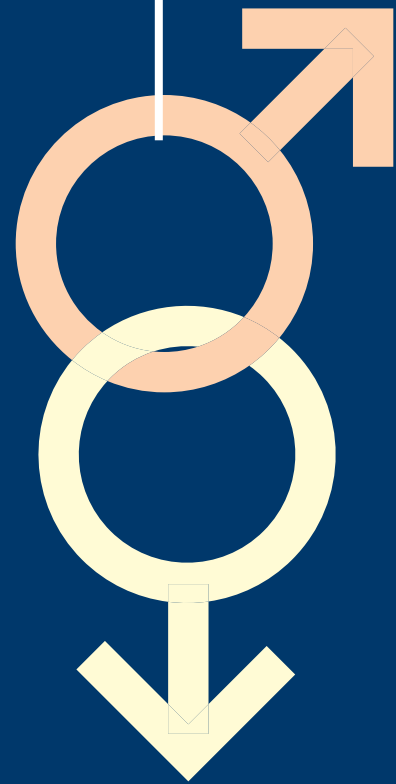


SUMMARY REPORT of
**KEY FINDINGS AND
PROGRAM
RECOMMENDATIONS**

From
**FHI MSM PROGRAM EVALUATIONS
(Bangladesh, Indonesia and Nepal)**



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LIST OF ACRONYMS

AIDS	Acquired immune deficiency syndrome
APRO	Asia Pacific Regional Office
ASA	Aksi Stop AIDS
BCC	Behavior change communications
BCI	Behavior change intervention
BDS	Blue Diamond Society
BSS	Behavioral surveillance survey
BSWS	Bandhu Social Welfare Society
CBO	Community-based organization
CI	Confidence interval
CST	Care, support and treatment
DIC	Drop-in center
FHI	Family Health International
GN	Yayasan Gaya Nusantara
HIV	Human immunodeficiency virus
IA	Implementing agency
IBBS	Integrated biological and behavioral survey
IEC	Information, communication and education
M&E	Monitoring and evaluation
MOU	Memorandum of Understanding
MSM	Men who have sex with men
MSW	Male sex worker
NGO	Non-governmental organization
OE	Outreach educator
PC	Peer counselor
PE	Peer educator
PERWAKOS	Persatuan Waria Kotamadya Surabaya
PKBI	Perkumpulan Keluarga Berencana Indonesia
PLWHA	people living with HIV/AIDS
QA/QI	Quality assurance / quality improvement
SOP	Standard operational procedure
SSPs	Safer sex package
STI	Sexually transmitted infection
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
YPKN	Yayasan Pelangi Kasih Nusantara
YSS	Yayasan Srikandi Sejati

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EXECUTIVE SUMMARY

Regional studies suggesting high HIV infection rates and widespread high risk behavior among men who have sex with men (MSM), coupled with limited policy and programming focus on the HIV prevention, care and treatment needs of MSM across the Asia and Pacific region, prompted Family Health International (FHI), with funding from the United States Agency for International Development (USAID), to analyze the effectiveness of its MSM interventions in Bangladesh, Indonesia and Nepal and extract key findings and recommendations for future MSM programming.

Following an outline of the key activities of the FHI-supported implementing agencies (IAs) in these three countries, evaluation of their impact through triangulation and interpretation of output, outcome and qualitative data, reveals that an overall positive program effect on knowledge, sexual risk behaviors and access to commodities and services was achieved through the variety of behavior change, advocacy, networking, community mobilization and capacity building interventions implemented. However, the quality and coverage of interventions was seen to differ from one site to the next and a clear need to promote a minimum package of priority interventions, and to improve organizational capacities and program monitoring was identified. Specific recommendations for improving the quality of the range of services provided (from drop-in centers and clinical services to peer education and outreach) were made and are detailed in chapter 6, “Synthesis of key findings and associated program recommendations”.

1. INTRODUCTION

In the Asia and Pacific region, men who have sex with men (MSM) are often neglected in efforts to prevent the spread of HIV, and in the treatment of those with HIV infection and AIDS. And yet, many studies demonstrate that MSM communities in Asia have high HIV infection rates related to the practice of high-risk behaviors. These include diverse and concurrent sexual networks with both men and women with high levels of partner turnover and low levels of condom use (Family Health International/Asia Pacific Division, 2005).

Family Health International (FHI), with funding from the United States Agency for International Development (USAID), works with local partner organizations or implementing agencies (IAs) to implement interventions aimed at reducing the vulnerability of MSM to HIV infection in Asian and Pacific countries including Bangladesh, Cambodia, China, India, Indonesia, Nepal, Pakistan, Papua New Guinea, Thailand, and Vietnam.

To determine the common elements of the various MSM programs, the effectiveness of FHI’s MSM program approach and inform future MSM programming, FHI conducted evaluations of FHI-supported MSM interventions in Bangladesh, Indonesia and Nepal, and prepared a summary report of these country evaluations.

The purpose of this report is to present key data from the country reports, and extract key findings and recommendations for FHI and IA MSM programming from the data and analysis contained in the country reports.

2. METHODOLOGY

2.1 Country evaluations

2.1.1 Site selection

The programs below were selected based on the following criteria:

- The MSM interventions were relatively mature (implemented for nearly two or more years)
- Population-based behavioral data were available for evaluation purposes among the MSM populations of interest in the geographic catchment areas of the respective project sites

Country	Project Site	Implementing Agency
Bangladesh	Chittagong City Dhaka City Sylhet City	Bandhu Social Welfare Society (BSWS)
Indonesia	Jakarta	Yayasan Pelangi Kasih Nusantara (YPKN) Yayasan Srikandi Sejati (YSS).
	Surabaya	Persatuan Waria Kotamadya Surabaya (PERWAKOS) Yayasan Gaya Nusantara (GN),
Nepal	Kathmandu	Blue Diamond Society (BDS)

2.1.2 Purpose and objectives

The purpose of the three evaluations was to:

- Improve program design and implementation
- Identify possible ways to expand program activities and coverage
- Increase awareness of, and support for MSM programs
- Inform future project agreements between FHI and the IAs

The general objectives were twofold:

- Conduct a process assessment, including determining activities conducted and outputs reached
- Conduct an effectiveness or outcome assessment to determine the extent to which expected behavioral outcomes had been achieved

2.1.3 Design

All three country evaluations were designed by a team consisting of FHI senior technical officers, program managers and an external evaluation consultant. A consultant coordinated and oversaw the implementation of the three country evaluations and each country evaluation was conducted by a different research agency or team. Because of the commonalities of the various MSM intervention programs, all three evaluations were similar in design and methodology.

2.1.4 Data sources and collection

To assess program activities, the three evaluation teams reviewed program monitoring data, observed program facilities and activities, and conducted individual and group interviews with FHI country office staff, IA staff at all levels, program participants and external program stakeholders.

Program outcomes were measured by analyzing existing behavioral data from behavioral surveillance surveys (BSS) and integrated biological and behavioral surveys (IBBS), supplemented with individual and group interviews with IA staff and program participants.

2.2 Summary report

This summary report aims to:

- Outline the key MSM program activities conducted in each site
- Evaluate the impact of programs through triangulation and interpretation of output, outcome and qualitative data
- Determine common findings across the three country programs
- Develop lessons learned from the programs and recommendations on how MSM programs might be improved

This summary report was compiled by technical and program staff from FHI's Asia Pacific Regional Office (APRO) with expertise in surveillance, monitoring and evaluation, and MSM programming, and an external consultant contracted to help collate and analyze the major findings of the three country evaluations.

In order to synthesize the results of the three country evaluations, the consultant first developed a simplified logic model for the FHI programs in Bangladesh, Indonesia and Nepal. This logic model (attached as Appendix A) provided the framework for the evaluations of these MSM programs conducted in this summary report.

3. KEY FINDINGS FROM ANALYSIS OF BANGLADESH DATA

3.1 Brief description of the Bangladesh MSM Program

After conducting an MSM situational assessment in 1997, several individuals started the Bandhu Social Welfare Society (BSWS), the first male reproductive health organization in Bangladesh. BSWS grew rapidly from a staff of two people and one drop-in center (DIC) in 1997 to a staff of over 240 people with nine DICs, operating in six cities throughout Bangladesh in the period 2005 to 2006. In all these cities, BSWS adapted the Naz Foundation International sexual health promotion model or service framework (Khan 1999), consisting of: Center Services, including drop-in services, counseling, education and training; Field Services, consisting of outreach, community mobilization, condom and lubricant distribution, and referrals; and Health Services, including sexually transmitted infection (STI) and general health treatment, HIV testing, and pre- and post-test counseling. FHI began supporting BSWS in 2000.

3.2 Strategies and activities

FHI support for BSWS focused on implementation of the following strategies:

- Promotion of safer behaviors, particularly through peer education and condom and lubricant promotion
- Provision of STI management and care services
- Strengthening of advocacy, research and communication systems
- Capacity building of BSWS through skill development

As part of the promoting safer behaviors strategy, BSWS conducted the following activities:

- Outreach workers and peer educators contacted target groups through one-to one meetings and group discussions at cruising sites and DICs
- Referrals to drop-in centers that provide information, condoms and lubricants, counseling, skills development classes, social group meetings, STI clinics and telephone help lines
- Distribution of information, education and communication (IEC) materials by outreach workers/peer educators
- Condom and lubricant distribution by outreach workers/peer educators, and by counselors and doctors at the DICs

To increase access to STI services, the IAs:

- Distributed referral cards to DICs by outreach workers/peer educators
- Provided twice-weekly clinics in the DICs that delivered STI services, including STI-related counseling

In order to strengthen advocacy, research and communication systems, IAs:

- Developed advocacy strategies for HIV programs among MSM
- Conducted sensitization meetings with media representatives, local elites, law enforcement agencies, local administrators, journalists, students and activists
- Conducted and participated in research studies

- Held coordination meetings with staff from government and non-governmental organizations (NGOs), and participated together in World AIDS Day activities

In order to build the capacity of BSWS through skill development:

- FHI trained IA peer educators (PEs)
- BSWS staff attended finance and administrative trainings, training of trainer, and training of facilitator trainings

3.3 Activity outputs

3.3.1 Behavior change communications

Outreach and peer education

Figure 1 and Table 1 below illustrate that in the period 2000 to 2004, BSWS conducted an increasing number of outreach activities through its expanded number of field offices and programs.

Figure 1: Summary of outreach activity outputs conducted by MSW/MSM IA in nine program sites, Bangladesh, 2000-2004

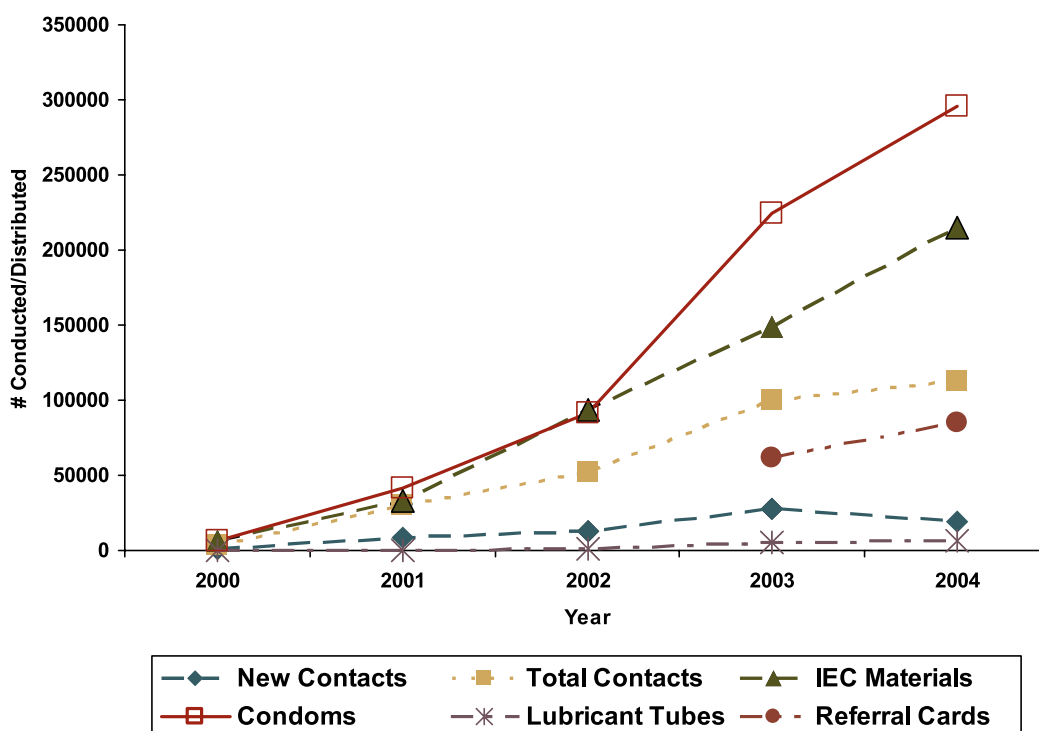


Table 1: Core process indicators for BSWS's peer education component

	2000	2001	2002	2003	2004	Total
No. of active PE	30	60	84	88	98	98
No. of one-to-one peer education contacts	3,013	29,663	51,961	100,214	112,603	297,454
No. and % of new one-to-one peer education contacts	947 (31%)	8,875 (30%)	13,145 (25%)	27,957 (28%)	18,768 (16%)	69,692 (24%)
No. of BCC materials distributed	6,090	32,622	94,006	149,363	215,334	497,415
No. of drop-in center referral cards given out by PEs				62,114	85,091	147,205

Overall: Between 2000 and 2004, 98 BSWS PEs reached just under 70,000 MSM and conducted almost 300,000 one-to-one PE contacts. The number of total contacts increased each year, from 3,013 in 2000 to 112,603 in 2004, and nearly doubled between 2002 and 2003. However, the number of new peer education contacts increased from 947 in 2000 to 27,957 in 2003, but decreased to 18,768 in 2004. The number of distributed behavior change communication (BCC) materials increased steadily, from 6,090 in 2000 to 215,334 in 2004.

Site specific: In Dhaka, peer educator contacts rose substantially from 16,550 in 2001 to 32,000 in 2003, and 37,000 in 2004; with around 5,000-7,000 new contacts each year. In Sylhet, contacts rose from 13,000 in 2001 to 16,000 in 2002, 22,700 in 2003, and 26,800 in 2004. However, Sylhet had the lowest of number of new contacts in the three areas and this number decreased over time (3,600 in 2001, 2,500 in 2002, 3,700 in 2003, and 500 in 2004). Peer education contacts in Chittagong appeared to be one or two years behind compared to the status of these interventions in Dhaka and Sylhet, with contacts starting slower; 8,000 in 2002, rising to 26,000 in 2003 and 24,500 in 2004. New contacts in Chittagong were 1,600 in 2002, 7,500 in 2003 and 5,700 in 2004.

Drop-in center activities

BSWS's nine drop-in centers were a major component of its behavior change intervention. As the number of functioning DICs increased from three in 2000 to nine in 2004, there were also sharp increases in the number of visits to drop-in centers, rising from 309 in 2000 to nearly 17,500 in 2004 (see Table 2).

In the period 2000 to 2004, there was a steady increase in the number of group meetings; from 271 in 2001 to nearly 800 in 2004. The sharp increases in new and total participants at these meetings tapered off from 2002 onwards, particularly the total participants which remained in the region of 17,000 each year from 2002 to 2004.

Table 2: Summary of BSWs DIC activity outputs in nine program sites

	2000	2001	2002	2003	2004	Total
No. of functioning DICs	3	4	6	8	9	9
No. of visits to DICs by MSW/MSM	309	1,994	2,420	9,951	17,422	32,096
No. of social group meetings	0	271	601	705	792	2,369
No. of social group meeting participants	33	7,384	17,163	16,384	18,620	59,584
No. of new participants		2,849	6,415	8,830	8,229	26,323
No. of participants in social capital building classes					304	304
No. of functional help lines				4	7	7
No. of help line calls received					752	752

3.3.2 Access to commodities and services

Condoms and lubricant

In the Bangladesh program, a strong component of the behavior change intervention (BCI) strategy was the promotion of condom and lubricant use by the peer educators in cruising sites, by counselors in the drop-in centers, and by doctors and counselors during the STI clinic sessions.

Overall: Figure 1 and Table 3 illustrate the sharp increase in the number of condoms and lubricant tubes distributed by peer educators, and at STI clinics and drop-in centers. Condoms distributed in both group and peer sessions increased each year, from 6,672 in 2000 to nearly 300,000 in 2004, with a 250 percent increase between years 2002 and 2003. The number of distributed lubricant tubes increased from 151 in 2001 to 5,870 in 2004.

Table 3: Condoms and lubricants distributed

	2000	2001	2002	2003	2004	Total
No. of condoms distributed at group and peer sessions	6672	41,033	91,165	224,246	295,384	658,500
No. of condoms distributed at STI clinics	0	257	2257	8862	13,896	25,272
No. of condoms distributed at DICs				6707	11,832	18,539
Total no. of condoms distributed	6672	41,290	93,422	239,815	321,112	702,311
No. of lubricant tubes distributed	0	151	1048	5508	5870	12,577

Site specific: In Dhaka, the numbers of condoms distributed increased considerably from 40,000 in 2001 to 75,000 in 2003 and 120,000 in 2004. In Sylhet, hardly any condoms were distributed; 5,000 in 2002, rising to over 30,000 in 2003 – 2004. This might be due in part to the shortage of condoms available for distribution (see ‘Triangulation and interpretation’). In Chittagong, 20,000 condoms were distributed in 2002, rising to 70,000 in 2003 and then stabilizing at 68,000 in 2004.

STI services

BSWS provided STI services to MSM, MSW and clients through twice-weekly STI clinics in its nine drop-in centers.

Table 4: STI clinical services

	2000	2001	2002	2003	2004	Total
No. of facilities providing STI services	3	4	6	8	9	9
No. of clinic sessions		312	504	770	942	2,528
No. of patient visits		3,064	5,933	6,823	8,357	24,177
No. of STI patients		1,297	2,234	2,037	2,030	7,598
No. of new STI patients		298	2,060	1,899	1,840	6,097
No. of condoms distributed at STI clinic		257	2257	8,862	13,896	25,272

Overall: With the increase in facilities providing STI services, the number of clinic sessions increased steadily in the period 2001 to 2004 (312 in 2001 to 942 in 2004), as did the number of patient visits, which included both general health patients and STI patients. There were a total of almost 7,600 STI patient visits in the period 2000 to 2004. Following the initial increase from zero in 2000 to 1,297 in 2001, there was a relatively constant number of about 2,000 patients treated for STIs per year until 2004. As part of BSWS’s BCI strategy, its peer educators distributed an increasing number of DIC and STI referral cards, from 62,114 in 2003 to 85,091 in 2004 (see Table 1).

Site specific: This relatively stable total number of new STI patients per year masked a close to 50 percent drop in STI patient visits in Dhaka in the period 2002 to 2004 at a time when general health visits, counseling sessions and condoms distributed in the clinics were increasing. In Chittagong, from 2002 to 2003, there was a leveling off of patients diagnosed with a STI, also at a time when there were increases in the number of total patients, counseling sessions and condoms distributed. In Sylhet, from 2002-2003, there was a sharp decrease in the number of patients diagnosed with a STI (STI patient visits halved in 2003 (380) and 2004 (262) compared to levels in other cities) at a time of only slight decreases in the number of total patient visits and counseling, and an increase in the number of condoms distributed in clinics.

VCT and CST

Increasing access to voluntary counseling and testing (VCT), and care, support and treatment (CST) services was not a program strategy of BSWS. Therefore, no related outputs were measured.

3.3.3 Advocacy and networking

As part of the FHI agreement, BSWS developed and began implementing an advocacy strategy on HIV programs for MSM, and conducted three sensitization meetings in 2003. In 2004, the IA also conducted five sensitization meetings with local elites, media personnel, and law enforcement agencies in Dhaka and at several field offices. Staff in some field offices also conducted unofficial local-level advocacy efforts such as talking and working with police constables, neighborhood religious leaders, local thugs, shop keepers and other gatekeepers at various cruising sites.

For networking, BSWS also coordinated with government and NGOs on events such as World AIDS Day, the AIDS Candlelight Memorial Day, and Human Rights Day at both national and local levels. In addition, BSWS organized the annual National Consultation Meetings on Male Reproductive Health. It also coordinated with eleven NGOs in delivering services to MSM and MSW, and conducted sensitization sessions with numerous NGOs.

BSWS also conducted six research studies and participated in four studies conducted by other organizations.

3.3.4 Capacity building of implementing agencies

As part of the first two-year agreement (2000-2002) with FHI, BSWS recruited additional staff, adapted and expanded its financial management system, and attended numerous training sessions and workshops. From 2003 to 2004, BSWS developed strategic and operational plans, and staff attended numerous trainings, workshops and conferences.

3.4 Outcomes

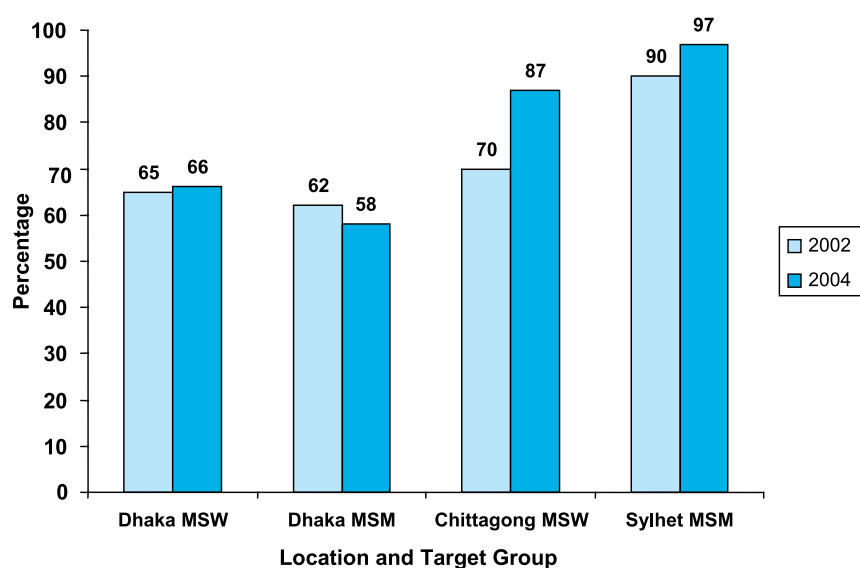
In the Bangladesh evaluation, program effects were measured by BSS at two points in time (March-May 2002 and October 2003-February 2004), for two populations (MSW and other MSM), and in three locations (Dhaka city, Chittagong city and Sylhet city).

3.4.1 Behavior change communications

Program coverage

In the Bangladesh evaluation, program exposure was defined as being contacted by somebody or attending an NGO session regarding MSM and HIV/AIDS in the past 12 months. As seen in Figure 2, BSWS had variable coverage rates for the different program locations and target groups.

Figure 2: Exposure to MSM/MSW interventions in Dhaka, Chittagong, and Sylhet, Bangladesh, 2002 and 2004



In Dhaka, coverage rates for both MSW and MSM remained almost the same from 2002 to 2004, with about two-thirds of the MSW and about three-fifths of the non-MSW MSM surveyed exposed to a MSM HIV intervention. Among MSW in Chittagong, coverage increased considerably from 70 percent in 2002 to 87 percent in 2004. Among MSM in Sylhet, a high coverage of 90 percent in 2002 increased to 97 percent in 2004.

Risk perception

From 2002 to 2003, there was a significant increase in risk perception among Dhaka MSW (from 3 percent to 30 percent). Among Dhaka MSM, the increase was not significant (from 14 percent to 20 percent). Among MSW in Chittagong, risk perception remained about the same in both years at around 40 percent. Among MSM in Sylhet, risk perception in both years was very low (13 percent in 2002 and 7 percent in 2003).

Among MSW in Dhaka, in 2004, there was no significant difference in risk perception between exposed and non-exposed MSWs. However in 2003, significantly more exposed MSWs placed themselves at high or medium risk than non-exposed MSWs. Among MSM in Dhaka, there was neither a significant difference between exposed and non-exposed MSM on risk perception, nor a significant increase from 2002 to 2003 for exposed or non-exposed. Among Chittagong MSWs, significantly more exposed MSWs than non-exposed MSWs placed themselves in high or medium risk categories but there were no significant changes from 2002 to 2004 for exposed or non-exposed.

Differences and changes in knowledge and use of condoms and lubricant

Dhaka MSW: Among MSW in Dhaka, there appeared to be a moderate program effect on changes in knowledge, and use of condoms and lubricant, with significant increases among MSW in Dhaka who reported:

- Knowledge that avoiding anal sex and using a condom every time when engaging in anal sex could reduce their risk of HIV infection (from 38 percent in 2002 to 60 percent at the end of 2003, $p < 0.001$).

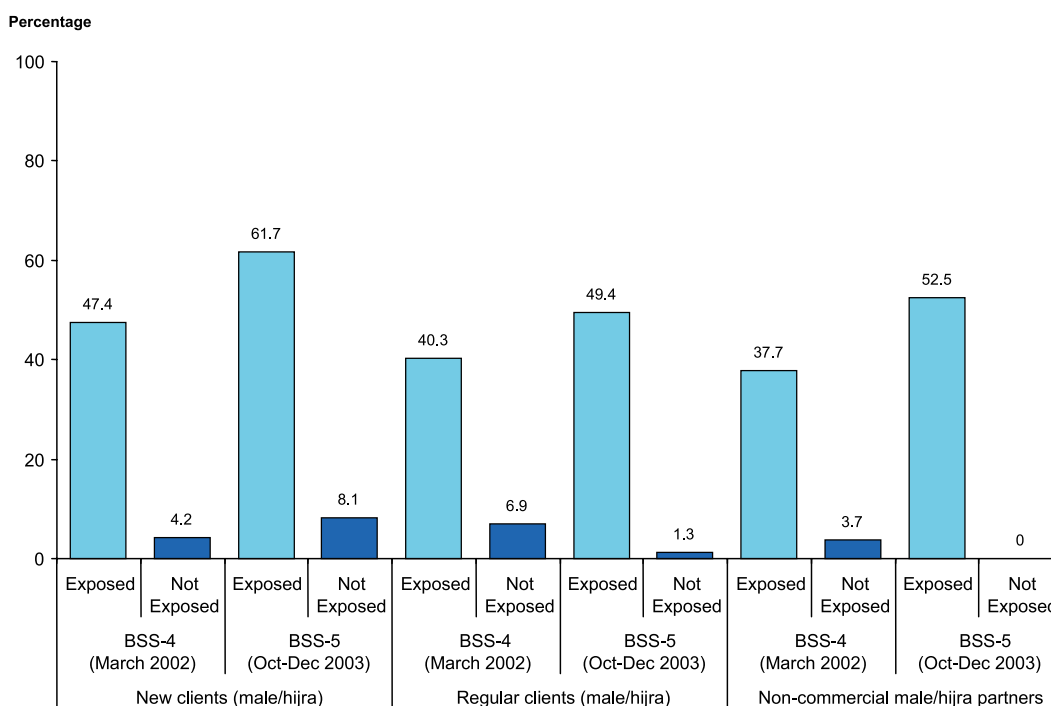
- Using a condom the last time they had anal sex with a new male client (from 32 percent in 2002 to 44 percent in 2003, $p < 0.01$)
- Using a condom the last time they had anal sex with a non-commercial male partner (from 24 percent in 2002 to 37 percent in 2003, $p < 0.05$)
- Using condoms consistently with new male clients in the past week (from 10 percent in 2002 to 18 percent in 2003, $p < 0.01$)

However, there was no significant difference in the proportion of Dhaka MSW reporting consistent condom use with non-commercial male partners in the past month (9 percent in 2002 and 6 percent in 2003).

In addition, when comparing Dhaka MSW who had been exposed and not exposed to a MSM intervention, a significantly greater proportion of the exposed MSW in both 2002 and 2003 reported positive knowledge and behavioral outcomes. The differences in knowledge between exposed and non-exposed MSWs were striking. For example, in 2003, significantly more exposed MSW in Dhaka knew how to avoid risk of HIV infection (exposed 84 percent, non-exposed 14 percent, $p < 0.001$); used condoms the last time they had anal sex with a new client (exposed 62 percent, non-exposed 8 percent, $p < 0.001$); used condoms consistently with new clients in the past week (exposed 27 percent, non-exposed 2 percent, $p < 0.001$); and used a condom last time with a non-commercial male partner (exposed 53 percent, non-exposed 0 percent, $p < 0.001$).

Figure 3 highlights that, overall, differences in condom use behavior between exposed and non-exposed suggested good program effects with very large differences in condom use between exposed and non-exposed with all partner types; new clients, regular clients and non-commercial partners. Positive condom use trends were seen among the exposed for both rounds, except for no change with regular clients. It is also noteworthy that for all client types, last time condom use for non-exposed was 8 percent or less and was as low as 0 percent for non-exposed non-commercial partners in round 5 (see Figure 3).

Figure 3: Dhaka, MSWs - Last time condom use in anal sex with different types of partners by exposure to intervention



Consistent condom use in the past week was nearly non-existent among non-exposed with no sign of change. Even among exposed, consistent condom use in the past week remained very low with new clients (26 percent), regular clients (16.7 percent) and non-commercial partners (8.5 percent). In consistent condom use there were emerging signs of condom use decisions based on perceived risk of partners.

Among Dhaka MSW, there was not much difference in condom use between commercial sex with new clients and non-commercial partnerships. In addition, among exposed MSW in Dhaka, partner risk profiling was still immature, as suggested by the fact that while last time condom use among the exposed had increased with all partners, MSW were no more likely to use condoms with one time clients than with a non-commercial partner. Based on the risk profile of the non-exposed, the (still) modest gains among the exposed should be viewed positively.

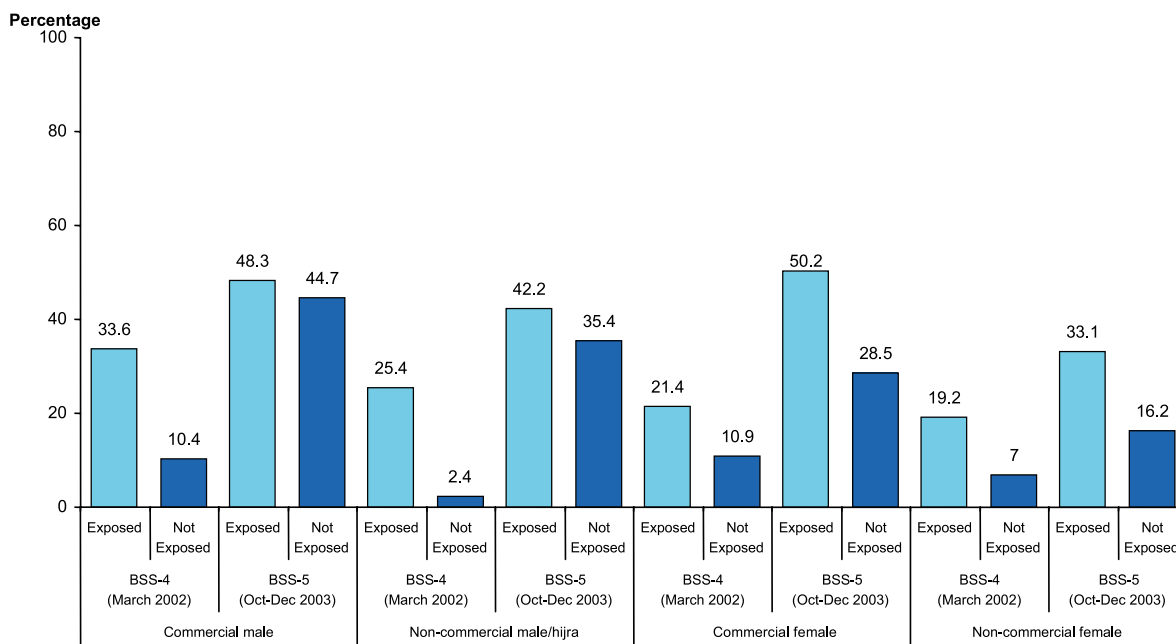
Dhaka MSM: The program effect on knowledge and use of condoms and lubricant among MSM in Dhaka appeared to be less than that among MSW. Significantly more Dhaka MSM reported:

- Knowledge that avoiding anal sex and using a condom every time when engaging in anal sex could reduce their risk of HIV infection (from 61 percent in 2002 to 74 percent at the end of 2003, $p < 0.01$).
- Using a condom the last time they had anal sex with a commercial male partner (from 25 percent in 2002 to 47 percent in 2003, $p < 0.001$)
- Using a condom the last time they had anal sex with a non-commercial male partner (from 17 percent in 2002 to 39 percent in 2003, $p < 0.001$)

However, there was a significant decrease in the proportion of Dhaka MSM reporting consistent condom use with commercial male partners in the past month, from 12 percent in 2002 to 5 percent in 2003 ($p < 0.01$), and an insignificant decrease in the consistent use of condoms with non-commercial partners, from 8 percent to 7 percent ($p < 0.562$).

In addition, greater proportions of exposed MSM reported more positive outcomes than non-exposed MSM, but with fewer differences than with MSW. In 2002, significantly greater proportions of exposed MSM reported: knowledge on how to reduce their risk of infection, the use of condoms during their last sexual encounter and consistent use of condoms with both commercial and non-commercial male partners. However, there were no significant differences between the two groups in 2003, except for knowing how to avoid HIV infection (exposed 84 percent, non-exposed 58 percent, $p < 0.001$) and using condoms consistently with non-commercial male partners in the past month (exposed 90 percent, non-exposed 4 percent, $p < 0.05$).

Figure 4: Dhaka, MSMs - Last time condom use in anal sex with different types of partners by exposure to intervention



The fact that differences in knowledge and condom use between exposed and non-exposed were less noticeable in the latest round suggested that the non-exposed were catching up. In the latest round, differences in condom use by MSM exposed and non-exposed were only evident with female partnerships, with more exposed MSM reporting last time condom use with commercial female partners and non-commercial female partners.

Chittagong MSW: There was also evidence of program effect on knowledge and condom use among MSW in Chittagong with significant increases in the following key behavioral indicators:

- Used a condom the last time with a new male client (from 15 percent in 2002 to 45 percent in 2003, $p < 0.001$)
- Used condoms consistently with new clients in the past week (from 3 percent in 2002 to 22 percent in 2003, $p < 0.001$)
- Used a condom the last time with a non-commercial male partner (from 8 percent in 2002 to 22 percent in 2003, $p < 0.05$).
- Used condoms consistently with non-commercial male partners in the past week (from 2 percent in 2002 to 17 percent in 2003, $p < 0.001$).

In addition, in both rounds significantly greater proportions of Chittagong MSW exposed to a MSM intervention knew how to avoid infection, compared to the non-exposed.

There were significant differences in last time condom use with new and regular clients, and consistent condom use for all partners, between exposed and non-exposed in round 5. However, there was no significant difference in these outcomes between exposed and non-exposed in round 4. This could be taken as evidence of delayed program effect. However there were significant improvements across the board from round 4 to round 5 in both last time and consistent condom use for those exposed to interventions.

Sylhet MSM: There were several positive knowledge and behavioral changes among MSM in Sylhet with significant increases in:

- Knowing how to avoid HIV infection (from 60 percent in 2002 to 78 percent in 2003, $p < 0.001$)
- Last time condom use with a commercial male partner (from 15 percent to 51 percent, $p < 0.001$)
- Last time condom use with a non-commercial male partner (from 8 percent in 2002 to 26 percent in 2003, $p < 0.01$)
- Consistent condom use with non-commercial male partners in the past month (from 3 percent in 2002 to 15 percent in 2003, $p < 0.01$)

There was no significant difference in Sylhet MSM reporting consistent condom use with commercial male partners in the past month.

Because of the high coverage rates (over 90 percent) and therefore the small sample of non-exposed in Sylhet, it is not meaningful to compare outcomes by exposure levels.

Differences and changes in the use of STI services

From 2002 to 2003, there was a significant increase in MSW who reported seeking formal medical treatment for their last STI symptom (from 46 percent in 2002 to 84 percent in 2003, $p < 0.001$) and a significant decrease in MSW reporting at least one STI symptom in the past year (from 75 percent in 2002 to 62 percent in 2003, $p < 0.01$). There were similar trends with MSM in Dhaka: a significant increase in MSM who reported seeking STI medical treatment (from 50 percent in 2002 to 79 percent in 2003, $p < 0.001$) and a significant decrease in MSM reporting at least one STI symptom in the past year (from 70 percent in 2002 to 39 percent in 2003, $p < 0.001$).

When comparing by level of program exposure, a significantly greater proportion of MSW in Dhaka exposed to an intervention had sought formal medical treatment for their last STI symptom in the past year. For example, in 2003, 94 percent of exposed MSW had sought formal treatment, compared to only 65 percent of MSW not exposed ($p < 0.001$). This was also the case for MSM in Dhaka. In 2003, 83 percent of exposed MSM had sought formal medical treatment, compared to only 33 percent of those not exposed ($p < 0.01$).

In the Chittagong clinic from 2002 to 2003, there was a significant increase in MSW reporting to have sought formal medical treatment for their last STI symptom in the past year (from 62 percent in 2002 to 73 percent in 2003, $p < 0.05$) and a significant decrease of MSW reporting at least one STI symptom in the past year (from 81 percent in 2002 to 47 percent in 2003, $p < 0.001$).

When comparing by exposure level, significantly greater proportions of exposed MSW in Chittagong had sought formal medical treatment in both 2002 and 2003. However, in 2003, there was no significant difference between exposed and non-exposed MSW reporting to have had at least one STI symptom in the past year.

From 2002 to 2003, there was a significant increase in MSM in the Sylhet clinic reporting to have sought formal medical treatment for their last STI symptom (from 63 percent in 2002 to 81 percent in 2003, $p < 0.001$) and a significant decrease of MSM reporting at least one STI symptom in the past year (from 76 percent in 2002 to 61 percent in 2003, $p < 0.001$).

Because program coverage was over 90 percent in Sylhet, the outcomes of those exposed and not exposed to a MSM intervention cannot be compared.

Differences and changes in the use of VCT services

Due to the low HIV prevalence among MSM in Bangladesh, increasing access to VCT and CST services was not a program strategy of BSWS. Therefore, the use of VCT services was not measured in the Bangladesh evaluation.

3.4.2 Access to commodities and services

STI and VCT Services

Refer to the BCC section above.

Condoms and lubricant

Refer to the BCC section above.

3.4.3 Advocacy and networking

No advocacy or networking outcomes were defined or measured.

3.4.4 Capacity building of implementing agencies

No capacity building outcomes were defined or measured.

3.5 Triangulation and interpretation

3.5.1 Behavior change interventions

Dhaka

Overall the program was successful in considerably increasing knowledge and risk perception. However both variables were surprisingly low in 2002; even with a tenfold increase, the risk perception indicator remained at 30 percent. With this low risk perception and modest knowledge of HIV/AIDS, condom use would be slow to improve.

Coverage, levels of knowledge, risk perception and last time condom use with clients and non-commercial partners were all similar and on a positive trajectory for both MSM and MSW. This suggested that continued efforts at improving knowledge and risk perception would result in safer behavior gains. The main differences between MSM and MSW groups were in consistent condom use with commercial partners, which had increased for MSW (from 10 to 18 percent), but decreased for MSM from 12 to 5 percent). In addition, the effects of exposure on condom use were much stronger for MSW than MSM. Condom use increased among non-exposed MSM at around the same rate as those involved in FHI activities. This might suggest that MSM have better independent access to health information or condoms.

Chittagong

The significant increases in risk perception, knowledge and condom use in exposed versus non-exposed, provided evidence of good program effect among MSW in Chittagong. However, whilst the knowledge differences between exposed and non-exposed were significant, they were difficult to interpret. The significant decrease in knowledge between rounds for those non-exposed (from 66 to 29 percent) may indicate mobility and an untapped population group with poor service access in Chittagong

BSS data indicated Chittagong's large increases in program coverage from 70 percent 2002 to 86 percent in 2003. Chittagong provided the best improvements and performance in consistent condom use. This might be explained by the fact that Chittagong had the highest condom distribution (field and STI clinics) per capita.

Sylhet

The high program coverage in Sylhet may be showing payoffs; while risk perception was unusually low, last time condom use was showing some of the biggest improvements. The very low risk perception was difficult to explain in relation to other cities given the high levels of knowledge.

3.5.2 STI services

Dhaka

In general, symptom recognition among MSW in Dhaka was high and those exposed to interventions were highly likely to seek formal medical treatment for STI care (94 percent). However, with two-thirds reporting at least one STI symptom, the low number of patient visits (352 in 2003) may indicate that formal care was being sought outside of FHI supported clinics. Similar observations also applied to MSM in Dhaka. This was perhaps unsurprising given that the evaluation team noted quality issues after observing several STI clinic sessions, including: a lack of a standard clinic management strategy, poor physical conditions in some clinics, a lack of standard examination procedures, no patient follow-up mechanisms, an inconsistent policy for distributing medicines and poor record keeping.

In Dhaka, there was supporting evidence for behavior change. While symptom recognition was high for both exposed and unexposed MSM, the exposed were around half as likely to have reported a symptom in the past 12 months, which to some extent confirmed the differences in reported condom use.

Chittagong

The increase in the number of patient visits from 794 to 1,286 and then 1,318 in the last year suggested, but provided no clear evidence for, improvement in health seeking behaviors. In the context of 29,492 referral cards distributed, this would suggest the need for improvement in referral to these services.

4. KEY FINDINGS FROM ANALYSIS OF INDONESIA DATA

4.1 Brief description of the MSM program

In Indonesia, FHI implemented the Aksi Stop AIDS (ASA) project. The overall goal of ASA interventions targeting MSM groups was to decrease HIV prevalence among these populations in selected provinces in Indonesia. At the time of the evaluation, the ASA program supported nine Indonesian NGOs and community-based organizations (CBOs), or IAs, that worked directly with MSM, MSW and waria, and also their clients. Although the specific strategies varied for each IA, ASA supported these organizations to implement the following general strategies:

- Increase and sustain safer sex behavior and appropriate health seeking behavior through BCI. The program promoted a balance of safer sex behaviors including abstinence, being faithful (partner reduction) and condom use. However, because of the high-risk nature of these populations, there was a particular focus on increasing the use of condoms and water-based lubricant during anal sex
- Increase access to commodities such as condoms and lubricant by establishing distribution linkages with condom producers, and access to services by implementing a referral system for STI services, VCT services, and CST services
- Create a favorable environment to support program implementation and behavior change through advocacy with government agencies and networking with other organizations
- Strengthen the capacity of IA staff to manage and implement the interventions

Although ASA's program targeting MSM groups consisted of nine IAs, this evaluation assessed the activities conducted and outcomes achieved by the following four:

- Yayasan Srikandi Sejati (YSS), which worked with the waria community in Jakarta
- Persatuan Waria Kotamadya Surabaya (PERWAKOS), which worked with the waria community in Surabaya
- Yayasan Pelangi Kasih Nusantara (YPKN), which worked with MSM and MSW in Jakarta
- Yayasan Gaya Nusantara (GN), which worked with MSM and MSW in Surabaya

These four IAs were selected because they had the most mature interventions and, therefore, had therefore the greatest likelihood of measurable change. In addition, these organizations operated in the same areas from which BSS data on MSM, MSW and waria were available. Detailed descriptions of each of these organizations are included in the individual IA evaluation reports.

4.2 Strategies and activities

As part of the behavior change intervention strategy, the IAs conducted the following activities:

- Recruited and selected outreach workers, peer educators, buddies, and volunteers
- Outreach workers and peer educators contacted target groups through one-on-one and group discussions, and discussed HIV/AIDS and MSM groups issues, distributed printed materials, condoms and lubricant, and referred individuals to STI, VCT and CST services

- Conducted edutainment activities
- Two IAs also published newsletters and one maintained a telephone hotline and Web site

To increase access to and use of condoms and water-based lubricant, the IAs conducted coordination meetings and developed memorandums of understanding (MOUs) with condom and lubricant suppliers, and established and maintained condom and lubricant distribution outlets.

To increase access to STI, VCT, and CST services, the IAs: conducted coordination meetings and developed MOUs with appropriate service providers, referred individuals to the appropriate services, and the two waria IAs also visited and provided support to people living with HIV/AIDS (PLWHA).

To help create a favorable environment to support program implementation and behavior change, the IAs conducted limited advocacy and networking activities, including: routine information sharing of program progress with the local AIDS commissions and other stakeholders; regular meetings with representatives of the waria communities, and other MSM groups and stakeholders; and collaboration meetings with condom and lubricant suppliers, and STI, VCT and CST service providers.

To develop the capacity of implementing agencies to better implement the ASA program targeting MSM groups, IAs underwent FHI-supported training in basic outreach skills, financial management, monitoring and evaluation, and mapping. Some IAs also received FHI-supported training in care and support, STIs and VCT, and case management. The IAs also participated in exchange visits, workshops and conferences.

4.3 Activity outputs

For this report, the activity outputs are presented by implementing agency and by three key strategies: behavior change interventions; access to STI, VCT and CST services; and creating a favorable environment to support program implementation and behavior change.

The outputs related to access to condom and water-based lubricant have been integrated in the behavior change interventions strategy. With regard to the strategy related to capacity building of the implementing agencies, the output indicators are not described in this section since information in the IA's and FHI/ASA's database was limited in terms of reporting specific details on the type of staff recruited, trained and the number of participants by type of training.

4.3.1 Yayasan Srikandi Sejati: waria in Jakarta

Behavior change interventions

Field staff reached over 1,500 new waria in 2003 and 1,700 in 2004. From January through September 2005, YSS also reached over 1,360 waria. Repeated contacts with about 4,000 waria in 2003, 6,000 in 2004 and nearly 5,500 waria in 2005 were also conducted by the field staff. During outreach activities, over 1,200 BCC materials were distributed in 2003, 3,600 in 2004, and nearly 9,000 in 2005.

To increase the access to condoms for waria, YSS conducted one coordination meeting with DKT International, a social marketing condom supplier, each year from 2003 to 2005, resulting in three annual MOUs. YSS also established and maintained 10 condom distribution outlets, such as cigarette-selling kiosks, in 2003, and 12 in 2004 and 2005. Field staff distributed over 83,000 condoms in 2003, 281,000 in 2004, and 141,000 in 2005. In addition, the distribution of safer sex packages (SSPs), a packet containing one condom with a sachet of water-based lubricant and BCC material, started in 2003. Approximately 13,000 SSPs were distributed in both 2004 and 2005.

Field workers also referred nearly 1,000 waria each year for STI services and as of the end of September 2005 had referred over 700 waria in that year. YSS field workers also referred waria in the Jakarta area for VCT services: 23 in 2003, 73 in 2004, and 78 in 2005.

Also, as part of its behavior change interventions, YSS conducted edutainment sessions. In 2004, YSS conducted six edutainment activities with 700 waria participants and four edutainment activities with 2,000 participants in 2005 (also including clients).

Access to STI, VCT and CST services

To make STI services more available to waria in Jakarta, YSS conducted 12 coordination meetings with STI service providers in 2003, 10 meetings in 2004, and 12 meetings in 2005. The clinic of Perkumpulan Keluarga Berencana Indonesia (PKBI) became the STI referral clinic for the waria community in Jakarta. To ensure that services were waria-friendly, YSS had three staff members working at the clinic, one as an administrator and two as counselors. As stated earlier, outreach workers referred 1,053 waria for STI services in 2003, nearly 1,000 in 2004, and 710 in 2005. Of the waria who were referred in 2003, 836 attended the STI clinic, 247 in 2004, and an unreported number in 2005. The total number (referred and non-referred) of waria attending the STI clinic in 2003 was 836 in 2003, 833 in 2004, and 763 waria in 2005. Of the waria attending the clinic in 2003, 645 received anal examinations and 372 were treated for STIs. In 2004, of the 833 waria attending the STI clinic, 532 underwent anal examinations and 292 received treatment for STIs. In 2005, of the 763 waria attending the STI clinic, 694 received anal examinations and 202 were treated for STIs.

The PKBI clinic, with two waria counselors, also provided VCT services for waria in Jakarta for a subsidized fee of about US\$ 0.5. In 2003, YSS field staff referred 23 waria in Jakarta for VCT services, of which all 23 attended the clinic. In 2004, field staff referred 73 waria, of which 40 attended. In 2005, field staff referred 78 waria and 15 clients, but the number actually going for services was not yet reported. There were no data reported on the number of waria receiving counseling and being tested for HIV.

From 2003 to 2005, YSS conducted three annual coordination meetings and established three MOUs with CST service organizations. In addition, a YSS counselor and two case managers visited waria living with HIV/AIDS at least every two weeks. In 2003, YSS had 18 active buddies (2 short of the target) who conducted four meetings and helped care for waria who were ill. In 2004 and 2005, YSS had 20 active buddies who conducted 10 meetings each year, meeting all annual targets. In 2005, YSS reported handling 15 cases. YSS also formed a support group for waria living with HIV/AIDS called Srikandi Urip that met once a month.

Create a favorable environment to support program implementation and behavior change

As reported by the FHI program database, YSS conducted 15 advocacy and networking activities with 108 participants in 2003, and 12 activities in 2004, meeting all annual targets. No data were reported for 2005.

4.3.2 Persatuan Waria Surabaya: waria in Surabaya

Behavior change interventions

In the few remaining months of 2003, PERWAKOS field staff reached 103 new waria, followed by nearly 1,500 waria in 2004 and 580 waria from January through September, 2005. In 2004, only 1,386 repeated contacts were reported by field staff, whereas in 2005 (until September) 3,219 repeated contacts were recorded.

While talking with contacts, field staff distributed 225 BCC materials in 2003, around 2,000 in 2004 and over 3,600 in 2005.

PERWAKOS conducted eight coordination meetings with condom and lubricant producers in 2003, two in 2004 and two in 2005, meeting all set targets. These meetings resulted in two MOUs each year from 2003-2005. PERWAKOS also established and maintained eight condom and lubricant distribution outlets in 2003 and 2004, and 11 in 2005. According to PERWAKOS, field staff distributed 912 condoms in 2003, 18,888 condoms in 2004, and 9,281 condoms in 2005. In addition, 549 safer sex packages were distributed in 2004 and 2,070 in 2005.

Field staff conducted group discussions with a total of 1,068 participants through a total of 33 sessions in 2003 and 2004.

In the last quarter of 2003, field staff referred six waria for STI services, but this number increased dramatically to nearly 2,500 in 2004 and to over 1,000 in 2005. Field staff also referred 21 waria for VCT services in 2003 and 62 in 2004 (2005 data was not yet reported).

Also, as part of BCC, PERWAKOS conducted three edutainment sessions in 2004 with over 2,500 participants. This was one session less than the annual target and far below the expected number of participants.

Access to STI, VCT and CST services

In the last quarter of 2003, PERWAKOS conducted four coordination meetings with STI service providers, 10 meetings in 2004 and 12 meetings in 2005. From these meetings, Puskesmas Perak Timur became the referral clinic for STI treatment for waria in Surabaya. In addition, arrangements were made for a mobile clinic to visit several locations on a monthly basis to examine and treat waria for STIs.

In the last few months of 2003, PERWAKOS field staff referred six waria for STI services. All attended the clinic. In 2004, field staff referred 2,811 people of whom 326 were clients. Of the referred waria (n=2,485), only 30 were reported to have actually attended the clinic. However, a total of 721 waria (referred and non-referred) attended the services at the clinic. Of the waria attending (n=721), 480 received anal examinations and 235 received treatment for STIs. From January to September 2005, field staff made 1,088 referrals to STI services. Although the number of referred waria actually attending the clinic was unreported, a total of

591 referred and non-referred waria attended in 2005. Of those attending, 590 underwent anal examinations and 357 were treated for STIs.

In 2003, PERWAKOS field staff referred 21 Surabaya waria to Puskesmas Perak Timur for VCT. All 21 went for services, received counseling and were tested for HIV. PERWAKOS also referred 62 waria for VCT in 2004. No data were yet reported for 2005.

In both 2003 and 2004, PERWAKOS conducted one coordination meeting with CST service organizations and two such meetings in 2005. These meetings resulted in one MOU for both 2003 and 2004, and two MOUs in 2005. In 2003, PERWAKOS had a counselor conduct 25 visits to waria living with HIV/AIDS, with no data reported for 2004 and 2005. PERWAKOS had 12 active buddies from 2003 to 2005, who conducted 12 meetings each year, and handled 21 cases in 2003, 11 cases in 2004 and 26 cases in 2005. PERWAKOS also provided home care packages to four PLWHA in 2003, seven in 2004. No data reported for 2005. PERWAKOS also referred 21 PLWHA for treatment in 2003, 11 in 2004 and two in 2005, all of whom also received treatment.

Create a favorable environment to support program implementation and behavior change

In 2003 PERWAKOS conducted six advocacy and networking activities with 185 participants. In 2004, PERWAKOS conducted five advocacy and networking activities with 95 participants and four activities in 2005 with 75 participants, meeting both years' annual targets

4.3.3 Yayasan Pelangi Kasih Nusantara: MSM and MSW in Jakarta

Behavior change interventions

With activities starting in May 2003, field staff reached 1,984 new contacts in that year (17 percent MSW and 83 percent MSM). New contacts decreased in 2004 to 1,264 (77 percent MSW and 23 percent MSM) and increased to 3,631 in 2005 (38 percent MSW and 62 percent MSM). In addition, field staff reached 308 repeat contacts in 2003, followed by 2,065 total repeat contacts in 2004 (89 percent MSW and 11 percent MSM), and 2,388 in 2005 (75 percent MSW and 24 percent MSM). Field coordinators and workers also conducted group discussions with MSW and MSM: five discussions with 80 participants in 2003, four discussions with 91 participants in 2004 and seven discussions with 420 participants in 2005. While talking with contacts, field staff distributed a decreasing number of BCC materials over time: 11,919 distributed items in 2003, 5,259 in 2004 and 4,834 from January to September, 2005.

In order to increase MSM and MSW's access to condoms and lubricant, YPKN conducted one coordination meeting with a condom supplier in both 2003 and 2004 and two meetings in 2005. These meetings resulted in a signed MOU in 2003 with DKT International, another MOU with the district health office in 2004 and two MOUs in 2005 (one with DKT International and one with the district health office). YPKN purchased Protector Condoms at a subsidized rate from DKT International and received Artika condoms for free from the district health office. In 2003, YSS established and maintained 30 condom distribution outlets. This increased to 45 outlets in 2004 and 2005. In 2004, YPKN conducted one meeting with a lubricant supplier, which also resulted in a MOU. Field staff distributed 8,328 condoms in 2003, 17,044 in 2004 and 12,377 in 2005. In addition, YPKN distributed nearly 9,600 SSPs from 2003 to 2005.

YPKN field staff referred 703 people (98 percent MSW and 2 percent MSM) for STI services in 2003, 688 (74 percent MSW and 26 percent MSM) in 2004, and 503 (61 percent MSW and 39 percent MSM) in 2005. According to the FHI program database, YPKN did not make any referrals for VCT services in 2003 and 2004, and no numbers were reported for 2005.

Other YPKN BCC activities included one edutainment session in 2003 with 600 participants, two sessions in 2004 with nearly 1,000 participants and three sessions in 2005 with over 1,600 participants.

Access to STI, VCT and CST services

To increase MSW and MSM's access to STI services, YPKN conducted three coordination meetings with STI service providers in 2003, and an unreported number of meetings in 2004 and 2005. As with YSS and waria in Jakarta, the STI referral clinic for MSW and MSM in Jakarta was the PKBI clinic. To increase the number of MSW and MSM receiving STI treatment, a mobile clinic also visited some of the massage parlors, usually during the program's bi-monthly meetings.

In 2003, field staff made a total of 703 (MSW 98 percent and MSM 2 percent) referrals for STI services, of which 16 actually attended the clinic. However, a total of 22 MSW and MSM patients attended the clinic, of whom 14 underwent anal examinations and 20 received treatment for STIs. In 2004, these numbers increased to a total of 688 (MSW 74 percent and MSM 26 percent) referrals by field staff, of which 66 attended the clinic. Also in 2004, a total of 264 referred and non-referred patients attended, of whom 233 received anal examinations and 148 were treated for STIs. In 2005, field staff made a total of 503 (MSW 61 percent and MSM 39 percent) referrals, of which an unreported number attended the clinic. Nevertheless, in 2005, a total of 404 attended the clinic, of whom 369 had anal examinations and 154 received treatment for STIs. The FHI database did not report any VCT and CST-related data for YPKN.

Create a favorable environment to support program implementation and behavior change

The FHI/Indonesia program database did not report any YPKN advocacy and networking activities for 2003 and 2004. It did show that YPKN conducted the following meetings in 2005:

- Monitoring and evaluation meeting with Komisi Penanggulangan AIDS Daerah and other stakeholders, two meetings with 32 participants
- Yayasan Srikandi Sejati, four meetings with four participants
- Yayasan Mitra Indonesia, four meetings with four participants
- Perkumpulan Keluarga Berencana Indonesia, two meetings with two participants
- DKT International, two meetings with eight participants
- Pengembangan Kemitraan dalam Pemberdayaan Masyarakat , two meetings with 10 participants

4.3.4 Gaya Nusantara Surabaya: MSM and MSW in Surabaya

Behavior change interventions

Field staff contacted 2,183 new individuals (94 percent MSM and 6 percent MSW) in 2003, 2,331 in 2004 (92 percent MSM and 8 percent MSW) and 1,345 (91 percent MSM and 9 percent MSW) from January through September 2005. In addition, field staff reached an increasing number of repeat contacts: 7,070 in 2003, 12,012 in 2004 and 12,015 from January to September 2005. Field staff also conducted three group discussions in both 2003 and 2004 (attended by about half of the set targets for participants), and nine sessions in 2005.

While conducting outreach activities, field staff distributed 2,155 BCC materials in 2003, 1,346 in 2004, and 839 from January through September 2005. In addition, but not with ASA funds, GN published and distributed a monthly magazine (400 copies per issue), which focused on Indonesian MSM lifestyle, including sexual health matters.

GN met with DKT International once a year from 2003 to 2005 to discuss condom and lubricant supply issues, and to establish three annual MOUs. No outlet data has been reported for the period 2003 to 2005. However, in the Reflections and Recommendations Workshop, staff explained that because the outlets were not functioning well, GN decided in 2004 to distribute condoms and lubricant only through its field workers. Field staff distributed an increasing number of condoms: 4,578 in 2003, 7,900 in 2004 and 10,392 in 2005. In addition, a variable number of SSPs distributed was reported: 6,633 in 2003, 384 in 2004 and 10,069 in 2005.

GN field staff referred 95 individuals (69 percent MSM and 31 percent MSW) for STI services in 2003, 29 individuals (100 percent MSM) in 2004 and 38 individuals (95 percent MSM and 5 percent MSW) from January to September 2005. Only nine individuals (100 percent MSM) were referred for VCT services in 2005.

GN conducted several other BCI. In 2003, GN conducted four edutainment sessions with over 3,000 participants and another four sessions in 2004 with nearly 3,000 participants. Data for 2005 was not yet reported. From 2003 to 2005, GN ran a telephone hotline, which received 114 callers in 2004 and 380 callers in 2005. GN also maintained a Web site with an unrecorded number of hits or unique IP addresses.

Access to VCT, STI and CST services

As with PERWAKOS and the waria community in Surabaya, Pusekmas Perak Timur was the STI referral clinic for MSW and MSM in Surabaya. In 2003, GN made 95 referrals to the STI clinic (79 percent MSM and 21 percent MSW). No other program data related to STI services were reported for this year. In 2004, GN met twice with the STI service provider and field staff made 29 referrals to the clinic, all well below the annual targets. Of the 29 referrals, only eight attended the clinic. However, a total of 50 MSM (both referral and non-referral) were seen at the STI clinic, of which all received anal examinations and five were treated for STIs. In 2005, field staff made 38 referrals. A total of 103 MSM (MSW and MSM), both referral and non-referral, attended the clinic in 2005, of whom 102 received anal examinations and 21 were treated for STIs.

GN did not begin VCT referral activities until 2005, at which time field staff referred nine MSM, all of whom went for services. In that same year the data from the VCT clinic showed that only 26 MSM received counseling, of whom 23 underwent an HIV test.

GN reported conducting three coordination meetings with CST service organizations in both 2004 and 2005, resulting in one MOU for each year. No referral cases to CST services were reported by GN.

Access to VCT, STI and CST services

Although the FHI/Indonesia program database reported very little on GN's advocacy and networking activities, GN reported to have conducted the following:

2004:

- Monitoring meetings, two times per month, 25 participants per event
- Coordination meeting with stakeholders, four times
- Coordination meeting with hospital, one time per week
- Coordination meeting with BDNA, two times
- Coordination meeting with STI clinic

2005:

- Monitoring meetings, two times per month, 25 participants per event
- Coordination meeting with stakeholders, four times
- Coordination meeting with hospital, one time per week
- Coordination meeting with BDNA, two times
- Coordination meeting with STI clinic and district-level health office, four times

Additional collaborative activities with the Provincial AIDS Prevention Committee and other institutions included seminars, conferences, radio and TV broadcasts, policy review meetings, World AIDS Day, Archipelago AIDS Reflection Night as well as various advocacy efforts with government offices. GN also reported to have conducted a monthly radio program in 2003 and 2004, and a bi-monthly radio program in 2005.

4.4 Outcomes for the waria and MSM/MSW programs

The outcomes were assessed through the IBBS (Jakarta)/BSS (Surabaya) in 2002 and the BSS in 2004 (in both cities). Since these surveys were conducted by city and by MSM group (MSM, MSW and waria), the outcomes, unlike outputs, are presented in this report in the same way.

4.4.1 Waria in Jakarta and Surabaya

The program targeting waria in Jakarta started right after the dissemination of IBBS survey's findings in December 2002, whereas in Surabaya the program started later, in September 2003. In Surabaya, only BSS was conducted in 2002. In both cities, there were no previous interventions targeting waria prior to the establishment of YSS interventions in Jakarta and PERWAKOS interventions in Surabaya.

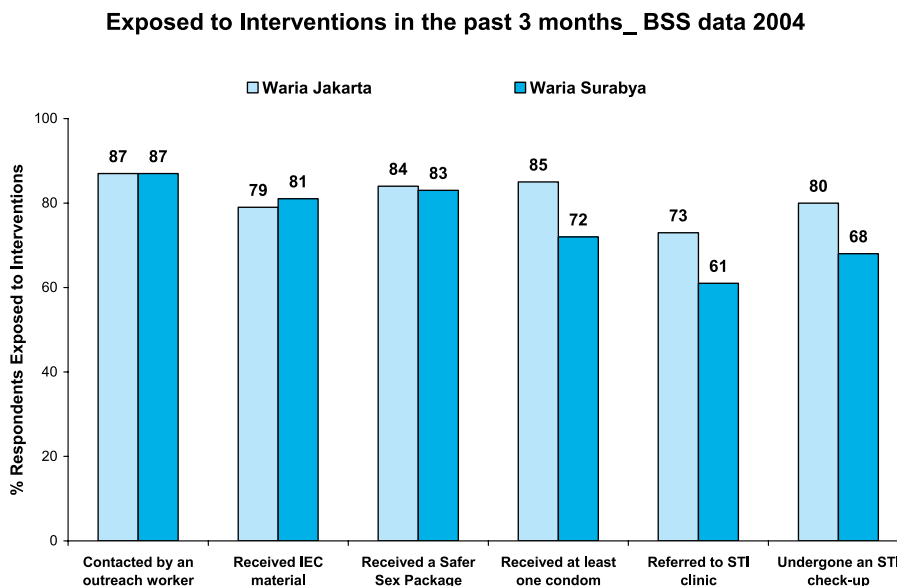
Key behavioral outcomes significantly increased from 2002 to 2004 for waria in both cities.

- Increase in condom use at last anal sex with a client: Jakarta, from 43 percent in 2002 to 81 percent in 2004 ($p < 0.001$); Surabaya, from 40 percent to 71 percent ($p < 0.001$)
- Increase in consistent condom use during anal sex with clients: Jakarta, from 14 percent to 56 percent ($p < 0.001$); Surabaya, from 10 percent to 49 percent ($p < 0.001$)
- Increase in use of water-based lubricant with condoms at last anal sex: Jakarta, from 13 percent in 2002 to 43 percent in 2004 ($p < 0.001$); Surabaya, from 11 percent to 22 percent ($p < 0.001$)

- Increase in seeking VCT services: Jakarta, 0 percent in 2002 to 43 percent 2004 ($p < 0.001$); Surabaya, percent to 20 percent ($p < 0.001$)
- Decrease in any unprotected anal sex in the past month: Jakarta, from 66 percent to 48 percent ($p < .0001$); Surabaya, 88 percent to 47 percent ($p < 0.001$)

Despite some issues related to the quality of the program data collected by the organizations, the BSS data in 2004 were in line with the process indicators reported by the two CBOs, as they showed a high coverage for some components of the interventions in the past three months prior to data collection in 2004. As Figure 5 shows, the majority of waria surveyed had been contacted by field staff, had received either IEC materials or a condom, had received a SSP, had been referred to a STI clinic and had undergone a STI check-up, all in the three months prior to being interviewed in 2004. However, as already reported above, less than half of waria (about 44 percent) in Jakarta and one-fifth in Surabaya reported having taken a HIV test at a VCT center in the past year.

Figure 5: Program coverage among waria in Jakarta and Surabaya



In addition, waria in Jakarta exposed to interventions in the past three months (i.e., contacted by an outreach workers, received a safer sex package, referred to a STI clinic, received either BCC materials or condom) were more likely to use water-based lubricant with condom at last anal sex (OR 3.3, 95 percent, CI 1.4 - 7.1) and to have gone for a STI check-up (OR 13.6, 95 percent, CI 6.3 – 29.3) compared to those who were not exposed. In Surabaya, waria exposed to interventions were more likely to undergo a STI check-up at STI clinic (OR 50.7, 95 percent, CI 19.1 – 134). With regard to other selected outcomes (knowledge and behavioral outcomes) in both cities, there were also encouraging differences between those who were exposed versus those not exposed, but these differences were not statistically significant ($p > 0.05$). This might also be due to the short timeframe (the past 3 months) used for these outcomes related to exposure to interventions in the survey. This effectively excluded those who may have been exposed to interventions outside of the three-month timeframe from the denominator “exposed to intervention”.

4.4.2 MSW and MSM in Jakarta and Surabaya

The program targeting MSM and MSW implemented by YPKN in Jakarta was established in May 2003. In Surabaya, the program implemented by GN started early in 2003. However, GN was already established in Surabaya prior to the support of ASA, implementing sporadic and small scale interventions.

Compared to the interventions targeting waria in Jakarta and Surabaya, the interventions targeting MSW showed slight success in terms of coverage and behavior change by some components of interventions, whereas the interventions targeting MSM were to some degree less successful, particularly in terms of coverage in Jakarta.

Key behavioral outcomes among MSW in 2002 and 2004:

- Increase in condom use at last anal sex with a client: Jakarta, from 56 percent to 84 percent ($p < 0.001$); Surabaya, from 53 percent to 47 percent ($p = 0.6$)
- Increase in consistent condom use during anal sex with clients: Jakarta, from 16 percent to 53 percent ($p < 0.001$); Surabaya, from 18 percent to 29 percent ($p < 0.05$)
- Increase in use of water-based lubricant with condoms at last anal sex: Jakarta, from 15 percent to 69 percent ($p < 0.001$); Surabaya, from 0 percent to 24 percent ($p < 0.001$)
- Increase in seeking VCT services: Jakarta, from 0 to 21 percent ($p < 0.001$); Surabaya, from 2 percent to 15 percent ($p < 0.001$)
- Decrease in any unprotected anal sex in the past month: Jakarta, from 71 percent in 2002 to 46 percent in 2004 ($p < 0.001$); Surabaya, from 58 percent to 50 percent ($p = 0.1$).

Key behavioral outcomes among MSM in 2002 and 2004:

- Increase in condom use at last anal sex with another male: Jakarta, from 31 percent to 62 percent ($p < 0.001$); Surabaya, from 26 percent to 41 percent ($p < 0.01$)
- Increase in consistent condom use during anal sex with males: Jakarta, from 13 percent to 49 percent ($p < 0.001$); Surabaya, from 23 percent to 19 percent ($p = 0.4$)
- Increase in use of water-based lubricant with condoms at last anal sex: Jakarta, from 31 percent to 61 percent ($p < 0.001$); Surabaya, from 0 percent to 34 percent ($p < 0.001$)
- Increase in seeking VCT services: Jakarta, from 1 to 10 percent ($p < 0.001$); Surabaya, from 0 percent to 11 percent ($p < 0.001$)
- Decrease in any unprotected anal sex in the past month: Jakarta, from 58 percent in 2002 to 36 percent in 2004 ($p < 0.001$); Surabaya, from 84 percent to 56 percent ($p < 0.001$)

Because of the lack of quality monitoring and evaluation (M&E) data, it was particularly difficult to confirm whether the program data were consistent with the BSS data related to coverage for some components of the interventions in the past three months prior to data collection in 2004. As Figure 6 shows, about half of the MSW in Jakarta and Surabaya had been contacted by field staff, had received either BCC materials or a condom and had been referred to a STI clinic. A majority of them had received SSPs. However, when looking at health seeking behavior outcomes, only about one fifth of MSW in both cities had undergone a STI check-up in the past three months prior to being interviewed, and 21 percent in Jakarta and 15 percent in Surabaya reported an HIV test at a VCT center in the past year. Although the level of HIV testing in 2004 could be considered low for MSW, it is important to note that in 2002, this level was about 0 percent in both cities.

Figure 7 shows a similar pattern for MSM in both cities but with a much lower and worrying coverage, particularly for MSM in Jakarta but also for health seeking behavior outcomes.

Figure 6: Program coverage among MSW in Jakarta and Surabaya

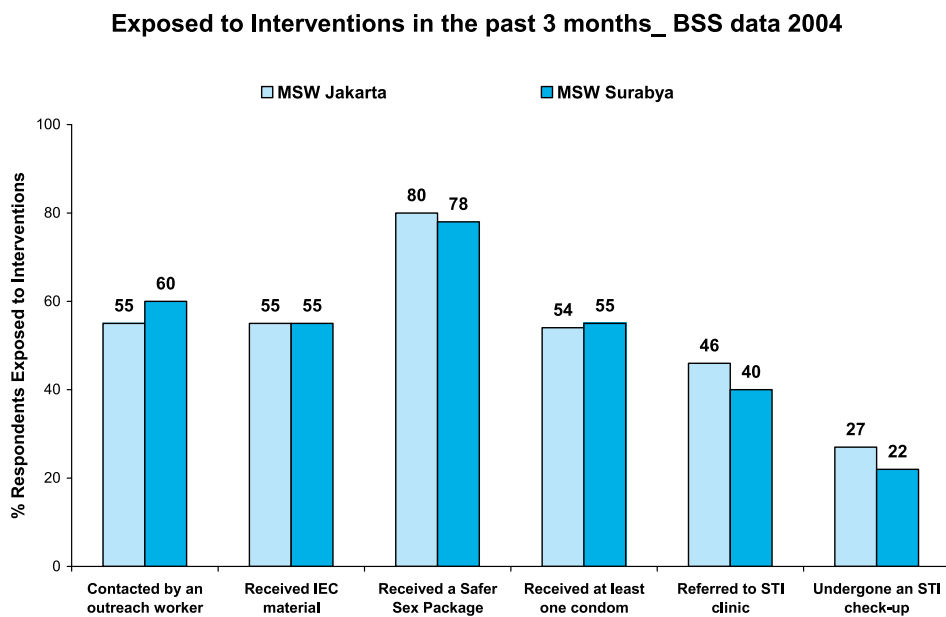
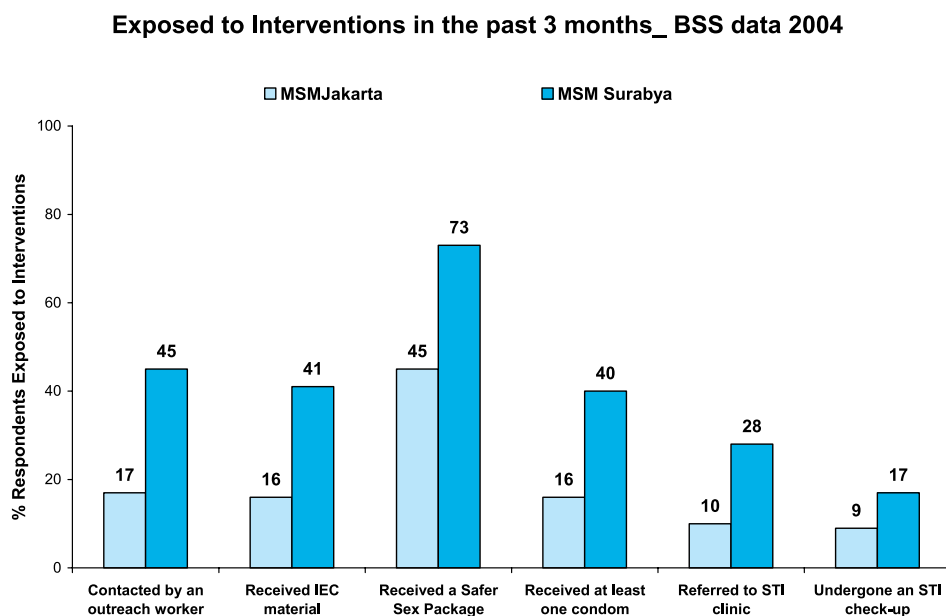


Figure 7: Program coverage among MSM in Jakarta and Surabaya



MSW in Jakarta exposed to interventions in the past three months were more likely to undergo a STI check-up at a STI clinic (OR 8.3, 95 percent, CI 14.1 – 16.9), use water-based lubricant with a condom at last anal sex with a client (OR 3.6, 95 percent, CI 1.4 – 9.4) and to undergo a HIV test in the past year (OR 6.4, 95 percent, CI 3 – 13.7) compared to those who were not exposed.

Although encouraging differences were found for the other knowledge and behavioral outcomes, they were not significant. Similar patterns were found among MSW in Surabaya for all the knowledge and behavioral outcomes; encouraging, but not statistically significant, differences for those exposed to interventions compared to those who were not.

MSM in Jakarta exposed to interventions were also more likely to undergo a STI check-up at a STI clinic (OR 11.8, 95 percent, CI 4.4 – 33.5) and to undergo a voluntary HIV test in the past year (OR 3.2 95 percent, CI 1 – 9.6). MSM in Surabaya exposed to interventions were more likely to report non misconception about HIV transmission and prevention (OR 2.5, 95 percent, CI 1.2 – 5.1) and to undergo an STI check-up (OR 3.7, 95 percent, CI 1.7 – 8.5). In both cities, most of the other selected outcomes (knowledge and behavioral) showed encouraging, though not statistically significant differences ($p > 0.05$).

4.5 Triangulation and interpretation

4.5.1 Waria in Jakarta and Surabaya

Despite some issues related to the quality of data collected, the program data for both CBOs demonstrated positive trends for the majority of the outputs between 2003 and 2005, with the exception of the number of new contacts, which decreased from 2004 to 2005, and the number of participants who attended edutainment activities in Surabaya. The 2004 BSS data was, however, in line with the process indicators reported by the two CBOs as they showed a high coverage for some components of the interventions in the past three months prior to data collection in 2004.

In terms of outcomes, all key sexual and health seeking behavior indicators significantly increased during the two-year time period. However, the BSS data in 2004 also revealed that only 43 percent of the waria in Jakarta and 20 percent in Surabaya had been tested for HIV in the past year. This corresponded with the low number of waria referred to VCT clinics as reported in their program data from 2003 to 2005; a total of 174 and 83 warias in Jakarta and Surabaya respectively during this period. This was certainly due, as explained by the qualitative data collected during the evaluation, to a lack of understanding about the benefits of the VCT services and ARV treatment combined with fears of stigma and discrimination if diagnosed positive, and the lack of availability of waria-friendly clinics in the areas where waria work and/or live.

The low numbers of persons tested could also be explained by the fact that results were not given immediately and sometimes took several days, and the lack of medical follow-up after testing and treatment (as reported by the staff of these organization during group discussions). The proportion of waria attending an STI check up in the past three month was quite high in Jakarta (80 percent) and a bit lower in Surabaya (68 percent). However, the organization staff expected the level of STI check-ups to be higher since the organizations promoted a STI check up every three months. Staff attributed the lower level of STI check-up among waria to: some obstacles related to misconceptions about STI symptoms, the limited number of clinics, a lack of privacy in some clinics, inappropriate opening hours of the clinics and the fact that some warias did not have official identity cards that allowed them to receive care and treatment at the governmental hospital.

In addition, as seen in the outcomes section, a majority of behavioral outcomes showed positive and encouraging differences between those who had been exposed to interventions and those who had not been exposed in the past three months. Some of these differences were found statistically significant and some were found to be only encouraging.

The value of the community organization might have also contributed to the relative success of these interventions in terms of coverage and outcomes. All the members from both CBOs were from the waria community and the STI clinic in Jakarta was also staffed with waria, which facilitated the contact with the beneficiaries. Staff members truly cared about their community and, as one person from the organization said, they worked under the principles of *asah* (care), *asih* (love), and *asuh* (take care).

YSS staff in Jakarta explained that there had been a sharp increase in demand for condoms, particularly in “hotspots”, supporting the evidence of self-efficacy of the communities in using condoms. The targeted IEC materials, e.g., the SSP, which took into consideration waria’s insights, were also considered by YSS staff as one of the important factors contributing to the success of their interventions; though they were not diversified enough. Edutainment activities were perceived as culturally appropriate and a good medium to transfer knowledge and mobilize communities. The community generally perceived condoms and water-based lubricant sachets as available, but there were some concerns related to the affordability (particularly the cost of the water-based lubricant), the quality of these commodities and the functioning of the condom outlets as reported by the staff of these CBOs.

The key weakness of the interventions implemented by the two CBOs was related to interventions reaching the clients of the waria. Staff of both CBOs expressed their difficulties in reaching clients. Although clients were mainly reached through their edutainment activities, it was difficult for the waria to approach them through interpersonal communication as they expressed their shyness to discuss sexual health with clients (lack of empowerment) and also the client’s disinterest in discussing this matter with them.

Considering that no other targeted interventions reaching waria were implemented during this period in both cities, these findings demonstrated the contribution of interventions implemented by YSS in Jakarta and PERWAKOS in Surabaya to these behavioral changes. In addition, data obtained from STI clinics in Jakarta (Perkumpulan Keluarga Berencana Indonesia) and Surabaya (Puskesmas Perak Timur), which were also supported by the ASA program and where waria were also referred, corroborate the consistency of these positive changes in sexual behaviors beyond 2004. STI cases among waria diagnosed in these clinics decreased from 2004 to 2005. In Jakarta STI clinics, 34 percent (n = 663) were diagnosed with an STI in 2004 but only 13 percent (n = 688) in 2005 ($p < 0.001$). The same patterns were found in Surabaya clinic: a decrease from 17 percent (n = 527) to 7 percent (n = 413) among waria in 2004 and 2005 respectively ($p < 0.001$).

Although the capacity building of staff and the advocacy and policy strategies were crucial components of the program, the evaluation did not look further into the link between these two strategies and the impact of their interventions. However, some qualitative information related to these strategies had been reported by the staff. The self-reported strengths were that the organizations are well established and have a strong leadership, and that the IAs have good working relationships with government health and social welfare offices, local AIDS commissions, and other NGOs. Reported weaknesses included: the lack of a well-formulated advocacy strategy, staff not adequately trained on this topic, and interaction with government agencies and other NGOs was often limited to only HIV/AIDS and reporting. Issues related to a lack of program planning, and monitoring and evaluation were also identified

4.5.2 MSM and MSW in Jakarta and Surabaya

Major issues related to the quality of the M&E data collected from 2003 to 2005 were also identified for both CBOs during the evaluation. In addition, for some key process indicators the data were not consistently disaggregated by group, i.e., MSM and MSW. However, after revising and adjusting the data, the MSM and MSW data from Jakarta showed some positive trends for the number of new and repeated contacts, number of condoms distributed, number of beneficiaries attending edutainment activities, number of beneficiaries referred to STI services, and the number of condom outlets established. There were no data reported for referral to VCT and CST services. For the project in Surabaya, only a few positive trends were identified: the number of repeated contacts, and the number of condoms and SSPs distributed.

Because of the lack of quality of the program data, it was particularly difficult to confirm whether the output indicators were consistent with the BSS data (2004) related to the coverage of some components of the interventions in the past three months prior to data collection in 2004. The coverage of these interventions was, however, dramatically low, particularly for MSM in Jakarta where MSM locations were spread out over the megalopolis and difficult to reach by only one CBO. In terms of outcomes assessed with the IBBS and BSS in 2002 and 2004, all key sexual and health-seeking behavior indicators for MSM and MSW in both cities significantly increased during the two-year time period, except for condom use at last anal sex with a client for MSW in Surabaya, which decreased from 53 percent in 2002 to 47 percent in 2004, but was not statistically significant.

The BSS data in 2004 revealed that only 21 percent of MSW and 10 percent of MSM in Jakarta had been tested for HIV in the past year. The same patterns were found for MSW and MSM in Surabaya: 15 percent and 11 percent, respectively. These findings also corresponded with the small number of beneficiaries referred to VCT services by the field staff, as illustrated by the outputs indicators reported by each agency. This low rate of testing was likely due to a lack of understanding of the benefits of VCT and ART combined with fear of stigma and discrimination if diagnosed positive, the lack of availability of MSM-friendly clinics, and the lack of medical follow-up after testing and treatment as reported by the staff of these organization during group discussions. Another contributing factor could be the lack of promotion of VCT services by the outreach workers, which could explain the quasi absence of monitoring data related to the referral to these services. However, as mentioned previously, the BSS data showed a much better situation in 2004 compared to 2002. This was illustrated by a significant increase in MSM and MSW in both cities seeking VCT services in the past year.

Given the quasi non-existence of previous and other current interventions targeting MSM and MSW in Jakarta and Surabaya, the moderate changes in sexual behaviors from 2002 to 2004 (condom use and health seeking behaviors) were, however, encouraging and could also be attributed to the interventions of YPKN in Jakarta and GN in Surabaya.

The key weakness for MSM and MSW programs in both cities was the low coverage of interventions. However, it should be noted that the MSM/MSW population in Jakarta (approximately 100,000) was significantly larger than the waria population (about 2,000), and due to stigma and discrimination the MSM population was likely to be more hidden. Waria, who were organized as a community, and MSW by the nature of their work, were more visible and, therefore, more accessible as illustrated by the data on coverage (Figures 5, 6 and 7): in the past three months, 87 percent of the waria in Jakarta and the same proportion in Surabaya were contacted by an outreach worker, compared to 55 percent of MSW in Jakarta and 60 percent in Surabaya, and only 17 percent of MSM in Jakarta and 45 percent in Surabaya.

The staff of the two organizations stressed the importance of a peer approach by a direct community member accompanied by BCC materials tailored to their populations. Staff also stressed the importance to diversify the type of behavior change interventions, particularly those aimed at reaching hidden MSM.

Both organizations implemented capacity building and advocacy and policy strategies. However, the evaluation team found the same issues and findings described in the section related to waria.

5. KEY FINDINGS FROM ANALYSIS OF NEPAL DATA

5.1 Brief description of the MSM Program

Chartered in 2001, Blue Diamond Society (BDS) was the only MSM sexual health organization in Nepal. BDS offered integrated drop-in center services, field-based services and STI clinical services. FHI began supporting BDS's Kathmandu-based interventions in 2002.

5.2 Strategies and activities

Although these changed slightly over time and across the different written agreements, the FHI-supported component of BDS followed these general strategies:

- Behavior change communication
- Local advocacy and networking
- Social and community mobilization
- Linkages to services and products
- Capacity building of the institution and its partners

5.3 Activity outputs

5.3.1 Behavior change communications

Outreach and peer education

Between 2002 and 2004, BDS provided peer education and outreach to a total of 11,078 MSMs and also conducted 16,278 repeat contact visits. As shown in Table 5 below, there was unevenness in outreach outputs over time and a sharp decrease in the number of contacts over time from 7,738 in 2002 to only 599 in 2004. This may be explained by numerous factors including:

- A saturation of easily identified MSM in the project catchment area over time
- A change in the definition of MSM contacts, put into effect in 2004 that required beneficiaries to self-identify as MSM in order to be counted as a contact
- The increasing political instability and frequency of police crackdowns on group activities in public places.

In comparison, the number of repeat contacts and BCC materials distributed decreased between 2002 and 2003 but increased to annual highs in 2004 (Table 5). There were sharp increases in the number of safe sex commodities over time: condoms distributed and the number of lubricant tubes distributed increased each year from 2002 to 2004. There was also a steady increase in the number of STI referrals made over time (Table 5).

Table 5: Key BDS outreach and peer education activity outputs

Indicator/Year	Apr-Dec 2002	Jan-Dec 2003	Jan-Dec 2004	Total
Number of NEW contacts	7,338	3,141	599	11,078
Number of REPEATED contacts	6,300	4,099	5,879	16,278
Number of MSM educated through group meetings	8	44	1,807	1,859
Number of IEC materials distributed	7,080	5,808	8,547	21,435
Number of condom demonstrations	285	549	1,911	2,745
Number of MSM reached through condom demonstrations	6,300	4,187	6,504	16,991
Number of condoms distributed	28,370	64,926	182,073	275,369
Number of lubricant tubes distributed	1,877	1,056	11,700	14,103
Number of referrals for STI treatment and counseling	199	519	1,723	2,441

Drop-in center activities

There was one FHI-supported DIC operated by BDS in Kathmandu, and BDS operated an additional five DICs funded via other donors. The DICs offered a number of services to MSM, including one-on-one education, counseling, group sessions and discussions, and video shows on HIV, AIDS and STIs. BCC materials, condoms and lubricant were also distributed at the DICs. The DICs also served as resource centers for collaborating institutions and technical advisors.

There were large steady increases in the number of visitors; from 1,223 in 2002, to 3,638 in 2003, to nearly 6,000 in 2004. There were about 55 HIV/AIDS orientation participants in both 2002 and 2003, and this increased to 155 in 2004. The number of video shows increased from 18 with 416 participants in 2002 to 45 with 1,126 participants in 2003, but dropped back down to 12 shows with 428 participants in 2004.

5.3.2 Access to commodities and services***Condoms and lubricant***

To increase access to condoms in Nepal, BDS conducted four coordinating meetings for social marketing condom provider organizations (i.e., Social Marketing Distribution and Population Services International). However, planned meetings with government agencies regarding the supply of free condoms never actually took place. As previously discussed, there was a steady increase in the volume of socially marketed condom distributed by BDS via field staff between 2002 and 2004.

STI services

Starting in 2003, STI clinic services were provided on a weekly basis at the FHI-supported DIC in Kathmandu. However, these sessions stopped after the implementing agency and FHI learned of poor quality medical treatment, discriminatory behavior toward some MSM and breaches in confidentiality by the contracted clinic. At the time of the evaluation, no STI services were provided at the DIC. Instead, field and office project staff encouraged and assisted MSM to attend other STI clinics. As discussed previously, there was a steady increase in the number of referrals to STI services. To further increase access to STI services, BDS conducted several coordination meetings with different clinics, which, since the conclusion of the evaluation, resulted in a new STI clinic specifically for MSM.

VCT and CST services

While referral to VCT services was not part of BDS's documented strategic activity plan, referrals were routinely conducted during outreach and peer-education contacts and at the DIC. However, no output monitoring data was available that tracked and quantified this activity. Due to almost non-existent availability of care, support and treatment services in Kathmandu, very few referrals were believed to have been made.

5.3.3 Advocacy and networking

For BDS, advocacy and networking were major organizational strategies, whereby BDS described itself as an organization that “provided health and advocacy services to gay men, as well as to lesbians, bisexuals and transgender people in Nepal.” Although BDS also conducted other advocacy and networking activities, with FHI support it conducted the following:

- Meetings with various stakeholders, including other HIV/AIDS NGOs, police, journalists, TV producers, lawyers and human rights organizations
- Mass awareness campaigns, such as mass gatherings and cultural shows
- Special days and festivities, including World AIDS Day, National Condom Day, Gay Pride March, New Year's Eve and the Nepali festivals of Teej and Tahir
- Regular media campaigns, including weekly newsletters, occasional radio programs, and articles and letters to newspapers

5.3.4 Capacity building of implementing agencies

With FHI support, BDS established an office and DIC, and recruited staff. Staff also underwent numerous trainings in outreach and communication skills, counseling, financial management, and advocacy. Staff also participated in mapping exercises and exposure visits to other HIV/AIDS organizations.

5.4 Outcomes

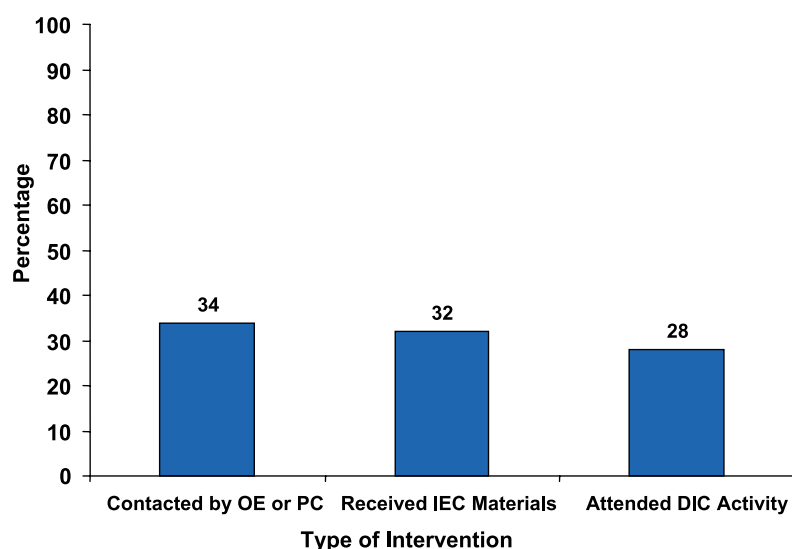
It is important to note that the outcome evaluation was limited by the fact that only one round of 2004 IBBS data was available. Hence, it was not possible to conduct time trend analysis of outcome measures, as had been possible for the Bangladesh and Indonesia programs. It is also important to note that the IBBS data can be used to help evaluate outcomes related to BCC intervention coverage and to assess potential program effects by comparing measures between those exposed versus those not exposed to program interventions.

5.4.1 Behavior change communications

Program coverage

According to 2004 IBBS data, 37 percent of the MSM in program areas had been exposed to at least one type of BDS-implemented MSM behavior change intervention in the previous 12 months. More specific coverage data is given in Figure 8 below.

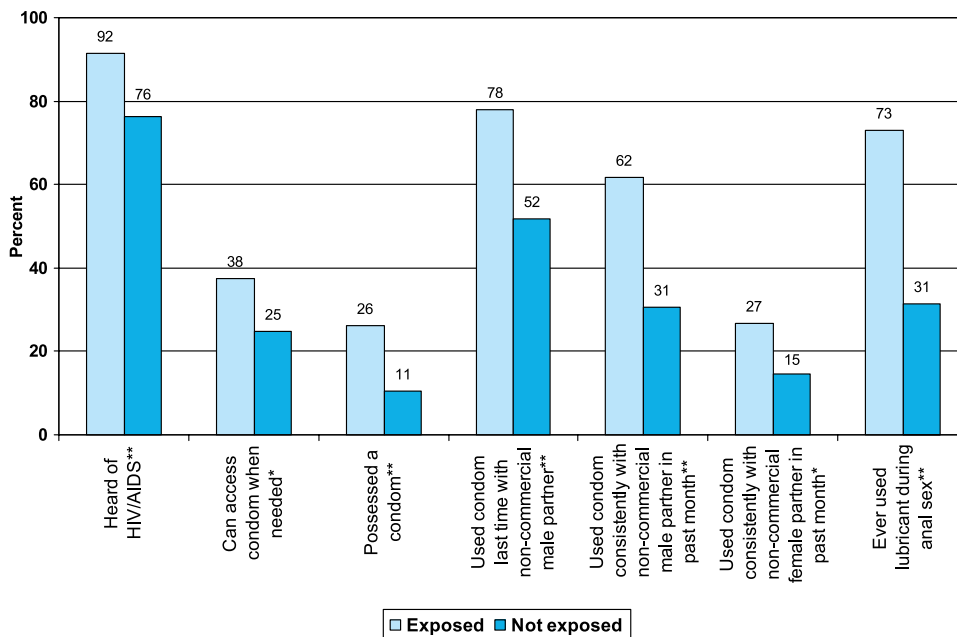
Figure 8: Exposure to MSM interventions in Kathmandu, Nepal, 2004



Differences and changes in knowledge and use of condoms and lubricant

In 2004, a significantly greater proportion of MSM exposed to the BDS interventions reported significantly greater levels of the key knowledge and behavioral indicators given below (Figure 9). In addition, a borderline significant relationship ($p = 0.58$) was observed for use of condoms during last sex with a commercial male partner. To determine whether the confounding influences of other demographic or socioeconomic variables (i.e., age, marital status, income, mobility, caste and education) might explain these findings, multiple logistic regression models were constructed. These models showed no evidence of weakening of statistical associations which made it unlikely that inherent differences in respondents accounted for the findings observed and gave further evidence that the BDS program accounted for these effects.

Figure 9: Knowledge and condom-related outcomes for MSM, Kathmandu, 2004

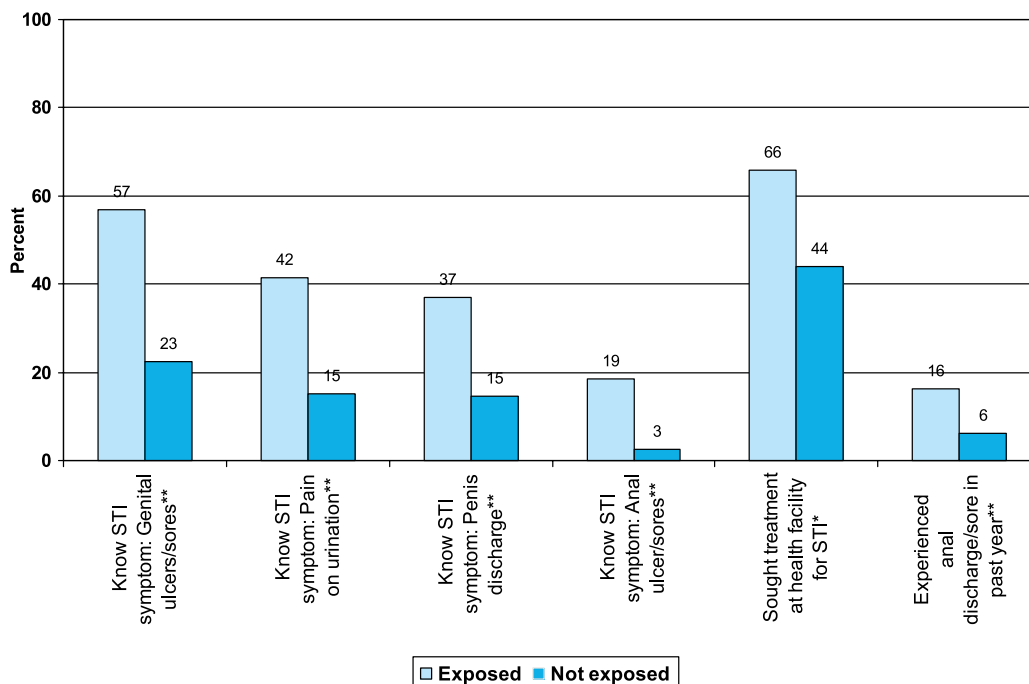


- $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Differences and changes in the use of STI services

MSM interventions also appeared to have positive program effects in increasing MSM’s knowledge of STIs and health-seeking behaviors. As shown in Figure 10, significantly greater proportions of those exposed to BDS interventions had knowledge about various STI symptoms than those not exposed. In seeking treatment, a significantly greater proportion of exposed MSM also reported that they went to a health facility for treatment the last time they experienced STI symptoms. In reporting STI episodes, significantly more exposed MSM self reported anal discharge and soreness than those not exposed. That said, self-reported STI symptoms were often misreported and this finding could be explained by the greater knowledge, and willingness to report STI symptoms among the exposed group. No other significant differences between those exposed and not exposed to a MSM intervention related to the reporting of other STIs.

Figure 10: STI-related Outcomes by Exposure Level for MSM, Kathmandu, 2004



* $p < 0.05$, ** $p < 0.01$

Differences and changes in the use of VCT services

A significantly greater proportion of respondents exposed to BDS programming knew where to go for confidential HIV counseling and testing than those not exposed (34 percent versus 14.1 percent, $p < 0.01$). A greater proportion of those exposed also reported to have ever been tested for HIV, albeit still at low rates; only 14 percent of those exposed to the MSM intervention compared to only 6 percent of those not exposed ($p < 0.01$).

5.4.2 Access to commodities and services

STI and VCT Services

As already reviewed in the BCC section, referrals made during community-based outreach work and DIC contacts appeared to have a positive program effect in increasing access to both STI and VCT services.

Before February, 2005, the Nepal Fertility Care Center directly operated an STI clinic at the DIC but reported problems related to the quality of services, discriminatory behavior, breaches in confidentiality by medical staff and declining attendance rates. As a result, these direct services were discontinued. Instead, BDS field and office staff encouraged, and in many cases directly assisted, beneficiaries to go to other STI clinics. In interviews, representatives with these other organizations reported that BDS was doing a good job in raising the awareness of MSM about STIs and HIV, and that there was good coordination between their services and BDS. They further reported that, on average, about five BDS-referred MSM attended these clinics every month. In interviews, partner organizations also explained the importance and usefulness of BDS providing an overall MSM orientation to service providers.

BDS field and office staff also provided referrals to VCT services, although this was less formalized than efforts for STI services and activities were not quantified.

Condoms and lubricant

BDS efforts to increase access and use of condoms were impressive given the increasing volume of condoms directly distributed by BDS. However, activities aimed at increasing the access of free and socially marketed condoms and lubricants by establishing linkages with services providers were very limited and probably had little effect.

5.4.3 Advocacy and networking

BDS embarked on networking and advocacy activities but these were relatively new activities and were being conducted in a rather ad hoc manner driven by conceptual strategies.

Networking: BDS established strong networks with a number of organizations implementing HIV/AIDS-related programs targeting high-risk groups, with partner organizations that provide clinical and legal services, and with other FHI-supported implementing agencies. Networking with these groups helped further implement MSM behavior change interventions in several ways. For example, interviews with outreach educators, peer counselors, beneficiaries and representatives of other organizations revealed that field staff from different organizations coordinated with each other to identify target groups and refer them to appropriate services or organizations. This type of coordination helped BDS field staff identify additional MSM, and to provide them with HIV/AIDS information and services.

Working relationships with other organizations: Interviews with FHI, other funding agencies, and BDS's partner organizations revealed that BDS maintained good working relations with all of them. The partner organizations appreciated BDS's program activities, as well as their approach for meeting organizational objectives. However, some organizations expressed that BDS activities were heavily focused on risk reduction and that the organization made little attempt to motivate MSM to stop sex work and identify alternative sources of livelihood. In addition, BDS's funding agencies and partner organizations reported that BDS had achieved great success in networking and advocating with international organizations on the rights of sexual minorities. However, several suggested that BDS should focus on networking and advocacy with more national-level organizations.

Police brutality: BDS staff expressed that despite police personnel stating that they would respect the rights of sexual minorities, there were repeated cases of police abuse, harassment, and exploitation of MSM. In interviews, partner organizations stated that BDS needed to motivate MSM to change their behavior to avoid facing difficult situations with the police.

Films and documentaries: As revealed in interviews with outreach educators, the movies shown at the DIC provided MSM with information on sexual orientation, issues of living with HIV/AIDS and safer sex practices. Peer counselors and beneficiaries also stated that these types of films were particularly effective in raising the awareness of MSM who were unable to read or use the Internet.

Special Days and Festivals: Group interviews with program participants and individual interviews with BDS staff conveyed that the celebration of Gai Jatra had been successful in drawing the public's attention to the existence of a MSM community and the need to respect their individual rights. These collaborations were also instrumental in demonstrating unity,

solidarity and togetherness among the MSM communities throughout Nepal, raising awareness about HIV/AIDS and promoting condoms among both the public and MSM. BDS staff and beneficiaries celebrating National Condom Day and World AIDS Day were also effective in helping build networks with other organizations and in mainstreaming MSM into the national HIV/AIDS prevention program.

Internet and Web site: Although Web site and Internet services can be faster, more accessible and reach a larger number of people than print media, a very small percentage of Nepal's population had access to the Internet. Since BDS's target group and the majority of its field staff had little formal education, the use and impact of the Internet was limited. However, such services had great potential in reaching MSM of higher economic standing and were often reluctant to approach BDS face-to-face. In addition, the Internet and Web site were instrumental in BDS networking and in conducting advocacy at the international level.

5.4.4 Capacity building of implementing agencies

BDS had undergone numerous FHI and non-FHI supported capacity building activities, including trainings in various management and technical areas, field-based exercises, exchange visits, and national and international workshops and conferences. Although the evaluation could not quantify this, there was undoubtedly improvement in the capabilities of BS staff to manage and implement interventions. When FHI first began working with MSM organizations, the IAs had little, if any, experience managing HIV interventions. Thus, in the beginning, FHI provided a somewhat standardized program and management training package. However, many of the more recent capacity building activities seemed to have occurred on an ad hoc basis.

5. 5 Triangulation and interpretation

Based on the triangulated analysis of BDS program M&E data, in-depth qualitative assessments and the results of a single population-based survey, conducted about three years after BDS activities were initiated, there is adequate evidence to indicate that BDS programming has resulted in reduced risk behavior among MSM in Kathmandu. The evidence for this cause-and-effect relationship can be summarized as follows:

- The high intensity of BDS behavior change intervention outreach and DIC outputs (Table 5). Despite the unevenness observed in some output indicators over time, the overall magnitude of the outputs achieved was evident and by 2004, 37 percent coverage was achieved (i.e., exposure to BDS intervention in the previous 12 months, Figure 8).
- Significantly increased knowledge and safer sex behaviors were reported among MSM exposed to BDS interventions than those not exposed (Figure 9). These associations persisted, and in some cases were strengthened, after multivariate statistical adjustment for key potential demographic and sociodemographic factors of interest. This means that it is unlikely that the reported higher knowledge and less risky behaviors among MSM exposed to BDS interventions were due to self-selection biases, whereby those already practicing safer behaviors might disproportionately be exposed to interventions. On the contrary, BDS programming specifically targeted MSM who were practicing high-risk behavior.

- BDS was the only organization actively conducting HIV prevention interventions among MSM in Kathmandu during the time period of interest (2002-2004) so that competing attribution issues were not very likely. This further supported the plausibility of the linkage between BDS activities resulting in safer behaviors.

Further repeated survey rounds will be important to assess whether BDS program coverage is increasing over time, and whether further increases in safer behaviors are observed among MSM and are needed to corroborate the success of the interventions. While the likely improvements in safer behaviors observed thus far were encouraging, they should be even greater as coverage is further increased up and beyond 37 percent.

6. SYNTHESIS OF KEY FINDINGS AND ASSOCIATED PROGRAM RECOMMENDATIONS

The three country evaluations suggested a number of findings and recommendations applicable to MSM programming in general.

Key Finding # 1:

Issues have been identified relating to program management that impede agencies in increasing coverage and the impact of interventions. The majority of the training courses attended by staff focused on the technical aspects of the program and not on management and/or organizational development. In addition, there was no clear framework on which the programs were founded.

Recommendations:

- The organizational capacity of the agencies needs to be addressed and improved as a priority. It is recommended that a comprehensive organizational capacity and individual skills needs assessment be conducted, particularly in the light of the way in which the agencies choose to expand their activities and the availability of their resources. Based on the findings of the capacity and skills needs assessment, the agencies, along with the appropriate donors, should develop and implement a relevant and feasible capacity building plan. This will allow strategic decisions on the prioritization of future activities to be made in a systematic and coherent manner, and in line with the organizational capacity of each agency.
- In all of the evaluated agencies, there was clear need for better management policies, clearer job descriptions and more professional behavior. These developments are essential, particularly for agencies to effectively expand their activities and coverage. However, to maintain community support, access and relevance, it is important to find an effective balance and foster a synergy between developing professional structures and remaining rooted in the different groups.
- Develop a conceptual framework for MSM interventions highlighting the minimum package of interventions and standard operational procedures (SOPs) for MSM interventions. Such a framework should be aimed at assisting agencies to develop and implement comprehensive and evidence-based MSM interventions. A common framework would also make assessing program effectiveness and the sharing of lessons learned easier and more meaningful. However, a conceptual framework on paper would not be sufficient; staff and volunteers would need to be trained on effective interventions and behavior change.

Key Finding # 2:

Emerging from the three program evaluations were encouraging trends in terms of knowledge, sexual and health seeking behaviors that could be attributed to the interventions, although the quality and the coverage of interventions differed from one program to another. These interventions included, in general, key activities such as peer-outreach, “edutainment”, IEC materials and condoms and/or safer sex package distribution, referral to services, local advocacy and capacity building of the agencies to manage HIV interventions. In addition, drop-in centers and associated services were highly valued by program participants and served as useful hubs for various activities.

Recommendations:

- The framework for MSM interventions should include at least these priority interventions/activities (as a minimum package) for any agency starting to implement a new program. Additional interventions could be then added according the resources and the capacity of the agency. The agency should focus on improving the quality of the current interventions by implementing SOPs and program's quality assurance / quality improvement (QA/QI) assessments, before considering geographic expansion.
- Assist agencies in developing a relevant strategic communication strategy supporting the different activities, and aimed at increasing safe sex and appropriate health seeking behaviors. Formative research prior to developing this communication strategy should be conducted. Relevant channels/media and messages familiar and specific for each population should be identified. At this stage, the involvement of the members of each targeted community is crucial. The quality of the design and production of materials are also essential to attract the attention of appropriate populations. Collaboration with the private sector (marketing/advertisement agency) in developing the strategy and materials should also be considered.
- DIC should also be considered if resources and environment allows it. The DIC should be conveniently located and serve the different specific MSM groups. DIC should also provide a range of services, such as individual and group-level interventions, STI and general health treatment, HIV counseling and testing, vocational skills training, and “hot topic” discussion groups. In addition, social activities aimed to mobilize the groups/communities could also be organized when no other public venues exist, such as bars or discotheques where MSM gather. Each DIC should be separate from administrative offices and should be run by a professional manager.

Key Finding # 3:

Outreach and peer education programs resulted in significant improvements in the first years of implementation but less dramatic changes in later years. In addition, IA staff described how it has become more difficult to identify and talk with new MSM as the programs mature.

Recommendations:

- Early on in prevention efforts, outreach and peer education programs may be important to mobilize MSM communities, but they need to be altered to contact additional new MSM once the initial pool of easy-to-contact vulnerable MSM has been reached.
- MSM programs also need to focus beyond the outreach/peer education and referral to services interventions by integrating community-based, individual and group level interventions and social marketing campaigns in order to better address the dynamic nature of the HIV epidemic and the changing lifestyle and needs of MSM sub-populations.
- Intensive individual contacts of peer education and outreach activities may be limited in gaining extensive coverage and unable to reach the number and types of individuals needed to curb the HIV epidemic. Program managers may want to consider adding to their strategic communication component a scaled-up but highly targeted multi-media campaign to cover larger proportions of the most-at-risk MSM populations, particularly

hidden populations/groups. Such a social marketing campaign should include the use of alternative and relevant media, such as ads in targeted magazines, text messaging to mobile phones, Web sites and community-based events in strategic venues.

- With regard to specific venues such as massage parlors (as seen in Jakarta, Indonesia) or saunas, the implementation of structural interventions aimed to alter the physical environment in which people take risk should be considered by program managers as being complementary to peer education and outreach activities in order to increase the coverage of the interventions, particularly to reach hidden MSM (clients of MSW).

Key Finding # 4:

Use of clinical services (STI and VCT) remained low. On top of the stigma and discrimination related to sexual orientation, there were also fears of being stigmatized or discriminated if being diagnosed and identified positive by peers, the general population and health care providers. Misconceptions about care, support and treatment benefits, and fears over a lack of privacy and breach of confidentiality in health services were also prevalent. Generally, the availability of relevant and attractive services remained low in these countries.

Recommendations: Program managers should assist the agencies in:

- Identifying relevant services on the basis of key criteria such as location and fittings of the premises, privacy, willingness to care for MSM and existence of protocols or SOPs.
- Developing institutionalized (supported by a letter of agreement or a memorandum of understanding between the agency and the clinical service) referral networks to these relevant services and effective procedures for follow-up and monitoring.
- Sensitizing clinic staff (health care providers and support staff) on MSM issues, building the capacity of health care providers on MSM clinical management, and implementing or updating existing SOPs for clinical management and regular QA/QI assessment.
- Developing a communication strategy aimed to position in positive light and to promote the use of these services among MSM, and encourage field staff to promote these services among their peers.

Key Finding # 5:

There were condom and water-based lubricant shortages and some community members perceived that the condoms available from the programs were of poor quality.

Recommendations:

- Assist the agencies to develop linkages to local social marketing agencies (e.g., Population Services International or DKT International), supported by a MOU or a letter of agreement. The agreement should include the provision of the initial stock by the social marketing agency to the implementing agency, capacity building of the implementing agency's staff in identifying non-traditional outlets for condoms and lubricant, managing revolving funds and stock of commodities, marketing commodities, and the provision of promotional materials. The implementing agency should agree to provide monitoring data to the social marketing agency and buy the commodities using the revolving funds.

- Negotiate with government and/or private sector companies (condoms and water-based lubricant manufacturers) to provide free condoms and/or water-based lubricant for MSM who cannot afford to purchase them and for distribution during special events.
- Before distributing generic condoms, it is recommended to trace the manufactory company and the existence of quality testing of these condoms. Usually, social marketing agencies can help in finding the required information. If quality testing is confirmed, it will be necessary to promote the condoms with a message guaranteeing the quality of the condoms. If not confirmed or if it is not possible to find reliable information, it will be recommended to stop or not start the distribution of these condoms and consider destruction

Key Finding # 6:

Various advocacy and networking activities, as a means to create favorable environments for program implementation and behavior change were implemented. However, only one agency had an advocacy plan. Although the plan was a good first step, the activities were too centralized and focused mainly on national level advocacy, neglecting the local issues where interventions are implemented. Misunderstandings between networking and advocacy activities were also found among the majority of staff.

Recommendations:

- Disentangle the concepts of networking and advocacy and clearly articulate separate networking and advocacy strategies. Each strategy or plan should specify strategically-identified outcomes, different targeted audiences or partners and a menu of possible activities.
- Develop an advocacy strategy that includes a local or field-level focus, with staff at different levels working more with local police officers, religious leaders, shopkeepers, guards and other gatekeepers, to enable staff to conduct field activities more effectively and to influence community norms. The advocacy strategy should also focus on working with local decision makers to increase access of MSM to prevention and treatment programs. The networking strategy should include a local or site-level focus that encourages field staff to network with other organizations, to coordinate activities and resources where feasible, to share experiences and promising practices, and to refer MSM to appropriate services.
- Develop linkages, where possible, with agencies experienced in policy and advocacy programs to develop and implement local level advocacy action plans.

Key Finding # 7:

The quality of program interventions was not being monitored to a sufficient degree. Field staffs did not always conduct follow-up visits to all sites. Moreover, the quality of the monitoring data and particularly the use of program data by staff of the agencies were found to be low. Through the three program evaluations, several problems in retrieving and analyzing the program process data were found. Moreover, there were some problems with the opportunistic use of available population-based surveillance data for program evaluation purposes. These surveys were not conducted with program evaluation as a primary concern, and their design and implementation should be better customized for this function in the future.

Recommendations:

- Assist the agencies to develop program logic with clear inputs, outputs and, particularly, outcomes. Meaningful indicators and targets should be selected, with clear articulation in written agreements between donor(s) and agencies. Where feasible, a standardized definition of program coverage and its calculation should be developed.
- Increase supervision, monitoring and support of intervention activities including routine QA/QI assessments. The QA checklists should be consistent with the SOPs used by the agencies. This will help identify areas of weakness for further programmatic strengthening.
- Implement participatory program reviews, in which agencies and donor(s) jointly and periodically review and verify monitoring data, reflect on program progress and (re)plan future actions.
- Building the capacity of the staff at each level, on M&E and QA/QI assessments is crucial.
- Large-scale HIV prevention programs should plan on conducting population-based behavioral monitoring surveys using appropriate probability-based methods before program activities are initiated (i.e., baseline survey) and then at the end-of-the project as well. Ideally, multiple rounds of surveys should be conducted to most effectively monitor trends in program coverage and key behavioral outcomes over time.
- Whilst it is important that the design and implementation of such surveys involves a mix of NGOs/CBOs/institutions providing and not providing services in order to preserve community participation in the development of appropriate tools for data collection, to promote the enrollment of participants, and the understanding and the ownership of the key findings, care must be taken to minimize the introduction of bias into survey results, particularly those related to the “behavioral” and “exposure to interventions” indicators.
- It is important that the “exposure to intervention” section of the survey questionnaires is customized to the MSM interventions in question. This will help maximize the usefulness of these data for assessing program coverage and the relationship between program exposure and key outcomes of interest. A one-year timeframe is recommended to be used for exposure to interventions.

Appendix A: Simplified Logic Model for FHI-supported MSM Programs in Bangladesh, Indonesia and Nepal

Intended Activities		Expected Results	
Strategies	Activities	Outputs	Outcomes
1. Increase and sustain safer behaviors through BCC.	<p><u>Outreach and Peer Education</u></p> <ul style="list-style-type: none"> Conduct one-to-one and group discussions Distribute IEC materials Distribute condoms & lubricant Refer individuals to STI, VCT & CST services <p><u>Drop-in Center</u></p> <ul style="list-style-type: none"> Provide “safe space” and location for social events. Conduct group discussions Provide counseling Distribute condoms & lubricant Refer individuals to STI, VCT & CST services <p><u>Edutainment</u></p> <ul style="list-style-type: none"> Conduct edutainment activities (Indonesia only) 	<p><u>Outreach and Peer Education</u></p> <ul style="list-style-type: none"> # of new contacts # of repeat contacts # of IEC materials distributed # of condoms & lubricant distributed # of referrals to STI, VCT & CST services <p><u>Drop-in Center</u></p> <ul style="list-style-type: none"> # of visitors; # and type of social events # of discussions, # of participants # of counseling sessions # of condoms & lubricant distributed # of referrals for STI, VCT & CST services <p><u>Edutainment</u></p> <ul style="list-style-type: none"> # of events # of participants 	<p>Increase in the use of condoms at last sex with clients, sex workers, regular partners</p> <p>Increase in consistent use of condoms with clients, sex workers, regular partners</p> <p>Increase in the use of STI, VCT and CST services</p> <p>Decrease in the number of self-reported STIs</p>
2. Create a favorable environment to support program implementation and behavior change through advocacy and networking.	<p><u>Advocacy</u></p> <p>Depending on IA, conduct:</p> <ul style="list-style-type: none"> Sensitization or other advocacy meetings Mass awareness campaign Media campaign <p><u>Networking</u></p> <ul style="list-style-type: none"> Coordinate with government and other organizations for services and on national events such as World AIDS Day 	<p><u>Advocacy</u></p> <ul style="list-style-type: none"> # and type of advocacy meetings # and type of meeting participants # and type of mass awareness campaign # and type of campaign participants <p><u>Networking</u></p> <ul style="list-style-type: none"> # and type of coordination meetings # and type of meeting participants # and type of event # and type of event participants 	<p>Decrease in harassment of and violence toward IA field workers</p> <p>Decrease in harassment of and violence toward MSM</p> <p>Decrease in stigma and discrimination of MSM and PLWHA</p> <p>Increase in coordination of services and events among government and NGOs</p>
4. Strengthen the capacity of IA staff to manage and implement the intervention	<p>Provide training to IA staff, including:</p> <ul style="list-style-type: none"> Outreach and peer education Program management Financial management STI clinical management and counseling VCT CST Advocacy 	<ul style="list-style-type: none"> # and type of training # and type of training participants 	<p>Improvement in the capabilities of IA staff to manage and implement the interventions</p>

