

BANGLADESH FINAL REPORT

September 1997–September 2007

USAID'S IMPLEMENTING AIDS PREVENTION AND CARE (IMPACT) PROJECT



USAID
FROM THE AMERICAN PEOPLE





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**Bangladesh Final Report
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for

**USAID’s Implementing AIDS Prevention
and Care (IMPACT) Project**





Bangladesh Final Report

*Submitted to USAID
By Family Health International*

August 2007

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In partnership with

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The IMPACT/Bangladesh program was managed by a team of dedicated individuals based in Dhaka, Bangkok, and Arlington who showed unwavering support and total commitment to their work. To them, we say thank you for a job well done. Finally, heartfelt thanks to the many local and international consultants, who provided strong technical assistance to the IMPACT program and contributed greatly to our achievements.

GLOSSARY OF ACRONYMS

ABC	Abstinence, Be faithful, and use Condoms, when appropriate
AIDS	Acquired Immunodeficiency Syndrome
APD	Asia Pacific Department (FHI)
ARH	Adolescent Reproductive Health
ART	Antiretroviral Therapy
BAP	Bangladesh AIDS Program
BCC	Behavior Change Communication
BCI	Behavior Change Intervention
BSS	Behavioral Surveillance Survey
CA	Cooperating Agency
CBO	Community-Based Organization
CoC	Continuum of Care
COCAT	Condensed Organizational Capacity Assessment Tool
CS&T	Care, Support, and Treatment
DFID	Department for International Development, UK
DGHS	Directorate General Health Services
DIC	Drop-In Center
ECR	Expanded Comprehensive Response
ESM	Enhanced Syndromic Management
ESP	Essential Services Package
EWC	East-West Center
FBO	Faith-Based Organization
FHI	Family Health International
FSW	Female Sex Worker
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GIS	Geographical Information Systems
GoB	Government of Bangladesh
HAPP	HIV/AIDS Prevention Project
HBC	Home-Based Care
HBSW	Hotel-Based Sex Worker
HIV	Human Immunodeficiency Virus
HNPSP	Health Nutrition Population Sector Program
IA	Implementing Agency
ICDDR,B	International Center for Diarrhoeal Disease Research, Bangladesh
IDU	Injection Drug User
IHC	Integrated Health Center
IMPACT	Implementing AIDS Prevention and Care
JSI	John Snow Incorporated
KABP	Knowledge, Attitude, Behavior, and Practices
M&E	Monitoring and Evaluation
MACCA	Masjid Council for Community Advancement
MARG	Most-at-Risk Group
MCWC	Maternal and Child Welfare Center
MDG	Millennium Development Goal
MIS	Management Information Systems
MOHFW	Ministry of Health and Family Welfare
MPH	Master's of Public Health
MSCS	Marie Stopes Clinical Services
MSM	Males who have Sex with Males

MSW	Male Sex Worker
NAC	National AIDS Committee
NASP	National AIDS/STD Program
NASROB	National Assessment of Situation and Responses to Opioid/Opiate use in Bangladesh
NEP	Needle Exchange Program
NGO	Non-Governmental Organization
NIPHP	National Integrated Population and Health Project
NSDP	NGO Service Delivery Program
ODPUP	Organization for Development Programs for Underprivileged
OGAC	Office of the US Global AIDS Coordinator
OI	Opportunistic Infection
OVC	Orphans and Other Vulnerable Children
PE	Peer Educator
PEP	Post-Exposure Prophylaxis
PHN	Population, Health, and Nutrition Office of USAID
PLHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PPT	Pre-Packaged STI Therapy
PPTCT	Prevention of Parents-to-Child Transmission
QAC	Quality Assurance Center
QAT	Quality Assurance Team
RFA	Request for Assistance
RTI	Reproductive Tract Infection
SMC	Social Marketing Company
SO	Strategic Objective
SOAG	Strategic Objective Agreement Grant
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SW	Sex Worker
TA	Technical Assistance
TC-NAC	Technical Committee-National AIDS Committee
TOCAT	Technical and Organizational Capacity Assessment Tool
TOT	Training of Trainers
UFHP	Urban Family Health Project
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
VSO	Voluntary Service Overseas
WB	World Bank
WHO	World Health Organization

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I. EXECUTIVE SUMMARY

FHI IMPACT/Bangladesh began activities in 2000 to support interventions for people most vulnerable to HIV. During the life of the IMPACT project, FHI Bangladesh received US\$14,225,000 to lead the response to HIV in Bangladesh. FHI has supported USAID/Dhaka's strategy and the Bangladesh Ministry of Health's priorities by concentrating on groups most vulnerable to HIV/AIDS. The FHI IMPACT program, in collaboration with other partners, worked to reduce HIV/AIDS vulnerability among several high-risk groups including female, male, and transgender sex workers and their clients, men having sex with men, and intravenous drug users through targeted interventions.

During the program, IMPACT/Bangladesh supported behavior change and care and support programs for a wide variety of community-based organizations, including faith-based organizations, non-governmental organizations (NGOs), and groups addressing the needs of people living with HIV and AIDS (PLHA). Within a short time, IMPACT became a recognized and respected partner among the donor and NGO community working in Bangladesh due to the strong programmatic and technical expertise FHI brought to the table.

The country program experienced significant growth in the early years of the program and by 2005 FHI was managing sub-agreements with 18 implementing agencies. The program included national surveillance system strengthening, behavior change communication to reduce risk and vulnerability to HIV (including condom promotion among high-risk populations), improving management of sexually transmitted infections (STIs), and building capacity of government and NGO partners to plan, implement, and monitor HIV/AIDS interventions.

Over time, IMPACT/Bangladesh expanded its activities to include training of health providers in syndromic management of STIs, STI studies and five rounds of Behavioral and Serological Surveillance surveys (BSS) with the same target groups from 2001 to 2005, and voluntary HIV Counseling and Testing (VCT) activities. IMPACT supported VCT centers in three cities, conducted Bangladesh's first-ever in-country training for VCT center staff, and assisted the government in validating and introducing Rapid Test Kits in Bangladesh. The program also supported several behavior change initiatives through its implementing agencies. Additionally, FHI sponsored a five-day HIV Clinical Management training event for 13 doctors from implementing partner organizations as well as other NGOs.

FHI, in partnership with CARE, initiated injection and other drug use interventions in four cities in Bangladesh. High level multi-sector advocacy work continued from 2002 to 2005 for supporting drug user interventions, as did the design of a comprehensive tripartite response to the growing HIV epidemic among injection drug users, including work with police, prison, Formal Department of Narcotics Control (DNC), and local communities/NGOs. FHI and its partners expanded service utilization at drop-in centers (DICs) through an effective outreach media campaign encouraging behavior change.

In addition, four prototype integrated health centers, called *Modhu-Mita* centers, were established. As a testament to its success, Modhu-Mita became the brand name for a range of HIV/AIDS prevention services supported by FHI and its partners, such as the needle exchange program, drop-in and crisis support centers for drug addicts, and medical facilities for sex workers.

During the IMPACT program, FHI supported six projects that worked with hotel-based sex workers in 200 hotels in major cities around the country. FHI directly funded street-based

interventions, including outreach activities, peer education and STI and drop-in center services for sex workers. FHI supported two males who have sex with males (MSM) interventions in nine cities, including interventions targeting transgender people (*hijras*). FHI with its partners also developed an HIV/AIDS workplace intervention project addressing the special needs of rickshaw-pullers in Chittagong.

FHI provided technical assistance to a PLHA peer support organization to strengthen their capacity to address the needs of PLHA through improved quality and expansion of services and scale-up of programmatic activities to include counseling services, out-patient care services, a referral network for in-patient care, and advocacy and BCC materials to address stigma and discrimination. Beginning in 2004, FHI, with its partners, helped implement a process called Integrated Analysis and Advocacy (A2 Project). This project provided synthesized national epidemiological and behavioral information, which provided a clear picture of the local HIV/AIDS situation, and developed models that explored intervention alternatives. For example, if an intervention focused on consistent condom or STI prevention what potential impact would this have on the epidemic among a particular targeted population? Would these types of interventions be more likely to bring about a reduction in infection rates compared to other interventions, such as VCT? In collaboration with FHI, a local technical expert and several program managers worked to produce the first information-based estimate of the number of PLHA in Bangladesh. This estimate was recommended by the technical working group on size estimates and endorsed by the government of Bangladesh. As a result Bangladesh has national size estimates on risk populations as well as those infected with HIV. This allows for an analysis of coverage rates.

During the IMPACT project, FHI was considered one of the leading HIV prevention agencies in Bangladesh. FHI shared experiences, and materials as well as technical assistance and training support with numerous NGOs and donors. FHI assisted Bangladesh's National AIDS/STD Program by providing input into the National HIV/AIDS Strategy, the National Advocacy/BCC Strategy, National STI Guidelines, and the GFATM second round proposal. FHI continued to lead coordination efforts by organizing regular donor meetings and chaired USAID's AIDS Task Force meetings, where partners met to coordinate activities and discuss lessons learned. As a member of the ARV Task Force, FHI lead the development of National ART Guidelines for Bangladesh.

During the IMPACT project, FHI initiated an innovative project with the United States Peace Corps that matched Peace Corps Volunteers with appropriate implementing agencies to help build their organizational capacity. Through this collaboration, FHI supported an AIDS awareness 5K run and 1K walk in 2005. During the event, FHI disseminated HIV/AIDS outreach materials to more than 200 participants. Approximately 150 community members participated in the run/walk.

II. PROGRAM OBJECTIVES, STRATEGIES, IMPLEMENTATION, AND RESULTS

A. Introduction

FHI IMPACT/Bangladesh began activities in 2000 to support interventions for people most vulnerable to HIV. To date, FHI Bangladesh has received US\$14,225,000 to lead the response to fight HIV in Bangladesh. FHI has supported USAID/Dhaka's strategy and the Bangladesh Ministry of Health's priorities by concentrating efforts on those groups most vulnerable to HIV/AIDS in this low prevalence setting. The FHI IMPACT Program, in collaboration with other key players, worked to reduce HIV/AIDS vulnerability among several high-risk groups including female, male, and transgender sex workers and their clients, men having sex with men (MSM), and intravenous drug users through targeted interventions.

The IMPACT/Bangladesh program supported behavior change and care and support programs of a wide range of community-based organizations, including faith-based organizations, non-governmental organizations (NGOs) and groups for people living with HIV and AIDS (PLHA). By 2005, IMPACT/Bangladesh was managing sub-agreements with 18 implementing agencies. Program priorities included national surveillance system strengthening, behavior change communication to reduce risk and vulnerability to HIV (including condom promotion among high-risk populations), improving management of sexually transmitted infections (STIs), and building capacity of government and NGO partners to plan, implement, and monitor HIV/AIDS interventions.

Over time, IMPACT/Bangladesh expanded its activities to include training of health providers in syndromic management of STIs, STI studies and five rounds of behavioral surveillance surveys (BSS) with the same targeted groups from 2001 to 2005, and Voluntary HIV Counseling and Testing (VCT) activities. IMPACT supported VCT centers in three cities, conducted Bangladesh's first in-country training for VCT centers, and assisted the government in introducing and validating Rapid Test Kits in Bangladesh. The program also supported several behavior change initiatives through its implementing agencies. Additionally, FHI sponsored HIV Clinical Management training for 13 doctors from partner organizations and other NGOs.

B. Country Context

Bangladesh is a low-lying, riparian country located in South Asia with a largely marshy jungle coastline of 710 kilometers (440 miles) on the northern littoral of the Bay of Bengal. Formed by a deltaic plain at the confluence of the Ganges (Padma), Brahmaputra (Jamuna), and Meghna Rivers and their tributaries, Bangladesh's alluvial soil is highly fertile but vulnerable to flood and drought. Hills rise above the plain only in the Chittagong Hill Tracts in the far southeast and the Sylhet division in the northeast. Straddling the Tropic of Cancer, Bangladesh has a subtropical monsoonal climate characterized by heavy seasonal rainfall, moderately warm temperatures, and high humidity. Natural calamities, such as floods, tropical cyclones, tornadoes, and tidal bores, affect the country almost every year. Bangladesh also is affected by major cyclones—on average 16 times a decade.

Bangladesh gained independence from Pakistan in 1971. The official language is Bengali (Bangla). English is widely spoken especially in government and commercial circles. Over 86 percent of the population is Muslim, and small Hindu, Buddhist, and Christian minorities.

Religion is the main influence on attitudes and behavior. Since 1988, Islam has been the official state religion.

The current estimated population of Bangladesh is 147 million, with about 996.1 people per square kilometer. The infant mortality rate is 65/1,000. The life expectancy for males is 61 years and for female is 62 years. The overall literacy rate is 62.6 percent.

HIV/AIDS in Bangladesh

For many years Bangladesh has escaped the HIV/AIDS epidemic that is affecting countries all around it. However, recent national surveillance data indicate that the country should step up prevention efforts, with a 9 percent HIV infection prevalence rate among one group of injection drug users (IDUs) in the capital city, Dhaka. HIV prevalence remains less than 1 percent among other vulnerable groups surveyed, namely men, women, and *hijras* (transgender) who sell sex, and their male clients: truck drivers and their helpers, dock workers, STI patients and MSM.

Unfortunately, the low HIV infections present in these groups are not due to a decrease in their risk behavior. In actuality, the current situation is that more men including rickshaw pullers and students continue to buy sex more than anywhere else in Asia. The majority of men still do not use condoms in commercial sex encounters and female sex workers report the lowest condom use in the region. The alarming reality is that about two-thirds of rickshaw pullers and truck drivers surveyed have never used a condom and very few even realize they are at risk of exposure to HIV. Consistent condom use with regular and new partners remains low in all groups.

The HIV epidemic in Bangladesh, from an epidemiological perspective, is evolving rapidly. Bangladesh is poised to join the list of Asian countries experiencing an HIV epidemic among IDUs. After five completed rounds of National Serological and Behavioral Surveillance, FHI found that HIV rates in one cohort of IDUs in Dhaka reached 1.4 percent and 1.7 percent in 2000 and 2001, respectively, and increased sharply to 4 percent in 2002. In 2003, HIV prevalence reached 9 percent in this group. About 80 percent of IDUs in central Dhaka engaged in needle sharing with multiple partners the last time they injected drugs. Simultaneously, recent BSS data indicate an increase in risk behaviors such as sharing of injection equipment and a decline in consistent condom use in sexual encounters between IDUs and female sex workers. BSS data also indicate that the IDU population is well integrated into the surrounding urban community, socially and sexually, thus raising grave concern about the spread of HIV infection.

IDUs are highly mobile, traveling from other cities to Dhaka where they inject drugs. A considerable proportion of heroin smokers share needles/syringes during their injections. More than half of the heroin smokers had commercial and non-commercial female sex partners in the last year and many had multiple sex partners. Condom use, both in the last sex act and consistently in the last month, was very low with both commercial and non-commercial partners. In the past five years roughly 10 to 20 percent of the drug users are new injectors. Contrary to the common belief, injection drug users are not isolated. These male IDUs are linked with the rest of society—they have regular sex partners, they buy sex from women, as well as other men, they sell blood, and they also move between cities and inject.

The data from the fifth round of the serological surveillance confirms the fears from the previous round that there is an impending epidemic among the injection drug users in Central Bangladesh and that one of their local neighborhoods is already experiencing an epidemic. However, one success story with IDUs seems to be in the Northwest of the country, needle exchange program where only a quarter of the participating injectors share needles and HIV infection remains extremely low.

Given the high-risk behavior in Bangladesh, HIV will not be confined to the drug injecting community for long. All the risk factors that give birth to explosive HIV epidemics are present in Bangladesh today. Once HIV prevalence crosses the 10 percent level, an epidemic becomes very difficult to control. Policy makers and programmers within the government of Bangladesh, bilateral agencies, and national and international NGOs have a key role to play in recognizing the urgency of this situation and taking immediate action.¹

THE NATIONAL RESPONSE

Recognizing the HIV/AIDS threat, the Government of Bangladesh (GoB) developed and approved a comprehensive “Policy on HIV/AIDS and STD Related Issues” in 1997 to provide guidance and support to respond to the epidemic. The National AIDS Committee (NAC) was created in 1985 to ensure policy direction and to promote multi-sector efforts to address HIV/AIDS. The Minister of Health and Family Welfare (MOHFW) chairs the NAC, while the Director General of Health Services is responsible for the National AIDS/STD Program (NASP), which coordinates and supports the national response.

As a sign of its commitment to address HIV and other STIs, the GoB enlisted and secured a five-year (2001–2005) US\$40 million World Bank credit and US\$10 million Department for International Development (DFID) grant to support a range of interventions in the HIV/AIDS Prevention Project (HAPP). However, the slow implementation pace led to the project being restructured, resulting in a shorter duration and reduced funding. The revised project is being implemented with technical and management support by UN agencies. USAID and FHI have made significant contributions to HAPP including providing peer education training, behavior change communication (BCC) materials, and condoms.

In addition to HAPP, Bangladesh successfully applied for funding from the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) for an HIV/AIDS intervention project targeting youth. The initial tranche of US\$6 million (March 2004–February 2006) was implemented by a Management Agency, Save the Children, USA, on behalf of the principal recipient, MOHFW. As with HAPP, FHI has contributed significantly to the GFATM by providing technical assistance in developing IDU interventions, sharing FHI’s monitoring and evaluation (M&E) resources and tools, and in proposal development. Last year, local technical experts and program managers collaborated with FHI to produce the first information-based estimate of the number of PLHA in Bangladesh. This national estimate of 7,677 PLHA falls within wider estimate range from UNAIDS of 700 to 19,000 PLHA.

¹ “HIV in Bangladesh: The Present Scenario,” National AIDS/STD Programme, DGHS, MOHFW, p. 3

Table 1 presents a summary of estimates of population² and PLHA for each vulnerable group, as developed by FHI, recommended by the Working Group (a sub-committee of the technical committee from the national aids committee (TC-NAC), and endorsed by the GoB.

Table 1. Size Estimates of Most-at-Risk Groups in Bangladesh and Average Estimated Number of PLHA in Each Group

Most-At-Risk Groups	Size Estimate Low	Size Estimate High	Average Estimate of PLHA
Injection Drug Users	20,000	40,000	444
MSW and MSM	40,000	150,000	450
Brothel-based Sex workers	3,600	4,000	55
Street-based Sex workers	37,000	66,000	453
Hotel-based Sex workers	14,000	20,000	128
Clients of Female Sex workers	1,882,080	3,136,800	1,882
<i>Hijras</i> (Transgenders)	10,000	15,000	62
Returnee External Migrants	268,000	536,000	3,015
National Total MARGs	2,274,680	3,967,800	6,489
National Total Pop. at Lower Risk*	1,191,559	2,012,375	1,188
Estimated National Total Average Number of PLHA			7,677
National Range PLHA: ~ 700 – 19,000		National Avg. PLHA: ~ 8,000	

* *Partners of members of MARGs, TB patients, and blood transfusion recipients*

UN Response and Donor Support to National Response

United Nations agencies have played a major role in the national response to HIV/AIDS. WHO and UNDP began working on HIV/AIDS in Bangladesh several years before UNAIDS started operations in 1996. UNAIDS works with the UN Theme Group to coordinate the UN response to HIV prevention in Bangladesh. The UN Theme Group on HIV/AIDS, recently expanded to include bilateral donor agencies, international NGOs, and the Secretary of the MOHFW, shares information, and plans and monitors coordinated action among members and with other partners.

C. Implementation and Management

1. Implementation

Prior to mid-2000, FHI/IMPACT provided technical support in Bangladesh on an as needed basis. However, during FY00, FHI/IMPACT was awarded US\$1.2 million in field support to

² Size estimates were established after compiling all available information using standardized methodologies, as well as the UNAIDS workbook for size estimations on HIV infected people.

expand activities in Bangladesh. This funding allowed FHI to provide direct technical support and direction to the HIV component of USAID's bilateral program. At this time, a provisional FHI/IMPACT Bangladesh office was set up in Dhaka and a resident advisor was hired on a short-term contract to coordinate start-up.

In FY01, the USAID mission in Bangladesh made US\$2.5 million available for field support, which allowed the IMPACT program to further expand and to reach large numbers of high-risk core groups in Bangladesh. By FY02, IMPACT increased its activities to include a project on male sexual health and risk reduction programs for hotel-based and alternate-venue sex workers, identified areas to start interventions with sex workers in alternative sex worker venues, completed one round of the National Rapid Assessment of the Situation and Responses of Opioid/Opiate Use in Bangladesh (NASROB), and started risk reduction programs for drug users in different parts of Bangladesh.

In FY03 a US\$50 million HIV/AIDS Prevention project that had begun in 2001 and was funded by the World Bank and DFID remained almost entirely unimplemented. In a World Bank, DFID, and GoB reprogramming workshop in May 2003, it was decided to reduce this US\$50 million project to US\$24 million and to change the implementing arrangements. UN-agencies took over implementation from the Ministry of Health/National AIDS/STD Program for the remaining life of program—less than two years. This project addressed blood safety, mass communication, technical assistance, serological surveillance and some support for people most vulnerable to HIV/AIDS. In FY03, IMPACT/Bangladesh was asked to join this project and support targeted interventions in 15 cities in Bangladesh, while new geographic areas for expansion had already been identified. In several of these cities, such as Dhaka, Chittagong, Shylhet, Comilla, and Barisal, interventions targeting different groups ran parallel to each other. For example street-based sex workers' and hotel-based sex workers' interventions went on at the same time in the same location. However, the fourth round of national surveillance showed that these interventions were able to achieve some change in risk reduction.

In FY04, FHI supported the fifth round of behavioral surveillance covering IDUs and other drug users, female and male SWs, male sex workers, *hijras*, MSM, truckers, and rickshaw pullers. The Male Reproductive Health Survey started, which explored sexual behaviors of men in the general population. The GIS Database, which mapped HIV/AIDS programs in Bangladesh, was updated. Size estimates were developed for IDUs, brothel, street, and hotel-based SWs, and MSM. During this program year, FHI collaborated closely with numerous NGOs and donors by sharing experiences and materials and by providing technical assistance/training to many groups, including the World Bank/DFID-funded HIV/AIDS Prevention Project. FHI provided strong technical leadership to Bangladesh's National AIDS/STD Program by offering input into the National HIV/AIDS Strategy, the National Advocacy/BCC Strategy, National STI Guidelines, and the GFATM proposal. FHI continued to lead coordination efforts by organizing regular donor meetings and also chaired the AIDS Task Force meetings, where partners met to coordinate activities.

As IMPACT funding would end in FY05, FHI Bangladesh moved forward with an ambitious agenda to prepare for follow-on activities through a new request for assistance (RFA). Accomplishment highlights include increasing collaboration and planning with key partners to organize a coordinated HIV response in Bangladesh; developing the "Modhumita" campaign for the Integrated Health Centers; participating as a global FHI pilot site for STI Quality Assurance/Quality Improvement initiatives, including the development of STI guidelines and tools; developing the "tripartite project" as a response to HIV among IDU in Dhaka including

detoxification, treatment, and rehabilitation interventions in collaboration with Dhaka NGOs and GoB institutions (e.g., Prisons, Police, and Department of Narcotics Control).

During FY06, USAID provided continuation funding through a bilateral award, Bangladesh AIDS Program (BAP). In addition, a long-term research study with UNC and ICDDRB will continue with IMPACT funds through June 30, 2006; all other IMPACT sub-agreements were closed out between October 2005 and March 2006. During FY06, FHI Bangladesh ran under two concurrent USAID funds: IMPACT and BAP.

2. Management

Staffing and Management

The FHI IMPACT/Bangladesh Office went through a rapid expansion phase in FY03 in order to manage the increasing number of sub-agreements, consultancies, and technical assistance. The office grew from 24 staff members in FY03 to 33 staff members in FY04. In an effort to keep overhead costs to a minimum, only one office, in Dhaka, was established and continued throughout the life of the project.

Due to FHI's rapid expansion in FY03, the Bangladesh Country Office focused on building strong management systems, including an implementing agency (IA) management data base that indicated life of project (LOP) budget, end dates, specific technical assistance (TA) needs, actions to be taken, and responsibilities of different office staff. Country office (CO) staff also developed a travel matrix to track:

- Program Officers conducting monthly IA monitoring visits to their IAs,
- Finance Officers conducting bi-monthly monitoring visits, and
- Technical Officers visiting every three months (with the exception of the BCC trainers/monitors who visited IAs on a monthly or bi-monthly basis).

Furthermore, a comprehensive monitoring and evaluation plan was developed in the second half of FY03. In addition, a personnel policies and procedures manual for locally hired staff and an administrative and financial procedures manual for the office were finalized. The management capacity was also strengthened through the recruitment of a deputy director in FY03, who was in charge of the technical and program unit, and in FY04 the recruitment of an associate director in charge of the Finance/Admin/Human Resources unit.

FHI's Asia Regional Office (ARO), along with several external consultants, complemented FHI Bangladesh's CO team by providing strong management and technical support. During all external TA missions, efforts were made to build capacity and expertise of local FHI staff and implementing partners. An example of activities that took place include training of local technical and field personnel to deliver training, peer mentoring, and quality assurance systems.

Implementation through Local Partners

Most of the support for IMPACT's implementing partners was provided through sub-agreements. Initially, FHI hoped that local partners could develop their own proposals, but over time it became apparent that most groups lacked the capacity to do so. To resolve this challenge, the country office team worked closely with partners to determine which activities would go into the proposals and to help these organizations finalize their program strategies, activities, workplans, and budgets.

Technical Assistance

Providing technical assistance to local partners was at the core of IMPACT/Bangladesh's program strategy. Much of this assistance was provided by external consultants due to limited technical expertise in country (i.e. counseling and testing), although local consultants were used whenever possible. One challenge encountered early in the project was arranging for technical assistance support during a time that was both appropriate for the program and convenient for the partners. By developing technical assistance plans at the beginning of the fiscal year, IMPACT/Bangladesh was able to better coordinate this portion of the program.

Monitoring and Evaluation

The Bangladesh country program lacked an effective monitoring and evaluation (M&E) system to track program implementation early in the program. With technical assistance from FHI Arlington, the Bangladesh office worked to address this weakness and developed an M&E country strategy in 2005. One phase of the strategy included training implementing partners in M&E, which took place later in the program.

Capacity Building and Sustainability

Over the life of the program, IMPACT/Bangladesh provided consistent and high-quality technical assistance to its partners to better implement and sustain HIV/AIDS interventions as well as build local capacity. Training and capacity building were integral to FHI's programs implemented with local partners. To continue building skills and networks, FHI supported representatives of select IMPACT partner organizations as well as FHI country office program staff to attend international conferences, such as the World AIDS Conference, the International Conference on AIDS and STIs in Bangkok, and technical leadership meetings conducted by the Asia Regional Office.

Level of Efforts

The table below shows the breakdown of the level of efforts in each subproject.

FHI/IMPACT BANGLADESH		
Program Element	IMPACT, US\$	% Allocation
HVOP		
Bangladesh SRISTI HBSWs Pilot Project	US\$135,785	1.0%
Advocacy at Policy Level for HIV Risk Reduction	US\$28,647	0.2%
AVAS: Hotel-based HIV/AIDS/STI Prevention	US\$71,559	0.5%
Marie Stopes Bangladesh Ltd. (FHI)	US\$182,516	1.3%
Bangladesh Country Program Implementation Support	US\$1,216,322	8.6%
DRISTI - HBSW Project (Comilla)	US\$29,687	0.2%
HIV/STI Workplace Project for Male Workers	US\$66,090	0.5%
Bangladesh: National HIV and BSS Dissemination Workshop	US\$26,931	0.2%
BCI for SW, MSM, and DU	US\$794,899	5.6%
SJA-HBSW project (Sylhet)	US\$170,645	1.2%
SAS-HIV/AIDS/STI Prevention Project	US\$76,185	0.5%
Bangladesh: 1999 Bangladesh BSS	US\$76,360	0.5%
BWHC-HBSW Project (Dhaka)	US\$326,099	2.3%
Light House HIV/AIDS Prevention and Control Project	US\$75,322	0.5%

FHI/IMPACT BANGLADESH		
Program Element	IMPACT, US\$	% Allocation
DRISTI/FHI-SBSW Project	US\$46,257	0.3%
YPSA-FHI SBSW Project	US\$132,582	0.9%
ODPUP	US\$249,692	1.8%
Bangladesh: HSI-HIV/AIDS Prevention Project	US\$55,300	0.4%
Bandhu: Male Sexual Health Program	US\$1,029,455	7.3%
MSBL: Hotel-based Sex Worker Project	US\$93,988	0.7%
Bangladesh Bandhu Male Sexual Health Project	US\$581,409	4.1%
HASAB: Strengthening Local NGO Interventions	US\$409,702	2.9%
GHS: Management of Clear Process	US\$30,506	0.2%
University of Illinois/Wayne Weibel	US\$13,298	0.1%
HASAB Training	US\$56,756	0.4%
MRC MODE Ltd.	US\$11,688	0.1%
CARE: HIV Risk Reduction for IDU	US\$407,464	2.9%
Bangladesh OMQ HBSW and Alternate Venue Assessment	US\$37,478	0.3%
Fourth Round of Bangladesh BSS	US\$78,136	0.6%
HARC-SA of HBSW (three cities)	US\$28,419	0.2%
EWC: Tim Brown TA	US\$24,345	0.2%
Clear Process Project supervised by APRO (2000-2001)	US\$7,107	0.1%
Bangladesh OMQ Third Round BSS	US\$65,344	0.5%
HIV/AIDS/STD Alliance HASAB	US\$231,342	1.6%
National Drug Use Assessment NAS	US\$58,322	0.4%
GSRC-Mapping 2002	US\$61,858	0.4%
Residence Based Sex Trade	US\$9,543	0.1%
GSRC GIS Database Development	US\$95,664	0.7%
HDI Social Marketing	US\$383,109	2.7%
HBSW outside Dhaka (ASHEKE)	US\$33,926	0.2%
BAPS HBFSW Project (Old Dhaka)	US\$71,987	0.5%
HBSW Intervention (Barisal City)	US\$32,420	0.2%
AVAS: HBSW HIV/AIDS Prevention (Barisal)	US\$42,636	0.3%
MSCI: Sexuality Training for FHI Bangladesh	US\$57,341	0.4%
DRISTI: HBSW HIV/AIDS/STI prevention (Comilla)	US\$100,399	0.7%
CARE: Pre-Implementation Assessment injecting drug use practices-Dhaka and Pabn	US\$3,999	0.0%
PRDA: HIV/AIDS GIS Mapping Database	US\$125,684	0.9%
Bangladesh HVOP Field Support	US\$493,326	3.5%
HDI Campaign Technical Assistance	US\$285,863	2.0%
International Organization for Migration	US\$63,917	0.5%
Unitrend Ltd.	US\$71,824	0.5%

FHI/IMPACT BANGLADESH		
Program Element	IMPACT, US\$	% Allocation
Community-Health Rehab Education and Awareness (CREA)	US\$52,824	0.4%
Ashokti Punorbashon Nibash (APON)	US\$45,177	0.3%
Dhaka Ahsania Mission (DAM)	US\$55,419	0.4%
Shustha Jibon	US\$45,901	0.3%
Health and Education-Less-Privileged People (HELP)	US\$45,107	0.3%
ICDDR,B-Peer Education Project Assessment	US\$21,586	0.2%
HTXC		
ICDDR,B STI Lab Support	US\$30,903	0.2%
Bangladesh HTXC Field Support	US\$54,288	0.4%
HBHC		
Ashar Alo Society	US\$200,849	1.4%
Bangladesh HBHC Field Support	US\$76,152	0.5%
HVCT		
HASAB: HIV/AIDS Counseling Support Project	US\$97,878	0.7%
Bangladesh: ICDDR,B Strengthening of VCT Service	US\$96,780	0.7%
Bangladesh HVCT Field Support	US\$41,918	0.3%
HVSI		
ICDDR,B Male Reproductive Health	US\$146,816	1.0%
Research and Surveillance	US\$257,000	1.8%
ICDDR,B-Fifth Round of Bangladesh BSS	US\$173,487	1.2%
Bangladesh HVSI Field Support	US\$111,560	0.8%
East West Center (EWC)	US\$14,864	0.1%
John Snow Inc. Research and Training Institute (capacity building for IAs)	US\$19,326	0.1%
Formworks architectural firm conducting IHC renovations (#1)	US\$13,544	0.1%
Formworks architectural firm conducting IHC renovations (#2)	US\$33,714	0.2%
Formworks architectural firm conducting IHC renovations (#3)	US\$7,935	0.1%
HRSB		
STI Prevention and Care	US\$99,249	0.7%
UNC Sexual and Reproductive Health	US\$138,400	1.0%
ICDDR,B STI Study (Enhanced Syndromic Management (ESM) vs Pre-packaged STI Therapy (PPT))	US\$191,665	1.4%
HRSB Field Support	US\$20,854	0.1%
UNC Task Order	US\$223,863	1.6%
OHPS		
Condom Lubricant SM	US\$979	0.0%
NGO Capacity Building	US\$109,445	0.8%
Bangladesh OHPS Field Support	US\$56,220	0.4%

FHI/IMPACT BANGLADESH		
Program Element	IMPACT, US\$	% Allocation
General		
Bangladesh Country Program Management	US\$2,069,877	14.6%
IMPACT Field Support General	US\$729,166	5.2%
Total	US\$14,141,880	100%

FHI/IMPACT BANGLADESH		
Program Element	IMPACT, US\$	% Allocation
HVOP		
Validation of STI syndromic case management	US\$279,439	13.2%
Improving STI services for most-at-risk populations	US\$240,338	11.3%
HVSI		
Establishing the National STI Surveillance System	US\$157,160	7.4%
Population-based survey of male sexual behavior	US\$158,433	7.5%
National pre-assessment of the IDU situation and response	US\$5,889	0.3%
Sexually transmitted and blood-borne infection prevalence assessment among MSM: Qualitative, behavioral, and biological studies	US\$121,932	5.7%
Improving national biological and behavioral surveillance	US\$84,167	4.0%
Program management, implementation, and operation cost	US\$1,077,642	50.7%
Total	US\$2,125,000	100.00%

Implementation Constraints

Due to a lack of coordination on the part of the government and key donors, several projects were funded to provide the same services. For example, two or three different NGOs were funded to work with hotel-based sex workers. However, there was little coordination among the NGOs to ensure wide spread coverage and consistent approaches and messages. In addition, the lack of coordination made implementation difficult as there was little collaboration and sharing of lessons learned.

Since HIV prevalence is low in Bangladesh, it was difficult to address wrongly held beliefs, such as the fact that HIV/AIDS does not exist. People could not see HIV, but they can see TB, STIs, or child malnutrition. Given the host of other health-related priorities from within the target groups, such as food, clothing, shelter, and economic security it is difficult for the population to make a disease that could affect an individual in 6–10 years a priority today.

Additionally, working with existing marginalized groups (sex workers, IDUs, and MSM) in Bangladesh has its own challenges. Religious beliefs and lack of acceptance of the target groups, especially sex workers and the MSM groups, made it difficult to establish community-based clinics when there is no community acceptance of MSM or IDUs.

D. Bangladesh Program Timeline

Intervention Areas	FY 01	FY 02	FY 03	FY 04	FY 05	FY 06
Surveillance and Research						
MSM/Hijra prevention program						
• Contract established	X					
• Peer-led prevention activities implemented	X					
IDU project						
• National assessment of Injection Drug Use	X					
• Assessment and planning for project focusing on IDUs	X					
Sex workers						
• Needs assessment and strategy development	X					
• TA for self-organization of SWs				X		
• Household survey on clients of sex workers in six divisions in Bangladesh				X		
At risk client groups, rickshaw pullers						
• Needs assessment and strategy development	X					
General						
• 2003 and 2004 update of the Geographical Information Systems NGO database			X	X		
• Study on anal-rectal STIs through ICDDR,B with assistance from UNC				X		
• Network study among drug users (including higher socio-economic groups)				X		
• Exchange visit to police intervention in Cambodia				X		
• Workplace intervention for police on HIV/AIDS				X		
• Conduct three pre-surveillance workshops to redesign BSS system					X	
• Disseminate fifth round of BSS result					X	
• Conduct sixth round BSS					X	X
• Identify IA, develop sub-agreement (SA) and implement seventh round National BSS					X	
• Conduct male reproductive health survey in three geographic divisions in Bangladesh					X	
• Conduct RDS pilot survey among IDU MSM					X	
• Develop SA for updating 2004 GIS					X	
• Help design and implement PPT and ESM interventions					X	
• Complete mobility study focusing primarily on migration between Mumbai and different areas in Bangladesh						
• Expand national assessment of situation and responses of opiate use in Bangladesh (NASROB-II) coverage to 39 cities					X	
• Conduct evaluation of MSM/MSW/hijra intervention					X	
• Conduct evaluation of FHI life skills training					X	
• Conduct study on IDU at prisons					X	
• Conduct assessment of IDUs Sexual Networks and Risk Behavior					X	

Intervention Areas	FY 01	FY 02	FY 03	FY 04	FY 05	FY 06
STI Care and Support						
<p>MSM/<i>Hijra</i> prevention program</p> <ul style="list-style-type: none"> For MSM, MSW, and transgender in Dhaka, Rajshahi, Iswardi, Nator through ODPUP For MSM, MSW, and transgender in Dhaka, Chittagong, Sylhet, Mymensing, Comilla, Rajbari, Savar through Bandhu 				X X		
<p>IDU project</p> <ul style="list-style-type: none"> Risk reduction, STI management condom promotion for IDU in four new cities Advocacy to create an enabling environment for risk reduction activities for IDU in Bangladesh through SSC 				X X		
<p>Sex workers</p> <ul style="list-style-type: none"> STI services for sex workers and their clients in 30 hotels in Barishal through AVAS STI services for sex workers and their clients in 20 hotels in Comilla through DRISTI STI services for sex workers and their clients in 20 hotels in Brahmanbaria, 20 hotels in Rangpur, and 20 hotels in four more cities through MSBL STI services for sex workers and their clients in 70 hotels in Sylhet through SJA Situation assessments in six cities in preparation for program expansion STI services for sex workers in up to 80 hotels through Bangladesh women’s health coalition (BWHC) STI services for sex workers and their clients in street-based clinics in Comilla through DRISTI STI services for sex workers and their clients in street-based clinics in Bogra through Lighthouse STI services for sex workers and their clients in street-based clinics in Barisal through SAS STI services for sex workers and their clients in street-based clinics in Chittagong through YPSA STI incidence study among hotel-based sex workers through ICDDR,B with assistance from UNC 				X X X X X X X X X X	X	
<p>Other</p> <ul style="list-style-type: none"> STI counseling and care training and supervision STI component of the male sexual health project, prevention interventions for IDUs, hotel-based sex workers and component of UFHP collaboration with CARE, SMC, and HASAB as well as specific UFHP “male only clinics” Condom social marketing program implementation TA for improving mass media strategy and implementation Condom promotion, counseling, education, advocacy, networking, health care and treatment, and organization capacity building for people living with HIV/AIDS in Dhaka, Sylhet, and Chittagong through AAS 		X X X X			X	

Intervention Areas	FY 01	FY 02	FY 03	FY 04	FY 05	FY 06
Sex workers <ul style="list-style-type: none"> • Project Implementation • TA for self-organization of SWs • Interventions for hotel-based SWs and their clients expanded from four to 13 cities • Interventions for street-based SWs and their clients expanded from one to five cities • Interventions for residence-based SWs and their clients established in three cities • Establishment of an HIV/AIDS in the workplace activity for male garment workers (clients of sex workers) • Develop two new SAs for Bogra and Chittagong division • Close out six SAs with hotel-based or street-based female sex workers and their clients 	X X	X	X X X X	X	X	X
At-risk client groups, e.g. rickshaw pullers <ul style="list-style-type: none"> • Project implementation • HIV/AIDS in the workplace intervention for rickshaw pullers • Support intervention in Chittagong • Identify IA and develop SA for Dhaka intervention 	X	X	X	X X	X X X	
Trainings <ul style="list-style-type: none"> • Training in peer education • Training on behavior change communication • Training seminar on human sexuality and personal risk assessment • Support/strengthen police intervention in seven police training institutes • Help develop training curriculum and manuals for police training • Identify IA and help implement advocacy training for journalists/police/media • Provide peer education training for all BCI partners under HASAB project 	X X X	X X		X X X	X	
Other <ul style="list-style-type: none"> • Establish satellite clinics in new geographic areas for the different sex workers and their clients, MSM and IDU groups • Develop advocacy strategy and advocacy tools • Develop and distribute IEC/BCC materials to BCI partners • Evaluate the first phase of condom social marketing campaign and develop strategies for the second phase • Select market research firm to design and conduct study and use the study findings to develop second phase of condom social marketing campaign • Develop FHI's Media Bank • Distribute BCC manuals to BCI partners • Support police intervention in seven training police institutes in Bangladesh 			X		X X X X X X X	X

Sub-objectives to support these two major objectives were

- a) Conduct surveillance and research to measure the outcome and impact of interventions and to identify programming gaps
- b) Enhance the capacity of NGOs to design and implement HIV/AIDS prevention programs
- c) Support VCT programs so that people most vulnerable to HIV can learn about their HIV status, and provide care and support to those infected and affected by HIV/AIDS
- d) Increase an enabling environment for effective HIV/AIDS prevention interventions

FHI, through a bilateral agreement between USAID and the Government of Bangladesh, worked with NGOs to implement HIV/AIDS prevention, care, and support interventions among female, male, and transgender sex workers and their clients; MSM; drug users; and people with HIV/AIDS.

Besides direct support for interventions, FHI/IMPACT worked closely with several organizations to build partnerships and programs aimed at creating an enabling environment to combat HIV/AIDS. Furthermore, FHI/IMPACT worked with research institutions and other organizations to ensure the availability of data for informed programming decisions.

Intervention Strategies

IDU strategies

- Build capacity for project implementation
- Provide comprehensive inpatient and outpatient drug treatment and rehabilitation for male and/or female IDUs
- Develop a continuum of care by creating referral mechanisms with partner agencies and other service agencies
- Create economic and rehabilitation opportunities for recovering drug users by organizing self-help groups, providing vocational skills, and linking them with available micro-credit facilities
- Advocate for the creation of a supportive environment for intervention programming and change the definition of socially appropriate behavior to incorporate risk reduction measures
- Improve knowledge and understanding about HIV/AIDS/STI transmission and prevention among drug users to reduce their risk
- Socially market condoms and lubricants
- Work to ensure that rehab centers are more user friendly and offer high quality services
- Promote ABC practices among IDUs and their sex partners through outreach and rehab centers
- Provide STI clinical management services for IDUs and referral services for their partners
- Strengthen VCT services for IDUs—counselors trained to routinely assess VCT client’s drug use, and offer evidence-based counseling interventions to modify drug use, and provide routine referral for substance dependent clients to drug rehabilitation services

Sex worker intervention strategies

- Enhance the capacity of peer educators (PEs) for sex workers, site workers, project staff, and the organization through various activities in an effort to better program effectiveness
- Make integrated health centers (IHCs) more user friendly and ensure the quality of the services offered
- Promote ABC practices among sex workers and their clients through outreach.

- Create a supportive environment for working with sex workers through advocacy programs
- Conduct formative research for geographical expansion
- Strengthen VCT services for sex workers
- Provide STI clinical management services for sex workers and referral services for their clients
- Socially market condoms and lubricants

Males having sex with males (MSM) and *hijra* strategies

- Promote ABC practices among MSM/*hijras* through outreach and CHC
- Make CHC more user friendly and ensure the quality of the services offered
- Provide STI clinical management services for the MSM/male sex workers/*hijras* and referral services for their clients
- Social marketing of condoms and lubricants
- Create a supportive environment for working with MSM and *hijras* through advocacy
- Enhance capacity of MSM/male sex workers, PEs, project staff, and the organization through various activities

PLHA intervention strategies

- Promote organizational activities to bring more PLHA under program coverage
- Provide HIV/AIDS education, counseling, and prevention skills for PLHA and their affected family members
- Provide health care/treatment support for PLHA
- Advocate/network with public/private stakeholders for reducing stigma and discrimination and establishing linkages for the continuum of care
- Increase NGO organizational capacity
- Improve counseling and out-patient healthcare service quality

Clients of Sex workers strategies

- Enhance the capacity of the clients, PEs, project staff, and the organization through various activities
- Make CHC more user-friendly and ensure the quality of the services offered
- Promote ABC practices among clients through outreach and CHC
- Create a supportive environment for working with the clients of sex workers through advocacy programs
- Strengthen VCT services for the clients
- Provide STI clinical management and referral services for the clients
- Socially market condoms and lubricants

The Behavior Change Intervention Strategy

BCC was an integral part of FHI Bangladesh's evidence-based behavior change strategy through targeted interventions. This strategy employed peer education and outreach; capacity building of sex workers, peer educators, hotel site workers and project staff on peer education and life skills, STI and HIV/AIDS knowledge, sexual negotiation and male and female condoms use skills, and STI treatment seeking behavior; advocacy; STI case management; and promotion of condoms and lubricants both for female sex workers and their clients.

FHI conducted BCC development and communications assessment workshops with target populations and project staff for developing and implementing specific BCC strategies, messages, and materials to make sure that BCC was integrated with the overall program goal, cross-cutting

to each strategy, inter-linked with each program component to reinforce each other and inclusive of products, services, activities, materials, and other communications means.

The following descriptions briefly explain how BCC cut across overall IMPACT programming to achieve program goals.

Surveillance and research: FHI continued to conduct surveillance and research for informed programming, measuring the results of national responses and filling in the gaps. It used the sero-surveillance reports and other available research/data to identify hotspots and to advocate for evidence-based programming through national dissemination seminars, press releases, and printing and distribution of advocacy documents.

Care and support: FHI worked with PLHA peer support groups, to train counselors and health service providers, strengthen VCT service facilities, and develop appropriate communication strategies, media, and materials for reducing stigma and discrimination against people living with HIV and AIDS. These included community courtyard meetings, celebrity posters, and an interfaith-based talk show on television.

Coordination for expanded comprehensive response: FHI continued to lead multi-donor and multi-sectoral coordination of HIV/AIDS responses with HAPP, GFTAM, GoB, Expanded Thematic Group (UNAIDS), and so on through donor meetings, AIDS task force meetings, and coordination efforts.

Prevention interventions: FHI's prevention interventions include three components: 1) advocacy, 2) primary prevention, and 3) social mobilization. This leads to a comprehensive response to HIV prevention balanced with A (abstinence), B (being faithful), and C (correct and consistent use of condoms) results.

Advocacy: Advocacy programs included divisional advocacy meetings for risk reduction programs for IDUs and other MARGs; training for police in police training academies; special advocacy training programs for police, narcotics control staff, and journalists; and training and advocacy with religious leaders (Imams).

Primary prevention: FHI's primary prevention programs target most at risk groups such as IDUs, female sex workers, MSW and MSM, and clients of sex workers. These programs focus on local advocacy and community mobilization; STI, counseling, BCC, and VCT services through integrated community health centers (IHCs); peer education and outreach; and condom distribution and risk perception promotion.

BCC activities for prevention interventions and education included psycho-social skills in critical thinking, communication, decision making, self awareness, negotiation, and life skills for the targeted high-risk groups. The program has developed a new campaign to raise HIV self-risk awareness among the most at-risk populations through peer education and outreach to promote Modhumita IHCs as safe and friendly places for prevention activities and treatment, and also promote linkages to socially marketed condoms and STI clinics provided by other USAID-funded programs.

For clients of sex workers, there was BCC at the workplace (garment factories, export processing zones, labor associations) and continuation and expansion of a nation-wide social marketing campaign implemented through a local organization, the Social Marketing Company.

BCC also encouraged and increased condom use for the prevention of STIs and HIV among male and female sex workers and other high-risk groups. Along with the condom social marketing campaign, there was demonstration and distribution of condoms through IHCs and peer educators. Female condoms were also promoted to increase condom negotiation alternatives for female sex workers. Lubricants for consistent condom use were also promoted.

F. Program Results

The Bangladesh IMPACT program's accomplishments fall into the following six major areas of success—prevention, care and support, behavior change communication, capacity building, surveillance and research, and global leadership. Please see specific program results from IA activities in section IV. Please see specific output data in Attachment A.

As noted earlier, FHI's IMPACT Program in Bangladesh targeted the following populations:

- Female sex workers—hotel- and street-based
- Male sex workers
- Clients of sex workers
- Men who have sex with men
- Transgender people (*hijras*)
- Rickshaw pullers, garment factory workers

1. Program Outputs

Prevention

Interventions with sex workers (hotel- and street-based) and their clients

- The most successful work under the IMPACT project was reaching hotel-based sex workers. Previously, no other organizations could either identify hotel-based sex workers or reach them for motivation in behavior change. Early in FHI's intervention, staff faced great challenges in approaching hotel managers but eventually earned their trust so that these gatekeepers could lead FHI staff and partners to sex workers. Due to these efforts, FHI was able to continue and expand interventions with hotel-based sex workers around the country. FHI began working in the capital, Dhaka, and by the end of IMPACT, FHI was working in nine cities. The total number of one-to-one peer education contacts with hotel-based sex workers by the end of the project was 1,170,665.
- The initial target groups of FHI's interventions were female sex workers (hotel- and street-based), MSM, and *hijra*/transgender. In the first group, there were seven IAs working with female sex workers, one IA working with MSM, and one organization working on care and support issues. Gradually the number of IAs increased, reaching 28, and interventions increased to include condom promotion, and STI and counseling services.
- Another project success was informing sex workers about condoms and lubricants. Prior to FHI's project interventions, most of these women had never heard of HIV/AIDS and did not know that using condoms could help prevent transmission of STIs including HIV. Although consistent use of condoms by the sex workers will require ongoing efforts, the rate of condom use has increased significantly during the course of the IMPACT project. Total number of condoms distributed throughout the life of the project is 5,404,814.
- 13,714 hotel-based female sex workers attended STI clinics throughout the life of the project. A total of 5,035 street-based sex workers received STI services.

Interventions with MSM including male sex workers

- The MSM community has formed a community-based organization to address their special needs and this organization now includes offices all over the country.
- 13,724 MSMs and *hijra* received STI services throughout the life of the project.

Interventions with transgender people (hijras)

- The *hijra* community realized their vulnerability towards STI and HIV infection and formed a separate community-based organization which focuses its efforts on providing knowledge and STI treatment support to their community.

Interventions with people living with HIV/AIDS

- PLHA formed an organization, Ashar Alo Society, which has been working with FHI since 2002 to provide care, support, and treatment to PLHA and their families. FHI also provides close technical support for improving PLHA and affected individual's quality of life. FHI is also engaged in developing communication materials and messages as part of a stigma and discrimination reduction campaign to prepare communities to accept and support PLHA with compassion, tolerance, and sensitivity. PLHA groups offer education and support to members to help meet the challenges of reducing transmission of risk behaviors.

Widow Opens a Window of Hope

"When I lost my husband to AIDS, I felt immense uncertainty... hopeless, helpless. A widow at the age of 25, my dreams were shattered. During those dark days, there were no peer-led support groups available. A physician at the hospital extended great support and I realized that he may not always be available to do the same for others in need. I turned this devastation around, joined a NGO, and started working as a voice for people affected and infected by HIV and AIDS."

There was no looking back for Habiba and several years later, Ashar Alo Society (AAS) was formed. "I feel that AAS is a platform from where PLHA issues can be raised collectively and I believe it is a driving force in changing the lives of affected individuals and families. When PLHA join AAS, they feel that they are no longer alone – that there is a collective "we," which instills hope and a desire for positive thinking and living. I am happy when I see that AAS makes a difference within families and communities. With assistance from AAS, they are able to disclose their status to their loved ones and receive acceptance and support from them."

"In the past, I thought that the government would never respond or acknowledge the needs of PLHA. It gives me a sense of accomplishment when I see that our government has started to mention care and support issues – this was just a dream before."

Habiba, the Executive Director of Ashar Alo Society, has seen her organization grow from a staff of four with only 10 members in Dhaka to a staff of 19, working in four divisional cities in Bangladesh and serving almost half of the country's identified PLHA and over 750 family members.

Habiba is an outspoken advocate for the positive people of Bangladesh and their families and communities. She is a counselor, a friend, an advocate, and a voice to the most discriminated against and stigmatized – a true champion of change.

Interventions with (Injection) Drug Users (IDUs)

- FHI initiated IDU projects with three IAs. IDUs were provided with treatment support in treatment centers and through community-based detoxification camps.
- 1,676 IDUs attended STI clinics and received treatment.

Care and Support

- The care and support intervention motivated PLHA through courtyard meetings and helped reduce stigmatization in urban and rural areas. This project was also successful in establishing an effective network among the private sector, especially with private banks and pharmaceutical companies. Through this collaboration, the care and support project was able to receive ARVs for a lower price and to provide these drugs to members of their organization.

STIs

- STI services employ the syndromic approach to diagnosis and treatment.
- Trained counselors offer STI counseling services including contact tracing and partner disclosure support, treatment adherence counseling, and STI prevention counseling.

Drop-In Centers

- 47 drop-in centers around the country are currently operating and fully functional.

Behavior Change Communication

- BCC training was provided to police cadets at all six National Police Training Academies to raise their awareness on HIV/AIDS and STIs.

Surveillance and Research

- GoB approved and endorsed the HIV estimation developed by FHI as well as five rounds of HIV surveillance (Behavioral Surveillance Survey) with ICDDR,B. With reliable data and size estimations, a better understanding of coverage rates is available.
- During the IMPACT project, several result-oriented studies were conducted, including the IDU SexNet Study, STI ESM-PPT Study, the NASROB study, and others. FHI contributed to the BSS study from Round 1 to 5 by providing funding and technical support for the activity.

Capacity Building

- IMPACT trained a total of 829 active peer educators (PE) for all intervention areas.
- The program met regularly with government, religious, political and local community-based leaders at both national and district levels.
- The program built the technical and programmatic capacity of implementing partners and key stakeholders. It provided ongoing support for implementing agencies in preparing subproject documents and routine programmatic, technical, and financial reports.
- Many of FHI's implementing partners have not previously delivered clinical services. In order to build technical capacity with these partners FHI provided the following pre-service training sessions to clinical service providers
 - 24 HIV/STI counselors trained
 - 9 STI doctors trained
 - 42 Minimum standard trainings for STIs
- FHI provided international technical assistance to support "Training in Training" to 14 local counselor and medical staff to boost local capacity to deliver HIV/STI counseling

training. The prospective trainers had previously undertaken VCT/STI counselor training and had a minimum of six months counseling field experience. These trainees were provided training in teaching methodology and engaged in supervised practice teaching. Feedback was provided on their preparation for training, presentation skills, and management of challenging group behaviors. These newly trained local trainers then provided training to new HIV counseling recruits.

- FHI/IMPACT held an AIDS awareness event on Friday, August 2, 2005. With various kinds of support from community officials, FHI and Ashar Alo Society, Peace Corps Volunteer Melissa Dale and her students organized the event at the Kurigram city stadium and provided HIV/AIDS materials to all participants. Approximately 200 people attended the event while 150 of these individuals officially participated in the 5K run or 1K walk. During the IMPACT project, more than 20 Peace Corps volunteers received general information on HIV/AIDS from FHI and are now involved in secondary projects with IAs around the country.

“I am A Huzur and I Talk About Sex.”

Enayet was furious when he first heard about an NGO that discussed sex, sexual diseases and HIV/AIDS. As an ex-Madrassa (religious school student), he felt this was against Islam. He attended a community advocacy meeting, hoping to publicly voice his opposition to this immoral work. Instead, he began to see things differently. He realized that he and other leaders had a responsibility to speak out and educate others on the dangers of HIV.

Enayet realized the potential risk and gravity of HIV. He reached beyond the group of sex workers and clients that he worked with. Enayet started motivation sessions within the very institution that he was educated.

Enayet, 34 years old, is an influential leader of a religious group. He explains that “sex outside marriage is a sin but we cannot ignore reality. That’s why I try to convey the message of safer sex.”

“People trust me to talk about sex as I am a huzur (religious leader),” he adds. As a champion of change, Enayet spreads awareness among Madrasas, and continues to impact lives with his motivation and dedication.

Program Growth

- Number of IAs increased significantly. In FY01 only nine IAs were working on minimum target interventions. The number had increased to 26 in FY05. Size estimations were not yet complete for the MARP target interventions, but geographic coverage increased.
- Number of working areas increased to cities all over the country from one city to nine across the country.
- Number of target populations increased to include female sex workers, male sex workers, MSM, IDUs, police, and clients of sex workers.
- Female condoms were introduced to the project for one year. Due to lack of supply and this was later dropped.
- STI clinics and treatment improved with initiation of an STI study conducted by University of North Carolina as well as a focused approach on improving the quality of services. During this time FHI developed an STI Guideline that has since been adopted by the GoB.
- New areas such as voluntary counseling and testing (VCT) and laboratory testing were identified as necessary components to the program. This allowed FHI to consider VCT in future programming.
- FHI’s monitoring and evaluation plan continued to be streamlined throughout the life of the project. For example, data for peer educators and STI clinics was not previously compiled together for the same IA and now it is, enabling program staff to reflect on how peer educators are doing with regard to bringing clients into the STI clinics.

Program Constraints

- It is difficult to ensure behavior change with regard to consistent use of condoms, particularly among sex workers who are easily disempowered by clients. Further programming focused on including clients of sex workers as they play a vital role in decision making with regard to consistent use of condoms.

- Clients of sex workers were difficult to reach as they are not a homogenous group (i.e. police, business men, civil servants, rickshaw pullers, truck drivers) and FHI did not focus resources on clients until the end of the program.
- Police intervention effected less behavior change than hoped because more national-level buy-in was needed.
- Condom supply was inconsistent until condoms were received directly from USAID. This meant that condoms were not distributed freely for every sex act, which most likely had an impact on the indicator of consistent condom use.
- Advocacy/networking at the national level was not as effective as it could have been. Staff lacked experience and the government lacked HIV/AIDS experience. This led to sensitization meetings taking place as opposed to an advocacy campaign with clear objectives.
- STI services were not utilized by target groups as expected, especially outside of Dhaka, mostly due to the lack of availability of trained doctors and counselors and poor quality of clinic set-up.
- Staff had little experience or understanding of the importance of utilizing monitoring data to improve program effectiveness. Once this was identified, staff were trained and given responsibility to check monitoring data and hold discussions with their respective IAs. As a result, data and program quality improved.

2. Service Output

These materials listed below were distributed to all the DICs. They were used by the clinic staff.

Female Sex worker Interventions

1. Patient files	1,000
2. Referral cards	1,000
3. Doctors prescription pads	500

PLHA Interventions

1. Health Books	500
2. Brochures	5,000
3. Stickers	5,000
4. ID Cards	65

Training and Outreach Communication Materials Produced and Distributed by FHI Bangladesh

All of the materials produced below were either distributed directly to the DIC (47 total) or to the numerous peer educators who were working at each DIC. By the end of the project there were approximately 1,000 peer educators working with all risk groups. Each peer educator was equipped with a set of materials to do his/her work. Beyond the materials themselves, all peer educators attended a training course on how to be peer educators as well as how to use the materials listed below.

All At Risk Groups

1. Talking Pictures	1,550 sets
2. Model Pictures	2,250 sets
3. STI Pictures	2,200 sets
4. Pocket flash cards	3,000 sets
5. Child Picture sets	3,000 sets
6. Money Sets	132,000 (500 Taka), 110,000 (100 Taka)
7. Male Reproductive Organ Apron	500

8. Female Reproductive Organ Apron	500
9. Guide Book for using Male and Female Reproductive Organ Aprons	2,000
10. Flip Chart (a love story)	3,000
11. How to Create an Effective Peer Education Project	3,000
12. Dildo (locally produced)	1,000
13. T-shirts	1,000
14. Lifeskills Umbrella	500
15. Bag: Peer Educ. Resource Trg. Kit	1,000
16. Life Skills Pens	1,000
17. Condom/Lubricant Storage Guidelines	30
18. Celebrity Posters	20,000
19. HIV/AIDS Question and Answer Book	2,000
20. Bangla dubbing: "With Hope and Help" (Thailand)	9 VHS copies
21. Bangla dubbing: "With Hope and Help" (Best of Five)	9 VHS copies
22. Edutainment Audio Album Tui Amar Sonali	1,000 copies
23. Long Term Effect of STIs (Flash Cards)	415 copies
24. Long Term Effect of STIs (pocket size)	2,000 copies
25. Outreach Referral Slip	200 pads
26. Modhumita Drop Box	80
27. Modhumita Min. Standards Poster	3
28. Modhumita Sticker	100,000
29. Modhumita Medicine Envelop	100,000
30. Modhumita Client Referral Cards	100,000

Female Sex worker Interventions

1. Condom Wheel	4,100
2. Client Leaflets	155,000
3. Female Condom Leaflet	10,000
4. Jumble Card	1,000
5. Puzzle: Female Reproductive Organ (Internal parts)	1,000
6. Puzzle: Female Reproductive Organ (External parts)	1,000
7. Female Condom Q&A Booklet	1,000
8. Modhumita Badge	500

Street-Based Female Sex worker Interventions

1. Handbag Black	500
2. Jute Bag White	500

Hotel-Based Female Sex worker Interventions

1. Modhumita HBP Photo Diary	200
2. Modhumita HBP Permanent Membership Card	2,000
3. Modhumita HBP Referral Card cum Temporary Membership Card	5,000

4. Modhumita HBP Door Message Board	2,000
5. Modhumita HBP Calendar	2,000
6. Modhubarta magazine	4,000
7. Modhumita Signboards	10
8. Modhumita HBP Mood Poster	7
9. Modhumita HBP Interior Poster	8
10. Modhumita HBP Bulletin Board	4
11. Modhumita Door/Name Plate	15
12. Modhumita HBP Doctor's Curtain	2

For Male Sex worker Interventions

1. Bandhu Literacy Booklet	25,000
2. Photonovella 1: Shustho Jiboner Pothe	3,000
3. Condom Wheel for MSM/MSW	1,000
4. Shustho Jibon Literacy Booklet	3,000
5. ODPUP Literacy Booklet	50,000
6. ODPUP HIV and AIDS Why am I at risk?	50,000
7. Shustho Jibon: HIV and AIDS Why am I at risk?	30,000
8. Modhumita MP Photo Diary	300
9. Modhumita MP Permanent Membership Card	5,000
10. Modhumita MP Referral Card	20,000
11. Modhumita MP Signboard	1
12. Modhumita MP Mood Poster	5
13. Modhumita MP Interior Poster	4
14. Modhumita MP Bulletin Board	2
15. Modhumita MP Doctor's Curtain	1

Materials for PLHA interventions

1. AAS Brochure (Bangla)	3,000
2. AAS Brochure (English)	3,000
3. Stickers	3,400
4. PLHA Film: Hathe Rakho Hath	2 Beta Copies, 2 DVDs

Materials for IDU interventions

1. DNC Flipchart	1,000
2. Modhumita IDU Referral Card	6,000
3. Modhumita IDU Signboard	1
4. Modhumita IDU Mood Poster	6
5. Modhumita IDU Interior Poster	4
6. Modhumita IDU Bulletin Board	2
7. Modhumita IDU Information Sheet	6,000
8. Modhumita IDU Brochure	6,000
9. Modhumita IDU Doctor's Curtain	1

Guidelines, Research Reports, and Other Documents Produced by FHI Bangladesh

1. Quality Assurance 4-pager	2,000
2. STI Minimum Standard Guidelines	300
3. STI Toolkit	300

4. STI Clinical Guidelines	100
5. HIV in Bangladesh Where is it Going? (English)	700
6. Drugs: Treatment Works	800
7. HIV in Bangladesh Where is it Going? (Bangla)	569
8. HIV in Bangladesh Is Time Running Out? (English)	5,000
9. NASROB	1,500
10. FHI folder	2,000
11. National HIV Serological and Behavioral Surveillance (2000-2001)	500
12. GIS Database (2002)	1,500
13. GIS Database CD (2003)	1,500
14. Condom/Lubricant Storage and Disposal Guidelines	30
15. HIV in Bangladesh The Present Scenario, 2004. A summary document of the Fifth Round of National Surveillance	500
16. FHI Focus in Bangladesh, February 2005 (English)	2,000
17. FHI Focus in Bangladesh, February 2005 (Bangla)	3,000
18. FHI Focus in Bangladesh, February 2004 (English)	2,000
19. HIV in Bangladesh The Present Scenario, 2004	2,000

Studies Conducted

FHI Study/Assessments under IMPACT

Name of Study/Assessment	Type (Study or Situational Assessment)	Implementing Agency	Year	Comments
Behavioral Surveillance Survey (BSS) second round	Study	CARE-Bangladesh	1999-2000	
Behavioral Surveillance Survey (BSS) third round	Study	ORG-MARG-Quest Ltd	2000-2001	Quest Ltd has changed to AC Nielsen
Behavioral Surveillance Survey (BSS) fourth round	Study	HARC (HIV/AIDS Research and Welfare Center)	2002	
National Assessment of Situation and Responses to Opioid/Opiate Use	Situational Assessment	FHI, CARE-Bangladesh, and HASAB	2001-2002	This was done in collaboration

Name of Study/Assessment	Type (Study or Situational Assessment)	Implementing Agency	Year	Comments
A Situational Assessment of the Residence-Based Sex Trade in Dhaka, Bangladesh	Situational Assessment	FHI	2002	
Mapping HIV/AIDS Prevention and Care Activities in Bangladesh	Updated and Validation	Population Research Development Associates	2002	GIS Database (Update and Validation of 20 Districts and Dhaka and Chittagong City)
A Situational Assessment of the Hotel-Based Sex Trade in five cities of Bangladesh	Situational Assessment	Org Marg Quest Ltd and HARC (HIV/AIDS Research and Welfare Center)	2001	Two agencies were involved due to geographic coverage. It was done in Dhaka, Chittagong, Barishal, Comilla, and Rajshahi
Assessment of Drug Use Practices in Pabna and Dhaka	Assessment	CARE-Bangladesh	2003	
Mapping HIV/AIDS Prevention and Care Activities in Bangladesh	Updated and Validation	Geographic Solutions Research Center	2003	GIS Database (Updated and validation of 64 districts)
Hotel-Based Sex workers Baseline Study in Sylhet	Situational Assessment	Sylhet Jubo Academy (SJA), Sylhet	2003	Under financial and technical assistance from FHI
Behavioral Surveillance Survey (BSS) fifth round	Study	ICDDR,B Centre for Health and Population Research	2003-2004	
“I will use it for my safety” Intensive Monitoring of the Introduction of Female Condoms within FHI supported HIV Prevention Interventions in Bangladesh	Monitoring Report	AVAS, DRISTI, SAS, and YPSA	2003-2004	This four-month long monitoring exercise was done with hotel- and street-based participants
An Assessment of Injection Drug Using Networks and HIV Risk in Bangladesh	Study	JSI Bangladesh	2003-2004	

Name of Study/Assessment	Type (Study or Situational Assessment)	Implementing Agency	Year	Comments
Mapping and Situation Assessment of Hotel-Based Sex workers	Situational Assessment	Marie Stopes Bangladesh Limited (MSBL)	2003-2004	MSBL sub-contacted House of Consultants Limited. This was done in six cities: Khulna, Bagura, Pabna, SirajGonj, Chandpur, and Teknaf
HIV/AIDS Program in Bangladesh	Update and Validation	Population Research Development Associates	2004	GIS Database
Report on Situation Assessment for Expanding Care and Support Program in Rajshahi	Situational Assessment	Ashar Alo Society	2004	
A Baseline Survey on Drug Users of Chandpur	Baseline	CARE-Bangladesh	2004	
A Baseline Survey on Drug Users of Ishwardi	Baseline	CARE-Bangladesh	2004	
A Baseline Survey on Drug Users of Pabna	Baseline	CARE-Bangladesh	2004	
A Baseline Survey on Drug Users of Narayanganj	Baseline	CARE-Bangladesh	2004	
STI study: ESM vs. PPT among HBSW in Dhaka, Bangladesh	Study	ICDDR,B and University of North Carolina	2004-2006	
Positioning of Implementing Agency Clinics for High-risk Groups in Bangladesh	Study	MRC-MODE Ltd.	2005	
Rickshaw Puller's Behavioral Baseline Assessment in Selected Areas in Chittagong	Baseline Assessment	Health Solution International (HSI)	2005	
Hotel-based Sex workers Behavioral Situational Assessment in Chittagong and Cox's Bazar	Baseline Assessment	HELP	2005	
Assessment of Injection Drug Users (IDUs) Sexual Networks and Risk Behavior in Indonesia and Bangladesh	Study	JSI Bangladesh	2004-2005	JSI implemented the Bangladesh portion.

Name of Study/Assessment	Type (Study or Situational Assessment)	Implementing Agency	Year	Comments
Street-based Sex workers behavioral situational assessment in Shantahar and Naogaon	Situational Assessment	Light House, Bogra	2004	
Hotel-Based Sex workers Behavioral Situational Assessment in Srimongol and Sunamgonj	Situational Assessment	Sylhet Jubo Academy (SJA) Sylhet	2004	
Male Reproductive Health Survey	Study	ICDDR,B Centre for Health and Population Research	2004-2005	
Assessment of a Peer Education Project for HIV Prevention among Hotel-Based Sex workers in Dhaka	Study	ICDDR,B Centre for Health and Population Research	2005-2006	Time frame May 25, 2005–October 24, 2005. It started under IMPACT and will continue until January 2006.
Pre-Test of Logo for Demand Generation	Qualitative Study	AC Nielsen Bangladesh	2005	
Validation of Rapid Test Kits for HIV Diagnosis using the WHO/UNAIDS Algorithm	Validation Study	ICDDR,B, Centre for Health and Population Research	2005	

III. LESSONS LEARNED AND RECOMMENDATIONS

Lessons Learned

- Initially communication materials were developed for hotel-based sex workers and MSM. As interventions expanded to other most-at-risk groups it became clear specific targeted communication materials need to be developed for each target group due to their different lifestyles. MARPs are not a homogenous group. They were segmented for the purpose of developing communication materials that specifically targeted their behavior and lifestyle (i.e. *hijras* vs. hotel-based sex workers).
- Since each target group is unique, special consideration should be given to a client group's unique needs. Rather than developing homogeneous programs for the general population, special programs need to be developed and fine-tuned after field testing for most-at-risk client groups to most effectively address their needs.
- The importance of engaging government institutions and key stakeholders was critical to project success. For example, often the police would raid the hotels or cruising spots, which made it difficult to reach the target hotel-based sex worker population. Through continuous discussions with local and national police, peer educators were able to ensure that the target population received services.

- Clients are less likely to use STI services if doctors are not trained on proper STI examinations. Additionally female sex workers prefer to have female doctors.
- Clients were easily lost to follow-up due to VCT services not being conducted at the IHC. Clients were sent to Jagori test site, which is part of ICCDR, B.
- Peer educators need refresher training to keep them motivated.

General Recommendations

- An effort should be made to recruit doctors with STI training and experience (especially female doctors) to treat STI patients. Female clients, such as sex workers, prefer to be attended to by a female doctor. If a female doctor is present, clients are more likely to use the services at the clinic.
- NGO clinic laboratories should be equipped with modern testing facilities so that they can perform HIV testing on site as opposed to having to send clients to Dhaka for testing. All too often clients were lost to follow-up.
- Since most NGOs refer complicated STI cases to government facilities, a collaborative system (or referral system?) should be developed with these government facilities that will facilitate treatment of referred STI patients.
- Material development should be ongoing to ensure continual engagement of the target population.

IV. HIGHLIGHTS OF IMPLEMENTING PARTNER ACTIVITIES

A. Implementing Partners List

Implementing Agencies

1. Ashar Alo Society (AAS)
2. Ashokti Punorbashon Nibash (APON)
3. AVAS
4. Bandhu Social Welfare Society (BSWS)
5. Bangladesh Women's Health Coalition (BWHC)
6. CARE Bangladesh
7. Society for Community-Health Rehabilitation Education and Awareness (CREA)
8. Dhaka Ahsania Mission (DAM)
9. DRISTI
10. HIV/AIDS and STD Alliance Bangladesh (HASAB)
11. Health and Education for Less-privileged People (HELP)
12. ICDDR,B Centre for Health and Population Research
13. John Snow International
14. Light House
15. Marie Stopes Bangladesh Limited (MSBL)
16. Organization for Development Programs for Underprivileged (ODPUP)
17. Shustha Jibon
18. Sylhet Jubo Academy (SJA)
19. Social Advancement Society (SAS)
20. South-South Centre
21. Young Power in Social Action (YPSA)

B. Subproject Highlights

Ashar Alo Society (AAS)

Geographic focus: countrywide

Target population: People living with or affected by HIV/AIDS

Length of support: December 16, 2003 – December 15, 2005

Level of support: US\$203,090

Goal

Fight for the rights of PLHA, to create an environment for them to live free from stigma and discrimination, and to allow them access to care and support.

Accomplishments

- Registered as first self-help group of PLHA from Ministry of Social Welfare (2002)
- Expanded its coverage in Sylhet, Chittagong (2003), and Rajshahi (2005)
- Offered counseling and education program for its members
- Is the central point of support and information for health care and treatment for its members
- Received subsidy on ARV (50 percent) from Beximco and received ARV and nutritional support free of cost from private sector companies for 13 people (2004)
- Set five years strategic planning of AAS through a participatory workshop (2004).

Recommendations

- Create specific policies or programs to support those infected with and affected by HIV/AIDS at government level as well as focus on implementation of care and support and integration with prevention efforts
- Encourage involvement of the government and an established network of NGOs to provide care and support services across Bangladesh

Ashokti Punorbashon Nibash (APON)

Geographic focus: Dhaka

Target population: Female drug users

Length of support: June 15, 2005 – December 14, 2005

Level of support: US\$73,769

Goal

Prevent HIV among poor female drug users through drug treatment and provision of comprehensive sexual health services in Dhaka City.

Accomplishments

- Conducted detoxification for 46 individuals, long term rehabilitation for 15 individuals
- Conducted skills training for 33 recovering drug users
- Held two community sensitization meetings
- Conducted 16 family sessions on co-dependency, HIV, family support

Recommendations

- Increase treatment and rehabilitation options for female drug users of all socio-economic classes
- Increase availability of outdoor games and sessions. Recreation can help retain clients and gives them a positive outlet for their energy. Clients find it difficult to remain inside for extended durations of treatment
- Increase community mobilizing activities to generate income for ex-drug users
- Provide additional resources to address the more complex health issues of female drug users

AVAS

Geographic focus: Barisal city

Target population: Hotel-based sex workers and their clients

Length of support: July 1, 2002 – October 31, 2005

Level of support: US\$140,450

Goal

Reduce the risks of STI and HIV transmission among hotel-based sex workers and their clients in 33 hotels involved in the sex trade in Barisal.

Accomplishments

- Reached 538 hotel-based sex workers through outreach with messages on HIV and AIDS
- Made 42,637 contacts with the target population through 5,306 group meetings
- Made 247,018 contacts through one-to-one sessions

- Provided 1,096 STI clinic services to sex workers
- Developed a strong relationship with professional and civil society and addressed the misconceptions from religious groups. Worked with Imams during weekly Jumma prayers
- Increased number of condoms distributed :452,094 male condoms, 6,626 tubes of lubricants, 6,513 female condoms
- Improved sex worker's perception of their health, hygiene, and STI awareness

Recommendations

- Increase number of sensitization meetings/workshops with religious leaders to disseminate accurate messages on HIV/AIDS and STIs
- Set up STI labs in DICs or refer patients to other lab for more precise results
- Develop the education capacity of Peer Educators and Site Workers to improve their impact
- Provide rehabilitation options for sex workers by providing skill development training
- Provide special services for younger sex workers by providing reproductive health education and life skills training
- Conduct exchange visits among implementing agencies to enhance knowledge and information and enrich activities

Bandhu Social Welfare Society (BSWS)

Geographic focus: Dhaka, Chittagong, Sylhet, Mymensingh, Rajbari, and Comilla

Target population: Men who have sex with men, male sex workers, and *hijras*

Length of support: October 1, 2000 – October 30, 2005

Level of support: US\$1,634,821

Goal

Reduce the risk of HIV and STI transmission among men who have sex with men (MSM) and their partners in six major cities in Bangladesh.

Accomplishments

- Distributed 801,895 condoms and 16,299 tubes of lubricant
- Provided 20,966 clinic contacts
- Diagnosed 6,229 STIs
- Conducted 269,708 field based BCC sessions/one-to-one contacts
- A significant number of the target community received HIV/AIDS and STI transmission and prevention messages, IEC/BCC materials, and condoms and lubricants for safer sex practice
- Improved collaboration and strong networking relationships continued with different sectors at national and international level including private organizations, NGOs, and donor agencies
- Advocated for the inclusion of MSM issues in the National Guideline for HIV/AIDS/STD prevention

Recommendations

- Develop a general male sexual health strategy that addresses anal sex as a normative male sexual practice

- Build coalitions with other MSM sexual health interventions to address legal, judicial, and social impediments to sexual-health focused interventions among MSM
- Address the high levels of disempowerment, low esteem, and self-destructive behaviors of ³*kothi*-identified males as key elements MSM sexual health interventions/strategies
- Increase the number of community-based organizations to work more effectively with MSM

Bangladesh Women’s Health Coalition (BWHC)

Geographic focus: Dhaka city

Target population: Hotel-based sex workers

Length of support: September 15, 2003 – November 14, 2005

Level of support: US\$355,935

Goal

Reduce the STI/HIV/AIDS transmission risk among hotel-based sex workers and their clients in 70 hotels involved in sex work within Dhaka city.

Accomplishments

- Reached 2,500 sex workers and 12,031 clients in 70 hotels
- Peer educators made 24,749 one-to-one contacts and 83,977 group contacts
- Site workers made 75,269 one-to-one and 46,673 group contacts
- Maintained targeted STI service standards. Serves as model clinics for other FHI interventions
- Host for the first IHC to be branded by Madhumita
- Conducted 565 STI sessions with 6,323 STI patient services
- Coordinated study on STI case management conducted by ICCDDR,B and UNC
- Distributed 2,330,127 male condoms, 187,93 female condoms, and 9,544 tubes of lubricant

Recommendations

Once quality is achieved, the most crucial concern is to sustain the quality, which can be done through

- Effective supervision in overall project activities
- Promoting condoms
- Strengthening monitoring systems by project management, BWHC central management, and FHI

³ *Kothi*: a male sex worker

CARE Bangladesh

Geographic focus: Rajshahi and Dhaka districts

Target population: IDUs

Length of support: November 15, 2003 – December 31, 2005

Level of support: US\$534,763

Goal

Reduce the risk of HIV transmission among drug users (IDUs and heroin smokers) in Chandpur, Chanpara, Iswardi, Narayangonj, and Pabna.

Accomplishments

- Trained 1,116 peer educators and provided 597 peer educators with refresher training
- Treated 2,007 STI cases, 390 abscesses, and 3,628 general ailments
- Held 136 meetings with 1,527 drug users
- Detoxified 259 drug users through detox camps

Recommendations

- **Drop-in-centers**
 - Sub-contract with credible and trained NGOs to provide appropriate clinical services for MARGs. NGO staff attitudes affect clinical service attendance and an orientation regarding the needs and issues of the target population (and difficulties one may encounter while providing services) would improve capacity
 - Add laboratory facilities to DICs for immediate diagnosis and treatment to improve compliance
 - Include other socio-economic classes in drug treatment services and provide alternative options for clients not interested in attending DICs
 - Form DIC management committees—this strategy proved effective in mobilizing community acceptance and responsibility of the DICs, building stakeholder ownership and sustainability
- **Detox camps**
 - Support for post-detoxification is critical to reintroduce ex-drug users back into the communities and prevent relapse. While many received vocation training and skills, all lacked the capital investment needed to kick-start self-employment endeavors
 - Increase emphasis on social rehabilitation and reintegration to improve family support
 - Rely on Indigenous Leaders Outreach Model (ILOM) risk reduction model, a useful technical guide and easy for staff to follow
 - Involvement of drug users in self-help groups is important to motivate other members of the target group to go through detox and improve success rates

Society for Community-Health Rehabilitation Education and Awareness (CREA)

Geographic focus: Greater Dhaka

Target population: Injection drug users

Length of support: June 1, 2005 – November 30, 2005

Level of support: US\$76,244

Goal

Prevent the spread of HIV and STIs among marginalized male and female IDUs by providing comprehensive treatment of sexually transmitted infections and drug use followed by psycho-social rehabilitation in Greater Dhaka City.

Accomplishments

- Admitted 135 male and 18 female clients for detoxification
- Treated 44 male clients and eight female clients for STIs
- Performed 85 individual and 45 group sessions on motivational enhancement, high-risk management, and available services
- 153 IDU clients received short term detoxification (135 male and 18 female)
- Referred 21 IDUs to Jagori clinic for VCT.

Recommendations

- Increase community detoxification to reduce costs and increase societal awareness/community participation
- Improve comprehensive client follow-up system from in-house detoxification to mainstreaming
- Expand vocational training and awareness building program
- Introduce peer-led follow-up and after care
- Separate detoxification, rehabilitation clients, and day care clients

Dhaka Ahsania Mission (DAM)

Geographic focus: Dhaka

Target population: Injection drug users

Length of support: June 15, 2005 – December 14, 2005

Level of support: US\$76,473

Goal

Prevent the spread of HIV and STIs among marginalized male IDUs by providing comprehensive, quality treatment of drug addiction and STIs in Greater Dhaka City.

Accomplishments

- Detoxified 201 clients and rehabilitated 29
- Provided short term detoxification for 136
- Conducted two community-based detoxification camps with 50 clients
- Provided 1,715 day care service contacts
- Provided 83 IDU clients with STI treatment
- Trained 30 IDUs on vocational skills

Recommendations

- Finalize protocols/modules before projects start to ensure better quality
- Introduce outreach initiative for improved referral mechanisms
- Disseminate results and recommendations from these new initiatives in Bangladesh to encourage a national response

DRISTI

Geographic focus: Comilla

Target population: Female sex workers

Length of support: March 24, 2002 – October 30, 2005

Level of support: US\$170,787

Goal

Reduce vulnerability and risk of HIV/AIDS/STI infections among street-based sex workers and their clients in Comilla.

Accomplishments

- Organized 17 advocacy meetings with local influential people, reaching 643 participants
- Organized 43 social awareness/community education sessions with key stakeholders and client groups, reaching 865 people
- Organized six street dramas on HIV and prevention, reaching 1,150 targeted individuals
- Provided 188,265 sex worker contacts and 124,400 client contacts
- Distributed 584,054 condoms
- Diagnosed 603 STIs

Recommendations

- Increase community awareness on HIV/AIDS and STIs. Current low awareness may be one of the major hurdles to prevent HIV/AIDS in Bangladesh

HIV/AIDS and STD Alliance Bangladesh (HASAB)

Geographic focus: Country wide

Target population: Female sex workers

Length of support: October 1, 2001 – September 30, 2005

Level of support: US\$809,481

Goal

Strengthen the capacity of civil society, non-governmental, and governmental organizations to respond to the increasing demand of HIV/AIDS prevention, care, and support activities in Bangladesh.

Accomplishments

- Trained six master trainers, developed and pre-tested a counseling training curriculum, and set up a counseling training related information resource center within the counseling support project
- Provided 4-week core training to 27 counselors, 2-day supervisor's orientation to 24 supervisors, and 3-day basic orientation course to seven participants

Recommendations

- Incorporate supportive visits into skills development training
- Introduce further specialization training (e.g. STIs management, psycho-sexual disorders, IDUs management, PPTCT, etc.) for counselors who received pre-service training
- Create a counseling support network to improve professionalism, increase skills, and reduce burn out

Health and Education for Less-Privileged People (HELP)

Geographic focus: Chittagong and Cox's Bazaar

Target population: Hotel-based sex workers and IDUs

Length of support: May 1, 2005 – October 31, 2005

Level of support: US\$63,187

Goal

Reduce the spread of HIV/STIs among hotel-based sex workers and drug users in Chittagong City and Cox's Bazaar.

Accomplishments

- Improved linkages and networks with AAS and Jagori, ensuring VCT services and HIV support
- Distributed more than 87,000 male condoms, 660 female condoms, and 695 tubes of lubricant
- Served 688 individuals through clinic sessions; 222 diagnosed with STIs
- Conducted 3,255 one-to-one contacts and 57 social group meeting at DICs
- Conducted 798 group meetings at hotel site, reaching 3,078 sex workers,
- Conducted 102 spot sensitization meetings reaching 1,121 hotel boys (work in hotels and take clients to sex workers), pimps, and clients

Recommendations

- Address the constructions of masculinity through education and awareness programs
- Address the socio-political conditions, which also impede interventions for marginalized populations (IA and donor)
- Increase peer educator responsibilities and training. HIV/AIDS/STD awareness and condom use and risk behavior change increased greatly through peer education approach
- Increase advocacy with street/patrol police, law enforcement agencies, media, and local administration
- Advocate with the government to provide support and create an environment under which HELP and like minded NGOs can extend their operations and enhance contributions

ICDDR,B: Centre for Health and Population Research

Geographic focus: Study sites in Bogra, Chittagong, Cox’s Bazar, Dhaka, Faridpur, and Rajshai
 Target population: Male reproductive health survey - men (18-49 years)
 Length of support: September 1, 2004 – August 31, 2005
 Level of support: US\$167,278

Goal

Describe the sexual behaviors of men in the general population in the selected geographic areas of Bangladesh, estimate the prevalence of known risk factors of HIV infection among study subjects, etc.

Accomplishment

Final study report disseminated and submitted to FHI

ICDDR,B: Centre for Health and Population Research

Geographic focus: Study sites in Dhaka
 Target population: Assessment of a peer education project for HIV prevention among hotel-based sex workers in Dhaka
 Length of support: May 25, 2005 – April 30, 2006
 Level of support: US\$18,483

Goal

Document the differential effects of various peer education communication strategies and of peer educator characteristics in a peer education program for hotel-based sex workers.

Accomplishment

Final study report disseminated and submitted to FHI

ICDDR,B: Centre for Health and Population Research

Geographic focus: Chandpur, Chapai Nawabgonj, Chittagong, Dhaka, Khulna, Rajshahi, Sylhet, and all the existing brothels in Bagerhar, Dalautia, Faridpur, Jamalpur, Jessore, Madaripur, Mongla, Mymensingh, Patuakhali, and Tangalil
 Target population: Most-at-risk groups
 Length of support: May 25, 2003 – May 30, 2004
 Level of support: US\$179,000

Goals

- Document behaviors leading to vulnerability for HIV infection among selected population groups
- Determine trends of behaviors over the rounds of surveillance

Accomplishment

Dissemination and published summary of findings (*HIV in Bangladesh: The Present Scenario*).

JSI

Geographic focus: Dhaka

Target population: IDUs

Length of support: April 1, 2005 – June 30, 2005

Level of support: US\$18,495

Goal

Learn about the sexual relationships, types of sexual partners, and patterns of risk behavior among injection drug users in Bangladesh.

Accomplishment

- Identified major characteristics of IDUs and their patterns related to sexual behaviors and other risk behaviors

Recommendations

- Improve monitoring of current HIV prevention interventions for drug users and review implementation strategy to increase use of services
- Promote condoms to IDUs
- Conduct observational studies to ascertain the identity of new entrants for early targeting
- Start institutional level programs for police, students, and low income employees
- Continue investigations to identify the channels and customers to whom IDUs sell their blood

Light House

Geographic focus: Bogra, Noagoan, and Santahar cities

Target population: Street-based sex workers

Length of support: December 16, 2003 – October 31, 2005

Level of support: US\$75,553

Goal

Reduce vulnerability and risk of HIV and STIs among street-based sex workers and their clients in Bogra, Noagoan, and Santahar.

Accomplishments

- Increased coverage from 361 street-based sex workers (SBSWs) in 2004 to 734 in 2005
- Expanded DIC services to Santahar area
- Identified 4,982 clients through one-to-one contact and oriented 105 clients on condom use through formal one-day orientation
- Increased the knowledge of 199 SBSWs through 10 one-day long orientations
- Completed 20 video showings and 155 BCC sessions for SBSW
- Provided STI management service to 401 sex workers
- Distributed 240,810 male condoms, 2,322 female condoms, and 1,952 tubes of lubricant

Recommendations

- Expand geographical coverage of intervention
- Continue STI management for SBSW partners and their clients
- Conduct professional counseling by trained counselors

- Improve quality of DICs and STI clinics
- Start VCT services for SBSWs
- Address youth in prevention efforts

Marie Stopes Bangladesh Limited (MSBL)

Geographic focus: Brahmanbaria, Khulna, and Rangpur

Target population: Hotel-based sex workers

Length of support: June 15, 2003 – October 31, 2005

Level of support: US\$284,684

Goal

Reduce the risks of STI and HIV transmission among HBSWs and their clients in Brahmanbaria, Khulna, and Rangpur.

Accomplishments

- Increased hotel coverage to 74 over the life of project, covering 2,150 HBSWs
- Conducted mapping on HBSWs in six cities (Bogra, Chandpur, Khulna, Pabna, Sirajgonj, Teknaf)
- Conducted advocacy meetings with hotel management (19), police (11), journalists (7), religious leaders (2), government health officials (6), city corporation/local elites (15)
- Trained 11 general practitioners to conduct quality STI services for male clients of hotel-based sex workers, providing services to 2,300 male clients
- Distributed 595,626 male condoms
- Distributed 11,813 female condoms
- Distributed 5,680 tubes of lubricant

Recommendations

- Focused advocacy and health education for making clients of sex workers responsive
- Re-assess selection of PFT members to ensure team members are interested and available to engage in PFT activities such as community mobilization
- Continued and need based advocacy with journalists

Organization for Development Programs for Underprivileged (ODPUP)

Geographic focus: Dhaka, Iswardi, Natore, and Rajshahi

Target population: Hotel-based sex workers

Length of support: January 15, 2004 – October 31, 2005

Level of support: US\$278,193

Goal

Reduce the vulnerability to HIV/AIDS and STI infections among MSM, transgenders, and their associates in four major cities (Dhaka, Iswardi, Natore, and Rajshahi).

Accomplishments

- Peer educators made 117,967 one-to-one contacts; 3,416 group sessions by peer educators and counselors
- Brought 66,248 MSM to the DICs

- Conducted 2,579 counseling sessions and 86 clinical sessions
- Provided 894 patients with clinical services, of which 263 were STI clients
- Distributed 186,820 condoms and 2,060 tubes of lubricant

Recommendations

- Create an enabling environment for HIV/AIDS prevention for the MSM community through local level advocacy and greater involvement with the general mass
- Use folk and local media approaches on HIV/AIDS issue among the mass community
- Introduce baseline and post intervention survey to measure project output and success
- Sensitize health service personnel on different diseases, especially STIs among MSMs, to ensure MSM friendly health services

Shustha Jibon

Geographic focus: Dhaka

Target population: *Hijras*

Length of support: May 1, 2005 – December 31, 2005

Level of support: US\$46,003

Goal

Reduce the risk of HIV and STI transmission among the *hijra* (transgender) population and their partners in Shyampur and Saver Thana, Dhaka district.

Accomplishments

- Delivered HIV and STI prevention messages during outreach to 7,336 people
- Distributed 63,295 condoms and lubricants
- Conducted 135 social group meetings

Recommendations

- Assure a minimum literacy for field level staff

Sylhet Jubo Academy (SJA)

Geographic focus: Sylhet

Target population: Hotel-based sex workers

Length of support: February 1, 2003 – September 30, 2005

Level of support: US\$157,688

Goal

Reduce the risks of HIV/AIDS/STI transmission among hotel-based sex workers and their clients in Sylhet.

Accomplishments

- Reached 360 sex workers; 111,576 contacts by peer educators (group and one-to-one)
- Achieved strong networking with 70 hotels and hotel owners
- Provided 2,372 STI services
- Distributed 501,554 male condoms and 1,786 female condoms

Recommendations

- Emphasize the critical role of hotel owners and management play in achieving the project goal
- Collaborate and coordinate activities with different stakeholders to create awareness level and get necessary support for the project
- Employ functional education techniques to make literate, confident, and efficient peer educators and also create conceptual level of understanding for better professional development
- Use both qualitative and quantitative methods to promote condom use among the sex workers and their clients (counseling, one-to-one education, motivational activities, etc.)

Social Advancement Society (SAS)

Geographic focus: Barisal

Target population: Street-based sex workers

Length of support: December 16, 2003 – October 31, 2005

Level of support: US\$74,649

Goal

Reduce the risk of HIV and STI infection among street-based sex workers and their clients within Barisal.

Accomplishments

- Registered 796 sex workers throughout the project period
- Conducted 58,132 one-to-one contacts with the sex workers
- Held 1,136 group meetings with 8,033 participants
- Provided 825 STI treatment services
- Distributed 359,862 male condoms, 9,054 female condoms and 3,416 tubes of lubricant

Recommendations

- Expand interventions after assessment to increase coverage and impact
- Include more work with clients, such as important factors related to spreading HIV and STIs

- Provide direct services to clients, not just referrals
- Improve condom negotiation skills of sex workers
- Encourage donors to communicate with the notional policy makers regarding the status of sex workers and HIV programming
- Provide satellite STI/clinic sessions for sex workers not located in the immediate project area

South-South Centre

Geographic focus: Barisal, Chittagong, Dhaka, Khulna, Rajshahi, and Sylhet cities

Target population: policy makers and program managers

Length of support: May 25, 2004 – December 24, 2004

Level of support: US\$23,662

Goal

Work with policy-makers, planners, program managers, and law enforcement personnel to create an enabling environment that facilitates the successful continuous implementation of HIV Risk Reduction Program for Drug Users in order to prevent an HIV epidemic in Bangladesh.

Accomplishments

- Organized five divisional sensitization workshops in regional cities
- Organized a national workshop for key stakeholders on HIV risk reduction

Recommendations

- Form a lead working group for inter-ministerial coordination on the issue of injection drug use and HIV prevention among the Ministries of Home Affairs DNC, Police and Prisons); Health and Family Welfare (NASP); Law, Justice, and Parliamentary; and Information
- Review the role of the Narcotics Control Act and related legislations for creating a supportive environment for Harm Reduction Interventions
- Create facilities for free treatment and rehabilitation for drug users
- Secure treatment for HIV positive patients at divisional and tertiary level hospitals

Young Power in Social Action (YPSA)

Geographic focus: Chittagong

Target population: Street-based sex workers

Length of support: December 16, 2003 – October 31, 2005

Level of support: US\$127,759

Goal

Reduce the vulnerability and risk of HIV and STI infection among street-based sex workers and their clients in Chittagong.

Accomplishments

- Increased number of peer educators from 15 to 20
- Increased outreach coverage of street-based sex workers to 1,055
- Increased geographical coverage to include additional 30 spots

- Distributed 924,911 condoms and 3,146 tubes of lubricant
- Conducted 76,589 one-to-one sessions and 36,768 group sessions on HIV

Recommendations

- Provide alternative income generating skills training for sex workers
- Provide parallel services for clients of sex workers

ATTACHMENT A: IMPLEMENTING PARTNERS MATRIX

Ashar Alo Society (AAS)	: Peer Support for PHA
Ashokti Punorbashon Nibash (APON)	: Preventing HIV/AIDS among poor female injection drug users
Asheke	: Preventing HIV/AIDS among HBSW
Association for Voluntary Action for Society (AVAS)	: HBSW HIV/AIDS/STI Prevention in Barisal
Bandhu Social Welfare Society (BSWS)	: Male Sex Workers Intervention
BAPS (Bangladesh AIDS Prevention Society)	: Preventing HIV/AIDS among HBSW
Bangladesh Womens' Health Coalition (BWHC)	: Hotel-Based Sex Work Project in Dhaka
CARE Bangladesh	: HIV Risk reduction for IDU
CARE	: BSS Capacity Building
Community Health Rehabilitation and Awareness (CREA)	: Comprehensive Treatment & Psychosocial support
Dhaka Ahsania Mission (DAM)	: Prevention of HIV among IDUs through comprehensive treatment
DRISTI	: Preventing HIV/AIDS among HBSW and SBSW
East West Center	: Providing Regional Support for Integrated Analysis
Formworks	: Renovation works for CREA (L)
Formworks	: BWHC Mohakhali DIC Renovation for QA
Formworks	: BWHC South & BSWS Mirpur Renovation for QA
Geographical Solutions Research Center (GSRC)	: GIS Database Development
HARC (HIV/AIDS Research Center)	: Situational Assessment of HBSW
HASAB (HIV/AIDS and STD Alliance Bangladesh)	: HIV/AIDS Prevention & Care Counseling Support
Howard Delafield International (HDI)	: Technical Assistance
Health Solutions International (HSI)	: HIV/AIDS & STI Prevention for Rickshaw Pullers
Health and Education for the Less Privileged People (HELP)	: HIV/AIDS Prevention for Hotel Based SWs and IDUs
International Centre for Diarrhoeal Disease Research (ICDDR,B)	: Assessment of a Peer Education Project HBSW
International Centre for Diarrhoeal Disease Research (ICDDR,B)	: Laboratory Support Package
International Centre for Diarrhoeal Disease Research (ICDDR,B)	: STI study ESMvs.PPT among HBSW in Dhaka
International Centre for Diarrhoeal Disease Research (ICDDR,B)	: 5 th Round of Bangladesh BSS
International Centre for Diarrhoeal Disease Research (ICDDR,B)	: Strengthening HIV Voluntary Counseling and Testing
International Centre for Diarrhoeal Disease Research (ICDDR,B)	: Male Reproductive Health Survey
International Organization for Migration (IOM)	: Police Intervention
Light House	: HIV/AIDS/STI Prevention
MRC	: Research for Demand Generation Campaign
Marie Stopes Bangladesh Ltd (MSBL)	: HBSW Prevention Project
MSCI	: Strengthening sexuality and gender training
Organization for Developed Programs for Under Privileged (ODPUP)	: HIV/AIDS/STD Prevention Program
ORG-MARG Quest Limited	: BSS III
ORG-MARG Quest Limited	: FSW Assessment
PRDA	: GIS Mapping Database
Shustha Jibon (SJ)	: HIV and STI Prevention for Hijras
Sylhet Jubo Academy (SJA)	: HBSW Project in Sylhet
Social Advancement Society (SAS)	: HIV/AIDS/STI Prevention
South-South Centre (SSC)	: Advocacy Policy Level HIV Risk Reduction
SRISTI	: Hotel based SW in Khilgaon Dhaka City

ATTACHMENT B: COUNTRY PROGRAM FINANCIAL SUMMARY

FHI Bangladesh IMPACT Obligation Amount By Year (US\$)	
FY98	\$200,000.00
FY99	\$0.00
FY00	\$200,000.00
FY01	\$1,200,000.00
FY02	\$2,525,000.00
FY03	\$3,200,000.00
FY04	\$3,600,000.00
FY05	\$3,300,000.00
Total	\$14,225,000

ATTACHMENT C: CASE STUDIES



Photo: Tara O'Day

Widow Opens a Window of Hope

"When I lost my husband to AIDS, I felt immense uncertainty... hopeless, helpless. A widow at the age of 25, my dreams were shattered. During those dark days, there were no peer-led support groups available. A physician at the hospital extended great support and I realized that he may not always be available to do the same for others in need. I turned this devastation around, joined a NGO, and started working as a voice for people affected and infected by HIV and AIDS."

There was no looking back for Habiba and several years later, Ashar Alo Society was formed. "I feel that AAS is a platform from where PLWHA issues can be raised collectively and I believe it is a driving force in changing the lives of affected individuals and families. When PLWHAs join AAS, they feel that they are no longer alone – that there is a collective "we", which instills hope and a desire for positive thinking and living. I am happy when I see that AAS makes a difference within families and communities. With assistance from AAS, they are able to disclose their status to their loved ones and receive acceptance and support from them."

"In the past, I thought that the government would never respond or acknowledge the needs of PLWHAs. It gives me a sense of accomplishment when I see that our government has started to mention care and support issues – this was just a dream before."

Habiba, the Executive Director of Ashar Alo Society, has seen her organization grow from a staff of 4 with only 10 members in Dhaka to a staff of 19, working in 4 divisional cities in Bangladesh and serving almost half of the country's identified PLWHAs and over 750 family members.

Habiba is an outspoken advocate for the positive people of Bangladesh and their families and communities. She is a counselor, a friend, an advocate and a voice to the most discriminated against and stigmatized – a true champion of change.

Ashar Alo Society has been working with FHI since 2008 to provide care, support, and treatment to people living with HIV and AIDS (PLWHA) and their families. FHI also provides close technical support for improving PLWHA and affected individual's quality of life. FHI is also engaged in developing communication materials and messages as part of a stigma and discrimination reduction campaign to prepare communities to accept and support PLWHAs with compassion, tolerance and sensitivity.

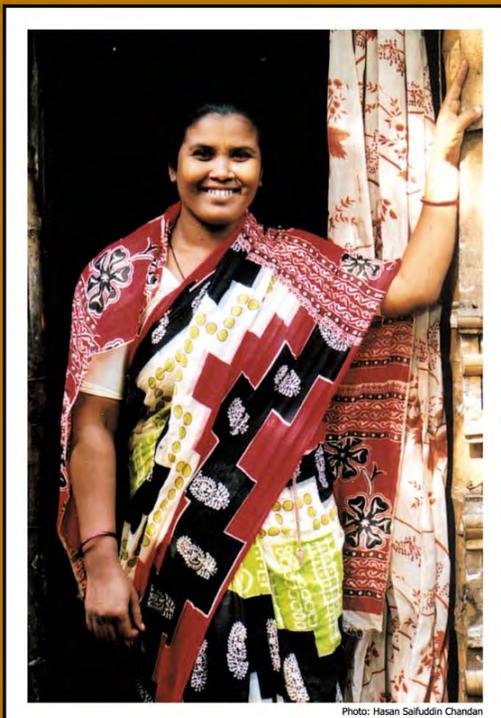


Photo: Hasan Saifuddin Chandan

Hasina Negotiates a Better Life

A year ago, Hasina, a prostitute, wouldn't have dared to dream of a home of her own. "I had forgotten that I was a human being. I was dirty, abused, and was regularly involved in fights. I wanted revenge on this society that had turned me into a prostitute."

When Hasina first walked into the Light House Health Center, she was wary. With each visit, her interest grew and she came to believe that she still had a place in society. "Things change when our behavior changes," she says. "A year ago, people in this town hated us - training not only gave me skills to protect myself from HIV, but also gave me a new attitude. For the first time in 9 years, I have rented a room. I have made it into the home I left behind, and will never conduct my business here. Sex is my business, but now I interact with clients in a decent way, and am able to negotiate with them to use condoms. Earlier, all I cared about was how much I got paid. Now I know the dangers of unsafe sex and the risk of HIV."

For homeless prostitutes like Hasina, renting a home was impossible a year ago. Their understanding of behavior change has given them a voice with which to negotiate safe sex, and a roof over their heads. Twenty-three street based prostitutes live in rented homes, some with their children. Their changing status in society is reflected through landlords who are now willing to rent their houses.

Hasina is no longer a street-fighter. She is a champion for change and persuades her peers to visit the Health Center and learn about safe sex and the importance of regular STI check-ups and treatment.

Light House, a partner agency of FHI, provides counseling, free condoms, STI health services and BCC training to prostitutes. FHI currently supports four interventions targeting street based prostitutes in different parts of Bangladesh.



Photo: Murad Ahmed

Koli Turns Jail Time Into Class Time

A few hours before the police arrested Koli and 29 other prostitutes at a hotel in June 2003, a peer educator had given her a few female condoms. Koli held on to them, not realizing that the few sessions with her Peer Educator were going to change the course of her life. This was Koli's third time in a jail, and this time she wanted to do something meaningful.

"On my second night in jail, we were all watching a TV program on HIV prevention. Many of us had heard of HIV, but only two of us had some idea what it was. This prompted me to share my knowledge with them, and when I saw that all the women, including my peers, were enthusiastic, I felt encouraged to continue."

"All my inmates knew what condoms were, some described them as balloons, but when I spoke about a female condom, only my peers had heard of it. When I showed them a female condom, they were all astonished. They wanted to know how it should be used. I explained how and told them the benefits of using one. All of them who had no time for motivational sessions in hotels became passionate listeners in jail."

With legal assistance, Koli was out of jail in a month, and immediately started working as a Peer Educator with AVAS, an NGO working on HIV prevention in Barisal. With training and Behavior Change Communication materials, Koli now has far more knowledge and support to continue her passionate work outside prison.

Koli is a true champion of change. Her self-motivation has given her a life mission to save other prostitutes from HIV and STI.

AVAS is one of 20 NGOs working with FHI in Bangladesh. The female condom was first introduced to AVAS in October 2003, and was well accepted among the women as a back up negotiation device.

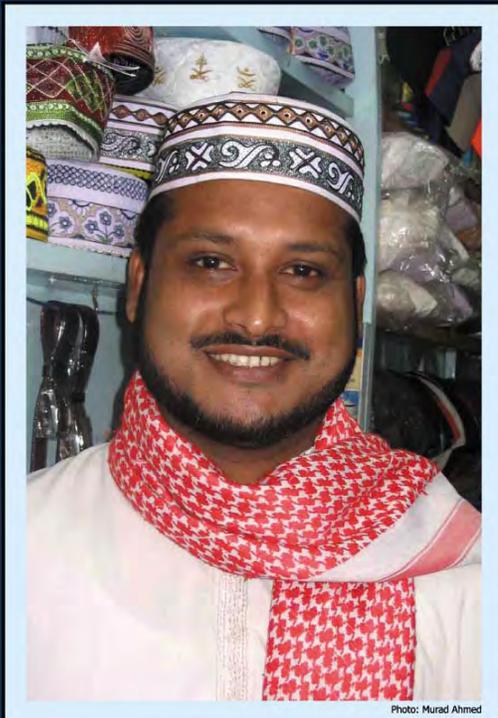


Photo: Murad Ahmed

I am A Huzur and I Talk About Sex

Enayet was furious when he first heard about an NGO that discussed sex, sexual diseases and HIV, AIDS. As an ex-*Madrassa* (religious school) student, he found this intolerable, shameless and against Islam. He attended a community advocacy meeting hosted by the local NGO, Association of Voluntary Action for Society (AVAS) in August of 2002, hoping to publicly voice his opposition to this immoral work. Instead, he began to see things differently. He realized that he and other leaders had a responsibility to speak out and educate others on the dangers of HIV. As he became more sensitized, he decided to take a second job as a Site Worker for AVAS, while continuing with his managerial work at a hotel in Barisal.

As his work with the hotel continued, Enayet realized the potential risk and gravity of HIV. He became determined to reach beyond the group of sex workers and clients that he worked with. Enayet voluntarily started motivation sessions within the very institution that he was educated.

Enayet, 34 years old, is an influential leader of a religious group and is an active associate of Barisal's City Mayor. He explains that "sex outside marriage is a sin but we cannot ignore reality. That's why I try to convey the message of safer sex. I don't think every *Madrassa* student is without sin. Some students visit hotels for sex. Motivation and awareness is a must."

He received basic, refresher and special training from FHI and AVAS and has, so far, spread safer sex messages to 30 graduate students of *Mahmudia Madrassa*, an institute established by his grandfather. Three Principals of similar institutions have already asked him to visit their *Madrassas* and talk about HIV prevention.

"People trust me to talk about sex as I am a *huzur* (religious leader)", he adds. As a champion of change, Enayet reaches people even NGOs cannot reach. He voluntarily spreads awareness among *Madrassas*, and continues to impact lives with his motivation and dedication.

AVAS, is one of 20 NGOs implementing the IMPACT project in Bangladesh, with FHI guidelines and support. "Who is vulnerable to HIV?" a BCC session and supporting material developed by FHI, has been one of the most effective in convincing all cross-sections of society.

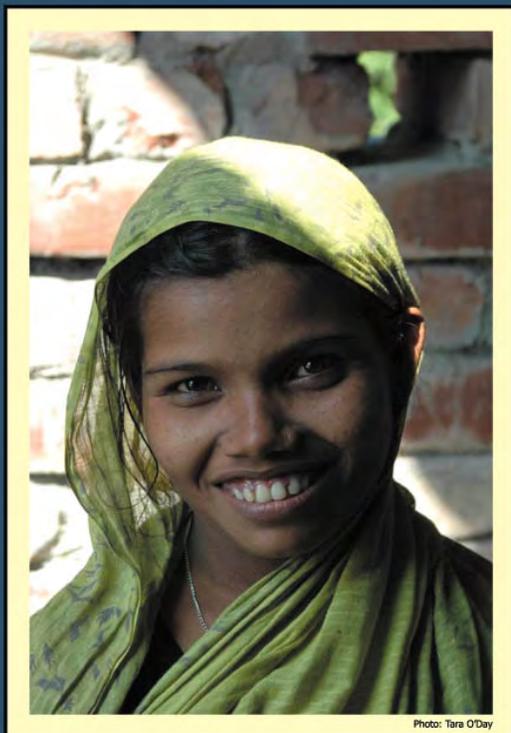


Photo: Tara O'Day

Lovely - A Face with a Voice

Lovely is a speech-impaired commercial prostitute. Like so many impoverished rural women, she came to the city in search of work and ended up on the streets. Lovely was faceless, struggling to survive among hundreds of prostitutes in the city. Without the power to communicate and protest sexual abuse, she was repeatedly infected with STIs, and became pregnant twice.

"Lovely is one of six speech-impaired prostitutes in the Northeastern city of Bogra in Bangladesh", says her outreach worker. "When we reached her in 2001, she was very unhealthy, slept beside street dogs and had unprotected sex. Lovely was one of the most vulnerable to HIV, because she was unaware of HIV and could not communicate verbally. We took her to our Health Center where she could bathe, relax and learn how to read and write. We also showed her how to negotiate condom use and explained why it was so important to protect herself from HIV. Lovely listened and learned. Very quickly she realized her personal safety and health were most important to her. She visited our STI clinic services and received treatment."

Lovely now knows how to use male and female condoms and is a champion on her street, distributing condoms to her peers and using her new skills and knowledge to protect herself from STIs and HIV.

Light House, a partner agency of FHI, provides counseling, free condoms, STI health services and BCC training to street-based prostitutes. FHI currently supports four interventions targeting street based prostitutes in different parts of Bangladesh.

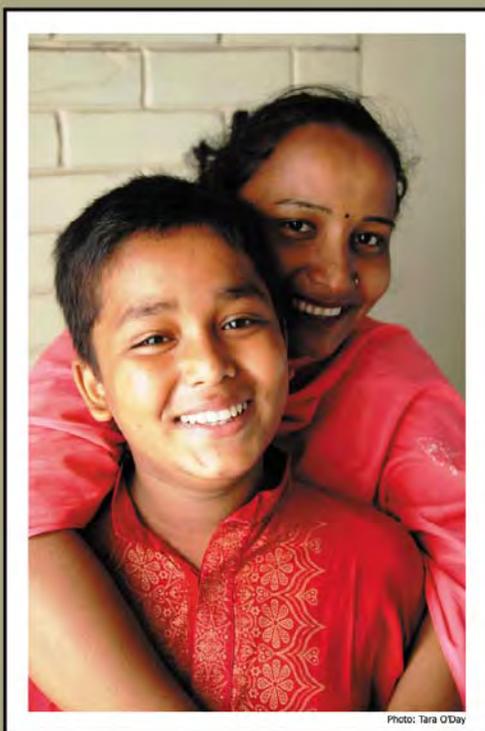


Photo: Tara O'Day

"My Child" - A Game that Changed Lutfa's Child's Life

Lutfa was little more than a child herself when she entered the sex trade. By the time she was 17, she was a mother, a married woman, and the bread winner for her family. Being married didn't change anything - her husband refused to let her give up this work. She handed over all her earnings and savings - when he left her and their child, he took it all.

Lutfa was sick with STIs when she was found by Bangladesh Women's Health Coalition (BWHC) in Dhaka and asked if she wanted to work as a Peer Educator for them. Being illiterate, she doubted her own ability, until a game called "My Child", opened her eyes.

"My Child, one of the Behavior Change Communication tools used during the Peer Educator training, got me thinking about my son's future. I opened a bank account for the first time and now deposit Tk. 500 (about \$10) every month from my salary. I now have over Tk. 6,000 in savings and will send my son to school next year. In 5 years, I will use it to start a business so I no longer have to be a prostitute. If luck favors me, the profit will pay for my son's higher education."

By turning training into action, Lutfa motivates her peers to visit the Health Center...and even banks for the first time. Now, life has new meaning and hope for their children.

As a peer educator, Lutfa is a champion of change. She has inspired and motivated other women with children to open bank accounts and save for their children's future.

BWHC, a partner agency supported by FHI, works with hotel-based prostitutes in Dhaka. The Health Center offers counseling, treatment, free condoms, life skills training and motivation for behavior change.

ATTACHMENT D: PUBLICATIONS PRODUCED

1. STI Minimum Standard Guidelines
2. STI Toolkit
3. STI Clinical Guidelines:
4. National HIV Serological and Behavioral Surveillance (2000-2001)in collaboration with ICDDR,B
5. HIV in Bangladesh: The Present Scenario, 2004. A summary document of the 5th round of National Surveillance
6. “HIV in Bangladesh: Where is it Going?” Background document for dissemination of the third round of national HIV and behavioral surveillance, October 2002 (Bangla version), Government of Bangladesh.
7. Data analysis report of male-to-male sexuality and sexual health in Rajshahi, Ishwardi, and Natore, January 2003 (draft)
8. NASROB report (drug use) – reprint of July 2002 report
9. An Assessment of Migrant Workers’ Vulnerability to HIV/AIDS, 2003, HASAB
10. Collection of STI articles on Bangladesh (1974-2002), FHI/BANG/ICDDR,B 2003