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Bangladesh AIDS Program

Mid-Term Evaluation and Future Directions

September 2007

This publication was produced for review by the United States Agency for International Development. It was prepared by David Hales, Andrew Kantner, Sharful Islam Khan, and Billy Pick through the Global Health Technical Assistance Project.

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This document was submitted by The QED Group, LLC, with CAMRIS International and Social & Scientific Systems, Inc., to the United States Agency for International Development under USAID Contract No. GHS-I-00-05-00005-00.

CONTENTS

ACRONYM LIST

A^2	Integrated Analysis and Advocacy
AAS	Ashar Alo Society
ABC	Abstinence, Be Faithful, Condom Use
ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
APON	Ashokti Punorbashon Nibash
ARV	Anti-retroviral
BAP	Bangladesh AIDS Program
BCC	Behavior change communication
BSS	Behavioral Surveillance Survey
BSWS	Bandhu Social Welfare Society
CA	Cooperating agency
CBO	Community-based organization
CCM	Country Coordinating Mechanism (GFATM)
COCAT	Condensed Organizational Capacity Assessment Tool
CREA	Society for Community-Health Rehabilitation Education and Awareness
DAM	Dhaka Ahsania Mission
DIC	Drop-in Center
DFID	Department for International Development (UK)
DGHS	Directorate General of Health Services
FBO	Faith-based organization
FHI	Family Health International
FSW	Female sex worker
GFATM	Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria
GOB	Government of Bangladesh
HAPP	HIV and AIDS Prevention Project
HBFSW	Hotel-based female sex worker
HELP	Health and Education for the Less-Privileged People
HIV	Human Immunodeficiency Virus
HNPSP	Health Nutrition Population Sector Program
HS	Heroin smoker
HSS	HIV Sentinel Surveillance
IA	Implementing agency
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
IDU	Injecting drug user
IEC	Information, education, and communication
IHC	Integrated Health Center
IMPACT	Implementing AIDS Prevention and Care Program
InHealth	The Integrated Health Care Services Project
JOBS	The Job Opportunities and Business Support Project
MACCA	Masjid Council for Community Advancement

MARP	Most-at-risk population
M&E	Monitoring and evaluation
MOHFW	Ministry of Health and Family Welfare
MOHA	Ministry of Home Affairs
MSM	Men who have sex with men
MSW	Male sex worker
NASP	National AIDS and STD Programme
NGO	Nongovernmental organization
NSDP	NGO Services Delivery Program
OI	Opportunistic infection
PEPFAR	President's Emergency Plan for AIDS Relief
QA/QI	Quality assurance/quality improvement
QA/QI Project with InHealth	Quality Assurance Project for Targeted STI and HIV Counseling and Testing Services in Bangladesh
QAT	Quality assurance team
PLWHA	People living with HIV/AIDS
RP	Rickshaw puller
RTM	Research, Training, and Management International
SA	Sub-agreement
SBC	Strategic Behavioral Communication
SMC	Social Marketing Company
SOW	Scope of work
STI	Sexually transmitted infection
SWOT	Strengths, weaknesses, opportunities, and threats
TC	Technical Committee, National AIDS Commission
TOT	Training-of-trainers
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary counseling and testing
YPSA	Young Power in Social Action

I. EXECUTIVE SUMMARY

The Bangladesh AIDS Program (BAP) is a three-year initiative designed to reduce the spread of HIV among the country's most-at-risk-populations, including injecting drug users (IDUs), sex workers, and men who have sex with men (MSM). Family Health International (FHI) is the primary implementing partner for BAP; it collaborates with a range of local organizations, including three major partners and multiple implementing agencies (IAs) on a wide range of program activities.

Over four weeks in September 2007, an external evaluation team conducted a comprehensive review of BAP as it begins its third and final year of operation. The team's observations and findings fell into six different categories: (1) Coordination; (2) U.S. Agency for International Development (USAID) and U.S. Government (USG) Support; (3) Implementation and Performance; (4) Implementing Agencies and Interventions; (5) Strategic Information; and (6) Policy and Advocacy. Highlights of the observations and findings include:

- Bangladesh lacks a simple framework for coordination, which acknowledges the realities of the situation (multiple players, increased funding, limited capacity of the National AIDS and STD Program [NASP], etc.) while simultaneously focusing stakeholders' attention on scaling up the tactical interventions that are proven and already working in the country among most-at-risk populations.
- Unless steps are taken by the various stakeholders to change course, there is little likelihood for improving the coordination of interventions targeting most-at-risk populations over the next 12-24 months. It is quite likely that coordination problems will persist beyond that timeframe if no changes to the coordination mechanisms and processes are made.
- In HIV prevention, it is essential to maintain uninterrupted delivery of the services and commodities that reduce risk behaviors and the risk of infection/transmission among those populations with the greatest vulnerability. In Bangladesh, this ability to sustain interventions without interruption has been difficult in recent years.
- In general, BAP performance should meet or exceed most of its targets by the end of the project in September 2008. However, most indicators are capturing processes and outputs rather than impact. Therefore, it is difficult to assess the overall effectiveness of BAP, particularly in the area of behavior change.
- On balance, IAs seem satisfied with the support they receive from FHI. However, some of them would prefer to be given more latitude and flexibility in managing their day-to-day operations. After hearing the concerns of several IAs, members of the evaluation team were left with a general sense that FHI tends to treat its IAs more as vendors than as partners.
- The evaluation of BAP programming raised questions about how these populations were prioritized when resource allocations were being made, particularly when taking into consideration the core competencies and/or constraints facing USAID, FHI, BAP partners and IAs. Inadequate prioritization among risk populations is not limited to BAP. None of the major HIV/AIDS initiatives in Bangladesh (e.g., HIV and AIDS Prevention Project [HAPP], Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria [GFATM], Health Nutrition Population Sector Program [HNPSP], and the Asian Development Bank [ADB]) have done a good job of prioritizing these populations.

- There is no clear indication of the priority attached to different BAP-funded activities. This lack of prioritization stems from the wide range of activities that have been carried out under the program. While the BAP strategy and indicators are focused on field-based interventions for most-at-risk populations, a large percentage of program resources have been directed to activities as diverse as technical assistance on the national HIV behavioral surveillance and the development of national guidelines on the management of opportunistic infections (OIs) and post-exposure prophylaxis.
- Within their operating parameters, the Modhumita Integrated Health Centers (IHCs) provide valuable services to their clients. Increased access to HIV testing and sexually transmitted infection (STI) services has certainly had a positive impact on the most-at-risk populations who can go to Modhumita centers. However, there are a number of concerns about the Modhumita approach, including (1) the range of services offered, (2) the advantages and disadvantages of gold-standard voluntary counseling and testing (VCT) and STI services, (3) the value of the centers as a branded network, and (4) the value of the brand overall.
- Given the relatively low priority attached to HIV/AIDS within the Government of Bangladesh (GOB), it is not clear if BAP's policy and advocacy work related to national leadership and commitment will lead to any substantial change in the current situation. However, this does not diminish the importance of this work.

The evaluation team's recommendations for the final year of BAP focus on issues that can be effectively addressed during the available timeframe. The primary recommendation is to identify and strengthen priority interventions for IDUs, hotel-based sex workers, MSM, and hijra in order to capitalize on lessons already learned and to provide a basis for the GOB and the donor community to scale up the country's response in the years ahead.

In addition, the evaluation team made a series of recommendations on possible future directions of USG-funded HIV/AIDS programs in Bangladesh. Ongoing issues related to the capacity of the GOB were the driving force behind the core recommendations, which specifically address coordination and collaboration, strategic information, and continuous improvement of successful interventions. The full set of recommendations also reflect a parallel desire and opportunity for USAID to make a more strategic contribution to the Bangladesh response as additional funding through mechanisms such as the Global Fund and SWAps becomes available for tactical activities.

II. INTRODUCTION

The overarching objective of the Bangladesh AIDS Program (BAP) is to reduce the spread of HIV among the country's most-at-risk-populations, including IDUs, sex workers, and MSM. The project was launched in 2005 and is scheduled to end in September 2008. Its original three-year budget was $12.5 million; this amount was reduced by approximately 13% in 2006. By the end of the second year of the project (September 2007), the project had disbursed $3.4 million.

FHI is the primary implementing partner for BAP. In addition, there are three major collaborating partners: Social Marketing Company (SMC); Masjid Council for Community Advancement (MACCA); and Research, Training, and Management (RTM) International. BAP is essentially a follow-on to the USAID-funded FHI Implementing AIDS Prevention and Care Program (IMPACT) Cooperative Agreement in Bangladesh and it has implementing arrangements with many of the same organizations used by that project.

This report documents the findings and recommendations of an evaluation undertaken in September 2007 to assess BAP's progress and its contributions to USAID's goal of reducing the spread of HIV in most-at-risk population groups. To that end, the members of the evaluation team were guided by the following list of eight tasks:

Determine the overall progress and effectiveness in relation to the expected results of BAP over the past two years

1. Document the effectiveness of BAP to target their activities to groups of individuals most at risk
2. Assess and document the effectiveness of BAP's behavior change communication activities to increase the practice of STI and HIV prevention behaviors among individuals most at risk
3. Determine the major constraints to accomplishing the expected project results
4. Assess the status and utilization of quality HIV and STI services in intervention areas
5. Determine the extent to which the GOB HIV and STI surveillance systems are being used for effective decisionmaking
6. Document the results of BAP efforts to improve the capacity of local organizations and the private sector to participate in HIV prevention efforts
7. Determine what components of the current strategy have been most/least effective and what can be done to ensure an effective follow-on project.

III. PROGRAM BACKGROUND

In terms of HIV/AIDS, Bangladesh is a low prevalence country. The seventh round of the country's national serological surveillance for HIV reported a seropositive rate below 1% from 23 sentinel sites across the country. Sampling at these sentinel sites is focused on population groups considered most at risk for HIV (e.g., IDUs, female sex workers [FSWs], male sex workers [MSWs], men who have sex with men [MSM], transgenders, and heroin smokers [HSs]). Clients of sex workers, essentially a bridging population between risk groups and the general population, are also included in the surveillance.

Despite its status as a low prevalence country, there are concerns that HIV is gaining ground in Bangladesh, particularly among IDUs. For example, according to the latest serological surveillance, 7% of all IDUs living in Dhaka's Old City tested positive for HIV. In addition, a recent modeling effort by the Integrated Analysis and Advocacy (A^2) Project suggests that Bangladesh may be on the cusp of a major surge in HIV cases among IDUs and FSWs. The same model also showed a heightened risk of Bangladesh moving toward a generalized epidemic (over 1% seroprevalence in the general population), based on heterosexual transmission. However, it is worth noting that HIV prevalence among sex workers, both female and male, is still well below 1% and has not changed appreciably across recent rounds of sero-surveillance.

According to various sources, there are a number of factors contributing to the growing concern about HIV/AIDS in Bangladesh. These factors include:

- Large-scale sex industry, much of it underground; high levels of sexual contacts and partner exchange per day among certain groups of FSWs, reported to be some of the highest in Asia.
- Low use of condoms by IDUs, sex workers, and their clients.
- High rates of needle sharing among IDUs.
- Significant blood selling by IDUs; approximately 21% of them in the country sell blood.
- High rates of STDs, especially syphilis and genital herpes.
- Limited coverage of MSW, MSM, and transgender interventions.
- High rates of stigma and discrimination against most-at-risk populations and people living with HIV/AIDS (PLWHA).

Conversely, there are other factors that are typically cited for the continued low prevalence of HIV/AIDS in Bangladesh. These factors include:

- Bangladesh has a relatively small IDU population (estimated between 20,000 and 40,000), who live mostly in and around Dhaka. NOTE: There are legitimate questions about the accuracy of these figures.
- While many IDUs are sexually active, they report having relatively few sexual partners, on average only 1.0 regular and 1.1 commercial sex partners per month. Therefore, sexual transmission among IDUs may be lower in Bangladesh than in other countries with high IDU infection levels.
- There is currently very low seroprevalence among FSWs in Bangladesh; consequently, the likelihood of HIV transmission to clients is low.

- Concurrent, multiple-partner sexual behavior is not commonplace among the general population in Bangladesh, which greatly reduces the risk of transmission.
- The country's near-universal use of male circumcision reduces the risk of HIV transmission.
- STD levels have been declining in recent years.

To help ensure that Bangladesh remains a low prevalence country, BAP is implementing a multi-pronged strategy to achieve its two core objectives, which are: (1) increased utilization of a broadened range of integrated, high quality STI and HIV prevention and care services, provided through specialized health centers, peer education and outreach, and behavior-change interventions; and (2) increased use of strategic information for decision making to improve the country's response to HIV/AIDS.

The program's main strategic approaches are:

- Improved quality and expanded availability of culturally appropriate, gender sensitive and sustainable HIV/AIDS prevention and care programming.
- Enhanced NGO (non-governmental organization), FBO (faith-based organization), and private sector capacity to design and implement HIV/AIDS programs.
- Generation of strategic information through monitoring, evaluation, surveillance, and research to produce integrated analysis for program planning and to model the outcome and impact of interventions.
- Dissemination of strategic information to assure appropriate use of data for evidence-based policy development and decisionmaking.

Tactically, the focus of the program is reflected in the 10 BAP indicators:

1. Number of individuals reached through the program (disaggregated by FSWs, MSWs, hijras, IDUs, PLWHA, and clients of sex workers)
2. Number of behavior change interventions (disaggregated by FSWs, MSWs, hijras, IDUs, PLWHA, clients of sex workers, VCT, care and support, faith-based, prison, and police)
3. Number of Modhumita Integrated Health Centers
4. Number of new members to Integrated Health Centers
5. Number of STI clinics
6. Number of patients treated for STI symptoms (disaggregated by FSWs, MSWs, hijras, IDUs, and clients of sex workers)
7. Number of contacts (one-to-one and group) (disaggregated by FSWs, MSWs, hijras, IDUs, PLWHA, clients of sex workers, and rickshaw pullers [RPs])
8. Number of condoms distributed through the intervention (disaggregated by FSWs, MSWs, hijras, IDUs, PLWHA, clients of sex workers, and RPs)
9. Number of facilities providing voluntary counseling and testing
10. Number of clients receiving counseling and testing at VCT centers

In implementing its program, BAP is currently working with 24 Implementing Agencies that are operating IHCs across most major urban areas in Bangladesh.

IV. METHODOLOGY

The evaluation team relied on a proven methodology for its assessment of BAP, which combined document review, informant interviews and site visits. The integrated work on data collection was supplemented by regular debriefings and discussions among members of the evaluation team, which, in turn, fed directly into an analysis of the inputs and a synthesis of the findings and recommendations.

The members of the team reviewed an extensive collection of project documentation provided by FHI, USAID, and other BAP stakeholders, including partners and IAs; ICDDR,B; GOB ministries; UNICEF (United Nations Children's Fund); UNAIDS; and various international NGOs. The team received an extensive briefing from senior staff at FHI, which was led by the Country Director; the team also had several follow-up discussions with FHI's Deputy Country Director regarding specific issues related to FHI/BAP operations. In addition, the team interviewed a broad range of stakeholders and interested parties who could provide useful and candid input on BAP as well as possible future directions for USAID-funded HIV/AIDS programs in the country. Interviewees represented the broadest spectrum of BAP and BAP-related constituencies, including senior managers, junior staff, field workers, clients, donors, technical experts, government officials, and others. (See Annex 3 for a list of persons visited and Annex 4 for documents reviewed.)

The team also made a number of visits to BAP and non-BAP sites to see operations first-hand. Given the "franchise" nature of most BAP operations (e.g., the Modhumita-branded Integrated Health Centers), the team decided it was not necessary to visit a large number of different sites and is comfortable that it made an adequate number of site visits. Due to time and financial constraints, the team did not conduct a formal evaluation of process, output, and outcome data. It is also important to note that logistical problems with Ramadan and weather did limit the mobility of the review team. However, the findings and recommendations of the team were not compromised by this limitation.

V. OBSERVATIONS AND FINDINGS

This section of the report captures the key observations and findings of the evaluation team in six major sub-sections, each of which covers a different aspect of BAP. The six sub-sections are: (1) Coordination; (2) USAID/USG Funding and Programmatic Support; (3) Implementation and Performance; (4) Implementing Agencies and Interventions; (5) Strategic Information; and (6) Policy and Advocacy.

COORDINATION

In Bangladesh, coordination of the HIV/AIDS response is generally poor:

- The National AIDS Committee, which sits within the Ministry of Health and Family Welfare (MOHFW), plays a limited role in the response and coordination is not seen as one of its core responsibilities.
- NASP is under-staffed, under-funded and does not currently have adequate technical capacity to coordinate the national response.
- The Country Coordinating Mechanism (CCM) focuses solely on GFATM applications and appears to play little or no role in ongoing coordination with other donor/funding organizations and/or agencies. Although the MHFW is the Primary Recipient of GFATM funds, Save the Children (USA) was selected to act as a "management agency" and has demonstrated limited interest in coordinating with other organizations/agencies.
- A United Nations (UN) Theme Group on HIV/AIDS does meet in Bangladesh, but membership is limited to UN agencies. There is no Expanded Theme Group for coordination with partners who are outside the UN system.
- There are regular consultations among key international partners supporting the HNPSP; however, HIV/AIDS is only a small part of the SWAp. There appears to be limited coordination between the government's HAPP and other programs such as BAP, ADB, and GFATM Rounds Two and Six. (UNICEF was designated as temporary Management Support Agency for HAPP in 2007 and will continue in this role under HNPSP through 2008.)
- There have been some efforts to coordinate across initiatives at the field level. The most successful example seems to be the links between HAPP-funded drop-in centers for IDUs and BAP-funded rehabilitation programs for the same population.
- Within BAP, the most effective coordination appears to be the informal communications between the various IAs.

NATIONAL AIDS/STD PROGRAM

The remit for NASP specifically charges the organization with a coordinating role in the country's response to HIV/AIDS. Despite years of financial support and technical assistance, including extensive institutional strengthening work under HAPP, NASP continues to have insufficient capacity to play a significant role in coordination or oversight of the national response. When presented with significant opportunities to build its capacity by managing well-funded activities (e.g., GFATM grants in Round Two and Six), NASP has relinquished key responsibilities to an international NGO.

Bangladesh does have many of the policies and strategies in place that outline its core responsibilities in implementing an AIDS response (e.g., National Policy, National Strategic Plan, and Behavior Change Communication [BCC] Strategy). However, there is a danger that these documents – as well as NASP itself, which is supposed to be coordinating the implementation of the response in line with these policies and strategies – have been marginalized by the lack of strong political commitment. Strong political and financial backing from the government to NASP is required for external funding or technical assistance to make any substantive difference in NASP operations.

The AIDS response in Bangladesh would clearly benefit from a strong and functional NASP and the organization has demonstrated its potential to serve as an effective body. With strong, professional leadership and a knowledgeable and stable staff, NASP would be well positioned to make a solid and sustained case to other government agencies, ministries, and officials that expanded support for an effective response to the growing AIDS epidemic would be in the country's best interest.

INTERVENTIONS

The concentrated nature of the epidemic in Bangladesh means that NGOs and CBOs (community-based organizations) play a primary role in the response. Their ability and willingness to work with marginalized most-at-risk populations has been and will continue to be critical to the success of the response. Historically, there has been limited formal coordination among the organizations implementing interventions, due in part to the fact that there were a relatively small number of funding partners, implementers and interventions. As available funds increase, the number of funding sources, the number of IAs, and the number of intervention sites have all grown. This has lead to an increasing need for more and better coordination to maximize coverage, consistency, and cost-effectiveness and minimize wasteful and/or avoidable overlaps and duplication. It is also worth noting that issues with coordination can be traced to differing philosophies (e.g., the rights-based approach of CARE, the DFID [Department for International Development] preference for SWAps, and USG policies regarding harm reduction). Coordinating across the differences in these approaches and policy positions requires strong leadership and a serious commitment to the principles of coordination by all involved.

Unless steps are taken by the various stakeholders to change course, there is little likelihood for improving the coordination of interventions targeting most-at-risk populations over the next 12-24 months. It is quite likely that coordination problems will persist beyond that timeframe if no changes to the coordination mechanisms and processes are made. Factors that influence the coordination dynamic include: (1) Lack of leadership from NASP (see above); (2) limited*/ad hoc* bilateral coordination between programs such as BAP and HAPP; (3) the uncertainties surrounding the end of BAP in September 2008 and smooth transition to a new USAID program in late 2008 or early 2009; (4) the transition from HAPP to HNPSP funding in January 2008, which raises the possibility of a gap in funding for interventions and the possible introduction of a new set of performance measures; (5) the selection of a permanent Management Support Agency for HNPSP in 2008; (6) the establishment of a new Program Support Office to provide technical assistance for HNPSP; (7) the role of Save the Children as the management agency for GFATM Round Six; (8) the possible and likely introduction of new implementing organizations into the mix via the GFATM Round Six bidding process, which would need to be included in any coordination process; (9) the differences in intervention and/or service delivery "packages" supported by different funding partners and mechanisms for various risk populations; and (10) the possibility that competition among NGOs and CBOs as they vie for funding from different sources may result in decisions not to coordinate in order to secure a larger share of the funding.

Bangladesh lacks a simple framework for coordination, which acknowledges the realities of the situation (multiple players, increased funding, limited capacity of NASP, etc.) while simultaneously focusing stakeholders attention on scaling up the tactical interventions that are proven and already working in the country among most-at-risk populations. Coordination in Bangladesh has been treated as a purely strategic issue – or an abstract concept – when what is needed is basic coordination at the field-level to ensure better coverage, consistent and appropriate quality of interventions, uninterrupted availability of services and commodities, as well as an equitable and transparent distribution of responsibilities and funding. This approach to coordination – essentially, bottom-up as opposed to top-down – would necessarily give the highest priority to the needs of the target populations and the perspectives and capacity of the implementing NGOs and CBOs that work directly with those populations.

In the context of BAP, the coordination across IAs is limited. It does appear that the best form of coordination is the informal discussions between the IAs, although it is not clear how much these discussions actually improve the quality of BAP interventions. For example, the geographic distribution of intervention sites cannot be overcome by informal discussions and appears to cause coordination problems. In Chittagong, the IHC for clients of sex workers is quite far from the IHC for hotel-based sex workers, which undermines the effectiveness of referrals for clients who want STI treatment. Also, as BAP budgets have been cut, the IAs have become more focused on their own programs and survival, which is a major disincentive to coordinate. In a time of declining budgets, this disincentive is heightened by the management focus on quantitative BAP indicators and pressure on IAs to meet these targets.

There are also issues of coordination within BAP between FHI and IAs. It appears that these issues are related to inefficient and/or inadequate communication among the various program stakeholders. For example, multiple IAs clearly misunderstood the condom distribution policy and mechanisms, which resulted in product stock-outs in IHCs. Another example is how convoluted organizational structures and chains-of-command – for example, the relationship with SMC and the operation of Shurockkha/Modhumita IHCs – has limited the effectiveness of both communication and coordination.

FUNDING

In HIV prevention, it is essential to maintain uninterrupted delivery of the services and commodities that reduce risk behaviors and the risk of infection/transmission among those populations with the greatest vulnerability. In Bangladesh, this ability to sustain interventions without interruption has been difficult in recent years, primarily due to management issues within HAPP. Implementing agencies would be funded for short periods of time, the funding would stop, and then it would restart several months later, which seriously undermined the continuity of their interventions. (The BAP corollary is the budget cuts for IAs that limit their prevention work; see below.) Although steps have been taken to prevent this problem from occurring in the future, there are serious concerns among stakeholders that the transition from HAPP to HNPSP in January 2008 may result in another funding gap.

There are similar concerns about possible gaps in funding under GFATM Round Six. It is important to note that this is only speculation among certain stakeholders at this point. However, it reinforces the serious concerns that implementing organizations have about the GoB's ability to manage funding gaps and the inability of funding organizations to work together to ensure that the funds are available to maintain the continuity of interventions.

Although the ramifications are not as severe, budget cutbacks can have a similarly negative impact on interventions. While BAP has managed to avoid gaps in funding to its IAs, the

cutbacks on funding for organizations working directly with risk populations have limited the effectiveness of their interventions. For example, there is significant unmet demand for STI services among sex workers and MSM. The unmet demand varies by location and day with some sites having available slots for STI patients on clinic days. On balance, however, demand exceeds supply. In addition, insufficient prioritization of both risk populations and program activities has also short-changed those IAs whose work is having a more focused impact on key risk populations. For example, the public health cost-benefit of funding IHCs serving hotel-based sex worker, MSM, and hijra populations is clearly higher than funding IHCs for the broadly defined population of clients of sex workers. Unfortunately, there was an apparent lack of communication and coordination within BAP between FHI and the IAs when budgets cuts were decided. This appears to have adversely affected the level of service provision and the morale of the IAs.

One specific challenge facing USAID as it explores options for future HIV/AIDS programs in Bangladesh is to coordinate with other stakeholders in the Bangladesh response to ensure to the best of its ability that members of risk populations who have become reliant on USAID-funded interventions for services and commodities are not abandoned should a new program have different priorities. It is equally important to ensure that any new priorities are based on sound public health principles and accurate epidemiologic data.

NGO COORDINATION AND COLLABORATION

One of the primary opportunities for broader NGO collaboration is between BAP and HAPP. While there are instances of field-level coordination and collaboration, including IDUs from HAPP DICs (drop-in centers) being referred to BAP rehab programs and PLWHA from HAPP DICs being referred to BAP IAs for care and support, there is no structured mechanism for leveraging coordination and collaboration among two of the primary HIV/AIDS initiatives in the country. Discussions with several BAP and HAPP IAs as well as with FHI, CARE, and UNICEF reinforced the breadth and depth of the opportunity to coordinate and collaborate more formally and more effectively. Given the complementarities of the two initiatives, this is a significant missed opportunity. And with the expansion of HIV/AIDS interventions under GFATM Round Six, there is now an even greater imperative to develop mechanisms that make for efficient and effective coordination and collaboration.

A second major opportunity in this area is with other USAID-funded initiatives in Bangladesh. For example, several IAs participating in BAP apparently have different procedures in place for referring clients to clinics supported by the NGO Service Delivery Program (NSDP), which supports local health care services. Health and Education for the Less Privileged People (HELP) and Young Power in Social Action (YPSA), two BAP IAs that operate programs for sex workers in Chittagong, have been given different directives regarding referrals to the Smiling Sun clinic in that city. HELP staff know little about the Smiling Sun facility while YPSA is actively referring clients there and has even signed a memorandum of understanding with the organization. Again, the lack of formal mechanisms to encourage coordination and collaboration is a missed opportunity, one that could easily be addressed.

USAID AND USG SUPPORT

The overriding issue related to USAID support for BAP has been the reduction in USG HIV funding to Bangladesh. This cutback has had a significant negative impact on the program, including a direct effect on its ability to implement interventions and meet original performance targets. While USAID/Bangladesh and FHI have worked hard to adjust program goals and targets to match the reduced funding, the fallout from the budget cuts continues to resonate throughout the program. For example, the cutback has had a major impact on morale across BAP as staff and

stakeholders question the commitment of USAID to their work. While morale may seem like a trivial issue, it is a critical factor in the implementation of interventions for marginalized populations. In addition, the cutback has undermined USAID's credibility among local organizations in Bangladesh. This loss of credibility is a potential serious development that could have a longer-term impact on USAID's relationships with local NGOs. Lack of communication and/or understanding regarding the USAID funding process between the Mission and FHI and subsequently, between FHI and BAP partners/IAs has exacerbated the current situation.

The budget cutback aside, it appears that the USAID/Bangladesh has provided the requisite support for BAP during the first 21 months of program implementation. In the context of a Cooperative Agreement, communication and collaboration between USAID and FHI seems to be good and reporting by FHI has been timely. Unfortunately, the many positive aspects of USAID and USG support have been overshadowed by the budget cuts.

IMPLEMENTATION AND PERFORMANCE

This sub-section of the report covers three topics: (1) Achievements over the First 24 Months of BAP Implementation; (2) Program Management; and (3) Training and Technical Assistance.

Achievements over the First Two Years of BAP Implementation

The performance indicators compiled by the monitoring and evaluation (M&E) system for the project show good results to date. As can be seen in Annex 2, the number of individuals reached by program services have often attained or exceeded targets established for the first two years of the project. The number of FSWs. MSWs, MSM, and transsexuals (hijra) reached by the project was generally in line with expectations (although there have been some problems in defining the target population for the MSW and MSM group – see below). During the first year of the project, the number of IDUs reached by the project (2,770) was close to target (3,000), but the more ambitious goal for the second year has not been met. The average number of IDUs reached over the four quarters of Year 2 was 2,276 compared to a target of 5,000. The number of people living with HIV/AIDS receiving care, support and treatment services is also below anticipated levels, possibly reflecting the fact that only one IA is offering these services and the number of people living with HIV/AIDS is still low in Bangladesh.

The project reports that the number of sites covered by Behavior Change Interventions (BCI) in the second year of the project has exceeded expectations. (In the project's M&E system, BCI coverage is defined as the number of sites providing BCIs at hotels for hotel-based sex workers, IHCs for IDUs, and cruising spots for street-based sex workers.) It was anticipated that 209 sites would be covered during the second year of the project. But despite problems with law enforcement agencies (which included raids at hotels and cruising sites) and the political situation in the country, the project managed to cover 1,445 sites by the end of the fourth quarter of FY 2007. Most of these sites are for FSWs (370) and the clients of sex workers (811).

The number of Modhumita branded IHCs as well as clinics offering STI and VCT services are slightly below goals set for Year 2, shortfalls that no doubt reflect budget cuts that affected the project during its second year. (Rather than opening new IHCs, FHI has said that its priority is to keep existing sites fully operational during the last year of BAP.) On a more positive note, the number of clients being treated for STIs and using VCT services is well above anticipated levels.

Several methodological issues have confounded the interpretation of certain BAP indicators. For example, there is an ongoing discussion between USAID and FHI about the baseline figures for MSM and MSWs as well as the number of these men who can be reached by the program. NASP is currently working on size estimations for both populations. An initial estimate indicates that

there may be 28,000 male prostitutes in Bangladesh. An earlier analysis in 2003 put this figure at 17,000 just within BAP intervention areas.

In addition, BAP has been using inappropriate formulas for measuring the numbers of clients reached by program interventions. As stated in the BAP Quarterly Report Q3 (April to June 2007), "For calculating the contribution of contacts with clients of prostitutes, 100% of the clients who use the SMC Shurockkha/Modhumita IHCs are counted under contacts." The same report also states that 100% of all people watching the MACCA televised talk show and 100% of all people attending Friday Jumma sermons under the MACCA umbrella are counted as a client-of-sex-worker contact. Essentially, BAP has been counting 100% of heterosexual males reached by program activities as clients of sex workers when the accepted standard is 10%. It should be noted that MACCA expressed a specific concern to the evaluation team about reporting all viewers of its talk show and all attendees of Jumma prayers as clients of sex workers.

While overall figures cited in BAP quarterly performance reports are plausible for the number of men reached with HIV prevention messages, the question is whether it is reasonable to assume that all of these men are actual clients of sex workers. A just completed survey on the Sexual Behavior of Men in Bangladesh reports that 27% of never-married men and 13% of ever-married men have had non-marital sex. These estimates, rather than the commonly recommended default value of 10%, is now being used by FHI to calculate a more realistic estimate of the number of sex work clients reached by MACCA initiatives. While the change more adequately reflects the number of clients of SW, in the future, more attention should be given to accurate forecasting of targets during the program-planning phase.

In general, BAP should be able to meet or exceed its targets for most program interventions by the end of the project in September 2008. However, most indicators are capturing processes and outputs rather than impact. Therefore, it is difficult to assess the overall effectiveness of BAP, particularly in the area of behavior change. Unfortunately, many key behavioral measures from the BBS show little change over the past several years; for example, condom use remains low among sex workers and their clients, and needle sharing among IDUs remains high. On a more optimistic note, the sixth round of the BSS (Behavioral Surveillance Survey) does report that needle sharing and condom use are lower among IDU clients reached by NGO interventions. The M&E challenge is to track these improvements back to specific interventions such as BAP. While it may be difficult to attribute outcomes and impact to specific BAP interventions, there should be sufficient data to indicate the overall effectiveness of interventions, given the extent of HIV prevention services in Bangladesh.

Program Management

On balance, IAs seem satisfied with the support they receive from FHI. However, some of them would prefer to be given more latitude and flexibility in managing their day-to-day operations. This seems appropriate for the more experienced organizations, but definitely not appropriate for the more nascent ones. In addition, there appears to be an opportunity for more frequent and extensive consultations between FHI and the BAP IA network, particularly for addressing difficult program management issues. For example, some IAs feel that FHI made a unilateral decision on how to implement budget cuts after the overall BAP budget was reduced, when this process could have been more inclusive, consultative and more productive.

In light of other instances which reflect the lack of dialogue in areas as diverse as program direction, training requirements and M&E, the IAs seem to have a valid concern when it comes to the nature of their relationship with FHI. After hearing the concerns of several IAs, members of the evaluation team were left with a general sense that FHI tends to treat its IAs more as vendors

than as partners. On one level, this could be due to FHI's focus on performance, quality, and fiduciary responsibility. However, on another level, there seems to be a sense within FHI that IAs are not an integral part of BAP management and operations. They are seen solely as implementers – i.e., organizations that are given funding to do specific tasks – which helps explain why the IAs do not feel like full-fledged partners in the program. For example, it is relatively easy to find phrases alluding to "the responsibility of BAP as opposed to the IAs" in program documentation, which reinforce the separation between FHI and the IAs. In general, BAP would be well served if there were a stronger sense of partnership and collaboration across the entire program network, which eliminate the perceived barriers between FHI and the individual IAs.

Training and Technical Assistance

BAP provides a wide range of training and technical assistance to various stakeholders in the program with the primary beneficiaries being the GOB and the program's IAs. Activities range from training for BAP IA program managers on minimum standards, toolkits, and clinical guidelines to quality assurance (QA) monitoring and training for STI and VCT services to guidance for IAs on QA/QI (quality improvement) tools such as client exit interviews and facility assessment methods. In general, the quality and value of the training and technical assistance has received high marks. Where there have been shortcomings (see below), FHI has moved to address them.

The Government has also benefited from BAP technical assistance. For example, the development and publication of National STI Guidelines was a significant milestone in Bangladesh. BAP is also working with NASP and EngenderHealth to develop and publish national guidelines on the clinical management of HIV/AIDS, OIs, and counselling for HIV patients, all of which will contribute to the country's AIDS response. It should be noted that non-BAP NGOs (e.g., CARE and other NGOs working under the HAPP project) have found BAP training materials and service provider guidelines useful for their own work.

BAP has invested heavily in strengthening the management, administrative and finance capacity of its IAs. In fact, RTM – one of the program's primary partners – is solely dedicated to this task. RTM has used a variety of tools to assess, train and support IAs, including COCAT (Condensed Organizational Capacity Assessment Tool) and SWOT (strengths, weaknesses, opportunities, and threats) instruments. Three training manuals (for financial management, human resource management, and gender) were developed for use in these capacity building efforts. Extensive on-site coaching and mentoring was undertaken to better tailor materials to the needs of individual IAs. In addition, leadership and team building exercises were conducted as part of RTN training programs.

The implementation of some aspects of RTM training and technical assistance has been problematic. For example, there were concerns among some IAs that the training did not fully acknowledge their existing capacity or adequately address their particular needs; there were concerns that the training was too "cookie cutter." (Many IAs have a long history of working with FHI/IMPACT and did not need to undergo basic management and administrative training again.) There were also complaints that instruction and training materials were often in English when trainees would have more comfortable with Bangla. To FHI's credit, they also recognized these shortcomings and are actively addressing them. For example, it is likely that formalized RTM training will be replaced with more focused mentoring activities of individual IAs (e.g., smaller IAs such as Nongor).

Given the importance of peer education in BAP initiatives for most-at-risk populations, it was surprising to find concerns among stakeholders about the current state of outreach worker

training. Although the primary responsibility for this activity belongs to the IAs – supported by FHI-delivered training-of-trainers (TOT) activities – there appears to be a gap between the TOT and the knowledge of actual peer educators. For example, there appears to be little agreement in the IA network on best practices for working with various risk populations or in different settings. Regardless of the cause of the overall problem, FHI would be well advised to work with the IA network to resolve it.

IMPLEMENTING AGENCIES AND INTERVENTIONS

The findings listed below are related to the work of BAP IAs. The findings are grouped under 13 sub-headings that reflect key issues with a particular focus on most-at-risk populations targeted by the IAs.

Priority Populations

As noted previously, BAP IAs work with a wide range of most-at-risk populations, including IDUs, hotel and street-based sex workers, hijra, MSM, and clients of sex workers. However, a review of BAP programming raises questions about how these populations were prioritized when resource allocations were being made, particularly when taking into consideration the core competencies and/or constraints facing USAID, FHI, BAP partners and IAs.

For example, many BAP interventions target clients of sex workers. While clients are a legitimate most-at-risk population by international standards, their risks are lower in the highly concentrated epidemic in Bangladesh because of transmission dynamics and widespread male circumcision. In addition, BAP previously used a very inappropriate formula for measuring the numbers of clients reached by program interventions. As stated in the BAP Quarterly Report Q3 (April to June 2007), "For calculating the contribution of contacts with clients of prostitutes, 100% of the clients who use the SMC Shurockkha/Modhumita IHCs are counted under contacts." The same report also states that 100% of the people watching the MACCA televised talk show and 100% of the people attending Friday Jumma sermons under the MACCA umbrella are counted as a client-of-sex-worker contact. Essentially, BAP counts 100% of heterosexual males reached by program activities as clients of sex workers when the accepted standard is 10%. BAP now assumes that 27% of never-married and 13% of ever-married males have had extra-marital sex and uses these figures to calculate the number of client contacts resulting from MACCA activities.

The impact of poorly defined priorities is also demonstrated in the recent decision to cut two of the 12 IHCs for hotel-based sex workers while retaining 16 IHCs for clients of sex workers. All available data in Bangladesh, points to hotel-based sex workers being at substantially greater risk of contracting HIV and, as a marginalized population, having more limited access to services.

According to FHI, total BAP budget outlays for Years 1 and 2 totaled $3.4 million. Twenty-two percent of the total BAP budget over the past 2 years has gone to IDU programming. Another 16% was spent on interventions for hotel-based sex workers, 13% for clients of sex workers, and 11% for MSM. The question of priority stems from the funding for clients of sex workers. Given the unmet need for services among populations with far greater risk and who are already in existing BAP catchment areas, it is questionable why 13% of the program budget has been assigned to an essentially low-risk, less-marginalized population, particularly in such a non-strategic fashion (e.g., rebranding existing Shurockkha facilities as Shurockkha/Modhumita IHCs to increase the overall number of IHCs, not to target specific catchment areas or higher-risk populations). While clients of sex workers can be a critical population to address in a concentrated epidemic, the dynamics of the situation in Bangladesh argue for a much more

targeted, prioritized approach to this population (e.g., one that closely links clients to specific sex worker populations).

Insufficient prioritization among risk populations is not limited to BAP. None of the major HIV/AIDS initiatives in Bangladesh (e.g., HAPP, GFATM, HNPSP, ADB) have done a good job of prioritizing these populations. While there is certainly a consensus that IDUs in Old Dhaka are the most at risk, the limited data available on the size and distribution of different risk populations in the country makes it hard to establish more focused priorities, which in turn makes it difficult to develop an effective set of interventions.

Priority Activities

The three largest recipients of BAP funding over this period were the Bandhu Social Welfare Society (BSWS; for MSM services), the Social Marketing Company (for clients of sex workers), and the Bangladesh Women's Health Coalition (for hotel-based FSWs [HBFSWs]). It should be noted that SMC also provides procurement, logistics, and distribution support for all BAP IAs (most importantly for condoms and lubricants); supports BAP by leveraging SMC-branded condoms for disease prevention; undertakes media campaigns (e.g., Baaji Quddus and ABC [Abstinence, Be Faithful, Condom Use]); promotes HIV awareness and prevention; and collects blood serum for measuring national HIV seroprevalence among clients of sex workers.

A recent cost analysis has concluded that IDU projects have higher running costs than other interventions, largely since IDU clients are typically based at project facilities for longer periods of times than is the case for other risk groups. IHCs providing care and support services (e.g., Ashar Alo Society [AAS] outlets) were also more costly to operate than IHCs for female and MSWs. The 16 Shurockkha/Modhumita IHCs serving clients of sex workers were the cheapest to operate, owing in part to economies of scale introduced by adding HIV services to pre-existing facilities. Personnel costs in these IHCs were also shared between SMC and BAP.

When interviewing various stakeholders in BAP and reviewing program documents, there is no clear indication of the priority attached to different BAP-funded activities. This situation stems from the wide range of activities that have been carried out under the program. While the BAP strategy and indicators are focused on field-based interventions for most-at-risk populations, a large percentage of program resources have been directed to activities as diverse as technical assistance on the national HIV behavioral surveillance and the development of national guidelines on the management of OIs and post-exposure prophylaxis.

While all of these activities contribute to an effective response to HIV/AIDS, given the resource limitations facing BAP and the nature of the epidemic in Bangladesh, it is surprising that there is not a clearer, stronger sense of priorities within the program. If these priorities were well defined and openly shared with stakeholders, it would be easier for IAs to understand how and why decisions are being made when the program budget is reduced. (As is the case with prioritizing risk populations, there is a comparable lack of prioritization of activities across the various HIV/AIDS initiatives in the country. This gap could lead to serious inefficiencies in the national response as additional funds – e.g., GFATM Round Six – are dispersed.)

NOTE: There is a parallel problem of prioritizing activities across the response in Bangladesh. For example, BAP, HAPP, and GFATM all want to work across the various risk populations, which limits the effectiveness of their efforts. Conversely, it could be more productive to have different funding organizations and mechanisms and their IAs target different risk populations and work with them more broadly and deeply. This type of an approach would reduce competition, promote coordination and collaboration, and strengthen the consistency of service delivery in a resource-constrained setting. It would also enable and encourage funding

mechanisms and their IAs to develop specific areas of expertise, essentially improving their long-term ability to provide effective services to key risk populations in a continually evolving environment.

Modhumita Integrated Health Centers

Within their operating parameters, the Modhumita IHCs provide valuable services to their clients. Increased access to HIV testing and STI services has certainly had a positive impact on the populations who can go to Modhumita centers. Also, the underlying value of an IHC as a "safe haven" for marginalized populations cannot be underestimated. However, there are a number of concerns about the Modhumita approach, including (1) the range of services offered, (2) the quality of services offered, (3) the value of the centers as a branded network and (4) the value of the brand overall.

The DIC for risk populations is a proven and successful model in Bangladesh. The Modhumita IHC is a basic variation of the DIC model that was implemented under the IMPACT project. The range of services provided by BAP and IMPACT are roughly similar, with the one major difference being that BAP has significantly expanded the availability of VCT services at its IHCs. The scale-up of VCT from the time of the IMPACT project through the current BAP project is the result of technological advances, enhanced training, program design and strategy, and environmental factors.

Despite the fact that IMPACT clinics were instituted as STI and VCT health service facilities, the clinics also provided general health services for the MARP (most-at-risk population) target population. Under IMPACT, it became difficult to determine whether the MARP patient visits were primarily for STI and VCT or for other health issues with pro forma STI examinations to meet the treatment criteria. This raised concerns regarding using HIV prevention funding for non-HIV-related health activities.

As the final evaluation report of the IMPACT project noted, IMPACT worked to develop "a continuum of care by creating referral mechanisms with partner agencies and other service agencies" rather than providing a wide array of general health services at its drop-in centers. This issue is important because experience in Bangladesh has shown that marginalized risk populations are more responsive to behavior change initiatives when they can access a broad range of services in a friendly, non-discriminatory environment, particularly general health services.

With the advent of BAP, FHI began to strictly oversee IA clinics' provision of STI and VCT with referrals out for other health related concerns. Although clinic services are now within the BAP continuum of care strategy and funding parameters, this has led to the perception among some IAs and clients that health services have been diminished. In addition, requiring Modhumita clients to go to government clinics and/or private doctors for general health services undermines the effectiveness of the IHC.

The quality of STI and VCT services at Modhumita IHCs – as well as the overall quality of IHC operations – appears to be generally high. BAP has worked hard to improve, standardize, and monitor the quality of service delivery at the IHCs. The question that comes up among many stakeholders is whether the standards are too restrictive, given demand for and coverage of services as well as budget limitations, particularly for STI services. There appears to be an opportunity to allow some flexibility in service delivery without compromising the overall quality. One specific example cited by multiple IAs was that shortening the time required to see each STI patient would not necessarily compromise quality and it would enable an IHC to handle

more patients and would be more cost-effective.1 Unfortunately, IA concerns about this type of quality issue are not captured by the existing QA/QI tools, which primarily measure satisfaction with the service provided among clients, not with more programmatic issues that occur when certain quality standards are followed.

It should also be noted that various IAs and clients have concerns about the performance of the doctors who are contracted to provide services at IHCs. This is a long-standing issue in Bangladesh and there is no obvious solution in light of the national shortage of doctors and nurses and the reluctance of many health care professionals to work with stigmatized risk populations.

Outreach and peer education continues be a valuable and credible way to reach target populations. However, there were concerns voiced by some IAs and peer educators that BAP's commitment to the continuing refinement of these approaches has been lacking and that outreach and peer education efforts are stagnant. For example, they appear to be overly reliant on the repetitive use of a static set of messages and materials. While the basic quality of BAP messaging and materials is solid and useful, these could to be reviewed more frequently to determine whether they continue to adequately engage clients and prospective clients in an ongoing dialogue that is more likely to lead to sustained behavior change. While it can be expensive to regularly refresh IEC (information, education and communication) and BCC (behavior change communication) messaging and materials, it can be a cost-effective way to improve the performance of an HIV/AIDS program, particularly when accompanied by other improvements in outreach and peer education methods.

The 46 Modhumita-branded IHCs are positioned as a network of service providers with a built-in ability of clients to move between centers using their Modhumita ID card as a form of common currency. (It should be noted that the Modhumita ID cards have been very well-received by clients; they value the quasi-official imprimatur that a printed ID card infers, particularly when dealing with the police.) The reality in the field is that the IHCs tend to be more stand-alone or more narrowly networked with a parallel facility operated by the same IA. In many cases, the stand-alone nature of an IHC is appropriate; for example, the rehabilitation programs for IDUs are focused out of necessity on their specific clients. On the other hand, there are other examples where street-based sex workers were reportedly turned away from IHCs targeting hotel-based sex workers and vice versa. One IA even reported that clients with Modhumita ID cards were being refused service in Chittagong because they were registered with an IHC in Dhaka. Given the effectiveness of vertical programs for risk populations that tend to coalesce around their peers, it may be unnecessary and misleading to position Modhumita as a network of service providers.

The overarching value of the Modhumita branding is debatable. It is, however, important to separate the quality controls that were put in place as part of the Modhumita initiative from the core branding. (Although quality is considered a component of the Modhumita brand positioning, the actual quality controls could be implemented independent of the branding, particularly since many of the quality controls are invisible to clients.) The basic quality controls – e.g., customer service protocols – appear to have made some contributions to the operation of the DICs that were being rebranded as IHCs. The core branding – the name, logo, exterior signage, interior posters, display strips, etc. – does not appear to have contributed significantly to the quality of

1 The issue of quality related to the delivery of STI services is complicated by the fact that BAP played a central role in the development of the new national guidelines and BAP would appear to be inconsistent if its IHCs did not follow those guidelines. However, the issue of the duration of patient visits does raise valid questions about the unmet demand for services and the cost-effective use of doctors. The STI issue is further complicated by the fact that non-BAP service delivery sites (e.g., HAPP sites) are being pressured to follow the new national guidelines and, as a result, are struggling to meet the demand for services and maintain their budgets. Consequently, some service providers report growing animosity about the guidelines and BAP's connection to them.

service delivery. In fact, different IAs made it clear that in the absence of BAP funding that they would drop the Modhumita branding. More importantly, the Modhumita branding does not appear to have gained any traction with other HIV/AIDS initiatives; for example, there is no indication that HAPP or GFATM-funded DICs currently branded with an IAs name are inclined to re-brand as Modhumita IHCs. Barring an unexpected shift in perception among other initiatives and/or IAs, the sustainability of the Modhumita brand appears to fall solely on USAID.

Injecting Drug Users

The fact that USAID funding cannot be used for certain IDU interventions (i.e., needle exchange) has not undermined BAP's ability to make a valuable contribution to the continuum of services required to reduce the impact of HIV among this critical risk population. The rehabilitation efforts supported by BAP, including the three-month rehabilitative and psychosocial programs managed by organizations such APON (Ashokti Punorbashon Nibash), CREA (Society for Community-Health Rehabilitation Education and Awareness) and DAM (Dhaka Ahsania Mission) as well as the socio-economic initiative managed by JOBS (Job Opportunities and Business Support), are essential for any long-term reduction in risk among the IDU population. In addition, there are functional links between other types of IDU interventions (e.g., HAPP-funded drop-in centers and outreach programs) that enable individual drug users to enter BAP-funded rehab programs; however, these links can and should be strengthened to improve the continuity of services for IDUs.

The major dilemma for BAP interventions for IDUs – and for Bangladesh as a whole – is the fact that demand for IDU treatment and rehabilitation services far outstrips supply. As a result, dozens of IDUs – potentially, hundreds of IDUs – who are keen to go into rehab, are unable to get into a program. These same limitations have a spillover impact on the JOBS program because the number of individuals completing rehab is far higher than the number of people they can accommodate. (NOTE: As the GOB moves forward with a pilot of oral substitution therapy, it will be important for participants in the pilot to have access to the type of socioeconomic rehabilitation offered by JOBS.)

There is also a specific issue around rehabilitation services for HSs, many of who engage in risky sexual behavior and are at risk of using injecting drugs. Currently, the BAP priority is rehab for IDUs. As a result, according to representatives from BAP IAs and other NGOs working with drug users, HSs have limited access to rehab services, despite the fact that demand for these services is very high among this population and that HSs constitute a large percentage of the overall drug-using population in the country. Given financial limitations and other capacity issues, it does make sense for BAP to focus on getting IDUs into rehab, but the importance of also including more HSs should not be overlooked; in fact, across the national response, access for HSs should be expanded in coming years if HIV infections are going to be prevented.

Two-week detoxification programs are no longer funded by BAP due to a combination of an extremely high relapse rate and budget constraints. The extremely high relapse rates associated with these programs have been well documented over multiple years in Bangladesh. In fact, it appears that key IAs were reluctant to implement two-week detox programs because they were so ineffective. However, the net result is a positive one: Participants in the BAP-funded IDU programs now go through a full three-month rehabilitation.

To date, very little work has been undertaken to understand why the relapse rate from detox and rehab is so high. For example, CREA conducted a survey of 166 relapsed detox clients; however, the findings are limited and there is no data on the relapse rate from three-month rehab. While this survey contributed to the decision to eliminate BAP funding for two-week detox, it appears

to have simply reinforced an already strong belief within CREA about the limited effectiveness of detox not linked to rehab. In addition, the findings from the survey included a recommendation that reinforced the belief that more work needs to be done to understand the problem of relapse: "The questionnaire needs improvement to provide an opportunity to better evaluate potential behavior change and benefits of detoxification and rehabilitation programs on relapse cases." There was a parallel recommendation that reinforced the same conclusion: "Ask more questions about history of relapse and reasons why." (It is worth noting that BAP is currently working with ICDDR,B [International Center for Diarrhoeal Disease Research, Bangladesh] on a new study, which should strengthen the knowledge base on relapse. It would also be valuable to look at research conducted in other countries related to relapse and detox/rehab programs.)

One additional concern related to IDUs is the limited post-rehab follow-up if the client does not transition to the JOBS program. While there is some follow-up with these clients by outreach workers, the above-mentioned CREA survey also recommended, "There should be more focus on follow-up care after rehabilitation programs are over." In general, better information on the outcome and impact of rehab would be invaluable in strengthening the program. For example, the data that is available on clients who have participated in JOBS support the high value of that program and the opportunity to significantly expand it. In general, given the limited USAID funding for HIV/AIDS in Bangladesh, the success of the continuum-of-services model for HIV prevention among IDUs should be documented and disseminated in order to promote and support scale-up of these services by Government and other donors.

Hotel-Based Sex Workers

Large numbers of clients, continuing low rates of consistent condom use and high rates of STIs put hotel-based sex workers at high risk of HIV infection. BAP IAs appear to do a good job of providing services for hotel-based sex workers who fall within their catchment areas. In addition, BAP has capitalized on the important role that gatekeepers play in the hotel sex trade and has developed activities to communicate with them. However, gatekeepers and clients would definitely benefit from far more attention; gatekeepers because of their influence among sex workers and clients and clients because they are known to be clients, who are actively involved with sex workers in the hotel venue. Given the size of this risk group, BAP should consider the integrated populations of hotel-based sex workers, gatekeepers and their clients to be prime constituencies for interventions. Unfortunately, budget cuts have lead to a reduction in the number of IHCs serving hotel-based sex workers and there are major gaps in coverage within BAP catchment areas, especially for known clients.

Street-Based Sex Workers

The programs that are most effective at reducing the risks facing street-based sex workers in Bangladesh, including the risk of HIV, have strong self-help, empowerment, and organizing components. Currently, BAP is unable to fund these types of programs, including, for example, the model used by Durjoy Nari Sangha because of USG policy against supporting organizations that do not have an explicit policy opposing prostitution. Given such constraints, BAP appears to have no significant comparative advantage in the provision of services for this population. As mentioned above, BAP would have been well served by prioritizing risk populations as well as program activities to ensure that USAID funding was being spent in a targeted, cost-effective manner, which is why, for example, working with hotel-based sex workers and the related constituent populations makes more sense.

Men Who Have Sex with Men

The response targeting the MSM population in Bangladesh is problematic on multiple levels, many of which are beyond the scope of BAP. The size of the MSM population is unclear and is probably under-estimated. Due in large part to poor planning and execution, existing interventions often under-perform. Interventions tend to have a narrow prevention focus – for example, STI treatment – as opposed to a broader framework of human and sexual rights and social development; consequently, the interventions have limited appeal and impact. High-risk behaviors are common. Stigma and discrimination against MSM is pervasive. The risk of HIV infection among this population remains very high. And GFATM Round Six, which specifically targets most-at-risk populations, does not include any interventions for MSM.

The general picture related to MSM interventions in Bangladesh is complicated by the fact that the current size estimate of risk populations mixes MSWs with MSM. Needless to say, these two groups are distinct and would ideally be disaggregated in the size estimation. However, from an intervention perspective, it is difficult – and may have limited value – to completely separate the two populations; for example, popular cruising spots attract MSWs and MSM and both populations would benefit from HIV prevention activities. In addition, there is a transactional component to many MSM relationships that would not be considered formal sex work by those MSM who engage in this type of sex. It is also extremely shortsighted for interventions to focus solely on MSWs, given the risk associated with the entire MSM population, including MSWs. (Note: Historically, BAP has not disaggregated MSWs from MSM in its internal data. For example, the baseline value and the initial targets were a combined MSW and MSM number, whereas BAP is now attempting to target MSWs and only count those individuals.)

Relative to the scope of the interventions for clients of sex workers, BAP activities for MSM and/or MSWs do not appear to be sufficiently responsive to the overall needs of the risk population, including MSM who do and do not identify as such. In addition, the attempt to focus on MSWs is likely to be shortsighted. As mentioned above, the narrow focus on interventions such as STI treatment negatively affects the appeal and impact of MSM interventions. And while STI and VCT services are valuable components of MSM interventions, it undermines the credibility of the BAP when MSM clients are not able to access other health services at an IHC, given their unique medical needs and the stigma and discrimination they face in Bangladesh at large.

Hijra

Reaching hijra in Bangladesh with HIV services is challenging because it is such a tight-knit community. BAP has been able to leverage the capacity of IAs that work with hijra and members of this risk population are receiving some valuable services. However, as is the case with MSM interventions, the services for hijra are also too narrowly focused. For example, BAP tends to minimize the larger issues of gender and sexuality that are fundamental in the hijra community. In light of the human rights issues faced by hijra, including stigma and discrimination, interventions must move beyond safe sexual practices and STI and VCT services.

Unfortunately, it appears that BAP has had issues with developing open and productive relationships with hijra leaders, who play a major role within the hijra communities. As a result, when budget cuts were made to the program, the perception among hijra communities – however unintentional – was that once again activities for hijra were not a priority. BAP activities for hijra appear to be insufficiently responsive to the needs of the risk population; for example, there is significant unmet demand for STI services; there are serious questions about the quality and commitment of clinical staff; there is inadequate provision of general health services and access

to specialized referral care; and the high cost and poor availability of transportation to intervention sites discourages greater facility utilization.

Clients of Sex Workers

According to the original M&E definitions employed by BAP, it could be reasonably argued that clients of sex workers are the primary beneficiaries of BAP. There are also more Modhumita-branded IHCs for clients of sex workers than any other single risk population if one considers hotel-based and street-based FSWs as separate categories. The Social Marketing Company's original 16 (now 14) Shurockkha/Modumita branded IHCs constitute BAP's principal intervention for clients of sex workers. The MACCA awareness raising interventions through TV and Imam sermons are also reaching some sex worker clients (see below).

There is currently little evidence that BAP's efforts to serve clients of sex workers are having a substantial impact on the Bangladesh epidemic, primarily since HIV seroprevalence is still very low among the clients of sex workers. It is worth noting that the IHCs targeting clients of sex workers are treating a modest number of patients for STI symptoms even though these IHCs have comprised 25% of the total number of branded BAP centers. The number of contacts with clients of sex workers also appears to be insufficiently frequent to lead to any sustained behavior change.

One highlight of the work with clients of sex workers is the participation of the MACCA. The development of a book of *kuthbas*, which can be used by imams to raise awareness about HIV/AIDS, has been well received by the Muslim community and the Ministry of Home Affairs (MOHA). MACCA has also used BAP funding to train and sensitize nearly 1200 imams on HIV/AIDS. The television talk show hosted by the Chairman of MACCA has helped raise the profile of HIV/AIDS in the religious sector. Overall, the work of MACCA is valuable, but by counting 100% of individuals who hear Friday Jumma sermons or watch an episode of the talk show as a contact, BAP has conflated the number of people reached with IEC messages with in-depth quality behavior change communication.

People Living with HIV/AIDS

Ashar Alo Society (AAS) is the sole BAP IA providing services for people living with HIV/AIDS. The AAS clients clearly benefit from the BAP-funded services, particularly the on-going counseling and support groups. Many of the services they require, including general health services, ARVs (anti-retrovirals), CD-4 testing, drugs for OIs and nutritional support, are not covered under BAP funding, although some of the services are covered by other funding organizations. For example, the corporate responsibility program at the Dutch-Bangla Bank provides ARVs for some of the AAS clients. People living with HIV/AIDS, including AAS clients, continue to face serious stigma and discrimination when they are referred to government facilities for secondary and tertiary care and treatment. For example, hospital staff at the Infectious Disease Hospital in Dhaka, which is the primary referral hospital for HIV/AIDS in the city, requires PLWHA to supply their own commodities for examinations and treatment.

The programmatic dilemma for BAP is the fact that AAS is not reaching PLWHA from core risk populations (e.g., IDUs, sex workers, MSM), even when other BAP IAs refer clients to the organization. There is broad agreement that people from these risk populations are not accessing services at AAS facilities because they do not feel comfortable there. The overwhelming percentage of AAS clients are returning external migrant workers and their wives and children. Given the current clientele and the focus of AAS, it is difficult – if not impossible – to mix this population with IDUs, sex workers, etc. Vertical service delivery by risk population in Bangladesh is the norm precisely because people respond much better to interventions when they

are in their respective peer groups. Despite all the good work that it does, AAS is not an organization that is equipped to deal with the challenges of dealing with less mainstream risk populations.

GFATM Round Six and HNPSP include funds for care, support and treatment for PLWHA in Bangladesh. However, it is not clear if an organization such as AAS will be able to access funds from either of these sources. It is also not clear how PLWHA who are members of most-at-risk populations such as IDUs, sex workers, MSM, and hijra will benefit from a wider availability of care, support, and treatment under GFATM and HNPSP.

Other Risk Populations

There appears to be growing concern in some quarters about the impact of returning external migrants on the spread of HIV in Bangladesh. While it is true that there is an upsurge in official external migration for employment – largely to the Middle East – there is extremely limited data on the situation as it relates to HIV/AIDS. And some of the data that does exist can be misleading. People cite statistics showing the large percentage of PLWHA who are returning external migrants; however, many of these people have received an HIV diagnosis as the result of job-related testing and they are more likely to seek care and treatment than marginalized risk populations. This inflates their percentage representation in the PLWHA figures.

There is a clear and compelling need to collect more data on the role that returning external migrants play in the evolution of the epidemic before making a significant shift in the national response to focus more on this population. This is especially true if it leads to any diversion of resources away from the primary risk populations. Unfortunately, it would not be unprecedented to see the government shift resources from challenging work with IDUs, sex workers, and MSM to more politically acceptable work with a more mainstream population. While this is not necessarily an issue for BAP directly, it could have a major impact on the overall context of the AIDS response in Bangladesh in the future, which could, in turn, effect BAP's programming.

STI and VCT Services

BAP has positioned Modhumita-branded IHCs as providers of "gold standard" STI and VCT services. Supporting this positioning has been a major component of BAP's work and has included the development of an extensive portfolio of protocols, standards, guidelines, trainings, and assessments for both types of services. In general, it appears that Modhumita clients do receive higher-quality STI and VCT services than is the norm in the other facilities, despite the fact that the QA/QI support within BAP has consistently identified problems, gaps, and/or non-compliance issues with service delivery at individual IHCs.

High-quality service is always an admirable goal, but the bar may have been set too high in Bangladesh. For example, the lack of flexibility in the protocols is having an adverse impact on the number of clients being served, the relationship with individual IAs, and the uptake of the protocols by other non-BAP service providers. There is also a lively debate among BAP and non-BAP service providers about the value of gold-standard services in resource-constrained settings. Most providers recognize the value of setting the bar high as an incentive to continuously improve the quality of service delivery, but they are reluctant or unwilling to sacrifice availability and/or coverage for a gold standard.

It is also worth noting that the various risk populations served by BAP have unique medical needs, particularly in the area of STI diagnosis and treatment. Consequently, it is important that health professionals working with these populations have the right knowledge, skills, and attitudes. There are recurring complaints from clients about the unsuitability of many of the

contract doctors who staff the STI clinics at IHCs. It should be noted that BAP has conducted regular STI clinical management trainings for doctors to address this problem; however, it is equally important to note that the problem continues to exist. The general shortage of doctors and nurses combined with the reluctance of many of these professionals to work with risk populations is a long-standing problem in Bangladesh. It is unfortunate that BAP – to date – has not been more successful in finding a solution to this problem, particularly since the performance of the doctor or nurse is the single most important factor in service delivery. However, given the persistence and pervasiveness of the problem, a solution may be beyond the capacity of a single project.

Condoms

In a concentrated epidemic, condom use is one of the most important and most effective ways to limit the spread of HIV. Unfortunately, condom use in Bangladesh remains alarmingly low across key risk populations. BAP has had success in improving condom availability for its target risk populations, but there is clearly room for improvement in the behavior change component of the program, particularly among hotel-based sex workers, actual clients of hotel-based sex workers, MSM, and hijra.

The condom-distribution component of BAP has been fairly successful. Members of the various risk populations clearly appreciate the access to free condoms. In addition, BAP's work on lubricant has been responsive to the needs of the target populations and, as a result, seems to be well received. There have been some nagging problems with condom supplies at some IHCs because of a misunderstanding over the formula used to calculate initial orders of condoms for a particular IHC. IAs were mistakenly using the same calculation for reorders as well, which often led to a shortfall in quantity at certain IHCs. This does not appear to have been a widespread problem, but it does indicate a need for more focus on the unique relationship between central BAP staff and individual IAs.

It was surprising to see that the free condom distributed through BAP was such a generic one. In most countries, consumers generally prefer branded condoms to generic or no logo ones, even if that branding is relatively minor. There are a number of different branded condoms available through the USAID Contraceptive Product Catalog, which could be suitable for Bangladesh and that might increase the appeal and uptake of condoms within risk populations. However, shifting to a branded condom is only a small step. There is an ongoing need for innovation in condom programs; increasing distribution is important, but increasing acceptance and use is far more important.

STRATEGIC INFORMATION

Surveillance

Health and behavioral surveillance surveys (HSS [HIV Sentinel Surveillance] and BSS) are functioning well and providing essential information for tracking the HIV/AIDS epidemic in Bangladesh. However, some stakeholders noted that neither system was "sensitive enough" to reliably measure national HIV seroprevalence among risk groups in hotspot areas around the country (e.g., border areas) or HIV spread into the general population. These surveys sample MARPs that are living in areas with intervention coverage, which tend to be areas where these populations are concentrated. However, it also means survey data may not accurately reflect the situation among MARPs outside intervention catchment areas or in the general population.

Some stakeholders noted that surveillance and qualitative research could be expanded for migrants who are returning to Bangladesh from overseas work. For example, the number of PLWHA being reported by AAS in Sylhet may be an early warning sign that HIV is increasingly active in populations outside the risk populations being targeted by BAP and HAPP. This is a large epidemiological unknown that can't be totally discounted when considering future strategies for combating HIV in Bangladesh.

Research and Modeling

Bangladesh has undertaken a wide range of studies on HIV/AIDS knowledge, risk behavior, prevention, and risk populations. BAP has contributed to this research effort in multiple ways, including its support for the BSS and behavioral research studies on IDUs and sex worker client networks. BAP has also contributed to HIV/AIDS policy research by completing an inventory of existing policy and legal frameworks. In addition, the program has recently completed a trend analysis of the BSS, which provides comprehensive documentation of the changing behavioral dynamics underlying the spread of HIV in the country. BAP has also supported modeling work on the likely spread of HIV that has been useful for advocacy work with key constituencies, especially government ministries and officials.

BAP may have missed some opportunities by not collaborating with researchers on more operational research to test the effectiveness of service delivery and behavior change approaches. However, it is important not to overlook BAP's financial and programmatic constraints. In general, Bangladesh's response would benefit if operational research was an integral part of targeted interventions for the different risk populations. In fact, this type of research could make a significant contribution to the design, implementation, and evaluation of models that could be replicated by other programs in Bangladesh.

Monitoring and Evaluation

Overall, the BAP M&E system appears to be working reasonably well. For example, it seems to capture the required information for the BAP indicators and the quality of the data appears to be sound, given the quality controls (e.g., data quality audits, field visits, trip reports) that are currently in place. Although some IAs expressed frustration with the M&E system during the first two years of the program, it appears that a subsequent revamp of the system and additional training has addressed these concerns.

Given the straightforward nature of the BAP indicators, their value is primarily to assess the outputs of the program (e.g., the number of people reached, the number of contacts, the number of facilities, the quantity of commodities). Unfortunately, the BAP indicator set does not provide any broader or deeper information on outcomes and impact, which are important measures of the efficacy of a program. Consequently, the M&E system provides little or no information or insights on how to measure the effectiveness of behavior change interventions. The BSS does look at exposure to HIV prevention interventions as they relate to behavior change among MARPs. While changes in behavior by the target populations measured over the rounds of BSS may be, to some extent, the result of BAP (and others) program activities and other extraneous variables that allow BAP to claim some attribution, BAP should still undertake periodic efforts to measure the effectiveness of the BAP-funded interventions in changing behavior among target populations.

One of the particular challenges facing program and project-level M&E in Bangladesh is the lack of a national M&E framework with clearly defined indicators. As a result, there is little impetus for different programs and projects (e.g., BAP, HAPP, GFATM Round Six) to coordinate their

programming or their M&E initiatives. This lack of coordination makes it difficult to track the overall impact of interventions on the epidemic in Bangladesh.

POLICY AND ADVOCACY

National Leadership and Commitment

BAP is an active participant in the dialogue on national leadership and commitment, including important work on updating the Government's National Policy on HIV/AIDS and STDs. The current policy is now more than 10 years old and is not necessarily reflective of current programmatic priorities. In addition to regular and ongoing discussions with counterparts at key agencies in government (e.g., NASP) on this issue, BAP funded a policy audit, which concluded that the current policy in Bangladesh "lacks clear guidance on implementation"; needs to give greater priority to HIV prevention efforts among drug users; needs to more effectively address stigma, discrimination, and human rights; should develop greater cooperation with law enforcement officials; and should expand funding for the epidemic. The overarching conclusion of the policy audit was that "greater political leadership will be required to effectively combat the spread of HIV in Bangladesh."

Unfortunately, given the relatively low priority attached to HIV/AIDS within the Government, it is not clear if BAP's policy and advocacy work related to national leadership and commitment will lead to any substantial change in the current situation. However, this does not diminish the importance of this work.

NASP is generally supportive of BAP's commitment and contribution to the national response; however, due to high staff turnover within NASP, the actual knowledge and understanding of BAP's contribution to the national response is limited. Consequently, BAP has had to continually educate national-level leaders on its work as well as lobby for strong national leadership and commitment.

Community-Level Development

Several stakeholders expressed concerns that BAP IHCs were not more involved with community organizations (e.g., local government, community entrepreneurs, teachers and religious leaders). It was felt that more efforts were being expended to strengthen the managerial and service quality of IHCs than to promote community awareness, acceptance, and "ownership" of the IHCs. Given resource constraints and the high demand for more community participation, this is an area where it will always be possible to do more, particularly if sustainability of programming is a long-term objective. The question is how it fits within the mandate of a given program or project. Under BAP, the focus has been, appropriately, on service delivery for risk populations, not on sustainable community-level structures. In the future, it may be important for USAID and BAP to think about how it can expand its focus to increase community awareness and buy-in, similar to what has been done with MACCA.

VI. RECOMMENDATIONS

The recommendations in this report are separated into two categories: (1) Recommendations related to Year Three of the BAP and (2) recommendations related to possible USAID programs for HIV/AIDS in the future.

YEAR THREE OF BAP

Given the fact that there is only one year remaining in BAP, it is important to focus the recommendations on issues that can effectively be addressed during the available timeframe. The review team has prioritized six recommendations, which are designed to address issues regarding the effectiveness of BAP's core activities with most-at-risk populations as well as generate useful insights for future USAID programming and influence the HIV/AIDS response in Bangladesh more generally.

1. **Identify and strengthen priority interventions for priority risk populations.** Existing BAP interventions with key risk populations are an important part of the overall response in Bangladesh and will be influential in the scale-up of HNPSP and GFATM interventions for these populations. By focusing on a narrower set of interventions and risk populations, BAP can refine prevention approaches that lead to sustained behavior change and reduced risk of HIV transmission and infection.

   Recommended prioritization of risk populations:

   - Injecting drug users
   - Hotel-based sex workers
   - Men who have Sex with Men
   - Hijra

   Possible priority interventions by risk population:

   - Injecting drug users
     - Collaborate with other non-USG IDU service providers to insure that a continuum of services and linkages are available to members of this risk population.
     - Increase capacity of three-month rehabilitation programs; explore the option of increasing the number of places for HSs in rehab.
     - Increase number of referrals to the JOBS program among "graduates" of rehabilitation.
     - Add "after care" programs to the three-month rehabilitation to help with the transition to JOBS for those enrolled in that program and to provide psychosocial support to those who do not participate in JOBS. After-care programs should include support groups for recovering IDUs. It should also include community follow-up by outreach workers.
     - Support the oral substitution pilot at ICDDR,B by adding slots for participants in the JOBS program.

- Evaluate or pilot a halfway house for recovering IDUs with one of the IDU IAs.

- Hotel-Based Sex Workers
  - Focus more attention on the "community" around hotel-based sex work, including the sex workers themselves, clients, hotel owners, and other gatekeepers. Use the dynamic of this community to mutually reinforce lower risk behaviors (e.g., consistent condom use). It should be noted that clients in these hotels are actual clients, not prospective and/or potential clients, which increases their value as a target population.
  - Expand outreach and peer education efforts to improve coverage in existing BAP catchment areas.
  - Strengthen the outreach and peer education efforts by improving and updating materials in collaboration with the IAs working with hotel-based sex workers.
  - Overstock free condoms in the hotels to avoid any shortage at point of use. Also ensure that IHCs for hotel-based sex workers are never short of condom stocks.
  - Ensure sufficient coverage of STI services to meet the demand in IHCs for hotel-based sex workers; specifically, add clinic days and hours if necessary.
  - Generate demand for VCT services and ensure sufficient coverage to meet the demand in IHCs for hotel-based sex workers; specifically, add clinic days and hours if necessary.
  - Work with JOBS to pilot a program for hotel-based sex workers interested in transitioning out of sex work.

- Men who have Sex with Men
  - Expand outreach and peer education efforts to improve coverage in existing BAP catchment areas. In known hotspots, work with all MSM, not just identified MSWs.
  - Strengthen the outreach and peer education efforts by improving and updating materials in collaboration with the IAs working with MSM.
  - Develop initiatives to reach MSM who do not want to be identified as such.
  - Ensure that IHCs for MSM are never short of condom stocks.
  - Ensure sufficient coverage of STI services to meet the demand in IHCs for MSM; specifically, add clinic days and hours if necessary. Also, it is important that the doctors who provide the STI services have the qualifications and understanding to work with the MSM community.
  - Generate demand for VCT services and ensure sufficient coverage to meet the demand in IHCs for MSM; specifically, add clinic days and hours if necessary.
  - Consider adding basic general-health services as a complement to existing STI, VCT, and preventions services in MSM IHCs.
  - Conduct advocacy activities with government stakeholders on behalf of the MSM community to reduce stigma and discrimination; e.g., the issue of MSM activities being excluded from GFATM Round Six.

- Hijra
  - Expand outreach and peer education efforts to improve coverage in existing BAP catchment areas.
  - Strengthen the outreach and peer education efforts by improving and updating materials in collaboration with the IAs working with hijra.
  - Ensure that IHCs for MSM are never short of condom stocks.
  - Ensure sufficient coverage of STI services to meet the demand in IHCs for hijra; specifically, add clinic days and hours if necessary. Also, it is important that the doctors who provide the STI services have the qualifications and understanding to work with the hijra community.
  - Generate demand for VCT services and ensure sufficient coverage to meet the demand in IHCs for hijra; specifically, add clinic days and hours if necessary.
  - Consider adding basic general-health services as a complement to existing STI, VCT, and preventions services in hijra IHCs.

  NOTE: Existing interventions for street-based sex workers should be maintained through the end of the BAP. While there is no recommendation to increase funding for these interventions, funding should not be reduced. In general, programs for clients of sex workers should be scaled back, except for MACCA initiatives; while MACCA initiatives do not actually target clients of sex workers, they do increase awareness, help create an enabling environment and reduce stigma and discrimination.

2. **Free up funding for priority interventions by dramatically reducing and/or eliminating funding for lower priority activities.** To ensure that priority interventions have sufficient funding, BAP should move as quickly as possible to streamline its operations in order to save money that can be redirected to priority interventions.

   Recommended cutbacks:

   - Terminate all general management training for BAP IAs; work on a case-by-case basis with IAs who have demonstrated needs and weaknesses.
   - Terminate all non-essential clinical training for BAP IAs and contractors.
   - Eliminate funding for IHCs operated by SMC. These centers appear to be under-utilized by BAP clients and they are likely to revert to their functionality as Shurocckha centers without BAP funding. Their target population is the amorphously defined "clients of sex workers" who are at far lower risk of HIV infection than other populations in Bangladesh. Also, many clients of sex workers do not face the same levels of stigma and discrimination as more marginalized risk populations do when seeking health services; they are more likely and able to access services from other facilities. (NOTE: The elimination of BAP funding for the SMC IHCs will have a negative impact on the BAP indicators that tracks the number of centers and the number of STI sites. The IHC indicator could easily be dropped; the reason for the decrease in STI sites can be rationalized because of the increase in STI patients treated for STI symptoms at other sites, which will now be able to see more patients.)

Other possible cutbacks: (illustrative only)

- Suspend all efforts to re-brand DICs and IHCs.
- Reduce the number of international consultants providing technical assistance to BAP.

3. **Improve the relationship between FHI and the IAs.** The quality of the relationship between FHI and many implementing IAs needs to be addressed if BAP is going to have a successful third year of implementation. Fundamentally, the problem appears to stem from IAs perception that FHI has a tendency to treat them as *vendors* who have been paid to perform certain tasks as opposed to treating the IAs as *partners* who are included in an open and transparent manner. This underlying problem was exasperated by the budget cuts that had to be made to the program.

   Improving the relationship between FHI and IAs will require good faith efforts on everyone's part. However, it falls to FHI to be proactive. Possible ways to address this issue: reinforcing their role as a managing partner, not a donor or policeman; including IAs in budget discussions and decisionmaking process; soliciting the opinion of IAs on how to improve interventions; holding regular meetings with IAs working with the same risk populations; including USAID staff in the meetings with IAs to help them understand the donors role in BAP; et cetera. Without a concerted effort to improve these critical relationships, there could be longer-term damage to USAID's reputation in the local NGO and CBO community. (Note: It is unlikely that FHI will be able to satisfy all of the requests from the IAs and probably unnecessary that they do so. However, it is important that FHI made a concerted good-faith effort to address the situation.)

4. **Conduct an independent SWOT analysis of the "gold standard" approach to IHC operations, especially STI and VCT services, and the corresponding QA/QI protocols and processes.** This should be a cost-effective, qualitative, rapid assessment designed specifically to pull out practical lessons learned about the value of a "gold standard" approach and the effectiveness and cost-effectiveness of the QA/QI backstop. An external consultant with no ties to any of the BAP organizations and who has experience in health-quality issues in resource-constrained countries should conduct the analysis. The results of this analysis would be useful for all organizations in Bangladesh involved in the delivery of STI and VCT services. Specifically, it will help inform the ongoing debate about balancing quality of services against demand and cost.

5. **Develop a systemic solution to address the problem of over-segmentation by risk population at Modhumita IHCs.** Currently, there appear to be recurring incidents where Modhumita clients were denied services because they were registered at a different IHC or they were members of a different risk population. While these may be isolated cases, they do reflect the concern that the Modhumita IHCs do not function as a cohesive network. Regardless, it is important not to turn clients away, particularly when they are seeking STI services as a result of outreach efforts.

   In addition, there is a parallel concern that individual IHCs are not taking full advantage of the investment in their infrastructure and operations by over-segmenting the risk populations. For example, if there are both hotel-based and street-based sex workers in the same catchment area, it may be possible to operate separate STI and VCT clinics for the respective populations in the same facility thereby preserving the value of allowing at-risk populations to associate primarily with their peers. It would require careful planning and execution to use

one facility to serve multiple risk populations, but it could be a cost-effective way to expand the availability of services in key areas and among core risk populations.

6. **Expand the work with MACCA to include stigma and discrimination issues related to marginalized, most-at-risk populations (IDUs, sex workers, MSM and hijra) as well as people living with HIV/AIDS.** As a faith-based organization, MACCA has played a unique and important role within BAP in increasing awareness about HIV and its work with *Imams* has expanded the reach of the program in an important direction. In the final year of BAP, it would be valuable to build on the relationship with MACCA and support them to work on the broader issue of stigma and discrimination as opposed to making HIV/AIDS prevention their sole focus. Work on stigma and discrimination will actually benefit broader prevention efforts because the success of many of those initiatives hinges on a more accepting attitudes. For example, the CREA site for in Old Dhaka worked very hard to engage with the local community to get them to accept the value of their rehabilitation work with IDUs. Conversely, Badhan has had problems with its IHC for hijra because of ingrained stigma and discrimination among landlords and community members.

   The success of the kuthbas on HIV/AIDS knowledge and prevention is an excellent model for work that MACCA could do in the third year of BAP. Kuthbas on stigma and discrimination could be an invaluable tool. In addition, given the enthusiasm of the Chairman of MACCA for HIV/AIDS work, it would also be sensible to have an open-ended discussion with the organization about what they could do around stigma and discrimination or other HIV/AIDS issues that they could effectively address.

FUTURE DIRECTIONS FOR USAID

As funding for the HIV/AIDS response in Bangladesh steadily increases over the next few years – e.g., the combined funds available from GFATM Round Six, HNPSP and ADB are in excess of $100 million – it is important for USAID to program its bilateral funding in ways that add value to the other resources available in the country. And despite the increased funding for the Bangladesh response, there are both opportunities and gaps that would benefit from USAID support within the current parameters for USG HIV/AIDS funding. The fundamental challenge is to consistently focus on the strategic impact of the support, not on more tactical issues such as the coverage of interventions or simply providing funds for activities that can and should be supported by government.

Strategically, one of the most important issues facing the HIV/AIDS response in Bangladesh is the limited leadership provided by government. Issues of political will and commitment have been problematic since the start of the country's response. The international community has supported numerous initiatives to strengthen the capacity of government to provide leadership and to actively manage the response, including, most recently, significant support for a capacity building effort funded under HAPP in 2006-2007. Unfortunately, none of the initiatives have yielded a sustained change. In addition, key government institutions such as NASP are not as effective as they could be. This makes it extremely difficult to make a case for investing more resources in strengthening institutions that have not demonstrated an ability to take advantage of technical assistance.

It is important to note that the government's limited capacity for leadership has a profound effect on the issues of coordination and collaboration. There has been no clear sense of priorities in the national response and no formal mechanisms for ensuring that the efforts of the various stakeholders in the response are integrated in ways that maximize their impact. Over the next few months, the consequences of the issues with leadership, coordination, and collaboration will

become clearer as GFATM selects implementing partners for Round Six interventions and the overlaps or synergies with HAPP, HNPSP, and BAP interventions can be evaluated.

Given the issues related to government capacity, one possible scenario is to support a strategic set of three activities to empower organizations that are actively involved in the actual implementation of interventions to take more responsibility for critical components of the response. These are (1) coordination and collaboration, (2) strategic information, and (3) continuous improvement of successful interventions. For this strategy to work it is critical to encourage NASP to assume an oversight role. All the work could certainly be done under their auspices. It should, however, be driven by the needs of implementing organizations and their stakeholders as well as the long-term strategy of the GOB.

1. **Develop and sustain an approach to improving coordination and collaboration that is based on the needs of the most-at-risk populations and the knowledge of organizations that have worked directly with these populations as opposed to the traditional top-down approaches.** While it is essential that any needs-based approach to coordination and collaboration include a strong compact with government, there is an opportunity to develop and deploy a tactical approach would enable the organizations with the most field-based knowledge and experience to be actively involved in the day-to-day, operational aspects of the coordination and collaboration, freeing up NASP to have an appropriate oversight role.

   One example of a tactical, needs-driven approach to coordination and collaboration that could be further refined in Bangladesh is the one used by RDM/A in the Greater Mekong Regional HIV/AIDS program. Under this regional USAID initiative, a "minimum package of services" was defined for the risk populations targeted by the program. This minimum package was then mapped against a geographical information system (GIS) database that contained information about hotspots for HIV risk and vulnerability, high-risk population size estimations, estimated HIV prevalence in high-risk populations, the presence of HIV/AIDS programs and activities, and program or service coverage.

   There are differences in the HIV/AIDS situation in Bangladesh that would necessitate adjustments to the Mekong approach. For example, there are many more stakeholders in Bangladesh who must be engaged in coordination and collaboration, ranging from government ministries and agencies to (MoHFW, MoHA, NASP, etc.) to funding partners (bilateral donors, World Bank, GFATM, etc.) to implementing organizations (international NGOs, local NGOs and CBOs, government). In addition, Bangladesh has a proven record of innovation and successful engagement with most-at-risk populations, including the early development of the multi-faceted drop-in center for specific risk populations. Consequently, it would be possible to expand the "minimum package of services."

   Bangladesh is well positioned to develop *intervention continuums by risk population* that would essentially map – and show the links between – the different types of activities that are in place or planned. The intervention continuum for IDUs should cover activities as diverse as the initial contact with individual IDUs by peer educators and outreach workers, drop-in centers and the various services available there, ongoing outreach activities, physical and psychosocial rehabilitation, socioeconomic rehabilitation and after care. An IDU continuum would also include planned activities and/or other opportunities such as the upcoming pilot at ICDDR,B on oral substitution therapy and the viability of putting patients on substitution therapy into socioeconomic rehabilitation.

   Once an *intervention continuum* is sufficiently complete, the multiple stakeholders involved in the various activities, including implementing organizations and donor, GOB funding mechanisms, would plot their activities on the continuum. For example, CREA and APON

(implementing organization) and USAID (funding mechanism) would be listed under IDU physical and psychosocial rehabilitation; CARE-Bangladesh (implementing organization), HNPSP, and GFATM (funding mechanisms) would be listed under IDU drop-in centers; JOBS and USAID under socioeconomic rehab; and ICDDR,B under oral substitution pilot.

Each *intervention continuum by risk population* becomes an invaluable, open-source tool that could be used by all stakeholders to identify and track which organizations are doing specific interventions as well as how and where these activities should be coordinated and how and where gaps should to be filled.

This approach to coordination and collaboration could be a valuable strategic initiative because it repositions coordination/collaboration as a bottom-up activity, not a top-down one. In the process, the response becomes more pragmatic, less theoretical, and more driven by the needs of stakeholders who are most concerned about impact on risk populations. All too often, coordination and collaboration is an abstract exercise precisely because it is not linked to activities at the field level, where coordination and collaboration is most important. The intervention continuums will make it clear to all stakeholders exactly who is doing what, making it much easier to integrate their activities.

If successful, this approach could be a useful model for other countries that continue to struggle with the day-to-day realities of coordination and collaboration as there continues to be a lack of practical models that can help improve this situation.

As is the case with the Mekong project, the intervention continuums could be overlaid with relevant GIS data to further enhance the tool by adding national, regional and city coverage information, both by location and by risk population. (USAID/Bangladesh funded much of the background work on the GIS approach that was ultimately used in the Mekong project.)

2. **Transform the existing collection of Modhumita IHCs into a smaller, streamlined network of service delivery sites for key risk populations. Both the network and the individual sites should be replicable and scaleable models that are actively contributing to the development and proof-of-concept of effective interventions that have a verifiable impact on the epidemic in Bangladesh. In addition, the network and sites should be designed to fill coverage gaps in critical catchment areas for targeted risk populations.**

   The network of service delivery sites should build on what has worked and is working in Bangladesh, including the drop-in center approach with a wide range of services for clients as well as outreach and peer education. The sites do not need to have common branding because most of the IAs who have day-to-day responsibility for their management and operations already have credibility within their target populations and the positive associations with their own names can easily be leveraged. The challenge – and ultimately the major contribution to the Bangladesh response – is to work closely with the IAs to refine, improve, expand the multiple components of the intervention sites in ways that ensure the innovations add value and can be shared with any and all organizations working with similar populations. For example, it may be valuable to integrate reproductive health services into sites that serve FSWs to reduce the number of unintended pregnancies among this population. Demonstrating efficient and cost-effective interventions and disseminating that knowledge and experience as widely as possible would be an invaluable contribution to the Bangladesh response to HIV/AIDS.

   The increasing availability of funding in Bangladesh reduces the need for USAID to do larger-scale service delivery. Other funding mechanisms (e.g., HNPSP and GFATM) have the resources to support a significant expansion of service delivery sites and supporting activities. Strategically, USAID would have a far greater impact by using its network of service delivery

sites to test and demonstrate improvements in collaboration with qualified implementing organizations.

3. **Develop an accessible HIV/AIDS resource center for Bangladesh that improves access to national and international data on HIV/AIDS for individuals and organizations working on the country's response. The resource center would play a central role in identifying and filling gaps in knowledge, particularly those related to most-at-risk populations in the country.** Bangladesh is in the unusual position of simultaneously having a glut and dearth of information on the HIV/AIDS situation in the country. For example, there are a surprisingly large number of valuable reports from reputable sources (operational research, qualitative research, meta-analysis, etc.) on the HIV/AIDS situation in Bangladesh that is not widely known or shared within the HIV/AIDS community. Many IAs do not have access to useful information because there is no central repository for data, no mechanisms for cataloging what is available and no forum for identifying or filling information gaps.

   Bangladesh would be well served by a national HIV/AIDS resource center, similar to the successful one funded by PEPFAR (President's Emergency Plan for AIDS Relief) in Ethiopia. Given the history of innovative interventions targeting most-at-risk populations and the ongoing lessons learned from the management of a concentrated epidemic, a Bangladesh AIDS Resource Center would be useful at national, regional, and international levels. The importance of the role of a resource center in identifying and filling gaps in knowledge should not be underestimated. Currently, there is not central mechanism to identify or fill these types of gaps; as a result, most research is commissioned in a very *ad hoc* manner, which results in many interesting but not necessarily useful studies. Bangladesh would clearly benefit from a more strategic approach to knowledge generation and information management.

   Resources centers can be expensive endeavors if they are not established and managed properly. USAID could provide the seed funding and the technical assistance to ensure an efficient and effective launch of the center as well as the systems to maintain the long-term quality and integrity of its operation. In addition, USAID would work with other funding mechanisms (HNPSP, GFATM, private foundations, commercial enterprises, and corporate social responsibility programs, etc.) to ensure the sustainability of the resource center.

The three strategic initiatives outlined above could easily scaled up or down to correspond to different funding levels. Although they could be implemented individually, they would be most valuable if they were developed and deployed as a package. Even as a package, there is a large degree of flexibility to respond to the available budget; each of the activities should be designed to be highly cost-effective and to leverage funding from other sources.

In addition to the initiatives mentioned above, there are several others that could be effectively integrated into a future USAID program in Bangladesh. While they are somewhat less strategic than the activities in the core package, all of them would have a macro-impact on the response.

- **Provide support to the GFATM CCM in Bangladesh through the GFTS mechanism.** While there are serious concerns about the capacity of government to lead/manage the HIV/AIDS response, the multisectoral nature of the CCM makes it an excellent candidate for reform and improvement. Currently, it focuses solely on GFATM applications and plays no role in the ongoing M&E of GFATM-funded interventions. With high-quality technical assistance, it is possible that the CCM could be transformed into an organization that could

demonstrate the value of thoughtful and transparent leadership to government and other stakeholders in the Bangladesh response.

Improvements in the operation of the CCM would also make it more likely that GFATM-funded interventions would be better coordinated with those supported by other funding mechanisms. In addition, a functioning CCM may eliminate the need to have an external organization serve as a management agency, which would help streamline the response.

- **Support the development of a national M&E plan.** Currently, Bangladesh does not have a national M&E plan. There are numerous reasons given for this situation, but it is a significant gap in the national response and contributes to the proliferation of indicators at the project level. The process of developing a national M&E plan would also be an opportunity to engage government around a practical issue and help draw senior decision-makers into the larger discussion about the government's commitment to its HIV/AIDS response.

- **Develop a strategic and tactical plan to address the shortage of qualified health professionals willing and interested to work with most-at-risk populations.** Since the launch of targeted interventions for risk populations in Bangladesh, these interventions have struggled to retain doctors and nurses to provide services such as STI diagnosis and treatment. Over the years, there has been very little innovation in how these services are delivered and the complaints from key risk populations have remained constant and consistent. As interventions are scaled-up with GFATM and HNPSP funding, the demand for health professionals will grow exponentially and nothing is being done to prepare for this surge. As care, support and treatment options increase in Bangladesh, there will be an increase in demand for qualified staff in primary, secondary and tertiary facilities who are comfortable working with people living with HIV/AIDS. Currently, there are few doctors and nurses who have shown a willingness to work with these patients.

- **Launch a targeted initiative to develop and test interventions that can substantially increase condom use among most-at-risk populations.** Low condom use among risk populations continues to be a serious problem in Bangladesh. In fact, condom use in commercial sex in Bangladesh is the lowest in Asia. There have been some minor, incremental improvements in isolated settings, but there is a significant gap in the national response because of low condom use. Key risk factors that fuel concern about an impending explosion of HIV in the country could be largely mitigated by a substantial increase in condom use. Given Bangladesh's experience in working with most-at-risk populations and the potential impact of increased condom use, it is an ideal place to test ways to make condom interventions more effective. Assuming this initiative is successful, it would provide an invaluable evidence base for prevention programs around the world, most of which are struggling to increase condom use enough to have a significant impact on the spread of HIV.

- **Provide NASP with an opportunity to demonstrate leadership by phasing out USAID financial support and technical assistance for the behavioral surveillance in Bangladesh.** Technically, this recommendation is for an activity that should be excluded from future USAID support for HIV/AIDS in Bangladesh. However, now that the government has more than adequate funds to finance the national BSS and the technical expertise to implement the survey exists in-country (e.g., ICDDR,B), there is an opportunity for NASP to take ownership of this important tool. By taking ownership and by demonstrating their capacity to allocate funding, sign contracts with implementing organizations to complete the survey and publish the findings, NASP would be able to demonstrate and strengthen their leadership capacity. (NOTE: As NASP takes ownership of the BSS, it would provide an excellent opportunity to integrate the HSS and BSS into Integrated Bio-Behavioral Surveillance.)

USAID also should consider shifting from a Cooperative Agreement to a Task Order so that the Mission has more control over the direction of the program. While there are pros and cons to both mechanisms, a contract is a more appropriate mechanism when trying to establish and maintain a strategic direction, especially one that relies heavily on working closely with other stakeholders and requires a high level of responsiveness to take advantage of opportunities and fill gaps as they arise.

ANNEX 1 SOW

EVALUATION OF THE BANGLADESH AIDS PROGRAM STRATEGY TO REDUCE HIV/AIDS TRANSMISSION FOR MOST AT RISK GROUPS

(GH Tech Revised 06-26-07)

United States Agency for International Development
Office of Population, Health and Nutrition
United States Mission Bangladesh
April 2, 2007

A. PURPOSE OF THE EVALUATION

The purpose of this evaluation, planned for September 2007 is two-fold:

1. Review, analyze, and evaluate the effectiveness of, the Bangladesh AIDS Program (BAP) in achieving program objectives and contributing to USAID/Bangladesh's efforts to reduce HIV/AIDS transmission among high-risk groups.

2. Provide specific recommendations and lessons learned to ensure an effective follow-on program.

B. BACKGROUND

USAID HIV/AIDS ACTIVITY

Bangladesh AIDS Program

USAID awarded FHI a bilateral cooperative agreement, the Bangladesh AIDS Program (BAP), a three-year agreement to be implemented from October 2005 to September 30, 2008 with a potential total of $12.5 million of funding. BAP assists local NGOs working with vulnerable groups. FHI provides technical assistance to NGOs in order to: educate people on HIV risk reduction; improve prevention efforts and the management of sexually transmitted infections (STIs); minimize the contextual and policy-related constraints; increase linkages between prevention and care; and improve monitoring and evaluation of HIV prevention programs. FHI also supports the annual HIV Sero-Surveillance and provides technical assistance to the Social Marketing Company for a nationwide condom campaign, which targets vulnerable groups and retailers, and solicits the support of policy makers.

FHI has three partners who are assisting in implementing BAP including Social Marketing Company (SMC), Masjid Council for Community Advancement (MACCA) and Research, Training, Management International (RTM). The goal of the BAP is to reduce the transmission of HIV among most at risk populations and mitigate the impact amongst people infected with and affected by HIV/AIDS.

The objectives of BAP are:

1. Increased utilization of a broadened range of integrated, high quality STI and HIV prevention and care services, health centers and behavior change interventions; and

2. Increased use of enhanced strategic information for decision making to improve responses to the epidemic.

Four strategic approaches were designed to support the achievement of these objectives and are in line with the Ministry of Health's priorities and USAID's HIV/AIDS Strategy for Bangladesh. The strategic approaches are:

a) Expand the quality and availability of culturally appropriate, gender sensitive, and sustainable HIV/AIDS prevention and care programming;

b) Enhance the capacity of NGOs/Private Sector/FBOs to design and implement HIV/AIDS programs;

c) Strengthen the generation of strategic information through monitoring and evaluation, surveillance and research to produce integrated analysis and model the outcome and impact of interventions; and

d) Strengthen strategic information dissemination to assure appropriate use of data for evidence based policy development and decisionmaking.

BAP STRATEGY

Overall, Bangladesh is a low HIV prevalence country with an increasing HIV incidence among injecting drug users (IDUs) in some areas of high risk (e.g., central Dhaka). High sexual behavioral risks continues to exists, including low utilization of condoms and high incidence of STIs, particularly among hotel based sex workers; and injecting practices remain risky in several areas around the country. Sexual and injecting networks are overlapping hence the need for a comprehensive approach to risk reduction and support for persons already infected with HIV/AIDS.

Overall, the BAP strategy is appropriately focused on reaching "Most-at-Risk" populations including IDU, SW, MSM, Clients, PLWA through an "ABC" approached linked to increasing:

- The supply of integrated quality health services;
- The demand for prevention services through innovative branding and promotion; and
- The use or prevention and care programs through overall quality improvement.

In addition, the BAP strategy's second major focus is to conduct influential strategic information studies, support for monitoring and quality improvement, targeted evaluation and integrated analysis and modeling to improve the overall response to the epidemic in the country.

BAP has established an expanded HIV/STI program linked to enhanced supply of quality integrated health services and improved demand through innovative branding and promotion of those services linked to peer education and outreach. An increase in use of the prevention program and associated services has been accomplished over the first half of the BAP program as reflected by the outputs achieved in the first 18 months of the project:

1. Establishment of 59 STI clinics and over 15,800 persons treated for STI symptoms
2. 117 persons trained on the Minimum standards for targeted STI services
3. 55 doctors trained STI case management
4. 39 VCT sites that have provided over 2000 persons with pre and post-test counseling
5. Over 65,000 persons reached totaling over one million contacts with sex workers
6. Over 9.4 Million condoms distributed

IMPACT Project: The Predecessor of BAP

FHI Bangladesh began implementation of HIV/AIDS programming under USAID's IMPACT project in 2000. The IMPACT project was instrumental in developing the foundation for improving the quality and reach of HIV/STI services in Bangladesh. Some of the key accomplishments under the IMPACT project were:

- STI Facility Assessment clearly identifying gaps in STI treatment quality
- Development of a training curriculum for improving STI case management
- Strengthening of drop-in-centers and peer education for sex workers and MSM
- Identification of the scale of drug use in the country

- Increased collaboration and planning with USAID, DFID, UNICEF, and other stakeholders to organize a coordinated response to the epidemic in Bangladesh
- Developed the “Modhumita” campaign for Integrated Health Centers (formerly DICs)
- Developed the “Tripartite Project” as a response to HIV among IDUs in Dhaka in collaboration with Dhaka NGOs and Government institutions including Prisons, Police and Narcotics Control
- Conducted a multi-year STI research study in collaboration with UNC, ICDDR,B and Bangladesh Women Health Coalition to study the comparison between periodic presumptive treatments and enhanced syndromic management interventions with female sex workers in Bangladesh
- Provided guidance and technical assistance on multiple rounds of the national HIV behavioral surveillance
- Conducted a male reproductive health survey
- Assisted the Government of Bangladesh to estimate the size of vulnerable groups and people with HIV and people with AIDS.
- Through the A^2 Project, developed models of the HIV epidemic in Dhaka.

As a result of these activities, over three million high-risk individuals will be reached with prevention programs and over 2000 Imams will be trained on HIV/AIDS. BAP supports the prevention activities through a communication campaign involving the weekly sermons of religious leaders as well as religious television programming.

The goal of the Bangladesh AIDS Program is to reduce the transmission of HIV and STIs while ensuring that STI/HIV/AIDS prevention services remain accessible, gender-sensitive, of high quality, and sustainable in Bangladesh. More specifically, program objectives are to:

- Increase the practice of STI/HIV prevention behavior among individuals most at risk.
- Increase the utilization of quality HIV/STI services in intervention areas;
- Improve the quality and capacity of Government of Bangladesh HIV/STI surveillance systems for decisionmaking; and
- Improve capacities of local organizations and private sector partners to participate in HIV prevention efforts in local communities.

This evaluation will focus on the extent to which BAP activities have contributed to the achievement of these objectives. The evaluation will also document Best Practices and lessons learned from BAP activities.

C. EVALUATION OBJECTIVES/QUESTIONS

1. Determine the overall progress and achievements in relations to the expected results of BAP over the past 2 years.
2. Document the effectiveness of BAP to target their activities to groups of individuals most at risk.
3. Assess and document the effectiveness of BAP's behavior change communication activities to increase the practice of STI/HIV prevention behaviors among individuals most at risk.
4. Determine the major constraints to accomplishing the expected project results.
5. Assess the status of access and utilization of quality HIV/STI services in intervention areas.
6. Determine the extent to which the GOB HIV/STI surveillance systems are being used for effective decisionmaking.
7. Document the results of BAP efforts to improve the capacity of local organizations and the private sector to participate in HIV prevention efforts.
8. Determine what components of the current strategy have been most or least effective and what can be done to ensure an effective follow-on project

D. METHODOLOGY

It is recommended that the Evaluation Team consider a mixed-method evaluation approach with a focus on clients and potential clients at high risk for contracting HIV/AIDS. To the extent possible, the approach taken should be participatory.

Mixed-method evaluation is the class of evaluation where the evaluator mixes or combines quantitative and qualitative evaluation techniques, methods, approaches, concepts, or language into a single evaluation. The logic of inquiry includes the use of induction (or discovery of patterns), deduction (testing of theories and hypothesis), and abduction (uncovering and relying on the best of a set of explanations for understanding one's results). By using a mixture of quantitative and qualitative approaches, the evaluation team will gain insight on the impact of BAP activities (mostly from quantitative) and the processes (mostly qualitative) that lead to those impacts. Sequential and iterative approaches will be used to integrate the mixture of methods and will seek varying degrees of dialogue between quantitative and qualitative traditions at all phases of the evaluation.

Background Materials Review

Prior to conducting field work, the Team will review background materials such as Annual and Quarterly Reports, Indicators, Requests for Proposals, and other public documents related to the project (See Annex 1 for List of relevant documents and access information). In consultation with USAID/Bangladesh PHN staff, the Team will draft an assessment methodology/design for USAID approval.

TPM

The team will conduct a 2-day, team planning meeting (TPM) upon arrival in Bangladesh and before starting the in-country portion of the assessment. The TPM will review and clarify any questions on the assessment SOW, draft an initial work plan, develop a data collection plan, finalize the assessment questions, develop the assessment report table of contents, clarify team members' roles, and assign

drafting responsibilities for the assessment report. The TPM outcomes will be shared with USAID/Bangladesh and the health team will participate in sections of the TPM.

Key Informant Interviews and Site Visits

The Team will also collect information from key stakeholders and informants as follows (illustrative):

- At the national program level in Dhaka -

  Bangladesh AIDS Program/ FHI
  National STD/AIDS Program
  UNAIDS
  UNICEF- HAPP Project
  HIV-AIDS National Technical Committee
  National HIV-AIDS Task Force (key members)
  Technical Coordination Committee for GFATM CCM (key members)
  Save the Children USA- MSA for GFATM support on HIV
  Chairperson, STD/AIDS Network of Bangladesh
  CARE Bangladesh
  NGO Service Delivery Program (FHI-NSDP interface)
  EngenderHealth (Training on Care and Support)
  DFID - Alison Forder
  GTZ - Susanne Grimm
  World Bank - Dinesh Nair
  UNFPA - Rebeka Sultana
  Ministry of Home Affairs
  Department of Narcotics Control
  ICDDRB (BSS Surveillance, other research)—Tasnim Azim, Kim Streatfield

- The Team will visit project implementation sites including, for example, the HIV clinics and interventions for the MARPs implemented by the FHI, CARE, and HAPP/UNICEF supported NGOs (illustrative):

  IDUs (including the BAP Tripartite Project and JOBS Project)
  People living with HIV/AIDS
  Hotel based prostitutes (Female)
  Street based prostitutes (Female)
  Male and transgender prostitutes
  Clients of prostitutes

- The clinic visits may be conducted in Dhaka (3 days), Chittagong (3 days), Sylhet (2 days), Barisal (3 days) and Bogra (3 days) area. These are the major geographical areas where BAP works with the local NGOs to implement BAP.

- While visiting the clinics outside Dhaka, the team may like to meet with the local health and the local government authorities in the peripheral districts.

- The evaluation team may also like to visit activities intended for other than MARPs, e.g., youth, students, work force, and general population.

The details of daily activities, key informant interviews, and site visits will be determined in the TPM and depend on the date the evaluation team starts working.

E. TEAM COMPOSITION

Team Leader - The Team Leader will be responsible for overall management of the evaluation, including coordinating and packaging the deliverables in consultation with the other members of the team. The team leader will develop tools for the assessment and a design plan and share it with USAID/Bangladesh. The team leader will develop the outline for the draft report, present the report, and after incorporating USAID Bangladesh staff comments if necessary, submit the final report to USAID/Bangladesh within the prescribed timeline.

Skills/Experience:

The Team Leader should have:

1. At least 7 years working in the field of international health, preferably with an HIV/AIDS specialty;
2. Knowledge of health issues in Bangladesh;
3. A good understanding of USAID project administration;
4. Excellent writing and communication skills; and
5. Experience leading a team for international health program evaluations or related assignments; and
6. Advanced degree in Public Health or Related field

Team Members: **1) Host Country National and 2) HIV/AIDS Expert**
The Host Country National and the Health Expert will serve under the Team Leader. Duties will be determined in consultation with the Team leader, but are likely to include: conducting and documenting interviews with potential and current Most-at-Risk clients, service providers and other key informants; providing translation services as necessary for Team Leader; and assisting Team leader as directed in all aspects of completing evaluation deliverables.

Skills/Experience

The Host Country National and the Health Expert should:

1. Have at least 5 years experience working in the field of international health;
2. Be proficient in Qualitative and Quantitative health program evaluation skills;
3. Be proficient in English and Bangla language* (Reading, writing and speaking), be able to translate key informant interviews from Bangla into English accurately;
4. Have significant experience conducting health program evaluations;
5. Excellent writing and communication skills; and
6. Computer skills; and
7. Advanced degree in Public Health or related field.

*Preferable for both team members to be proficient in Bangla, but one team member may be sufficient.

F. LOGISTICAL SUPPORT

A six-day workweek is authorized while the Team is in Bangladesh. The evaluation team will be responsible for all offshore and in-country logistical support. This includes arranging and scheduling meetings, international and local travel, hotel bookings, working and office spaces, computers, printing, and photocopying. A local administrative assistant or secretary may be hired to arrange field visits, local travel, hotel, and appointments with stakeholders.

G. DELIVERABLES

The following deliverables will be required from the evaluators:

1. A draft assessment methodology/design developed (including key informants and geographic focus) and submitted to USAID Bangladesh PHN staff by the evaluator before field visit is made. The design may be modified after further discussions with USAID.

2. A debriefing presentation will be made to the USAID staff within four days of completing the field visits.

3. Power Point copies of all presentations/briefings for the Office of Population, Health and Nutrition use.

4. A draft report of the findings and recommendations, which is concise, actionable and solution oriented, will be developed by the evaluator and presented to USAID prior to departure from country.

5. Based on preliminary feedback from USAID to the draft report, a final report will be prepared within two weeks of departure from country and submitted to USAID for comments and feedback.

   The evaluator will be responsible for reviewing USAID and Family Health International comments on the draft report, and correcting any factual inaccuracies or omissions while being aware that this is an independent evaluation and that the findings and recommendations may not necessarily be reflective of USAID or Family Health International suggested revisions or comments. An electronic and 10 hard copies of the report, which will be no more than 40 pages not including annexes, should be sent to USAID within two weeks of the receipt of the comments. The draft format for the evaluation report is as follows:

   a) Executive summary (4-5 pages)

   b) Introduction

   c) Program background

   d) Methodology

   e) Observations, findings and conclusions

   f) Recommendations for future

   g) Annexes (including, but not limited to list of persons and organizations met, any questionnaires developed)

H. ESTIMATED LEVEL OF EFFORT

The following represents an estimate. The evaluation team will submit a work plan and timeline based on discussions at the TPM. This will be shared with the Mission prior to implementation.

Pre-departure arrangements include:
Travel approval; airline tickets; visa; lodging, work facility and vehicle transport arrangements; dates for meetings with USAID Bangladesh PHN staff and key contacts prearranged; in-country travel agenda and accommodations.

TITLE	Tasks and Work Days	Work Days in Bangladesh	TOTAL LOE
Team Leader	• 3 days document review (out of country) • 4 days travel (RT) • 2 days TPM • 4 days meetings - Dhaka • 12 days field work • 6 days follow-up fieldwork/discussion/report writing • 6 days report revision/finalization (out of country) • DC debriefing (3 days)	24 days	40 days
HIV/AIDS Expert	• 3 days document review (out of country) • 4 days travel (RT) • 2 days TPM • 4 days meetings - Dhaka • 12 days field work • 6 days wrap/follow-up fieldwork/report writing • 2 days report revision/finalization (out of country)	24 days	33 days
Host Country National—AIDS Expert	• 3 days document review • 2 days TPM • 4 days meetings - Dhaka • 12 days field work • 6 days wrap/follow-up fieldwork/report writing • 2 days report revision/finalization	29 days	29 days

TITLE	Tasks and Work Days	Work Days in Bangladesh	TOTAL LOE
Local Administrative Assistant	• 2 days TPM • 4 days meetings • 12 days field work • 2 days wrap/follow-up fieldwork/report writing	Est. 20 days	Est. 20 days
TOTAL		**97 days**	**122 days**

I. POINT OF CONTACT

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ANNEX 2. BAP PROGRAM TARGETS AND ACHIEVEMENTS DURING THE FIRST TWO YEARS OF PROJECT IMPLEMENTATION

(FROM OCTOBER 2005 THROUGH SEPTEMBER 2007)

(Compiled from Annual and Quarterly Reports submitted by FHI to USAID/Bangladesh.)

Indicators	Year 1 Performance 10/05-9/06	Year 1 Target	Year 2 Performance 10/06-9/07	Year 2 Target
Number of Individuals reached through programs for[1]:				
1. Intravenous Drug Users (IDUs)	2770	3000	2276	5000
2. Female Sex Workers (FSWs)	16799	10000	19448	20000
3. Male Sex Workers (MSWs) and Men having Sex with Men (MSM)	7942	90000	7540	100000
4. Transsexuals (Hijras)	3932	1000	4598	1500
5. People Living with AIDS (PLWHA)	576	400	230	600
6. Clients of Prostitutes	582171	1000000	427462	2000000
7. Number of Behavior Change Intervention (BCI) Projects	84	86	1445	209
8. Number of Modhumita Integrated Health Centers (IHCs) Established (Cumulative)	26	50	59	70
9. Number of New Members to IHCs	9605	10000	6019	30000
10. Number of STI Clinics (Cumulative)	54	50	60	70
11. Number of Patients Treated for STI Symptoms	12283	10000	19839	15000
12. Number of Contacts (One-to-One and Group Contacts)	1294711	1500000	4661232	2000000
13. Number of Condoms Distributed	8289071	6690000	8925341	9532500
14. Number of Facilities Providing Voluntary Counseling and Testing (VCT) (Cumulative)	33	44	45	70
15. Number of Clients receiving Counseling and Testing at VCT Centers	1386	1000	7389	5000

[1]. Performance figures for indicators 1-6 are the average number of clients reached per quarter over Years 1 and 2 of the project. Quarterly figures for each year are not additive since clients may be counted in more than one quarter (e.g., sex workers who return to IHCs for periodic testing and follow-up treatment). However, clients cannot be counted twice in a single quarter.

Source: Compiled from Kelly, Airawanwat, and Bardon 2007:10 and FHI/Bangladesh AIDS Program (BAP) Quarterly Report Q4, July-September 2007: 11-13.

ANNEX 3. PERSONS CONTACTED FOR THE EVALUATION

Iftekar Ahmed, Chief Executive Officer, CSR Centre, House 20, Road 5, Gulshan 1, Dhaka – 1212, Bangladesh

Dr. Julia Ahmed, Deputy Executive Director, Bangladesh Women's Health Coalition, 10/2, Iqbal Road, Mohammadpur, Dhaka-1207, Bangladesh

Dr. Munir Ahmed, Team Leader-Operations, HIV Program, Care Bangladesh, Pragati RPR Center (9th Floor), 20-21, Kawran Bazar, Dhaka-1215, Bangladesh

Dr. Nizam Uddin Ahmed, Director, HIV/AIDS Sector and South Asia Program Advisor, Save the Children, House No. 1 A(2), Road -91, Gulshan-2, Dhaka-1212, Bangladesh

Md. Shakawat Alam, Technical Coordinator, HAPP-HIV Program, Care Bangladesh, Pragati RPR Center (9th Floor), 20-21, Kawran Bazar, Dhaka-1215, Bangladesh

Shale Ahmed, Executive Director, Bandhu Social Welfare Society, 99 Kakrail (2nd and 3rd Floor), Dhaka-1000, Bangladesh

Dr. Yasmin H. Ahmed, Managing Director, Marie Stops Clinic Society, House #6/2, Block F, Lalmatia Housing Estate, Dhaka-1207, Bangladesh

Abul Kalam Azad, Chairman, Masjid Council for Community Advancement (MACCA), House 57 (Level 3), Road 07, Sector 04, Uttara, Dhaka 1230, Bangladesh

Dr. Tasnim Azim, Scientist, Head, HIV/AIDS Programme and Virology Laboratory, Laboratory Sciences Division, International Centre for Diahorreal Research, Bangladesh (ICDDR,B), GPO Box 128, Dhaka 1000, Bangladesh

Albert Prosad Bashu, Program Coordinator, APON (Addiction Rehabilitation Residence), Head Office and Female Rehabilitation Residence, 9/7 Iqbal Road, Mohammadpur, Dhaka-1207, Bangladesh

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Ali Forder, Health Adviser, UK Department for International Development (DFID), 10 Gulshan Avenue, Gulshan 1, Dhaka 1212, Bangladesh

Dr. Md. Mozammel Hoque, Deputy Programme Manager, National AIDS/STD Programme, Director General Health Services, Ministry of Health and Family Welfare (MOHFW)

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Mohammed Rafiqul Islam, Program Manager, HIV/AIDS Prevention Program, Young Power in Social Action (YPSA), House F10 (P), Road #13, Block-B, Chandgaan R/A, Chittagong-4212, Bangladesh

Kanta Jamil, Population, Health and Nutrition Officer, US Agency for International Development, American Embassy, Madani Avenue, Baridhara, Dhaka 1212

Md. Rezaul Karim, Financial Management Specialist, Research, Training and Management International, Navana Shefali, Suite 2/B, House 11, Road 14, Gulshan, South Avenue, Dhaka1212, Bangladesh

Robert Kelly, Associate Director, Bangladesh Country Office, Family Health International, House 5, Road 35, Gulshan-2, Dhaka 1212, Bangladesh

Dr. Baquirul Islam Khan, Project Manager, CREA (Society for Community-Health Rehabilitation, Education, and Awareness), 1/14 Iqbal Road, Mohammadpur, Dhaka-1207, Dhaka

Dr. Mozammel Hossain Khan, Medical Consultant, Dutch-Bangla Bank Limited, Sena Kalyan Bhaban (5th Floor), 195 Motijheel Commercial Area, Dhaka-1000, Bangladesh

Dr. Abul Bashar Md. Khashru, Programme Manager, National AIDS/STD Programme, Director General Health Services, Ministry of Health and Family Welfare (MOHFW)

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