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HIV and AIDS Interventions in Bangladesh Successes, Challenges and Ways Forward



James P Grant School of Public Health
Dhaka, Bangladesh

**James P. Grant School of Public Health
BRAC University**

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**HIV and AIDS Interventions in Bangladesh
Successes, Challenges and Ways Forward**

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Preface

Since the early 1990's, the spread of the Human Immunodeficiency Virus (HIV) in Asia has been rapid and, in some countries, epidemic, with an estimated 9 million people in Asia having been infected with HIV and over 3 million dying from HIV AND AIDS related illnesses¹.

Compared to its regional neighbors, Bangladesh is considered a low prevalence country, with a reported HIV prevalence rate of 0.1% for the general population and a reported 1207 people infected with HIV at the end of 2007. Low numbers should not be cause for complacency, however, as they are the result of incomplete reporting and UNAIDS estimates the number of HIV positive people in Bangladesh to be slightly more than 11,000² and recognizes that the prevalence rates are considerably higher for high risk groups, such as Intravenous Drug Users (IDUs) who have a 7% prevalence rate, according to the seventh round of sero surveillance. In one neighborhood in Dhaka, prevalence among IDUs has risen to 10.8 per cent.

Low prevalence of HIV in Bangladesh is both a blessing and a curse. On one hand, the virus seems to be contained mainly within high risk groups such as sex workers, IDUs and Men who have Sex with Men (MSM). It also means, however, that HIV AND AIDS is not a national public health priority. Furthermore, society at large has not been adequately sensitized to the issue, sustaining widespread stigmatization of People Living with HIV AND AIDS (PLHA) and misunderstanding of HIV AND AIDS issues.

It becomes important, therefore, to better understand what is driving the spread of HIV in Bangladesh. Is the virus contained to high risk groups or is Bangladesh gradually heading towards an epidemic? What are the country's current strategies

¹ UN Population Division statistic reports 3,461,000 HIV AND AIDS related deaths in the Asian region by the end of 2005. Retrieved from source: Linda Blondal and Howard White.(2007).Projecting Progress Towards the Millennium Development Goals.University of Sussex.

² UNAIDS(2007).UNAIDS Bangladesh Narrative Report 2007.Dhaka.

for fighting the spread of HIV and what groups and individuals are at the helm? Are there successes and challenges which can be learned from to inform future HIV AND AIDS policy and interventions? What are the most viable and effective ways for Bangladesh to move forward?

These questions prompted UNAID to commission this Report, which summarizes various successes and challenges of HIV AND AIDS interventions in Bangladesh as well as provides recommendations for ways to move forward. The task was carried out by the James P. Grant School of Public Health at BRAC University in Dhaka in 2008.

This report highlights the commonalities across sectors in terms of successes and challenges faced in addressing the AIDS issue. The report includes stakeholders' recommendations for further HIV AND AIDS research, better addressing PLHAs and increasing the effectiveness of collaborative interventions. The challenge rests in translating these recommendations into overall effective action throughout the country.

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Common Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BAP	Bangladesh AIDS Program
BCC	Behavior Change Communication
BWHC	Bangladesh Women's Health Coalition
BSWS	Bandhu Social Welfare Society
CBOs	Community Based Organizations
CHCP	Community Health and Care Partnership
CWFD	Concerned Women For Family Development
DFID	Department for International Development
DICs	Drop in Centers
FHI	Family Health International
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HAI	Help Age International
HAPP	HIV AND AIDS Prevention Project
HATI	HIV AND AIDS Targeted Interventions
HASAB	HIV AND AIDS and STD Alliance Bangladesh
HIV	Human Immunodeficiency Virus
ICDDR,B	International Center for Diarrhea Disease Research, Bangladesh
INGO	International Non Government Organization
IDUs	Injecting Drug Users
MACCA	Masjid Council for Community Advancement
MOHFW	Ministry of Health and Family Welfare
MSM	Men who have Sex with Men
MSW	Male Sex Worker
MJF	Manusher Jonno Foundation
NAC	National AIDS Committee

NASP	National AIDS/STI Program
NASROB	The National Assessment of Situation and Responses to Opiate use in Bangladesh
NGOs	Non-Governmental Organizations
OXFAM	Oxford Committee for Famine Relief
ODPUP	Organization of Development Program for the Underprivileged
PLHA	People Living With HIV AND AIDS
PIACT	Program for the Introduction and Adaptation of Contraceptive Technology
RPDO	The Regional Planning and Development Office (RPDO)
SAS	Government of Australia Small Activity Scheme
SES	Socio-Economic Status
SMC	Social Marketing Company
STI	Sexually Transmitted Infections
TDH Netherlands	Terre des Hommes Netherlands
UNAIDS	Joint United Nations Program on HIV AND AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCTC	Voluntary Counseling and Testing Centers
WHO	World Health Organization

Executive Summary

This report is derived from the realization that Bangladesh's response to HIV and AIDS, overall, has not kept pace with the ever increasing frequency of positive cases and the unfolding realities of the spread of HIV. The study has been commissioned by UNAIDS, carried out by the James P. Grant School of Public Health at BRAC University, Dhaka. The School of Public Health was responsible for creating a report that would identify the country's major HIV and AIDS interventions and analyze the key challenges and successes of those interventions. Moreover, the report would make recommendations for ways in which policy makers, researchers, non-government organizations, and civil society can move forward in the fight against HIV and AIDS. The report synthesizes the vast amount of preexisting literature on HIV and AIDS in Bangladesh and also incorporates individual, organizational and donor perspectives from 19 in-depth interviews.

Despite warning signs of a future epidemic in Bangladesh, there is still a lack of urgency, effective policy and coherent programming necessary to curb the spread of HIV and AIDS. This can be attributed to the country's low HIV prevalence of 0.1 per cent of the general population, which is very low for the region as well as globally. It can also be said that since transmission of HIV and AIDS tends to be contained within individuals connected to high risk behavior (paid sex, injecting drugs and sex between men), the spread of HIV and AIDS has never been contextualized as a threat to the mainstream population, unlike the African context within which the epidemic has been framed as a 'generalized' epidemic, with significant risk to the entire sexually active population. Furthermore, pressure to adhere to moral standards and religious principles in Bangladesh leads to widespread denial and suppression of taboo topics such as premarital and extramarital sex and homosexuality.

In the Asian region, three out of four adults living with HIV are men. Regionally, the number of women infected has increased from 19 per cent in 2000 to 24 per cent in 2007 . Women tend to contract the virus through husbands or boyfriends who have become infected via paid sex or injecting drugs. Therefore, to reiterate, prevention programs which slow the spread of HIV among the high risk male

population will invariably prevent HIV infection from increasing among women. HIV in Bangladesh (and in fact, throughout the Asian region) cannot spread independently of commercial sex, drug injecting and sex between men. The spread of HIV being 'concentrated' among these groups in addition to low incidence rates and widespread stigma surrounding HIV and AIDS, means that the graveness of the risk of an epidemic in Bangladesh has perhaps not been adequately considered or addressed by government and mainstream population. This report will analyze what is already being done in Bangladesh to curb the spread of HIV and AIDS and respond to those already infected. To begin, the report will introduce the country's high-risk target groups (SWs and their clients, MSM, IDUs, migrant workers, and PLHAs). The same section will outline the country's institutional framework for HIV and AIDS programs and major funding mechanisms for HIV and AIDS interventions. Second, the report will bring to light some of the common challenges within HIV and AIDS interventions, identified by the study's respondents who represent NGO, government, donor, and beneficiary perspectives. Despite challenges to HIV interventions, various respondents were eager to highlight certain accomplishments within the field. Therefore, in order to emphasize intervention progress, the report will outline common themes in intervention success. Finally, it will propose ways in which government, NGOs, policy actors and civil society can move forward towards more effective and successful HIV and AIDS interventions.

³ The Commission on HIV and AIDS in Asia.(2008).Redefining AIDS in Asia: Creating and Effective Response.Oxford University Press.p.7.

⁴ The Commission on HIV and AIDS in Asia.(2008).Redefining AIDS in Asia: Creating and Effective Response.Oxford University Press.p.8.

1. Introduction

1.1 OBJECTIVES

The following study is a critical analysis of the areas and interventions that have been addressed through HIV and AIDS prevention projects and programs. The report will identify the gaps in interventions, intervention successes, and recommendations to the national response to HIV and AIDS in an effort to paint a broader picture of this response. The document aims to help guide future strategies in HIV and AIDS prevention in Bangladesh.

Despite being considered a low prevalence country in terms of HIV and AIDS, Bangladesh risks experiencing a future epidemic with ever increasing prevalence rates among high risk groups. In efforts to avoid the epidemic scenario, it is helpful to take an overview of existing HIV and AIDS interventions and recognize within them, examples of best practices as well as pitfalls. The following report seeks to do the following:

- a) Examine current HIV and AIDS prevention and treatment interventions
- b) Highlight challenges and barriers within these interventions
- c) Identify successes within these interventions

In doing so, the report will bring to light gaps in current HIV and AIDS programs and policies. Moreover, the study will inform those policy makers and stakeholders responsible for developing and strengthening future HIV and AIDS interventions in Bangladesh.

1.2 METHODOLOGY

The study consisted of primary and secondary data collection and analysis. First, a desk review of current HIV and AIDS prevention and treatment interventions in Bangladesh was undertaken incorporating: open web research; stakeholder reports; scholarly research papers; national HIV and AIDS policy; government strategy documents. The literature review encompassed a wide range of perspectives, opinions and data from NGOs, donors, beneficiaries, and

government agencies. The review drew out common themes in target populations and priority issues. On the other hand, attitudes, opinions and data were often diverse and disparate among various stakeholders.

Nineteen in-depth interviews with stakeholders were carried out in order to reveal a more individual and candid perspective of the local environment surrounding HIV and AIDS. The stakeholder organizations were selected in order to cover a broad spectrum of groups and individuals involved in HIV interventions including NGOs, INGOs, donor agencies, beneficiaries, activists, government bodies, and research institutions. Respondents were interviewed concerning the successes and challenges experienced in HIV and AIDS interventions with an emphasis on outlining recommendations for the most effective ways forward in curbing HIV in Bangladesh (see Annex 1 for interview guides).

1.3 HIV IN THE BANGLADESH CONTEXT

Background

With a reported prevalence rate of less than 0.1 per cent, Bangladesh is considered a low risk country with regard to HIV infection . The first reported case of HIV was documented in 1989 and by the end of 2007, the Ministry of Health and Family Welfare had confirmed 1207 cases of HIV of which 365 had developed AIDS, and 123 had died. According to a 2004 United Nations study, the number of HIV infections in Bangladesh has tripled over the last six years⁶. In 2006, 216 new cases of HIV were reported and in the past year alone 333 new cases of HIV infection have been documented. With a population of nearly 150 million, an increase of just 1% in the rate of infection among the adult population in Bangladesh would mean more than a million additional HIV and AIDS cases. One cause for concern for effective HIV prevention strategies is the increasing prevalence among high risk populations: commercial sex workers (CSW), men who have sex with men (MSM), migrant workers, and injecting drug users (IDUs)⁷.

⁶ National AIDS/STI Program.(2008).2008 UNGASS Country Progress Report: Bangladesh.reporting period January 2006-December 2007.NAS^P MOHFW.Dhaka.

⁸ USAID.(2005).Health Profile: Bangladesh. Retrieved June 25th, 2008. from <http://www.usaid.gov>

⁷ USAID.(2005).Health Profile: Bangladesh.retrieved June 25th, 2008, from <http://www.usaid.gov>

Among the general population, concern lies in the fact that 59 percent of ever-married women and 42 percent of men of age 15-54 could not mention a single way to avoid contracting HIV⁸.

Possible contributory factors to the relatively low prevalence of HIV in Bangladesh are: until recently, low levels of intravenous drug use; a long history of Non-Government Organization (NGO) led interventions targeting high risk populations as identified above, as well as People Living With HIV and AIDS (PLHA)⁹. However, it is widely recognized by both the government and NGO sector that the country's low prevalence rate is not an accurate measure of HIV incidence in Bangladesh. UNAIDS estimates that roughly 11,000 people are living with HIV in Bangladesh¹⁰. Both UNAIDS and the Bangladeshi National AIDS/STD Program (NASP) urge that a perceived low prevalence rate must not give way to complacency and lead to avoidance of what could very well become a national epidemic. Low numbers of reported HIV cases in Bangladesh are due to incomplete reporting, the country's limited facilities for sentinel surveillance and voluntary counseling and testing, as well as social stigma and discrimination attached to HIV. In reality, Bangladesh faces significant risk factors for the spread of HIV, including:

- Huge and densely distributed population
- Poor economy resulting in limited facilities and funding for sentinel surveillance and voluntary counseling and testing centers (VCTC)
- Geographical and cultural proximity to two more-severely affected countries (India and Myanmar)
- High prevalence of other sexually transmitted infections (STIs)
- A very large population of mobile and 'hidden' sex workers (SWs)
- Large population of men engaging in unprotected commercial sex act as 'bridging' population
- Highest client turnover rates in the region with respect to hotel-based SWs

⁸ The World Bank.(2008).HIV and AIDS in Bangladesh.

⁹ National AIDS/STI Program.(2008).2008 UNGASS Country Progress Report: Bangladesh.reporting period January 2006-December 2007.NASP MOHFW.Dhaka.

¹⁰ UNAIDS.(2007).UNAIDS Bangladesh Narrative Report 2007.Dhaka.

- Low rate of condom use
- Gender inequality
- Rising prevalence of HIV among drug users
- Sizable population of migrant laborers accounts for significant percentage of people living with HIV
- Poor access to information on safe sex and STIs
- Limited HIV knowledge among the general population

Targeted Interventions

Asia has seen an estimated 9 million cases of HIV since the virus first appeared in the region more than 20 years ago. Although the epidemic varies considerably from country to country, HIV throughout the entire region is driven by unprotected commercial sex, the sharing of contaminated needles and syringes by injecting drug users, and unprotected sex between men. Throughout the Asian region it is widely accepted that men who buy sex make up the largest infected population group, many of whom are from 'mainstream' society. Due to common social norms, these men are likely to be married or will get married, and therefore will expose significant numbers of females who are otherwise categorized as 'low risk' because they are only engaging in sex with their husbands.

Due to the fact that relatively few women in the region have sex with more than one partner, the chain of HIV infection tends to end when the wives and girlfriends of infected men develop the virus, though some may transmit the virus to their unborn or newborn infants. But the probability of these women passing the virus to another man is generally very small¹². This means that currently the spread of HIV in Bangladesh cannot sustain itself among the 'general population' independently of commercial sex, drug injecting and men who have sex with men. Furthermore, this means that HIV interventions targeting prevention and transmission reduction among high risk populations can bring the spread of HIV

¹¹ Md Mofizul Islam, Katherine M. Conigrave.(2008). "HIV and sexual risk behavior among recognized high risk groups in Bangladesh: need for a comprehensive prevention program." *International Journal of Infectious Diseases*. 12:4. Pp.363-370.

¹² The Commission on HIV and AIDS in Asia.(2008). *Redefining AIDS in Asia: Creating and Effective Response*. Oxford University Press.

under control. NASP estimates that between 2.2 and 3.9 million are at elevated risk of contracting HIV because they engage in the aforementioned high risk activities. Targeted interventions, however, are complicated by high levels of HIV-related stigma and discrimination. Strong prejudice towards people living with HIV and AIDS (PLHA) and misconceptions about how the virus is transmitted make it difficult for PLHAs to receive healthcare for non-HIV related illness. Moreover, disease counseling, testing services and legal aid for PLHAs are limited to a few NGOs that are serving this need. Finally, the behaviors which place these people at higher risk (sex between men, injecting illegal drugs and in many cases, sex work) are criminalized in Bangladesh, making them subject to severe legal punishment and less likely to seek testing or treatment.

Sex Workers (SWs) and Clients

Men, specifically male clients of sex workers, will dominate the future of the HIV epidemic in Bangladesh more than any other high-risk population in terms of absolute proportions of new infections¹³. There are over 105,000 male and female sex workers in Bangladesh, working in the country's fourteen registered brothels and in various hotels and streets, though some sources estimate that there are as many as 150,000 women involved in the sex trade¹⁴. Brothel-based female sex workers reportedly see an average of 18 clients per week, while street-based and hotel-based workers see an average of 17 and 44 clients per week, respectively¹⁵. Hotel-based SWs are potentially at greater risk of contracting HIV due to client volume and turnover. The prevalence of HIV among SWs is less than one per cent with the exception of a few particularly vulnerable locations where it has been documented as 1.5 per cent and 2 per cent¹⁶.

An average sex worker will receive ten clients in one day. The largest brothel in Bangladesh, in Dalaudia, comprises 1,000 sex workers. Therefore, at Dalaudiabrothel alone, roughly 10,000 sex acts are taking place daily. Sex worker client turn-over in

¹³Amala Reddy, Tim Brown.(2006)The Asian Epidemic Model for Dhaka City: Technical Report: Analysis and Advocacy Project.Family Health International.

¹⁴ Simone Boneschi.(2004).Sex Workers of Jessore and Jamapur.Terre Des Homes Italia.

¹⁵ Ms. Mehrin A. Mahubub and Mr. Erik Nora.(2008)."HIV and AIDS in Bangladesh".The World Bank.www.worldbank.org/bd

¹⁶ ICDDR,B and National AIDS/STD Program.(2003-2004).National HIV Serologic and Behavioral Surveillance: Fifth Round.

Bangladesh is estimated to be among the highest in the world and condom use among the lowest¹⁷. An estimated ten per cent of men in Bangladesh are clients of SWs. One statistic states that condom use is extremely low among hotel-based sex workers in Dhaka and Chittagong at 40 and 36 per cent, respectively. Consistent condom use as well as maintaining regular clients is low for all SW sub-groups¹⁸. Taking into consideration low levels of condom use, partners of those involved in commercial sex are highly vulnerable to STDs and HIV and AIDS. The number of men who buy sex from women far outnumbers the amount of injecting drug users in the country and moreover, a great number of men who inject drugs also buy sex from women.

Therefore, interventions which increase condom use among sex workers and their clients will be more beneficial than other prevention interventions. Figure 1 shows how the HIV virus bridges populations of SWs, MSM, and clients of SWs to female partners.

Article 18 of the Bangladeshi constitution states, "The State shall adopt effective measures to prevent prostitution." However, SWs can register their names with a magistrate, signing an affidavit that they are entering the profession of their own will, are over 18 years of age, and are too poor to survive any other way.

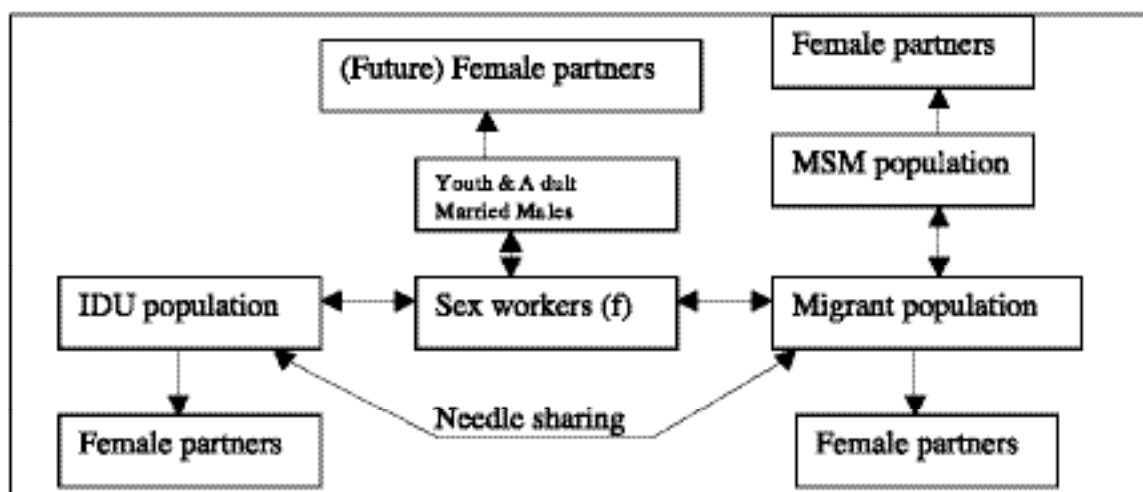


Figure 1: Example of General Population Bridging

¹⁷ ICDDR,B and National AIDS/STD Program.(2002).National HIV Serological and Behavioral and Surveillance: Fourth Round Technical Report.Director General of Health Services, Ministry of Health and Family Welfare, Government of Bangladesh.

¹⁸ Ms. Mehrin A. Mahubub and Mr. Erik Nora.(2006)."HIV and AIDS in Bangladesh".The World Bank .www.worldbank.org/bd

Intravenous Drug Users (IDUs)

Evidence suggests that HIV has reached epidemic levels among the IDU population in central Bangladesh. The National Assessment of Situation and Responses to Opiate use in Bangladesh (NASROB) study conducted in 2001 estimated that there were at least 5000 injecting drug users in the country. However many experts are concerned this number is underestimated and therefore optimistic since the estimated IDU population seems to be much smaller than in other countries in Asia¹⁹. A more realistic and recent assessment, perhaps, is the estimated 20,000-40,000 IDUs in Bangladesh, the figure generally accepted by non-government sources²⁰.

Injecting drug users, despite being a smaller target population, pose a considerable challenge to the fight against HIV. The actual prevalence of HIV in the IDU population is less than 2 per cent, except in the capital city, Dhaka, where prevalence increased from 1.7 per cent in 1999 to 7 per cent in 2006, marking the first concentrated epidemic among any high risk group in Bangladesh²¹. However, estimated prevalence of HIV among IDUs is said to be between 7 and 10 per cent, which is by far the greatest of any high risk group in the country. Effective harm reduction and behavior change strategies are required to slow the spread of HIV among IDUs, which will reduce drug injecting, promote the use of sterile equipment, and promote safe sexual practices between IDUs and their partners. For Bangladesh, it may be too late to halt the spread of HIV among the drug injecting population as the incidence rate among this group is already extremely high and infected IDUs have already introduced HIV into the commercial sex trade as clients and providers alike.

Another source states that 0.4 per cent of the adult male populations are IDUs with an estimate of 7,500 street-based users and 500 "other."²² Though fewer in numbers, the population of female IDUs must not be overlooked, as many of them are also engaging in the commercial sex trade. Given that a reported 63 per cent

¹⁹ Family Health International (2008). A Synthesis of the HIV Situation in Bangladesh: An Epidemic in Transition.

²⁰ A.Reddy, M. Hoque, R. Kelly.(2006-2007). "HIV transmission in Bangladesh: An analysis of IDU programme coverage". International Journal of Drug Policy. Vol18. Pp37-48.

²¹ Ms. Mehrin A. Mahubub and Mr. Erik Nora.(2008). "HIV and AIDS in Bangladesh". The World Bank. www.worldbank.org/bd

²² Anjali Reddy, Tim Brown.(2008). The Asian Epidemic Model for Dhaka City 2006 Technical Report. Analysts and Advocacy Project. Family Health International.

of IDUs shared needles in 2000 and 83 per cent in 2005, the risk of HIV transmission among this population has likely gone beyond the point of control²³.

The government, in its 2004-2010 Strategic Plan, has recognized the need to ensure safe practices among injecting drug users, including the provision of non-injectable drugs substitutes and sterile equipment, and to ensure the increased participation of former drug users in advocacy programs²⁴. Yet, only an estimated 31 and 61 per cent of the higher and lower national size estimates of IDUs, respectively, were in contact with any HIV prevention effort by the year 2006²⁵.

More emphasis must be placed on safe blood donation because a significant number of IDUs sell potentially infected blood to feed Bangladesh's reliance on blood-donations to meet transfusion needs of its general population²⁶. Moreover, crossovers between IDU and SW populations produce a particularly vulnerable sub-population at risk of spreading HIV. By 2008, surveillance studies suggested that approximately 44 per cent of female IDUs were also currently engaged in sex work²⁷. Furthermore, 26 per cent of male IDUs reported visiting female sex workers and only 13 per cent report wearing condoms with SWs²⁸. Over the course of one week, 76 per cent of IDUs report sharing at least one needle²⁹.

Men Who Have Sex with Men (MSM)

MSM are a diverse group from a variety of backgrounds and socio-economic statuses. Some MSM could be dually defined as 'gay' in the Western sense, but most would not use this classification. In fact, it is important to distinguish between the Western construct of homosexuality and the unique set of characteristics which are at play in identifying the MSM population in South Asia. Many are married or have girlfriends, often because they prefer relationships with women,

²³ BSS2 and 5; AEM

²⁴ Imaan, Najrana.(2008). Review Paper Analyzing the Existing Legal and Policy Provisions and Practices with Respect to Human Rights in Relation to People Living with HIV and AIDS in Bangladesh. Ain o Shelish Kendra (ASK).Bangladesh.

²⁵ A.Reddy, M. Hoque, R. Kelly.(2006-2007). "HIV transmission in Bangladesh: An analysis of IDU programme coverage".International Journal of Drug Policy.Vol19.Pp37-46.

²⁶ The World Bank.(2008).HIV and AIDS in Bangladesh.

²⁷ Md Mofizul Islam, Katherine M. Conigrave.(2008). "HIV and sexual risk behaviors among recognized high-risk groups in Bangladesh: needs for a comprehensive prevention program."International Journal of Infectious Diseases.12:4.Pp363-370.

²⁸ Amala Reddy, Tim Brown.(2008)The Asian Epidemic Model for Dhaka City: Technical Report: Analysis and Advocacy Project.Family Health International.

²⁹ Amala Reddy, Tim Brown.(2008)The Asian Epidemic Model for Dhaka City: Technical Report: Analysis and Advocacy Project.Family Health International.

but also because of the social expectation upon them to be in heterosexual relationships with women and to create families. Some MSM have feelings of love and attraction for other men, while some men have sex with men exclusively for physical satisfaction. Some are solely penetrated, while others choose only to penetrate. It is important to understand the nuances of MSM in Bangladesh and use this knowledge to help decrease stigmatization and discrimination of sex between men³⁰. Sex between men in Bangladesh (and in the greater subcontinent) is criminalized under Section 377 of the Bangladesh penal code³¹. Criminalization of MSM makes them subject to severe punishment by law as well as coercion and blackmail. It pushes MSM further underground in concealment of their sexual behavior making it difficult to reach them with health information and services.

The MSM population averages 0.2 per cent of the adult males in the country with a reported 25,000 MSM in the country in 2006. However, due to insufficient data, stigmatization, and the 'hidden' nature of MSM communities, it is quite possible that there are as many as 40,000-150,000 MSM³². It is reported that 47 per cent of MSM have other female partners (wives or girlfriends) who, as a result of not being targeted by HIV interventions, have not been sensitized to HIV transmission and prevention³³.

Table 1: Data on Men Who Have Sex with Men (MSM)

Total Reported Number of MSM in Bangladesh	25,000 (0.2 per cent of adult males) as of 2006
Estimated Number of MSM in Bangladesh	40,000-150,000
Ratio of Male Sex Workers (MSWs) to MSM	1 to 25 (0.04 per cent of adult males in Dhaka city working as MSWs)
MSM visiting Male SWs	88 per cent

³⁰Sharful Islam Khan.(2005). "MSM's sexual relations with women in Bangladesh." Culture, Health & Sexuality.

³¹ Fakir M.(2002). The out reach services for MSM provided by ODPUP— a situation analysis in Dhaka City. 14th International Conference on AIDS. Barcelona.

³²Amala Reddy, Tim Brown.(2008)The Asian Epidemic Model for Dhaka City: Technical Report: Analysis and Advocacy Project.Family Health International.

³³Amala Reddy, Tim Brown.(2008)The Asian Epidemic Model for Dhaka City: Technical Report: Analysis and Advocacy Project.Family Health International.

MSM visiting Female SWs	28 per cent
MSM reported using condoms	39 per cent
MSM with other Female Partners (wives or girlfriends)	47 per cent

Migrant Population

Another facet of high risk behavior associated with the spread of HIV and AIDS in Bangladesh is the migrant male laborer population, representing a considerable portion of SW clients. These laborers are both internal migrants (moving frequently for work within Bangladesh) and external (leaving Bangladesh for out-of-country jobs and then returning to Bangladesh). Due to the highly mobile nature of their work, a propensity for engaging in the sex trade and infrequent condom use, they are powerful vehicles for partner to partner transmission of HIV, accounting for infection of wives and girlfriends. General condom promotion through TV and radio is reportedly not effective due to social and religious constraints and voluntary counselling and testing centers for migrants are lacking in high risk areas³⁴.

According to the International Organization for Migration (IOM), Dhaka, the official number of people who migrate annually from Bangladesh to seek employment in other countries is approximately 250,000. Of the new 102 reported HIV and AIDS cases in 2004, 57 were identified as external migrants³⁵. Estimates say, however, as many as 400,000 Bangladeshi men could be migrating out of Bangladesh for work each year, predominantly to the Middle East, many of whom are known to leave informally. Married men and women who live apart are 2 to 3 times more likely to engage in extra-marital relations than those who live together. In a sample of 259 migrant workers and family members at 3 VCT units, 47 people (18.1 per cent) were HIV positive. Of these, 29 were adult males who had returned from abroad, 7 were wives of migrant workers, and 4 were children of HIV positive migrant workers. Less than one third of men had used a condom with the sex worker or during their last marital sex. It was also noted that only 9-18 per cent of men had ever discussed HIV with their spouse³⁶.

³⁴Alex Mercer, et al.(2007). "Sexual Risk Behaviour of Married Men and Women in Bangladesh associated with husbands work migration and living apart." *Sexually Transmitted Diseases*.35:5.

³⁵National AIDS/STD Program.(2004-2010).National Strategic Plan for HIV and AIDS.Directorste General of Health Services Ministry of Health & Family Welfare.

³⁶Alex Mercer, et al.(2007). "Sexual Risk Behaviour of Married Men and Women in Bangladesh associated with husbands work migration and living apart." *Sexually Transmitted Diseases*.35:5.p265-273.

A cross sectional survey took a sample of 433 boatmen from Teknaf, an identified high risk area and burgeoning local tourist spot which is already home to roughly 23,000 people. It is deemed high risk due to its location near the Myanmar border, a country with high HIV prevalence. Of ten hotels in Teknaf, eight were identified as being linked with the sex trade and residence-based sex workers were located in and around Teknaf. Of the sample of boatmen, 17 per cent had sex with CSW while abroad, 19 per cent had sex with another man, 14 per cent participated in group sex, and condom use was 0-4.7% in last month of their sexual activity. Only 30 per cent of boatmen in this sample had ever heard of HIV and AIDS and 14 per cent reported perceiving themselves to be at risk of contracting it³⁷.

Truck drivers and people who often interact with them and are near truck stops are at increased risk of HIV infection because of possible sexual mixing among truck drivers, sex workers, and people working/living in truck stand settings. Data shows that 57 per cent of truck drivers in the Tejgaon truck stand had sex with both a sex worker and with their wife within the past year³⁸. Another study took a random sample of 696 men and 206 women composed of truck stand workers and those who frequent truck stands and are at increased risk of contracting HIV because of risky sexual behaviour. STI prevalence of syphilis, gonorrhoea, and Chlamydia were 4.1 per cent, 7.7 per cent, 2.3 per cent, respectively for men and 2.9 per cent, 8.3 per cent, and 5.2 per cent for women. Risk reduction strategies such as condom promotion have been used to mitigate the spread of the disease. However, condom levels have not increased according to research³⁹.

Youth and HIV and AIDS

Though actual, reported casual sex between young people tends to be low, it must be assumed that a much larger percentage is actually engaging in premarital sex. A 2005 Round 2 survey under GFATM confirmed that 22 per cent of unmarried males and 2 per cent of unmarried females engage in premarital sex. Of these youth (aged 15-24) 55 per cent reported never using a condom. The same percentage is under the misconception that HIV can be spread by coughing and sneezing.

³⁷ Tasnim Azim et al.(2006). "An assessment of vulnerability to HIV infection of boatmen in Teknaf, Bangladesh." *Conflict and Health*. 2:5.

³⁸ Nazmul Alam et al.(2007). "Sexually Transmitted Infections and Risk Factors Among Truck Stand Workers In Dhaka, Bangladesh." *Sexually transmitted Diseases*. 32:4.Pp99-103.

³⁹ Nazmul Alam et al.(2007). "Sexually Transmitted Infections and Risk Factors Among Truck Stand Workers In Dhaka, Bangladesh." *Sexually transmitted Diseases*. 32:4.Pp99-103.

Bangladeshis are inclined towards denial when it comes to addressing sex between unmarried young people. Government and NGO stakeholders introduced HIV and AIDS information into the national curriculum in 2007 which demonstrates national recognition of the risk to young people and their dedication to educate and inform youth about the spread of the virus. Out of school youth and working youth, however, remain to be sensitized to HIV issues.

People Living with HIV and AIDS (PLHA)

In 2007, UNAIDS estimated there are roughly 12,000 people living with HIV in Bangladesh, totaling less than one per cent of the general population. The 2004-2010 Strategic Plan mentions the need for availability of treatment and care for PLHA throughout their lives and advocates voluntary testing and counseling practices. Moreover, GOB developed ART treatment guidelines in 2006 in order to improve quality and availability of treatment. However, according to a 2008 UNGASS Country Progress Report, these directives in no way meet the national demand for ART drugs. Low perceived incidence rates of people living with AIDS may be one reason why national needs for ART are unmet. In the Bangladeshi context cost of antiretroviral treatment is very high. The average cost per person per month using locally produced drugs is Tk3700 (USD54). Four organizations are currently funding treatment including Action Aid, GTZ, Dutch-Bangla Bank Limited, and Swiss Red Cross. The Plan upholds the need for a rights based approach to care, support and treatment with the necessity of creating national protocols and guidelines for HIV treatment and care⁴⁰. However, only 15 per cent of people requiring ART are receiving it.⁴¹ Furthermore, many of those holding positions in the health and welfare related ministries are not sensitized to the nature of HIV and AIDS or the needs and rights of PLHAs. As a result, Bangladesh's NGO sector has generally overseen the treatment and care of those infected with HIV.

⁴⁰ Imaan, Najrana.(2008). "Review Paper Analyzing the Existing Legal and Policy Provisions and Practices with Respect to Human Rights in Relation to People Living with HIV and AIDS in Bangladesh." Ain o Shalish Kendra (ASK).Bangladesh.

⁴¹ NASP.(2008). UNGASS Country Progress Report. Ministry of Health and Family Welfare.

1.4 INSTITUTIONAL FRAMEWORK FOR HIV AND AIDS IN BANGLADESH

Government Mechanisms: National AIDS Committee (NAC) and National AIDS/STI Program (NASP)

For over twenty years the Government of Bangladesh and many international and national NGOs have been working to combat the spread of HIV and AIDS. The National AIDS Committee (NAC) was developed in 1985 to respond to the nascent HIV epidemic. The NAC includes representatives from many government departments, civil society organizations, the private sector, and self-help groups. The NAC worked with various stakeholders to develop the National AIDS/STI Program (NASP) which, in 2003, completed its first strategic plan and is in the process of implementing its second National Strategic Plan for 2004-2010.

In 2007, NASP, with the assistance of UNAIDS developed the 'National AIDS Monitoring and Evaluation Framework and Operation Plan'. NASP is the Government organ responsible for the coordination of the national program to combat HIV and AIDS and all international donor activity. The main donors of HIV and AIDS prevention funding are USAID, the World Bank, UK Department for International Development (DFID) and GFATM (Global Fund to fight AIDS, Tuberculosis and Malaria). Three large international organizations act as coordinators and managers of roughly 100 smaller NGOs. Additional INGOs, NGOs and community based organizations (CBOs) are currently working independently on HIV and AIDS prevention for a total of roughly 250 organizations (see figure 2).

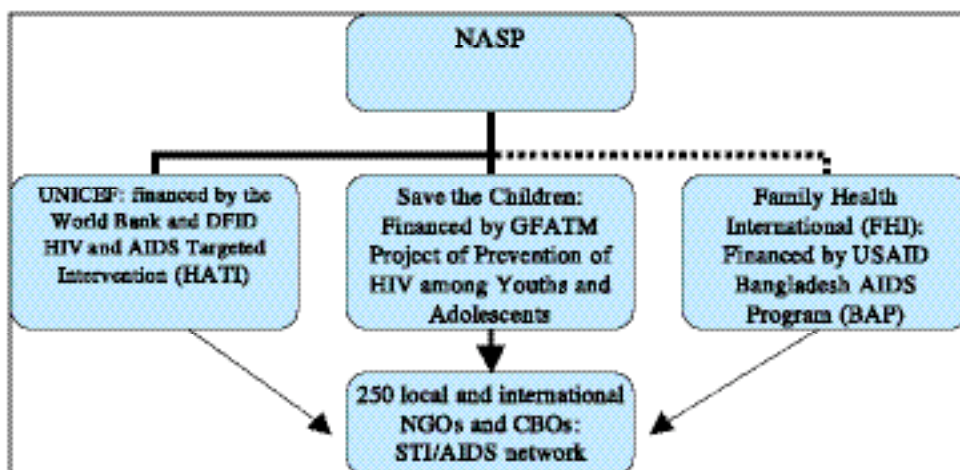


Figure 2: Implementing Partners of NASP

Major National-level Programs

Coming to completion in 2007, the HIV and AIDS Prevention Project (HAPP) and the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) Round 2 program were the first two major initiatives for HIV and AIDS prevention and treatment in the country. They were also the first major programs to address most at-risk populations. Currently, the major ongoing programs in Bangladesh are GFATM Round 6 the successor to HAPP, the HIV and AIDS Targeted Intervention (HATI). HATI and GFATM Round 6 possess their own managing agencies, policies and areas of implementation. However, there is notable overlap with regard to implementing partner organizations, whereby many partners receive funding from HATI in addition to GFATM.

HIV and AIDS Prevention Project (HAPP): 2001-2007

HAPP was funded by credit from the World Bank and a grant from DFID. The original budget was \$56 million, but due to delay the budget was reduced to \$26 million in June 2003. HAPP had four main components: high risk target population interventions; advocacy and communication; blood safety; and institutional sustainability and capacity development.

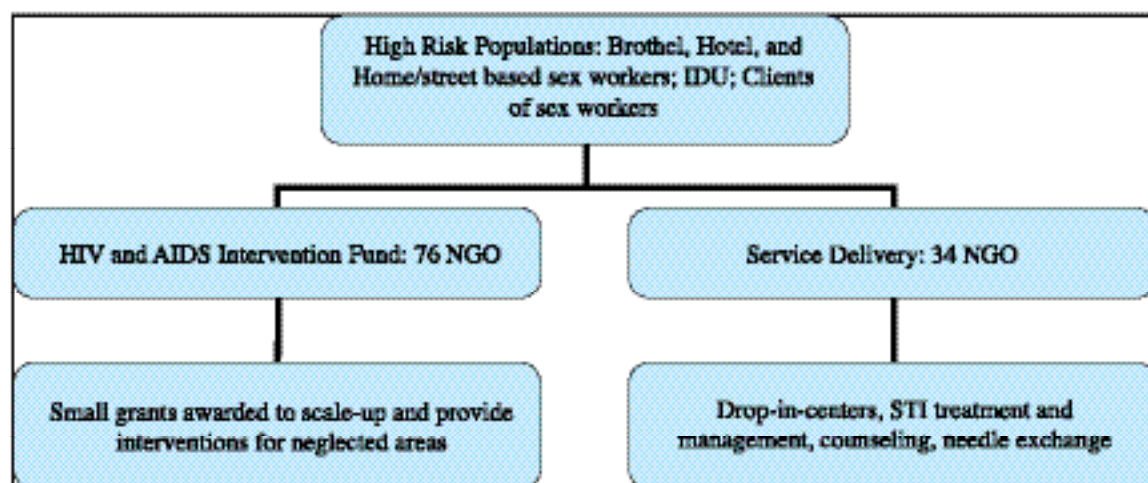


Figure 3: High Risk Component of HATI

The high risk interventions component was managed by the United Nations Children’s Fund (UNICEF) and broken into two separate projects: interventions and the provision of services (see figure 3). UNICEF was responsible for giving

funds to 110 selected NGOs while taking measures to develop the capacity of the selected NGOs and provide training on management of finances, monitoring, and evaluation.

The advocacy and communication components of HAPP were also broken into two projects: Community stakeholder awareness, sensitivity, and education training and the development of Behavior Change Communication (BCC) materials and advocacy of high risk groups. NASP provided the stakeholder training while UNICEF and John Hopkins's University partnered to develop the BCC and advocacy materials. The blood safety component for HAPP was separate from the other government initiative by the same name. However the World Health Organization (WHO), a managing partner for both initiatives, provided training for doctors and paramedics with regard to blood safety. The final component targeting the sustainability and capacity of institutions was much smaller than the other three components. The United Nations Population Fund (UNFPA) provided consultants to NASP to facilitate training and development in specialized areas.

HAPP ended in 2007 and has been replaced by HIV and AIDS Targeted Interventions (HATI), a program funded by the Government of Bangladesh and development partners. HATI's function is to aid the continuance of services offered by the 44 NGOs that had received HAPP funding, especially those organizations that provide services to high risk populations.

Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM): Rounds 2 and 6? The Government of Bangladesh has received GFATM funds for both Rounds 2 and 6. SAVE the Children USA was selected as the managing agent for this program. Round 2, which came to completion in 2007 and was targeted towards prevention among youth, provided 20 million dollars funding to seventeen NGOs to undertake the following: develop BCC materials and develop awareness campaigns (Mantra NGO); develop life skills education materials, increase condom accessibility, and initiate youth friendly health service programs (HASAB NGO); advocacy and policy change initiatives (Padakhep NGO); HIV and AIDS education and curriculum development (PIACT NGO); and develop baseline surveys, mid point surveys, and monitoring information systems (ICDDR,B).

GFATM Round 6 has a budget of 40 million dollars which is spread throughout over forty NGOs (some of which also receive HATI funding) all of whom continue to focus on prevention but with greater emphasis on high risk populations targeting sex workers, clients of sex workers, and IDUs.

Financing Instruments and Organizational Modalities for HIV and AIDS Programs Bangladesh has many development partners interested in offering aid to implement HIV and AIDS prevention and intervention programs. Its largest donors are the World Bank, USAID, DFID, and GFATM. The World Bank and DFID, as development partners for HAPP and HATI, contribute to a pooled fund delivery system with the Government of Bangladesh. A managing agency is selected to disperse funds among selected NGOs (figure 4). GFATM also requires a managing agency and has selected SAVE the Children USA in both Rounds 2 and 6. USAID works directly with FHI. Though NASP is involved, it is less direct than with other development partners (see figure 1). Other development partners play a variety of roles in the implementation of HIV and AIDS prevention and intervention programs. However, it is not within the scope of this review to document all development partners.

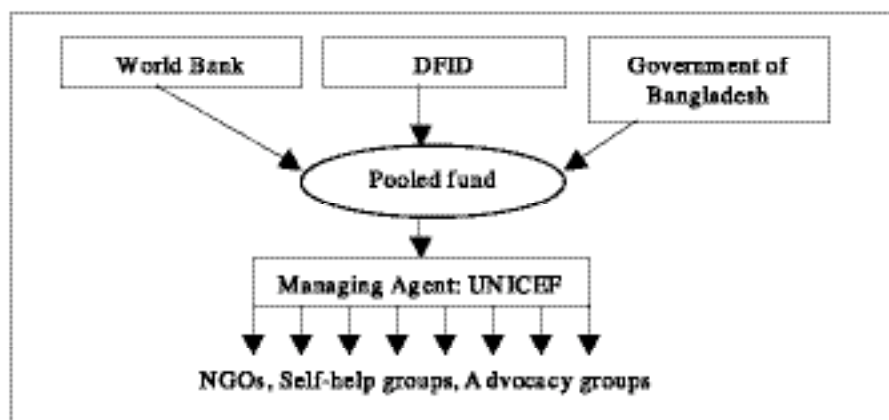


Figure 4: Pooled funding (HAPP and HATI)

NGO, CBO, and Civil Society HIV and AIDS Programs and Activities

Fortunately for HIV and AIDS interventions in Bangladesh, there is a strikingly dominant presence of Non-Government Organizations (NGOs) dedicated to filling in gaps and taking risks where political leadership fails to do so. Bangladesh has over 250 active registered NGOs, CBOs, peer support networks, self-help groups,

and advocacy groups involved in the prevention of HIV and AIDS. Activities implemented by the NGO community are 5-fold:

- Prevention
- Intervention
- Treatment
- Advocacy and stigma reduction
- Research

Annex 2 provides an overview of the seventeen NGOs interviewed for this study, highlighting their various HIV and AIDS programs and implementing partners. Some NGOs choose to focus all their attention on one target population, such as MSM, SWs or PLHAs. Others prefer to encompass all the high risk populations with their interventions. Alternately, some NGOs focus on one strategy throughout one target population, such as PIACT's HIV and AIDS education program targeting youth.

A small number of PLHA Self Help Groups in Bangladesh provide counseling and HIV treatment services to PLHA, including Anti-Retroviral Treatment (ART). These organizations also seek to draw attention to and improve the rights of PLHA, which includes increasing access to discrimination-free healthcare, education and employment, as well as urging government to legislate on behalf of PLHA. The majority of the country's NGOs concerned with HIV and AIDS are focused on HIV and AIDS and STI prevention, and reproductive and sexual health more generally. They are likely to have programs that merge with HIV and AIDS prevention issues (i.e. sexual health education, condom promotion, healthcare services for sex workers, behavior change communications materials, etc.) but generally are not referred to as HIV and AIDS NGOs.

There is a prevailing sense among these NGOs that community involvement is a key component to HIV program implementation and service delivery. Peer outreach workers, for example, are frequently and successfully used to reach people and communities with HIV and AIDS related information because they are more likely to be trusted than government officials or institutional bodies. Moreover, community involvement and community-based organizations can create more open and non-threatening spaces for discussion of sensitive topics such as HIV and AIDS to help sensitize political and social leaders, rather than from the top-down.

2. Challenges

Study respondents ranged from donor agencies, government bodies, NGOs, INGOs, research institutions, and beneficiaries. Despite varying motives and interests, common themes were revealed pertaining to programmatic challenges. The most common intervention challenges are the following:

- Intervention Funding; experiencing gaps, delays, and/or lack of funds
- Stigmatization and Discrimination of high-risk groups and PLHAs
- High Levels of Staff Turnover
- Government Hurdles
- Gaps in Expertise and Training
- Intervention Weaknesses
- Coordination Between Implementing Partners
- Policy Pitfalls
- Monitoring and Evaluation
- Antiretroviral Procurement

2.1 INTERVENTION FUNDING

All study respondents maintained that funding setbacks create barriers to successful HIV and AIDS interventions. Problems cited range from:

- Funding not sufficient
- Donor dependency
- Applying for funding is burdensome
- Gaps in funding
- Slow disbursement of funds
- Lack of corporate social responsibility

A slight divergence occurs when addressing funding challenges within HIV and AIDS interventions. Most NGO respondents would not claim that funding is always sufficient for their programs. The head of the Donor Consortium states that funding for HIV and AIDS interventions is more than sufficient for Bangladesh,

given the relatively low level of prevalence. Two respondents from major INGOs strongly agreed with this statement. For other organizations, funding may seem insufficient or unavailable. However, this likely has more to do with poor distribution, bureaucratic entanglements and slow disbursements from donor agencies.

Funding for HIV and AIDS interventions in Bangladesh is derived mainly from the GFATM, HAPP and HATI programs, HATI being funded by the World Bank, DFID and government of Bangladesh. Heavy reliance on external funds creates barriers to intervention successes, such as compliance with donor rules and funding regulations, gaps in donor funding, delayed release of funds, and short term funding contracts. The latter issue translates into a problem of sustainability, a critical challenge faced by a majority of NGO respondents. Funding which is only provided for 2-4 years is most often insufficient to derive sustainable positive outcomes for any given intervention. Furthermore, dependency on donors leads to donor driven initiatives that often do not address specific community needs and rather put in place policies that can restrict an organization's ability to satisfy the needs of the community. Donor dependency cannot be overlooked as a factor affecting intervention sustainability. Concerned Women for Family Development (CWFD) has received 22 years of USAID funding through the Smiling Sun Foundation, which they state has been a 'blessing and a curse' for the organization, as there would be a disastrous effect should USAID stop funding the organization. The NGO respondent noted that donor dependency leads to donor driven services being provided and donor priorities pursued. Some donors impose regulations on funding, such as provisions that NGOs cannot promote abortion or safe drug use. NASP and FHI respondents noted that FHI was once the leading advocate for IDU safe needle exchange programs. However, after receiving USAID funding, FHI was forced to comply with USAID's position against drug use, and thereby discontinue its needle exchange programs. An MSM representative and counselor adds to this point, in reference to non-procurement of condoms and lubricants specifically designed for MSM, that donors often do not have the needs and expectations of target communities at heart.

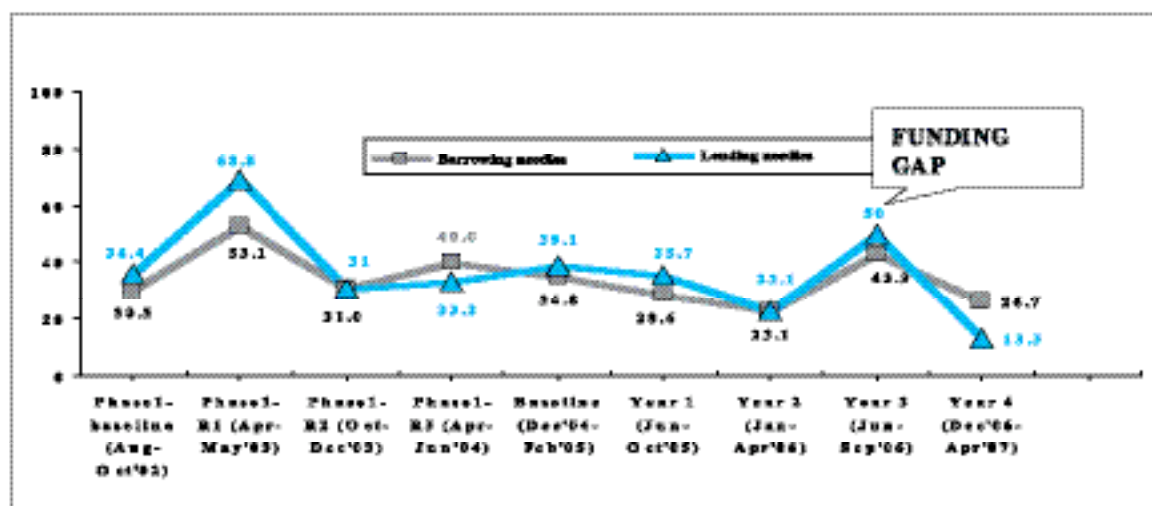
Another funding concern stresses the need for harmonization and streamlining of funding formats so that NGOs need not waste valuable energy and resources in rewriting and constantly adapting to the different formats and processes of various funding agencies. Likewise, donors should be better coordinated so that duplicated funding for the same or similar intervention happens less and money is allocated to a more diverse range of interventions.

A representative from a local NGO states that gaps in funding and irregular disbursements leads to periods of inactivity and reduction of intervention quality standards. The respondent blames lengthy bureaucratic processes, wherein NGOs must produce new project documents, revise them and wait for approval, creating gaps in funding up to 6 months. For a small-scale NGO this gap may be devastating (due to inability to produce rent on office space or distribute staff salaries) and considerable progress will likely be wasted.

Figure 5 shows that during one funding gap in year 3, the IDU increased needle-sharing behavior to levels almost equal to those at pre-intervention levels. As evidenced by this example, funding gaps translate into intervention loss and should be a priority issue for donor, government, and NGO sectors.

Figure 5: Funding gap ramifications for needle sharing behaviors

Source: Project Completion Report, CARE Bangladesh, HAPP 2004-2007



An NGO targeting SWs experiences regular delays in funding disbursements from one of its donors, which it says greatly reduce program quality and makes it

difficult for the organization to survive financially for up to 4 months at a time. Despite efforts, funding is often delayed and cut back demonstrated by the HAPP program scheduled to start in 2001 but which did not actually commence until June 2003. During a 2003 review session the \$46 million project budget was decreased to \$23 million, resulting in the exclusion of the MSM population. To further cut costs, the budget condensed two target groups so that "migrant workers" included clients of brothel based sex workers.

Some level of corporate social responsibility has made its way into the fight against HIV. Concerned Women for Family Development reports success in utilizing funding from Grameen Phone for women's healthcare purposes.

Likewise, Mukhto Akash states that Dutch Bangla Bank has provided ART medications to the organization as a sign of its commitment to curbing the spread of the virus.

2.2 STIGMATIZATION AND DISCRIMINATION

All study respondents, irrespective of individual goals and interests, stated that stigma and discrimination are major hurdles in tackling HIV within target populations, namely MSM, SWs, and IDUs.

Table 2: Primary Areas of Stigma and Discrimination

CHALLENGE PERTAINING TO STIGMA AND DISCRIMINATION	NUMBER OF RESPONDENTS
Marginalization of migrant laborers, SWs, MSM, and IDUs making them difficult to access with health services and information	12
Criminalization of MSM, SWs and IDUs	5
Disempowerment of women	4
Conservative society and religious standards	3
Discrimination towards PLHA by medical staff and family resulting in reluctance to care for them	3
Difficulties reintegrating IDUs into society to effectively avoid relapse	1

The activities of MSM, SWs and IDUs are deemed illegal, as is further discussed in the policy section, thereby creating challenges in learning about and addressing their high risk sexual behavior as well as rallying for greater government support and HIV and AIDS policy which would encompass their rights as well as the 'general' Bangladeshi population. An INGO representative stated that HIV is the country's most delicate development issue due to the harassment and fear imposed upon target populations as a result of criminalization of their actions, thus driving them further 'underground.' The respondent stated that though NASP seems to be supportive of needle exchange programs for IDUs, the Home Ministry is against such harm reduction strategies, and even harasses the organization's outreach workers by claiming that they are promoting drug use. The respondent added that police routinely perform raids in places where drug injecting is known to occur. They 'clean' the area of drug users which the respondent feels actually increases the spread of HIV and AIDS since it forces IDUs to remain mobile making them more difficult to reach with harm reduction programs. Outreach workers aim to provide a certain target of IDUs with clean needles, but after raids take place, they are generally unable to find the IDUs. Moreover, IDUs are timid to let their whereabouts be known to outreach workers for fear they may tip off the police. The INGO respondent further stressed the organization's failed efforts to effectively advocate for IDUs with police near high drug use zones. Because of high transfer rates in law enforcement personnel, many police officers are transferred to different stations when good rapport is finally established and advocacy efforts have begun to show signs of progress. Adding to discrimination against target groups is the fact that the religious sensibilities in highly conservative Muslim Bangladesh do not support the actions of MSM, SWs and IDUs.

The general population also suffers from stigma attached to sexuality and sexual health. Since people do not generally discuss these matters openly, knowledge of STI and HIV symptoms is low, particularly among men. Involving men in STI management is difficult because they tend to avoid health clinics due to shame and/or discomfort around female health practitioners. Instead, many men prefer to seek treatment from traditional healers or untrained pharmacists. Traditional practitioners and unauthorized ('quack') doctors carry out a considerable portion of treatment for premature ejaculation and impotence, which are typically regarded

as sexual disorders and stigmatized among males. In fact, the predominant sources of STI treatment in Bangladesh are pharmacies, homeopathic doctors, and herbalists⁴². A study revealed that 93.5 per cent of respondents in a community in Chakaria, Bangladesh go to unlicensed medical doctors when they suffer from sexual health problems. In the same study, 86.5 per cent reported taking herbal remedies for their sexual health concerns and 80.6 per cent went to homeopathic practitioners⁴³.

In Bangladesh, sex and sexuality are simply off-limits topics for the public domain, a fact which is demonstrated by a host of censorship policies restricting advertisement and discussion of sex-related topics. The word, 'condom' only made it into the media for the first time in a television advertisement in 1999. The role of government and a range of policy actors, therefore, cannot be underestimated. Political participation and support are major forces in setting and implementing national treatment and prevention strategies. In doing so, government officials and policy actors in Bangladesh must demonstrate leadership in taking on issues of discrimination and stigma as well as overcoming taboos relating to discussing sex in the public sphere. This is an especially tricky undertaking as it would contradict the cultural and religious beliefs of the vast majority of Bangladeshis (including, in most cases, government and policy makers themselves) and is by no means likely to be popular.

A major and indeed deadly illustration of stigma and discrimination is that which takes place towards PLHA. Widespread misconceptions exist regarding how HIV is prevented and spread as well as how PLHA are affected by the disease. In the opinion of an NGO working with PLHAs, people living with HIV and AIDS are predominantly poor, undereducated, and laboring as internal and external migrants, making treatment too expensive, unfamiliar and inaccessible. Moreover, women, who are widely disempowered in Bangladesh's patriarchal society, are generally blamed for being vectors of the spread of HIV and AIDS, probably from the association of rapid spread with Sex Workers. With a lack of independence, women face obstacles in getting to intervention facilities on their own and often are

⁴² CARE Bangladesh.(2006).Transport Workers at risk to HIV: Documenting our Experiences 2000-2004.Dhaka, Bangladesh.

⁴³ N. Ahmed et al.(2008).Sexual and Reproductive Health Concerns of Married Men and Access to Services In Rural Bangladesh.

not empowered to make their own decisions regarding their sexual activities or health. Respondents from the NGO add when HIV positive status is revealed to the individual's family or acquaintances, grave repercussions are likely, such as loss of affection, emotional support, and job, as well as denial of education, property or healthcare. For example, family or community members may discourage loans or investment in property because they assume the patient will not live much longer.

Respondents from a major research institution claim that a past program of theirs used a large number of condoms for HIV prevention training purposes which had to be discarded each week from their Chittagong office. Eventually the office landlady heard that the building was being referred to as, the "AIDS House" by community members. Fearful of the stigma attached to the office and anxious to maintain her own reputation, she immediately removed the office sign from the building without communicating with office staff. This reportedly caused great confusion and shame to people seeking guidance and HIV services from the office. Further drawbacks of HIV related stigma, as reported by local NGO, is that highly conservative attitudes and misconceptions pertaining to HIV and AIDS patients has led to low participation of the media and low media coverage of issues facing PLHAs.

Regarding migrant laborers, there is general anxiety (repeated throughout HIV and AIDS literature and interviews) regarding Bangladesh's proximity to Myanmar and India in regards to migratory transmission of the HIV virus. Both Myanmar and India have high rates of HIV infection. For this reason, migrant labor is seen as a high risk factor. Further indicators of their vulnerability have been identified in the prevalence of commercial sex workers, where increased extra marital sex with SWs and MSWs increases the migrant worker's chances of transmitting the virus to his wife or girlfriend⁴⁴.

2.3 HIGH LEVELS OF STAFF TURNOVER

Twelve of the respondents stressed low retention of government stakeholders, donors, medical personnel, and field workers as a major obstacle to HIV and AIDS interventions. Major challenges relating to staff turnover are:

- High turnover of donor staff
- High turnover of field staff
- Staff Commitment and Work ethic low due to quick turnover

⁴⁴ Imaan Najrans.(2008).Review Paper Analyzing the Existing Legal and Policy Provisions and Practices with Respect to Human Rights in Relation to People Living with HIV and AIDS in Bangladesh.Ain o Shalish Kendra (ASiK).Bangladesh.

Seven Respondents from large research institutions and NGOs state that donor staff turnover is just as great a frustration and challenge. A respondent from a large research institution states that turnover in donor agencies slows communication and makes momentum difficult to maintain. An NGO respondent adds that it is not only difficult to make progress when you have to retrain personnel and redevelop relationships with stakeholders, but often the people in decision making positions are not those with the most expertise or experience.

High poverty levels in Bangladesh translate into low-paid jobs in both the government and private sector. Moreover, many HIV and AIDS related service delivery and intervention programs often place doctors and staff in undesirable locations where they are far from their families and other resources. As a result, doctors will naturally gravitate towards higher salaries, which are predominantly offered by the government in posts in larger cities, leaving a vacuum of skilled medical staff in the NGO sector and in rural areas. A respondent from a local NGO states that government healthcare providers do not provide HIV and AIDS prevention services such as the NGO sector does. The respondent also noted that professional growth is limited for doctors working at a NGO and grassroots levels. They are anxious to take government jobs where they receive higher salaries, can perform postgraduate degrees, and have greater job security. NGO doctors have neither time nor money to pursue high-level degrees. The respondent added that NGO-based doctors receiving salaries from donors are forced to comply with the donor's agenda and regulations. For example, if a donor such as USAID is against harm reduction strategies for IDUs (the provision of safe needles, for instance) or do not support Menstrual Regulation (MR) services, doctors are restricted and must obey these terms.

A respondent from the Donor Consortium in Bangladesh notes that staff commitment and motivation decrease due to high turnover rates, especially among the government's civil servants, where the duration of one's position is never assured. Continual reshuffling occurs not only within ministries but also between ministries so that an employee may be reassigned to the Ministry of Health and Family Welfare (MOHFW) from the Ministry of Education. The MOHFW may wish to retain the employee for four years, but there are few mechanisms in place to ensure this, making it difficult for the employee to fully

invest his/her capacity in the project. Staffs generally lack a sense of ownership in their work due to persistent relocation. The respondent stated that there is a comparatively large amount of money going into the health and education ministries, making them a desirable posting for civil servants. Often, employees without health expertise, or even interest, end up in top positions within the MOHFW. The respondent states that it would be a great sign of improvement if the MOHFW were to appoint an AIDS expert to lead NASP, as this has not been the case to date.

2.4 GOVERNMENT HURDLES

Eleven of the study's respondents commented on the negative effects of government's overall slow decision-making and apathy towards HIV and AIDS policy enactment, citing the following challenges:

- Poor coordination and communication within NASP and NAC as well as between GOB and implementing partners
- GOB is weak in terms of upholding HIV and AIDS policy
- Low levels of activity within the National AIDS Committee (NAC)
- Time consuming and burdensome bureaucratic process slows pace of HIV interventions and results in funding gaps and dissemination of information

Half of total respondents claim that greater activity and efficiency in the National AIDS Committee (NAC) and National AIDS Surveillance Project (NASP) are vital components of the country's response to HIV and AIDS. Respondents from UNFPA stated that the NAC has been virtually dormant for three years, while NASP leans too heavily on its having completed extensive research in the area of HIV and AIDS, as NASP has yet to translate its research into effective action and policy.

All eleven respondents who highlighted the GOB as a challenge to intervention success drew attention to the slow pace of government response and action. NGO partners must include government stakeholders in their programs to ensure multi-sector unity. However, both NGOs and INGOs, all of whom rely on government allocation of funds from either HAPP or GFATM programs, claim the GOB is slow to announce information and release funds.

Ten respondents, including NGO, INGO and donor perspectives, state that since donors generally subcontract to NGO partners, government AIDS bodies have little knowledge of the nature of interventions which are being undertaken by various partners. As an INGO representative pointed out, NASP is the only unit under the MOHFW with a line director dealing with only one disease, and therefore should be demonstrating high levels of competence and taking a greater leadership role.

From a UNAIDS donor perspective, dealing with bureaucratic processes of the GOB slows interventions and there is a general lack of urgency regarding the response to HIV and AIDS. The same UNAIDS respondent stated how challenging it is to combat HIV and AIDS in a country with such a low documented prevalence rate, resulting in scarce recognition of the problem and no sense of priority. A perspective from the Donor Consortium highlights what they see as a structural problem within the GOB which leads directly to condom shortages and inefficient distribution. That is, condoms reserved for Family Planning programs within the MOHFW are given for free and kept completely separate from those procured for NASP for HIV prevention, which are sold at a nominal fee. In other words, the two government departments fail to coordinate and pool resources. Greater coordination in this sense could prevent shortages of condoms and help avoid distribution problems. Furthermore, this arrangement potentially raises the stigma level already associated with PLHA, by requiring them to have a 'separate' condom.

2.5 GAPS IN EXPERTISE AND TRAINING

Nearly all respondents commented on shortages of trained medical professionals and field staff along with overall lack of local expertise in the field of HIV and AIDS, in both government and NGO sectors, citing the following main points:

- Perceived low threat of the virus leading to apathy
- Non-experts in NASP and NAC
- Health workers and doctors unaware about HIV and AIDS and maintain many misconceptions
- Resources for training and monitoring field staff, nurses and doctors is insufficient

INGOs and donor agencies attributed gaps in expertise and training to the relatively low severity of the disease in Bangladesh and few Bangladeshis seeking higher education in this field. Four interview respondents, from both INGOs and NGOs, volunteered that employees in NASP are not even remotely expert in HIV and AIDS issues, but rather tend to be variously trained government doctors who have been transferred (by good merit or a favor) to a highly desired administrative posting. The range of inadequacy varies significantly, but multiple respondents stated that a number of health workers and officials in NASP are not familiar with the basics, such as the meaning of the acronym or how it is transmitted. A respondent from an NGO working directly with PLHAs reported accompanying a member of NASP to a conference, at which PLHAs were present. The respondent relayed that the official asked embarrassing questions to the PLHA that clearly demonstrated his lack of knowledge on the topic, creating an embarrassing situation. UNFPA agrees that NASP and NAC capacity in HIV and AIDS is lacking, and that moreover, NAC has remained inactive for 3 years.

Training doctors, nurses and field staff requires large amounts of resources, time and patience, as high attrition rates for field staff translate into frequent rehiring and retraining, according to an INGO working on HIV and AIDS related programs. Most NGOs in this study agreed that field staff lack training and capacity, but that there is insufficient budget and/or ineffective monitoring systems in place to ensure this does not happen. A local NGO respondent states that more urgently, sanitation and sterilization in healthcare facilities must be improved to effectively handle the health needs of the country, and minimize risk for HIV transmission within the healthcare setting.

2.6 INTERVENTION WEAKNESSES

Four respondents commented on poor focus and design of HIV and AIDS interventions as factors affecting the their success:

- Inadequate focus on PLHAs
- Poorly regulated and insufficient blood screening
- Insufficient and poorly managed condom supplies

Four respondents commented that a major deficit in HIV interventions in Bangladesh is a lack of focus on treatment and care of PLHA. Only three NGOs

out of 250 working on HIV and AIDS issues in Bangladesh work specifically with PLHAs. The government has no programs specifically targeting PLHAs. One of the three NGOs believes that PLHA are one of the greatest resources for HIV advocacy and training on the care and support for other PLHA. Treatment should not be seen as separate from prevention, because PLHA can spread HIV to others, and without treatment and counseling they may not be aware of how to avoid this and/or consider their lives desolate and will not bother taking precautions necessary to prevent spreading the virus.

Lack of blood screening was cited as a major intervention weakness by 3 respondents concerned about sale of unsafe blood, mainly donated by IDUs. According to one NGO, there are 92 safe blood centres in Bangladesh but due to a lack of quality monitoring, consistency can not be relied upon. An NGO respondent working to improve healthcare service delivery standards states that the majority of blood donated in the country is not screened for Hepatitis B and HIV and there is no active policy indicating that this type of screening is essential for safe blood supplies. Further, frequent emergency blood transfusions occur without proper screening or the patient's consent. Patient rights should be considered when performing blood transfusions by providing the public, the patient and their family with information regarding the quality of donated blood and the dangers and benefits of consenting to blood transfusions. Further, the respondent urges that more be done to ensure, at the service provider end, that blood screening be mandatory and routine and that IDUs seeking money for blood be sensitized to the issue and/or offered an alternative to blood donation.

Five respondents reported that condoms are sometimes reported to be, in various ways, unobtainable to those seeking them. An INGO respondents states that an important intervention weakness is that male condoms, by far the most widely available and used condom choice, which puts less control and decision making power in women's hands. Besides, due to high-risk targeted condom interventions, condoms have a stigma attached to them, as in, if you are using a condom you are 'engaging in something dirty or promiscuous.' Therefore, condoms generally have not been popular with women, whereas other forms of birth control are much more easily adoptable into one's sexual behavior. According to an INGO respondent, more should be done to popularize both male

and female condoms to women. In the same vein, a Social Market Company representative brought up the fact that women's negotiating power, specifically in paid sex environments like brothels, is very low. An MSM support organization, claims that condoms provided to the NGO by donor agencies are intended for heterosexual intercourse, whereas sex between men requires specific types of condoms. They also state that lubricants are difficult to procure in Bangladesh and donors do not provide these products. This complaint was contested, however, by the head of the Donor Consortium, who claimed that typically money for condom procurement is given to individual NGOs so that they can select the product based on their specifications. The respondent went on to add that shortages are more often a result of inefficient storage and allocation of condom supplies. For example, donor/programmatic stipulations often prohibit one stock of condoms from a particular source/program from being used when a shortage occurs on a different program.

2.7 COORDINATION BETWEEN IMPLEMENTING PARTNERS

Seven out of the nineteen stakeholder respondents commented on poor coordination and duplication of programs among partner organizations as well as donor bodies. Primary areas of concern are;

- Coordination between implementing partners
- Duplication of interventions among implementing partners

Within any cooperative institutional partnership compromises must be made. Arriving at those compromises is difficult without a consistent forum with which to address concerns. The STI/AIDS Network of Bangladesh was loosely formed under NASP and has gradually grown to consist of 224 organizational members committed to reducing the spread of STIs and HIV and AIDS in Bangladesh. The mission of the network is to enable, support and facilitate NGOs/CBOs to carry out effective intervention/program in STI/AIDS⁴⁵. While in theory this is a sound method for increasing communication and cooperation, it is an underutilized tool. Five respondents noted that differences in opinion, goals and methods caused ineffective partnerships. An NGO working with MSM cited the example that one

⁴⁵STI/AIDS Network of Bangladesh.(2008).

cannot comfortably speak publicly about MSM in the Bangladeshi cultural context, and so it is extremely difficult to get other stakeholders involved in the discussion who are much less supportive of interventions targeting MSM populations. These five respondents agreed that too many organizations tend to rally behind policies and programs that furthering their organizations' individual goals and the differences in organizational capacity (wherein one organization is reliant upon the other to provide tools and technical assistance) create an unequal power dynamic, where the organization lacking capacity feels they must compromise their own mission.

Little is done to monitor and improve efficiency of multi-partner interventions. A small NGO working with PLHAs states that the organization began to implement a project in Sylhet, targeting a particular group, only to find that another organization was simultaneously providing the same services to the same target group. The result was duplication of funds going into duplicated projects, which could have been avoided with better communication between partners. Marie Stopes Clinic Society has phased out brothel-based work because of the duplication that exists in this area and is now focusing on residence-based sex workers who are most difficult to access.⁴⁶ Poor communication and reluctance to share data as a byproduct of funding competition was reported by five respondents as primary reasons for duplication of interventions, the result being the wasting of essential intervention funds.

Bangladesh receives approximately \$20 million every year for HIV and AIDS prevention, treatment, and education. In an interview, the head of the Bangladesh Donor Consortium stressed that this funding amount is sufficient for Bangladesh given the relatively small scale of the viral infection in the country. He stresses that the problem lies in inefficient and unwise distribution. According to the Consortium, AIDS funding comes primarily from: 1) HATI, which is pooled from different donors, government controlled, and UNICEF run; 2) GFATM; 3) USAID/FHI. All three donors have individual procedures and formats to receive funding and unique reporting styles and funding restrictions. Coordination among donors is inefficient and they often will duplicate funding for the same intervention,

⁴⁶ Residence-based sex workers provide paid sex from their homes. They are often difficult to locate since many will claim to be housewives.

or similar interventions. The Consortium pointed to the 2008 Paris declaration on aid effectiveness, where international donor heads discussed donor harmonizing and streamlining solutions, as poor coordination and duplication are regarded as widespread problems spanning all NGO-donor relationships, not only in the Bangladeshi HIV and AIDS context.

2.8 POLICY PITFALLS

Overwhelming consensus regarding HIV and AIDS policy is that it looks good on paper but needs to be properly enacted and requires a host of revisions and modifications in order to be up to date, as it was written more than ten years ago. Further, five of the respondents called attention to the criminalization of SWs, MSM and IDUs as holding back progress on target population focused interventions. Major challenges cited are:

- GOB does not adequately address treatment and care
- Constitution of Bangladesh does not adequately address PLHAs
- Criminalization of high risk groups
- Restrictive Acts on media
- Policy is not enacted or upheld
- Revisions are necessary

Bangladesh's 1997 National AIDS Policy (NAP) and subsequent National AIDS Program Strategic Plan (NAPSP) papers (1997-2002 and 2004-2010) highlight the individual rights of PLHA. In supporting the rights of PLHA and marginalized groups (SWs, MSM, IDUs) they are, however, on the whole inadequate and ineffective. The NAP recognizes the importance of international human rights and Bangladeshi constitutional rights of its citizens, such as autonomy in decision-making, confidentiality and no discrimination from healthcare providers. There is, however, very little discussion about actual legal frameworks and no recommendations for setting up laws for the protection of PLHA.

Respondents from the NGO community generally agree that the GOB places its emphasis on prevention of HIV and AIDS and NGOs fill the gaps in treatment and care. NGOs consider this to be a significant defect in the government's response to HIV and AIDS, as it should ideally cover both. Two respondents from NGOs that

directly manage treatment and care of PLHAs suggest that this is a result of stigma enshrouding HIV positive people and misunderstandings surrounding transmission that the government simply isn't equipped to deal with. For example, there is no protocol for healthcare practitioners to administer surgery or other treatments to HIV positive people. In many instances HIV positive individuals are not treated at all for HIV and/or other medical problems. PLHA get medical advice and ART through NGOs and via support groups.

The Bangladesh constitution does not directly address PLHA but does provide scope for protection of their rights based on overall human rights. The State's responsibility to PLHA is on the basis of their entitlement to right to life and personal liberty and protection, as Bangladeshi citizens. On the contrary, parts of the constitution pose direct opposition to the rights of a majority of those living with HIV⁴⁷.

Section 377 of the constitution criminalizes sodomy and any sexual act which is "against the law of nature," in other words, non-procreative. MSM are most commonly associated with this offence, and as a result are unwilling to be tested or come forth with positive diagnoses for fear of arrest and punishment. The same fear of legal repercussions inhibit IDUs and sex workers from getting tested or treated, as various types of sex work and all drug abuse are illegal in Bangladesh. NGOs focusing on target populations, such as Bandhu (MSM) and Durjoy Nari Shangha (SWs), face particularly interesting challenges because their work is technically illegal, as they support men and women taking part in illegal activities. Working with MSM, Bandhu states that their advocacy efforts through donors in support of lobbyists, have achieved some degree of progress in changing mindsets of policy makers. However, no ratification of criminalizing policies has occurred.

Street and hotel-based sex work (also called, 'floating' sex work) is illegal in Bangladesh. However, since March 14th, 2000 when the High Court of Bangladesh defined sex work as legal though not socially recognized, brothel-based prostitution has been a regulated profession. There are 14 registered brothels in the country. Though not provided for by any written law, sex workers are recruited and bound to brothel-based sex work through a system of affidavit, or sex worker's license, issued by first class magistrate or notary public.

⁴⁷ Imaan, Nejrana.(2008). Review Paper Analyzing the Existing Legal and Policy Provisions and Practices with Respect to Human Rights in Relation to People Living with HIV and AIDS in Bangladesh. Ain o Shallah Kendra (ASK).Bangladesh

Floating sex workers are not provided with an affidavit and therefore, not registered with local police stations. Therefore, they cannot work in brothels or in any other regulated CSW zone. Instead, they migrate through streets, railway stations, bus terminals and ferry docks. It cannot go without mentioning, however, that brothel eviction is still a grave threat to SWs and has occurred to a varying degree in the recent past. This is despite mass eviction being a human rights violation against the right to life and livelihood enshrined in Article 31 of the constitution.

Two prohibitive acts, the East Bengal Undesirable Advertisements Control Act (1952) and the Indecent Advertisement Prohibition Act (1963) present yet another legislative hurdle in the dissemination of information on prevention and treatment of HIV and AIDS via the media on the basis that such information is indecent. Essentially, these acts make illegal any promotion of a product, treatment or words of advice which may affect, and render indecent, the mind of an otherwise 'normal' minded individual. The term, 'normal' is not defined in these acts⁴⁸. Such a highly regulated media environment does not lend itself to creating openness and awareness around sensitive topics such as sex and HIV transmission. However, media is a powerful social messaging tool and what may be deemed by some as 'indecent' content, may actually contain information with which to educate the population about the prevention and treatment of HIV and AIDS.

Generally, the National AIDS Policy (NAP) recognizes (but does not provide an actual legal framework) that the State should NOT:

- Be restrictive (in terms of housing, employment and education) to PLHA
- Make pre-marriage testing mandatory and/or refuse to issue wedding certificates to positives as it is not helpful in reducing transmission, due to increase in premarital sex

And that the State SHOULD:

- Discourage mandatory sterilization and abortion if parent/mother found to be positive

⁴⁸ Imaan, Najrana.(2008).Review Paper Analyzing the Existing Legal and Policy Provisions and Practices with Respect to Human Rights in Relation to People Living with HIV and AIDS in Bangladesh.Ain o Shalish Kendra (ASK).Bangladesh.

- Discourage required testing before a child is sent to a foster home, however foster parents should be made aware of the child's status
- Ensure confidentiality and voluntary disclosures
- Provide laws against moral policing; Provide laws against harassment
- Provide laws against blackmail or bribery of PLHA
- Ensure legal repercussions for those who do not abide by laws in place to protect the rights of PLHA

Supplements to the NAP are the National AIDS Program Strategic Plan (NAPSP) papers 1997-2002 and 2004-2010. The 1997-2002 Paper draws attention to the following target groups as top priority for HIV and AIDS prevention programs: Sex workers and clients; IDUs; Transport Workers; Migrant Workers; MSM; Adolescents. It is important to note that NAPSP (1997-2002) failed to take into consideration treatment for persons currently diagnosed and living with HIV and AIDS. NAPSP (2004-2010) repeats the first Paper, but adds to its recommendations:

- Reduction of discrimination and stigma
- Right to information pertaining to the prevention and treatment of HIV and AIDS
- Call for provisions for PLHA
- Rights-based approach to care, treatment and support
- Need for creating national protocols for treatment and support

Out of the total respondents for the study, 7 reported policy inadequacy as a major challenge to HIV interventions. An NGO respondent states that the GOB must show greater commitment to upholding NAP provisions and that the national AIDS policy, which is more than ten years old, needs significant revision. The respondent suggests that GOB's slow and inconsistent action results in high staff turnover and poor coordination of NASP employees. From a donor perspective, both UNAIDS and USAID agree that NAP is well-intended and takes into consideration universal human rights and marginalized populations, but requires updating and revision in order to be effective.

2.9 MONITORING AND EVALUATION

Nine respondents commented on the lack of an effective monitoring and evaluation system for HIV and AIDS interventions. A results-based monitoring and evaluation system is useful to HIV and AIDS intervention partners and policy actors because it answers the fundamental questions of whether an implementing organization's agreements were honored and outcomes achieved. For example, if the GOB is promising to achieve improvements in ART procurement, there needs to be some means of demonstrating this has or has not occurred, i.e., a form of measurement which includes documentation and proof of performance. Monitoring and evaluation systems improve transparency in reporting between government, NGOs and research institutions⁴⁹.

Respondents commented on monitoring and evaluation difficulties. Essentially, it is felt that the majority of intervention weaknesses could be eased if effective monitoring and evaluation systems were in place. All respondents who cited this challenge stressed that shortages in money and time were factors affecting documentation and follow-up. A research institute respondent stated that documentation and monitoring processes are tedious and time consuming for small and/or understaffed NGOs. A respondent from an INGO adds that it is difficult for organizations to scale-up programs without losing the ability to successfully monitor and evaluate outcomes. The respondent also notes that NGOs are often anxious about the evaluation process because it can bring to light programmatic shortcomings and failures. As a result of pressure to meet targets, program implementers spend vast amounts of energy meeting their program's target numbers, leaving little time and resources for documentation and evaluation processes. The same respondent, plus seven others, states that the donor and GOB should play a more active role in the monitoring and evaluation processes to ensure it gets done correctly.

2.10 ANTIRETROVIRAL PROCUREMENT

Six respondents, including NGOs and INGOs, stated that domestic, hassle-free and reliable procurement of ART should merit policy revision on a priority level and is essential in addressing PLHAs and preparing for future positive cases in Bangladesh.

⁴⁹ UNICEF.(2008).Bridging the gap: The role of monitoring and evaluation in Evidence-based policy making.

Both donor agencies and NGO respondents state that, as it is now, there are too many barriers to obtaining ART drugs for Bangladesh, such as registration and cost for importing ART and WHO approval requirements for domestic production of ART drugs, creating reliance on foreign manufacturers. In fact, the pharmaceutical company, Beximco has been producing ART locally. However, procurement is complicated under the UN system, since the drug is not WHO approved. As far as imported ART drugs are concerned, import costs are significant since ART is not on the Bangladesh 'essential drug' list.

An NGO which aims to provide ART to PLHAs claims that while India, the source of Bangladesh's ART drugs, has a policy for 2nd line ART drugs and is in the process of creating policy for 3rd line drugs, Bangladesh lags behind without any policy for ART procurement. An NGO respondent states further that ART drugs are also necessary in ensuring the safety of medial and field workers who are exposed to the virus. If ART drugs were made available, it would help reduce the fear and stigma attached to caring for PLHA

3. Successes, Despite Challenges that Remain

Bangladesh's response to HIV and AIDS does not meet the growing prevention and treatment needs of PLHAs and most at-risk populations. Causes for this disparity have been identified primarily as problems related to: overall poor coordination and communication; a weak base of HIV and AIDS knowledge and expertise; gaps in procurement of funding and resources; and HIV stigma and discrimination. Without drawing attention or concern away from these issues, it is important to highlight, what have proved to be so far, some strategies and partnerships as well as accomplishments made in the HIV and AIDS arena. It is important to note that barriers to intervention success far outweigh any advantages or benefits that Bangladesh has reaped in its fight against AIDS. This report brings to light the fact that much work remains to be done across all sectors to mitigate the spread of HIV and AIDS in Bangladesh. In reviewing intervention successes it is important to bear in mind the following challenges:

- Overall Lack of Coordination in the National HIV and AIDS Program
- Limited Functioning of National AIDS Committee and other bodies within national program
- Intervention Funding Problems (i.e. experiencing gaps, delays, and/or lack of funds)
- Stigmatization and Discrimination of high-risk groups and PLHAs
- High Levels of Staff Turnover at government, donor and NGO levels
- Gaps in Expertise and Training both within government AIDS bodies and within service delivery systems
- Intervention Weaknesses (i.e. shortages in commodity supplies such as condoms)
- Coordination Between Implementing Partners
- Policy Pitfalls (i.e. gaps in policy don't cover rights of PLHAs, policy needs revision, policy not upheld)
- Monitoring and Evaluation
- Antiretroviral Procurement

Without drawing away attention or concern from these issues, it is important to highlight, what have proved to be so far, some strategies and partnerships as well as accomplishments made in the HIV and AIDS arena. The following are examples of successes as noted by the study's respondents.

3.1 PARTNER COLLABORATION

NGO's are often criticized for not offering comprehensive prevention and treatment services. For example, while many NGOs provide HIV prevention counseling and can distribute condoms or IEC materials, they may not be equipped with voluntary testing facilities or counseling and treatment services for PLHAs. Moreover, some respondents stressed the lack of routine quality assurance monitoring in service delivery.

Despite this criticism, over 100 NGOs working under GFATM, HATI and FHI are actively focusing on HIV and AIDS in Bangladesh. There is general recognition that coordination among them is essential to overall intervention success. A number of organizations are utilizing partnerships or consortium approaches towards HIV and AIDS prevention, in order to enhance cooperation and communication. Capacity building is a major goal for larger organizations. In response, an umbrella system has been nourished in Bangladesh, under which smaller, local NGOs and self-help groups receive the support, both financial and technical, of larger NGOs until they have the capacity to work independently. In this way, Mukhto Akash, a PLHA organization, was formed after years of support under CARE. Similarly, this system has allowed organizations like Ashar Alo Society, Bandhu Welfare Society, and Durjoy (a SWs union) to become autonomous organizations receiving separate funding for self-staff projects and assistance from umbrella organizations only when it is needed. Respondents suggested strengthening coordination and partnership within and across sectors by bolstering the 'consortium approach' that has been previously applied in HAPP, HATI and GFATM intervention design.

Network building has also become a priority as more NGOs enter the HIV and AIDS arena and communication among stakeholders becomes more important so that each NGO knows what other organizations are implementing. FHI has started a mapping project to accurately describe which areas are being served and by

what organizations. These measures have been taken to help decrease duplication and stem the flow of wasted resources. Organizations targeting PLHA, such as Ashar Alo Society, HASAB, Marie Stopes and MACA, utilize an effective referral system which strengthens the response to treatment and care. Partner organizations that do not offer treatment services will refer positive cases to these organizations. As a result, membership numbers (PLHWA who have registered with Ashar Alo, MACCA and HASAB) have also increased.

Marie Stopes and CARE have been partners for almost ten years, collaborating to locate high risk populations and provide them with DICs as a means to increase access to treatment, counseling, and information provided by staff who have been sensitized to the key issues surrounding marginalized populations and barriers to health care.

In 2003 Bandhu availed support from organizations: HASAB, ICDDR, SMC, FHI, Ain-O-Shalish Kandro, University of Dhaka, and the National Institute of Mental Health. These partners provided facilitators for a consultation meeting held for MSM sexual health and capacity building.

3.2 SERVICE DELIVERY

Condom Distribution and Outreach Services

Most respondents maintain that condom shortages remain a challenge to intervention success. Over the past five years some respondents feel that improvements have been made, while others state that shortages persist as a major barrier. Bandhu has seen condom intervention success with its HIV prevention program for MSM, where its outreach workers distributed condoms at a subsidized price as well as health information at 'cruising spots' and clinics for MSM/MSW. They conducted voluntary meetings with MSM and found that of the men who participated in the HIV prevention program, they reported using condoms 63.7 per cent of the time. Of those not participating, 29.5 per cent reported using condoms⁵⁰. Bandhu provides clinical services for general health, STI treatment, psychosexual counseling, HIV testing and counseling of MSM⁵¹.

⁵⁰ Shaile K. Ahmed et al. Male sex workers in Dhaka, Bangladesh: Risk reduction through effective intervention. FHI, IMPACT, Bandhu Social Welfare Society, Dhaka; FHI, Bangkok; Naz Foundation International, Lucknow.

⁵¹ Bandhu Social Welfare Society (2006). Annual Report.

Drop In Centers

Drop in centers have been widely successful for a number of NGOs responding to SWs, MSM and IDUs, providing voluntary testing and counseling (VTC) services and distributing condoms. Ashar Alo Society claims to be the largest and foremost care and treatment center for PLHA, providing ART, medical and VCT services. Treatment programs are usually based at DICs providing services ranging from STI management to family counseling. While street-based outreach is essential, a fixed site is also important. DICs were thus established to provide space for counseling, consultation with project staff or physicians, and informal interaction between project staff and drug users. According to CARE, factors such as location, opening hours and user-friendliness are important considerations to establishing a DIC. Each NGO respondent claimed to be utilizing DICs in their interventions. FHI has even introduced rapid HIV test kits in 59 centers allowing testing to be more accessible outside of Dhaka city.

Workshops for Rights Awareness Building

With support from HASAB and CARE, who run human rights workshops for SWs, women engaged in commercial sex have overcome many social restrictions and have learned how to effectively voice their concerns to advocate for better treatment. A CARE respondent states that human rights abuses towards SWs have, in the past, prohibited them from sending their children to school and in some cases, have denied them the right to wear shoes. They have noted improvements in SW exercising their rights like wearing shoes, which is evidence of progress⁵².

Self Help Groups

According to CARE, two self-help groups, Prochesta and BODAR, have been formed by drug users. Among their objectives they aim to establish fundamental rights for IDUs, ensure health education, treatment and rehabilitation, and protest against harassment by police, local thugs⁵³. CARE, moreover, is regarded as a frontrunner in harm reduction programs for IDUs, providing needle exchange, condoms, detoxification services and VCT.

⁵²Terre des Hommes Italia.(2005).Brothel-based and Floating Sex Workers in Bangladesh Living Conditions and Socio-Economic Status.

⁵³ "Thugs" refers to hoodlums or ruffians; those who harass

3.3 AWARENESS RAISING

All respondents in the study noted that conservative attitudes have been changing as a result of numerous stakeholders training geared to sensitize GOB officials and influential community figures to HIV and AIDS issues. According to interviews and their 2005,06 annual reports, Ashar Alo Society aims to decrease stigma and discrimination by implementing educational programs tackling misconceptions about HIV infection. The key component to their success, they say, is the participation of PLHA in their community education programs.

Targeted HIV interventions aimed at most at-risk populations rely heavily on condom promotion and reduction of misconceptions surrounding condoms. In their annual report 2005, an NGO targeting SWs reported that condom use in eight brothels has increased from 800,000 to 2,200,000 per year in the course of their condom promotion program. However, it is noted by many NGOs that condom use is very difficult to accurately measure. The NGO has peer educators physically count the number of used condoms disposed in each room of the brothels they monitor. This is an unpleasant task and can lead to miscalculations of condom usage, as reported by other NGOs. Conversely, a respondent working with SWs claimed to have an effective system established in their Drop in Centers (DICs) wherein SWs drop used condoms in a box after they had accumulated. These condoms are then tallied and compared with the number of condoms supplied to each sex worker. Another significant achievement in condom awareness was made by Social Marketing Company (SMC), which utilized television media for condom promotion beginning in 1999. Until 1999, the word 'condom' was not allowed on television and organizations like SMC had to go through donors such as UNDP to create HIV and AIDS prevention television campaigns. Despite the fact that many censorship regulations persist in the media today, SMC are doing what they can to approve and air messages in mass media format.

Though advocacy by national and international organizations has centered on the rights of SWs and MSM, much work remains before the rights of marginalized populations are adequately protected under government policy in Bangladesh. Until 2005, the national response to HIV and AIDS failed to recognize MSM, but advocacy campaigns led by Bandhu have helped them gain recognition. Unfortunately, police brutality against MSM and SWs continues. Bandhu

recognizes there are many challenges to address before the rights of MSM are universally protected and recognized, but they feel supported in their endeavor by donor and NGO communities. Similarly, organizations like HASAB, Marie Stopes and Durjoy rally behind human rights recognition for CSWs through sensitization of police, brothel and hotel owners, and policy makers.

3.4 GOVERNMENT COLLABORATION

According to ten respondents, including NGOs, INGOs and a donor agency, the government of Bangladesh (GOB) is cooperative in many capacities in the joint cause to curb the spread of HIV. BRAC often partners with government, utilizing their medical facilities for complicated referrals. Other respondents such as the Population Council and CWFD, state that the GOB has collaborated on interventions, regularly taking research recommendations from Population Council. According to a respondent from a donor agency, the GOB regularly uses NGO data on VCT surveillance and data from ICDDR,B, in particular. Despite resistance to support of MSM from a policy angle, over the years Bandhu has successfully collaborated with the Government of Bangladesh and ICDDR,B to conduct National Serological and Behavior Surveillance programs to ensure appropriate HIV and AIDS prevention services are developed for the vulnerable male population. According to Marie Stopes' annual report (2004-2005) the GOB is also active in using NGO-developed materials such as the Quality Assurance Manual created by Marie Stopes in government trainings and policy development. Finally, in regards to youth education, HIV and AIDS information has been integrated into the Government's curriculum for grades 6-12 with PIACT as the curriculum's main developing and implementing partner.

3.5 PROGRAM EXPANSION

Many small-scale NGO programs have been able to scale-up over the years due, in large part, to the successes of Drop-In Centers (DICs), such as in the case of BRAC's program, 'Package for Clients of Sex Workers HIV and AIDS Prevention.' The project scaled-up in 2008, from reaching 6,000 clients of SWs to 10,000 by 2008. The respondent states that they managed this by slightly increasing the number of DICs. In the future, the government of Bangladesh is reported to be taking control of this project under HATI programming, integrating it with the Government Health Nutrition Population Sectoral program.

Bandhu Social Welfare Society has managed to scale up from one DIC to 12, adding a new DIC every year thus far. Moreover, Bandhu was able to reopen its offices in Chittagong, Old Dhaka, Comilla and Rajbari which had been closed due to change in funding criteria by USAID/FHI. The reopening was made possible with the help of their other donor, the Royal Netherlands Embassy. Bandhu has also extended its local and international networks. It is thought to be the largest MSM Program in South Asia, and has been recognized by UNAIDS as highly successful in the fight against HIV and AIDS. Bandhu is one of six organizations in Asia/Pacific and has been recognized by UNAIDS best practice collection (2006) on 'HIV and MEN who have Sex with Men in Asia and Pacific.'

HASAB has created some of the first half-way houses⁵⁴ for PLHA allowing for creation of job opportunities as well as providing security and safety through offering places for PLHA to sleep, receive treatment, and network with other PLHA.

3.6 TRAINING

MACCA was successful in training 15,000 Imams on how to effectively conduct sermons about HIV and AIDS awareness and prevention, without offending religious sensitivities⁵⁵. Additionally, they have succeeded in incorporating HIV and AIDS information into Khudba Guides to educate people about HIV prevention. Since there has not been a comprehensive follow-up study to test the outcomes of these projects, it remains to be seen what particular effects these faith-based interventions have had on the target population (predominantly Muslim males). However, MACCA insists its prevention and stigma reduction campaigns have been successful in decreasing discrimination towards PLHA, MSM and SWs.

An exciting and recent example of intervention-related training is the large-scale instruction of school teachers on how to handle new HIV and AIDS related content that was incorporated into national curriculum. The content has been developed for grade 6-12 national curriculum and is being taught in all schools (government, private and religious) since 2007. The NGO primarily responsible, the Program for

⁵⁴Half way houses, as reported by HASAB respondents, are shelter homes which have been created to provide services for PLHAs requiring temporary lodging and support

⁵⁵Imams are Muslim religious leaders who typically possess significant social influence

the Introduction and Adaptation of Contraceptive Technology (PIACT) has undertaken the task of training 15,000 'master trainers' from the country's private and public teaching universities and colleges so they can train their colleagues on the correct way to disseminate HIV and AIDS information to students via the curriculum module designed by PIACT. As there are roughly 30,000 teaching institutions in the country, PIACT has reached half. The curriculum was field tested in 2005, a process necessary in order to make the curriculum content acceptable to religious leaders, parents and policy makers. The HIV and AIDS curriculum component has been incorporated into pre-existing social and general science books and is graduated so that the complexity of information increases as students get older. The curriculum material covers prevention and treatment information as well as information addressing stigmatization of PLHA. According to PIACT, the process of acceptance was immensely difficult and the organization experienced a great deal of harassment along the way. Resistance still remains and many individuals object to the inclusion of the material in the national curriculum. On the same token, proponents of sex education had to make considerable compromises. For example, the word 'condom' is nowhere to be seen in the curriculum as it was so heavily contested by those against sex education. However, PIACT maintains that the new curriculum is a 'gateway for sex education' and will continue to be modified and expanded in the future to accommodate changing attitudes and updated HIV information. PIACT's funding for the curriculum project will eventually run out, at which point ownership of the project will become an issue. Whether or not the project gets handed to another public or private body is unknown. Other issues will also need to be dealt with such as how the content will be updated, whether there be scope for expansion of topics covered in the curriculum, and how effective are teachers in conveying HIV-related themes to students given the topic is highly sensitive.

Low levels of awareness and support are given to PLHA, especially from family members and spouses, which often lead PLHA to hide their status. As a response to stigma against PLHA, Ashar Alo Society utilizes the skills and knowledge of PLHA to inform others of the daily reality of HIV. In 2006, Ashar Alo conducted six training sessions to help its members become peer educators in HIV and AIDS. In addition, Ashar Alo conducted 5 orientation sessions on human rights, gender and HIV and AIDS with a total of 122 participants for orienting PLHA on their basic

human rights. Ashar Alo enlists PLHA to speak on behalf of HIV positive people and to inform the general population about living with HIV by dispelling myths and encouraging young people to get tested. This is done through public speaking, usually targeting young Bangladeshis. Ashar Alo provided training to 13 PLHAs and established a public speakers bureau. The organization prints a pamphlet in both Bangla and English titled, "Laughing with your child or laughing with an HIV positive person: Is there any difference?" The pamphlet targets HIV and AIDS myths explaining modes of transmission, risks of infection, and the course of the illness.

4. Towards More Effective Interventions and Policy

The desk study of HIV and AIDS intervention successes and challenges is based on evidence gathered from in-depth literature review and nineteen stakeholder interviews. The following is a synthesis of report findings, highlighting major, repeated themes. The recommendations below should be used to inform design and implementation of future HIV and AIDS interventions. Analysis of data highlights the following recurring themes: Need for increases government leadership and accountability; Expansion of intervention targeting; Empowerment of women; Advanced research; Improvement of HIV and AIDS training mechanisms; Improved coordination of intervention partners; Better monitoring mechanisms; HIV and AIDS policy revision

Recommendations	Organizational Reference
Increase GOB leadership and responsibility	<ul style="list-style-type: none"> ● NASP agenda-setting necessary to clarify its vision for mitigating the spread of HIV ● NGO and GOB relationship could be strengthened by the GOB recognizing that care and treatment are the GOB's responsibility. ● It is the government's job to know what NGOs are doing, where they are doing it, and where the money is coming from. NGO-Donor-Government sit together, make a plan, look at the strategies and policies, make some target indicators and plan to achieve the goals. ● NASP needs to delegate tasks to NGO's according to their expertise. ● GOB needs to eliminate restrictions on HIV awareness campaigns. ● GOB needs to lay out a plan for HATI post-December. They need to address 1 irregular funding , 2 management, and 3 long term programs. ● FHI: The Government-NGO-Donor partnerships can be strengthened by having a task force comes up with a common platform to activate NASP.

	<ul style="list-style-type: none"> ● GOB needs a clear financial strategy with long term vision, should be implemented by GOB.
<p>Expand Intervention Targeting</p>	<ul style="list-style-type: none"> ● A 'minimum standard' of quality for interventions should be practiced with appropriate M&E follow-up ● NGO's with capacity should increase livelihood programs for sex workers, increase life skills/awareness for youth, introduce general population HIV testing. ● Need more media awareness campaigns, mainstream the information for general public. Increase focus on sustainable behavior change interventions. ● More of a focus on men's behavior and men as the epidemic propagators ● Should target migrant population and CSW clients' wives; more media awareness campaigns using actors/actresses. ● There are 500,000 mosques in Bangladesh and they should be utilized more for general public awareness. ● Expand drug resistance programs for youth, protect street children ● Comprehensive package that targets harm reduction, treatment, and information to stop HIV from becoming a generalized epidemic starting in IDU population. ● Produce serials should be produced like local <i>natoks</i>, or plays.
<p>Empowerment</p>	<ul style="list-style-type: none"> ● Women need to be empowered economically. ● Expand attention to women, especially gender based violence. ● The issue of poverty should be addressed first in order to tackle the issue at the roots. This is what forces women into sex work
<p>Further Research by ensuring it is always reflective of specific gaps in HIV and AIDS knowledge</p>	<ul style="list-style-type: none"> ● Stigma and discrimination ● Studies can be done to assess the success of harm reduction, especially detox. ● Need operations research, what interventions are working, what aren't, what are new ones we can try

	<ul style="list-style-type: none"> ● We should do more operations research in this country. There should be research conducted among prison population. ● Other groups that need to be researched on are residence based sex workers. ● Condom awareness and attitudes. ● Research should be done to measure the impact and implementation and quality of all the research and funding that has been poured in to the HIV field in about 2/3 years time. ● Research should be compiled in a central location, shared and accessible to all to prevent duplication and waste of resources.
Service and training improvement	<ul style="list-style-type: none"> ● HIV-specific sensitization and standard procedure training for medical providers ● Increase training of health care staff in STI and HIV management. Need better integration of STI services with other primary health care, i.e. family planning etc. ● Sensitization of doctors
Coordinate interventions	<ul style="list-style-type: none"> ● Conduct a needs assessment, take inventory of what interventions exist, and eliminate duplication. ● Programs must be prioritized. It's necessary to come up with a best practice and use it consistently rather than duplication in various forms.
Monitoring	<ul style="list-style-type: none"> ● Proper monitoring services required to prevent NGOs from working in a scattered way with no knowledge of intervention outcomes. ● Need better ways to measure real outcomes and benefits. Every program should have monitoring and evaluation built into it and some evaluation should be from outside sources
Policy changes	<ul style="list-style-type: none"> ● Policy should outline rules against discrimination ● ART procurement, and home-based care. ● There is a need to conceptually revise the AIDS policy, most is a replica of other policies in other countries; code 377 should be reviewed.

INCREASE GOB LEADERSHIP AND RESPONSIBILITY

A majority of respondents conclude that increased government ownership and accountability is necessary to move interventions forward. They pointed to two ways in which this is needed: 1) the government should realize and act upon its responsibility to the care and treatment of PLHA in addition to its dedication to prevention strategies and 2) The government should develop its role as a leading intervention managing body. This would require thoroughly written terms of reference (TOR) for NASP officials, with clearly defined leadership responsibilities and measures to check NASP accountability. Also necessary would be serious agenda-setting to highlight NASP's vision for mitigating the spread of HIV.

Increasing GOB responsibility would likely reinvigorate NAC and NASP and improve government monitoring systems. This opinion was endorsed by twelve other respondents from different organizations⁵⁶. Three respondents stated that putting more development funds in the government's control would be the only incentive likely to make GOB more accountable and to finally witness a productive and efficient NASP and NAC. The majority of respondents, however, are simply not confident that the government could handle this responsibility and feel this would be a mistake.

Apparently, despite overall discontent with government effectiveness and accountability, there are some positive experiences from which GOB could glean best practice models, take lessons from these, and improve its health interventions. One NGO respondent stated that one should look towards the government's Health and Population Sector Program (HPSP) as a good model of health sector reform.

Further recommendations to the government include easing restrictions in the media and advertising so that HIV and AIDS related messaging can be more public and call for greater transparency regarding government spending and information dissemination. Currently, the Caretaker Government in Bangladesh is undertaking an initiative to enact the Right to Information Act, which would be a considerable

⁵⁶Based on the 2008 Paris Declaration meet focusing on donor effectiveness, the donor consortium head suggests eventually reaching a point where donor funds are put directly into the government's hands and the government act as subcontractor to implementing organizations, thereby strengthening national ownership of interventions and decreasing intervention duplication

step towards increasing government transparency. A similar Act in India has been widely successful and lauded by civil society and both public and private sector institutions, as they can now access public information and documentation from the government directly. Perhaps such an Act will help put pressure on GOB to be more accountable to its responsibilities, policies and the rights of its citizens.

EXPAND INTERVENTION TARGETING

Most stakeholders agree that interventions should be targeted towards high-risk groups such as MSM, SWs and IDUs in order to contain the spread of the virus within Bangladesh. However, nearly all respondents suggest that mass media campaigns need to be scaled-up to educate the general public. Respondents feel that no interventions can be successful without the support and sympathy of the general population. Recommendations that youth be targeted more heavily come from ten respondents.

Both donor agencies and NGOs suggest increasing behavior change communications (BCC) interventions to do this. Common BCC interventions include use of community theater, serial dramas, folk drama and songs as well as social messaging from famous actors to generate popularity of health messages.

Respondents stated that there is a lack of focus on the spouses of PLHAs, spouses of migrant laborers, youth, and migrant laborers. A final recommendation suggests more advocacy be done in the country's 50,000 mosques.

EMPOWERMENT

Five respondents stated that women's empowerment must be taken as a priority matter. These organizations included MACCA, CWFD and UNAIDS. All agree that economic empowerment of women is a cornerstone issue in empowerment and therefore better health. These respondents suggest further development of economic alternatives to sex work as methods of curbing the virus.

FURTHER RESEARCH

Future research recommendations are as follows:

- Ways towards alleviation of stigma and discrimination
- BCC and health education for vulnerable groups, as BCC materials remain

a key tool in behavior change; First, it is necessary to examine how far-reaching and effective current BCC materials are in changing health behaviors, then create greater scope and resources to develop new materials

- Studies on access and successes of harm reduction strategies
- Operational research to determine what interventions are working and which are not; Research into the effects of HIV and AIDS on prisoners
- Research into residence-based sex workers
- Condom awareness and attitudes
- Documentation of individual personal narratives (struggles, quality of care, etc.) of PLHA and use towards strengthening healthcare response
- Measuring the impact and quality of research and funding that has been poured in to HIV in the last three years
- More gender and sexuality research
- How to compile and disseminate information generated by all implementing partners

It is important to note that all donor agencies interviewed responded that operational research into intervention effectiveness was of primary research priority.

ADDITIONAL RECOMMENDATIONS

Less frequently voiced, but still common to five or fewer stakeholders are the following recommendations.

Service and training

HIV and AIDS sensitization and standard procedure training is necessary for all government and private medical providers, incorporating better integration of STI services with other primary health care. Additional focus should be on training counselors to deal with psychological impact on marginalized and stigmatized populations. Respondents report that effective training is the most important, foundational element to successful service delivery.

Coordinate interventions

NGOs need to conduct a needs assessment, taking inventories of what interventions have been done and which interventions currently exist in order to eliminate duplication.

Monitoring

Proper monitoring mechanisms are required for the 250 NGOs currently working in HIV and AIDS, to prevent them from operating without knowledge of intervention outcomes and duplicating interventions. There is a need for strategies for documenting real outcomes and reporting this information. A major focus should be given in respect of quality service and accountability measures. There need to be a good coordination among the M&E bodies from NASP and MSA . It happened that when they visit the field, the recommendations significantly vary from one to one. M&E person should have thorough knowledge about the subject they are monitoring.

Policy changes

First and foremost, removal of Section 377 which criminalizes MSM should take place immediately. Policy should outline rules against discrimination and punishment for harassment and abuse of marginalized populations must be upheld. Finally, there should be policy provisions for ART procurement and home-based care of PLHA. Overall, respondents stressed that HIV and AIDS policy should be produced and ratified with the full participation of the target population, implementing partners, and PLHA.

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ANNEX 1: STAKE-HOLDER INTERVIEW GUIDE

Name of Organization/ Interviewee:

Organization founded (date):

Nature of the Organization's work:

What Target Group(s) does the Organization work with:

What are PREVIOUS HIV and AIDS Initiatives (sort by relevance)

What are CURRENT HIV and AIDS Initiatives (sort by priority and project size)

What makes your approach different from the others working in the same field?

Organization is Funding whom / Funded by whom:

Successes in General: (policy implementation, community acceptance, etc.)

Successes within Target Group:

Successes with Partnerships:

(e.g. policy, implementation, community acceptance)

Partner Organizations: (ability to scale up, for wider networks, etc.):

Donor Partnerships:

Government Partnerships:

(e.g. policy, commitment, other aspects – socio-cultural, what are your opinion on government policy, commitment to your group?)

Challenges in General: (e.g. relapse with IUDs, stigma with sex workers, inability to reach migrant workers, hotel based or floating sex workers; conservative cultural environment - based on program experiences, problems, barriers based on specific examples of program experiences)

Challenges with Partnerships:

(Partner organizations, lack of capacity, gaps in communication between

international/national organizations, duplication, separate strategies, no coordination)

Donor: (e.g. discord/funds constraints; different agendas; global policies of USAID and its impact on local policies/politics and funds – and its direct effect on project staff)

Government: (e.g. policy, commitment, other aspects – socio-cultural)

Field staff: (Lack of training, lack of money, lack of people, resources, conservative attitudes)

Gaps at the community level – e.g lack of interest in HIV and AIDS, lack of funds and difficult to motivate persons at the community level

Program challenges for program officers and for individual target groups:
(e.g. gaps in integrated approaches to programs, no strong program to address clients, many 'missing' – residential based sex workers, migrant cross border sex workers, etc

Policy challenges for program officers and for individual target groups:
Are there enough policies but more changes required in programs? Do we need to make new policies or revise existing policies?

What areas of HIV and AIDS are being neglected? Who is affected? Are their areas which already exist but need to be strengthened?

What resources does the Organization use?:
(e.g. networking, capacity building, re-focusing and improving existing programs)

How can the Donor-Government-NGO community work together to consolidate efforts for HIV and AIDS prevention in a coordinated national response?

Specific examples of particular strategies on how to move this forward, any examples from other countries, or Bangladesh on how to move forward

How do you feel you are doing in terms of efficacy? Is there a shift required in order to achieve better efficacy? If yes, how do we move towards that shift to achieve better efficacy for this particular group?

How can government be more effective in the future for this particular group?

How can donors be more effective in the future for this particular group?

How can NGOs be more effective in the future for this particular group?

Recommendations

Specific examples of particular research prioritizing and why, to move this forward & (why?) for this particular group?

Policy recommendations

Programmatic recommendations

How can the target groups be more involved? How can they contribute towards averting this epidemic?

ANNEX 2: BENEFICIARY INTERVIEW GUIDE

Name of Interviewee:

Names of HIV and AIDS Programs and Projects (specific to the respondent) heard of or involved in (specifically by year and target groups, and their opinion on project(s)). How did you hear about this particular programme?

How long have you been attending this organization for?

What changes would you like to see in the current programmes so that it caters to the target groups better?

In your opinion how successful do you think the HIV AIDS Interventions has been for your target group? What are the main achievements? Please share specific examples.

Successes within the target group:

What are the barriers and challenges:

What can be done to address the issue of stigma and discrimination among the target /vulnerable population?

Name other areas of HIV and AIDS that are neglected. Are there programs which already exist but need to be strengthened? What can be strengthened with this particular target group or any other particular groups?

How are NGOS and Government and donors are doing in terms of efficacy?

How can the Government be more effective in the future for your group?

How can donors be more effective in the future for your group?

How can NGOs be more effective in the future for this particular group?

Give some recommendations to improve the situation of HIV and AIDS in the country for this particular group?

Cite specific examples of research recommendations and research prioritizing and why, to move this forward & (why?) for this particular group?

Other Recommendations:

- How much do you spend on your treatment? (if you are on treatment)
- Is the treatment easily available?
- What are the issues or needs pertaining to your target group?
- How can the target groups be more involved? How can they contribute towards averting this epidemic?

ANNEX 3: PARTNER ORGANIZATION GUIDE

Organization	HIV Programs
Ashar Alo Society Community Based Organization	<ul style="list-style-type: none"> ● Awareness, treatment, care, and support to prevent HIV and AIDS, funded by Action Aid Bangladesh ● Services: Knowledge sharing on HIV and AIDS and Life skills training
HASAB National NGO	<ul style="list-style-type: none"> ● HIV and AIDS Prevention Project (HAPP) for international migrants: <ul style="list-style-type: none"> ○ Target population - Clients of sex workers ○ Goal - Prevent HIV in clients of sex workers ○ Activity: Setup Community Service Centers and implement treatment of STIs and condom distribution, peer education, and counseling. ○ Activity: Extend access to service through Community Service Outlets ● GFATM Project on HIV and AIDS Prevention among Young People <ul style="list-style-type: none"> ○ Target population - Bangladeshi 15-24 years of age ○ Activity: Life skills education ○ Activity: Youth Friendly Health Services (YFHS) ○ Activity: Accessing Condoms for Young (ACY)
Bangladesh's Women's Health Coalition (BWHC) National NGO	<ul style="list-style-type: none"> ● HIV and STI prevention <ul style="list-style-type: none"> ○ Funded by FHI (will be completed in May 2008) ○ Activities: Condom promotion, STI management including seeking treatment and completing treatment, as well as prevention), and counseling ● Brothel based Sex workers' package under HAPP <ul style="list-style-type: none"> ○ Funded by Bangladesh government via UNICEF (completed program) ○ Target group - 8 brothels ○ Activities: Peer education, condom promotion, Training covering HIV and AIDS management

	<ul style="list-style-type: none"> ● Outreach Project of Socially Disadvantaged People Program <ul style="list-style-type: none"> ○ Funded by DFID, runs until March 2009 ○ Target group: Narayangani sex workers ○ Activities: Empowering sex workers to expect basic rights and gain access to services, life skills education and behavior change prompted through BCC methods
<p>PIACT Bangladesh National NGO</p>	<ul style="list-style-type: none"> ● Developing BCC for HIV and AIDS prevention ● Implement programs for prevention and treatment of HIV and AIDS and STIs through community based projects
<p>Concerned Women for Family Development (CWFD) National NGO</p>	<ul style="list-style-type: none"> ● Adolescent empowerment Program: equips adolescents with preventative measures of reproductive health, including the prevention of HIV and Life skills education.
<p>Bandhu Social Welfare Society National NGO</p>	<ul style="list-style-type: none"> ● Shustha Jiban (main donor FHI/USAID): sexual health program for Hijras <ul style="list-style-type: none"> ○ Activity: Outreach services - field teams in 4 cities distributing Behavior Change Communication resources, condoms, STI treatment referrals, counseling, helpline information, and awareness/community building ○ Activity: Clinical services ○ Activity: Community building - to develop sustainable risk reduction with social group meetings and activities, sexual education classes, building self esteem and empowerment ○ Activity: Hidden sexualities – transgender and HIV, a sexual health program for Hijras in Dhaka
<p>Marie Stopes Clinic Society Non-Profit NGO</p>	<ul style="list-style-type: none"> ● Prevention of HIV and AIDS hotel based sex workers <ul style="list-style-type: none"> ○ Target population: Sex workers in Brahmanbaria, Rangpur, and Khulna Districts, 74 Hotels in 12 spots, FHI funded ○ Activity: Capacity development through peer education, clinical STI services, and Drop in Centers

	<ul style="list-style-type: none"> o Outcomes: 40 Peer educators and 86 site workers held one on one and group sessions, Project Facilitation Teams were formed and held advocacy meetings with hotel owners and managers, police officials and other government officials, 11,943 cases treated ● CARE, B funded HIV and AIDS prevention programs <ul style="list-style-type: none"> o Target population: Street based sex workers, transport workers, and drug workers: short duration o Activity: HIV and AIDS awareness, condom promotion, decrease the spread of HIV and AIDS and other STIs, Drop in Center development ● HIV and AIDS Prevention Program (HAPP): <ul style="list-style-type: none"> o Target Population: Drug using populations in Brahmanbaria, Sylhet, Chittagong, Cox's Bazar, and Teknaf, WB funded via UNICEF o Activity: VCT clinics opened in Rajshahi, and within clinics in Chittagong and Sylhet
<p>POPULATION COUNCIL International NGO</p>	<ul style="list-style-type: none"> ● Council activities are being funded through diverse donors including USAID, the Canadian International Development Agency, and Global Fund to Fight AIDS, Tuberculosis and Malaria <ul style="list-style-type: none"> o In Bangladesh, the Population Council carries out a combination of activities, including research, technical assistance, and capacity strengthening. From the outset. o Current research activities focus on improving the quality of, access to, and appropriate use of reproductive health services by both men and women; introducing a "safety-net" mechanism for poor women to help them utilize reproductive health services; preventing HIV infection; meeting the needs of young

	<p>people; and improving maternal and neonatal health.</p>
<p>Family Health International Non-Profit Organization</p>	<ul style="list-style-type: none"> ● Bangladesh AIDS Program: <ul style="list-style-type: none"> ○ From 2000–2005, FHI implemented USAID's IMPACT project in Bangladesh. ○ Since July 2005, FHI has managed USAID's Bangladesh AIDS Program (BAP), working with 21 local organizations and NGOs on 23 projects to provide a strong, coherent approach to outreach among the most vulnerable. ○ BAP is scaling up and integrating HIV prevention efforts and provision of clinical services. Drop-in centers-branded as Modhumita-provide health services for vulnerable populations in strategic HIV and AIDS "hotspots". ○ As of September 2006, the brand name is associated with 51 drop-in center serving those most vulnerable to HIV and AIDS throughout Bangladesh. By September 2008, one hundred drop-in centers will belong to the Modhumita network.
<p>ICDDR,B International Health Research Institution</p>	<ul style="list-style-type: none"> ● Voluntary Counseling and Testing: Jagori, open since 2002. <ul style="list-style-type: none"> ○ Jagori also works to promote a more positive community response to HIV and AIDS. Knowledge about HIV can stimulate discussion, thereby reducing stigma and discrimination. It encourages community action to address the issue, including the adoption of HIV and AIDS-sensitive policies ● Developed national guidelines for management of sexually transmitted diseases ● Bangladesh HIV surveillance: 7 rounds <ul style="list-style-type: none"> ○ As Bangladesh has continued to remain a low prevalence country for HIV, sampling concentrates on those populations that are considered to be most vulnerable to HIV, and those that may act as a 'bridge' from the most-at-risk to the general population.

	<p>Blood samples are collected voluntarily through organizations running HIV intervention programs</p> <ul style="list-style-type: none"> o The population groups considered to be most-at-risk have been: female sex workers in brothels, hotels, streets, and casual (part time); male sex workers; males who have sex with males (MSM); transgender (hijras); injecting drug users (IDU); heroin smokers <ul style="list-style-type: none"> ● Preventing HIV and AIDS among young people in Bangladesh: <ul style="list-style-type: none"> o A collaborative project between the Ministry of Health and Welfare and Save the Children USA. o Funded by The Global Fund to fight AIDS, Tuberculosis and Malaria. o Funded over five years in two phases, the project will support the 2005 UNGASS goal of 'ensuring that young people have the knowledge, skills and services that they need to protect themselves from HIV and AIDS', thus contributing to maintaining the current levels of HIV infection to combat the disease. o Save the Children USA, as the managing agency, has selected five lead organizations along with 12 others associate organizations from a wide range of NGO, private sector and research organizations to implement the project at the field level. ● Sexual behavior of men in Bangladesh: Research into sexual behaviors
<p>CARE Bangladesh International Relief and Development Organization</p>	<ul style="list-style-type: none"> ● HIV and AIDS Prevention Project (HAPP)-Drug Users Intervention - Funded by UNICEF <ul style="list-style-type: none"> o The goal of this program is to reduce the risk, spread and impact of HIV and AIDS among injecting drug users in Bangladesh. o Activity: multi-sectoral, harm reduction

	<p>intervention through drop-in centers, peer outreach using needle-syringe exchange program, detoxification (coupled with drug abstinence and rehabilitation), voluntary counseling and testing, sexually transmitted Infection (STI) management and treatment, abscess treatment, behavior change communication and advocacy with law enforcers and other government agencies.</p> <ul style="list-style-type: none"> o Partnership: other NGOs and the national STD and AIDS program. ● HIV Program Reflection and Learning Intervention - Funded by CARE UK <ul style="list-style-type: none"> o The program reflection and learning team links with staff to support effort to process data and information and convert it into knowledge learning that is shared and used to influence CARE's program and over time influences policies, resource allocation and programming for HIV in Bangladesh, thus moving closer towards being a resource organization. o Supports self-help groups vulnerable to HIV and AIDS for their institutional capacity-building and livelihood diversification activities.
<p>MACCA Local Faith-Based Organization</p>	<ul style="list-style-type: none"> ● Interfaith Response to HIV and AIDS Prevention, Care and Support: Funded by USAID via FHI <ul style="list-style-type: none"> o The project aims to promote community sensitization and awareness on HIV and AIDS prevention, care and support through involving faith leaders particularly Imams. o Activity: Imams are given training to better deliver necessary information in Juma Khutba (Friday Sermon) on HIV and AIDS prevention and care and religious approach to combating the threat as well. o Activity: 2000 Imams would be trained under the project in 3-year time.

	<ul style="list-style-type: none"> o Activity: A training module and sermon guidelines have been prepared, 855 religious leaders trained on HIV and AIDS sermon giving and around one million people received sermons through the mosques. 10 talk-shows and 52 question/answer sessions on HIV and AIDS aired through TV with participation of different religious leaders.
<p>UNAIDS Funding Agency</p>	<ul style="list-style-type: none"> ● Activities: Mobilizing leadership and advocacy for effective action on the epidemic, providing strategic information and policies to guide efforts in the AIDS response, tracking, monitoring and evaluation of the epidemic. Engaging civil societies and developing partnerships .Mobilizing financial, human and technical resources to support an effective response.
<p>UNICEF Management Agency</p>	<ul style="list-style-type: none"> ● HAPP: the technical advisor: 145 NGOs work under HAPP, 12 leading ones ● HATI: technical advisor ● Target Population: HAPP and HATI the target populations are the high risk groups: Brothel, Hotel, and floating sex workers; Sex workers clients; IDU; MSM since 2006
<p>NASP (National AIDS/STD Program) Government Program</p>	<ul style="list-style-type: none"> ● HIV and AIDS Prevention Project (HAPP): 2001 to 2007, funded by World Bank and DFID. The WB gave the credit and DFID provided a grant. HAPP activities were all managed by NASP, but NASP found partners to work on each of the 4 components. <ul style="list-style-type: none"> o The High Risk Intervention: Supposed to include the following groups: Brothel Based SW; Hotel Based SW; Street Based SW; IDU; Internal Migrants (switched to clients of SW); MSM; International Migrants; (MSM and International Migrants were cut form the program in June 2003) ■ This component was managed by UNICEF ● UNICEF contracted out to NGOs, developed

	<p>their capacity, and managed them (also gave financial management support)</p> <ul style="list-style-type: none"> ■ This component has two parts: Interventions and the provision of services ● 34 NGOs were selected to give services to the five high risk groups. Services were provided from DIC and included needle exchange, counseling, STI treatment, some general medical treatment, etcetera ● The HIV and AIDS Intervention Fund was the second part and 74 NGOs were selected to provide interventions for the five high risk groups. Mostly small NGOs were given grants to scale up their capacity to provide interventions for areas that were left out of the first part and to develop HIV and AIDS awareness among the general population <ul style="list-style-type: none"> ○ Advocacy and Communication: <ul style="list-style-type: none"> ■ Also has two parts ● NASP provided sensitivity and education/awareness trainings to religious leaders, teachers, and community leaders. Approx. 15,000 religious leaders were reached ● Development of BCC materials and advocacy: Done by UNICEF and John Hopkin's University. BCCP was John Hopkins' agent and initiated the development of materials. <ul style="list-style-type: none"> ○ Blood Safety: WHO was the managing partner and helped develop technical assistance, trained doctors and paramedics, developed awareness of safe blood. ○ Institutional sustainability and capacity development: UNFPA took charge of this and hired consultants to provide training and assistance in specialized areas for NASP. ■ GFATM round 2: \$20 million. Focused on youths. <ul style="list-style-type: none"> ○ Save the Children USA was selected through a "completely transparent process" to act as the managing partner.
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	<p>Save contacted NGOs, helped with capacity building, and managed them.</p> <ul style="list-style-type: none"> ■ 17 NGOs were given packages ● Development of BCC materials and awareness was given to Matra ● Development of Life Skills Education, condom accessibility, and youth friendly health services was taken over by HASAB (worked as a consortium) ● Advocacy and policy change towards a more congenial environment for discussion and policy development in HIV and AIDS was given to Padpakhep ● HIV and AIDS education and inclusion in school curriculum (a real innovation in Bangladesh) was handled by PIACT: the Bangladeshi people have not only accepted this they are demanding it be taught ● Base line surveys, mid point surveys: ICDDR,B manages the collection of data to be utilized in all future projects and programs ● GFATM Round 6: \$40 million: Save the Children USA, still the managing partner. Was developed along the same lines as the round 2 proposal except with the inclusion of interventions targeting Sex workers, Sex Worker's clients, IDU and PLHA, still in the youth age range. Now 40 plus NGOs are working under this package.
<p>USAID US Government Agency</p>	<ul style="list-style-type: none"> ● Government funded and has a cooperative agreement with FHI and for BAP was a direct bilateral agreement. USAID Impact Project 2000-2005 with FHI was a global agreement. Funds FHI (recipient) who sub-contracts to 23 implementing NGOs and 3 partner NGOs (SMC - Social Marketing Company; RTM; and MACCA) and was involved in the Bangladesh AIDS Program (BAP October 2005-September 2009). ● Most of the project sites are urban and are all over the country but some sites are close to

	<p>the border including Chapai Nawabanj, Nator, Shatkhira, Benapole of Jessore, Hill of Dinajpur)</p> <ul style="list-style-type: none"> ● Target: Most of the project sites are urban and are all over the country but some sites are close to the border including Chapai Nawabanj, Nator, Shatkhira, Benapole of Jessore, Hill of Dinajpur)
<p>Durjoy Nari Shangha National Sex Worker's Organization</p>	<ul style="list-style-type: none"> ● Social Mobilization and Advocacy The objective of this program is to organize street based sex workers, activists, development activists, women activists, lawyers, journalists, and other civil society members at different level to claim rights. ● Awareness and Capacity Building The objective of this program is to create awareness among sex workers, sex workers children as well as community people on rights, STD and HIV and AIDS, social stigma, discrimination, existing laws, and other health related issues like safe sex, immunization, effect of drugs, and environment. ● Protection of Sex Worker's Children The objective of this program is to protect sex workers children from abuse, oppression, trafficking, harassment, and social stigma. ● Mainstreaming The objective of this program is to mainstream the children for better future. ● Delivery of Humanitarian Aid and Service The objective of this program is to protect sex workers from social injustice, oppression and disaster. ● Local Resource Mobilization The organization collects and receives different donations from local elite and affluent. DNS gratefully receives personal donations in cash as well as in kinds such as medicine, clothes, and educational materials.



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