Public Health Programmes	-	-	-	-	3.19	-	-	7.15	-	10.35
BP3.2	Medical College Hospitals	0.08	-	-	-	-	-	0.03		-	0.12
BP3.3.1	MOHFW District/General Hospitals	0.02	-	-	-	-	-	0.04		-	0.06
BP3.3.3	Private/NGO Hospitals	0.14	0.06	0.04	0.16	-	-	1.66		-	2.06
BP3.4	Health Facilities at Upazila/Thana and Below	0.00	-	-	-	-	-	0.00		-	0.01
BP5.1	General Physicians	0.13	0.02	0.02	0.01	-	-	0.23		-	0.41
BP5.8	Providers of Home Health Care Services	-	-	-	-	-	924.55	-		7.32	931.87
BP7.1	Pharmacies	-	0.00	0.00	0.18	-	-	0.11		-	0.30
Total		0.4	0.1	0.1	0.3	3.2	924.5	2.1	7.2	7.3	945.2

Source: CGA data, NHA3

Table 3.13: HIV/AIDS Expenditure by Provider and Function, 2006 (in million Taka)

BNHA Code	Provider	Function									
		Inpatient care	Outpatient care	Provider initiated testing of HIV/AIDS	Medicines	Prevention of HIV/AIDS	Health Awareness creation of HIV/AIDS	Others / Not-elsewhere classified	Capital formation	Social science research	Total
BP2.1	GOB MOHFW Public Health Programmes	-	-	-	0.81	653.05	-	-	14.08	-	667.94
BP3.2	Medical College Hospitals	0.05	-	-	-	-	-	0.02		-	0.08
BP3.3.1	MOHFW District/General Hospitals	0.01	-	-	-	-	-	0.02		-	0.04
BP3.3.3	Private/NGO Hospitals	0.09	0.04	0.03	0.11	-	-	1.10		-	1.37
BP3.4	Health Facilities at Upazila/Thana and Below	0.00	-	-	-	-	-	0.00		-	0.00
BP5.1	General Physicians	0.09	0.01	0.01	0.00	-	-	0.15		-	0.27
BP5.8	Providers of Home Health Care Services	-	-	-	-	-	638.22	-		6.44	644.66
BP7.1	Pharmacies	-	0.00	0.00	0.12	-	-	0.08		-	0.20
			-	-	-	-	-	-	-	-	-
Total		0.2	0.1	0.04	1.0	653.0	638.2	1.4	14.1	6.4	1,314.6

Source: CGA data, NHA3

Table 3.14: HIV/AIDS Expenditure by Provider and Function, 2005 (in million Taka)

BNHA Code	Provider	Function									
		Inpatient care	**Outpatient care**	**Provider initiated testing of HIV/AIDS**	**Medicines**	**Prevention of HIV/AIDS**	**Health Awareness creation of HIV/AIDS**	**Others / Not-elsewhere classified**	**Capital formation**	**Social science research**	**Total**
BP2.1	GOB MOHFW Public Health Programmes	-	-	-	8.91	470.09	-	-	4.26	-	483.26
BP3.2	Medical College Hospitals	0.03	-	-	-	-	-	0.01		-	0.05
BP3.3.1	MOHFW District/General Hospitals	0.01	-	-	-	-	-	0.01		-	0.02
BP3.3.3	Private/NGO Hospitals	0.06	0.02	0.02	0.07	-	-	0.70		-	0.86
BP3.4	Health Facilities at Upazila/Thana and Below	0.00	-	-	-	-	-	0.00		-	0.00
BP5.1	General Physicians	0.06	0.01	0.01	0.00	-	-	0.09		-	0.17
BP5.8	Providers of Home Health Care Services	-	-	-	-	-	635.46	-		4.82	640.28
BP7.1	Pharmacies	-	0.00	0.00	0.08	-	-	0.05		-	0.13
			-	-	-	-	-	-	-	-	-
	Total	**0.2**	**0.03**	**0.03**	**9.1**	**470.1**	**635.5**	**0.9**	**4.3**	**4.8**	**1,124.8**

Source: CGA data, NHA3

3.6 Household Out of Pocket (OOP) Expenditure[2]

Total OOP for 2007 was Taka 2.95 million, while OOP expenditures were Taka 1.96 million and Taka 1.24 million for the two preceding years (Tables 3.15-3.17). In all three years, households spent the highest amount in NGO hospitals; constituting almost 70 percent of total OOP in 2007.

Table 3.15: HIV/AIDS Patient Out of Pocket Expenditure, 2007 (in million Taka)

BNHA Code	Provider	Function					
		Inpatient care	Outpatient care	Provider initiated testing of HIV/AIDS	Medicines	Others / Not-elsewhere classified	Total
BP3.2	Medical College Hospitals	0.08				0.03	0.12
BP3.3.1	MOHFW District/General Hospitals	0.02				0.04	0.06
BP3.3.3	Private/NGO Hospitals	0.14	0.06	0.04	0.16	1.66	2.06
BP3.4	Health Facilities at Upazila /Thana and Below	0.00				0.00	0.01
BP5.1	General Physicians	0.13	0.02	0.02	0.01	0.23	0.41
BP7.1	Pharmacies		0.00	0.00	0.18	0.11	0.30
							-
	Total	**0.37**	**0.08**	**0.07**	**0.35**	**2.08**	**2.95**

Source: Rannan-Eliya et al., 2008

Table 3.16: HIV/AIDS Patient Out of Pocket Expenditure, 2006 (in million Taka)

BNHA Code	Provider	Function					
		Inpatient care	Outpatient care	Provider initiated testing of HIV/AIDS	Medicines	Others / Not-elsewhere classified	Total
BP3.2	Medical College Hospitals	0.05				0.02	0.08
BP3.3.1	MOHFW District/ General Hospitals	0.01				0.02	0.04
BP3.3.3	Private/NGO Hospitals	0.09	0.04	0.03	0.11	1.10	1.37
BP3.4	Health Facilities at Upazila /Thana and Below	0.00				0.00	0.00
BP5.1	General Physicians	0.09	0.01	0.01	0.00	0.15	0.27
BP7.1	Pharmacies		0.00	0.00	0.12	0.08	0.20
							-
	Total	**0.25**	**0.05**	**0.04**	**0.23**	**1.38**	**1.96**

Source: Rannan-Eliya et al., 2008

[2] Estimates for household Out of Pocket (OOP) expenditures have been drawn from Rannan-Eliya et al., 2008.

Table 3.17: HIV/AIDS Patient Out of Pocket Expenditure, 2005 (in million Taka)

BNHA Code	Provider	Function					
		Inpatient care	Outpatient care	Provider initiated testing of HIV/AIDS	Medicines	Others / Not-elsewhere classified	Total
BP3.2	Medical College Hospitals	0.03	-	-	-	0.01	0.03
BP3.3.1	MOHFW District/ General Hospitals	0.01	-	-	-	0.01	0.01
BP3.3.3	Private/NGO Hospitals	0.06	0.02	0.02	0.07	0.70	0.06
BP3.4	Health Facilities at Upazila /Thana and Below	0.00	-	-	-	0.00	0.00
BP5.1	General Physicians	0.06	0.01	0.01	0.00	0.09	0.06
BP7.1	Pharmacies	-	0.00	0.00	0.08	0.05	-
			-	-	-	-	
	Total	**0.16**	**0.03**	**0.03**	**0.15**	**0.87**	**0.16**

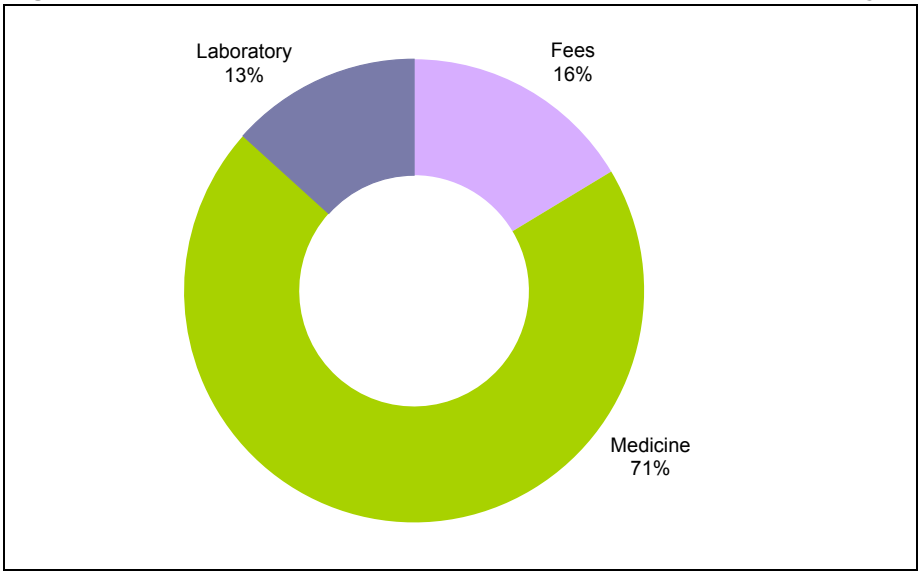
Source: Rannan-Eliya et al., 2008

For outpatient care, PLWHA reported a per capita rate of 10.1 visits annually to NGO providers. Non-NGO outpatient providers constituted 5.6 more visits per capita annually – non-NGO providers were almost universally qualified, modern providers in the private sector. For inpatient care, public providers accounted for the most care – 32 percent of inpatient admissions occurring in medical college hospitals and 39 percent in upper tier government hospitals.

Per capita outpatient expenditure on HIV/AIDS is Taka 1,977 and inpatient per capita expenditure is Taka 1,717 (in 2007-08), significantly higher than the national per capita expenditures on these health functions at Taka 156 and Taka 160 (according to the latest National Health Accounts (NHA3)). PLWHA OOP is higher than the estimated per capita expenditure on health by Bangladeshis (Taka 1,111, NHA3). Unlike the GTZ study, estimates for the Bangladesh per household health expenditures are not inclusive of the transportation costs.

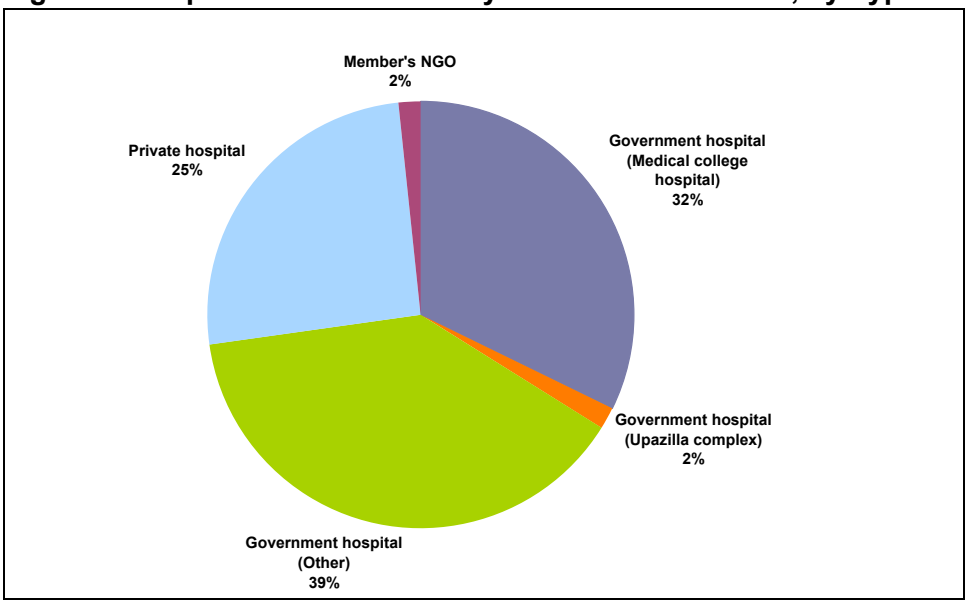
For household outpatient costs, related travel expenses account for the highest share – almost twice the amount required for medical costs (Taka 4,408 versus Taka 1,977 respectively). Among medical expenses, two thirds were expended on purchasing drugs. Medical fees accounted for the bulk of inpatient expenditure (Taka 1,032) at both public and private hospitals.

Figure 3.4: Composition of Outpatient Medical Expenditures by PLWHA



Source: Rannan-Eliya et al., 2008

Figure 3.5: Inpatient Admissions by PLWHA in Past Year, by Type Provider



Source: Rannan-Eliya et al., 2008

About 41 percent of the PLWHA under the study were being administered Antiretroviral Therapy (ART). The vast majority of those undergoing ART (96 percent) were being provided with free services. The four respondents who reported accessing paid ART belonged to the highest wealth quintile. Of these PLWHA, monthly ART expenditures average Taka 2,862, with a minimum of Taka 1,850 and a maximum of Taka 3,000. All the ART discontinuations reported by the PLWHA studied were cases receiving free treatment and were related to supply constraints.

3.7 HIV/AIDS Expenditure and NASA Indicators

UNAIDS has developed highly detailed and disaggregated programming activities (functions) related to HIV/AIDS prevention, care and treatment, called NASA indicators, that are globally comparable. A preceding subsection (1.3) provides a discussion on the NASA approach and lists the eight indicators. Under this assignment, effort has been expended to estimate HIV/AIDS related expenditures for the eight NASA categories.

Table 3.18 and Figure 3.6 presents the findings on Bangladesh HIV/AIDS outlays according to the major NASA indicators. Most of the HIV/AIDS related funds in Bangladesh are aimed at prevention and awareness creation related activities. In 2007, Taka 927.8 million ($13.4 million) was spent on prevention strategies, which is around 98% of the total HIV/AIDS expenditure. Taka 7.15 million was spent on program management and administration, while Taka 0.87 million (emanating solely from households) was disbursed on care and treatment. Unlike the sub-Saharan African countries the amount spent on care and treatment is small – Taka 0.87 million which is 0.1 percent of the total HIV/AIDS expenditure.

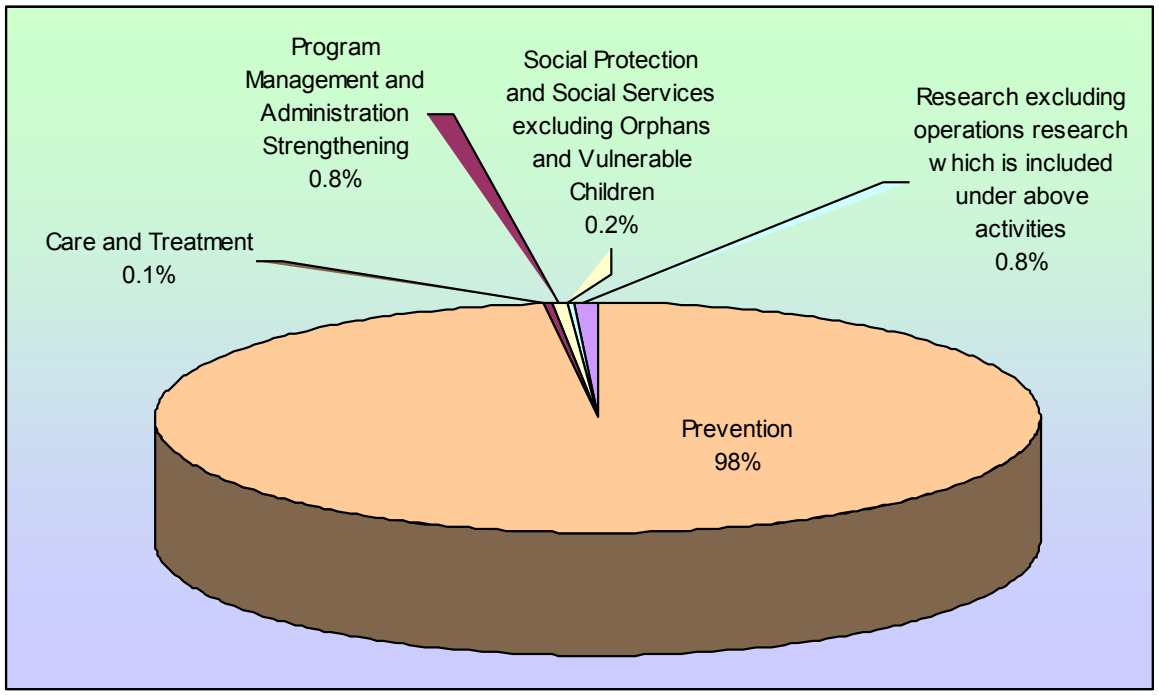
Almost all of the resources expended by the foreign development partners (termed ROW) and NGOs go to prevention activities. The component entitled Social Protection and Social Services excluding Orphans and Vulnerable Children received some resources, albeit a quite small amount, from NGOs while research received some financing from NGOs and ROW. About 70 percent of MOHFW's expenditure went to Program Management and Administration Strengthening, while the rest was expended in prevention activities.

Table 3.18: HIV /AIDS Expenditure by NASA Indicators, 2007, (in million Taka)

NASA Indicators (Functions)	Financing Agent				Total	%
	MOHFW	Households	Non-profit institutions /NGOs	Rest of the World (ROW)		
Prevention	3.19	-	193.95	730.60	927.74	98.2
Care and Treatment	-	0.87	-	-	0.87	0.1
Orphans and Vulnerable Children					-	0.0
Program Management and Administration Strengthening	7.15	-	-		7.15	0.8
Incentives for Human Resources					-	0.0
Social Protection and Social Services excluding Orphans and Vulnerable Children	-	1.28	0.80	-	2.08	0.2
Enabling Environment and Community Development					-	0.0
Research excluding operations research which is included under above activities	-	-	0.32	7.00	7.32	0.8
Total	**10.3**	**2.2**	**195.1**	**737.6**	**945.2**	100.0
Percent share	1.1	0.2	21	78	100	

Source: NHA3

Figure 3.6: Percentage HIV/AIDS Expenditure by NASA Indicators, 2007



IV. HIV/AIDS Expenditure by Major Programs

Broadly speaking, Bangladesh's HIV/AIDS prevention and treatment activities are being supported by three major multi-year programs. These are: HAPP, BAP and GFATM. GFATM channels most of its resources through the Project on Prevention of HIV/AIDS among Youth and Adolescents in Bangladesh. In addition, the government, several development partners, international and national NGOs are implementing their respective programs. Table 4.1 presents the summary of expenditure of each of the programs for 2005 to 2007.

GFATM is the largest program accounting for almost Taka 316 million in 2007, which is close to one-third of the total outlay on HIV/AIDS related expenditure. GFATM is closely followed by HAPP, with Taka 313.3 million expended in 2007.

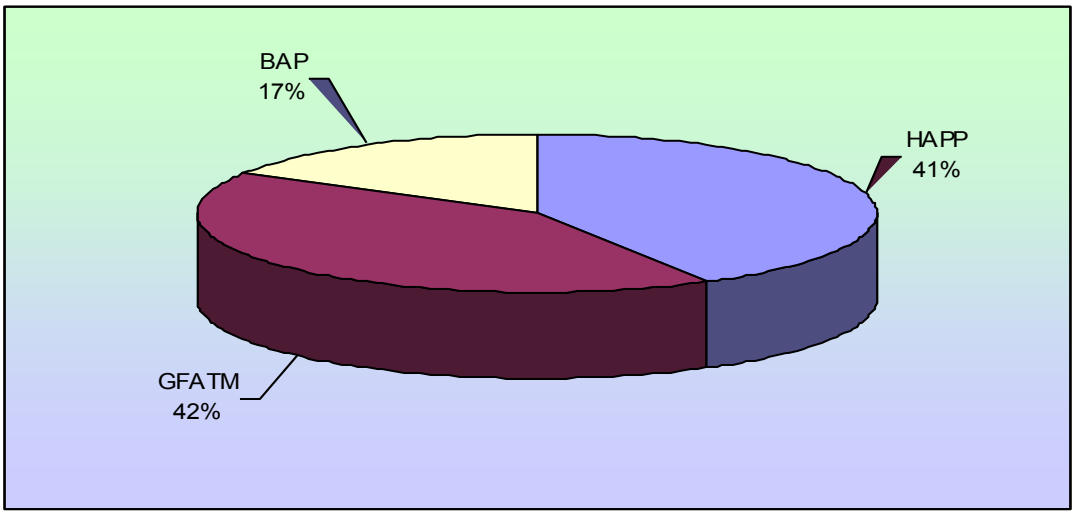
Table 4.1: HIV/AIDS Expenditure by Major Programs (in million Taka)

Program	2005	2006	2007
HAPP	403	702	313
GFATM	216	204	316
BAP	0	125	125
Total	**618.6**	**1029.9**	**754**

Note: HAPP: $26.23 million over multiple years; IDA Credit $19.22 million; DFID grant $6.38 million, GOB $0.63 million

HAPP and GFATM's share in terms of total HIV/AIDS expenditure is similar (41% and 42% respectively), and the two collectively make up for over four-fifths of the aggregate outlay (Figure 4.1). BAP, principally supported by USAID, make up for 17% of the expenditure.

Figure 4.1: Distribution of Annualized Expenditure by HIV/AIDS Programs, 2007



The programs for preventing HIV/AIDS being currently implemented in Bangladesh, with funding from GOB and Development Partners (DP): (a) HIV/AIDS Prevention Project (HAPP); (b) Project on Prevention of HIV/AIDS among Youth and Adolescents in Bangladesh; and (c) Bangladesh AIDS Programme (BAP). These programs are briefly described in the following sub-sections (a more detailed description is provided in Annex III).

4.1 HIV/AIDS Prevention Project (HAPP)

The HIV/AIDS Prevention Project (HAPP) is a $26.23 million project, financed by IDA Credit ($19.22 million), DFID grant ($6.38 million) and GOB ($0.63 million). The government agency responsible for the project is the National AIDS/STD Programme (NASP). UNICEF manages the project on behalf of the government. The project is implemented by 37 NGOs grouped in 12 consortia.

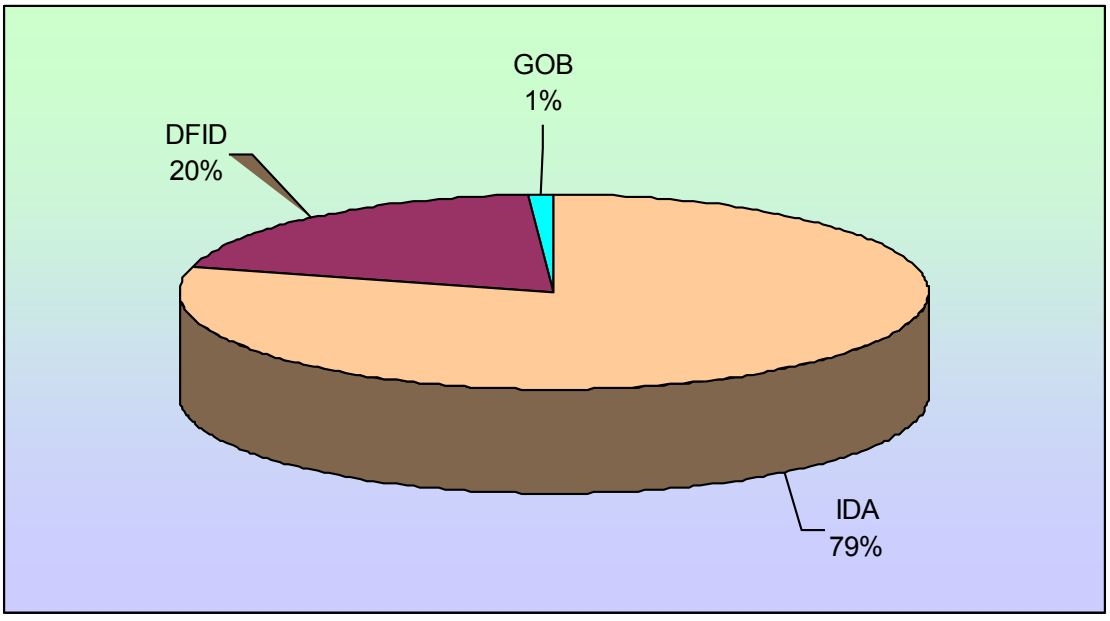
As has been mentioned, the chief funding source for HAPP is the IDA, followed by DFID and GOB. In 2006-07, the "pool fund" also provided some financial support ($147,000) to HAPP. Total expenditure of HAPP in 2007 is Taka 313.3 million, of which about 79 percent is sourced from IDA (Table 4.2, Figure 4.2).

Table 4.2: HAPP Expenditure: Annualized Sources of Funding (in million Taka)

Source of funding	2005	2006	2007
IDA	316.8	511.0	247.8
DFID	79.2	127.7	61.9
GOB	6.6	63.1	3.5
Total	**402.6**	**701.8**	**313.3**

Source: Survey of development partners 2008

Figure 4.2: Distribution of Annualized HAPP Expenditure by Source, 2007



Funds for NGO activities under HAPP are channeled through UNICEF, which disburses money to the lead agencies according to the terms of contracts it has with them. The lead agencies, in turn, disburse money to their partner agencies and local implementing agencies in accordance with the terms of their MOUs. The NGOs implementing HAPP provide 6 packages for various categories of vulnerable people.

The goal of HAPP is "to control the spread of HIV infection within high-risk groups and to limit its spread to the general population, without discriminating and stigmatising the high-risk groups." In keeping with project objectives, direct interventions with high-risk groups are

where most of the funding goes – Taka 235.9 million from a total of Taka 313.3 million in 2007. Although communication and advocacy is an important component in any HIV/AIDS related program, HAPP expenditures for 2007 do not include this component.

Table 4.3a: HAPP Expenditure by Component, 2005 to 2007 (in million Taka)

Components	2005	2006	2007
High-risk group interventions	213.0	284.8	235.9
Communication and advocacy	82.5	100.5	-
Blood safety	22.6	189.1	49.4
Project support and institutional strengthening	84.6	127.4	27.9
Total	**402.6**	**701.8**	**313.3**

Source: Survey of development partners 2008

Table 4.3b: HAPP Expenditure by Source and Function, 2005 (in million Taka)

Source of funding	Function				Total
	High-risk group interventions	Communication and advocacy	Blood safety	Project support and institutional strengthening	
IDA	168	65	18	67	317
DFID	42	16	4	17	79
GOB	4	1	0	1	7
Total	**213**	**82**	**23**	**85**	**403**

Source: Survey of development partners 2008

Table 4.3c: HAPP Expenditure by Source and Function, 2006 (in million Taka)

Source of funding	Function				Total
	High-risk group interventions	Communication and advocacy	Blood safety	Project support and institutional strengthening	
IDA	207	73	138	93	511
DFID	52	18	34	23	128
GOB	26	9	17	11	63
Total	**285**	**100**	**189**	**127**	**702**

Source: Survey of development partners 2008

Table 4.3d: HAPP Expenditure by Source and Function, 2007 (in million Taka)

Source of funding	Function				Total
	High-risk group interventions	Communication and advocacy	Blood safety	Project support and institutional strengthening	
IDA	187.3	-	39.4	21.1	247.8
DFID	46.0	-	9.5	6.5	61.9
GOB	2.6	-	0.5	0.4	3.5
Total	**235.9**	**-**	**49.4**	**27.9**	**313.3**

Source: Survey of development partners 2008

4.2 Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) may be described as "an independent, public private partnership mechanism". GFATM is providing support to GOB efforts aimed at prevention, control and care of HIV/AIDS among selective populations, i.e. high risk groups and young people.

The "Project on Prevention of HIV/AIDS among Youth and Adolescents in Bangladesh" is a $720 million five-year project funded by GFATM. Begun in March 2004, the goal of this project is "to prevent HIV infections in young people aged 10-24, and thereby to help avert a generalised HIV epidemic in Bangladesh." The target age group constitutes almost a third of the country's population and numbers about 38 million. In addition, policy makers, parents, teachers and religious leaders are targeted to create an enabling environment. The general population is also covered by the project.

The key players of this project are: (a) the Ministry of Health and Family Welfare (MOHFW), which is the Principal Recipient, and NASP; (b) Save the Children-USA, which is the Management Agency; and (c) implementing partners (NGOs, community-based organisations private sector organisations, and professional bodies), which are the Sub-Recipients. Funds from GFATM are disbursed to the implementing partners through Save the Children-USA. The project is implemented by 5 lead agencies and 12 associate organisations representing NGOs, the private sector and research institutions.

4.3 Bangladesh AIDS Project (BAP)

Initiated in October 2005, the Bangladesh AIDS Project (BAP) is a USAID-funded project. BAP has 3 partner agencies and 34 implementing agencies. BAP was designed to contribute to USAID's overall goal of reducing the transmission of HIV amongst most-at-risk groups and mitigate the impact on HIV/AIDS-infected and affected people. The four main target groups are: (a) male and female sex workers and transgenders; (b) injecting drug users; (c) people living with HIV/AIDS; and (d) clients of sex workers.

While USAID is the main source of funding for BAP, Family Health International (FHI) acts as a financing mechanism. FHI disburses resources to its partner and implementing agencies in keeping with the terms of their agreements. USAID expended Taka 124.6 million under BAP in 2006, with the marginal increase to Taka 124.8 million in 2007.

V. Conclusions and Implications

Bangladesh has conducted two rounds of National Health Accounts (NHA) to date. Under the third round (NHA3) it adds another dimension to the usual round of activities by developing an HIV/AIDS Health Accounts for 2004-2005 to 2006-2007. The HIV/AIDS subaccounts have been created within the context of NHA. This report presents the findings on HIV/AIDS related expenditures in Bangladesh.

The HIV/AIDS subaccounts aimed to present its estimates in accordance with the BNHA framework. However, some effort was also expended in an attempt to disaggregate expenditures based on the NASA boundaries. Further effort and resources are warranted to present comprehensive estimations in accordance with the NASA classifications.

The report presents programmatic expenditures by major programmes in operation (i.e. HAPP, GFATM, BAP). While NHA estimations were actual expenditures, the data for the programmes were drawn from budgeted allocations. In a few instances, programmes provided expenditure data for the whole project period; attempts were made to allocate expenditure to various programme components by review of project documents and interviews with relevant personnel.

In Bangladesh, HIV/AIDS related expenditure is a recent phenomenon and constitutes a very small share of the total health expenditure in Bangladesh – less than one percent. HIV/AIDS expenditures consist of activities on awareness creation, prevention and treatment. Of the funds that are channelled toward HIV/AIDS programming, most of it is expended primarily for awareness creation and prevention. Outlay for treatment comprises a small segment of total HIV/AIDS expenditure. As Bangladesh remains a country with low prevalence rates of HIV/AIDS, out of pocket expenditures incurred by households is low.

The multilateral and bilateral donors are the key funding agencies for HIV/AIDS expenditures. However, the key implementing agencies remain the NGOs, both local and international. NGO funding for these activities/programmes emanate from both the donors and the government.

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Annexure

Annex I: Additional Tables

Table A1: HIV/AIDS Expenditure by Financing Agent (in million Taka)

Funding Agent	2000	2001	2002	2003	2004	2005	2006	2007
Public Sector	1.2	0.6	47.9	115.1	23.1	483.3	667.9	10.3
Private Sector	**5.7**	**4.7**	**5.7**	**56.3**	**106.8**	**139.5**	**134.2**	**197.3**
Households	-	-	-	0.7	1.4	0.9	1.4	2.2
Non-profit institutions/NGOs	5.7	4.7	5.7	55.6	105.4	138.6	132.8	195.1
Rest of the World (ROW)	**78.7**	**110.9**	**119.8**	**227.8**	**335.9**	**502.0**	**512.4**	**737.6**
Total Expenditure	**85.6**	**116.2**	**173.4**	**399.2**	**465.9**	**1124.8**	**1314.6**	**945.2**

Table A2: HIV/AIDS Expenditure by Provider (in million Taka)

Provider	2000	2001	2002	2003	2004	2005	2006	2007
GOB, MOHFW Public Health Programmes	1.2	0.6	5	115.1	22.7	483.3	667.9	10.3
Medical college hospitals						0.0	0.1	0.1
District/General hospitals						0.0	0.0	0.1
Private/NGO Hospitals						0.9	1.4	2.1
Health Facilities at Upazila/ Thana and Below						0.0	0.0	0.0
General Physicians						0.2	0.3	0.4
Providers of HIV/AIDS Services	84.4	115.6	168.4	284.1	443.2	640.3	644.7	931.9
Pharmacies						0.1	0.2	0.3
Total Expenditure	85.6	116.2	173.4	399.2	465.9	1,124.8	1,314.6	945.2
Total Expenditure (US$ in million)	1.7	2.2	3	6.9	7.9	18.3	19.6	13.7

Table A3: HIV/AIDS Expenditure by Function (in million Taka)

Function	2000	2001	2002	2003	2004	2005	2006	2007
Inpatient care						0.16	0.25	0.37
Outpatient care						0.03	0.05	0.08
Provider initiated testing of HIV/AIDS						0.03	0.04	0.07
Medicines				0.1	9.5	9.06	1.04	0.35
Prevention of HIV/AIDS	1.2	0.5	47.7	105	13	470.09	653.05	3.19
Health Awareness creation of HIV/AIDS	84.4	115.6	125.5	284.1	442.7	635.46	638.22	924.55
Others / Not-elsewhere classified						0.87	1.38	2.08
Capital formation	0	0.1	0.2	10	0.6	4.26	14.08	7.15
Social science research						4.82	6.44	7.32
Total Expenditure	**85.6**	**116.2**	**173.4**	**399.2**	**465.9**	**1,124.8**	**1,314.6**	**945.2**

Annex II: Data Collection Methodology

The methodology used for conducting this part of the study consists of the following:

- Documents review
- Survey of government agencies, development partners[3] (DP), and non-governmental organisations (NGO) involved in major HIV/AIDS prevention programs
- Calculation of expenditure incurred on such programs.

As part of the NHA3 endeavour, health related expenditure data in general and HIV/AIDS expenditure in particular have been collated through adopting the three processes highlighted above.

2.1 Documents Review

In order to get a clear picture of the HIV/AIDS prevention programs in Bangladesh, the Study Team reviewed a number of documents relating to these. These include: (a) project appraisal documents of GOB and funding agencies such as the World Bank; (b) project proposals, work plans, reports and financial records of NGOs implementing these programmes; and (c) relevant documents prepared by organisations that manage these programmes on behalf of GOB and development partners (DP).

2.2 Survey of Relevant Organisations

In order to obtain data on HIV/AIDS expenditure in Bangladesh, the Study Team conducted a survey of the following types of organisations:

- Development partners providing funds and/or technical assistance to HIV/AIDS programmes
- National AIDS and STD Programme (NASP) – the government agency responsible for HIV/AIDS programs
- International NGOs channelling funds and/or providing technical assistance to HIV/AIDS programs
- National NGOs implementing various HIV/AIDS programs

2.3 GOB Data

The Government of Bangladesh (GOB) HIV/AIDS expenditure data has been obtained from the computerized database maintained by the Controller General of Accounts (CGA), Ministry of Finance (MOF). Termed "CGA data" henceforth, the database provided to the research team covers the period of 1998-2007. The data itemizes government annual expenditure by program. The source of funding for GOB is broadly classified as revenue budget and development budget. Whilst the revenue budget typically covers recurring expenditures such as salaries, rents and other fixed costs, the development budget supports investment projects as well as those with a fixed-term of activities. Donors often limit their contributions to the government's development budget. The CGA database, however, does

[3] For the purposes of this report, the terms Development Partner and Donor/ Donor Agency are used synonymously.

not provide a breakdown of outlays by the two components – revenue and development. It should be noted that the CGA data reports *actual* expenditure of GOB in a given period of time, as opposed to funds that have been allocated or earmarked.

The Health, Nutrition and Population Sector Programme (HNPSP) 2003-2010 is the overarching program through which all health related activities of the government are implemented. In the health sector of Bangladesh, the donors have the option to finance activities through GOB as well as through NGOs or the private sector. Donors also spend directly on some activities (e.g. technical assistance/consultancy on feasibility studies). The overwhelming presence of donors in the HIV/AIDS programmes in Bangladesh warranted a questionnaire-based survey that was carried out under NHA. Effort was expended to cover all bilateral and multilateral agencies.

2.4 NGO Survey

Similar to donors, a sample of NGOs, international and local, involved in the HIV/AIDS sector were also interviewed under NHA. Table 3.1 presents the distribution of NGOs surveyed by division. Of the 235 NGOs involved in HIV/AIDS programming, 82 NGOs were covered under NHA3. Almost all the major districts (cities and towns) were covered under the various surveys conducted for NHA3; thus, NGOs located in these sites were approached for expenditure information. The NGO visits aimed mainly at cross-checking the data obtained from the funding agencies.

Table 2.1: Divisional Distribution of NGOs Covered

Division	Sampled	Listing
Barisal	19	27
Chittagong	12	20
Dhaka	21	122
Khulna	7	38
Rajshahi	22	22
Sylhet	1	6
Grand Total	82	235

Source: NHA3, Members Directory 2006, STI/AIDS Network of Bangladesh

Multiple approaches were pursued to obtain information from NGOs. A listing of NGOs working on HIV/AIDS was obtained from the Member's Directory 2006 of the STI/AIDS Network of Bangladesh. In addition, the listing of NGOs implementing programs under various packages was obtained from the financing agents, funding sources or implementing agencies. For instance Family Health International (FHI) identified the NGOs involved under BAP while the National AIDS/STD Programme (NASP) shared the names of NGOs associated with the HIV/AIDS Prevention Project (HAPP).

2.5 People Living with HIV/AIDS (PLWHA) Survey Data

GTZ, in collaboration with other development partners, provides counselling and treatment to high-risk populations and their families under a project, People Living with HIV/AIDS (PLWHA). Under this activity, mean annual medical care expenditures made by these patients and their families have been obtained. This database was made available to the research team for private sector expenditure data on HIV/AIDS.

The GTZ study found that the average annual expenditures for PLWHAs (Taka 3,694 per capita (US$55)) were substantially higher than OOP for the general population – "four to five times the average level of out-of-pocket spending in the population as a whole, showing that the PLWHA population suffer a significant financial burden as a result of the need to obtain medical treatment" (Ref: Rannan-Eliya, et al. 2008, pg. 42). Annual per capita expenditure for outpatient care (Taka 1,977), accessed by 53% of the PLWHA population was higher than for inpatient care (Taka 1,717), which was accessed by 47%.

About 70% of per capita outpatient expenditure is spent on purchasing drugs, which comes to Taka 1,390 per capita, the largest component in outpatient costs. The next two items were medical fees at Taka 322 and laboratory charges at Taka 265. Travel costs for outpatient medical care came to a significant Taka 4,408 for outpatients.

Medical and hospital fees constitute the principal expenditure with inpatient treatment. About 60% (Taka 1,032) of per capita inpatient expenditure was spent on this item. From the remainder, 23% was spent on drugs and 17% on laboratory tests.

Outpatient expenditures were mostly incurred through private sector providers (private physicians and drug outlets); in the case of inpatient spending, however, expenditures made for admission to public facilities and to private facilities were almost evenly split. Average cost per admission is higher at the private hospitals.

2.6 Limitations of the Data

NGO coverage was limited by non-response from a number of NGOs approached. In addition, under NHA3, several of the smaller district towns were not covered; hence, NGOs located at these sites were not approached.

Annex III: Major HIV/AIDS Programs

The following programs for preventing HIV/AIDS are being currently implemented in Bangladesh, with funding from GOB and Development Partners (DP): (a) HIV/AIDS Prevention Project (HAPP); (b) Project on Prevention of HIV/AIDS among Youth and Adolescents in Bangladesh; and (c) Bangladesh AIDS Programme (BAP). These programs are briefly described in the following sections.

HIV/AIDS Prevention Project (HAPP)

Background

The "HIV/AIDS Prevention Project" (HAPP) is a $26.23 million project, financed by IDA Credit ($19.22 million), DFID grant ($6.38 million) and GOB ($0.63 million). The government agency responsible for the project is the National AIDS/STD Programme (NASP). UNICEF manages the project on behalf of the government. The project is implemented by 37 NGOs grouped in 12 consortia.

Sources of Funding

As has been mentioned, the chief funding source for HAPP is the IDA, followed by DFID and GOB. In 2006-07, the "pool fund" has also provided some financial support ($147,000) to HAPP. Total expenditure of HAPP in 2007 is Taka 313.3 million, of which about 79 percent is sourced from IDA.

Provider

UNICEF has a contract with GOB for: (a) facilitating the procurement of 6 NGO packages (Procurement of NGO Services – PNS); (b) managing and implementing the HIV/AIDS Intervention Fund (HAIF) by contracting different organisations; and (c) implementing a large part of the second component of the project (Communication and Advocacy).

For project implementation, UNICEF has entered into contracts with the lead agencies of the NGO consortia, under which their scopes of work have been spelled out. The partner agencies and local implementing agencies of each consortium have a memorandum of understanding (MOU) with their lead agency describing their terms of reference.

Funds for NGO activities under HAPP are channelled through UNICEF, which disburses money to the lead agencies according to the terms of contracts it has with them. The lead agencies, in turn, disburse money to their partner agencies and local implementing agencies in accordance with the terms of their MOUs.

The NGOs under HAPP provide a number of services from their Drop In Centres (DIC) from 145 DIC across 45 districts of Bangladesh. The centre-based services include: (a) health education, (b) counselling, (c) Sexually Transmitted Infection (STI) management, (d) referral for Voluntary Counselling and Testing (VCT), (e) abscess management, (f) referral for drug treatment and detoxification, (g) recreational activities, and (h) facilities for resting and bathing. The DICs also perform the following outreach activities: (a) community-based

detoxification (for 2 weeks), (b) condom promotion and distribution, (c) needle and syringe exchange, and (d) Behaviour Change Communication (BCC) activities such as folk song sessions.

Function

The NGOs implementing HAPP provide 6 packages for the following categories of vulnerable people: (a) street-based sex workers; (b) brothel-based sex workers; (c) hotel and residence based sex workers; (d) Men having Sex with Men (MSM) and transgender sex workers; (e) clients of sex workers; and (f) Injecting Drug Users (IDU).

The goal of HAPP is "to control the spread of HIV infection within high-risk groups and to limit its spread to the general population, without discriminating and stigmatising the high-risk groups." To reach this goal, the project has undertaken the following broad activities, which are the four components of HAPP:

- **High-risk group interventions:** This component is aimed at scaling up NGO activities targeting vulnerable groups to support and work with them to limit the transmission of HIV/AIDS. The vulnerable groups include: (a) commercial sex workers (CSW); (b) injecting drug users (IDU); and (c) migrant populations. The major interventions provided by HAPP include awareness raising through the use of behavioural change communication (BCC) materials, life skills programmes, establishment of referral systems, and provision of condoms and syringes.

- **Communication and advocacy:** The aim of this component is to increase the awareness and knowledge of the general population, civil society and policy makers on HIV and AIDS. Activities include the development of an advocacy strategy, mass communication, workshops and meetings with various groups like religious leaders, teachers, students, adolescents, and community leaders, etc.

- **Blood safety**: This component builds upon the government's Safe Blood Transfusion Programme (SBTP) and includes activities like investments in blood safety supply and reagents, improvement of voluntary blood donation, quality assurance, rational use of blood, and promotion of regulation of blood banks.

- **Project support and institutional strengthening:** Under this component, the managerial, technical and research capacity of NASP, SBTP and MOHFW is strengthened for dealing with HIV/AIDS. Capacity building interventions include training, research, consultancy and technical assistance.

Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) may be described as "an independent, public private partnership mechanism". GFATM is providing support to GOB efforts aimed at prevention, control and care of HIV/AIDS among selective populations, i.e. high risk groups and young people. It's resources are channelled primarily through the Project on Prevention of HIV/AIDS among Youth and Adolescents in Bangladesh.

Background

Project on Prevention of HIV/AIDS among Youth and Adolescents in Bangladesh

The "Project on Prevention of HIV/AIDS among Youth and Adolescents in Bangladesh" is a $720 million project funded by GFATM. It is a collaborative project between the Ministry of Health and Family Welfare (MOHFW) and Save the Children-USA, which manages the project on behalf of the government. The project is implemented by 5 lead agencies and 12 associate organisations representing NGOs, the private sector and research institutions.

This is a five-year project, which started in March 2004 and will end in February 2009. The goal of this project is "to prevent HIV infections in young people aged 10-24, and thereby to help avert a generalised HIV epidemic in Bangladesh." The project goal is designed to link with that of NASP to "control the spread of HIV infection within vulnerable populations and to limit its spread to the general population, without stigmatising the vulnerable populations."

The objectives of this project are the following:

- Provision of HIV prevention information, skills and services to young people.
- Collection of data necessary for informing the development of national policy and programmes for the prevention of HIV/AIDS among young people aged 10-24.
- Strengthening of the capacity of partner organisations for effective implementation, monitoring and evaluation of the project.

The strategies undertaken for implementing this project include:

- Behaviour Change Communication (BCC) activities for promoting awareness and sensitisation about HIV and safe sexual behaviour among young people.
- Improvement of health services for making them more youth friendly for counselling and treatment of STIs.
- Undertaking life skills education, outreach activities and peer education for promoting safer sexual behaviour and encouraging more openness in seeking counselling and treatment.
- Conducting advocacy with gatekeepers for creating an enabling environment for youth to adopt safe sex behaviour.
- Generating evidence based information for providing a strategic direction for interventions.

The project primarily targets young people between the ages of 10 and 24. This age group constitutes almost a third of the country's population and numbers about 38 million. In addition, policy makers, parents, teachers and religious leaders are targeted for creating an enabling environment. The general population is also covered by the project.

The main activities undertaken under this project include the following:

- Providing HIV prevention information to young people through mass and printed media.
- Making health services more youth friendly.
- Providing life skills education through youth organisations, movements and clubs.
- Improving condom access through social marketing.

- Integrating HIV prevention information into the secondary school and higher secondary curricula.
- Conducting advocacy and sensitisation of gatekeepers – religious and community leaders, policy makers and parents.
- Carrying out baseline and evaluation surveys.
- Undertaking in-depth studies on community dynamics, sexual practices and attitudes of young people.

During 2004-07, the project has achieved the following:

- Incorporated HIV/AIDS information into text book curriculum.
- Approved National Standard for Youth Friendly Health Status.
- Given Life Skills Education to young people to protect themselves from HIV/AIDS.
- Created significant brand image titled "Bachte holey jante hobe – Live to Learn".
- Aired a TV drama serial and radio magazine programme on HIV/AIDS.
- Highlighted the role of journalists.
- Shared media campaign activities with key ministries.
- Bridged between national and local leadership in prevention of HIV/AIDS.
- Proven experience in public private partnership modality.
- Published a number of documents related to HIV/AIDS.
- Promoted national leadership in HIV/AIDS programme that resulted in Global Fund Round-6 grant as new response.
- Developed a standard MIS for monitoring and evaluation.

The key players of this project are: (a) the Ministry of Health and Family Welfare, which is the Principal Recipient, and NASP; (b) Save the Children-USA, which is the Management Agency; and (c) implementing partners (NGOs, community-based organisations private sector organisations, and professional bodies), which are the Sub-Recipients. Funds from GFATM are disbursed to the implementing partners through Save the Children-USA.

Bangladesh AIDS Project (BAP)

Background

Initiated in October 2005, the Bangladesh AIDS Project (BAP) is a USAID-funded project implemented by Family Health International (FHI). BAP has 3 partner agencies and 34 implementing agencies (Annex C). BAP was designed to contribute to USAID's overall goal of reducing the transmission of HIV amongst most-at-risk groups and mitigate the impact on HIV/AIDS-infected and affected people.

The following are the specific objectives of BAP:

- Creation of a supportive environment for HIV and STI prevention through social mobilisation.
- Enhancing the capacity building of project staff, peer educators, site workers, and the organisation.
- Promotion of risk elimination and risk reduction practices amongst sex workers and their clients through outreach and Integrated Health Centres (IHC).
- Creation of options for high quality STI services for sex workers and their clients.

- Creation of options for VCT services for hotel-based sex workers.
- Increasing the utilisation of IHC services for sex workers and their clients.
- Increasing the right of knowledge, skills and access to products for correct and consistent use of condoms at high risk sexual encounters.

USAID is the main source of funding, while Family Health International (FHI) acts as a financing mechanism, disbursing resources to its partner and implementing agencies in keeping with the terms of their agreements. In preventing HIV/AIDS, the project works with four main target groups: (a) male and female sex workers and transgenders; (b) injecting drug users; (c) people living with HIV/AIDS; and (d) clients of sex workers. The main activities carried out for these target groups are briefly narrated below.

Male and female sex workers: There are a total of 14 implementing agencies that provide services to hotel and street-based female and male sex workers under BAP. These implementing agencies provide services to the target groups through 36 IHCs. The services include counselling and treatment of STIs, peer education, condom and lubricant distribution, and limited recreational facilities. In addition, 26 of the IHCs provide VCT services.

Injecting Drug Users (IDU): A total of 8 implementing agencies offer the following services to IDUs: (a) short-term (2 weeks/14 days) detoxification in the IHCs; (b) long-term treatment and rehabilitation; (c) drug and family counselling; (d) risk reduction education; (e) STI and TB screening and management; (f) general health care; (g) VCT; (h) routine abscess management, follow-up and after care; (i) skills training; (j) opportunities for economic and social rehabilitation; (k) establishment of self-help groups; and (l) advocacy for the creation of a supportive environment to establish a referral mechanism for external medical care.

People Living with HIV/AIDS (PLWHA): BAP, through one of its Implementing Agencies (IA), provides care and support to those individuals who test positive. The IA provides family and partner counselling, nutritional and caregiver counselling and training services from 3 of its IHCs in Dhaka, Sylhet and Chittagong. In addition, the IHCs undertake home visits, Combined Members' Day (CMD) for sharing and learning, and advocacy and networking for reducing stigma and discrimination.

Clients of sex workers: Although the main focus of BAP interventions is the most-at-risk groups, some of its activities are also directed towards the clients of sex workers. Peer educators and site workers distribute condoms to this group of men. The project also undertakes BCC activities to raise their awareness