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EVALUATION

USAID/Bangladesh: A Midterm Performance Evaluation of the Modhumita Project for HIV/AIDS

DECEMBER 2012

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Abu Abdul-Quader, Billy Pick, Darrin Adams, Hasan Mahmud, and Mary Wieczynski Furnivall through the GH Tech Bridge II Project.

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Global Health Technical Assistance Bridge II Project (GH Tech) USAID Contract No. AID-OAA-C-12-00027

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ACRONYMS

AAS	Ashar Alo Society
AIDS	Acquired Immune Deficiency Syndrome
AOR	Agreement Officer's Representative
AOTR	Agreement Officer's Technical Representative
ART	Antiretroviral Therapy
BAP	Bangladesh AIDS Program
BCCP	Bangladesh Center for Communications Program
BRAC	Bangladesh Rural Advancement Committee
CAAP	Confidential Approach to AIDS Prevention
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
COI	Conflict of Interest
CoPCT	Continuum of Prevention, Care, and Treatment
COSW	Clients of Sex Workers
COTR	Contracting Officer's Technical Representative
CRIS and MIS	Clinical Research and Medical Information Systems
DOTS	Directly Observed Treatment, Short Course (TB)
FHI	Family Health International
FP	Family Planning
FSW	Female Sex Worker
FY	Fiscal Year
GH Tech	Global Health Technical Assistance Bridge II Project
GOB	Government of Bangladesh
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HPNSDP	Health, Population, and Nutrition: Sector Development Program, 2011-2016
ICCDR, B	International Center for Diarrheal Disease Research, Bangladesh
IEDCR	Institute of Epidemiology, Disease Control & Research
IOM	International Organization for Migration
LOE	Level of Effort
M&E	Monitoring and Evaluation
MAB	Mukto Akash Bangladesh
MACCA	Masjid Council for Community Advancement

MARP	Most-at-Risk Population
MCH	Maternal/Child Health
MHC	Modhumita Health Center
MOHFW	Ministry of Health and Family Welfare
MSM	Men Who Have Sex with Men
MSW	Male Sex Worker
NASP	National AIDS/STD Program
NGO	Nongovernmental Organization
OPHNE	Office of Population, Health, Nutrition and Education
OST	Opioid Substitution Therapy
PEPFAR	President's Emergency Plan for AIDS Relief
PICT	Provider-Initiated Counseling and Testing
PLHIV	People Living with HIV
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PWID	People Who Inject Drugs
QA	Quality Assurance
QI	Quality Improvement
RCC	Rolling Continuation Channel
RH	Reproductive Health
SCI	Save the Children International
SMC	Social Marketing Company
SOW	Scope of Work
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWAp	Sectorwide Approach
TA	Technical Assistance
TB	Tuberculosis
TG	Transgender
UNAIDS	Joint United Nations Program on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

EXECUTIVE SUMMARY

BACKGROUND

Bangladesh is a low-HIV-prevalence country. Prevalence remains very low (<0.1%) in the general population and relatively low (<1%) in most population groups at high risk of infection. These groups include people who inject drugs (PWID), male and female sex workers (MSWs, FSWs), and men who have sex with men (MSM), who include transgender (TG) persons. There are approximately 6,300 people living with HIV (PLHIV). The epidemic is driven by unsafe, illegal drug injection and risky sexual practices, including multiple partners and low condom use. The Government of Bangladesh (GOB) has identified additional populations who might represent an emerging risk or be of increased vulnerability to HIV. These include returning migrants and their partners; GOB case reporting indicates that more than half of new HIV infections reported in 2011 occurred in this population.

Under the President's Emergency Plan for AIDS Relief (PEPFAR), assistance from the United States Agency for International Development (USAID) aims to strengthen the national response through improved prevention and care services for the most-at-risk populations (MARPs) and PLHIV. The main mechanism for delivering USAID support for HIV/AIDS to the GOB is the Modhumita Project. The project is implemented by Family Health International (FHI) 360 in partnership with the Social Marketing Company and the Bangladesh Center for Communications Program. The project began in September 2009 and is scheduled to end in September 2013. Total funding amount is estimated at $11,900,856.

The project's goal is to support Ministry of Health and Family Welfare efforts to maintain HIV seroprevalence of less than 5% among MARPs. Via two results, the project objective is to support an effective HIV/AIDS strategy through improved prevention, care, and treatment services for MARPs and PLHIV, and through a strengthened national response:

Result 1: *Increased and sustained use of high-impact HIV prevention, care, and treatment services by MARPs through high-quality, evidence-based, and holistic program approaches*

Result 2: *Strengthened government leadership, multilevel coordination, and use of data for decision-making to support HIV/AIDS prevention efforts and effective programming for MARPs*

In November 2012, the USAID/Bangladesh Mission conducted a midterm performance evaluation of the Modhumita Project. The evaluation team's objectives were 1) to determine how successful the project has been in delivering high-impact HIV prevention, care, and treatment services to MARPs and PLHIV, and 2) to identify ongoing technical assistance needs and barriers to and recommendations for improving GOB capacity to lead HIV/AIDS efforts. The team also aimed to clarify the added value of USAID's investments to the national response to HIV/AIDS and to recommend how USAID could direct any future efforts in this area.

The evaluation approach included primarily qualitative and very limited quantitative assessments via group interviews, individual interviews, document reviews, and field observations. This document is the evaluation team's report.

SUMMARIZED FINDINGS AND CONCLUSIONS

Results of USAID/Bangladesh's investment in HIV/AIDS: Compared with total HIV funding for the country, USAID's modest resources and contributions provide a significant portion of service coverage for MARPs and PLHIV and contribute more to meeting national targets than its proportion of funding would suggest. Appropriate and timely responses focusing on MARPs and PLHIV have helped contain the spread of HIV, and the USAID-funded Modhumita Project has played a significant role in this targeted, evidence-based response. Modhumita sites have created "Centers of Excellence" that non-United States Government (USG)-funded sites have replicated, thus taking USAID's investment in service delivery to scale. USAID's support has also helped make more effective use of available resources through institutional strengthening within the National AIDS/STD Program (NASP) and national-level strategic information such as behavioral surveillance.

Effectiveness of the Modhumita Project: The project supports HIV prevention, care, and treatment activities for MARPs and PLHIV via 33 existing Modhumita Health Centers (MHCs), 14 additional voluntary counseling and testing (VCT) sites, and mobile/satellite VCT. Targeted MARPs include MSWs, TG populations, FSWs, clients of sex workers (COSW), and PWID. Agencies that receive funding from other development partners refer to the project for VCT.

Project interventions have increased MARP and PLHIV access to and use of quality comprehensive HIV/AIDS services by building on previous USAID investments. Many project activities meet globally accepted best practices. The application of innovations during project implementation has helped address specific barriers to services based on lessons learned. The project has supported a pilot opioid substitution therapy (OST) program that has become a globally recognized evidence-based intervention for PWID that can be taken to scale. There is consensus among stakeholders that the project plays a critical role in the national HIV/AIDS response and has helped set new standards for quality, transparency, and accountability. Overall, the project has met or exceeded many of its key performance targets.

Project gaps and challenges include the project's support for some activities that have only negligible impact on the HIV epidemic, leading to suboptimal use of resources (e.g., activities targeting the general population; the disproportionate focus on COSW; activities with the Department of Women Affairs). Underlying this issue is the suboptimal use of national- and program-level data to inform strategic project programming. Other gaps include the lack of a clear and appropriate strategy for strengthening national program leadership capacity and the dissemination of project innovations and lessons learned.

A comparison of the project's fiscal year 2012 data on populations tested for HIV and test results highlights issues for strategic consideration. These include activities in districts with few or no positive HIV tests and a possible disproportionate focus on programs for COSW and tuberculosis (TB) patients. Infection rates within some specific populations are well below national estimates, indicating a possible need to target future activities to segments that are more vulnerable to HIV.

Factors that adversely affect project performance are environment and funding constraints. For example there is only a nascent public sector leadership role in the national HIV/AIDS response, with few mechanisms for systematically identifying areas for project support. Lack of research funding limits the project's ability to assess outcomes for risk reduction behaviors and take

evidence-based interventions to scale. This shortcoming has been more evident in light of recent reductions in project funding.

Sustainability of the national HIV/AIDS response and related project contributions: The GOB and stakeholders recognize the need to increase the sustainability of the national HIV/AIDS response through mainstreaming selected services into the general health sector. Nonetheless, all stakeholders recognize the unique needs of MARPs and PLHIV and the complementary roles played by civil society. Issues and challenges include support for NASP to help it assume its national leadership role and innovative nonhealth sector efforts, such as increased engagement of political, religious, and law enforcement leadership.

A real threat is the continued reduction in funding and delayed and inadequate use of existing funding for programs targeting MARPs and PLHIV, which would seriously jeopardize gains and could adversely alter the future course of the epidemic. Already, major development partners such as USAID have reduced funding for HIV/AIDS. There is potential for curtailed services for MARPs and PLHIV before the GOB is fully able to assume responsibility for an operational national HIV/AIDS response.

Within its scope, the Modhumita Project has contributed to increasing the sustainability of services to MARPs and PLHIV. Its contributions include increased quality and accessibility of comprehensive services, strengthened workforce capacity within implementing agencies, and increased beneficiary ownership through participation in the project. The project has also contributed significantly to reducing stigma and discrimination, and has encouraged the engagement of community leaders in HIV/AIDS efforts, including law enforcement officers and imams (worship leaders at mosques). Project-supported rights-based approaches address barriers to services and other key issues, such as violence, and have lifted up affected communities to find their voices for advocacy.

Gaps in and opportunities for the national HIV/AIDS response: One fundamental issue is the significant GOB delay in implementing behavioral surveillance surveys and research, including emerging trends studies and up-to-date population size estimates. As a result, USAID, the GOB, and other stakeholders cannot optimally target resources or quantify how investments have contributed to population-level impact.

The seroconversion of international migrants has become a major concern among the GOB and stakeholders. Currently, activities reaching migrants seem scattered, lacking evidence-based interventions or accurate targeting, and rigorous assessments among migrants are required before expanding services and interventions. Other gaps and challenges include pervasive stigma and discrimination and difficulty attracting and retaining experienced health professionals, particularly at subnational levels.

There are many opportunities that USAID might consider linking with, leveraging, or supporting to increase service delivery and capacity development. These include the updating of national guidelines and protocols to facilitate mainstreaming public sector services; the release of future research studies; the interest of the Islamic Foundation Bangladesh in strengthening its involvement in the national HIV/AIDS response; and promising approaches in the public sector to increase community-level engagement in HIV/AIDS.

RECOMMENDATIONS

The following recommendations are for the Modhumita Project to consider during the remaining life of the project. Some of the recommendations might have implications for project scope or funding and require consultation with USAID/Bangladesh before implementation.

The Modhumita Project should **strengthen the use of project data for strategic decision-making and implementation**. This includes quarterly data analyses to understand program performance and adjust activities accordingly. The project should also use surveillance and program data, including HIV and sexually transmitted infection test results, to reassess and adjust COSW programming and TB entry point into HIV testing. The project should investigate how programming to MARPs might reach segments within specific populations who are more vulnerable to HIV or have higher infection levels than what the project currently captures (e.g., TG populations, FSWs).

Additionally, the project should assess the uptake and effectiveness of the "Flying Squads," a crisis management intervention for MARPs, with broader community-level involvement and policy and advocacy efforts. Also the project should move beyond community-level implementation into broader structural and policy spheres.

In partnership with the other USG initiatives supporting the local media (e.g., Voice of America), the project should also conduct **a media content analysis** to determine the project's effect on strengthening the media in Bangladesh (e.g., increase in positive/decrease in negative coverage, overall trends in media reporting on HIV/AIDS).

The project should conduct **qualitative formative assessments** to strengthen programming and the overall national HIV/AIDS response. Priorities include formative assessments among PLHIV and HIV-infected migrants to understand sources and destinations; social, network, demographic, and behavior risk profiles; and possible network patterns and characteristics.

The project should work with USAID during its annual work planning process to prioritize and readjust activities accordingly. As a data source for this process, the project should conduct an in-depth analysis for all MHCs and other VCT centers to **determine how potential project support should continue or be adjusted**. The project should also reassess and adjust **the composition of services for each targeted population.** Opportunities include referrals to post-abortion care services and emergency contraception for FSWs and expanded savings groups for MARPs.

There are a number of activities the project could strengthen. These include the investigation and implementation of **increased beneficiary engagement in the project.** Possibilities include participation in project facilitation teams and in designing and implementing formative assessments. The project should share **best practices and lessons learned with national- and subnational-level stakeholders** for wider applicability. Of particular interest are innovative practices and project processes and tools that lead to accountability and transparency. The project should also investigate and implement ways to **continue religious leader engagement in HIV/AIDS and programs for MARPs and PLHIV** utilizing existing structures. Possibilities include imam training, curriculum updates, HIV/AIDS messaging through Friday services, and increased participation in project activities.

The project should continue to **provide technical support to NASP** to strengthen the national HIV/AIDS response. Opportunities include working with the World Health

Organization to explore the feasibility of revising national HIV counseling and testing guidelines to include provider-initiated counseling and testing, given the country's low prevalence. The project should also draw on the considerable expertise within the project consortium to document promising best practices and potential interventions for international migrants as appropriate for Bangladesh (e.g., source and destination programs, "know before you go" activities with the Bangladesh Rural Advancement Committee, recruitment agencies, imams).

As feasible and appropriate, the project should **include nonproject-funded partners in technical trainings and quality assurance/quality improvement activities** (e.g., Global Fund-supported partners in training for programming to MSWs and their inclusion in project facilitation teams). This will help extend USAID's investments in best practices and lessons learned beyond the immediate scope of the project. In addition, the project should investigate the possibility of **leveraging nonhealth-specific resources**, as appropriate and especially to other USAID-funded activities. Possibilities include linkages to microcredit schemes for FSWs and MSM and to public sector leadership development and transparency initiatives.

Using project consortium data and expertise, the project might be requested to **assist USAID and other stakeholders with documenting the national HIV/AIDS response.** Documentation elements might include an exploration of the current capacity of the GOB, where resources exist, to assume leadership of the HIV/AIDS response and an assessment of which HIV/AIDS services and systems can be appropriately mainstreamed within the public sector and which elements should remain outside the public sector. The project might also document how USAID's programming on lesbian, gay, bisexual, and TG populations affects equality in Bangladesh.

I. INTRODUCTION

This report presents the results of a midterm performance evaluation of the Modhumita Project, a project of the United States Agency for International Development (USAID) that addresses HIV/AIDS in Bangladesh. This introduction presents a brief statement of the purpose, scope, and methodology of the evaluation. Chapter II provides a brief background of HIV/AIDS in Bangladesh and the national response to HIV/AIDS. It also summarizes the nature and type of support provided by the President's Emergency Plan for AIDS Relief (PEPFAR) and USAID in support of the national response. Chapter III presents the evaluation's methodology. Chapter IV provides the evaluation's findings, organized under process-level and results-level headings. Chapter V presents the evaluation's conclusions, arranged under the headings of the evaluation's questions. Chapter VI presents the evaluation team's recommendations based on the findings and conclusions. Appendices follow the body of the report, and include the evaluation's scope of work (SOW), persons contacted, methodology tools, project data, and references.

PURPOSE AND SCOPE

The primary purpose of the Modhumita Project's midterm formative evaluation is to determine what aspects of the project are working well, or perhaps not as well, and why. Specifically, the evaluation aims to:

- Examine how successful the implementing partner, Family Health International (FHI) 360, has been in building the organizational and technical capacities of the Government of Bangladesh (GOB), nongovernmental organizations (NGOs), and the private sector for the implementation of high-impact HIV prevention, care, and treatment services among most-at-risk populations (MARPs)
- Identify barriers to and recommendations for improving the capacity development of government for leadership of HIV/AIDS prevention efforts, as well as ongoing technical assistance needs, with a focus on coordination and use of data for decision-making to support effective programming for MARPs
- Clarify the added value of USAID's investments to the national response to HIV/AIDS and recommend how USAID could direct any future efforts in this area

AUDIENCE AND INTENDED USE

The Modhumita Project midterm evaluation's prime audience is USAID. Specifically, this includes the Office of Population, Health, Nutrition and Education Team in the Bangladesh Mission, the USAID Asia Bureau, and the Office of HIV/AIDS in the USAID Bureau for Global Health. Other key audiences include the Bangladesh Ministry of Health and Family Welfare (MOHFW) and the project's implementing partners.

USAID will use the findings, conclusions, and recommendations to inform any modification and midcourse corrections, as necessary, to help guide the implementing partner throughout the remainder of project implementation. In addition, the midterm evaluation will help inform USAID/Bangladesh's future investment in and support for the national HIV/AIDS response.

II. BACKGROUND

HIV/AIDS IN BANGLADESH

Bangladesh remains a low-HIV-prevalence country. Although the rate of new HIV infections increased by more than 25% between 2001 and 2011,[1] prevalence remains very low (<0.1%) in the general population and relatively low (<1%) in most population groups at high risk of infection. These groups include people who inject drugs (PWID), male and female sex workers (MSWs, FSWs), and men who have sex with men (MSM), who include transgender (TG) persons (locally known as *hijra)*. The Joint United Nations Program for HIV/AIDS (UNAIDS) estimates Bangladesh has approximately 6,300 people living with HIV (PLHIV).[2]

The epidemic is driven by unsafe, illegal drug injection and risky sexual practices, including multiple partners and low condom use. These practices increase rates of sexually transmitted infections (STIs), particularly among sex workers, and fuel HIV/AIDS transmission. Various proxy markers of risk for HIV transmission among at-risk groups, such as active syphilis for unsafe sex and hepatitis C infections for unsafe injection practices, are on the increase.

In the *2011 National HIV Serological Surveillance Report—Round 9*, HIV prevalence ranged between 0.4% and 5.3% among PWID, between less than 1% and1.6% among FSWs, and between 1% and 3.2% among *hijra*. Although there were no HIV-positive results among MSWs in this particular survey, the positive active syphilis results (1.5% to 4.5%) suggest similar risk behaviors that are associated with syphilis and HIV (e.g., unprotected anal intercourse, low condom use during cross-border sex work). Study methodology limitations (e.g., recruitment of MSW participants in a clinic) reduce the ability to generalize these results to MARPs in Bangladesh.

The GOB has identified other populations who might represent an emerging risk or have an increased vulnerability to HIV. These include returning migrants and their partners; GOB case reporting indicates that more than half of new HIV infections reported in 2011 occurred in this population. Although mobility and migration in themselves are not risk factors for HIV transmission and acquisition, some MSWs, TG persons, and FSWs report selling sex when migrating to other countries. The national HIV serological surveillance reports do not include international migrants or other possibly at-risk populations; as a result, there are few data to quantify the effect of other populations on Bangladesh's HIV epidemic.

THE NATIONAL HIV/AIDS RESPONSE

The National AIDS/STD Program (NASP) is the lead agency within the GOB overseeing the national HIV/AIDS response. The response itself is guided by the *Third National Strategic Plan for HIV/AIDS, 2011-2015* (subsequently referred to as the *National HIV/AIDS Strategic Plan*), which in turn supports the country's *Health, Population, and Nutrition: Sector Development Program, 2011-2016* (HPNSDP). National objectives for HIV/AIDS include implementation of services to prevent new HIV infection; provision of universal access to treatment, care, and support services for PLHIV and those affected; strengthening coordination mechanisms and management

[1] UNAIDS Regional Fact Sheet, 2012

[2] UNAIDS, *Country Progress Report: Bangladesh.* April 4, 2012, pg. 6

capacity to ensure an effective multisector HIV/AIDS response; and strengthening strategic information services and research for an evidence-based response.

The country response, led by civil society and primarily funded by external development partners such as USAID, the United Kingdom's Department for International Development (DfID), and the Global Fund to Fight AIDS, Tuberculosis and Malaria, has been successful in containing the epidemic and preventing an expansion into MARP groups. More recently, the GOB has moved to take a greater role, both in a leadership and service delivery capacity.

The GOB faces a number of challenges as it proceeds to assume responsibility for financing, managing, and overseeing the national HIV/AIDS response. These challenges include the absence of a comprehensive and systematic surveillance system; low coverage of HIV counseling and testing (HCT) services; few research-informed, evidence-based interventions to address migration and HIV; and delays in releasing HIV/AIDS funds through procurement packages.

NGOs and community-based organizations (CBOs) provide the majority of HIV/AIDS service delivery, care, and treatment, and are especially adept at addressing the specific needs of MARPs and PLHIV. Service coverage rates are low; for example, fewer than 25% of PWID, MSM, and sex workers are served by HIV prevention programs.[3]

Table 1 presents the current funding levels and sources for the national HIV/AIDS response in Bangladesh. It is important to note that World Bank-funded resources for HPNSDP have not yet been released and that the rolling continuation channel (RCC) funding from the Global Fund will only start at the end of 2012. In addition, the USAID funding amount is based on a projection from historical levels.

Table 1: Current Funding for Bangladesh's National HIV/AIDS Response

Funder	Amount US$
Global Fund Phase 2 RCC December 2012-January 2014	$34 million
HPNSDP—Sector Program for NASP July 2011-June 2016	$25.76 million
GOB Resources for NASP July 2011-June 2016	$9 million
UN Joint Team on HIV/AIDS	<$2.5 million
USAID October 2012-September 2014	$3 million
TOTAL	**Approximately $74 million**

USAID/BANGLADESH ASSISTANCE FOR HIV/AIDS

Under PEPFAR, assistance from the United States Government (USG) aims to strengthen the national response through improved prevention and care services for MARPs and PLHIV. HIV/AIDS activities are informed by Development Objective Three—*Health Status Improved*—of USAID's fiscal year (FY) 2011-2016 Country Development Cooperation Strategy for Bangladesh. USAID will contribute to the national goal, as defined in HPNSDP, of maintaining the prevalence

[3] UNAIDS Regional Fact Sheet, 2012

of HIV among at-risk groups below 5%. The main mechanism for delivering USAID support to the GOB is the Modhumita Project.

THE MODHUMITA PROJECT

The Modhumita Project is a Mission-funded bilateral Cooperative Agreement (No. 388-A-00-09-0123-00) awarded to help local NGOs and the GOB implement HIV activities. The project is implemented by FHI 360 in partnership with the Social Marketing Company (SMC) and the Bangladesh Center for Communications Program (BCCP). It began in September 2009 and is scheduled to end in September 2013, with total funding estimated at $11,900,856. Funds to support activities implemented in FY 2013 are estimated at $2,071,433. The project is a continuation of HIV/AIDS activities that began in 2001 under the USAID-funded IMPACT project.

The project provides technical assistance to NGOs that provide cost-effective, high-impact HIV prevention, care, and support services for MARPs and PLHIV, and develops the capacity of the GOB to utilize strategic information to improve the stewardship and strategic leadership for its national HIV/AIDS response. The project fills a unique niche in Bangladesh by focusing on effective use of HIV/AIDS services for MARPs and PLHIV. It is located in 18 high-risk urban areas across the country.

The project's goal is to support MOHFW efforts to maintain an HIV seroprevalence of less than 5% among MARPs. The project's objective is to support an effective HIV/AIDS prevention strategy through improved prevention, care, and treatment services for MARPs and PLHIV, and a strengthened national response. The project aims to achieve these objectives via two results:

Result 1: *Increased and sustained use of high impact HIV prevention, care, and treatment services by MARPs through high-quality, evidence-based, and holistic program approaches*

Result 2: *Strengthened government leadership, multilevel coordination, and use of data for decision-making to support HIV/AIDS prevention efforts and effective programming for MARPs*

The project uses three technical implementation approaches to ensure a responsive, effective program: 1) strategic behavioral communications; 2) the Continuum of Prevention, Care, and Treatment (CoPCT); and 3) the FHI 360 Quality Improvement Model. Project activities include:

- Providing HIV prevention and HIV education to MARPs, such as PWID, sex workers (female, male, TG persons), PLHIV, clients of sex workers, and migrants
- Providing HIV services including screening and treatment for STIs, HIV voluntary counseling and testing (VCT), tuberculosis (TB) services, and family planning/reproductive health (FP/RH) services (in collaboration with the Smiling Sun Franchise Project)
- Partnering with local organizations to develop an innovative service system integrating primary (e.g., drop-in activities) and specialty care, e.g., detoxification and rehabilitation; abscess management; VCT; drug counseling; referral to antiretroviral therapy (ART); and opioid substitution therapy (OST) for PWID

- Supporting CBOs to provide care and support services for PLHIV in collaboration with the Global Fund
- Addressing the special needs of FSWs, MSM, and TG individuals to ensure gender equity and equal access to services
- Maintaining a rigorous monitoring and evaluation program through regular supervision and monitoring visits with a strong electronic data management system
- Conducting advocacy activities to reduce stigma and discrimination against MARPs and PLHIV and to support policy changes to strengthen HIV prevention programs
- Providing capacity building support to NASP and other government counterparts
- Assisting the GOB with updated guidelines on clinical and outreach services

Project Development Hypothesis

If USAID/Bangladesh provides improved prevention, care, and treatment services for MARPs and PLHIV, then the HIV prevalence among MARPs will stay below 5%.

It is assumed that the Modhumita Project's interventions will strengthen GOB leadership, coordination, and use of data for decision-making, and thereby strengthen the national response to HIV/AIDS.

III. EVALUATION METHODOLOGY

EVALUATION QUESTIONS

USAID/Bangladesh determined that a midterm evaluation of the Modhumita Project would be important to assess the project's achievements and remaining challenges and to recommend how the project could best meet its objectives during its remaining life. The evaluation would also provide recommendations to help inform USAID/Bangladesh's future investment in and support for the national HIV/AIDS response.

To this end, evaluation questions included:

1. How effective has the project been in increasing and sustaining the use of high-impact prevention, care, and treatment services by MARPs?
2. To what extent is the project strengthening the national program's leadership capacity in managing national HIV/AIDS activities and strengthening health systems in Bangladesh?
3. What are the barriers to increased service delivery and capacity development, and are there any recommended changes to the current technical assistance structure?
4. To what extent has the Modhumita Project been able to support the scale-up of innovative approaches to HIV prevention among MARPs in Bangladesh?
5. How does the project meet the national needs and fill critical gaps in responding to the national strategy on HIV/AIDS?
6. Should the project continue implementing interventions at the same level or with changes during its final project years and what are the cost implications?
7. If USAID were to take a more comprehensive approach to supporting HIV interventions in Bangladesh, how should USAID target its increased investments?

EVALUATION APPROACH AND PROCESS

The Global Health Technical Assistance Bridge II Project (GH Tech) assembled an evaluation team consisting of Billy Pick and Darrin Adams (USAID/Washington), Abu Abdul-Quader (CDC/Atlanta), Hasan Mahmud (independent consultant), Mollah Mahmud Ahmed (independent consultant; logistics), and Mary Furnivall (team leader and independent consultant). A review by USAID/Bangladesh and GH Tech found that the evaluation team posed no real or perceived conflicts of interest.

The evaluation team conducted fieldwork in Bangladesh during November 2-21, 2012. The team used a rapid appraisal approach to draw on multiple evaluation methods and techniques to quickly and systematically collect and analyze data. Through an iterative process, the team developed a list of evaluation questions with potential follow-up probing questions, based on the evaluation questions set forth in the Scope of Work (Appendix A).

The evaluation approach included primarily qualitative and very limited quantitative assessments. The evaluation team used group interviews, individual interviews, document reviews, and field observations as tools to gather information. See Appendix B for a list of persons contacted, Appendix C for the evaluation calendar, Appendix D for the evaluation discussion guide and the list of stakeholders with whom the evaluation team consulted, and Appendix J for references.

Group interviews: The evaluation team used group interviews as the primary information source. Group interviews were semi-structured with the team following a list of key questions and conducting in-depth probing questions when pertinent, interesting information was offered. The ideal group size for group interviews is eight to 12 individuals. This is a qualitative primary data source.

Individual interviews: At certain times, particularly during meetings with the GOB, the evaluation team conducted interviews with individuals. This approach allows for more in-depth probing for insights and information and is particularly useful when the questions pertain to sensitive issues. This is a qualitative primary data source.

Document reviews: The evaluation team reviewed documents available from USAID, the GOB, and the project prior to the fieldwork. This review helped inform the questions prepared in advance of interviews and site visits. The team gathered additional documents during the interviews and site visits. Document reviews included the comparison of the execution of activities against designed and forecasted implementation and a comparison of targets against results. This is a qualitative and quantitative secondary data source.

Field observations: The team validated questions and findings through an observation process primarily conducted during site visits in the field. Field observations included project activities and data quality management. This approach is particularly useful to ascertain how certain elements of a project are actually implemented in comparison with the project design and work planning process. This is a qualitative primary data source.

During its time in Bangladesh, the evaluation team divided into two to visit Chittagong and Sylhet concurrently to observe project operations and interview field-level informants. While in Dhaka, the team often divided into two groups as well to meet with national, subnational, and civil society stakeholders and Modhumita Health Centers (MHCs). All selected sites and stakeholders were chosen in consultation with USAID/Bangladesh and Modhumita Project leadership. The sample of MHCs reflected the mix of project-targeted MARPs (e.g., PWID, FSWs) and the range of implementation partners (e.g., Ashar Alo Society, SMC). The team relied heavily on these visits to address evaluation questions, gain insights into project achievements and challenges, and verify different opinions presented by various informants.

During field visits, the evaluation team gathered at the end of each day to record the notes they had taken during the interviews. By sharing each other's notes and discussing the implications at the end of each day, the team members helped stimulate recall and clarification of what was said or observed (and what was not said or observed). The assessment team took care to make a full account of the gathered information, even recording statements that appeared to represent an outlier perspective and that seemed at odds with the preponderance of information gathered.

At the end of the field trips, the evaluation team set aside three days to review the recorded information to refresh its recall and brainstorm on findings, conclusions, and recommendations. The team presented preliminary findings and recommendations on November 19 to USAID/Bangladesh and the Modhumita Project team. Comments and further information generated from debriefing discussions have been incorporated in this report, written through the team members' virtual teamwork.

METHODOLOGICAL LIMITATIONS

The methodology employed by the evaluation team has a number of limitations that are commonly encountered for an evaluation of this type conducted within a limited time period. The evaluation was based on qualitative assessments and discussions with project and implementing agencies' team members. The CBOs visited were selected by convenience, and selection factors included ease of accessibility within Dhaka, Chittagong, and Sylhet. Within the time available it was not possible to collect quantitative data. This limitation was minimized by use of existing performance-related data collected by the project. Language differences presented barriers to in-depth conversations during some group discussions and site visits. The evaluation team members relied on translations by Modhumita Project staff, corroborated by Bengali-speaking team members.

There are limitations on the extent to which an evaluation using the described methodology can assess the quality of services. Collection of data to measure quality was not required in the SOW. Site visits allowed for a limited assessment of quality through observation and questioning. Quality was primarily assessed on the basis of whether systems were in place to measure and improve upon quality, such as monitoring visits using checklists based on standard operating procedures or some other criteria. However, the evaluation team took care not to generalize observations from one site into findings that apply to the entire program.

IV. FINDINGS

EVALUATION QUESTION NUMBER ONE

How effective has the project been in increasing and sustaining use of high-impact prevention, care, and treatment services by MARPs?

Process-level Findings

Via 33 existing MHCs, 14 additional VCT sites, and mobile/satellite VCT, and through technical assistance that builds upon and strengthens existing organizational structures and capacity, the project targets HIV prevention, care, and treatment activities to MARPs and PLHIV. Identified through research and surveillance, these MARPs are MSWs, TG populations, FSWs, clients of sex workers (COSW), and PWID.

Other agencies that receive funding from other development partners (e.g., the Global Fund) refer to the project for VCT. The project provides VCT services to returning migrants, who then receive referrals to care and support services if HIV-infected. The project has placed VCT in 10 TB hospitals, and infected clients also receive referrals to care and support services.

Appendix E provides a list of project-supported MHCs and their implementing agencies. During project year 2, the project reduced or eliminated support to several MHCs and streamlined activities due to significant reductions in funding. Appendix F presents a map of the project's service sites. Appendix G contains the project results framework.

Strengths: The general consensus of stakeholders is that the project fills critical needs in HIV/AIDS service delivery and with impressive technical and organizational project operations. They feel the project brings accountability and transparency to HIV/AIDS services with implementing staff who are well trained and well supervised, and deliver effective quality services to those most at risk for or living with HIV. Project-supported services meet many globally recognized best practices in the design and delivery of HIV/AIDS services for MARPs and PLHIV.

- The project delivers comprehensive services for MARPs and PLHIV, including HIV risk reduction messaging, condom and lubricant distribution, VCT, STI screening and treatment, TB screening and referrals to treatment, counseling and referrals to FP services, and FP counseling integrated into VCT. MHCs refer to HIV care and support services provided by the Ashar Alo Society (AAS) and Mukto Akash Bangladesh (MAB) for PWID. These services include opportunistic infection management, in- and outpatient management, diagnostic support, VCT, FP services, and support for members, including monthly members' days.
- Some of the implementing agencies conduct physical follow-up with clients to ensure linkages to care and support after HIV testing (e.g., VCT services from the National Institute of Diseases of the Chest and Hospital). AAS and MAB track care and support services by patient.
- Much of the project design and implementation was and continues to be sensitive and aligned to available data regarding epidemic and context, with many interventions that are accordingly appropriate. The project added services in response to client demand (e.g., FP, TB) and was able to use USAID FP and TB funds to meet these needs. In addition, the

project addresses a rights-based approach with such activities as the recent implementation of "Flying Squads"[4] to respond to violence and harassment by civilians and law authorities.

- Many of the project's implementing agencies connect to nonhealth-specific resources for complementary support services. Examples of this include linkages to job placement, income-generation activities, and vocational training.
- Many stakeholders from targeted populations supported under the project have played key roles in project design and implementation. For example, *hijra* in Dhaka advocated directly with service providers and religious leaders to increase understanding and acceptance of TG individuals and their health needs. The project supports AAS and MAB, which are run by PLHIV. This level of PLHIV engagement is viewed very positively by the GOB.
- The project has targeted gatekeepers and opinion-makers to address HIV/AIDS issues related to MARPs and PLHIV. Although the project no longer funds the Masjid Council for Community Advancement (MACCA) for work with imams, trained imams continue to advocate on behalf of MARPs and PLHIV through Friday services to community members. Some imams take part in the Flying Squads.

In conjunction with the Department of Narcotics Control and the United Nations Office on Drugs and Crime (UNODC), the project cofunds the country's first OST service for PWID. With support from Modhumita, the International Center for Diarrheal Disease Research, Bangladesh (ICCDR, B) implements project-supported activities, and UNODC provides methadone. The project also supports community-based drug rehabilitation services, with the needle and syringe program provided by the Global Fund. Drug rehabilitation services include HIV and drug risk reduction messaging, VCT, STI screening and treatment, TB screening and referrals to treatment, detoxification and rehabilitation, referrals to care and support, referrals to OST, referrals to nonhealth-specific activities, abscess care, case management, and vocational training and job placement. Project support also provides a foundation for OST service expansion, which receives strong support from both the health and drug enforcement sectors.

The project built on and strengthened existing quality assurance (QA) systems within implementing agencies. The focus is on monitoring the quality of VCT, STI screening and treatment, and syphilis testing services. The project established quality improvement (QI) teams at project district levels, and the project conducts quarterly coordination meetings with project staff. The project also performs quarterly data quality assurance assessments and, based on the findings, provides detailed recommendations to inform each program area (e.g., feedback to VCT counselors). Overall, data quality management is strong at the national project level and within individual implementing agencies.

Project stakeholders, beneficiaries, and clients have reported considerable reduction in HIV- and MARPs-related stigma and discrimination, and in part this can be attributed to the project. Although stigma and discrimination continue to be major barriers to services and acceptance,

[4] The "Flying Squads" are crisis management teams for MARPs with support for harassment, medical needs, counseling, and legal assistance. There are three tiers: 1) teams of influential community members and peer outreach workers available 24 hours to respond to crises; 2) support and resources from project implementing agencies; and 3) alliances of lawyers and legal support, activists, and media who advocate on behalf of high-risk populations.

MARPs and PLHIV cited improvements including greater acceptance among themselves and within their communities, resulting in better access to resources and services.

Other strengths include the fact that many of the project-supported implementing agencies, including AAS, MAB, and Confidential Approach to AIDS Prevention (CAAP), provide a full range of prevention, care, and treatment services. This approach has increased successful linkages to and retention in care and treatment services for HIV-infected individuals. Also, the project has leveraged partner resources that have greatly benefited the project. For example, SMC's sizeable cost share enhances the scale of service delivery and distributes USAID-provided no-logo condoms at little cost through its expansive network.

Gaps and challenges: At the process level, the project does not appear to make optimal use of national- and program-level data to inform strategic programming. For example, although the selection of project interventions is, on the whole, aligned to available data regarding epidemic and context, activities targeting the general population and youth do not appear to be based on HIV surveillance and program data. Some implementing agencies make broad assumptions regarding the HIV risk of different populations assumed to be COSW.

Although, as stated in the strengths section above, the project uses QA/Quality Improvement (QI) protocols to deliver quality services, the project misses opportunities to use program data to better target interventions for successful outcomes. There are opportunities to collect and use data in a relatively inexpensive manner to better inform both the project and the national HIV/AIDS response. For example, there is no trends analysis using VCT data, particularly behavioral data. There is no risk factor assessment of PLHIV. Project-collected referral data could be used to better understand the composition of COSW.

Other gaps and challenges include:

- The package of comprehensive services is not entirely tailored to the needs of each target population (e.g., FP for TG persons; TB services for COSW provided at drop-in centers where COSW can access TB screening with general health care providers without fear of denial of access).
- There is a need to expand work with religious leaders as a critical approach to an increasingly sustained national HIV/AIDS response for MARPs. Key issues include working with imams to reduce stigma and discrimination, promote a greater understanding of risk reduction behaviors and available services, and mitigate family and other forms of violence within their communities.
- The project has not seized a comprehensive range of opportunities to address internalized stigma and discrimination within specific types of at-risk populations, which leads to a lack of support to those infected with or affected by HIV (e.g., *hijra* who report not knowing a single individual infected with HIV yet live within communities that, with support and resources, could act as caring and supportive communities for PLHIV).
- Although the Flying Squad is a relatively new intervention, the project should implement the full package of support and focus on working with imams and with sensitizing law enforcement to prevent harassment.

- It is unclear if HIV-infected individuals from all targeted key populations receive comprehensive support services (e.g., AAS support groups focus on migrants and wives; the only support groups for infected MSWs and FSWs are in Dhaka).

Results-level Findings

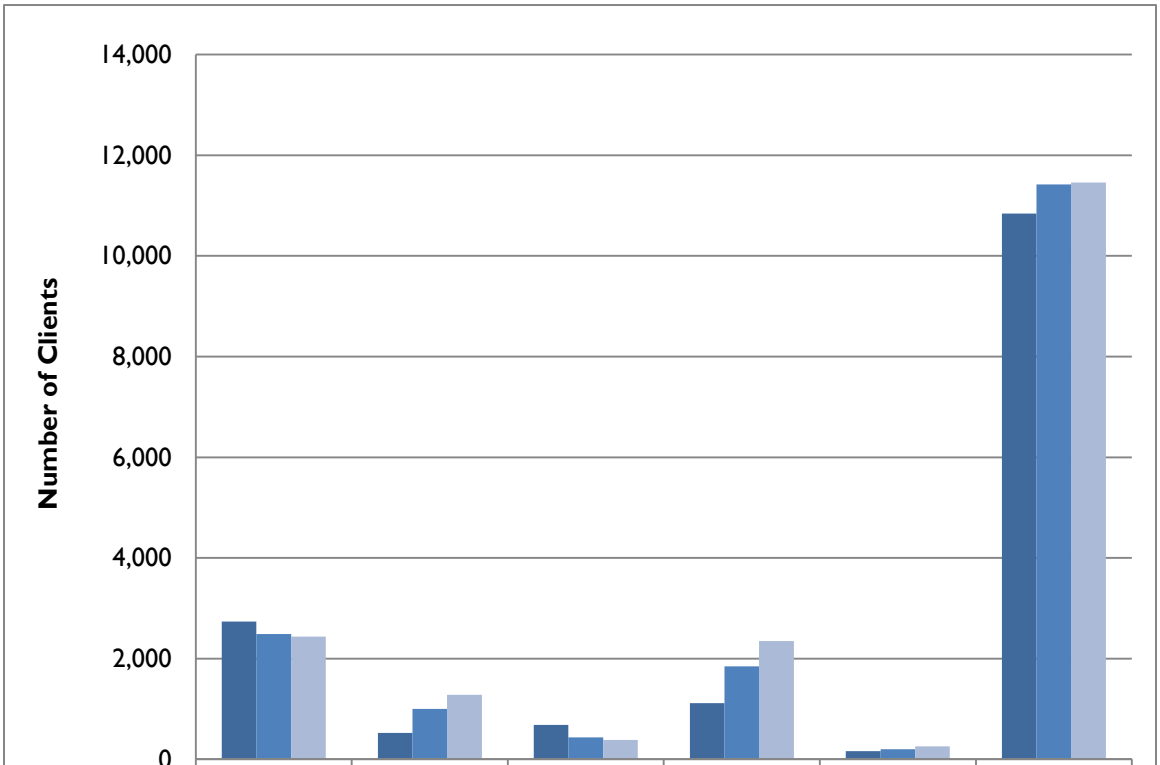
Appendix H presents results against targets for selected project indicators for the first three years of project implementation. Overall, the project has met or surpassed its targets. However, excessive target achievement might indicate a disproportionate focus on specific activities during project implementation or a need to readjust assumptions when establishing targets.

Observations about results against project indicators include:

- The project has focused on reaching COSW with HIV prevention interventions (90% of total reached in project year 3, indicator: number of targeted population reached with individual- and/or small group-level HIV prevention interventions that are based on evidence and/or meet minimum required standards).
- During project year 3, the project achieved only 54% of its target regarding the number of new hijra members to Modhumita sites.
- During project year 3, the project achieved only 60% of its target regarding the number of PWID receiving drug treatment; of this only 34% of targeted women received services.

Figure 1 demonstrates the number of new members to MHCs by project year and by population. For MSWs, PWID, PLHIV, and COSW, numbers have increased each project year, but have decreased for FSWs and *hijra*. The vast majority of new members to MHCs are COSW.

Figure 1: Number of New Members to Modhumita Health Centers by Project Year



	FSW (Hotel- and Street-Based)	MSW	Transgender	PWID	Care and Support	COSW
Year One	2,734	522	680	1,116	163	10,841
Year Two	2,491	998	433	1,845	202	11,418
Year Three	2,440	1,279	381	2,349	259	11,461

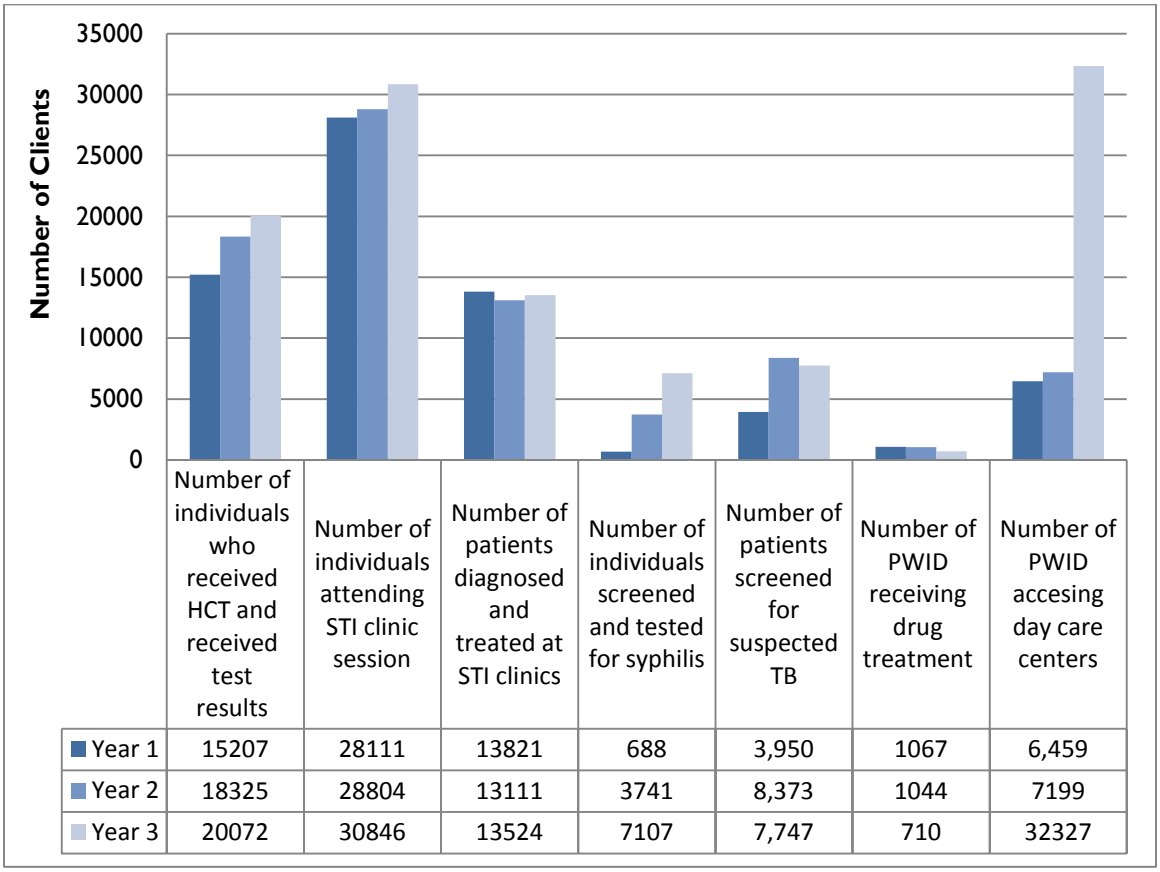
Figure 2 presents the number of clients, by type of client, who have received services at MHCs during each project year. The numbers of individuals receiving HCT, STI screening, and syphilis screening and testing have increased each project year, while numbers receiving STI treatment remain approximately level. Individuals screened for TB increased between project years 1 and 2, but dropped slightly during year 3. The number of PWID receiving OST dropped during project year 3, but that year the project witnessed a dramatic increase in PWID accessing day care centers.

Appendix I contains a comparison of populations, by division in which the project works, who were tested for HIV during project year 3 and received positive test results. Table 2 presents a summarized comparison of testing numbers and test results by targeted population. The following are observations about these data:

- In Rajshahi and Rangpur districts, no tested clients received positive test results. Only one client in Barisal received a positive test result.
- The population with the highest number of individuals tested through the project was COSW, but very few were found to be HIV-infected (0.1%).

- Across all targeted districts, the percentage of HIV infection within the category of "others" is highest at 7.1%. However, the risk of individuals within this category is unclear (e.g., does the category comprise MARPs who declined to reveal risk behaviors, or returned international migrants with unspecified risk behaviors?). Infection rates within this category are highest in Dhaka (19.8%) and Sylhet (15.2%).

Figure 2: Number of Clients Receiving Services at Modhumita Health Centers by Project Year



	Number of individuals who received HCT and received test results	Number of individuals attending STI clinic session	Number of patients diagnosed and treated at STI clinics	Number of individuals screened and tested for syphilis	Number of patients screened for suspected TB	Number of PWID receiving drug treatment	Number of PWID accesing day care centers
Year 1	15207	28111	13821	688	3,950	1067	6,459
Year 2	18325	28804	13111	3741	8,373	1044	7199
Year 3	20072	30846	13524	7107	7,747	710	32327

- Within districts that reported a "care and support" category (Dhaka, Chittagong, and Sylhet), 6.6% of tested individuals in that category were infected. The characteristics of this category are also unclear (e.g., does it reflect repeat testing or family member testing?).
- Within districts that reported a "TB patient" category (Dhaka and Chittagong), few tested individuals were infected (0.2%).
- Within all districts, only 0.2% of TG individuals and 0.05% of FSWs received positive test results. These results are well below what the *2011 National HIV Serological Surveillance Report – Round 9* indicates as the HIV prevalence range for these populations.
- Within districts where PWID received positive results (Dhaka, Chittagong, and Khulna, the percentage of HIV infection (1.34%) falls within the HIV prevalence range of 0.4%-5.3% for this population, as indicated by the *2011 National HIV Serological Surveillance Report—Round 9*.

- In Sylhet, none of the tested MARPs received positive test results.

At the result level, and similar to the identified gap above in process-level findings, the project does not appear to make optimal use of national- and program-level data to inform the strategic allocation of resources. This includes the use of data to inform decisions about specific activities or partners. For example, there is little use of data to determine whether services should continue where HIV infections are not occurring, or to inform the potential consolidation of services. Other issues include the use of data to identify gaps in services (e.g., service coverage with *hijra*) or the appropriate focus of activities and resources on specific target audiences.

Table 2: Comparison of Populations Tested for HIV during FY 2012 and Test Results

	Target Groups								
Indicator	**Total**	**MSWs**	***Hijra***	**PWID**	**Care & Support**	**COSW**	**TB Patients**	**Others**	**FSWs**
Number of individuals who received HCT and received test results	20,072	2,876	980	2,096	651	5,688	1,971	2,138	3,672
Number of tested individuals who received results positive for HIV	245	8	2	28	43	6	4	152	2
Percent infected	1.22%	0.28%	0.20%	1.34%	6.61%	0.11%	0.20%	7.11%	0.05%

It is important to note the constraints in analyzing achievements related to project Result One. Measurement of the project's effect on specific behaviors (e.g., risk reduction behaviors, treatment adherence) is precluded by the availability of funding for the necessary surveys. There are few national or subnational data regarding service coverage by target population, and there is a lack of precision on size estimates for MARPs. As a result, it is difficult to gauge the project's contribution to population-level service coverage at national and/or subnational levels or by specific targeted populations.

EVALUATION QUESTION NUMBER TWO

To what extent is the project strengthening the national program's leadership capacity in managing national HIV/AIDS activities and strengthening health systems in Bangladesh?

Process-level Findings

There are two overall approaches under project Result Two: strengthen GOB leadership and strengthen the policy environment. Activities under the former include technical assistance to NASP to strengthen coordination and communication among HIV partners, facilitation of the interministry coordination committee, and project participation in technical working groups. Activities under the latter include media advocacy and mainstreaming HIV prevention responses within other line ministries.

Strengths: Stakeholders report an overall improvement in national-level coordination during the past six months among UNAIDS, Save the Children International (SCI), NASP, and the Modhumita Project. These stakeholders now meet on a regular basis, often two or three times a week, and address issues such as resolving or avoiding duplication of efforts. This strengthened coordination may assist in monitoring the continuity of services and results as the GOB health sector program adopts HIV/AIDS activities.

The project provides technical assistance to the GOB and stakeholders. For example, the project participates in the development of transition plans with the GOB to ensure service continuity as the Government assumes responsibility for specific elements of service delivery and procurement and supply management. Stakeholders report effective project participation in technical working groups; results include GOB endorsement of project guidelines and protocols.

The project has attempted to mainstream HIV/AIDS services within the public sector as appropriate. For example, the project worked with the Department of Narcotics Control to establish a government-driven response and monitoring of OST services. Within the parameters of the program description, the project embedded VCT services within TB hospitals.

Other strengths include the secondment of a procurement specialist to NASP. The specialist provided 150 days of technical assistance to develop government procurement packages for HIV/AIDS services, including prevention services for hotel-, resident-, and street-based FSWs, and prevention services for PWID, MSM, and TG individuals. In addition, the project trained journalists and media house editors in reporting about HIV/AIDS, MARPs, and PLHIV to reduce stigma and discrimination. The project also created media fora in Dhaka, Chittagong, and Sylhet to cover news in electronic and print media.

Gaps and challenges: The project lacks a clear and appropriate strategy for determining activities related to Result Two. Current forms of support are a collection of discrete and not entirely interlinking activities. Underlying this issue is the need for a systematic analysis, underpinned by a rationale, to determine the scope and duration of project-provided assistance. This is a larger issue for the GOB, national-level stakeholders, and development partners.

However, there are gaps that can be addressed or mitigated by the project itself. For example, the Modhumita Project is responsible for supporting interministry coordination. However, SCI and UNAIDS are not included in this forum; the lack of participation by key national-level stakeholders does not lead to optimal coordination of HIV/AIDS resources and interventions within the country.

In some of the targeted geographic areas, there has been limited interaction between the project and local government leadership, including the health sector. Some government officials were unaware of the project itself or the fact that it is funded by USAID. Given USAID's prominence in the health, education, and other sectors in Bangladesh, this results in lost opportunities for advocacy and strengthening local public sector leadership**.**

Other gaps include the lack of learning and sharing meetings between national and subnational stakeholders. As noted in the findings for Evaluation Questions #1 and #4, there are missed opportunities to collect and use data to better inform both the project and the national HIV/AIDS response. These opportunities include VCT trends analysis with behavioral data, PLHIV risk factor assessments, and the dissemination of project innovations and best practices.

The project's work with media professionals seems to have achieved positive results but has not been sufficiently evaluated. Simple cost-effective methods exist to gauge the effect of this assistance and strengthen the institutionalization of the media's response to HIV/AIDS within the GOB and media houses.

The project also misses opportunities to target limited project resources for assistance that would result in more successful outcomes within the GOB. The project could pass roles to other stakeholders who are better suited for specific tasks. For example, the interministry coordination role is best suited for UNAIDS, per its global mandate for high-level country coordination of the national HIV/AIDS response as part of its support to NASP. UN Women is best suited for assistance to the Department of Women Affairs for awareness building programs with low-literacy groups. The project has provided assistance to activate district AIDS committees in specific geographic areas. There is little evidence of results, and the question remains if the role of assisting districts in policy and planning is best suited to the project or whether this assistance should await GOB activation and oversight of these bodies.

EVALUATION QUESTION NUMBER THREE

What are the barriers to increased service delivery and capacity development and are there any recommended changes to the current technical assistance structure?

The following describes several barriers that inhibit increased service delivery and capacity development within the Modhumita Project or the national HIV/AIDS response itself. Additional barriers are discussed in Evaluation Question #5.

The allocation of limited resources for most impact: Data-informed, evidence-based resource allocation is critical for maximized impact, especially considering the limited resources available for HIV/AIDS in the country. Not all resources are allocated in the most optimal manner for interventions that are most relevant to containing Bangladesh's HIV epidemic. Some resources are targeted to populations that do not demonstrate significant risk based on national- or project-level data. This gap is in part due to the lack of a national surveillance and strategic information system and an implemented research agenda.

Previous USAID-funded HIV projects provided technical and financial support for activities such as the Integrated Biologic and Behavioral Surveillance Survey and other types of behavioral surveillance surveys. There has been no behavioral surveillance or measurement at the national level since 2007, partly because of reductions in USAID funding. ICCDR, B and the Institute of Epidemiology, Disease Control & Research (IEDCR) produce the annual HIV serological surveillance surveys, conducted with sex workers, PWID, heroin smokers, combined PWID and heroin smokers, MSM, and TG individuals. However, these surveys do not include populations to be considered as emerging risk and higher vulnerability (see Evaluation Question #5), such as international migrants.

Stigma and discrimination: A social barrier, stigma occurs at multiple levels. Members within a society can stigmatize those perceived to be at risk for HIV as well as those who are infected with HIV. Within marginalized groups themselves, members may have stigmatizing attitudes toward those infected, and internalized stigma carried within individuals may lead to self-blame, low self-esteem, limited self-efficacy, and a reluctance to seek services. For those who are infected, stigma may also result in a failure to disclose to family and friends. Stigma might be prevalent within the workplace. For example, in addition to stigma directed at MARPs and

PLHIV, health care and other interviewed providers reported that working on HIV as a career choice can lead to stigmatization within the health sector. This can affect career advancement and was cited as a possible cause for high staff turnover.

Discrimination, or institutionalized stigma, has led to legal and policy barriers that threaten efforts to provide MARPs and PLHIV with comprehensive HIV/AIDS services. These barriers persist despite concerted policy and advocacy efforts. For example, selective interpretations of laws by individual members of the police force (e.g., penal code sections such as #377 on the illegality of promoting homosexuality) have been used to harass outreach workers. FP is available only to married couples.

The public sector leadership role in the national HIV/AIDS response: Another major barrier is the willingness and capacity of the GOB to assume a greater leadership role. While the GOB has assumed a greater role in the national HIV/AIDS response during the past several years, the lack of a formalized relationship between NASP and the Directorate General of Health Services has led to bottlenecks in the Government's intent to strengthen leadership. Currently, NASP is unable to meet its full mandate, such as strengthened coordination across ministries. The National AIDS Committee requires regular meetings to provide the necessary leadership and advice to NASP. There is delayed and inadequate use of existing funding for HIV/AIDS.

Other public sector issues include the ambivalent attitude some GOB entities exhibit regarding the extent of their leadership role. For example, in some cases they appropriately want to lead and oversee the decision-making process for specific activities but are unclear as to how to make decisions based on timely evidence-based analysis. Also, although the GOB intends to assume responsibility for the provision of specific HIV/AIDS services, the MOHFW requires more strengthening to assume this role at this time. For example, the GOB plans to distribute antiretroviral drugs through district hospitals. There is concern among stakeholders that this might result in a break of services.[5]

The relationship between the GOB and civil society service providers: Bangladesh's civil society currently plays a vital role in the national HIV/AIDS response, but it is unable to effectively partner with the public sector. For example, although the GOB often contracts health care services to civil society or private institutions to hasten service delivery, civil society organizations working on HIV are not accorded the same level of approval enjoyed by ministerial-level government institutions. This does not mean that civil society organizations should be treated the same as government institutions, but they should not be impeded in their service delivery efforts by other branches of government. For instance, police would not harass FSWs or PWID in a government-run clinic, whereas civil society organizations serving the same populations might have a different experience.

Civil society HIV/AIDS partners are threatened by the potential shift of funding from development partners to the GOB. If the GOB were to become the only funding source for civil society-provided HIV/AIDS services, it is quite possible that civil society participation would be curtailed. In addition to an arduous and slow-moving GOB procurement process, bidders are required to submit a percentage of total costs as a bank guarantee with applications, and many implementing agencies are unable to comply. As such, there is the potential to seriously

[5] Stakeholders report that this transition will be delayed to at least June 30, 2013, and even if drug distribution will happen through the public sector, the MOHFW has expressed interest in implementing agencies uplifting drugs from medical stores and distributing drugs through their programs.

jeopardize currently successful efforts undertaken by civil society projects, thereby resulting in the loss of gains made in containing the epidemic.

Human resources for health: A major barrier for both public- and civil society-provided HIV/AIDS services is that public sector human resources for health are generally weak at the field level. Personnel trained in HIV/AIDS services continue to have high turnover rates caused not only by the effects of stigma, as discussed above, but also by salary and promotion concerns. Similar to the human resources for health barriers faced by the GOB, civil society organizations also report difficulties in finding and retaining qualified staff. In several cases, the departures of trained VCT and/or laboratory staff led to significant gaps or breaks in services (e.g., Bandhu Social Welfare Society, VCT at TB hospital in Dhaka).

Opportunities for strengthened service delivery and capacity development: Despite these barriers, the GOB, stakeholders, development partners, and the Modhumita Project can build on or leverage many existing opportunities for strengthening the national HIV/AIDS response. These include, but are not limited to the following:

- Some entities within the MOHFW employ innovative approaches to strengthening capacity and service delivery. For example, the Department of Community Medicine in Sylhet places medical students in rotations with AAS and assigns students to schools to help teach the HIV/AIDS component of the national education curriculum.
- The World Health Organization (WHO) is in the process of updating national HCT guidelines to include provider-initiated testing (PICT), which will help mainstream HIV testing into the general health sector.
- NASP is planning to release a national mother-to-child HIV transmission study which will help inform potential programming and support, and UNICEF is piloting prevention of mother-to-child transmission (PMTCT) with the GOB and AAS in Dhaka, Sylhet, and Chittagong.
- The Islamic Foundation Bangladesh, which oversees Bangladesh's more than 300,000 mosques and 1 million imams, already includes basic HIV/AIDS information in its 45-day imam training and has communicated its interest in strengthening its participation in the national HIV/AIDS response.
- There are opportunities to explore public/private collaboration. The Hope Care Center in Chittagong represents a unique approach to providing HIV care and treatment through private medical practitioners who volunteer time at the local CBO for PLHIV.
- There are promising applications of mobile technology solutions for HIV/AIDS (e.g., communications, adherence monitoring, data transfer).

Recommended changes to the current technical assistance structure: The project's technical assistance structure consists of three approaches: strategic behavioral communications, the CoPCT model, and the FHI Quality Improvement Model. This underlying structure has acted as the foundation upon which the project has accomplished many objectives and results, which in turn has contributed greatly to the achievements of the national HIV/AIDS response. As such, the evaluation team does not recommend any changes to the project's overall technical assistance structure during the remaining life of the project. However, recommendations for

strengthening specific challenges and gaps within the project are presented in Section VI: Recommendations.

EVALUATION QUESTION NUMBER FOUR

To what extent has the Modhumita Project been able to support the scale-up of innovative approaches to HIV prevention among MARPs in Bangladesh?

USAID has supported HIV/AIDS activities in Bangladesh for well over a decade and during this time has contributed to the development and expansion of innovative approaches for MARPs and PLHIV. These approaches address specific barriers to services, improved project uptake, and client satisfaction and retention. Examples include the following:

- The project has added specific client-informed services to the CoPCT model, including FP counseling and services and TB screening. The project is beginning to build implementing agency capacity to access nonhealth support, such as instituting group savings accounts for FSWs at MHCs, income generation, counseling and referrals, and referrals to vocational rehabilitation for FSWs, PWID, and *hijra* through existing schemes.
- Some of the implementing agencies that use the project's innovative QI model report the use of QA/QI processes and tools at nonproject-funded sites. As such, USAID's investment is being taken to greater scale outside the project's catchment areas.
- Through implementing agencies, the project implements novel rights-based and violence-reduction efforts through the Flying Squads.
- The project is helping to increase community acceptance of and engagement with MARPs and PLHIV. Activities include imam training through MACCA and project facilitation teams that consist of project staff and members from the larger community (e.g., police, imams). These efforts help create awareness of HIV prevention, care, and treatment, and possibly reduce stigma and discrimination, while creating a safer, more conducive environment for service provision for MARPs and PLHIV.
- Other project innovations are based upon collaboration with other USAID-funded projects. Examples include collaboration with Smiling Sun health care providers to mainstream access to FP services and products for selected MARPs and PLHIV. They also work to reduce stigma and discrimination among providers and work with SMC to increase condom accessibility and availability through condom depots.

The larger remaining question is whether certain adopted innovations constitute effective HIV/AIDS public health interventions and merit expansion, with results beyond just increased service uptake. Another question is how to disseminate project innovations for adoption by the GOB and other development partners. Currently, there is limited dissemination of promising best practices or innovations between project partners and other stakeholders because of constraints in project funding (see findings for Result Two).

Nonetheless, the project consortium has the capacity to employ qualitative or quantitative approaches to answer questions linking innovative approaches to improved results and/or outcomes. Research questions about project-supported innovative approaches that can be studied before expansion include the following:

- Can MHCs serve as model "Centers of Excellence" for accountable, transparent, and effective service delivery (e.g., AAS, OST services at central treatment centers)?
- Does the CoPCT model reduce loss to follow-up (for pre-ART services/ART services; from project sites to AAS/MAB; from nonproject sites to VCT to AAS/MAB)?
- Has coordination with Smiling Sun providers increased FP service use by specific cadres of MARPs (e.g., hotel-based FSWs, PLHIV)?
- Can linkages to nonhealth support services (e.g., vocational training and other social protection services) be mainstreamed effectively by project- and nonproject-supported implementing agencies?
- Can other innovations further reduce vulnerability for MARPs via MHCs (e.g., increasing Grameen Bank microcredit to FSWs)?
- Has the full Flying Squad package been effectively implemented, resulting in successful outcomes?
- Do existing implementing agencies adequately meet the care and support needs of specific MARPs who experience especially high levels of stigma and discrimination (e.g., MSWs, TG populations)?
- Does mainstreaming services affect uptake by specific target audiences (e.g., is the placement of VCT/TB/STI services in MHCs for COSW more results- and cost-effective than using public health care centers or private providers)?
- Does (and if so how much) the project facilitation team model contribute to improved service access and a more enabling environment at the local level? Does target audience participation increase and influence results?

EVALUATION QUESTION NUMBER FIVE

How does the project meet the national needs and fill critical gaps in responding to the national strategy on HIV/AIDS?

The *National HIV/AIDS Strategic Plan* outlines three areas where the GOB and stakeholders must strengthen and focus interventions for the country to successfully contain the HIV/AIDS epidemic. These are 1) expanded coverage for MARPs and improvements in the quality of services delivered; 2) addressing issues related to emerging risk and higher vulnerability, particularly for certain clearly identified population groups; and 3) increased quality treatment, care, and support for PLHIV.

1. **Expanded coverage of quality services for MARPs:** A priority area of focus within the *National HIV/AIDS Strategic Plan* is that interventions reach a significant percentage of specific types of MARPs (e.g., PWID and street-, hotel-, and residence-based FSWs). Gaps and challenges in expanding the service coverage for MARPs include:
   - The need to access underserved and/or "hidden" populations among MARPs who are unlikely to be reached by current interventions as designed. These populations include residence-based sex workers, MSM who do not identify themselves as such, and more marginalized communities of *hijra*. There is limited coverage of FSWs in brothels.

- Lack of precision on size estimates for MARPs and relevant behavioral surveillance data, which does not allow for quantifiable analyses of service coverage by population or outcome-level behavioral measurement.
- Inconsistent frequency of contact and effectiveness of interventions to achieve sustained behavior change. Challenges include low levels of comprehensive HIV knowledge, accurate perceptions of HIV risk, self-efficacy, and health care-seeking behaviors (e.g., STI treatment, HCT).
- Lack of capacity at all levels within the GOB, especially in regard to programmatic and financial management, procurement and supply management, and overall governance.
- The potential for service disruption or contraction as the GOB assumes responsibility for HIV/AIDS services (e.g., HIV rapid test kit stock outs; national GOB plans to support only 20 VCT sites nationwide, which is lower than current numbers).

Stakeholders uniformly recognize the role the project plays with the provision of quality services for MARPs. Implementing agencies provide a large proportion of services targeting PWID, MSWs, TG individuals, street- and hotel-based FSWs, and COSW. The country relies on the project for VCT services since it provides most of the VCT available in the country. MHCs act as referral VCT sites for Global Fund-supported activities. The Modhumita Project currently purchases all HIV rapid test kits for country.[6]

In addition, the *National HIV/AIDS Strategic Plan* recognizes the need for enhanced provision of primary health care, HIV treatment and care, and drug treatment and prevention services for PWID as a critical element in preventing HIV transmission. The project has provided the bulk of financial support for the design, delivery, and ongoing evaluation of OST services. This is a major accomplishment and brings the PWID component of the *National HIV/AIDS Strategic Plan* in line with global best practices.

2. **Issues related to emerging risk and higher vulnerability:** The *National HIV/AIDS Strategic Plan* cites the need to be attentive to issues related to emerging risk and higher vulnerability, particularly for identified population groups. These groups include international migrant workers, prisoners, especially vulnerable children and adolescents, heroin smokers, and transport workers. The plan recognizes the lack of sufficient research and evidence on which to base the design and expansion of HIV/AIDS interventions to these specific audiences.

The project has worked with the GOB and other stakeholders on activities targeting possibly vulnerable populations (e.g., returned international migrants, transport workers as COSW, recovering PWID). However, the paucity of data constrains evidence-based decisions regarding the level and scope of activities with many of the above-mentioned populations.

Some resources do exist in Bangladesh to help the GOB address these issues. For example, the International Organization for Migration (IOM) is conducting research on international migrants and is developing partnering agreements with the governments of Bangladesh and Malaysia for providing health care services for Bangladeshi migrants. The project previously funded community-based migration activities in Dhaka with IOM from which lessons learned can be

[6] Although HIV test kits were not included in the original Global Fund proposal, they are now included in the RCC.

drawn. Project consortium members can draw on considerable international expertise to inform programming in Bangladesh with possibly vulnerable populations.

3. **Increased quality treatment, care, and support for PLHIV:** The *National HIV/AIDS Strategic Plan* predicts that the numbers of PLHIV will increase substantially over the next five years from the current level. Since there are only five ART centers in Bangladesh, of which three are in Dhaka, only 681 individuals receive ART.[7] ART is still not available through the government health system, despite the GOB's expressed intentions to procure commodities and eventually provide services.

Other challenges include the limited provision of diagnostic services for opportunistic infections and disease progression monitoring. Many other services that are required to provide more complex HIV treatment needs are negligible (e.g., post-first line ART, hepatitis C and TB co-infection management, services to address the elevated risk of other morbidities such as cervical cancer or diabetes).

Through support to AAS, MAB, and CAAP, the project has been instrumental in developing a community-based response to care and treatment for PLHIV from diverse MARP groups. In light of the lack of services and capacity in the public sector, project support for PLHIV-run civil society organizations has ensured a uniformly lauded high standard of clinical and psychosocial care and treatment for PLHIV in Bangladesh.

[7] UNAIDS, *Country Progress Report: Bangladesh*. April 4, 2012, pg. 45

V. CONCLUSIONS

The evaluation team drew the following conclusions from an analysis of background material and findings from each of the evaluation questions. Many of these conclusions cut across the evaluation questions. For ease of reference, the conclusions are grouped under themes.

RESULTS OF USAID/BANGLADESH'S INVESTMENT IN HIV/AIDS

- Bangladesh remains a low-prevalence epidemic, and appropriate and timely responses focusing on MARPs and PLHIV, supported in large part by USAID over the last decade, have helped contain the spread of HIV. The USAID-funded Modhumita Project has played a significant role in this targeted, evidence-based response.

- USAID's modest resources and contributions, compared with total HIV funding for the country, provide a significant portion of service coverage for MARPs and PLHIV and contribute more to meeting national targets than the proportion of its funding would suggest. USAID's funding has improved the overall quality of Bangladesh's HIV/AIDS services through activities such as the Modhumita "Centers of Excellence" that other non-USG-funded sites have replicated. USAID's support has also helped make more effective use of available resources through activities such as institutional strengthening within NASP and national-level strategic information such as behavioral surveillance.

THE EFFECTIVENESS OF THE MODHUMITA PROJECT

- Overall, project interventions have increased MARP and PLHIV access to and use of quality comprehensive HIV/AIDS services by building on previous USAID investments. Many activities meet globally accepted best practices, and the application of innovations has helped address specific barriers to services or lessons learned during project implementation. A project-supported pilot OST activity has become a globally recognized evidence-based intervention for PWID.

- Although project interventions are, on the whole, implemented well and of high quality, not all investments accurately target outcomes that would have a demonstrable impact on the HIV epidemic and thus lead to suboptimal use of resources (e.g., activities targeting the general population; the disproportionate focus on COSW; gaps in reaching *hijra* and PWID; activities with the Department of Women Affairs).

- A comparison of the project's FY 2012 data of populations tested for HIV and test results highlights issues for strategic consideration. These include project activities in districts with few or no positive test results for HIV, and a possible disproportionate focus on programs for COSW and TB patients. Infection rates within some specific populations are well below national estimates, indicating a possible need to target future activities to segments of the population more vulnerable to HIV.

- Several factors affect project performance but are constrained by funding. These include the lack of research to assess changes in risk reduction behaviors or inform the project of the results of behavioral interventions and the inability to take evidence-based interventions to scale.

SUSTAINABILITY OF THE NATIONAL HIV/AIDS RESPONSE AND PROJECT CONTRIBUTIONS

- There is a recognized need by the GOB and stakeholders to increase the sustainability of the national HIV/AIDS response through mainstreaming selected services into the general health sector where appropriate. Stakeholders recognize the unique needs of MARPs and PLHIV and the complementary roles played by civil society.
- Over the life of the project, services targeted to MARPs have been scaled back due to funding constraints. Continued reduction in funding would seriously jeopardize gains and could alter the future course of the epidemic.
- NASP requires more support from stakeholders, including USAID, to assume its intended national leadership role. This is especially crucial in light of the possibility of decreased donor funding and the glacial movement of the national health sector toward financial responsibility for the national HIV/AIDS response.
- Innovative nonhealth sector efforts (e.g., imam education and sermon development, journalist training, law enforcement engagement) have shown to be valuable in increasing access to and use of HIV/AIDS services by MARPs, in reducing stigma and discrimination, and in creating an environment in the general population in which HIV can be discussed more freely. Scaled-up efforts may lead to a more sustained national HIV/AIDS response.
- Within its scope, the project has contributed to increasing the sustainability of services to MARPs and PLHIV. These contributions include:
  - Increased quality and accessibility of comprehensive services via civil society through assistance with mainstreaming services within the public sector and within the limits of its program description
  - The creation of an HIV/AIDS service delivery model that has been replicated and can be taken to scale via other funding sources (e.g., Global Fund, Health Sector Support)
  - Enhanced sustainability and effectiveness of interventions through public-private collaboration (e.g., journalists and media, Smiling Sun clinics)
  - Strengthened workforce capacity within implementing agencies
  - Increased beneficiary ownership through participation in project design and implementation and community empowerment activities
  - Significant contribution to reduced stigma and discrimination
  - More engaged community leaders (e.g., law enforcement, imams)
  - Rights-based approaches to address barriers to services and other key issues (e.g., stigma, discrimination, violence) and lift up affected communities to find their voices for advocacy

OTHER GAPS IN AND OPPORTUNITIES FOR THE NATIONAL HIV/AIDS RESPONSE AND IMPLICATIONS FOR USAID

- Currently USAID (as well as the GOB and other stakeholders) cannot optimally target resources or quantify how investments have contributed to population-level impact. This is largely due to the significant delays within the GOB to implement the country's HIV/AIDS research agenda as outlined in the *National Strategic Plan for HIV/AIDS 2011-2015*. This includes behavioral surveys and other studies, including emerging trends and up-to-date estimates of population size.

- The issue of HIV and international migrants has become a major concern to the GOB and stakeholders. Current activities reaching migrants seem scattered with little to no evidence base or targeting. Such efforts will have little impact on reducing HIV transmission. Rigorous assessments among migrants are required before USAID supports expanded interventions.

- There are many opportunities that USAID might consider linking with, leveraging, or supporting to increase service delivery and capacity development. These include the updating of national guidelines and protocols to facilitate mainstreaming public sector services; the future release of a national mother-to-child HIV transmission study and PMTCT pilot interventions; the interest of the Islamic Foundation Bangladesh in strengthening its involvement in the national HIV/AIDS response; and promising approaches in the public sector to increase community-level engagement in the HIV/AIDS response.

VI. RECOMMENDATIONS

The following recommendations are for the Modhumita Project to consider during the remaining life of the project. Some of the recommendations might have project scope or funding implications and require consultation with USAID/Bangladesh before implementation.

1. The Modhumita Project should **strengthen the use of project data for strategic decision-making and implementation by:**
   - Conducting quarterly data analyses to understand programmatic performance (e.g., HIV testing and results by location/population; service coverage by population/activity; tracking and loss to follow-up for project/nonproject-issued referrals) and using these analyses to adjust and strengthen implementation strategies
   - Reassessing and adjusting COSW programming using surveillance and program data, including HIV and STI testing results
   - Investigating the "Other" and "Care and Support" project data categories to better understand individuals' risk, with programming adjusted accordingly
   - Investigating how to optimize programming and outreach in order to reach higher-risk segments of MARPs (e.g., the project's proportion of positives for TG persons and FSWs is much lower than the national reported prevalence)
   - Considering achievements and gaps in meeting prior years' targets when establishing annual project targets
   - Fully utilizing the Flying Squad activity to address multiple levels of stigma and discrimination and assessing its uptake and effectiveness
   - In collaboration with other USG partners working with local media, conducting a media content analysis to determine the project's effect on strengthening the media in Bangladesh (e.g., increase of positive/decrease in negative coverage; overall trends in media reporting on HIV/AIDS)
2. The project should conduct **qualitative formative assessments** to strengthen project programming and the overall national HIV/AIDS response. Priorities include:
   - In partnership with IOM, AAS, MAB, and ICDDR, B, conducting formative assessments among HIV-infected migrants to understand the social, network, demographic, and behavioral risk profiles of PLHIV who are returned migrants
   - In partnership with ICDDR, B and collaborating with AAS, CAAP, and MAB support groups, conducting formative assessments among other PLHIV to understand social, network, demographic, and behavioral risk profiles
3. The project should work with USAID during its annual work planning process to prioritize and readjust activities accordingly. Both the project and the Mission should **revisit the process by which activities are selected for inclusion in annual work plans.** For example, the Mission can use coordination meetings with NASP, development partners, and other stakeholders to discuss prioritizing activities during the remaining life of the project.

This process can also help NASP champion the use of evidence and data for resource allocation (e.g., shifting resources from low-impact activities targeting the general population).

As a data source for this work plan readjustment process, the project should conduct an in-depth analysis for all MHCs and other VCT centers to **determine how potential project support should continue or be adjusted**. Related to this point, the project should also reassess and adjust **the composition of services for each targeted population.** Opportunities include but are not limited to:

- Referrals to post-abortion care services and emergency contraception for FSWs
- The expansion of savings groups for infected FSWs and MSWs
- Appropriate referrals to general health services (e.g., TB and FP service referrals for COSW)

In addition and with collaboration from the Mission, the project should assess which **activities under Result Two can stop under the Modhumita Project**, either through elimination or by passing the activity to other stakeholders. Possibilities include ending project support for district AIDS committees and passing interministry coordination to UNAIDS and work with the Department of Women Affairs to UN Women.

4. The project should strengthen a number of implementation approaches and activities. This includes the investigation and implementation of **increased beneficiary engagement in the project.** Possibilities include participation in project facilitation teams and in the design and implementation of formative assessments.

   The project should strengthen the sharing of **programmatic best practices and lessons learned with national and subnational level stakeholders** for wider application. Of particular interest are innovative practices (see Evaluation Question #4) and project processes and tools that lead to accountability and transparency.

   In addition, the project should investigate and implement ways to use existing structures to **continue engagement with religious leaders in HIV/AIDS and programs for MARPs and PLHIV.** Possibilities include, but are not limited to:

   - Strengthening imam training with curriculum updates to address treatment, care, and OST, and issues related to MARPs, PLHIV, migrants, stigma and discrimination, and violence
   - Supporting continual HIV/AIDS messaging through Friday services
   - Facilitating participation in project activities, such as Flying Squads and PLHIV support days

5. The project should continue to **provide technical support to NASP** to strengthen the national HIV/AIDS response. Priorities include:
   - Working with WHO to revise national HCT guidelines to include PICT
   - Drawing on the considerable expertise within the project consortium to document promising best practices and potential interventions for international migrants as appropriate for Bangladesh (e.g., source and destination programs, "know before you go" activities with the Bangladesh Rural Advancement Committee, recruitment agencies, and imams)
   - Working in tandem with UNAIDS as it leads government and stakeholder coordination
6. As feasible and appropriate, the project should **include nonproject-funded partners in technical trainings and QA/QI activities** (e.g., Global Fund-supported partners in training for programming to MSWs and their inclusion in project facilitation teams). This will help extend USAID's investments in best practices and lessons learned beyond the immediate scope of the project.
7. The project should investigate the possibility of **leveraging nonhealth-specific resources** as appropriate and especially to other USAID-funded activities. Possibilities include but are not limited to:
   - Linkages to microcredit schemes for FSWs and MSM
   - Linkages to public sector leadership development and transparency initiatives
8. Using project consortium data and expertise, the project might be asked to **assist USAID and other stakeholders with documenting the national HIV/AIDS response.** Documentation elements might include:
   - An explanation of the current position of the GOB where requisite resources exist, but the public sector lacks appropriate technical and organizational capacity to adequately implement the national HIV/AIDS response.
   - An assessment of which HIV/AIDS services and systems can be appropriately mainstreamed within the public sector and which elements must remain outside the public sector.
   - Documentation of USAID's programming on lesbian, gay, bisexual, and TG rights in Bangladesh.

APPENDIX A. SCOPE OF WORK

Global Health Technical Assistance Bridge Project
GH Tech
Contract No. AID-OAA-C-12-00027

SCOPE OF WORK
(9/21/12)

I. TITLE:

USAID/Bangladesh: Modhumita HIV Prevention Midterm Program Evaluation

Contract: Global Health Technical Assistance Bridge II Project (GH Tech)

II. PERFORMANCE PERIOD

Evaluation preparations should begin in mid-October 2012 depending on the availability of the selected consultants. In-country work will be completed o/a Nov 4-20, 2012, and final report and closeout concluding by Dec 24, 2012.

III. FUNDING SOURCE

Mission-funded

IV. PURPOSE: BANGLADESH MODHUMITA HIV PREVENTION MIDTERM PROGRAM EVALUATION

USAID/Bangladesh seeks the services of a qualified organization with expertise in monitoring and evaluating development projects in Bangladesh for the development and implementation of a midterm (Oct-Dec 2012) evaluation of USAID/Bangladesh's Modhumita HIV Prevention Program.

V. PROJECT BACKGROUND AND CONTEXT

The Modhumita HIV Prevention Program is a Mission-funded bilateral Cooperative Agreement No. 388-A-00-09-0123-00 awarded to assist local NGOs and the government to implement HIV activities in Bangladesh. The Project is implemented by Family Health International (FHI) in partnership with the Social Marketing Company (SMC) and the Bangladesh Center for Communications Program (BCCP). The project provides technical assistance to NGOs to provide cost-effective high-impact HIV prevention, care and support services for most-at-risk populations (MARPs) and people living with HIV/AIDS (PLWHA) and develops the capacity of the Government of Bangladesh (GOB) to utilize strategic information to improve the stewardship and strategic leadership for their national HIV/AIDs response. The project began in September 2009 and is scheduled to end in September 2013. The project is a continuation of HIV/AIDs activities, which began in 2005. The project is located in 18 high-risk urban areas across the country, with the total funding amount estimated to be $15,169,879.

HIV/AIDs in Bangladesh

HIV/AIDS infection in Bangladesh remains at a very low level in general population (<0.1%) and at a relatively low level in most at risk population groups (<1%). The exception is among people

who inject drugs (PWID), where prevalence continues to grow. Although the number of infections in the country is estimated at about 7,500, only 2,088 positive cases have been reported as of the end 2010.

The most recent epidemiological data from Round 8 National Serological Surveillance 2010 show that HIV prevalence among PWID in Dhaka now exceeds the 5% threshold, having reached 7% in 2007 (over 10% in one part of Dhaka). Modeling exercises predict a growing epidemic along the lines seen in other Asian countries.

Interactions between HIV-infected PWID and other key populations poses the threat of a rapid rise in the number of infections and the development of a "critical mass" of HIV cases in Bangladesh among MARPs), which include female, male and *hijra* (transgender) prostitutes, IDUs, men who have sex with men (MSM), clients of prostitutes, and the sexual partners of all these groups.

Previous USAID HIV/AIDS Efforts: Bangladesh AIDS Program

The Bangladesh AIDS Program (BAP) was implemented from October 2005 to October 2009. The activity was a Mission-funded bilateral Cooperative Agreement awarded to implement HIV activities with high-risk groups. BAP was implemented by Family Health International 360 (FHI360) in partnership with SMC and a faith-based organization, Masjid Council for Community Advancement. The primary focus of BAP was implementation of MARP-specific interventions through local NGOs. BAP's second major focus was working with the GOB to conduct influential strategic information studies, support for monitoring and quality improvement (QI), targeted evaluation and integrated analysis and modeling to improve the overall response to HIV in Bangladesh.

The goal of BAP was to reduce the transmission of HIV and STIs while ensuring that STI/HIV/AIDS prevention services remained accessible, gender-sensitive, of high quality and sustainable in Bangladesh. More specifically, program objectives were 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 GOB HIV/STI surveillance systems for decision-making; and
- Improve local organizations' and private sector partners' capacity to participate in HIV prevention efforts in local communities.

A midterm evaluation of the program was conducted in September 2007, and the report is available for consultation. The evaluation emphasized the need to focus on issues that could be effectively addressed during the available time frame. For example, the primary recommendation was to identify and strengthen priority interventions for IDUs, hotel-based sex workers, MSMs, 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 addressed coordination and collaboration, strategic information, and continuous improvement of successful interventions.

The evaluation recommendations also reflected a parallel desire and opportunity for USAID to make a more strategic contribution through mechanisms such as the Global Fund and SWAps.

The recommendations were addressed in designing the follow-on for BAP, the Modhumita HIV Prevention Program, and reflected in results expected from the follow-on project.

Modhumita HIV Prevention Project Intent

The Modhumita Project serves as the follow-on program to BAP and continues with the current approach of HIV prevention through working with MARPs, maintaining current coverage rates and improving the quality of services for the vulnerable groups. This project fills a unique niche by focusing on effective use of HIV prevention services for the MARPs. It is located in 18 high-risk urban areas across Bangladesh.

Project Development Hypothesis

If USAID/Bangladesh provides improved prevention, care and treatment services for MARPS, then the HIV prevalence among MARPS will stay below 5%.

It is assumed that the Modhumita Project's interventions will strengthen GOB leadership, coordination and use of data for decision-making, and thereby strengthen the national response to HIV/AIDS.

Project Goals and Objectives:

The goal is that Bangladesh maintains HIV seroprevalence of less than 5% among MARPs. The Modhumita Project objective is to: "Support an effective HIV/AIDS prevention strategy through improved prevention, care and treatment services for most-at-risk populations (MARPs) and a strengthened national response"

The Modhumita Project seeks to achieve this objective by pursuing two results:

Result 1: *Increased and sustained use of high-impact HIV prevention, care and treatment services by MARPs through high-quality, evidence-based and holistic program approaches.*

Result 2: *Strengthened government leadership, multilevel coordination and use of data for decision-making to support HIV/AIDS prevention efforts and effective programming for MARPs.*

Project Priorities:

The priorities of the Modhumita Project are to increase the commitment and capacity of the GOB and local NGOs to provide appropriate, cost-effective targeted interventions, including clinical services for MARPs; strengthen service delivery; integrate HIV programming with other programs mostly through nonfunded partnerships with other agencies (e.g., TB, FP/RH, primary health care information and services); and help build a supportive environment to strengthen HIV prevention services including efforts to reduce violence, stigma and discrimination associated with HIV and membership of MARPs.

The Modhumita Project also assists in strengthening the national policy environment, improving data analysis, enhancing the use of data for decision-making, knowledge sharing and advocacy. The Modhumita Project provides support for the GOB to ensure the stewardship and strategic leadership for the national response and pledges to work within the parameters of the National AIDS/STD and TB Programs.

The project activities will prioritize:

- Reaching MARPs, particularly people who inject drugs, men who have sex with men, transgender, and hotel-based sex workers, educating them on the effectiveness and acceptability of HIV preventive services and providing VCT services to detect their disease status;
- Expanding use of condom, reduce needle sharing among PWID, and build provider capacity in monitoring and follow-up of the targeted MARPs;
- Reaching PWID with innovative programs to economically rehabilitate them into the community and monitor their drug-free status after recovery;
- Reaching PLWHA with care and support services, including referrals for antiretroviral treatment (ART);
- Integrating HIV information and services into TB control and FP/RH programs;
- Expanding community networks to carry forward HIV prevention messages;
- Implementing advocacy activities to reduce stigma and discrimination;
- Coordinating effectively with other partners on mapping of at-risk populations, size estimation and coverage rates;
- Focusing HIV information and services in high-risk areas and developing an annual work plan that reflects collaboration and opportunities for synergies with USAID partners and non-USAID organizations that currently are working in HIV;
- Identifying needed policy changes to strengthen HIV prevention programs;
- Educating and involving mainstream health service providers as a resource to strengthen care and support services;
- Assisting the GOB with updated guidelines on clinical and outreach services;
- Developing models of innovative interventions for the vulnerable groups and conducting advocacy with GOB and other donors for scale-up of effective interventions; and
- Identifying critical gaps in the national response and implementing activities to fill in gaps.

The project supports HIV Service Centers that undertake a targeted communications approach with MARPs and the associated populations. The project's activities focus on strategic geographic and epidemiological hotspots, and targeted interventions for MARPs will be identified and coordinated with GOB, USAID and other funding partners.

VI. EVALUATION PURPOSE

This external evaluation is a midterm, formative evaluation whose objectives are to help determine what components and project aspects are working well and why, which perhaps are not and why, to take into account any new and significant contextual information, and to make modifications and mid-course corrections if necessary to help guide FHI and its partners over the second half of project implementation. Specifically, the contractor should examine how

successful FHI360 has been in building the organizational and technical capacities of the GOB, NGOs and the private sector for the implementation of high-impact HIV prevention, care and treatment services to MARPs. The evaluation should identify barriers to, as well as ongoing TA needs and recommendations for improving the capacity development of government for leadership of HIV/AIDS prevention efforts, specifically their ability to coordinate and use of data for decision-making to support effective programming for MARPs. The evaluation should clarify the value-added of USAID's investments to the national response to HIV/AIDS, and should recommend how USAID could direct any future efforts in this area. In summary, the evaluation will help all involved to better understand the midterm results and contributions of the project, and help to refocus and strengthen it.

VII. AUDIENCE AND INTENDED USE

The prime audience of this evaluation report will be the USAID/Bangladesh Mission, specifically the Office of Population, Health, Nutrition and Education (OPHNE) Team, the USAID/Asia Bureau and Bureau for Global Health/Office of HIV/AIDS, and the implementing partners, FHI360, in partnership with SMC and BCCP. An executive summary and recommendations will be provided to the MOHFW. USAID will use the report to make changes to the project if warranted. The USAID Evaluation Policy dictates transparency and active and wide sharing of results, which requires that USAID make a description of methods, key findings and recommendations available to the public online within three months of the evaluation's conclusion. As with all program evaluations, transparency must be balanced with diplomacy. Thus, USAID/Bangladesh will maintain a version of the evaluation report that contains potentially procurement-sensitive information regarding the recommended future of USAID investments, while widely circulating an identical version of the evaluation report that omits this sensitive information through the Development Experience Clearinghouse (DEC) and to implementing partners and other stakeholders, including the GOB.

VIII. EVALUATION QUESTIONS

The evaluation should document the findings on the following questions.

1. How effective has the project been in increasing and sustaining use of high-impact prevention, care and treatment services by MARPs?
2. To what extent is the project strengthening the national program's leadership capacity in managing national HIV/AIDS activities and strengthening health systems in Bangladesh?
3. What are the barriers to increased service delivery and capacity development and are there any recommended changes to the current TA structure?
4. To what extent has the Modhumita Project been able to support the scale-up of innovative approaches to HIV prevention among MARPs in Bangladesh?
5. How does the project meet the national needs and fill critical gaps in responding to the national strategy on HIV/AIDS?
6. Should the project continue implementing interventions at the same level or with changes during its final project years and what are the cost implications?
7. If USAID were to take a more comprehensive approach to supporting HIV interventions in Bangladesh, how should USAID target its increased investments?

Note: During the team planning meeting conducted during the first two days of field work with the entire evaluation team in Dhaka, the evaluation team suggested to the Mission changes to the original evaluation questions. The Mission concurred with the changes. The original Evaluation Question #6 was as follows:

Should USAID continue funding this activity at the same level, at a reduced level or should USAID enhance its engagement on HIV activities, pending the availability of funds? If USAID were to take a more comprehensive approach to supporting HIV interventions in Bangladesh, how should USAID targets its increased investments?

The revised evaluation questions split the original question into two parts, with the new Evaluation Question #6 focused on project programming during the remaining life of project and the new Evaluation Question #7 addressing recommendations for USAID/Bangladesh regarding future investments in HIV/AIDS.

IX. EVALUATION DESIGN AND METHODOLOGY

This will be an external evaluation, but should be conducted in consultation with the Bangladesh/OPHNE Team and FHI360 to ensure that the team has the fullest possible background and contact information. 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. The methodology should combine a review of quantitative and qualitative evaluation techniques and approaches to obtain information, opinions, and data from counterparts, contractors, partners, clients, beneficiaries, GOB entities, and other donors. The approach should also be participatory and should involve the use of questionnaires as appropriate.

The evaluation team should begin work with a desk review of the following project documents provided by USAID/Bangladesh and a broad range of other background documents that may include documents that relate to HIV/AIDS testing and counseling services, social marketing of health commodities and communication strategies that seek behavior change—particularly in increasing public knowledge of HIV risks. This review will provide useful background information on the Modhumita Project's progress and constraints in relations to the achievement of the project's objective and expected results. USAID and the Modhumita Project will provide the assessment team with a package of briefing materials, including:

- The Program Description for the Modhumita HIV Prevention Project
- Project quarterly and annual reports, work plans and management reviews developed as part of routine monitoring
- Project Monitoring and Evaluation Plan
- The World Bank-UNAIDS publication: 20 Years of HIV in Bangladesh—Experiences and Way Forward
- National HIV Serological Surveillance Report (2007)
- Behavioral Surveillance Survey Report 2009
- Joint Assessment of Targeted Interventions for HIV in Bangladesh (2009)

- National Strategic Plan for HIV/AIDS 2011-2015
- Midterm evaluation of the Bangladesh AIDS Program, September 2007
- The GHI Bangladesh Strategy
- USAID/Bangladesh Country Development Cooperation Strategy 2011-16 (Draft- as cleared by the front office)

The team will also find the USG PEPFAR Guidelines as useful consultation documents for evaluating the project activities. The team may also find the FHI360 Web site (www.fhi360.org) and background information on the state of the Bangladesh health care system useful. The team should review other public documents relevant to the project.

It is anticipated that the evaluation team leader, assisted by the two evaluation members, will facilitate and conduct a two-day team planning meeting before starting the evaluation. USAID/Bangladesh's focal person will participate in the two-day team planning meeting. The agenda will include but not be limited to the following items:

- Clarify team members' roles and responsibilities;
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion;
- Finalize a *work plan* for the evaluation;
- Review and request clarifications on *evaluation questions*;
- Review and finalize the *assignment timeline* and share with USAID;
- Finalize *data collection plans and tools*;
- Review and clarify any logistical and administrative procedures for the assignment;
- Develop a *preliminary draft outline* of the team's report; and
- Assign drafting responsibilities for the final report.

X. DATA COLLECTION METHODS:

Data collection methodologies will be discussed with and approved by USAID prior to the start of the evaluation. As a lessons learned from previous evaluations, the midterm and final evaluation needs to be carried to the extent possible in a **positive** and **participatory approach**.

By reviewing both quantitative and qualitative information, the evaluation team will gain insight on the impact of the Modhumita Project's activities (mostly from quantitative) and the processes (mostly qualitative) that lead to those impacts. Sequential and iterative approaches should be used to integrate the mixture of methods at various stages of the evaluation.

XI. DATA ANALYSIS METHODS

Prior to information gathering, the evaluation team will develop and present, for USAID review and approval, a data analysis plan that details how stakeholder interviews will be transcribed and

analyzed; what procedures will be used to analyze qualitative data from key stakeholders interviews; and how the evaluation will weigh and integrate qualitative data from these sources with quantitative data from project monitoring records to reach conclusions.

XII. DELIVERABLES

Work Plan: During the team planning meeting, the evaluation team will prepare a detailed work plan, which will include the methodologies (including the operational work plan & evaluation design) to be used in the evaluation. The work plan will be submitted to the AOTR at USAID/Bangladesh for approval no later than the sixth day of work in-country.

Detailed Report Outline: During the team planning meeting, the evaluation team will prepare a report outline that will be submitted with preliminary findings prior to debriefs at the conclusion of the in-country portion of the assignment.

Debriefing with USAID: The team will present the major findings of the evaluation to USAID/Bangladesh through a PowerPoint presentation. The debriefing will include a discussion of achievements and issues as well as any recommendations the team has for possible modifications to project approaches, results, or activities. The team will consider USAID comments to revise parts of the draft report accordingly, as appropriate.

Debriefing with Partners: The team will present the major findings of the evaluation to USAID partners (as appropriate and as defined by USAID) through a PowerPoint presentation prior to the team's departure from the country. The debriefing will include a discussion of achievements and activities *only*, with no recommendations for possible modifications to project approaches, results, or activities. The team will consider partner comments and revise the draft report accordingly, as appropriate.

Draft Evaluation Report: After debriefing, the evaluation team leader will submit a draft of the final report on the findings and recommendations to the USAID AOTR/COTR prior to the team leader's departure from Bangladesh. The written report should clearly describe findings, conclusions, and recommendations. USAID will provide comment on the draft report within five days of submission.

Final Report: The team will submit a final draft report to GH Tech Bridge II and USAID incorporating the team responses to Mission comments and suggestions no later than five days after USAID/Bangladesh provides written comments on the team's draft final evaluation report (see above). The final report will then be edited/formatted by GH Tech Bridge if the final draft is approved by USAID/Bangladesh prior to November 30, 2012. GH Tech Bridge II will provide the edited and formatted final document approximately one month after USAID provides final approval of the content. If USAID/Bangladesh is not able to sign off on the final draft before November 30, USAID/Bangladesh may need to go through another mechanism to finalize the report.

The format of the final report will include a table of contents, executive summary, methodology, findings, and recommendations. The report will be submitted in English, electronically. The report will be disseminated within USAID. A second version of this report excluding any potentially procurement-sensitive information will be submitted (also electronically, in English) for dissemination among implementing partners and stakeholders. It will be posted on DEC and the GH Tech Web site.

XIII. REPORTING GUIDELINES

The findings from the evaluation will be presented in a draft report at a full briefing with USAID/Bangladesh and possibly at a follow-up meeting with key stakeholders.

The format for the evaluation report is as follows:

1. **Table of contents**
2. **Executive Summary**—concisely state the most salient findings and recommendations (2 pp);
3. **Introduction**—purpose, audience, and synopsis of task (1 p);
4. **Background**—brief overview of Modhumita Project in Bangladesh, USAID program strategy and activities implemented in response to the problem, brief description of FHI, purpose of the evaluation (2-3 pp);
5. **Methodology**—describe evaluation methods, including constraints and gaps (1 pp);
6. **Findings/Conclusions/Recommendations**—for each objective area; and also include data quality and reporting system that should present verification of spot checks, issues, and outcome (17-20 pp);
7. **Issues**—provide a list of key technical and/or administrative, if any (1-2 pp);
8. **Future Directions** (2-3 pp);
9. **References** (including bibliographical documentation, meetings, interviews and focus group discussions);
10. **Annexes**—useful for covering evaluation methods, schedules, interview lists and tables--should be succinct, pertinent and readable.

The final unedited draft version of the evaluation report will be submitted to USAID/Bangladesh in hard copy (5 copies) as well as electronically. The report format should be restricted to Microsoft products and 11-point type font should be used throughout the body of the report, with page margins one inch top/bottom and left/right. The report should not exceed 30 pages, excluding references and annexes.

Upon submission of the draft evaluation report to USAID prior to the evaluation team's departure from Bangladesh, which should incorporate the oral comments provided by USAID at the debriefing, the Mission shall have five days to provide written comments on the draft report. The evaluation team will then have five days to incorporate these comments and to submit a final draft of the report to the Mission and to GH Tech. USAID then has three days to approve the final draft and/or send final comments. The Team Leader then has an additional three days to make any necessary changes to the final draft, if necessary.

GH Tech Bridge II will provide an electronic version of the edited and formatted final document about one month after USAID provides final approval of the content. The report will then be released as a public document on the USAID Development Experience Clearinghouse (DEC) (http://dec.usaid.gov) and the GH Tech Project Web site (www.ghtechproject.com).

XIV. TEAM COMPOSITION/SKILLS AND LEVEL OF EFFORT

A team of four members will work on the evaluation team. GH Tech Bridge II will hire two independent consultants and other team members will be staff from USAID/W and from CDC. The team should include specialists with the following areas of expertise: HIV/AIDS and infectious diseases, behavior change communication/community mobilization, monitoring & evaluation, and sustainability and health systems.

The Team Leader should be an international consultant and a team member will be the local technical consultant who should be fluent in Bangla, and have an excellent understanding of the Bangladesh public health system.

Team Leader/Technical Specialist: Should be an independent consultant and have an MPH or related postgraduate degree in public health. S/he should have at least 10 years senior-level experience working in health systems programs in a developing country. S/he should have extensive experience in conducting qualitative evaluations and assessments. Excellent oral and written skills are required. The team leader should also have experience in leading evaluation teams and preparing high-quality documents. This specialist should have wide experience in implementation of USAID-funded HIV programs and should have a good understanding of health systems in South Asia, preferably in Bangladesh. S/he should also have a good understanding of project administration, financing, and management.

The team leader will take specific responsibility for assessing and analyzing the project's progress towards quantitative targets, factors for such performance, benefits/impact of the strategies, and compare with other possible options. The team leader will also look at the sustainability of Modhumita Project approaches and activities as well as the ability of the project to leverage and influence MOHFW and Global Fund programming, including adoption of Modhumita Project innovations by the MOHFW.

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. S/he will provide leadership for the team, finalize the evaluation design, coordinate activities, arrange meetings with the help of the local administrative assistant, consolidate individual input from team members, and coordinate the process of assembling the final findings and recommendations. S/he will also lead the preparation and presentation of the key evaluation findings and recommendations to the USAID/Bangladesh team and key partners. The team leader will submit the draft report, present the report and after incorporating USAID Bangladesh staff comments, submit the final draft report to USAID/Bangladesh within the prescribed timeline.

HIV/AIDS and M&E Specialist: The HIV/AIDS specialist will have at least 7-10 years of experience in management of, or consulting on, HIV and RH programs. S/he should have a proven background and experience in HIV and a strong understanding of the challenges facing HIV program in Bangladesh with wide experience in implementation of behavior change communication, as well as community mobilization programs in the areas of HIV/AIDS. S/he should also have a good understanding of the relevant national programs in HIV, FP/RH and MCH, including the public and private sector.

The HIV/AIDS specialists will be responsible for assessing the ability of the project to achieve outcomes in HIV and provide technical leadership in HIV. The HIV/AIDS specialist will also

assess the technical quality of the Modhumita Project's HIV interventions. S/he will analyze the project's service delivery and capacity building interventions and assess the effectiveness and appropriateness of the approaches adopted by the project. S/he will document key lessons learned and provide recommendations for modifications in approach, results, or activities. S/he will also look at the sustainability of project approaches and activities as well as the ability of the project to leverage and influence MOHFW and Global Fund programming, including adoption of Modhumita Project innovations by the MOHFW.

Logistics Coordinator: GH Tech will also hire a logistics coordinator who will serve under the Team Leader. Duties will be determined in consultation with the Team Leader but are likely to include providing translation services as necessary for the Team Leader; arranging logistics for the team; and assisting the Team Leader as directed in all aspects of completing evaluation deliverables.

XV. LOGISTICS

Funding and Logistical Support

The proposed assessment will be funded through GH Tech Bridge II using Mission field support funds. GH Tech will provide technical and administrative support, including identification and fielding appropriate consultants.

GH Tech will be responsible for all offshore and in-country logistical support. This includes arranging and scheduling meetings, international and local travel, hotel bookings, working/office spaces, computers, printing, and photocopying. A local logistics coordinator will be hired to arrange field visits, local travel, hotel and appointments with stakeholders.

Scheduling

O/a October 2012 through o/a December 2012, pending consultant availability with in-country work preferably starting o/a November 4th. The following represents a rough time line.

Task Deliverable (days for completion)	Total LOE	Team Leader LOE	Regional Consultant LOE	Logistics Coord. LOE
Planning for team arrival (6 days)	6 days			6 days
Review of background documents and offshore preparation work including calls to Mission to set up appointments and site visits (3 days)	7 days	3 days	3 days	1 day
Int'l team members travel to Bangladesh (2 days)	4 days	2 days		
Team planning meeting, preparation for field work and in-brief with USAID (2 days)	6 days	2 days	2 days	2 days
Information gathering, including interviews with key informants (stakeholders and USAID staff) and site visits (8 days)	24 days	8 days	8 days	8 days
Discussion and analysis in country including discussion with OPHNE and report writing (3 days)	6 days	3 days	3 days	
Debrief meetings with 1) USAID (with PowerPoint) and 2) partners & other stakeholders, including GOB (1 day)	2 days	1 day	1 day	

Task Deliverable (days for completion)	Total LOE	Team Leader LOE	Regional Consultant LOE	Logistics Coord. LOE
Incorporate feedback from debrief meetings and submit draft report (1 day)	2 days	1 day	1 day	
Depart Bangladesh/Travel home (2 days)	4 days	2 days		
USAID and partners provide comments on draft report (8 days)				
Team revises draft report and submits final draft to USAID and GH Tech (5 days)	8 days	5 days	3 days	
USAID to approve final draft and/or send final comments for incorporation (5 days)				
Team Leader to make any necessary final draft changes as necessary (3 days)	4 days	3 days	1 day	
GH Tech to edit and format final report (one month)				
Total Estimated LOE	73 days	30 days	22 days	17 days

A six-day work week (Saturday-Thursday) is authorized for the assessment team while in Bangladesh.

XVI. RELATIONSHIPS/RESPONSIBILTIES

GH Tech will coordinate and manage the evaluation team and will undertake the following specific responsibilities throughout the assignment:

- Recruit and hire the evaluation team.
- Make logistical arrangements for the consultants, including travel and transportation, country travel clearance, lodging, and communications.

USAID/Bangladesh will provide overall technical leadership and direction for the evaluation team throughout the assignment and will provide assistance with the following tasks:

Before In-country Work

- SOW. Respond to queries about the SOW and/or the assignment at large.
- Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CVs for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- Documents. Identify and prioritize background materials for the consultants and provide them to GH Tech, preferably in electronic form, at least one week prior to the inception of the assignment.
- Local Consultants. Assist with identification of potential local consultants, including contact information.
- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.

- Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation) and if necessary, identify a person to assist with logistics (i.e., visa letters of invitation etc.).

During In-country Work

- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.

- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).

- Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders.

- Facilitate Contact with Implementing Partners. Introduce the evaluation team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After In-country Work

- Timely Reviews. Provide timely review of draft/final reports and approval of deliverables.

XVII. MISSION CONTACT PERSON

Primary:
Thibaut Williams
Agreement Officer's Representative (AOR)
Office of Population, Health and Nutrition
USAID Bangladesh
Tel: 880-2-885 5500 x 2515
Cell: 01713-009879
Email: twilliams@usaid.gov

Alternate (to be cc'ed on all correspondence):
Dr. Sukumar Sarker
Alternate AOR
Office of Population, Health and Nutrition
USAID Bangladesh
Tel: 880-2-885 5500 x 2313
Cell: 01713-009878
Email: ssarker@usaid.gov

XVIII.COST ESTIMATE

GH Tech will provide a detailed cost estimate for this activity.

APPENDIX B. PERSONS CONTACTED

BANGLADESH

Ashar Alo Society (AAS; targets PLHIV)

Habiba Acter, Executive Director

Asma Parvin, Deputy Director

Md. Sanman Hossinin, Project Coordinator

Sabiha Yasmin, VCT Counselor

Mohammed Ali, Counselor

Dr. Mahmudul Hasan, Sr. Medical Officer

Dr. Nilufan, Medical Consultant

Sadia Atrin Zeetu, Admin Officer

Md. Sanwar Hossain, Project Coordinator, Mohammadpur

Asma Labib, Deputy Director, Sylhet

Tahmina, Divisional Director, Sylhet

Arif, Counselor, Sylhet

Sanowar, Project Coordinator, Sylhet

Rahman, Peer Counselor, Sylhet

Badhan Hijra Sangho (targets TG persons, MSWs)

Md. Jahirul Haque Buiyan, Center Manager

Met with 30+ *hijra* (names not included for privacy considerations)

Bandhu Social Welfare Society (targets TG persons, MSWs)

Didarul Alam, Program Officer, Dhaka

Nazrul Barat Ron, Sr. Advocacy Officer, Chittagong

Md. Nazmul Hoque, Sr. Program Officer, Chittagong

Md. Molrib Ulla, Co. MACCA, Chittagong

ASM Rahmat Ullah Bhuriya, Global Fund Program Manager

Bangladesh Center for Communications Program (BCCP; Project Consortium Member)

Dr. Zeena Sultana, Deputy Director

Bangladesh Rural Advancement Committee (BRAC; targets TB patients)

Morntaz Nassim, Project Officer

Dr. Naznin Sarkr, Sr. Medical Officer

Md. Saiful Islam, District Manager

Md. Yeamim Miah, Sector Specialist

Momotaz Nasrin, Counselor

Bangladesh Women's Health Coalition (targets FSWs)

Md. Rezaul Karim, Project Manager

Care Bangladesh

Dr. Rupali Sisir Banu, Team Leader, Global Fund HIV Program

Md. Abu Taher, Team Leaders, EMPHASIS Project HIV Program

Chittagong Medical College & Hospital

Prof. Dr. A.Q.M. Serajul Islam, Professor, Head of Dermatology & STDs

Confidential Approach to AIDS Prevention (CAAP; VCT Center)

Dr. Halida Hanum Kahandker, Executive Director

Dr. Md. Rashidul Hoque

Noor Naharbegum, Advocacy Officer

Sayed Tanverhabib

Dr. Ucol Jebunneni Begim, Coordinator

Dhaka Ahsania Mission (targets PWID)

Mr. Md. Mosharrof Hossain, Center Manager

Family Health International (FHI) 360 (Modhumita Project Prime Partner)

Misti McDowell, Country Director

Dr. Nadia Farheen Rahman, Technical Director

Sultana M. Aziz, Senior Technical Officer/Team Leader, SBC

Nadira Yasmin, Technical Officer/Team Leader, Monitoring & Evaluation

K.S.M Tarique, Senior Program Officer/Team Leader, Program

Global Fund-Supported MSM Drop-In Center, Sylhet

Faruque Ahmed, Center Manager

Shadat Hossain, Advocacy Officer

Haran Kumar, Counselor

Government of Bangladesh, Civil Surgeon Office, Sylhet

Dr. Md. Qamrul Islam, Civil Surgeon

Government of Bangladesh, Director General, Health Services

Dr. Sefayet Ullah, Director General

Government of Bangladesh, Divisional Health Office, Chittagong

Dr. Sheikh Shahabuddin Ahmed, Divisional Director

Dr. Salauddin Mahmud, Assistant Director

Government of Bangladesh, Divisional Health Office, Sylhet

Dr. Iqbal Hossain Chowdhury, Divisional Director, Health

Government of Bangladesh, Health Education Bureau

Dr. Wahid Akhand, Chief

Government of Bangladesh, Ministry of Home Affairs

Mohammad Iqbal, Director General, Department of Narcotics Control

Md. Amir Hussain, Assistant Director General, Department of Narcotics Control

Aktaruzzman Md. Mostofo Kamal, Director, Treatment, Department of Narcotics Control

Dr. Md. Akhtaruzzaman, Resident Psychiatrist, Central Drug Addiction Treatment Center

Government of Bangladesh, National AIDS/STD Program (NASP)

Dr. M Abdul Waheed, Line Director

Government of Bangladesh, Sylhet Medical College

Dr. Sibbir Ahmed, Head of Community Medicine

Institute of Epidemiology, Disease Control & Research (IEDCR) & National Influenza Centre, Bangladesh

Professor Mahmudur Rahman, PhD, Director

International Center for Diarrheal Disease Research, Bangladesh (ICDDR, B)

Dr. Tasnim Azim, Director, Centre for HIV and AIDS

Dr. Sharful Islam Khan, Project Director, Centre for HIV and AIDS

Dr. Tanveer Khan Ibne Shafiq, Medical Officer, OST Pilot Study, Centre for HIV and AIDS

Symoom Md. Abu Sayem, Senior Field Research Officer, OST Pilot Study, HIV/AIDS Programme, Laboratory Sciences Division

International Organization for Migration (IOM)

Sarat Dash, Chief of Mission

Dr. Samir K. Howlader, National Programme Officer, Migration Health Department

Md. Saiful Islam Shaheen, Training Officer, Migration Health Department

Islamic Foundation Bangladesh

Shamim Mohammed Afzal, Director General

Md. Taher Hossain, Director, Training

Md. Shahabuddin Khan, Director, Planning

Maulana Abdullah Al-Maruf, Director, Translation and Editing

Syed Mohammed Shah Amran, Deputy Director, Imam Training

Zahangir Hossain, Deputy Director, Imam Training

Joint United Nations Program on HIV/AIDS (UNAIDS)

Leo Kenny, Country Coordinator

Dr. Munir Ahmed, Social Mobilization & Partnership Advisor

Mukto Akask (targets HIV-Infected PWID)

Nazurl Islam, Program Officer, Baksibazar

National Institute of Diseases of the Chest and Hospital

Dr. Khairul Hassan Jessy, Medical Officer

Samaj Kalyan O Unnayan Shangstha, Social Welfare and Development Organization, Chittagong

Md. Salah Uddin, Assistant Director

Gosho Chowdhary, Drop-In Center Manager

Save the Children Inc.

Dr. Simon Rasin, Director, HIV/AIDS Sector

Dr. Rima Rahman, Deputy Director, Management and Program Implementation

Save the Children International (SCI), Sylhet (Global Fund-supported drop-in center for PWID)

Morshed Billal Khan, Manager, HIV & AIDS, Save the Children

Shymol Borua, Sr. Officer, Technical Intervention, Save the Children

Subir Chandra Das, Center Manager

Shustho Jibon (targets TG persons/MSWs)

Bakul Haji, Executive Director

Met with 30+ hijras (names not included for privacy considerations)

Social Marketing Company (SMC; Project Consortium Member)

Dr. A Z. M Zahidur Rahman, Head, Behavior Change Communication

Dr. A. S. M. Habibullah Chowdhury, Program Coordinator and Focal Person, Bangladesh AIDS Program

Toslim Uddin Khan, General Manager, Program

Ashfaq Rahman, Managing Director

Md. Mahbubur Rahman, Head of Marketing

Shamser Uddin Mostafa, Program Officer, Chittagong

Md. Shafiqul Islam, Counselor, Chittagong

G.M. Kawsar Talukdar, Lab Technologist, Chittagong

Md. Rahmat Ullah, Program Organizer, Chittagong

Bakul Kummar Modak, Program Organizer, Chittagong

Abida Sultana, Program Organizer, Chittagong

Md. Abdul Gani Khan, Sputum Collector, Chittagong

Abdul Hossen, Community Volunteer, Chittagong

Md. Mahmud, Teacher, Chittagong

Amir Hossen, Trader, Chittagong

Md. Shohel, Student, Chittagong

Rana Das, Student, Chittagong

Mahbubur Rahman Sharif, Program Officer, Sylhet

Joyesree Talukdar, Program Organizer, Migrant, Sylhet

Sylhet Jubo Academy (targets FSWs)

AHM Faisal Ahmed, Executive Director

Romendro Narayan Das, Center Manager

Nishi Kanta Chanda, Project Manager

Shymol Kumar Sen, Finance & Administration Officer

Dolon Kanto Chowdhury, Outreach Supervisor

Faisal Alam, Office Assistant

Moulana Asanuddin, Religious Leader and PFT Member

United Nations Office on Drugs and Crime (UNODC)

ABM Kamrul Ahsan, HIV & AIDS Specialist

United States Agency for International Development (USAID)

Richard Greene, Mission Director

Gregory Adams, Acting Director, Office of Population, Health, Nutrition & Education

Sukumar Sarker, Senior Clinical Officer, Office of Population, Health, Nutrition & Education

Samina Choudhury, Project Management Specialist, Office of Population, Health, Nutrition & Education

Marunga Manda, Evaluation Specialist, Program Office

Jeff de Graffenreid, Officer, Program Office

Kaiser Ali, Contract Specialist, Office of Acquisition & Assistance

Young Power in Social Action (targets FSWs)

Farhana Lobris, Technical Officer

Shilamoni, Paramedic

Shakila Yesmin, Center Manager

Khaleda Roegum, Program Manager

Soman Mondol, Microbiologist

Aghrab-ul-Hossain, Outreach

Mosammat Layli, Outreach Supervisor

APPENDIX C. MIDTERM EVALUATION CALENDAR

Date	Activity		Notes
Sat Nov 3	Team members arrive in Dhaka		Abu arrives : Nov 02 at 8:05 Mary arrives Nov, 03 at 15:15, Flight :EK 586 Hassan : in country Consultants collected at airport by hotel (Lakeshore) shuttle Billy, Darrin, Abu collected by the Embassy
Sun Nov 4	Team planning meeting	8:30–17:00	TPM venue: Hotel Lakeshore (Same hotel team members staying) Billy arrives : Nov 04 at 5:15 Darrin arrives : Nov 04 at 5:15
Mon Nov 5	Team planning meeting	8:30–1:00	TPM venue: USAID/Embassy
	Meet USAID mission; depart from hotel at 2:00 pm	2:00–5:00	Email USAID evaluation work plan/calendar for review
	In-brief with Mission Director Richard Greene	3:30–4:00	
	In-brief with health team	4:00–5:00	
Tues Nov 6	Modhumita Project briefing (9:00–11:00; FHI offices; depart from hotel at 8:40)		Transport for the day: hired car for the consultants
	Meet SMC (Mary, Hassan, Darrin) and BCCP (Abu, Billy) at FHI venue : Possibly break into two groups	11:00–12:00	Daily Team briefing meeting time is flexible and subject to team members' decision on daily basis.
	All have lunch around FHI then UNAIDS team leaves around 1pm		UNAIDS Mr. Leo Kenny, Coordinator IDB Bhaban, Agargaon, Dhaka
	Stakeholder interview : Team A—UNAIDS; IDB Bhaban	2:00–3:30	
	Team B–LD-NASP, Gulshan-1	2:00–3:30	NASP Dr. Dr. M A Wahid Line Director, NASP
	UNAIDS: Abu, Billy, Darrin NASP: Thibaut, Mary, Hassan		
	Team debriefing at Lakeshore :	5:00–5:45	

Date	Activity	Notes
Wed Nov 7	Health and Program Office Meeting Leave the hotel: 8:15 Team A: Abu, Hassan, Darrin Team B: Billy, Mary, Thibaut Stakeholder interview : Everyone: Head of HIV program, ICDDR, B 9:00–10:30 Stakeholder interview : Team visit to SMC 11:00–12:00 Lunch: 12:00–1:00 pm Team A: Billy, Abu, Team B: Darrin, Hassan, Mary, Thibaut Stakeholder interview : Team A–SCI; Gulshan 3:30–4:30 Team B–CARE; Kawran Bazar 2:00–3:30 Team debriefing at Lakeshore : 5:00–5:45	ICDDR, B Dr. Tasnim Azim Head of HIV Program House 13, Road 8, Block G, Niketan, Gulshan-1 Social Marketing Company (SMC) Dr. Zahid Hossain Social Marketing Company SMC Tower, 33 Banani C/A Dhaka–1213 01710956834 Save the Children Inc. Dr. Simon Rasin Director HIV/AIDS Sector House 35, Road 43, Gulshan 2, Dhaka CARE Dr. Rupali Sisir Banu, HIV Program Progoti Tower, Kawran Bazar, Dhaka
Thurs Nov 8	Health and Program Office Meeting Team A: leave hotel: 7:30 Abu, Thibaut, Darrin, Team B: leave hotel at 7:30 Billy, Mary, Hassan Stakeholder interview : Team A–Dhaka Ahsania Mission/PWID; Nimtoli 9:00–10:00 Team B–SustaJbn/TG persons-MSW;Savar 9:00–10:00 Stakeholder interview : Team A–Mukto akas/PLHIV; Baksibazar 11:30–12:30 Team B–Bandhu/MSW; Mirpur 11:30–12:30 Lunch: 1:30–2:00 pm interview :	Dhaka Ahsania Mission/PWID; Nimtoli Mr. Md.Mosharrof Hossain, Center Manager 143/1 Nawbab Katra ,Nemtolly (3rd Floor), Dhaka-1000 Cell # 01733-546768 SustaJbn/TG-MSW;Savar Mr. Bakul Haji Taltola (Dakkhin Para), Islampur, Dhamrai, Savar, Dhaka Cell : 01716-413643 Bangladesh Women's Health Coalition/FSW; Mohakhali Mr. Md. Rezaul Karim, Project Manager

Date	Activity		Notes
	Team A–Bangladesh Women's Health Coalition/FSW; Mohakhali Team B–Asar Alo/PLHIV; Md.pur Team debriefing at Lakeshore :	2:00–3:30 2:00–3:30 5:00–5:45	64/2 , New Airport Road, Mohakhali, Dhaka –1212 Cell : 01713-011612 Bandhu/MSW; Mirpur Ms. Lucky Akhter, Program Officer Mirpur: House-31/KHA, Road-03, Uttor Beshil, Mirpur-1, Dhaka-1216 Phone: 9010206, Cell: 01923345179 Ashar Alo/PLHIV; Mohammadpur Mr. Md. Sanwar Hossain, Project Coordinator 8/1, Aurangajeb Road (2nd Floor), Mohammadpur, Dhaka-1207, Phone: +880-2-9133968, 8159268 Mukto Akash/PLHIV; Baksibazar Mr. Nazrul Islam, Program Officer 5 Nabab Katra, Nimtoli, Bakshibazar, Dhaka Cell: 01818-405965
Fri Nov 9	DAY OFF : Team A: Chittagong: Billy, Darrin, Hassan Team B: Sylhet: Abu, Thibaut, Mary Dhaka—Chittagong : Nov 09, at 10:10 am (approx 40 min fly) Leave hotel: 8:00 Dhaka—Sylhet ; Nov 09, at 12:50 pm (approx 40 min fly) Leave hotel: 11:00		Driver—Sylhet –Mr. Selim, 01199036393 Mr. Jebul, 01712497254 Driver–Chittagong—Mr. Mansur, 01813672654
Sat Nov 10	Health and Program Office Meeting Stakeholder interview : Team Syl–Asar Alo/PLHIV; Uposahar Team Ctg–SMC/COSW; W Madarbari Stakeholder interview : Team Syl–Syl Jubo Academy/FSW; Uposahar Team Ctg–Global Fund site) Lunch at Hotel (ctg/Agrabad, Syl/Rose Valley) : 1:30–2:30 pm	 9:00–10:30 9:00–10:30 11:00–12:30 11:00–12:30	Ahsar Alo/PLHIV; Shahjalal Uposahar Ms. Tahmina Begum, Divisional Coordinator House # 6 (1st floor) Road # 31, Block D, Shahjalal Uposhohor, Sylhet Phone-0821-812053 Cell: 01711-315138 SMC/COSW; W Madarbari Mr. Shamsher Uddin Mostafa, Program Officer

Date	Activity		Notes
	Stakeholder interview : Team Syl–Global Fund site	2:00–4:00	Nasrin Villa, 1st Floor, 274 D/T Lane, West Madarbari
	Team Ctg–Bandhu/MSW; Muradpur	2:00–4:00	Chittagong Cell: 01817-771222/01716-614541
	Team debriefing at Hotel:	5:00–5:45	Monsurabad PWID Drop-In Center Bandhu Manshion (1st floor) , Kashai para, Tempu Garage New Munsurabad , Kornel Hat, Chittagong *Implementing Partner: Samaj Kalyan O Unnayan Shangstha* Mr. Salah Uddin Assistant Director Cell : 01817771809 Mr. Gishu Chowdhiry Drop-In Center Coordinator Cell: 01822444064 Sounth Surma PWID Drop-In Center "Turab House" Momin Khola Raster Mukh, Humayun Rashid Squire, Fenchuganj Road, Sylhet *Implementing Partner: SCI*–Direct Implementation Mr. Morshed Khan Manager—TC, Learning Component, HIV/AIDS Sector Save the Children, House # 14, Road # 1, Block-E, Shahjalal Upashahar, Sylhet Cell : 01741139025**)** Jubo Academy/FSW; Shahjalal Uposahar Mr. Nishi Kanata Chanda, Center manager House -21, Main Road, Block-B Shahjalal Uposhahar, Sylhet Cell: 01711-030018

Date	Activity	Notes
		Bandhu/MSW; Muradpur Md. Nazmul Hoque, Program Officer CDA Avenue, Muradpur, Ground Floor, Asian High Way Chittagong-4203 Phone : 031-553676/01718573574
Sun Nov 11	Health and Program Office Meeting Stakeholder interview : Team Syl–Div. Dir–Health 11:00–12:30 Team Ctg–Div Dir–Health 11:00–11:30 Stakeholder interview : Team Syl–CS 9:00–10:30 Team Ctg–CS 9:00–12:30 Lunch at Hotel (ctg/Agrabad, Syl/Rose Valley) : 1:00–2:00 pm Stakeholder interview : Team Syl–SMC/COSW; Kumarpara 2:00–3:30 Team Ctg–Young People in Social Action/FSW; Nalapara 2:00–4:00 Team debriefing at Hotel : 5:00–5:45	Div. Dir–Health Dr. Iqbal Hossain Chowdhury Divisional Health Office, Sylhet 01711189236, 0821-841846 Div Dir—Health Dr. Sheikh Shahabuddin Ahmed Divisional Director Health 5 Loyal Road, Laldighi, Chittagong 01716843441, 031-611129 Civil Surgeon Dr. Md. Quamrul Islam Civil Surgeon Office, Sylhet 01711357553 sylhet@csdghs.gov.bd Civil Surgeon Dr. Md. Abu Tayub Civil Surgeon Office, Chittagong 01819313329 SMC/COSW; Kumarpara Mr. Mahbubur Rahman Sharif, Program Officer Mojir Mansion, 43/B, 1st floor, Kumarpara, Sylhet Cell: 01721-724972

Date	Activity	Notes
		Young People in Social Action/FSW; Nalapara Ms. Shakila Yesmin, Center Manager 78, Uttar Nalapara, Thana Double Muring, Chittagong Cell : 01717302205
Mon Nov 12	Health and Program Office Meeting Team Ctg–Pof. S Islam, President, Dermatology Society 9:00–10:30 Stakeholder interview : Team Syl–Head Skin VD; MAG Osmani MC 9:30–10:30 Team Syl–Head Comty. Med MAG Osmani 9:30–10:30 Stakeholder interview : Team Ctg–BRAC/VCT; Export Processing Zone 11:00–1:00 Lunch at Hotel: 1:30–2:30 pm *(Sylhet team travel to Dhaka at 1:55 pm)* Team Ctg–Beneficiary meeting 2:00–4:30 Ashar Alo—PLHIV/6-8 beneficiary (dif category) *Chittagong flight back at 15:50*	Syl- MAG Osmani Medical College Head Community Medicine : Dr. Md. Sibbir Ahmed, 01711385500 Head Skin VD : Dr. Mamun Md. Ali Ahmed, 01711138446 Ctg–President, Dermatology Society Pof. Sirajul Islam, cell: 01711749446 Ctg–BRAC/VCT; Export Processing Zone Ms Momotaz Nasrin, Counselor DOTS Corner, Export Processing Zone Hospital Road # 3,Chittagong Export Processing Zone, Chittagong Cell:01916358395/Mr. Modiuddin, Lab tech Ctg–Beneficiary meeting Ashar Alo Society O R Nizami Road Md. Ali Hasan, Divisional Coordinator 01716017633
Tues Nov 13	Stakeholder interview : Badhan Hijra/TG populations-MSW; Kuril 9:00–11:00 am Billy, Abu, Mary, Hassan, Darrin Stakeholder interview : Director, IEDCR 12:00–1:00 pm Billy, Abu, Mary, Hassan, Darrin Lunch at Lake shore : 12:00–1:00	Badhan Hijra/TG populations-MSWs; Kuril Mr. Md. Jahirul Haque Bhuiyan, Center Manager Ka-66/1 Azhar Plaza (5th floor), Kuril Chowrasta, Badda, Dhaka–1229 Phone:8849741, Cell: 01712-251472 Director, IEDCR Prof. Dr. Mahmudur Rahman DGHS, Mohakhali, Cell: 01711595139

Date	Activity	Notes
	Leave hotel at 1pm Stakeholder interview : Team A–Directorate General for Narcotics Control 3:00–4:00 Abu, Darrin, Hassan, Team B–OST, Department of Narcotics Control/ICDDR, B 2:30–4:00 Billy, Mary, Thibaut Team debrief	Directorate General for Narcotics Control Mr. Md. Iqbal 441 Tejgaon Industrial Area 887001/01714131416 OST, ICDDR, B Mr. Sayeem Department of Narcotics Control Hospital 441 Tejgaon Industrial Area Cell: 01713186930
Wed Nov 14	Health and Program Office Meeting Leave hotel by 8:00 Team A: Billy, Mary, Hassan Team B: Thibaut, Abu, Darrin Stakeholder interview : Team A–UNODC 9:00–10:00 Team A–Islamic Foundation Bangladesh 10:30–11:00 Team B–IOM 9:00–10:30 Stakeholder interview : Team A–National Institute of Diseases of the Chest and Hospital/VCT, Mohakhali 11:30–12:30 Team B–CAAP/MARPS/VCT, Banani 11:30–12:30 Lunch at Lakeshore 1:00–2:00 pm Team debriefing: 2:30–5:00 (set up remaining schedule)	Director General-Islamic Foundation Bangladesh Mr. Shamim Md. Afzal Islamic Foundation Bangladesh, Agargaon, C: 01711547028 UNODC Dr. Kamrul Ahsan IDB Bhaban, Agargaon, Shere-e-Bangla Nagar, C: 01713244600 IOM Dr. Anita A Davies House 13/A, Road 136, Gulshan -1 Ph-9887978 CAAP/MARPs/VCT, Banani Dr. Rashedul Alam Bhuiyan House # 63/D (1st Floor),Road # 15, Banani, Dhaka -1213 Phone: 9884266, 9881119 Cell: 01716830308 National Institute of Diseases of the Chest and Hospital/VCT, Mohakhali Dr. Khairul Hassan Jessy NIDCS (opposite Gausul Azam Mosque) Mohakhali Cell: 01819249608

Date	Activity	Notes
Thurs Nov 15	8:00–12:00: Individual work for team members 12:00–5:00: Internal team work/report writing Report outline discussion and team building for writing	*Team to plan the day after completion of field visits*
Fri Nov 16	DAY OFF	
Sat Nov 17	Internal team work/report writing At Hotel ; daylong	
Sun Nov 18	Internal team work/report writing Afternoon: prepare debriefs At hotel; daylong	
Mon Nov 19	Debrief USAID (8:00–9:00; USAID mission; depart from hotel at 7:20) Discussion with USAID about the presentation for the project (9:00–10:00) Debrief Modhumita Project (1:30–3:00 time)	Abu departs: Nov 19 at 16:45 PM Emirates Airlines, Flight Number: 0587
Tues Nov 20	Internal team work Submit draft evaluation report to USAID by close of business	Billy and Darrin depart at 21:05, Flight : EK 582
Wed Nov 21	Design team members depart	Mary departs at 09:55, Flight : EK 582 Airport drop by hotel shuttle

APPENDIX D. DISCUSSION GUIDE

Type of Stakeholder	Name
Modhumita Project	FHI SMC BCCP CBOs
GOB: National Level	NASP Directorate General of Health Services Directorate General of Narcotics Control
GOB: Subnational Level (District)	Divisional Director Of Health Civil Surgeon Head Of Dermatology Head Of Community Medicine
Multilateral Organizations	UNAIDS UNODC IOM
Other Partners	ICDDR, B National Interfaith Forum/Islamic Foundation Bangladesh Save The Children CARE International BRAC

#1: How effective has the project been in increasing and sustaining use of high-impact prevention, care and treatment services by MARPs?

Project Design and Implementation: The Four Knows	
• Do the project's objectives and technical strategies align to the current epidemic context in Bangladesh? (The Four Knows: epidemic) **Probe:** – Assess for adjustments made in response to research and data – How the project has used epidemiological data to assess/adjust prioritized high-transmission geographic areas/populations/project levels of effort	FHI SMC/BCCP National GOB UNAIDS ICDDR, B
• Do the project's objectives and technical strategies align to national and global best practices in HIV prevention, care, and treatment services for MARPs? (The Four Knows: response) **Assess** for purposeful incorporation of global, regional, and national best and promising practices into project programming	FHI SMC/BCCP National GOB UNAIDS ICDDR, B
• How was the project designed and is being implemented to respond to the Bangladeshi context? (The Four Knows: context) **Assess** for programming that is purposefully addressing gender, gender-based violence, **stigma & discrimination**, **legal and human rights**, culture, regional differences, environments in which MARPs operate	FHI SMC/BCCP National GOB CBOs UNAIDS ICDDR, B

Project Design and Implementation: Project Architecture	
• How does the project's architecture (implementation approaches) increase and sustain use of high-impact services by MARPs? For specific implementation approaches, assess: **Prompt: Strategic behavioral communications** – Approaches that are delivered through appropriate channels reaching intensity/dosage, with messages reinforced through multiple channels – Behavioral interventions promote the appropriate package of behavioral messages: • Risk reduction behavioral changes (partner reduction, condom use, personal and couple HIV status knowledge, safer sexual practices within a discordant sexual partnership) • Supportive behaviors (adherence) • Demand for and use of services (HCT, treatment) – The design and execution of specific tactical approaches (e.g. peer education) • Evidence of approaches based on best practices • Tactical approaches linked to quality assurance **Prompt: CoPCT** – The overall model for delivery CoPCT (e.g. civil society organizations/facility-based services and inter-relationship) – The provision of integrated health services for MARPs – The use and effectiveness of a client-driven referral network – The use and effectiveness of integrated HIV/AIDS services (e.g. FP/RH and Smiling Sun franchise; BRAC and HCT) – The reduction of facility-based stigma and discrimination based on universal precautions and infection prevention – Facilitative support to the provision of ensure essential medical commodities and supplies – Strengthening referral networks (intra-, inter- facilities) – The use/effectiveness of outreach-based services tied to facilities **Prompt: FHI Quality Improvement Model** – Assess the implementation and results of: • A systematic approach with identified leadership, accountability, and dedicated resources • The use of data and measurable outcomes to determine progress toward relevant evidence-based benchmarks • A focus on linkages, efficiencies, and provider & client expectations in addressing improvements in outcomes • How collected data are fed back into the QI process to ensure that goals are accomplished and are concurrent with improved outcomes • The continual and value-adding engagement of the project leadership team and Improvement team in QA/QI **Subawards** – How subawards scopes of work directly contribute to project objectives – How the project oversees the quality of technical implementation – How the projects knows that civil society capacity building have the intended results?	FHI SMC BCCP CBOs

Project Design and Implementation: Per Cadre of MARP	
• How has the project selected an appropriate response for each targeted population? **Prompt (overall):** – Assess the involvement of target populations and communities in design, implementation, and monitoring – Assess the level to which project design was based upon formative research and guided by theory – Assess the level to which interventions are tailored and delivered to appropriately segmented populations **Prompt (for each cadre of MARPs--PWID, FSWs, COSW, MSM, TGs, returning migrant workers):** – The measureable delivery of a minimum package of services – Enabling environment: policy & advocacy, legal services – Appropriate delivery models (support groups, outreach) **Prompt (for PLHIV):** – Approaches that promote the measureable delivery of a facility-based (community?) minimum package of services – Enabling environment: policy & advocacy, service decentralization, PLHIV involvement – Interventions targeting the range of sexual partners with a focus on discordant partners – Appropriate delivery models – Robust referral systems with focus on community-facility systems; case management **Prompt (for social marketing):** – How the project defines and measures the results of social marketing (e.g., access; alignment to behavioral objectives) – The alignment of marketing and distribution strategies to the target audiences/usage patterns, and research/investigation informing these strategies – The increasing sustainability of social marketing (e.g., margin schemes and how they incentivize different levels of the distribution chain; the growth of the whole market and evidence for the creation of new users and new markets; if the sales force reaches segments not reached by the market or replaces normal market forces; the engagement of the trade in social marketing and advocacy) – How program income is reinvested into the program and trends in cost recovery – How project addresses behavioral predeterminates (e.g. building self-efficacy/locus of control	FHI SMC BCCP CBOs
Project Monitoring and Evaluation:	
• How does the project measure results at the outcome level? • How does the project ensure coverage and scale for (sub) population-level impact? • How does the project ensure quality data? How and how often are data collected? What data are collected? • How does the project feedback data to help project implementation (e.g., to the CBOs)? • How does the project share data with the NASP? • How has the project defined "high-impact services" and determined whether the project is achieving this? – Assess for internal assessments and costing (The Four Knows: costs)	FHI SMC BCCP

Project Results:	
• What has been the project's performance against targets? – Assess for FY 2012 annual report – Assess cumulate results	FHI
• How does the project's architecture (implementation approaches) increase and sustain use of high-impact services by MARPs? **Assess** the project architecture's overall results on increased accessibility and availability – Geographic coverage – The consistent delivery of core/expanded packages of services tailored to each cadre of MARP **Assess project architecture and activities overall results on increased sustainability** – Health outcomes (e.g., the long-term ability of MARPs to adopt and maintain healthy behaviors and use of services) – Health service characteristics (e.g., maintained improvements in quality, accessibility, and equity of use) – **Workforce capacity**(e.g., maintained improvements in performance levels to achieve and sustain results) – **Institutional capacity** (e.g., the increasing effectiveness of public sector and civil society institutions to design, implement, and evaluate activities) – Financing and price (e.g., ensuring that activities or services are gradually tied to sustainable financing models or increasing cost effectiveness) – Capacity of recipient communities (e.g., increased participation of targeted populations in activity design, implementation, and evaluation; increased target audience/community ownership of and engagement in public health) – **Socio-ecological conditions** enabling the work of these agencies (e.g., enabling social and cultural environments that are required for sustaining project results)	FHI National GOB

#2. To what extent is the project strengthening the national program's leadership capacity in managing national HIV/AIDS activities and strengthening health systems in Bangladesh?

• How does the project align and contribute to national HIV/AIDS objectives?	FHI National GOB District GOB UNAIDS
• How does the project coordinate intervention implementation? **Probe:** – At the national level: • Civil society and GOB participation throughout the cycles of project implementation – At the project level: • Harmonized messages and activities across project partners? • Harmonized messages and activities between project and other HIV/AIDS activities? • Integration into non-HIV/AIDS interventions & services (e.g. other health, education, economic development)	FHI SMC BCCP National GOB District GOB CBOs (project level) SCI CARE BRAC

#3: What are the barriers to increased service delivery and capacity development and are there any recommended changes to the current technical assistance structure?

Closely tied to question #1 re: the major technical approaches/technical assistance structure:

- Strategic behavioral communications
- CoPCT
- Quality Improvement Model
- Subawards

• What are the barriers to increased HIV/AIDS service delivery and how should these be addressed? • How could the project address them? **Probe for both:** – Success, gaps, opportunities, recommended changes	All
• What are the barriers to increased capacity development regarding HIV/AIDS services and how could they be addressed? • How could the project address them? **Probe for both:** – Success, gaps, opportunities, recommended changes	All

#4: To what extent has the Modhumita Project been able to support the scale-up of innovative approaches to HIV prevention among MARPs in Bangladesh?

• In your opinion, has the project achieved any innovations? • If so, have these innovations been taken to scale? • In addition, are there any project successes/best practices that merit scale-up/ replication?	FHI SMC/BCCP National GOB ICDDR, B CARE, SCI
• Additional analysis based on observations and findings	

#5: How does the project meet the national needs and fill critical gaps in responding to the national strategy on HIV/AIDS?

• How does the project contribute to the realization of the *National Strategic Plan for HIV/AIDS*? **Probe:** – Assess for measureable contributions and any project adjustments made since the issue of the third version of the national strategy – Assess for continual and value-adding collaboration with the MOH at the national and subnational levels – Assess for public sector stakeholder perceptions of the value of the project, current and potential **Assess** for leveraging of activities/resources with Global Fund/Government, and where do we fit in the future?	FHI National GOB UNAIDS UNODC IOM ICDDR, B CARE SCI

#6: Should USAID continue the funding and scope for this activity at the same level, at a reduced level, or at an enhanced level, pending the availability of funds?

• Given what we know in terms of the HIV/AIDS response, what are your recommendations regarding the project's focus during its final years?	National GOB UNAIDS UNODC IOM ICDDR, B
• Given the fact that HIV prevalence in Bangladesh is very low, and if USAID investment were greatly reduced, how would you suggest for USAID to program a low level of funds for HIV/AIDS?	National GOB UNAIDS ICDDR, B
• Analysis based on findings, conclusions, and recommendations: • Recommendations for the remaining life of project • Recommendations for future activities	

#7: If USAID were to take a more comprehensive approach to supporting HIV interventions in Bangladesh, how should USAID targets its increased investments?

- In line with the *National Strategic Plan for HIV/AIDS,* aside from the USG what/who are the major resources/donors funding the national HIV/AIDS response and supporting infrastructure?
  - Assess for coverage, gaps, future plans, and opportunities
- Other considerations for USAID investments in HIV/AIDS:
  - USAID Forward
  - Global Health Initiative
  - Leveraged results through measurable wraparounds with other health/nonhealth activities
- Based on the above findings, how should USAID prioritize additional HIV/AIDS activities?

Present for short and medium terms

APPENDIX E. IMPLEMENTING AGENCIES AND MODHUMITA PROJECT SITES

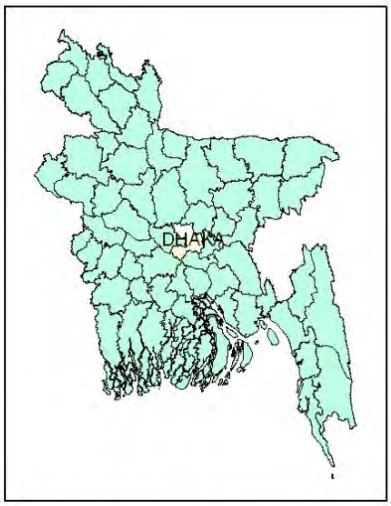
Organization Name	Description	Location	
		Division	District/Area
Modhumita Project Health Centers			
Ashar Alo Society	Care and support for PLWHA	Dhaka	Dhaka
		Chittagong	Chittagong
		Sylhet	Sylhet
Mukto Akash Bangladesh	PLWHA	Dhaka	Dhaka (Chankharpul)
Dhaka Ahsania Mission	Male PWID	Dhaka	Dhaka
			Mymensing
			Gazipur
Khulna Mukti Sheba	Male PWID	Khulna	Khulna
Society for Community Health Rehabilitation, Education and Awareness	Male/female PWID	Dhaka	Dhaka (Lalbagh)
Bandhu Social Welfare Society	Male sex workers/*Hijra*	Dhaka	Dhaka (Mirpur)
		Chittagong	Chittagong
		Dhaka	Mougbazar
Light House	Male sex workers/*Hijra*	Rajshahi	Rajshahi
		Natore	Natore
	Female sex workers	Bogra	Bogra
Shustho Jibon	*Hijra*/MSWs	Dhaka	Dhaka (Savar)
			Dhaka (Shympur)
Badhan Hijra Sangho	*Hijra*/MSWs	Dhaka	Dhaka (Sadarghat)
			Dhaka (Kuril)
Bangladesh Women's Health Coalition	Female sex workers	Dhaka	Dhaka (Mohakhali)
Drishti Research Centre	Female sex workers	Comilla	Comilla
Sylhet Jubo Academy	Female sex workers	Sylhet	Sylhet
Young Power in Social Action	Female sex workers	Chittagong	Chittagong
Ashokti Punorbashan Nibash	Female PWID	Dhaka	Dhaka (Mohammadpur)
Social Marketing Company	Services for all MARPs	Dhaka	Tongi
			Tejgaon
			Mymensing

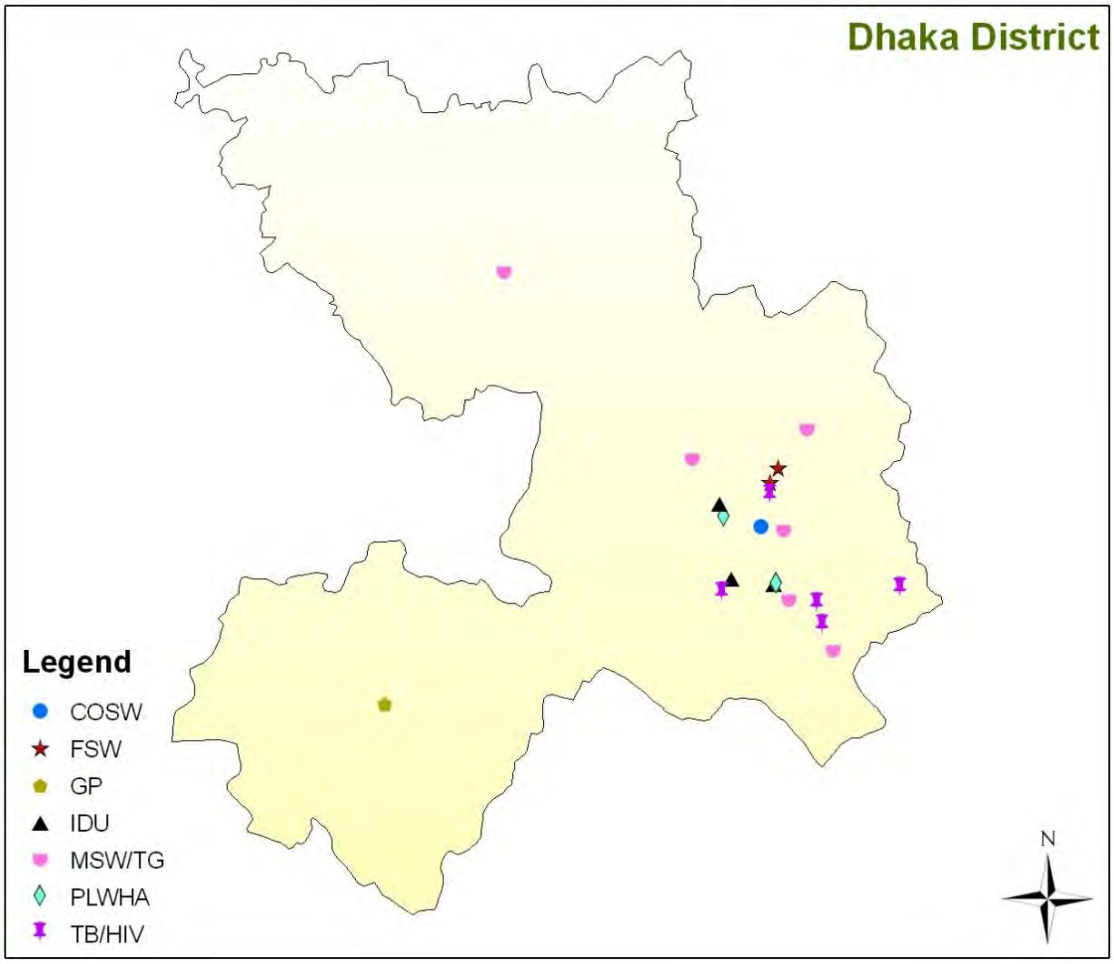
Organization Name	Description	Location	
		Division	District/Area
		Khulna	Khulna
			Jessore (Benapole)
		Rajshahi	Rajshahi
		Rangpur	Dinajpur (Hili)
		Barisal	Barisal
		Sylhet	Sylhet
		Chittagong	Chittagong
VCT Services			
Damien Foundation, Bangladesh	VCT	Dhaka	Mymensingh
			Tangail (Jalchatra)
			Netrokona
Bangladesh Rural Advancement Committee (BRAC)	VCT	Dhaka	Madartek
			Shympur
			Kamrangir Char
			Tongi
			Matuail
		Chittagong	Chittagong
National Institute of Diseases of the Chest and Hospital	VCT	Dhaka	Dhaka (Mohakhali)
Upazila Health Complex	VCT	Sylhet	Sreemongol
Upazila Health Complex	VCT	Dhaka	Nawabganj
Nalta Private Hospital	VCT	Khulna	Satkhira
VCT Satellite Teams			
Mukto Akash Bangladesh	VCT	Dhaka	Dhaka (Chankharpul)
Confidential Approach to AIDS Prevention	VCT	Dhaka	Dhaka
Drishti Research Centre	VCT	Comilla	Comilla (Burichang)
Modhumita Project Partners			
Bangladesh Center for Communications Program	Advocacy and communication programs	Country wide	
Social Marketing Company	Prevention marketing support programs	Country wide	
Collaborative Agreement			
Bangabandhu Sheikh Mujib Medical University	External quality assessment services	Dhaka	Dhaka

APPENDIX F. MODHUMITA SERVICES SITES MAPS

FHI360/MODHUMITA Project

Intervention Sites Dhaka District





APPENDIX G. MODHUMITA PROJECT SUMMARY RESULTS FRAMEWORK

Modhumita Project Summary Results Framework		
Narrative Summary: Goal & Purpose	**Narrative Summary: Project Strategies**	**Selected Measurement Indicators**
Goal: Support Ministry of Health and Family Welfare (MOHFW) efforts to maintain HIV seroprevalence of less than 5% among MARPs.		
Project Purpose: To support an effective HIV/AIDS strategy through improved prevention, care and treatment services for MARPs and PLHIV, and through a strengthened national response:		
Result 1: Increased and sustained use of high impact HIV prevention, care, and treatment services by MARPs through high-quality, evidence-based, and holistic program approaches	Initiatives to increase condom use High quality clinical and outreach services Innovative programming for PWID Increased use of effective FP/RH services	Number of condoms distributed through interventions • Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful • Number of new members to Modhumita sites • Number of individuals trained in HIV-related community mobilization for prevention care and/or treatment • Number of STI clinics/facilities providing VCT • Number of individuals who received HCT and received their test results • Number of clients testing HIV positive • Number of individuals attending STI clinic session • Number of patients diagnosed and treated at STI clinics • Number of PWID receiving drug treatment according to project defined services • Increased use of effective FP/RH services • Number of people trained in FP/RH with USG funds

Modhumita Project Summary Results Framework		
Narrative Summary: Goal & Purpose	**Narrative Summary: Project Strategies**	**Selected Measurement Indicators**
Result 2: Strengthened government leadership, multilevel coordination, and use of data for decision-making to support HIV/AIDS prevention efforts and effective programming for MARPs	Improved capacity for information use and management Strengthening Government leadership and the policy environment Implementation of the National HIV/AIDS Policy	• Number of government and NGO partners reporting data to NASP through clinical research and medical information systems (CRIS and MIS) • Number of local organizations provided with technical assistance for HIV-related policy development (workplace policy) Number of relevant government ministries involved with HIV prevention and care programming Number of health and social welfare NGOs involved with HIV prevention and care programming

APPENDIX H. SELECTED PROJECT TARGETS AND RESULTS BY PROJECT YEAR

Period: October 2009-September 2012

Indicators	Year 1			Year 2			Year 3		
	Annual Target	Achievement (Oct 2009-Sep 2010)	%	Annual Target	Achievement (Oct 2010-Sep 2011)	%	Annual Target	Achievement (Oct 2011-Sep 2012)	%
Number of the targeted population reached with individual and/or small group-level HIV preventive interventions that are based on evidence and/or meet the minimum standards required									
FSWs (Hotel- and Street-Based)	11,525	7,594	66	11,525	7,553	66	7,509	10,384	138
Male Sex Workers	4,800	5,689	119	4,835	6,671	138	5,770	8,261	143
Transgender	2,350	3,546	151	3,626	3,190	88	3,726	3,553	95
PWID	1,720	1,595	93	2,350	2,273	97	2,750	5,861	213
Care and Support	350	595	170	909	659	72	600	992	165
Clients of Sex Workers	400,000	451,597	113	407,500	496,064	122	429,175	389,344	91
TB Patients	0	2,905	0	0	2,110		4,000	2,183	55
Others**	0	0	0	0	0		3,335	5,161	155
Total	**420,745**	**473,521**	**113**	**430,745**	**518,520**	**120**	**456,865**	**425,739**	**93**
Number of the targeted population reached with individual and/or small group-level HIV preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required									
General Population	500,000	693,461	139	500,000	539,360	107.872	525,000	565,967	107.80324
Number of new members to Modhumita sites									
FSWs (Hotel- and Street-Based)	1,450	2,734	189	1,137	2,491	219	2,022	2,440	121
Male Sex Workers	575	522	91	117	998	853	760	1,279	168
Transgender	525	680	130	326	433	133	710	381	54

Period: October 2009-September 2012

Indicators	Year 1			Year 2			Year 3		
	Annual Target	Achievement (Oct 2009-Sep 2010)	%	Annual Target	Achievement (Oct 2010-Sep 2011)	%	Annual Target	Achievement (Oct 2011-Sep 2012)	%
PWID	595	1,116	188	565	1,845	327	1,105	2,349	213
Care and Support	195	163	84	175	202	115	125	259	207
Clients of Sex Workers	8,100	10,841	134	8,500	11,418	134	9,000	11,461	127
Others**	0	0	0	0	0	0	1,085	0	0
Total	**11,440**	**16,056**	**140**	**10,820**	**17,387**	**161**	**14,807**	**18,169**	**123**
Number of condoms distributed through interventions									
FSWs (Hotel- and Street-Based)	7,571,000	8,709,180	115	7,928,600	9,993,632	126	10,916,000	8,541,331	78
Male Sex Workers	2,911,000	2,408,157	83	3,105,000	2,628,431	85	3,030,250	3,124,255	103
Transgender	999,704	914,366	91	1,065,000	803,396	75	972,000	865,224	89
PWID	189,815	113,070	60	214,800	145,896	68	189,800	192,998	102
Care and Support	36,000	25,419	71	63,000	31,882	51	31,300	33,534	107
Clients of Sex Workers	2,772,860	2,307,082	83	2,991,128	2,427,614	81	2,322,750	2,703,621	116
Others**	903,000	864,000	96	911,000	942,000	103	973,000	876,000	90
Total	**15,383,379**	**15,341,274**	100	**16,278,528**	**16,972,851**	**104**	**18,435,100**	**16,336,963**	**89**
Number of targeted condom service outlets									
FSWs (Hotel- and Street-Based)	186	198		209	183		198	202	
Male Sex Workers	63	90		68	87		71	88	
Transgender	51	46		58	47		56	62	
PWID	18	19		20	23		29	27	
Care and Support	4	4		4	5		4	4	

Period: October 2009-September 2012

Indicators	Year 1			Year 2			Year 3		
	Annual Target	Achievement (Oct 2009-Sep 2010)	%	Annual Target	Achievement (Oct 2010-Sep 2011)	%	Annual Target	Achievement (Oct 2011-Sep 2012)	%
Clients of Sex Workers	118	98		130	118		140	142	
Others**	10	14		12	18		14	12	
Total	**450**	**469**		**501**	**481**		**512**	**537**	
Number of individuals who received testing and counseling services for HIV and who received their test results									
FSWs (Hotel- and Street-Based)	3,284	2,760	84	3,800	3,215	85	3,400	3,583	105
Male Sex Workers	1,952	1,679	86	2,300	2,360	103	2,290	2,876	126
Transgender	1,198	894	75	1,250	1,135	91	1,216	980	81
PWID	1,650	1,284	78	1,800	2,350	131	1,660	2,096	126
Care and Support	656	233	36	900	701	78	830	651	78
Clients of Sex Workers & General Population	7,360	6,085	83	8,050	6,746	84	7,684	7,633	99
TB patients	0	2,272		0	1,818		2,000	1,971	99
Others**	0	0		4,000	0		1,085	282	26
Total	**16,100**	**15,207**	**94**	**22,100**	**18,325**	**83**	**20,165**	**20,072**	100
Number of individuals testing HIV-positive									
FSWs (Hotel- and Street-Based)	NA	2		NA	2		NA	2	
Male Sex Workers	NA	4		NA	2		NA	8	
Transgender	NA	3		NA	4		NA	2	
PWID	NA	12		NA	38		NA	28	
Care and Support	NA	47		NA	102		NA	43	

Period: October 2009-September 2012

Indicators	Year 1			Year 2			Year 3		
	Annual Target	Achievement (Oct 2009-Sep 2010)	%	Annual Target	Achievement (Oct 2010-Sep 2011)	%	Annual Target	Achievement (Oct 2011-Sep 2012)	%
Clients of Sex Workers & General Population	NA	12		NA	24		NA	157	
TB patients	NA	3		NA	4		NA	4	
Others**								1	
Total	**NA**	**83**		**NA**	**176**		**NA**	**245**	
Number of individuals attending STI clinic session									
FSWs (Hotel- and Street-Based)	9,050	7,840	87	9,092	6,460	71	8,534	7,812	92
Male Sex Workers	4,650	5,250	113	4,664	5,934	127	5,210	7,584	146
Transgender	2,462	2331	95	2,677	1,773	66	2,300	2,012	87
PWID	2,680	928	35	3,002	1,412	47	1,924	1,565	81
Clients of Sex Workers	9,000	11,762	131	9,000	13,225	147	9,484	11,872	125
Others**	0	0		0	0		100	1	1
Total	**27,842**	**28,111**	**101**	**28,435**	**28,804**	**101**	**27,552**	**30,846**	**112**
Number of patients diagnosed and treated at STI clinics									
FSWs (Hotel- and Street-Based)	5,450	5,441	100	5,542	4,406	80	5,593	4,981	89
Male Sex Workers	2,518	2568	102	2,561	2,983	116	2,790	3,098	111
Transgender	1,144	1381	121	1,266	955	75	1,299	880	68
PWID	1,336	330	25	1,535	880	57	1,065	694	65
Clients of Sex Workers	3,500	4101	117	3,500	3,887	111	3,781	3,870	102
Others**	0	0	0	0	0		80	1	1
Total	**13,948**	**13,821**	**99**	**14,404**	**13,111**	**91**	**14,608**	**13,524**	93

Period: October 2009-September 2012

Indicators	Year 1			Year 2			Year 3		
	Annual Target	Achievement (Oct 2009-Sep 2010)	%	Annual Target	Achievement (Oct 2010-Sep 2011)	%	Annual Target	Achievement (Oct 2011-Sep 2012)	%
Number of individuals screened and tested for syphilis									
FSWs (Hotel- and Street-Based)	926	679	73	1,012	1,694	167	2,673	2,983	112
Male Sex Workers	505	1	0	514	714	139	950	1,510	159
Transgender	170	6	4	189	393	208	330	699	212
PWID	259	2	1	317	151	48	241	419	174
Clients of Sex Workers	700	0	0	700	789	113	725	1,496	206
Others**	0	0	0	0	0	0	20	0	0
Total	**2,560**	**688**	**27**	**2,732**	**3,741**	**137**	**4,939**	**7,107**	144
Number of patients screened for suspected TB	**1,985**	**3,950**	**199**	**2,274**	**8,373**	**368**	**6,084**	**7,747**	**127**
Number of PWID receiving drug treatment according to FHI-defined services									
Men	910	923	101	950	1,013	107	1,020	655	64
Women	184	144	78	184	31	17	160	55	34
Total	**1,094**	**1,067**	**98**	**1,134**	**1,044**	**92**	**1,180**	**710**	**60**
Number of PWID accessing day care center									
Men	2,400	5,692	237	2,650	6,337	239	18,600	27,399	147
Women	550	767	139	600	862	144	1,720	4,928	287
Total	**2,950**	**6,459**	**219**	**3,250**	**7,199**	222	**20,320**	**32,327**	**159**
Number of government and NGO partners reporting data to NASP through CRIS and MIS	25	25	100	25	24	96	22	22	100

Period: October 2009-September 2012

Indicators	Year 1			Year 2			Year 3		
	Annual Target	Achievement (Oct 2009-Sep 2010)	%	Annual Target	Achievement (Oct 2010-Sep 2011)	%	Annual Target	Achievement (Oct 2011-Sep 2012)	%
Number of local organizations provided with technical assistance for HIV-related policy development (workplace policy)	2	2	100	3	4	133	4	4	100
Number of relevant government ministries involved with HIV prevention and care programming	8	8	100	8	8	100	16	16	100
Number of health and social welfare NGOs involved with HIV prevention, care, and impact mitigation programming	25	25	100	25	24	96	24	24	100
Number of individuals trained in counseling and testing according to national and international standards	50	73	146	50	26	52	**35**	25	71
Number of individuals trained in HIV-related community mobilization for prevention, care, and treatment	550	553	101	570	570	100	**482**	642	133
Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	600	603	101	300	307	102	**300**	315	105
Number of people trained in FP/RH with USG funds									
Men				30	25	83	5	0	
Women				24	32	133	5	0	
Total	**Not set**			**54**	**57**	**106**	**10**	0	

Period: October 2009-September 2012

Indicators	Year 1			Year 2			Year 3		
	Annual Target	Achievement (Oct 2009-Sep 2010)	%	Annual Target	Achievement (Oct 2010-Sep 2011)	%	Annual Target	Achievement (Oct 2011-Sep 2012)	%
Number of counseling visits for FP/RH as a result of USG assistance									
Men				1,000	1,860	186	2,360	3,156	134
Women				1,500	3,087	206	3,740	3,368	90
Transgender				0	0		0	33	
Total	**Not set**			**2,500**	**4,947**	**198**	**6,100**	**6,557**	107
Number of USG-assisted service delivery points providing FP counseling or service	**Not set**			**39**	**41**		**42**	**50**	

** There is no standard definition for individuals who are classified in the "others" category. These might be individuals who declined to disclose risk behaviors

APPENDIX I. COMPARISON OF POPULATIONS WHO TESTED FOR HIV DURING FY 2012 AND WERE INFECTED, BY DIVISION

The following chart presents a comparison of populations targeted by the Modhumita Project who received testing and counseling for HIV, received their results, and were infected with HIV. The time period is FY 2012 (October 2011–September 2012). These data are presented by the divisions in which the project operates.

Division	Target group	Number of individuals who received testing and counseling services for HIV & received their test results				Number of tested individuals positive for HIV				
		Male	Female	*Hijra*	Total	Male	Female	*Hijra*	Total	% Total
Dhaka	**Total**	**5,378**	**2,121**	**813**	**8,312**	**87**	**39**	**2**	**128**	**1.52%**
	MSWs	1,381	0	0	1,381	7	0	0	7	0.51%
	Transgender	0	0	813	813	0	0	2	2	0.25%
	PWID	806	177	0	983	15	3	0	18	1.83%
	Care & Support	458	94	0	552	20	9	0	29	5.25%
	COSW	1,467	0	0	1,467	2	0	0	2	0.14%
	TB Patients	1,059	741	0	1,800	1	3	0	4	0.22%
	Others	207	122	0	329	42	23	0	65	19.76%
	FSWs	0	987	0	987	0	1	0	1	0.10%
Chittagong	**Total**	**1,999**	**1,404**	**14**	**3,417**	**23**	**17**	**0**	**40**	**1.17%**
	MSWs	361	0	0	361	0	0	0	0	0.00%
	Transgender	0	0	8	8	0	0	0	0	0.00%
	PWID	506	9	0	515	5	0	0	5	0.97%
	Care & Support	26	9	6	41	3	2	0	5	12.20%
	COSW	783	0	0	783	1	0	0	1	0.13%
	TB Patients	78	93	0	171	0	0	0	0	0.00%
	Others	245	97	0	342	14	15	0	29	8.48%
	FSWs	0	1,196	0	1,196	0	0	0	0	0.00%

Division	Target group	Number of individuals who received testing and counseling services for HIV & received their test results					Number of tested individuals positive for HIV				
Khulna	**Total**	**2,255**	**254**	**4**	**2,513**		**8**	**8**	**0**	**16**	**0.64%**
	MSWs	93	0	0	93		1	0	0	1	1.08%
	Transgender	0	0	4	4		0	0	0	0	0.00%
	PWID	446	4	0	450		4	1	0	5	1.11%
	COSW	1,363	0	0	1,363		3	0	0	3	0.22%
	Others	353	188	0	541		0	6	0	6	1.11%
	FSWs	0	62	0	62		0	1	0	1	1.61%
Rajshahi	**Total**	**1,487**	**488**	**124**	**2,099**		**0**	**0**	**0**	**0**	**0.00%**
	MSWs	619	0	0	619		0	0	0	0	0.00%
	Transgender	0	0	124	124		0	0	0	0	0.00%
	PWID	14	1	0	15		0	0	0	0	0.00%
	COSW	635	0	0	635		0	0	0	0	0.00%
	Others	219	31	0	250		0	0	0	0	0.00%
	FSWs	0	456	0	456		0	0	0	0	0.00%
Sylhet	**Total**	**1,124**	**963**	**28**	**2,115**		**40**	**20**	**0**	**60**	**2.84%**
	MSWs	305	0	0	305		0	0	0	0	0.00%
	Transgender	0	0	28	28		0	0	0	0	0.00%
	PWID	30	9	0	39		0	0	0	0	0.00%
	Care & Support	31	27	0	58		7	2	0	9	15.52%
	COSW	539	0	0	539		0	0	0	0	0.00%
	Others	219	117	0	336		33	18	0	51	15.18%
	FSWs	0	810	0	810		0	0	0	0	0.00%
Barisal	**Total**	**606**	**144**	**0**	**750**		**1**	**0**	**0**	**1**	**0.13%**
	MSWs	77	0	0	77		0	0	0	0	0.00%
	Transgender	0	0	0	0		0	0	0	0	0.00%
	PWID	59	0	0	59		0	0	0	0	0.00%
	COSW	468	0	0	468		0	0	0	0	0.00%
	Others	2	32	0	34		1	0	0	1	2.94%
	FSWs	0	112	0	112		0	0	0	0	0.00%

Division	Target group	Number of individuals who received testing and counseling services for HIV & received their test results					Number of tested individuals positive for HIV				
Rangpur	**Total**	**748**	**115**	**3**	**866**		**0**	**0**	**0**	**0**	**0.00%**
	MSWs	40	0	0	40		0	0	0	0	0.00%
	Transgender	0	0	3	3		0	0	0	0	0.00%
	PWID	35	0	0	35		0	0	0	0	0.00%
	COSW	433	0	0	433		0	0	0	0	0.00%
	Others	240	66	0	306		0	0	0	0	0.00%
	FSWs	0	49	0	49		0	0	0	0	0.00%
All Divisions	**Overall Total**	**13,597**	**5,489**	**986**	**20,072**		**159**	**84**	**2**	**245**	**1.22%**

APPENDIX J. REFERENCES

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