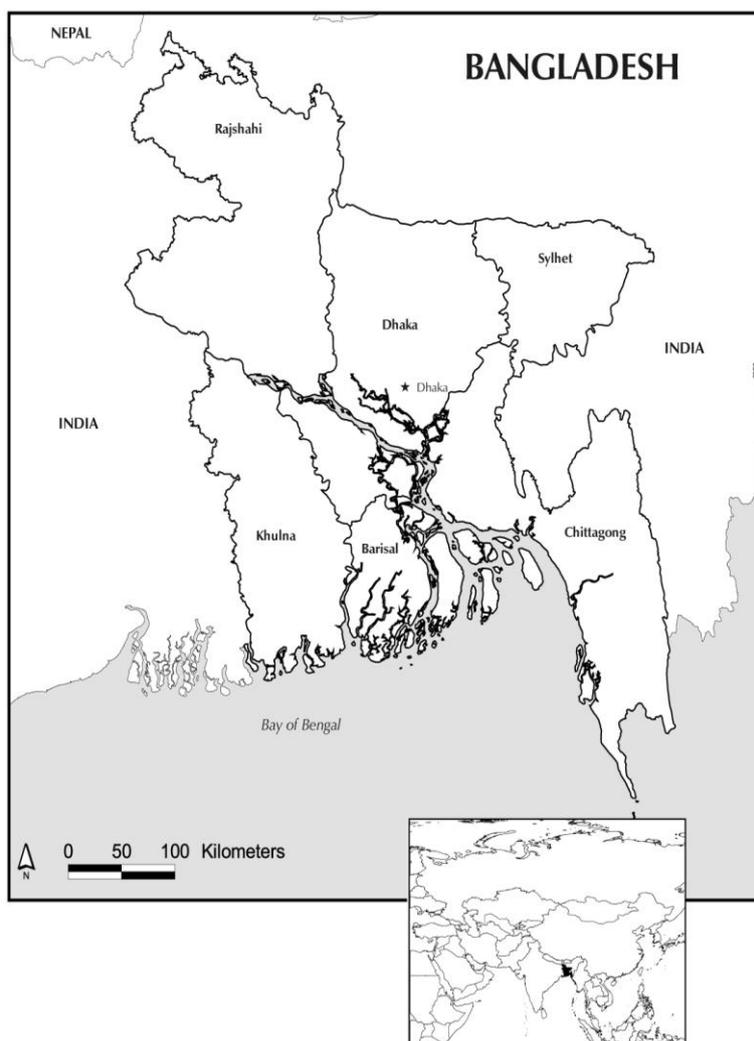


MISSION REPORT

Ex Ante Poverty Impact and Human Rights Assessment

for

Multisectoral HIV/AIDS Programme



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We have learned much through the discussions held with intermediaries and target group members from the poor communities of Chittagong. However, the final responsibility for opinions expressed in the report lies with the consultants and the report’s authors; they do not necessarily represent the opinions neither of the GTZ nor of the Government of the Peoples’ Republic of Bangladesh or the Chittagong City Corporation.

Executive Summary **(Summary Assessment and Recommendations)**

The “Multisectoral HIV/AIDS Programme (MSHAP)” in Bangladesh will enter into its second phase with the beginning of 2009. So far, the project does not explicitly contribute to the poverty alleviation of its target groups (mostly consisting of more or less marginalised Most-at-risk-populations, MARP). In order to prepare proposals for a more explicit poverty orientation of the project, an ex-ante Poverty Impact Analysis (PIA, according to the OECD-DAC guidelines) was commissioned, complemented by a “Human Rights Based Assessment”, which appeared to be at least as relevant an approach to re-think the project design as the PIA.

The PHRIA-team (Poverty and Human Rights Impact Assessment) arrived at the finding that the most important reason for the target groups to slide into poverty or to remain there is their very harsh stigmatisation and discrimination as sex workers, drug users (in particular injecting drug users), men having sex with men, and persons living with HIV and AIDS (PLWHA). The degree of discrimination often is such that even the own family outcasts them as bad and lost people. In particular with regard to PLWHA, one of the reasons for this discrimination is lack of and/or wrong information about HIV/AIDS and resulting shame and fear that are repressed by condemning the infected person.

The discrimination and fear accompanying the HIV/AIDS-problem not only causes poverty but the taboo and reluctance to look at the problem in a rational way most likely are also conducive to let the HIV spread unhindered. A problem that (nearly) everyone refuses to perceive may be underestimated or – paradoxically – overestimated; in any case it may evolve unnoticed.

The present single objective of the MSHAP is “**prevention, diagnosis, counselling, and treatment of STI, HIV, and AIDS are improved**” (in four cities). In the 2nd phase this should be complemented by a second objective (programme component): “**Public and social acceptance of vulnerable groups, including PLWHA, is improved.**” In chapter 7 of this report this objective is further explained and a results chain proposed.

This recommendation is made despite a certain paucity of information. It is the result of analysing various reports, poverty surveys, interviews and focus group discussions held predominantly with NGOs working for and with MARP and PLWHA and with some members of the aforementioned target groups in Chittagong.. The project needs to put this proposal into the overall context (not least into the context of available financial and human resources) with the assistance of the forthcoming Project Progress Review (PPR).

Acronyms and Abbreviations

AAS	Ashar Alo Society (“Light of Hope”, NGO for PLWHA)
AIDS	Acquired Immunology Deficiency Syndrome
ALO	Addiction Life Overcome (“Light”, NGO for addiction rehabilitation)
APON	Ashokti Punorbashon Nibash (NGO for addiction rehabilitation)
ART	Anti-Retroviral Therapy
BBS	Bangladesh Bureau of Statistics
BCC	Behaviour Change Communication
BD	Bangladesh
BGMEA	Bangladesh Garment Manufacturers & Exporters Association
BLAST	Bangladesh Legal Aid and Services Trust
BMZ	(German) Federal Ministry for Economic Cooperation and Development
CAFOD	Catholic Agencies for Overseas Development
CARE	Cooperation of American Relief Everywhere
CBN	Cost of Basic Needs
CCC	Chittagong City Corporation
CCDB	Christian Commission for Development in Bangladesh
CEO	Chief Executive Officer
CREA	Centre for Rehabilitation, Education and Awareness (for DU, Dhaka)
CSW	Commercial Sex Worker
DCI	Direct Calory Intake
DIC	Drop-in Centres (for sex workers, drug addicts)
DNC	Department of Narcotics Control (Ministry of Home Affairs)
DU	Drug User
FHI	Family Health International
FSW	Female Sex Worker
GFATM	The Global Fund to fight AIDS, Tuberculosis, and Malaria
GTZ	German Technical Cooperation (Gesellschaft für Technische Zusammenarbeit)
HASAB	HIV/AIDS and STD Alliance Bangladesh
HIES	Household Income and Expenditure Surveys
HIV	Human Immunodeficiency Virus
HNPSP	Health, Nutrition and Population Sector Programme (BD)
ICDDR,B	International Centre for Diarrhoea Disease Research of Bangladesh
IDU	Injecting Drug User
IEC	Information, Education, Communication
IRIN	Integrated Regional Information Networks www.IRINnews.org (part of UNOCHA)
JSAN	Joint Staff Advisory Note (IMF & IDA/WB)
KAP	Knowledge, Attitude, Practice
MARP	Most at Risk Populations
MoHFW	Ministry of Health and Family Welfare (BD)
MoLGRDC	Ministry of Local Government, Rural Development, and Cooperatives (BD)

MRDI	Management and Resources Development Initiative (Dhaka)
MSHAP	Multisectoral HIV/AIDS Programme (GTZ Bangladesh)
MSM	Men who have Sex with Men
MSW	Male Sex Worker
NASP	National AIDS/STD Programme (BD)
NGO	Non-Governmental Organisation
NSAPR	National Strategy for Accelerated Poverty Reduction (= PRSP of BD)
NSP	National Strategic Plan
OCHA	Office for the Coordination of Humanitarian Affairs (see also UNOCHA)
OHCHR	Office of the UN High Commissioner for Human Rights
OI	Opportunistic Infection
PFK	Projektfortschrittskontrolle (see PPR = Project Progress Review)
PH	Public Health
PIA	Poverty Impact Analysis
PLHIV	People Living with HIV
PLWH	People Living With HIV
PLWHA	People Living With HIV/AIDS
PPP	Purchasing Power Parity
PPR	Project Progress Review (of GTZ-sponsored projects)
QPA	Qualitative Poverty Assessment (found in WHO-Comments on the PRSP)
SAARC	South Asian Association for Regional Cooperation
SHG	Self-Help Group
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations' Special Session of the General Assembly on HIV/AIDS
UNOCHA	United Nations' Office for the Coordination of Humanitarian Affairs
UNODC	United Nations' Office on Drugs and Crime
UPHCP	Urban Primary Health Care Project (BD)
UPPR	Urban Partnerships for Poverty Reduction (UNDP slum upgrading project)
UTSA	United Theatre for Social Action
VCT	Voluntary Counselling and Testing
YPSA	Young Power in Social Action (NGO running DIC for sex workers & others.)

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1. Introduction

1.1 A note on methodology

An ex-ante Poverty Impact Analysis (PIA) should serve the purpose of defining more clearly which measures, with whom, and by what means will make a greater contribution to poverty reduction. It should also help us to define possible negative impacts. It is an instrument which should help to define an intervention - in this case, the second phase of a bilateral development programme so that it may be better targeted to achieve poverty reduction goals.

In our view the core elements of the PIA-approach are the stakeholder and institution analysis (PIA-module 2) and the “transmission channel” analysis (PIA-module 3), the latter essentially being a structured checklist to analyse the results chain(s) of the strategic plan of the project systematically for a number of factors the project will influence and change (or not). The stakeholder analysis is based on information from past and present. The transmission channel analysis is based on one or several development hypotheses about the future.

Both these elements are also work steps in designing and re-designing strategic project plans. Hence, they are (or should be) part of the project planning routines an implementing agency like GTZ is applying. As a consequence, there is a certain methodological overlap of doing a PIA and a Project Progress Review (PPR).

There have been several drawbacks in carrying out this ex-ante PIA at this stage of the Multi-Sectoral HIV/AIDS Programme (MSHAP). One of the drawbacks is that important parameters of the programme are yet to be defined by the forthcoming PPR. The main stakeholders and intermediaries for implementing the programme in its next phase have not (yet) been defined. We suggest including intermediaries who are oriented towards poverty alleviation and human rights. But the PIA-team does not know and was not in a position to explore the opinions of the Bangladesh authorities responsible for this project. It was also not possible to estimate the amount and the distribution of funding to the various possible future activities of the project.

This PIA was the first PIA conducted by explicitly integrating a human rights perspective in the impact assessment. Human rights standards as they relate to HIV/AIDS and the key human rights principles of non-discrimination, participation and accountability were reflected upon throughout the analysis. We could not thoroughly assess the principle of accountability of duty bearers, due to the reasons mentioned above. We have deliberately opted not to overstretch the PIA and therefore have not dealt in depth with all elements usually included in a human rights impact assessment (e.g. a comprehensive analysis of international human rights mechanisms and the national legal framework). Overall, this approach proved to be practicable. A major benefit of integrating a human rights perspective in the PIA consisted in linking the assessment of the poverty situation and of the capabilities of the rights-holders (target groups) to the realization or neglect of their human rights. This had important consequences for the identification of transmission channels and our recommendations for the next phase of the MSHAP.

Another drawback (not unexpected) was the unavailability of data that are necessary to answer all the questions of the ToR in depth (cf. Annex 1). Despite lots of poverty surveys and other reports, little specific information was available on the poverty and human rights situation of the specific target groups of the MSHAP. Therefore, if the project (i.e. the competent Bangladesh authorities and GTZ during the PPR-process and thereafter) decides to follow the recommendations of this PIA-report, more detailed explorations have to be made by the project before specific measures are planned and implemented.

All this highlights a difficulty in the timing of this PIA and in terms of PIA being a process partially overlapping, partially complementing the PPR-process. Because PIA was conducted before government counterparts have been consulted, it resulted in being a study with very little involvement of central and local government departments. The discussion on and the ownership of results and the decision on where to take the process beyond this study (with its only roughly indicative outcomes) remain missing elements, which are left to the PPR.

In retrospect, the best process to (re-)design a project by combining the PIA- and the PPR-process would be to do the first half of PIA (i.e. modules 1 – 2) first. Then the PPR should follow, producing the overall (re-)design of the project, defining the project system's boundaries, the objectives and main results chains. The latter should be subject to the "transmission channel analysis" (PIA-module 3), eventually complemented by the assessment of anticipated capabilities of the target groups (PIA-module 4). Preferably, all this should be done in close cooperation with the national implementing stakeholders. In principle, the whole unified process could be merged in a reformed PPR-process.

1.2 Short description of the "Multidisciplinary HIV/AIDS programme" (MSHAP)

Politically responsible organisation: Ministry of Local Government, Rural Development and Cooperatives (MoLGRDC)

Duration of the current phase: June 2004 to December 2008

Initial situation

It is not yet too late to gain control over the expansion of the HIV/AIDS epidemic in Bangladesh. So far, less than one percent of the total population of Bangladesh is infected by the HI-Virus. However, a prevalence rate of seven percent amongst drug users in Central Bangladesh, lack of knowledge and low risk perceptions regarding HIV/AIDS indicate the danger that the epidemic spreads rapidly within the whole population. The political responsible persons have declared their will to meet this challenge. A national strategy to combat the spreading of HIV/AIDS has been formulated already in 2004 and is being implemented in the framework of the National AIDS/STD-Programme (NASP). However, the related activities so far were limited to high risk groups and Government institutions in general were not much involved. This has reduced the effectiveness of combating HIV/AIDS. Since then a new multisector approach of combating HIV was introduced, involving different responsible departments and levels of the administration. In particular at the local level it turned out that the deficits of professional training in the State's Health Services in the fields of HIV/AIDS and sexually transmitted diseases (STD) as well as the lack of efficient coordination of the stakeholders on the local (including municipal) and national levels are critical factors for the successful implementation of the NASP. The political responsible stakeholders at the local level have committed themselves for combating HIV/AIDS.

Objective:

Prevention, diagnosis, advising on and treatment of sexually transmitted diseases (STD) and HIV/AIDS in Chittagong, Khulna, Rajshahi und Sylhet are improved.

Indicators:

1. The responsible Health Officers of the municipal administrations report regularly to the NASP at least about 60 % of the supervised organisations and service providers (the total number of supervised organisations probably is about 145).

2. Evaluation and Quality Management of prevention, diagnosis, advising on and treatment of STD and HIV/AIDS are part and parcel of the annual reporting of all implementing partners of the project.
3. Advising on and treatment of HIV/AIDS and STIs has been improved in the project areas according to the judgement of concerned patients (Evidence through gender-differentiated interviews of the patients).

Target groups and intermediaries

The project is targeting at all persons in the selected urban areas living under the menace of HIV, in particular young people (15-24 years) and high risk groups such as female and male sex workers, injecting drug users, migrant workers, transport workers as well as people living with HIV/AIDS. Within these groups, women are particularly vulnerable due to their disadvantaged socio-economic position in the society and are therefore addressed with priority.

The intermediaries are the employees of the MoLGRDC and the municipal administrations, of the Ministry of Health, Family and Welfare as well as representatives of education facilities, private sector and non-governmental organisations.

Mode of proceeding

The project supports municipal administrations and the Ministry in

- analysing urban HIV risk profiles;
- surveying data on the municipal health services' system;
- coordinating all actors relevant to combating HIV/AIDS;
- surveillance of the epidemiological course of STDs and HIV/AIDS.

A centrepiece of the approach is the establishment and advisory support of a municipal coordination committee that comprises representatives of the Health and Education sectors as well as the private economic sector under the guidance of the City Corporation. The staffs of the public and private advisory and treatment services including NGOs are being qualified through training, professional supervision, and provision of complementary equipment in order to enable them to better answer the needs of their clients and patients. Thus appropriate services can be delivered regarding prevention, diagnosis, advising on and treatment of sexually transmitted diseases (STD) and HIV/AIDS. The approach also includes the establishment and initiation of patient referral systems among different service providers and of a surveillance system of the HIV/AIDS epidemic. In addition, awareness raising campaigns on HIV/AIDS are promoted in the education and private economic sectors.

Decision makers and important personalities of public life are being familiarised with the overall concept of target group friendly, competent, and cooperating services at the municipal level that may serve as an example to be transferred to other municipalities.

Chain of Results ¹

Outputs	<ul style="list-style-type: none"> ▪ Urban HIV risk profiles; ▪ Data on the municipal health services' system; ▪ Coordination of all actors relevant to combating HIV/AIDS; ▪ Surveillance of the epidemiological course of STDs and HIV/AIDS; ▪ Regular evaluation and improvement of activities; ▪ Establishment of Coordination Committee; ▪ Counselling and training of staff, complementary equipment; ▪ Documentation of project experience for NASP and MoLGRDC; ▪ Lobbying and publications for decision makers and representatives of public life on the project approach.
Use of outputs	<ul style="list-style-type: none"> ▪ Staff of health services, NGOs etc. better answer the needs of their clients and patients and provide adequate services in prevention, diagnosis, advising on and treatment of sexually transmitted diseases (STD) and HIV/AIDS. ▪ Stakeholders in public health services and NGOs improve their methods and standards of prevention and treatment and cooperate in mutual patient referral systems. ▪ NASP and MoLGRDC align their strategies/policies and coordinate other interventions in the sector according to experiences made and useful innovations introduced. ▪ Leaders/entrepreneurs in the private sector use the information provided to contribute to preventing HIV/AIDS in their enterprises. ▪ Decision makers and public personalities support and promote the concept of combating HIV/AIDS through target group friendly, competent, and cooperating services.
Outcome	Prevention, diagnosis, advising on and treatment of sexually transmitted diseases (STD) and HIV/AIDS in Chittagong, Khulna, Rajshahi und Sylhet are improved.
Impact	The incidence of HIV/AIDS is kept at controlled levels and thus the increase of cases of impoverishment and economic loss is halted.

Results – What has been achieved so far

The responsible stakeholders at the local level are aware of the multiple dangers of the HIV epidemic menacing their cities and are prepared to get active. They have particularly welcomed the cross-sector approach of the project that encourages joint and more efficient usage of resources and safeguards unified quality standards in combating and treating HIV/AIDS. To do so, the above mentioned “Multi-sectoral HIV/AIDS Coordination Committee” has been established within Chittagong City Corporation (CCC).

In Chittagong, a comprehensive survey and analysis of the HIV/AIDS risk profile has been done, in the three other cities (Rajshahi, Khulna, Sylhet) these surveys are being done. On this basis, the need for HIV/AIDS health services in the city is being assessed and the necessary activities are planned. The training of health service staff on the subjects of HIV/AIDS, STD and infection prophylaxis has started. In cooperation with Family Health International (FHI) the project is improving the quality of public health services in STD and introduces a quality management system.

¹ Translated from the GTZ-offer to BMZ dated 07.01.2007, ch. 3.7

The „Join-in Circuit“ on HIV/AIDS, developed by the German Federal Office for Health Information has been established successfully in a number of countries. It has been adapted to the cultural context of Bangladesh with the aim of becoming an effective tool to contribute to informing young people (in particular students) about HIV/AIDS and STDs.

2. Background

2.1 Urban poverty in Bangladesh

Urbanisation is an inevitable and unavoidable feature in the process of development and population growth.

In Bangladesh rapid urbanization has taken place because of three main contributing factors:

- 1) Rural-to-urban migration (which is inevitable);
- 2) Natural growth of population in urban centers;
- 3) Geographical increase of the urban territory/constituency.

Population data from various surveys are neither fully comparable nor very consistent. Despite many variations in detail, depending on the source, they show similar trends and tendencies. Hence, in qualitative terms, we can be pretty sure about the following facts:

- 1) The urban population growth rate is at least double the rural population growth rate (data varying from 3.5 % p.a. to 6.0 %, probably referring to different cities; the national average population growth rate according to the CIA fact book was estimated in 2008 to be slightly above 2 %);
- 2) At present, the share of urban population in Bangladesh is roughly one quarter of the total population (and still below the average urbanisation rate of 29% in 2004 in South Asia).
- 3) However, Bangladesh will reach today's worldwide average urbanisation rate of 50 % by the year 2025 or latest by 2030.
- 4) Nearly half the population is living below the national poverty line. National statistics mask the changing distribution of poverty, which used to be much more prevalent in rural areas, but which has been rising quickly in urban areas. According to government statistics, the percentage of the population living in poverty in urban areas rose from 46.7% in 1991 to 52.5% in 2000, whereas in rural areas the rate fell from 47.6% to 42.3% over the same period (The Economist Country Profile, 2005). However, all poverty statistics are more or less flawed and do not even provide a uniform picture whether poverty is rising or falling in Bangladesh (McLeod, 2007)².
- 5) The 2005 slum survey of the six City Corporations of Bangladesh estimated that 35 % of the urban population live in slums (Dhaka: 37.4 % or 3.42 million; Chittagong: 35.4 % or 1.47 million). However, not everybody living in a slum area is poor.

An attempt to distinguish clearly rural from urban poverty is very difficult and not very helpful due to many reasons (one is due to different definitions of what is “urban” and what is “rural”). Nevertheless, very generally it can be assumed that there are more risks in urban

² In his report to the UNDP-BDP Poverty Group, Darryl McLeod points at difficulties and inconsistencies in national and global poverty monitoring estimates. Not entirely surprising, different indicators indicate different selected part(ice)l(s) of realities. Different, statistical operations, aggregations and “adjustments”, at times raising doubts, produce different images about situations. These images are not necessarily identical, as the case of poverty in Bangladesh shows.

areas to remain poor and more chances to escape from poverty respectively than in rural areas.

Typical urban elements of poverty are:

- High cost of living and monetarisation of urban life due to:
 - public and private transport,
 - cost of schooling,
 - high house rent or high cost and risks of illegal self construction,
 - cost for public services like drinking water, sewage, solid waste etc.,
 - high cost for food (limited or no possibility for subsistence urban agriculture).

- Environmental hazards and living situations with inherent health risks due to:
 - air and water pollution,
 - flooding and lack of drainage,
 - poor or no access to latrines or any sewerage systems,
 - no garbage collection and suitable disposal,
 - unhygienic, insufficient and climatically unsuitable shelter,
 - insufficient or no access to health services.

- Vulnerability due to changes in economic relations and currency instabilities:
 - drastic and sudden changes of buying power,
 - uncertainties of employment and income (even if the average income of slum dwellers e.g. in Dhaka generally is three times higher than that of the rural poor),
 - no or poor opportunities for self supply of services (e.g. own wells, transport, subsistence gardening, etc.)

- Unstable and heterogeneous social structures:
 - high population density, crowding (lack of space and privacy), leading to aggressiveness, poor security, and conflicts;
 - traditional structures, such as families or ethnic and religious groups fail to provide “safety nets”;
 - among the urban poor, above average number of female headed households that are particularly disadvantaged in many ways;
 - street children and other “pavement dwellers”;
 - drug addiction and discrimination of DU, in particular IDU; drug related criminality;
 - criminality and violence, blackmailing and endangering through organised crime, youth gangs, terrorist groups of fundamentalist or other ideological backgrounds, etc.;

- Spontaneous attacks by government offices, police and other “security” agents:
 - risk of forced evacuations as housing and (often integrated) workplaces are located on illegally occupied public or private land (squatter settlements);
 - summary house searches;
 - blackmailing.

In such circumstances the urban management capacity of urban local governments in general and the capability to cater for the basic civic needs of the poor in particular is heavily challenged. If more than fifty percent of Bangladeshi population will be living in urban areas of Bangladesh by the year 2025 (or 2030), the demand for habitat, health services, drinking water supply, drainage and waste water sanitation, and solid waste management services will dramatically increase, in particular in the future megacities of Dhaka and Chittagong.

In the international development discourse, it is widely agreed that good governance (in particular at the local level) is the key to poverty reduction. According to another general

experience, institutional strengthening of local government takes (much) longer than conventional targeted schemes to benefit the poor, but the eventual benefits and the sustainability gains would outweigh the costs. Therefore, projects that follow the “long term”-approach to build the capacities of local governments should be complemented with other “short term”-components that result in some more immediate relief, recognition, empowerment, self help etc. of the urban poor.

At the same time, practical “short term”-outputs of such components increase the visibility and the appreciation of the whole intervention by stakeholders and target groups, thus improving the basis for introducing also more inconvenient changes (e.g. like respecting neighbours’ rights, community policing, paying fees for services, collecting garbage and many more).

Governance versus Government

The concept of governance is complex and controversial. Before one can say what “good” governance is, one must be clear about what is meant by “governance”. An entry point into the debate is UNDP’s definition:

“The exercise of political, economic and administrative authority in the management of a county’s affairs at all levels. It comprises the mechanisms, processes and institutions through which citizens and groups articulate their interests, exercise their legal rights, meet their obligations and mediate their differences.”

Two aspects of this definition are relevant for promoting urban governance. First, governance is not government. Governance as a concept recognises that power exists inside and outside the formal authority and institutions of government. In many formulations, governance includes government, the private sector and civil society. Second, governance emphasises “process”. It recognises that decisions are made on complex relationships between many actors with different priorities.

Good urban governance

Once the adjective “good” is added, a normative debate begins. Adding such a value judgement to “governance” increases the controversy exponentially. Different people, organisations, governments and city authorities will define “good governance” according to their own experience and interest. Defining desired standards of practice of urban governance may coincide with the debate about decentralisation, i.e. re-organising power.

Source: UN-HABITAT: The Global Campaign on Urban Governance. Concept paper, 2nd edition: March 2002

2.2 HIV/AIDS in Bangladesh

The HIV/AIDS epidemic in Bangladesh is in its early stages. Current UNAIDS estimates suggest a prevalence of less than 0.1% in the general population and less than 1% among people engaging in risky behaviour. As in many other Asian countries, unprotected commercial sex and needle-sharing among injecting drug users (IDU) are the main risk factors driving the epidemic. Little is known on the course the HIV/AIDS epidemic will take in Bangladesh. The last round of sentinel surveillance documented a high prevalence rate of 7.1 % among injecting drug users in one neighbourhood of Dhaka, which indicates that the epidemic may spread from drug users to sex workers and ultimately to the general population (NSAP, 2008). It is however commonly recognized that, in Asian countries, HIV/AIDS will not develop to a “generalised” epidemic as in Sub-Saharan countries, due to the very low prevalence of “concurrent sexual relationships” in Bangladeshi society (UN, 2008). But, besides the individual hardship caused by each HIV infection, with a population of 140 Million, even a small increase can constitute in absolute numbers a burden for the health system³.

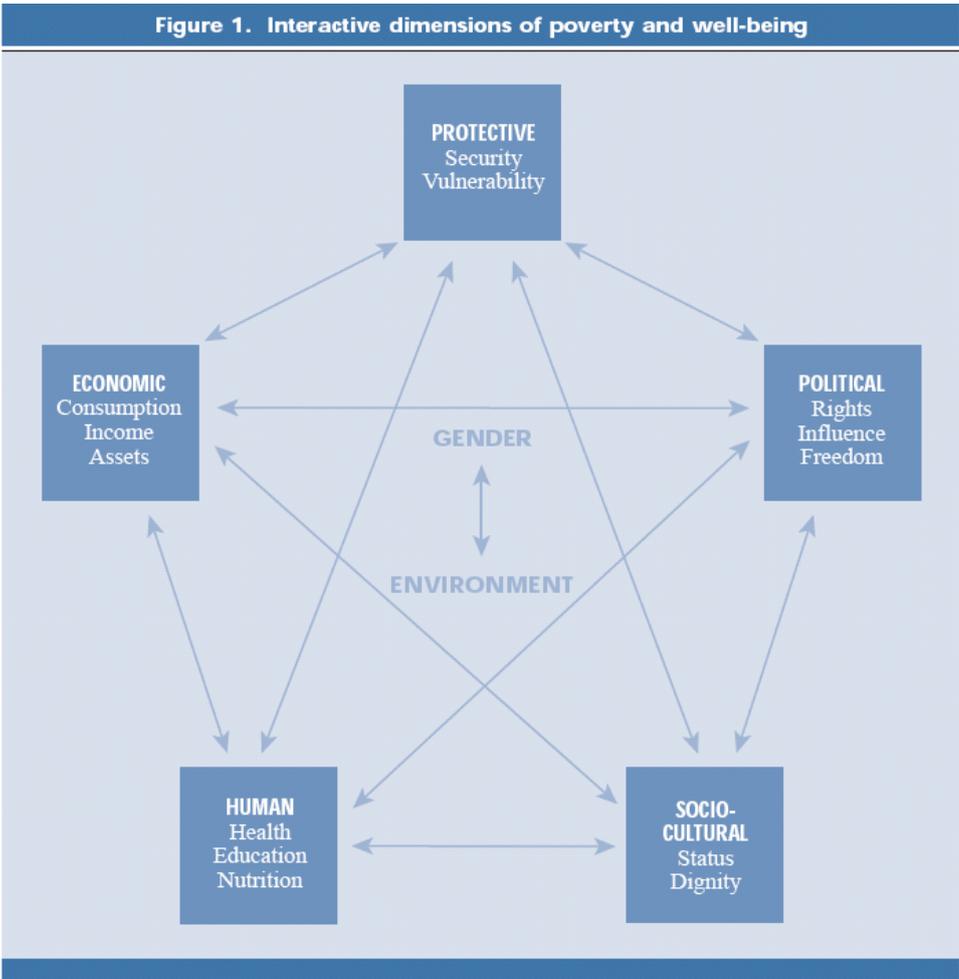
Reports suggest that there are overlaps between sex work and drug use in Bangladesh, as well as multiple interactions between the so called most at risk populations (MARP) - injecting drug users, male and female sex workers and men having sex with men - and other population groups (Azim et al., 2006; CARE, 2006). The survey conducted by the MSHAP in

Chittagong City showed for example that more than half of the interviewed students and internal migrants engaged in commercial sex. Low risk perceptions, poor condom use and a high level of sexually transmitted infections among these groups are further indications that the disease may spread to the general population. Interviews held during the PIA confirmed that, besides the well-known high risk groups, other groups are also vulnerable to HIV/AIDS. These groups include external migrants, internal migrants, unmarried young people in the urban context, and street children.

The main risk factors include a very low level of HIV/AIDS knowledge in the general population, a high mobility due to internal and external labour migration, a large commercial sex industry and apparently a rising drug use among all population groups⁴.

2.3 HIV/AIDS and Poverty in Bangladesh

The commonly agreed upon framework for describing poverty more precisely are the five interlinked dimensions of poverty as described in the OECD-DAC Poverty Reduction Guidelines (2001); these dimensions are also referred to as the “capability framework”, meaning that they describe the capabilities people have (or rather: are more or less deprived of) to escape from or to avoid poverty.



⁴ Understanding the country-specific course of the HIV/AIDS epidemic in Bangladesh is essential to develop adapted and effective responses. The PIA mission had the mandate to analyse the relationship between poverty/human rights and HIV/AIDS. A more thorough analysis of the epidemiological context will be done during the PPR.

Whereas poverty is worldwide recognized as an important social determinant of vulnerability to diseases such as Malaria and Tuberculosis, there is currently a public health debate about whether poor individuals and communities are particularly vulnerable to HIV (Shelton et al. 2007). However, it is widely recognized that HIV/AIDS most often causes individual, household and, in high prevalence countries, national poverty (Bates et al., 2004). Whether HIV/AIDS disproportionately affects the urban poor in Bangladesh or not remains to be confirmed by epidemiological research. High risk and vulnerable groups certainly are in many regards poor. But, to which extent does their poverty explain their vulnerability to HIV/AIDS? Despite not having statistical evidence, we dare to assume that poverty, particularly in its economic dimension, is not the sole determinant for HIV/AIDS vulnerability. Poverty as such does not lead to drug use or to HIV infections. Economic factors certainly greatly contribute to internal and external labour migration of poor population groups, and therefore may indirectly increase the eventuality of extra-marital sex, and thus vulnerability to HIV/AIDS. But extra-marital sex also occurs in the middle or upper class. Our interviews with persons in close contact to PLWHA indicate that HIV/AIDS is not confined to the poor population groups; upper class PLWHA are just able to hide their status better.

A direct causality between income poverty and HIV/AIDS vulnerability therefore seems questionable. Other poverty dimensions are more closely related to the HIV/AIDS vulnerability of poor population groups:

- Human: limited access of poor population groups to health and education services, including information on HIV/AIDS.
- Socio-cultural: widespread stigmatisation and discrimination of drug users and male and female sex workers; discrimination of men and particularly women living with HIV/AIDS, neglect of street children.
- Protective: Less capability to withstand external shocks and ill-health, particularly after having been infected by HIV/AIDS.
- Political: Less capability to claim their human rights, including cultural, social and economic rights.

Both drug use and HIV/AIDS are a cause of poverty in Bangladesh. The revelation of being HIV-positive in most cases appears to be a “safe” ticket for poverty (or to remain poor). The widespread **stigmatisation and discrimination** of PLWHA by their own families (maybe with some exemptions in upper class families), by the neighbourhood/community, by employers and by public health services, is such that the affected person is not only deprived of his/her social status and dignity but loses concurrently and very fast all other capabilities and resilience against becoming or remaining poor.⁵

Most HIV/AIDS interventions in Bangladesh have up to now focused on the human dimension of poverty, by investing efforts in increasing the access of high-risk groups to health services and information. Every HIV/AIDS intervention in Bangladesh (if successful) is basically also a contribution to avoid new cases of poverty in the sense that each HIV-infection prevented means at least one person (plus dependants) less poor. Hence, HIV/AIDS interventions may be qualified as inherently relevant to poverty reduction. Alleviating income poverty is surely a valuable development goal in itself but is not the most effective way to decrease HIV/AIDS vulnerability. An effective response to HIV/AIDS requires addressing the socio-cultural, political and protective dimensions of poverty besides its human dimension. Or to put it in other words, decreasing HIV/AIDS vulnerability calls for a human rights-based approach.

⁵ For more information on the poverty and human rights situation of specific target groups see chapter 3.3

2.4 HIV/AIDS and Human Rights in Bangladesh

It is now well recognized that vulnerability to ill-health is reduced when human rights are respected, protected and fulfilled. The Declaration of Commitment on HIV/AIDS, which was adopted by UN Member States, including Bangladesh, in 2001 clearly states: “*The realization of human rights and essential freedoms is essential to reduce vulnerability to HIV/AIDS.*”

Among the human rights principles and standards relevant to HIV/AIDS are the principle of non-discrimination, the right to life, the right to be free from torture and cruel, inhuman or degrading treatment or punishment, the right to privacy, the right to health, right to education, the right to freely receive and impart information (UNAIDS/OHCHR, 2006).

Despite having signed and ratified the respective international human rights treaties, the Government of Bangladesh (the main duty-bearer) still fails to meet its obligations to respect, protect and fulfil the human rights of those persons and groups vulnerable to or affected by HIV/AIDS (the rights-holders), as summarized in the following:⁶

Principle of non-discrimination

The constitution of Bangladesh includes equality before law and non-discrimination as a fundamental right of all citizens. The national HIV policy also explicitly states that no health care institution or health worker has the right to refuse treatment to PLWHA. In practice, these provisions are still being systematically violated, as PLWHA are routinely denied access to public and private health services.

The right to be free from torture and cruel, inhuman or degrading treatment or punishment

A well-documented report by Human Rights Watch in 2003 described how high risk groups, i.e. sex workers, injecting drug users and men who have sex with men were being regularly abducted, raped, beaten and subject to extortion by the police and by thugs commonly termed mastans.

Police reform is now a key human rights and governance issue in Bangladesh. Interviews held with various stakeholders during the PIA indicate that the attitude of police officials towards vulnerable groups has improved in the last two years. Nevertheless, sexual violence against female and male sex workers still is common, either committed by private clients or by Government officials. In the vulnerability survey conducted by the MASHP in Chittagong, 35% of female sex workers and 70% of male sex workers reported having been raped in the last 12 months. Whereas sexual violence against women is explicitly prohibited by the Bangladesh penal code and the 2000 Suppression of Violence against Women and Children Act, there is no provision that explicitly prohibits rape against men.

Right to privacy

Many public health services, provided they offer diagnosis and treatment of sexually transmitted infections (STI), do not offer the privacy and confidentiality required for patients to feel safe and comfortable and disclose their symptoms. Lack of privacy is one of the reasons for vulnerable groups not to use public health services.

Right to health

The right to health encompasses as a core obligation of Governments “*ensuring the right to access to health facilities and services on a non-discriminatory basis, especially for vulnerable or marginalized groups*” (UN, 2000). Attitudes of service providers towards PLWHA and other vulnerable groups indicate that this provision is not being fully respected in Bangladesh (see above).

⁶ For examples of the human rights situation of rights-holders (target groups) see chapter 3.3

According to international human rights law, the content of the right to health encompasses the availability and accessibility of HIV prevention, treatment, care and support for children and adults. It also includes the right to receive information on health and HIV-related issues in a way which is gender-sensitive and respectful of the culture of individuals and minorities.

Despite the commitment of the Government of Bangladesh to address the HIV/AIDS epidemic, a lot remains to be done to achieve even basic standards in HIV prevention and care. In Chittagong, the access of high risk and vulnerable groups to HIV and STI prevention and treatment is still very limited. Access to information on HIV/AIDS has increased in recent years. However, it is hardly accessible to the illiterate or to the indigenous population, as it is often provided in written form or through the national media in pure Bangla, not in dialect or in local languages. Access to ARV treatment for PLWHA is very limited throughout Bangladesh. The Government does not provide ARV drugs through its services. Locally produced drugs do not conform with WHO quality standards, and are not adapted to children's or pregnant women's needs. In any case, most PLWHA can not afford to buy these drugs at a high price on the local market. Provision of ARV through NGO's is irregular, their management of ARV therapy not always up to date with international standards, interruptions in ARV therapy are therefore frequent.

Key principles of a human rights-based approach are non-discrimination, accountability and participation/empowerment (UN, 2003; BMZ, 2004). In the context of HIV/AIDS in Bangladesh the following challenges need to be addressed, in order both to improve the human rights situation of both vulnerable and high-risk groups (the rights-holders) and to decrease their vulnerability to HIV/AIDS.

Non-discrimination

Reducing discrimination means addressing both de-jure, and, in our view more important in Bangladesh, de-facto discrimination.

Gaps in the legal and policy framework protecting the rights of vulnerable groups still exist in Bangladesh. Closing these gaps may include enacting regulations to protect high-risk groups and PLWHA from discrimination, reviewing laws criminalising drug use and male-to-male sex and/or prohibiting sexual violence against men.

Reducing de-facto discrimination requires first and foremost addressing the stigmatisation of vulnerable groups in family, community and society. HIV/AIDS-related stigmatisation discredits an individual in the eyes of the others, because he or she is associated with HIV/AIDS and "immoral" behaviour (drug use or/and extra-marital sex). Stigma is usually deeply rooted in the values, cultural norms and fears of societies. When stigma is acted upon it leads to discrimination, i.e. actions or omissions that directly or indirectly harm stigmatised individuals. Discrimination operates at different levels and may include social exclusion, denial of services or/and degrading practices and violence (DFID, 2007; UNAIDS, 2005). Unfortunately, all these aspects are present in Bangladesh.

Stigma and discrimination undermine the capability of individuals, groups and communities (only stigmatised persons are seen by the others as vulnerable to and responsible for HIV/AIDS) to protect themselves against the disease or/and to seek care. Changing these patterns requires to address fears and misconceptions associated with the disease and to challenge stereotypes and judgemental attitudes. This certainly needs time, but is essential, if vulnerability to HIV/AIDS is to be successfully reduced in Bangladesh.

Accountability

Our assessment indicates that, at the local level, many duty-bearers, including public health professionals and police officials, still do not comply with their obligation to respect and

protect the human rights of high risk groups. They either do not know their human rights obligations, or are not motivated, by sanctions or positive incentives, to comply with them.

Improving accountability therefore means encouraging duty-bearers to change their attitudes and practices towards high risk and vulnerable groups. In view of the prevailing organizational and political culture in Bangladesh, this seems quite a challenging task.

Participation and empowerment of rights-holders

Both high risk groups and PLWHA are not considered as full members of society and therefore often excluded from decision-making processes. Enabling participation therefore requires more than creating formal organisations of sex workers or PLWHA, which already exist in Bangladesh. It also demands to promote social acceptance in community and society for individuals, whose behaviour differs from the norm. Last but not least, most members of vulnerable groups, who are victims of human rights violations, either fear to claim their rights or do not know where to address themselves. Empowering them requires first to enable them to claim their rights by facilitating their access to adequate redress mechanisms.

2.5 Relevance of the project to national strategies and plans (PIA-module 1)

The MSHAP is relevant to the main poverty and health strategies of Bangladesh, i.e. the national Poverty Reduction Strategy (PRSP), the Health, Nutrition, and Population Sector Program 2004-2010 (HNSP) and the National Strategic Plan for HIV/AIDS 2004-2010 (NSP).

Health is considered by the PRSP as a key aspect of human poverty. One of the health targets of the PRSP is to reduce the spread of HIV, so that infection rates do not exceed 5% of the risk population. Priorities set by the PRSP to reach this target include the formulation of a policy framework to address HIV/AIDS, programmes for sex workers and targeted BCC activities (People's Republic of Bangladesh, 2005).

The Goal of the HNSP is to achieve sustainable improvement in health, nutrition and reproductive health, particularly of vulnerable groups, including women, children, the elderly, and the poor. The HNSP considers that, although Bangladesh is still a low prevalence country, unless risky behaviors are radically reduced, it may become a major development challenge. Priority should be given to activities to prevent sexual transmission of HIV and reduce the vulnerability of population with high-risk behaviours, such as injecting drug use (HNSP, 2005).

The National Strategic Plan for HIV/AIDS is based on the National Policy on HIV/AIDS and STD related issues and was adopted in 1997. It has five main objectives:

- 1) Provide support and services to the priority groups of people,
- 2) prevent vulnerability to HIV infection in Bangladeshi society,
- 3) promote safe practices in the health care system
- 4) provide care and services to PLWHA and
- 5) minimize the impact of the HIV/AIDS epidemic.

It includes virtually all possible sub-objectives and strategies, such as generating political and legal support for an effective response to HIV/AIDS, strengthening harm reduction programmes, reducing vulnerability arising from exploitation and abuse, or promoting rights based approaches to care, support and treatment of PLWHA. These strategies are not prioritized and no indicators were defined to monitor their implementation. Apparently an Operational Plan was developed with the assistance of UNAIDS, but not yet distributed to the public (NASP, 2008). The National AIDS Monitoring & Evaluation Framework for 2006-2010 is not directly related to the objectives set by the National Strategic Plan for HIV/AIDS and remains very vague (NASP, 2007).

Each HIV/AIDS programme in Bangladesh can easily be aligned to the national HIV/AIDS strategy. The specific contribution of the MSHAP is that up to now it is the only HIV/AIDS programme which is attached to the MoLGRDC, and aims at increasing the capacity of local government structures, i.e. City Corporations and other intermediaries, to deal with the HIV/AIDS epidemic.

(Additional statement on the relevance of the MSHAP for the achievement of the MDG cf. ch. 6 below).

Table 1: General poverty situation and relevance to national strategies and plans

Issue	Observations	Info Source/ Quality of Info (high, medium, low)
General poverty situation (in country, province, etc.)	<p>Urban population is rising in Bangladesh, including typical urban elements of poverty (high cost of living, environmental health hazards, unstable social structures).</p> <p>35% of the urban population live in slums, although not everybody living in a slum area is poor.</p> <p>HIV/AIDS high risk and vulnerable population often belong to the urban poor.</p>	<p>Info source: Poverty statistics and other surveys</p> <p>Quality: medium, statistic information often not accurate or reliable</p>
Specific observations on political, socio-cultural, and protective dimensions of poverty	<p>Income poverty is not the main determinant for HIV/AIDS vulnerability; other poverty dimensions are more closely related to HIV/AIDS.</p> <p>Human: limited access of poor population groups to health services.</p> <p>Socio-cultural: widespread stigmatisation and discrimination of drug users and male and female sex workers, discrimination of PLWHA.</p> <p>Protective: Less capability of urban poor and high risk groups to withstand external shocks and ill-health, particularly after having been infected by HIV/AIDS.</p> <p>Political: Less capability of urban poor and high risk groups to claim their human rights.</p>	<p>Info source: Reports, Interviews and focus group discussions</p> <p>Quality: good</p>
Existing national strategies (programmes) relevant to the intervention	<p>PRSP, HNRP and National Strategic Plan all consider HIV/AIDS. The strategies aim at reducing the vulnerability of high-risk groups and preventing the spread of HIV/AIDS to the general population.</p>	<p>Info source: Policy and strategy documents</p> <p>Quality: good but no information on implementation of strategies</p>
Short description of the intervention and how it aligns to national strategies	<p>The MSHAP targets all high risk and vulnerable persons in the selected urban areas.</p> <p>The MSHAP is attached to MoLGRDC. Its specific contribution to national strategies consists in strengthening the capacity of local government, i.e. City Corporations and other intermediaries to respond to the HIV/AIDS epidemic.</p>	<p>Info source: Project documents</p> <p>Quality: good</p>

3. Stakeholder and institutional analysis (PIA module 2)

A note on terminology that has a bearing on methodology:

PIA terminology uses the word “**stakeholder**” most of the time as a generic term for “agencies, organisations, groups or individuals who have a ... interest in the intervention”, including the target groups, which are the beneficiaries of the intervention. In our opinion, there is hardly a need for a generic term with such a broad meaning, therefore we prefer to limit the use of the word “stakeholder” to the “duty bearers” (using a notion of the human rights based approach), who are executing (public) duties in working towards achievement of the project’s objective.

We consider the “**target groups**” (beneficiaries, end-users) as “right holders”, who have a right to claim the fulfilment of their rights from the duty bearers, the project etc.

Useful third categories in a development project context are the “**intermediaries**”, which intervene between the two before mentioned main acting groups. They consist of organisations and individuals acting on behalf of the duty bearers, of the right holders, and/or on their own initiative towards achievement of the project’s objective (or towards changing it!); typically these are consultants, NGO, associations, foundations, other interest groups, other projects etc.

Furthermore, PIA-terminology distinguishes stakeholders and organisations correctly from **institutions**, the latter being “sets of rules, such as a constitution, a political regime, the executive-judicial relations, elections, or the habitual ways of doing things”. In particular the latter, in this case the stigmatisation and discrimination of PLWHA and DU, we have included in the analysis of the target groups, chapter 3.1.1.

It is worth mentioning that the conceptual terminology of the e-VAL-report (April 2008) on opinions of people informed of and involved in the implementation of the MSHAP, is different from the PIA-terminology and from our interpretation of it.

3.1 Target groups (right holders) of the project ⁷

3.1.1 High risk groups

Female Sex workers (FSW) ⁸

Although reliable quantitative information is rare, it is estimated that there is a rising commercial sex industry of approximately 105.000 male and female sex workers in Bangladesh (World Bank, 2007). The main venues of sex work are streets, hotels, residence and brothels, with various overlaps between these categories.

Very little is known on the situation of male sex workers, apart from the fact that, because they are having sex with other men, they are strongly stigmatised and discriminated (see following chapter).

Sex work as such is not prohibited by national laws in Bangladesh. Brothel-based sex workers can be recognised under the law and register for licenses provided they are working on their own will and are over 18. However, the Metropolitan Police Acts of the greater cities, such as Dhaka and Chittagong, prohibit soliciting another person in the public for the purpose of prostitution and therefore renders street-based sex work illegal (Human Rights Watch, 2003).

⁷ We do not use the PIA Matrix 2 in this subchapter because on the one hand it solicits in some columns information that we cannot provide (e.g. the “pro-poor agenda” of the target groups) and on the other hand it is not suitable to present the information we want to provide in this report.

⁸ Information source: YPSA, 2006 and 2007; GTZ/Chittagong City Corporation 2008; Human Rights Watch, 2003; Terre des Hommes, 2005; Interviews with YPSA Managers and Staff of drop in centre for sex workers in Chittagong; focus group discussion with female sex workers in Chittagong. Information quality: good

The poverty and human rights situation of female sex workers differs depending on the form of sex work they are engaged in. Most of the street-based sex workers are homeless, earn less income than residence or hotel-based sex workers, and are more frequently victims of arrests, as well as of direct physical and sexual violence. In Chittagong, there are an estimated number of 2.000 female street-based sex workers (YPSA, 2007).

In Chittagong, there are some common patterns characterising the situation of female sex workers:

- Choice is hardly ever a factor determining their entry into sex work. Gender-based violence, including trafficking of girls, coupled with income poverty, are the main determinants for sex work.
- Many girls and women come to Chittagong from the rural areas, to earn income for themselves or their families. Often, they were promised jobs in the city, for example as housemaids or garment workers. Upon arrival, they are being deceived, given sedatives, beaten or raped, and forced to engage as sex workers for a pimp. Other women have started working in the garment industry and engage into sex work for additional income, some are being forced to it by their husband.
- Sex workers try to hide their status from their family members, who remained in the village. If they can, they support them with their income.
- Many sex workers marry at least once if not more often. Their husbands are very often aware of their profession or/and are their pimps.
- Although many sex workers have the desire to “live a better life”, many remain in sex work. They see no alternatives to their current work, as they are considered and view themselves as “spoiled” and/or other jobs would not provide them with a comparable income.
- The knowledge of sex workers on HIV/AIDS and means of preventions has increased. However, their ability to negotiate condom use with their clients is still limited.
- Physical and sexual violence against sex workers by clients or by other persons such as the police and thugs (mastans) still is common. Interviews conducted during the PIA in Chittagong indicate that direct violence by the police has decreased in the last two years. Blackmailing and extortion still happens. Sex workers victims of abuse rarely complain or seek redress. YPSA’s drop in centre has referred a few cases to BLAST for legal support.
- Sex workers also face widespread stigmatisation and discrimination from neighbours and landlords.
- Sex workers fear using governmental health services, because of the lack of privacy and confidentiality.

Focus Group Discussion with female sex workers in Chittagong

(All women are working in facilities, such as hotels, coffee houses or pimp houses.)

“We try to negotiate condom use but it very much depends on our clients. Sometimes they accept, sometimes they refuse.”

“We often have to change our place of residence. When the landlords realise that we are sex workers, because we are going out at night, they throw us out. This can happen every 3 to 4 months. If we move far away, our children have to go to another school.”

“When we feel ill, we first go to a drop-in centre. At government facilities we have to wait for a very long time and we can not talk openly of our situation, because other women are listening.”

“We appreciate the drop-in centre because we can rest and meet other women. We would like to have a house where we could live in security with our children.”

Key factors in alleviating sex workers' living conditions include:

- Emotional and social support by peer counsellors or outreach workers;
- Access to sexual and reproductive health services, which respond to their specific needs and ensure privacy;
- Legal support and access to effective redress mechanisms in case of severe discrimination.

Apparently, a Sex Workers National Network was created a few years ago, with the aim of advocating for the human rights of sex workers and empowering them to claim their rights (Human Rights Watch 2003; Interview with NASP in Dhaka). In Chittagong, this network was not known. Whether at local level, formal organisations of sex workers are the adequate channel to raise awareness of human rights violations and promote their participation in decision-making processes, should therefore be carefully considered. In any case, it should be accompanied by other sensitisation activities to reduce their stigmatization in community and society.

Men having sex with men (MSM)⁹

To our knowledge there is no estimation of the number of men having sex with men, including male sex workers living in Bangladesh. Reliable information on their living conditions is hardly available.

The term “men who have sex with men”, usually encompasses transgenders (hijras) as well as homosexuals. There is a high stigma attached to sex between men in Bangladeshi society. Apparently, because they are stigmatised, many MSM face difficulties to find work and therefore engage in sex work.

De-jure discrimination of MSM still is present in Bangladesh. Section 377 of the penal code of Bangladesh criminalises men-to-men sex, which has been recognised by the Ministry of Law as being in violation of international law (Human Rights Watch, 2003), but has apparently not been reviewed since. In practice, the frequent arrests and abuses against MSM by police officials are being committed on other grounds, e.g. section 54 of the code of criminal procedure, which allows for arrest and detention without a warrant. There is also no law which specifically prohibits sexual violence against men.

A part from being arrested without being charged with any crimes, MSM are victims of serious human rights violations, such as extortion, abduction, physical assaults and sexual violence. The survey conducted by the MSHAP in Chittagong revealed an extremely high rate of surveyed MSM (69%), who had been raped in the last 12 months.

Drug users¹⁰

The exact number of DU and IDU in Bangladesh is not known. Estimates vary between 20.000 and 45.000. According to the Department of Narcotic Control there are approximately 5.000 IDU in Chittagong and a much higher number of Heroin Smokers¹¹. The vulnerability of DU, and particularly of IDU, to HIV/AIDS has been documented in several reports, including

⁹ Information source: Human Rights Watch, 2003; GTZ/Chittagong City Corporation 2008. Information quality: poor: quantitative data not sufficient, qualitative data comes only from one source.

¹⁰ Information source: NASP 2008; Care Bangladesh 2006; Human Rights Watch, 2003. Interviews with 4 NGO's working with DU (3 in Chittagong, 1 in Dhaka); Interview with DNC in Chittagong; Focus Group Discussions with male Ex-DU and street-based male IDU in Chittagong. Information quality: good, although primarily qualitative data.

¹¹ According to the DNC up to 1 Million in Chittagong and 4 Million in Bangladesh; this seems very high.

surveillance surveys. It is mainly due to unsafe injections and risky sexual behaviour. Among male IDU in Dhaka City, HIV prevalence increased from 1.4% in 1999 to 7.1% in 2006. Observers of the drug scene in Bangladesh agree that drug use has been increasing in recent years. Drug use patterns are subject to frequent changes depending on the availability and the price of drugs on the market. Drug addicts usually start taking drugs such as cannabis, alcohol or phensidyl (cough syrup), then tend to switch to heroin smoking. If heroin is not available or if it becomes too expensive, drug addicts often shift to injecting drugs (usually buprenorphine or mixed cocktails).

All our interview respondents, both persons in close contact with DU and DU themselves, concurred in the view that *“poverty is not the cause for drug addiction, but drug addiction leads to poverty.”* Drug use is spread across all social classes, but middle-class and poor drug addicts are more likely to slide into poverty, once they have started to take drugs.

A “typical” career of a male IDU in Chittagong shows the following pattern:

- He starts taking drugs when he is at school and does not complete his education.
- The reasons leading to drug use are manifold and include psychological and social factors such as peer pressure, curiosity and interest to try something new, difficult family relationships, dissatisfaction with one’s own life.
- If he is employed, he loses his job after a while because of his drug addiction and of the lack of acceptance of employers towards DU.
- At the beginning, he pressures his family to give him money for drugs and then starts stealing. Other family members often do not disclose the status of their addicted son or daughter as they fear stigmatisation (for example they fear that no man would marry the sister of a drug addict).
- If he loses the support of his family and is thrown out of the house, he very often finds himself on the street.

Street-based DU (most of them are IDU) live from casual activities, such as collecting and selling garbage or selling their blood. Due to their addiction and the stigmatisation they face, they have lost virtually all control over their lives. Society still considers drug addiction as a crime rather than as a health problem. Acceptance for needle and syringe exchange activities, which would lessen the vulnerability of IDU to HIV infection, is still low in Chittagong. The common perception is that drug users are “bad”, and that giving them free needles would only promote drug use.

Street-based IDU are particularly exposed to human rights violations, such as extortion and beatings by police officials and mastans. They are rarely arrested on the grounds of the narcotic control act, which prohibits the possession of drugs, but also foresees treatment in a detoxification centre in case of severe addiction. IDU are normally brought to jail because of other assumed or real offences, such as stealing. It is commonly acknowledged that drug use is available and a big problem in prisons, but there is no support offered to imprisoned DU.

Those DU who succeed in recovering from their drug addiction usually go through a hard process of detoxification, rehabilitation and social reintegration. In both rehabilitation centres we visited in Chittagong, the recovery rate after rehabilitation was estimated at 60% on average, and much lower for IDU.

Apart from a strong individual will to overcome drug addiction, key factors for a successful recovery are:

- Financial support of the family: Often families bring their sons to a rehabilitation centre, because they see no other alternatives and prefer to pay the cost of a 4-5 month

rehabilitation programme (approximately 30.000 Tk) than to continue paying for the drugs.

- Social support of the family after in-centre rehabilitation: Drug users often have not completed their education, have no skills, and have difficulties to find an employment. Families often fear a relapse and are reluctant to take them back.
- Peer support: Self-help groups of ex-DU give social and emotional support to their members, especially when they are depressed and think of taking drugs again.

It takes a long time for DU to be accepted and included again as a full member of their family and community.

Focus Group Discussion with 9 ex-DU in Chittagong

The 9 members of the focus group on the average have 5-6 family members, 4 are married, two before, two after recovery.

“During the addiction period, family abandons us, after recovery they neglect us. Our opinion is not respected and valued.”

“Neighbours and old friends don’t believe us, they rather ask us when we will start again taking drugs. Neighbours still think that we are not trustworthy, even after many years of recovery.”

Some ex-DU were jailed during their recovery period because of old accusations before treatment. “That is dangerous because to avoid taking drugs in jails is particularly difficult, jails are full with drugs. There is no support in prison.”

In some cases family members (wife), friends and the ex-DU network helped. But they also fear being totally abandoned if they start taking drugs again and it helps them to remain clean.

Female drug users ¹²

There is no reliable information on the number of female DU and IDU in Bangladesh. According to some sources, drug use seems to be increasing amongst women (CARE Bangladesh, 2006; PIA interview partners).

A survey conducted among 130 female IDU in the Dhaka region found that 2/3 were also sex workers. Most lived in slums (50%) or on the street (29%). Both sex workers and non-sex workers had experienced sexual violence and being jailed, although this was more common among sex workers. The survey suggests that, due to their injection and sexual risk behaviours, female IDU are extremely vulnerable to HIV/AIDS and may represent “transmission bridges” to the general community (Azim, 2006).

In Chittagong, a significant number of female DU, e.g. heroin smokers, also seem to be engaged in commercial sex (GTZ/Chittagong City Corporation, 2008). According to interview partners, once women have started taking drugs, their situation is particularly difficult. They often lose the support of their family and become street-based DU and sex workers. They are also often harassed by the police. They come to the drop-in centres and desperately ask for detoxification and rehabilitation, but up to now there are no rehabilitation facilities for female DU in Chittagong.

¹² Information source: Care Bangladesh 2006; GTZ/Chittagong City Corporation 2008; Azim, 2006. Interviews with NGO working with DU and IDU in Chittagong and Dhaka. Information quality: poor.

3.1.2 People living with HIV/AIDS (PLWHA) ¹³

According to UNAIDS estimates based on sentinel surveillances, approximately 11.000 Bangladeshis could have been living with HIV/AIDS at the end of 2005. A significant number of HIV/AIDS infections are either not known or not reported. By the end of 2007, only 1207 cases were officially known by the MoHFW (NASP, 2008).

Since its foundation in 2000, AAS has registered in its branches of Dhaka, Sylhet and Chittagong a total of 518 members living with HIV/AIDS, of which 364 are still alive. Among the members alive, 211 are male adults, 128 are female adults, one is a transgender adult and 24 are children. Approximately 95% of all members consist of returned external migrants, their wives and/or their children. The remaining members (5%) are commercial sex workers and drug users. In Chittagong, a few members are female garment workers.

Most members belong to poor population groups. Upper class PLWHA usually do not register as members, as they have the means and manners to hide their HIV+ status successfully and have access to treatment. Middle class PLWHA often refrain from becoming full members as well, because in their view AAS is an organisation "for the poor". However, they do come and ask for drugs.

Most male members were deported from their country of work (mainly Middle Eastern and Gulf countries) because of their HIV+ status and consequently lost their job. Apparently, many were not informed of their infection, and, after they came back to Bangladesh, spent time and very often all their savings and income in trying to diagnose and treat their illness.

Focus Group Discussions with male and female PLWHA in Chittagong

"I was outside our country in another one. There I got unwittingly involved in some riot and was arrested and had to go to prison. There my blood was taken and tested, without ever having been informed about the results of the test. Then I was isolated from the other prisoners without getting an explanation why. The other prisoners had been advised not to speak with me. A little later I was deported home. The only reason they gave me was: "You have bad blood". When I returned to my home village, the rural doctor there did normal blood tests (without testing it on HIV) and all the other results were almost normal. Then I moved to Chittagong. There I saw another doctor, he did tests an HIV, but did not disclose his finding that I am HIV+ to me. Instead he sent me to another doctor who made me stand naked in front of him and did this and that examination but told me nothing. Only after that I met the doctor of AAS and learned what was wrong with me."

"I felt generally sick and became thinner and went to see a doctor. He could not give me an answer and sent me to another doctor. He again made some tests and could not tell me anything. So I was passed on to some more doctors, always with the same (non-) result. Only the last one of these who had tested my blood suspected that I was HIV+ but he did not tell me. But he informed my wife, not me, that another HIV-test has to be done. After two other tests done in Chittagong, I received a report with test results which I could not understand and was referred to the AAS. They finally sent me to the Central Military Hospital (CMH) in Dhaka where the CD4-test was done and my HIV+ status confirmed."

"My husband was working in Muscat. He became ill and was sent back to Bangladesh. He did not know that he was HIV-positive. He went to India four times to treat his illness, sold his property and lost all his money."

Once their HIV+ status is disclosed, it is very difficult for them to find an employment. Most members are therefore dependent on the financial and social support of their family.

Focus group discussions with male and female PLWHA in Chittagong

2nd round of discussion with male PLWHA: "What is now your economic situation, your income?"

¹³ Information source: UNGASS 2008; Newspaper (Daily Star) Articles; Interviews with AAS; Interview with Dr. Serajul Islam; FGD with PLWHA in Chittagong. Information quality: as good as possible due to significant underreporting of HIV/AIDS cases, primarily qualitative information.

yyy is staff of AAS. All the others are jobless. One is working as a farm labourer on someone else's land. They have some precarious income here and there. They are discriminated if their HIV-status is known and therefore hardly find any employment.

"My husband was working in Dubai. We both are HIV+. We have two children, they are not infected. My family in law did not want to help us, after they heard that my husband is HIV+. Now we are living in the house of my sister. My sister and my sister's husband are supporting us."

The access of PLWHA to treatment and care is still extremely limited for two reasons: the high cost of ARV-drugs coupled with irregular supply, and the widespread discriminatory attitudes of health professionals.

Approximately less than 15% of the estimated number of those PLWHA who would require ARV treatment receive it (NASP, 2008). Most PLWHA can not afford to buy ARV-drugs, which cost between 7.000 and 8.000 Tk monthly on the free market. They therefore depend on the drugs provided irregularly by NGO such as AAS.

AAS and other sources report that HIV+ patients are still routinely denied access to health facilities and services, even for simple treatment, which concurs with the views of the PLWHA we talked with.

Focus group discussion with male and female PLWHA in Chittagong

3rd round of discussion with male PLWHA: PLWH are refused when seeking treatment and attention from any public services and often are simply told "go home" ("get lost" in the literary sense).

"A while ago, my husband was ill and needed treatment in a hospital. The doctors refused to treat him. The doctors told him: We will bring you to the police or to the jail and they will shoot you." At that point other women said this happened to them as well. "Doctors and nurses never want to treat you if they know you are HIV-positive."

Stigmatisation and discrimination at family and community level can take the following forms:

- PLWHA are discredited and looked upon as bad and dangerous;
- PLWHA have no decision-making power in their families;
- PLWHA are deprived of their property or/and heritage by other family members;
- Neighbours avoid any social contact with PLWHA;
- Children of PLWHA are excluded of social contacts with other children.

Focus group discussion with male PLWHA in Chittagong

xxx tells sobbing and crying about the discrimination and humiliation by his own family. He had once supported his sister financially when she got married but when he needed her help because he had got HIV, she rejected him. (*Many such nasty episodes were briefly mentioned by others like exclusion of their children from social contacts with other children, extortion of money and mentally blackmailing them and other HIV+ members of the family*). They also experienced fierce and sometimes violent discrimination by neighbours and the community around them. Example: One who was a vegetable seller in the mARkEt was physically driven away, everyone was told not to buy anything from him etc.

Women living with HIV/AIDS face even more severe discrimination. They are often blamed for having brought the virus to the family, not their husband, who usually infected them. According to AAS, male PLWHA often do not bring their wives with them, when they come to

the centre for monthly check-ups. It needs a lot of efforts from AAS to convince them to do so. Once their husband dies, women often lose the support of their family in law.

Focus group discussion with female PLWHA in Chittagong

“Both my husband and myself are HIV+. I have one son, who is not infected. My husband lives in the city, I live in the village with my family in law. First my family in law did not even want to eat with me and to share their food. Now their behaviour is a bit better. But they do not accept my child and are rude to him (she starts crying). The neighbours do not know. I sometimes get money from my brothers, who are living in Dubai.”

“At the end my husband knew that he had HIV/AIDS, he told his family but did not tell me. I am now a widow and live with my family in law. I have three children, they are not infected. First my family in law treated me rudely. Ashar Alo talked to them and their behaviour improved. “

“I was married as a second wife. My husband died in 2005. His first wife died as well. After my husband died my family in law rejected me. I did not inherit anything. My father in law took all the property of my husband. I went back to my family and now live with my brother. They accept me because I do all the household work. When I am sick and can not work they do not talk to me (she starts crying). Sometimes I think of leaving, but where to go? I then hate myself and want to die. The only thing that helps a bit is the counselling of Ashar Alo Society, than I feel a bit better.”

At that point, other women said they also at times have thought of committing suicide.

“My husband died three months ago. I live with my family in law but they do not talk to me (starts crying). My family in law told other neighbours: Do not talk to her, she is a bad woman. My sister in law tells me: You are a bad woman, because of you my brother died. I am Hindu. My family in law is afraid that Muslim families in the community will reject them, because they would think Hindus have brought the disease to the village. My sister tries to support me from time to time. “

Under these circumstances, most PLWHA feel quite powerless to fight the discrimination they experience from nearly everybody around them. They are outcasts.

Key factors in bringing them relief and helping them to gain more control over their lives (in the PIA terminology to raise their socio-cultural and protective capabilities) are:

- Interventions of AAS to sensitize the family and community to HIV/AIDS and the situation of PLWHA;
- Peer counselling and peer support through AAS.

Focus group discussion with female PLWHA in Chittagong

“I am a widow since five years. I have 4 sons and 2 daughters. 2 of my children are also HIV+. I live with my family in law. First they treated me very rudely. I have no money, I sold my property. Sometimes I get money from the neighbours. They know I am HIV+. At the beginning I faced many problems, but AAS talked to my family in law and my neighbours and things improved.”

“Counselling helps us. We are always looking forward to the members' day, because we can meet other HIV-positive women and talk to them. We can also talk to the counsellor. It is sometimes difficult to convince our families or families in law that we want to leave the house and go to Ashar Alo. If Ashar Alo talks to our families, it makes things better.”

In our discussions, PLWHA also expressed their need to:

- have regular access to affordable ARV-drugs;
- have the possibility to work and earn an income.

The first option would certainly, at least in the short and middle term perspective, lessen their vulnerability to the disease and increase their human and protective capabilities. The second option (raising their economic capabilities through direct income-generating activities) should

be considered with caution, due to its limited impact on the social context, in which PLWHA are living. According to AAS, income-generating projects for PLWHA usually have very limited success.

3.1.3 Other vulnerable groups

These groups were not included in the PIA, but it seems important to consider them, either because of their vulnerable situation (street children) or because they are potential clients of sex workers.

Internal migrant workers¹⁴

Chittagong has a large population of internal male migrant workers, most often coming without their families from other cities or rural areas of Bangladesh. They work as port, ghat and godown workers or as rickshaw pullers. The survey conducted by the HIV/AIDS program in Chittagong City showed that on average 60% of the respondents belonging to these groups had commercial sex in the last six months before the enquiry. Their knowledge and use of effective means of prevention, e.g. condoms, is very limited.

Unmarried young people in the urban context¹⁵

There is until now little information about sexual behaviour before marriage in Bangladesh, partly because of a long-held assumption that unmarried young people do not engage in sex. However, studies and surveys conducted in the last decade indicate that sex before marriage, particularly among urban unmarried young men, occurs in Bangladesh.

According to a representative survey conducted in 2005, 22% of all young men aged 15-24 years reported having had premarital sex. Surveys conducted in urban surroundings suggest the occurrence of premarital sex among urban young men may be much higher, i.e. between 72 and 88% (GTZ/Chittagong City Corporation 2008; Haider et al. 1997). The survey conducted by the MSHAP in Chittagong indicates that a high proportion of unmarried students may be engaged in commercial sex. Their knowledge about HIV/AIDS and the proper use of condoms is very limited.

External migrants¹⁶

The number of Bangladeshis working abroad has been steadily increasing since the mid-1980s, and in 2005 reached a total number of around 3 Million. The main countries of destination are Gulf and Middle Eastern Countries and other Asian countries, such as Malaysia. Most external migrants are men with a poor economic background and a low educational level. Less than 5% of migrants are professionals, half of them are unskilled workers (Siddiqui, 2005). They migrate in the hope to earn enough money abroad to support their other family members, who usually remain at home.

To our knowledge, no study has been conducted yet on the sexual behaviour of external migrants in their country of work. The fact that nearly all HIV+ members of AAS are returned external migrants indicates that risky sexual behaviour occurs. To which extent they are exposed to the risk of being infected by HIV remains to be assessed, but we dare to assume that they are vulnerable, due to their lack of knowledge prior to their departure and to the existence of a commercial sex industry in the Gulf countries.

¹⁴ Information source: GTZ/Chittagong City Corporation, 2008. Information quality: poor

¹⁵ Information source: NSAP, 2008; GTZ/Chittagong City Corporation, 2008; BMZ, 2004; Haider et al., 1997. Information quality: poor

¹⁶ Information source: Siddiqui, 2005. Information quality: poor

Street children ¹⁷

Another major group so far not addressed, but at high risk to become the hard drug addicts and PLWHA of tomorrow are street children. The exact number of street children is not known but the estimated numbers circle around 500,000 in the five major cities out of which probably 200,000 live in Dhaka, thus far exceeding the highest estimate of 40,000 for the IDU of the whole country. According to the PIA interview partner, because they live in an extremely unsafe and unstable environment, street children are exposed to the risk of taking drugs (they often start in a very young age sniffing glue or taking sleeping tablets) and to risky sexual behaviour, quite often in contact with high-risk groups like sex workers, MSM etc. They are also often victims of harassment, violence and sexual abuse.

3.2 Intermediaries

The following description of intermediaries is based on interviews we had with their representatives, written material handed out, and in some cases on Focus Group Discussions (FGD) with their clients. There are two exceptions: We did not meet anybody of the ADB-funded Urban Primary Health Care Project (UPHC) and of a Migration Agency. The MSHAP is already cooperating with some of the intermediaries, with others we recommend to consider closer cooperation (mentioned at the end of each respective paragraph). The idea of cooperating with migration agencies needs closer scrutiny by the project; we could not explore that proposition made by returned work migrants.

3.2.1 NGOs working with and for High Risk Groups and PLWHA

Intermediary Organisation (1)	Main tasks of organisation with regard to MSHAP (2)	Interests and pro-poor agenda, aspects that might hinder them to have a pro-poor agenda (details and risks) (3)	Rating of their pro-poor agenda (4)	Mitigating and/or reinforcing measures (5)	Info - source and quality (6)
Young Power in Social Action (YPSA)	Chittagong based NGO for social development in general; in HIV/AIDS: Provision of services to sex workers and their clients	Committed to work with high-risk groups. Focus on services for sex-workers. Activities to reach clients and to enhance community support are still at the beginning. Risk: Big player in Chittagong, engaged in many other fields, sometimes resented by Government authorities.	+	MSHAP may facilitate coordination with Government health authorities. MSHAP may consider further cooperation for outreach work and reducing discrimination.	YPSA 2006 and 2007; Interviews with YPSA staff; visit of drop-in-centre. Quality: good
ARK	Chittagong based NGO (outside the city boundaries) for treatment of DU	Non-profit charitable NGO. Focus on treatment and rehabilitation of DU (who pay cost-covering fees), residential facility far outside CCC. City office for outreach work and counselling of families of DU.	0		Interview with founder and director; FGD with clients in treatment. Quality: good
Addiction Life Overcome (ALO)	Chittagong based NGO/SHG for treatment of DU	Non-profit charitable NGO/SHG of former DU turned clean. Focus on treatment and rehabilitation of DU (who pay cost-covering fees). Interest to start free program for poor IDU but no funds	0	MSHAP may facilitate links to central level (GFATM) to start program for poor IDU	Interview with founding director; FGD with active IDU.
Cooperation of American Relief Everywhere (CARE)	Chittagong drop-in centre for DU / IDU, prevention of HIV/AIDS	Committed to work with and for high-risk groups. Focus on services for IDU (needle exchange programme, self-help, detoxification etc.)	+	MSHAP may consider joint support with CARE to expand harm reduction programme, including community support component, for IDU in Chittagong.	Interview with CARE project manager in Chittagong, visit of drop-in centre for DU.
Centre for Rehabilitation, Education,	Dhaka based NGO working with male and female street-	Focus on treatment and rehabilitation of IDU and other DU (who pay cost-covering fees). Involved in public	0	MSHAP may consider closer contact for drawing on CREA's	Interview with founder members.

¹⁷ Information gathered from Brother Ronald Drahozal, C.S.C., Executive Director APON (Ashokti Punorbashon Nibash) in Dhaka. Information quality: good, but merits cross-examination.

Intermediary Organisation	Main tasks of organisation with regard to MSHAP	Interests and pro-poor agenda, aspects that might hinder them to have a pro-poor agenda (details and risks)	Rating of their pro-poor agenda	Mitigating and/or reinforcing measures	Info - source and quality
and Awareness (CREA)	based IDU and DU	HIV-campaigning (together with MRDI; cf. ch. 3.2.2). Close cooperation with APON (cf. line below).		experience.	Quality: Credible but no cross-check possible
Ashokti Punorbashon Nibash (APON) Addiction Rehabilitation Residence	Dhaka based NGO running treatment & rehabilitation centres for male and female DU	Very committed to work with high-risk groups. Focus on services for DU and street children that are seen as the DU and high risk HIV-people of the future. Cost of services free for those who can't afford to pay.	++	MSHAP should consider closer contact for drawing on APON's experience, in particular on the issue of street children.	Interview with Director of APON; written material. Quality: good

Ashar Alo Society (AAS)	NGO/SHG of PLWHA (acting nationwide)	Support HIV/AIDS infected and affected people for ensuring their well being, improving their quality of life, health care and creating a society that is free from stigma and discrimination. Providing most services free of cost to registered members.	+	MSHAP may consider intensified cooperation and networking in reducing stigma and discrimination of PLWHA	Interviews with staff members; FGD with male and female PLLWHA; written material. Quality: good
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KEY	Strength/direction impact	++	+	0	-	--
		very positive	Positive	not relevant	negative	very negative

Young Power in Social Action (YPSA)

YPSA is a donor-funded social development organization with a focus on young people, poor and vulnerable groups. YPSA primarily works in the Greater Chittagong Division (City Corporation and surrounding rural districts, including Chittagong Hill Tracts), but in recent years has extended its scope to other regions of Bangladesh. YPSA runs projects across virtually all sectors, such as education, health, water, disaster management, micro-enterprise and micro-credit. It has 282 full staff members and 180 part-time staff members, plus approximately 500 volunteers. Its health projects are mainly financed by Family Health International, GFATM and UNICEF.

YPSA's work with HIV/AIDS high risk groups is focused on providing prevention and treatment services to female sex workers, and to a minor extent to their clients. Activities include:

- Prevention (VCT, condom distribution) of HIV and STI and treatment of STI in two "Integrated Health Centres" (drop-in-centres).
- Through outreach workers and peer educators, information and behaviour change communication (particularly negotiation of condom use) as well as condom distribution to sex workers and, to a minor extent to their male clients.
- Provision of safe recreational facilities to sex workers in the drop-in-centres.
- Psychological and social support through counselling and referral of sex workers to legal aid organisations in case of severe discrimination.

According to YPSA, the project could so far reach 1.200 sex workers out of an estimated 2.000 in Chittagong City. This number seems quite high, in view of the fact that each drop-in-centre has 4 female peer educators and 1 male peer educator for the clients.

The challenges identified by YPSA in strengthening their pro-poor and human rights approach include:

- Enhancing community support for their services, in view of the widespread stigmatisation of sex workers.
- Strengthening work with clients and with pimps, to overcome resistance to use condoms, to get treatment for STI or allow sex workers to negotiate condom use.
- Supporting children of sex-workers to prevent them from becoming street-based sex workers.
- Enhancing cooperation with Government structures (“NGO should create demand for Government health services, but Government health facilities should be willing and prepared to provide them.”)

We recommend considering closer cooperation between the MSHAP and YPSA if and when it comes to outreach work with sex workers and their clients as well as enhancing community support for their services.

ARK

“ARK” is a non-profit charitable NGO founded in 2000 and accredited both by Social Welfare and Narcotic Control Department. ARK is offering rehabilitation (detoxication and support) to male drug users, mainly heroin smokers (so far about 1,200 DU, mostly heroin smokers, have been treated). Relapse quota is about 40%, recovery rate (stable) about 60%.

One residential rehabilitation treatment takes four months, each time about 50 men, but in a rolling scheme (not one batch after the other) 4 months in-house, last month more exposure to outside world. Support continues after the in-house programme through peer counselling by the “ARK”-centre for recovering drug addicts in Chittagong city and self-help groups. ARK has one city office for outreach work to counsel DU where they are (~ 15% of inmates come through this “channel” to ARK). Also family members of active DU can seek help from ARK. ARK also created and supported a self-help group of ex drug users.

After rehabilitation, ARK clients may participate in a self-help-network of former DU who communicate with active DU and try to persuade them to take treatment with ARK. These Self-help groups also help ex drug-users when they are depressed and think of starting again with drugs.

ARK clients come mainly from the middle class (60-70%), 10% from the upper class and 10% from the lower class.

Addiction Life Overcome (ALO)

The NGO started in 2002 as self-help-group of former DU; all members and the staff are ex-DU. ALO offers treatment of 4 – 5 months at a cost covering cost of 30,000 Tk per course to all kinds of DU. So far, they had only few IDU (~ 4 – 5 per year), whom they accept free of cost. The relapse rate with 35% is quite low, 65 % remain clean after treatment.

After treatment, ALO calls all ex-DU every month for consolidation meetings (offering some refreshments, so-called “party”). The “cleaned” DU are handed over to their families; most are adopted again. If families fail to accept and take care of the ex-DU, there is little hope for the DU.

ALO thinks there is a need to involve more IDU’s in rehabilitation programmes. The organisation apparently did approach donors in this regard but without success. The MSHAP could consider facilitating links between ALO and funding mechanisms at central level, e.g. GFATM, to increase support for the rehabilitation of IDU.

Cooperation of American Relief Everywhere (CARE)

CARE has already extensive experience with harm reduction and HIV/AIDS prevention in Bangladesh (CARE, 2006). The project in Chittagong was created by Mary Stopes in 2004, than Care Bangladesh took over. Project staff consists of 7 persons: 1 coordinator, 2 assistants (one is a medical assistant), 5 outreach workers (3 are ex-IDUs, 1 is IDU, 1 is a non drug user), 2 cleaners.

The project has an advisory committee of 7 members consisting of the “elite of the neighbouring community”, e.g. landlords, house owners, and religious leaders. The main role of the committee is to increase acceptance in the community for the activities of the project. DNC in Chittagong de facto has accepted the programme incl. needle exchange for IDU and knows what is going on. CARE Bangladesh is addressing this issue at central level through advocacy. According to the coordinator, sensitisation of society and community in Chittagong is still very important (most think that drug users are bad and that giving them free needles will only promote drug use).

The project currently covers 8 areas. Some areas with a high concentration of drug users (e.g. port) are too far from the drop-in centre and therefore not included. The project currently has listed 450 DU, approximately 50 are women, 32 are IDU. The latter figure seems extremely low, considering the fact that there are currently no other harm reduction activities for IDU in Chittagong.

Activities include:

- Counselling of drug users in the centre or by outreach workers (for HIV testing drug users are referred to Ashar Alo Society or ICCDR,B).
- Provision of condoms and syringes/needles free of charge.
- Treatment of STI (syndromes management) and abscess treatment.
- The centre has a room where drug users can rest during day time (until 16:00). There is no separate room for women.
- Last year the project used the room of the Department for Narcotics Control (DNC) and conducted a two week detoxification for 5 drug users together with the doctor of the DNC. After detoxification the drug users were referred to ARK for the 4 month rehabilitation programme. This activity was facilitated by GTZ.
- Sensitisation meetings at community level (once a month).
- Two so-called “Narcotic Anonymous” meetings facilitated by one counsellor per month for recovering drug users. The aim of these meetings is to initiate peer support and self-help.

We recommend that MSHAP generally continues to cooperate with the CARE-project with the aim of expanding its harm reduction programme, including its community support component. MSHAP may also consider the proposal to support / improve / expand the small detoxification unit of the DNC in Chittagong together with CARE and in particular to open up that facility for women, too.

Centre for Rehabilitation, Education, and Awareness (CREA)

CREA started in 1999 and is based in Dhaka. The driving founder member is Dr. Baquirul Islam Khan, nowadays Project manager with the Grameen Bank. The NGO provides three months treatment for and VCT with regard to HIV. CREA provides a 90-day residential detoxification and rehabilitation service at no charge to street-dwelling, needle-sharing, male and female IDU who, on their own, never could afford such treatment.

To give the cleaned-up drug users a better chance to stay drug free after treatment, the programme (together with FHI), called *Modhumita* - Bengali for "sweet friend" - has linked up with Jobs Opportunity and Business Support (JOBS), an organisation originally funded by USAID to develop business and expand employment in Bangladesh. JOBS helps those who

have gone through the 90-day program to find work, decreasing the number who relapse after treatment.

FHI has estimated in 2004 that there are 6,000 – 8,000 IDU in Dhaka and about 45,000 DU, mostly heroin smokers. The capacity of CREA is to treat about 40 clients per month. They are self-financing by fees of 12,000.- Tk per month. DU wanting treatment but not being capable to pay for the cost of rehabilitation are referred to APON (see below).

In cooperation with MRDI (see below, ch. 3.2.2), CREA is involved in public HIV-campaigns (posters, TV, newspaper articles etc.) that are undertaken since about 4 years. CREA believes that good examples are necessary to reduce discrimination and fears of people.

Ashokti Punorbashon Nibash (APON)

APON, established on 1st Oct. 1994 is a local NGO based in Dhaka. It is registered with NGO Affairs Bureau, The Prime Minister's Office and with the Department of Narcotics Control, Ministry of Home Affairs and affiliated with Asian Federation of Therapeutic Community (AFTC) as Life Member. APON applies a rehabilitation program, adapting the Minnesota Model for drug addicts, using the principles of the 12 Step of Alcoholics/Narcotics Anonymous Program, Therapeutic Community and other related activities.

APON is the only NGO in Bangladesh that offers professional treatment services to female DU, too. More information is available on APON's website www.aponbd.org .

The services APON is offering to all DU who want to become clean include:

- Provision of drug dependency treatment and rehabilitation services and make it readily available and accessible for the users.
- Dissemination of information on drug addiction, treatment and rehabilitation, STI, HIV/AIDS, Hepatitis B, C and other drug related harms through
 - IEC material and awareness programme;
 - Outreach activities and peer led intervention.
- Provision of basic education, skill training and other relevant knowledge for employment of the recovering drug users.
- Provision of aftercare and follow up services for the recovering drug users
- Advocacy at the national level to establish the legal rights of the drug addicts for treatment services as mentioned in the Narcotics Control Act (1990).

The capacity of APON at present is to offer services to about 200-240 male DU, about 120 female DU and about 90 children per year. APON receives funding from various sources (FHI et al.), including donations from the commercial sector (Dutch-Bangla Bank, one mobile phone company). The total expenses at present are about half a million Tk (~ 5,000.- €) per month. DU contribute to the cost of their treatment according their capabilities to pay.

APON appears to be the most professional and experienced NGO for DU we have visited during our mission. The driving force is its Director, Brother Ronald Drahozal. **We recommend** establishing closer contacts for exchange of experience between MSHAP and APON, in particular if and when it comes to identify practical possibilities to work on the linked problems of drug abuse, street children and HIV-prevention.

Ashar Alo Society AAS

AAS is a, registered NGO and self-help organisation working for rights, support, care, empowerment and greater involvement of PLWHA in Bangladesh. Its ultimate goal is to support HIV/AIDS infected and affected people for ensuring their well being, improving their quality of life, health care and creating a society that is free from stigma and discrimination.

AAS was founded in 2000 with the support of Christian Commission for Development in Bangladesh (CCDB). AAS started working as the first independent self-help group of PLWHA in Bangladesh since 1st January 2002 with the support from FHI. Afterwards, AAS has been receiving financial support from UNDP (Regional HIV & Development Programme), UNICEF, CCDB, Action Aid Bangladesh, HASAB, CAFOD, Tides Foundation and FHI.

Besides Dhaka, AAS has gradually expanded its projects areas in Sylhet, Chittagong, Rajshahi, Jessore and Khulna districts.

AAS focuses on the following activities:

Free services for PLWHA and MARP, including Voluntary Counselling and Testing (VCT), monthly check-up (travel allowance for members is provided) for PLWHA, treatment of opportunistic infections, ARV treatment if available.

Peer counselling and social support (e.g. discussion with families to create acceptance of HIV/AIDS status of member and awareness of his/her needs regarding care), life skill training at very limited scale (amongst others in claiming the right to get treatment from public health services, how to try to motivate service providers not to refuse PLWHA.)

Information, Education, Communication (IEC), Community sensitisation: If members face stigmatisation and discrimination in their community, AAS organizes meetings with community (e.g. awareness rising on HIV/AIDS and ways of transmission). AAS also does some information sharing with high risk groups (e.g. explaining that one can live longer with HIV/AIDS if properly treated.) According to AAS, after these sessions more persons of high risk groups come to VCT.

Advocacy: AAS conducts advocacy towards Government so that they engage more in service provision. But according to AAS, this is very difficult, as government officials and NASP attach more importance to prevention and do not understand that treatment and support is also important for prevention. Media also do not take HIV/AIDS seriously enough and no strategy of broad information of the general public exists.

Training: Focus on health service providers and journalists.

Recently, AAS has linked a national level with with the women lawyers association and Ain o Salish Kendra (Human rights organisation) to document and investigate more systematically on human rights violations (e.g. denial of services to PLWHA).

The staff of AAS presently is a combination of HIV positive and non-positive persons. PLWHA members also take part in different major activities such as peer counselling, peer education, community sensitisation meetings, positive speakers bureau, experience sharing with MARP. AAS apparently enjoys a good reputation and some of its leading members seem to command some influence in advocacy of their case.

We recommend considering closer cooperation between AAS and MSHAP if and when it comes to working against stigma and discrimination of MARP, IDU and DU, PLWHA.

3.2.2 NGOs promoting Human Rights

Intermediary organisation (1)	Main tasks of organisation with regard to MSHAP (2)	Interests and pro-poor agenda, aspects that might hinder them to have a pro-poor agenda (details and risks) (3)	Rating of their pro-poor agenda (4)	Mitigating and/or reinforcing measures (5)	Info - source and quality (6)
Community Development Centre (CODEC)	Community Development of coastal communities	Focus on capacity development of poor and disadvantaged communities; human rights-based approach integrated in programme. Constraint: Focus on coastal and rural area, limited experience with HIV/AIDS issues	+	Experience in human rights-based and community development approach could be further assessed and used for HIV/AIDS programme	Discussion with management staff; project documents and publications, no possibility to crosscheck information (more scrutiny req.).
Bangladesh Legal Aid and Services Trust (BLAST)	Legal aid to the poor and disadvantaged groups	Focus on poor and disadvantaged groups, legal knowledge and experience in human rights education. Constraint: awareness raising activities focus on rural areas surrounding Chittagong; limited resources to expand activities	+	Facilitate links between BLAST and other NGO's working in health and HIV/AIDS sector; assess capacities and possibilities to support BLAST awareness raising activities in slums	Interview with coordinator, documents and newspaper articles on BLAST, no possibility to cross-check the information given (more scrutiny required).

Community Development Centre (CODEC)

CODEC was founded in 1985. Mainly funded by Danida, CODEC has since provided support to marginalised coastal communities, particularly the low caste Hindu Jalalas, in the southern part of Bangladesh. Originally, CODEC followed a community development and social mobilisation approach, by forming committees in rural areas, supporting them to assess their basic needs and to improve their living conditions by self-help activities.

The aim of its current programme (2007-2012) is to facilitate the participation of coastal communities in five districts (including Chittagong area) in development processes and in the realisation of their social, cultural and economics rights. CODEC explicitly **follows a human rights-based approach** by:

- Providing information and awareness raising on human rights in the community
- Initiating and facilitating behaviour change communication on issues such as harmful traditional practices (e.g. early marriage), child labour or violence against women
- Facilitating access to legal aid services
- Facilitating links between community-based organisations and Government and NGO service providers
- Advocating to ensure that rights and needs of disadvantaged coastal communities are considered in the implementation of the PRSP

CODEC itself does not engage in service provision, because according to its director, "it is not sustainable" and "Government should not be relieved of the pressure to deliver services to the poor."

HIV/AIDS is up to now not in the focus of the organisation, but is apparently integrated in health awareness activities.

Bangladesh Legal Aid and Services Trust (BLAST)

BLAST was founded in 1993 by lawyers as a not-for-profit trust with the aim of making the legal system in Bangladesh accessible to the poor and disadvantaged. BLAST now has 19 units throughout the country. It receives financial support by several donor agencies, the main sources being DFID and the Royal Norwegian Embassy.

BLAST conducts the following activities:

- Education and awareness-raising among disadvantaged groups, particularly women, in slums and rural areas;
- Free legal aid for the poor (litigation at court) in such areas as labour rights, discrimination of and violence against women, land and property rights, abuse by police and law enforcement agencies;
- Advocacy at national level on legal and human rights of the poor.

In Chittagong, the staff consists of 9 persons, of which 4 are lawyers. If a case is forwarded to its legal aid clinic, BLAST staff first tries to solve it by mediation (salish). If mediation proves to be unsuccessful, the case is filed and brought to the court. BLAST has not yet filed a case of discrimination against HIV+ persons, but has given sex workers legal aid in cases of domestic violence.

BLAST also conducts awareness-raising and sensitization activities on human rights in the rural areas surrounding Chittagong. It follows an approach called “a right to know” to provide basic and understandable information on topic-related rights. To this extent, BLAST cooperates with other NGOs and community-based organisations and uses their structures to deliver information. According to the coordinator of the Chittagong unit, BLAST has not yet addressed the issue of discrimination of PLWHA and high-risk groups (the issue has not yet been brought to their attention) but would be willing to do so.

Another organisation providing free legal aid to poor and marginalized groups is Ain-O-Shalish Kendra. Apparently, it has recently concluded an agreement with UNAIDS to assist HIV high-risk and vulnerable groups to protect their legal rights (UNGASS 2008). Up to now, it has no structure in Chittagong.

We recommend facilitating the links between NGOs providing services and NGOs promoting human rights and use their experience to address discrimination and stigmatisation.

3.2.3 Organisations suitable for networking and public campaigns

Intermediary organisation (1)	Main tasks of organisation with regard to MSHAP (2)	Interests and pro-poor agenda, aspects that might hinder them to have a pro-poor agenda (details and risks) (3)	Rating of their pro-poor agenda (4)	Mitigating and/or reinforcing measures (5)	Info – source and quality (6)
Chittagong Women Chamber of Commerce and Industry (CWCCI)	Skill development, leadership development, legal aid, empowerment of female member entrepreneurs and their staff	Economic empowerment of women and advocacy. Strong SME-orientation and counselling / training of members in all aspects of business aspects but also in general social issues.	0	MSHAP may explore using the networks of the CWCCI for awareness raising campaigns (e.g. through beauty parlours and other small women enterprises).	Visit of the CWCCI, interview with the lady president. Quality: good, but needs to be verified
Bangladesh Garment Manufacturers & Exporters Association	Implementation of all legitimate rights and privileges of garment workers regarding health,	BGMEA is interested in healthy workforces of their member. They do not have a particular pro-poor agenda. But they are facilitating awareness raising activities within	0	MSHAP should continue the approach to raise HIV awareness in garment factories through theatre	Website. Quality: insufficient.

Intermediary organisation	Main tasks of organisation with regard to MSHAP	Interests and pro-poor agenda, aspects that might hinder them to have a pro-poor agenda (details and risks)	Rating of their pro-poor agenda	Mitigating and/or reinforcing measures	Info – source and quality
(BGMEA)	welfare and safety. (= BGMEA's own secondary mission statement).	the workforce.		performances (cf. UTSA below) and consider other additional activities and follow-up	
Unite Theatre for Social Action (UTSA)	Theatre group for raising awareness on social issues	The group is interested in getting commissions; at the moment, MSHAP has hired them for HIV sensitisation performances in garment factories. They seem to be socially engaged actors.	+	Explore possibilities to employ UTSA and possibly other similar groups for sensitisation against HIV discrimination in slums etc.	Observation of one performance in a garment factory. Success needs to be evaluated.
Islamic Foundation Bangladesh (IFB); Chittagong Division	Training of imams on social problems, amongst others on reproductive health and HIV/AIDS	Apart from the general orientation of Islam towards poverty, IFB has no specific pro-poor agenda. The training they offer to imams once per year is insufficient (in their own judgement).	+	Explore possibilities to support and improve the training of imams regarding HIV/AIDS prevention.	Interview with the Chittagong Divisional Director. Quality: poor, to be further explored.
Migration agencies	Recruitment of migrant workers	No pro-poor or human rights-based agenda; risk: informal and profit-oriented recruitment structures hinder effective information of migrant workers.	--	Identify formal structures willing to cooperate in raising HIV-awareness of migrant workers before going abroad.	Siddiqui 2006, FGD with PLWH. Quality: very poor, information to be verified.
Management and Resources Development Initiative (MRDI)	Commercial (?) organisation in journalism and information dissemination	MRDI is producing and collecting/ analysing newspaper clips on various issues, also HIV/AIDS, to contribute to quality journalism. They claim to have a useful network of public opinion makers including training of Imams and journalists.	0	MSHAP may consider cooperation if and when it comes to addressing opinion makers and/or the general public on HIV/AIDS etc.	Brief discussion with one adviser (Md. Shahid Hossein). Information poor, to be verified.

Chittagong Women Chamber of Commerce and Industry (CWCCI)

The CWCCI is the creation of a charismatic lady entrepreneur (Mrs. Monowara Hakim Ali), who is a flamboyant and energetic self-made woman with a mission. Due to her own personal history (born into a conservative entrepreneur's family, her own experience as having been looked upon as a minor being and having successfully struggled to become an independent entrepreneur of her own), she has a strong motivation and, as it seems, the capability to empower other women. She is President of the CWCCI.

At present, the organisation has about 450 paying members. They can draw on getting support services like business development, technical advice, networking, skill improvement training, marketing, getting access to finance and legal aid. The president reacted positively to the idea to sensitise small business women, in particular beauty parlour owners and their clients, in health and specifically in HIV/AIDS and STD issues.

We recommend exploring this opportunity further if and when it comes to activities reducing the stigma and discrimination of MARP and PLWHA.

Bangladesh Garment Manufacturers & Exporters Association (BGMEA)

The BGMEA commenced activities in the late 1970s when the Bangladeshi readymade garments (RMG) industry was a negligible non-traditional sector with a narrow export base. Since its inception, the BGMEA has been working to promote and protect the interests of the RMG sector - it has helped boost RMG exports by 500%, allowing Bangladesh to become one of the chief RMG exporters worldwide. (More detail on website <http://bgmea.com.bd>).

The BGMEA set up its regional office in Chittagong in 1985. Chittagong is a strategically important commercial port and the gateway for all RMG exports.

The primary mission objective of the BGMEA is to establish a healthy business environment for a close and mutually beneficial relationship between the manufacturers, exporters and importers in the process ensuring a steady growth in the foreign exchange earnings of the country.

The secondary mission objective is to implement all legitimate rights and privileges of garment workers regarding health, welfare and safety. Referring to this mission statement, **we recommend** continuing the cooperation with BGMEA in activities to reduce stigma and discrimination of MARP and in preventing HIV infections through awareness raising, eventually by new activities complementary to the UTSA-theatre performances that are at present being shown in the garment factories.

United Theatre for Social Action (UTSA)

United Theatre for Social Action (UTSA) was launched in 1997 with a view to bring various social injustices on the stages. UTSA aims at developing a series of theatre units that serve specific social issues. Thus UTSA tries sincerely to create social awareness in the minds of people.

UTSA has established as many as 23 such type of theatre units. Some of the important ones are theatre units for various issues, such as psychodrama and theatre therapy for rehabilitation of the drug addicted, prisoners, prostitutes, working children, working women and many other socially disadvantaged groups. UTSA considers theatre as a powerful medium of moulding public opinion and of popular instruction.

UTSA is also engaged in theatre therapy, i.e. dealing with mentally retarded and physically handicapped patients. (More detail on website www.utsa.up.to)

Islamic Foundation Bangladesh (IFB); Chittagong Division

Islamic Foundation = supervisory body of the Government (~ “Ministry” for religion)

IFB is running a “Human Resource Development Project” to educate Imams to talk about HIV/AIDS (and other topics of family planning, gender etc.). There is one training course per year of four days. The training is funded by UNFPA. The training schedule was prepared with their assistance. According to the Divisional Director, trainings should take place more frequently. Funding is too small, participants get only 300 Tk/day including accommodation and per diem.

In the training schedule are, amongst others, the following sessions of one hour each:

- Definition and general information about STD and HIV/AIDS, their transmission and prevention (*by following the rules of Islam*).
This session is held by a specialised medical doctor from one of the two Chittagong Government Hospitals.
- Reproductive Health: What are the duties of men and women to maintain good reproductive health?
- Human Rights: What are the rights of women, what says the Quran?
- What is the role of women in social life, in the labour world?
- Gender: What is the situation in the society about men & women? Violence against women.
- Adolescent health.

There is some reporting back of the imams about what they were teaching in the mosque. Occasionally the IFB also sends agents around to observe what the Imams say. The monitoring and follow-up is “not systematic.” When imams give a message on HIV/AIDS, they usually tell people that HIV/AIDS comes from bad and immoral behaviour and that it is important to behave according the rules of Islam. They also say that one has to fear HIV/AIDS.

The sensitisation of the Islamic Foundation division should be continued, so that at least the staff in the Chittagong Division is more aware of HIV/AIDS.

We recommend that options for more intensive cooperation (e.g. in the training programme for imams) should be carefully explored. However, there are two risks: First the training programme could be misused, if it is not well designed and properly monitored. Second, critique by radical islamists, perhaps not in line with the official religious interpretation of the Islamic Foundation, could be voiced, once these groups hear of the programme. Therefore, before starting such a training programme, the political context (e.g. possible conflict between radical islamists and Islamic Foundation) should be analysed more thoroughly and talks held with the Islamic Foundation head office in Dhaka.

Migration Agencies

In Bangladesh, the main Government institution responsible for the management of international labour migration is the Ministry of Expatriates’ Welfare and Employment. Among others, it has the responsibility to address problems experienced by migrant workers and to ensure their welfare. From the 1980’s onward, private agencies under licence of the government carry out the recruitment of migrant workers. They are organised under the Bangladesh Association of International Recruiting Agencies (BAIRA), which was founded in 1984 and had a membership of around 700 agencies in 2002. At local level these agencies mainly work through a network of informal agents, who often engage in illegal practices and fraud, e.g. selling visas at a high price.

The protection of the human rights of migrant workers in their main countries of destination is particularly difficult as none of these countries have signed the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (ICMW). Bangladesh has concluded a number of bilateral agreements with labour-receiving countries, which include the respect of basic standards regarding work and social protection (including medical care). However, these agreements do not impose legal obligations on the respective countries.

Obviously, many migrants receive little or no information prior to their emigration on their working situation and their rights in their countries of destination. Concerted efforts to inform them of their social rights are important, including their right to be informed of the result of HIV/AIDS tests (the right to health and the right to information are covered by human rights treaties signed and ratified by virtually all countries) and to inform them of their risk to become infected by HIV/AIDS, if they engage in risky sexual behaviour. This is certainly beyond the scope of the MSHAP. However, **we recommend** that the project should assess whether there is at city corporation level, e.g. through formal migration agencies, potential for awareness-raising and information activities for out-migrating workers.

3.2.4 Other (donor funded) projects

Intermediary organisation (1)	Main tasks of organisation with regard to MSHAP (2)	Interests and pro-poor agenda, aspects that might hinder them to have a pro-poor agenda (details and risks) (3)	Rating of their pro-poor agenda (4)	Mitigating and/or reinforcing measures (5)	Info – source and quality (6)
Urban Partnerships for Poverty Reduction (UPPR)	Establishment of community based organisational structure in 13 slum wards (of 41) in Chittagong; 8 wards covered by CBO-health service	Explicit pro-poor agenda: Urban slum upgrading through community development (mobilisation and organisation of slum communities)	++	MSHAP should use the community organisation created by the project to access slum dwellers in awareness raising and reducing stigma and discrimination.	Interviews with Chittagong project manager and project director in Dhaka; visit in one slum community. Quality: very good.
Urban Primary Health Care Project (UPHCP)	Provision of primary health care services to urban poor (ADB funded)	Extensive network of primary health care centres and services developed in Chittagong. The extent to which these services are effective in reaching high-risk and vulnerable groups is not yet clear.	0 (insufficient information to judge)	Assess opportunities for cooperation	Project proposal document (UDHP 2005), visit of one health centre. Quality: poor.

KEY	Strength/direction impact	++	+	0	-	--
		very positive	Positive	not relevant	negative	very negative

Urban Partnerships for Poverty Reduction (UPPR)

The project is the follow-up of the former LPUPAP (Local Partnerships for Urban Poverty Alleviation, until 2007). The UPPR is financed by DFID with 120 Mio USD for the period 2008-2015 and implemented by UNDP/UN-Habitat. It follows a community development approach and starts in each (slum-) community with the mobilisation and organisation of the inhabitants, resulting in a 4-tier organisational structure:

- 1st tier: “Primary group”, consists of representatives and leaders of the community;
- 2nd tier: “Community”, consists of 200 – 250 households and is the core mobilisation constituency that elects the members of the primary group; 1st and 2nd tiers together are the “Community Development Committee (CDC)” that gets an “accreditation” of the City Mayor, and opens a bank account.
- 3rd tier: On the Ward level a “Cluster-CDC” is formed by representatives elected from the 8 – 10 CDC that are in one Ward. In Chittagong, the project has so far covered 13 Wards (of 41) since 2000.
- 4th tier: At the CCC-level the “federation” is formed by representatives elected from the cluster-CDC.

What one may regard as an organisational structure parallel to the local government structure seems to be in fact a supplementary one that is necessary to have any outreach, participation and self-help of the population living in the slum areas. It is endorsed by CCC.

The mobilisation process in each community takes two to three years before any physical or other activities beyond the mobilisation can start. (*That is in line with GTZ-experience in slum and squatter upgrading projects*).

During the first phase of the project, one of the priority needs often brought forward by the community representatives was health care. In eight wards covered by the project, health care services were not available for two reasons. First, no public health centres were available nearby and second, private health services were too expensive. The cluster-CDC and the federation therefore initiated a health care project. The project consists of outpatient consultations provided by two female doctors to women and children on a rotation basis. The

doctors attend eight cluster community centres on one day in a week for four hours. Outpatient consultations, which include health counselling and basic treatment, are held in the community hall room (built by the project). To finance these services for a period of 18 months approximately 700.000 Tk were collected from 54 CDC. Drugs are mainly financed by UNDP. Patients pay for each consultation a nominal fee of 20Tk. It was hoped that the fees would constitute a revolving fund out of which further services could be provided after the initial period of 18 months. Now that the first period comes to an end, the federation and UNDP realised that the money collected by the fees will not cover the costs for the next 18 months. New funds will have to be collected or provided by UNDP. The City Corporation has approved the project and the appointment of the two doctors by the federation. So far, no agreement has been reached to share the costs. One could, with support of the CCC Multisectoral HIV/AIDS Committee, explore the possibility of at least sharing the salary costs of both doctors between the City Corporation, UNDP, and the community. Some kind of financing by the donors will remain necessary, at least in the short and middle term (*which we do not consider as "non-sustainable" but necessary to have badly needed results – poverty alleviation without transfers from rich to poor is not feasible*).

We visited one community centre and could talk with one female doctor there as well as with a gathering of the women's leader group of the Cluster-CDC. Confidentiality for the clients coming for consultations was given by a thick curtain separating the community hall in two rooms. According to the lady doctor, it is difficult to talk with women about HIV/AIDS. But she often sees women with STI. She can give them some drugs to treat the infections. She does not see the husbands but encourages the women to talk with them and have them see a doctor.

The discussion with the women, who were interested and wanted to learn more about HIV, confirmed that it is very difficult to talk about it in the family and community, in particular if someone is HIV+; there is too much feeling of shame, fear of discrimination and exclusion (so far very justified, unfortunately). The women admitted to have seen in TV and heard in radio broadcasts something about HIV. They knew about the main means of transmission, but said that they were the leaders and that other women knew very little about HIV/AIDS and feared the disease very much, "because it is such a deadly disease."

HIV/AIDS-related sensitisation and awareness-raising activities could be implemented using the communal organisation structure created by the project. Activities such as the theatre performances of UTSA (United Theatre for Social Action) could easily be arranged in these communities.

We recommend exploring this opportunity, given the readiness of the UNDP-project and the openness and the interest of the women representatives.

We recommend exploring the possibility of initiating and facilitating a dialogue with the City Corporation with the aim of increasing its commitment to provide essential health services in (at least) the eight wards covered by the UNDP project.

Urban Primary Health Care Project (UPHCP)

The UPHCP is funded by the Asian Development Bank. It is now in its second phase, which is due to last until 2011. The aim of the project is to ensure the delivery of a package of preventive and curative health services to the poor in the six city corporations and in five urban municipalities. These are also the implementing agencies at local level, the executive agency being the MOLGRDC. In the City Corporations, project management is ensured by Primary Health Care Committees, chaired by the mayor or chief executive officer.

The approach of the project is to contract out as far as possible primary health care services to NGO's. The rationale behind this is that *"it would be too costly and time-consuming to contemplate significantly building up the Government role in service delivery"* and that the Government should with the assistance of the project *"build a publicly subsidized urban PHC network with the many existing NGOs and commercial players. (ADB, 2005)"* Support for capacity-building of city corporation health departments and partner NGOs is included in the project concept.

Besides centre-based primary health care services, the project promotes outreach activities at community level. It has a component for HIV/AIDS, STI and infectious disease control, which foresees the installation of 24 VCT centres as well as information and behaviour change communication through campaigns, community mobilization, and direct interventions by partner NGO's.

Chittagong apparently has the largest network of urban health care facilities funded and run by city corporations. In so far, the UPHCP has in its first phase supported 28 primary health centres, which depend of the City Corporation, and are being supervised in practice by the UPHCP project unit. Outreach primary health care workers are attached to these centres. One of their tasks is to conduct regularly sensitization meetings on health topics at ward level. We visited one of these urban primary health care centres, which was quite well frequented and had a small counselling room. By talking to the female doctor we had the impression that addressing sexual risk behaviour, STI and HIV/AIDS, was a sensitive issue for both for herself and for the health staff attached to the centre.

We did not have the opportunity to talk to project managers. But if, as the program concept foresees, UPHCP is involved in activities at community level, and supports NGO's working with HIV/AIDS high risk and vulnerable groups, opportunities for synergies and cooperation should be further explored by the project.

3.3 Stakeholders (the duty bearers)

The stakeholder analysis we as external mission can provide is very rudimentary. If not yet done, it would be worthwhile for the project to do a thorough analysis of all stakeholders at the central level and in particular of all organisations represented in the Multisectoral HIV/AIDS Committee in Chittagong (and in the other three cities where similar committees will be established). By doing so, the project could falsify our creeping suspicion that the Committee may be too big and heterogeneous in its composition to become really operational. The "Executive Committee" of 26 members seems to be a good forum for exchange of ideas and learning about everyone's activities; this was the generally very appreciating feedback we got in the interviews with some of the members. However, in operational terms we were unable to assess the value added – is better and clear leadership in implementing the agreed upon (project-) strategy, coordination, cooperation between all the 26 stakeholders already established? Or which process, headed and guided by whom, will lead to this result? What are the responsibilities? Who reports what to whom? These are questions of local government organisational development which we ask ourselves "out of our ToR"; we suggest that they should be explored and assessed in the course of the forthcoming Project Progress Review (PPR).

3.3.1 National level ¹⁸

Stakeholders (1)	Main tasks of stakeholder with regard to MSHAP (2)	Interests and pro-poor agenda, Aspects that might hinder them to have a pro-poor agenda (details and risks) (3)	Rating of their pro-poor agenda (4)	Mitigating and/or reinforcing measures (5)	Info - source and quality * (6)
Ministry of Local Government, Rural Development & Cooperatives (MLGRDC)	Supervisory body of local government organisations incl. City Corporations; therefore political partner of the project.	Interest to provide their own departmental services to local government structures in order to contribute to poverty reduction within their constituencies. Strong implementation departments instead of enabling Local Government to implement. Due to multiple duties, not all topics are dealt with the same professionalism.	+	Facilitating better cooperation with Ministry of Health, NASP, and GFATM.	Website; PIA-mission had no personal contact
Ministry of Health and Family Welfare	Running of the public health services in rural areas and secondary and tertiary health services in cities	Interest to maintain control of their highly centralised system.	0	Establishing better cooperation with City Cooperation through the Coordination Committee.	Interview with Joint Chief Health Economics Unit
National AIDS/STD Programme (NASP)	To prevent spreading of HIV/AIDS; improving conditions of life of PLWHA. Management of GFATM for Bangladesh.	Committed to pro-poor agenda in so far as the poor are more vulnerable to HIV-infections and HIV/AIDS causes poverty (due to severe discrimination). Objectives: (1) Keep HIV-prevalence low in high risk groups. (2) Inform general public.	+	NASP managers consider GTZ intervention as "essential" as it addresses the local (city) government level. GTZ should develop transferable model in Chittagong that may be duplicated by other City Corp.	Website etc. Interview with Dep. Programme Managers
Ministry of Home Affairs, Dept. of Narcotics Control DNC	Prevention of drug abuse, information campaigns etc.; running treatment centres (5 beds in Chittagong, detoxification only).	Awareness that drug abuse is causing poverty. "Poverty may be one reason for drug abuse but not a major one." In Chittagong, pragmatic approach to harm reduction activities (e.g needle exchange programme for IDUs).	+		Website; Interview with DNC Chittagong Zonal Officers

KEY	Strength/direction impact	++	+	0	-	--
		very positive	Positive	not relevant	negative	very negative

3.3.2 Chittagong City level ¹⁹

Stakeholders (1)	Main tasks of stakeholder with regard to MSHAP (2)	Interests and pro-poor agenda, Aspects that might hinder them to have a pro-poor agenda (details and risks) (3)	Rating of their pro-poor agenda (4)	Mitigating and/or reinforcing measures (5)	Info - source and quality (6)
Mayor and CEO of Chittagong City Corporation (CCC)	"Power promoters" of the MSHAP's objective. In-Charge of the Advisory Committee.				PIA-mission had no personal contact
Multisectoral HIV/AIDS Coordination Committee of	Maximise collaboration, coordination and integration of all	The focus is on HIV-high risk population groups; as far as they are at the same time poor, poverty aspects have not (yet) been dealt	0	Establishing better cooperation between all parties concerned, in particular the Chittagong	Strategy paper of the Committee. Comments

¹⁸ The PIA-mission had only two interviews with central level institutions, the NASP-office (under MoHFW) and the Health Economics Unit of the MoHFW). All statements made in the table are indicative and not well based on reliable and cross-examined information.

¹⁹ The PIA-mission had only few contacts with civil service and City Corporation stakeholders. Statements in the tables are indicative and based on one source only or on written information.

Stakeholders (1)	Main tasks of stakeholder with regard to MSHAP (2)	Interests and pro-poor agenda, Aspects that might hinder them to have a pro-poor agenda (details and risks) (3)	Rating of their pro-poor agenda (4)	Mitigating and/or reinforcing measures (5)	Info - source and quality (6)
the CCC	HIV/AIDS prevention, treatment, care, and support activities in CCC.	with explicitly. The other preoccupation is the qualitative improvement of health services provision to stem the spread of HIV/AIDS and STI.		line offices of MoHFW and the CCC-Health Division.	of 1 member & 1 observer of the committee in Chittagong.
Health Division of Chittagong City Corporation (CCC)	Running Primary Health Care Services in the CCC. Implementing Agency (partner organisation) of the project.	So far, there seems to be no explicit pro-poor agenda. Staffing problems: 3 of 5 officer level positions of the CCC-Health Division are vacant.	0	More comprehensive staff training in management, planning, communication strategies, development, process and result orientation etc.	Strategy paper of the Committee. Interview with the Project Director of CCC.
Urban Health Centres	Provision of Primary Health Care Services (with support from the ADB-funded UPHC-project).	No particular poverty orientation except for providing health care services to everyone; there may be still reservations about dealing with HIV patients and most at risk groups...	+	Sensitisation and professional training of staff to be continued / intensified (e.g. by mentoring, coaching)	Short visit of one Urban Health Centre only

3.3.3 Chittagong branch offices of line ministries

Stakeholders (1)	Main tasks of stakeholder with regard to MSHAP (2)	Interests and pro-poor agenda, Aspects that might hinder them to have a pro-poor agenda (details and risks) (3)	Rating of their pro-poor agenda (4)	Mitigating and/or reinforcing measures (5)	Info - source and quality (6)
Department of Narcotics Control DNC, Chittagong office (part of Ministry of Home Affairs)	Drug control and licensing; DU treatment (detoxification only)	DNC Chittagong Zonal Office director is well informed about state-of-the-art treatment of DU but has very limited possibilities to implement (e.g. there is no substitution therapy). Drug control act allows for suitable flexibility in practice (e.g. distinction between DU and dealers re. criminality). Pragmatic approach to harm reduction activities.	+	Support to improve DNC's very limited services for treatment of DU, e.g. in expanding the present detoxification facility and in changing the location.	Website; Interview with DNC Chittagong Zonal Officers.
Dept. of Social Services (part of Ministry of Social Welfare)	Registry of NGO; various social services and subsidies to specific groups, e.g. micro credits free of interest (!), disabled children, old agers etc.	Dept.'s mission is poverty alleviation, welfare and social programmes. The Dept. has some limited outreach capacity (3 community development officers, 4 social workers in CCC). We cannot assess effectiveness and efficiency of their work based on the information we received verbally.	+		Interview with Director of Dept. Quality of information: Very poor.
Islamic Foundation of Bangladesh, Chittagong Divisional Office (cf. ch. 3.2.3 above)	Training of Imams about various social problems from the point of view of "official" Islam in Bangladesh	General pro-poor agenda of Islam. The four-day training for Imams (offered once per year and considered as insufficient) comprises one hour on prevention of HIV/AIDS by following good Islamic behaviour but no advice in case prevention has failed.	+	It is worth to explore possibilities to improve the training of Imams qualitatively and quantitatively with regarding social problems of DU and PLWHA. It is a delicate matter in the present situation and should be dealt with accordingly.	Interview with Divisional Director. Quality of information: Good

KEY	Strength/direction impact	++	+	0	-	--
		very positive	Positive	not relevant	negative	very negative

4. Transmission channels: Anticipated results (PIA module 3)

4.1 Some thoughts about the effectiveness of the project

Every HIV/AIDS intervention (if successful) is in general also a contribution to avoid new cases of poverty in the sense that each HIV-infection prevented and each PLWHA well treated means at least one person (plus dependants) less poor or, if the person was already poor when getting infected, at least less deprived of any chance to escape from poverty. Hence, HIV/AIDS interventions may be qualified as inherently relevant to poverty reduction.

However, a closer look at the current design of the GTZ sponsored “Multisectoral HIV/AIDS Programme” reveals that there is no explicit poverty orientation and that the inherent poverty impact may occur only in the very long run and to an extent that may be proportional to HIV infections prevented or well treated by the better qualified health services. The outcome of the current intervention is stated as **“prevention, diagnosis, counselling, and treatment of STI, HIV, and AIDS are improved” (in four cities)**.

The project so far follows a fourfold approach to reach its objective, with a clear focus on the first two, closely related approaches, but has already engaged in some additional activities that go beyond the limits of the core approach:

- Improving capacities of health service providers and other relevant public and private organisations and intermediaries, in particular those of the four envisaged City Corporations, in order to enable them to respond to the rising HIV/AIDS epidemic.
- Establishing and facilitating coordination mechanisms between governmental and non-governmental organizations of the health, business and education (universities) sector in order to promote and harmonize HIV-related activities.
- To a small extent, directly supporting NGO that are conducting awareness-raising activities for and with vulnerable groups (students, garment workers) and are working with HIV/AIDS high risk groups and PLWHA in order to limit the spreading of HIV originating from these groups to other groups of the general population.
- In emergency cases, providing (very) limited humanitarian support, e.g. ARV-drugs to organisations working with PLWHA, to bridge the gap between insufficient capacities of public and private health service providers and already existing demand, for the time being.

Looking at the project’s objective and its past efforts to strengthen the “supply side” and the coordination of organisations and services dealing with the imminent HIV/AIDS epidemic, it appears that the “demand” and “use” of services from high risk and vulnerable groups seems to be relatively small, despite their pressing need of protection, care, and treatment.

The strategic complement that could contribute to limiting the spread of the HIV/AIDS epidemic as well as to reduce the risk for the vulnerable target groups of sliding into poverty, are activities aiming at breaking the ignorance, secrecy, fear, stigmatisation and discrimination of everything and everybody related with HIV/AIDS. Such an additional strategic orientation is very much within the scope of any HIV/AIDS intervention in general because the prevailing behaviour of ignoring, fearing, and repressing the perception and rational confrontation of the HIV/AIDS problem in the society is the best precondition for viruses spreading without hindrance.

At the same time, such a complement adds an explicit element of fighting poverty to the project design. Less (or ideally no) discrimination of vulnerable groups will at least offer them more chances to (re-)gain in the other dimensions of their “capability framework” (cf. ch. 5).

Therefore, the project should complement its approach by engaging much stronger in transforming the needs of high risk and vulnerable groups into a more pronounced demand to the service providers – or, to put it in the human rights based approach: The project should do more to encourage those in need to claim their rights from the duty bearers (i.e. public and possibly private health service providers).

The greatest hindrance to do this lies in the stigmatisation, discrimination, including in some cases social exclusion, of most DU, sex workers and PLWHA. Only upper class DU and PLWHA have the means and manners to hide their status successfully and thus may escape from social discrimination (in PIA terms: They dispose of sufficient protective capabilities).

Hence, parallel to continued efforts to strengthen the “supply side”, the project should start to engage in information, sensitisation and behaviour change communication activities in those areas of the cities where high risk and vulnerable groups live: In the slum and squatter settlements. Unless secrecy, stigma and discrimination around the issues of HIV/AIDS and drug addiction are successfully broken and unless people understand that these are health problems and not crimes,

- the demand for more qualified health services will not increase;
- the HIV/AIDS epidemic will continue to spread;
- each HIV+ patient (and each DU) will quickly decline into poverty.

The HIV/AIDS project should aim at an additional outcome: **“Public and social acceptance of vulnerable groups, including PLWHA, is improved.”** This recommendation is in line with the proposals of the male PLWHA focus group: “PLWHA have to be made acceptable by the Nation first, and then they can help themselves in changing the mindset of people around them.”

A practical possibility to implement this recommendation is offered by cooperating closely with the UNDP/DFID sponsored “Urban Partnerships for Poverty Reduction (UPPR)” project. The project should also consider using the potential of those NGO which are already engaged in awareness-raising and sensitisation activities at community level. The MSHAP may explore these opportunities further to define the operational options more precisely than our PIA-mission was able to (cf. ch. 3.2).

Besides the communication channels the HIV/AIDS project is already using, there are other channels it may further explore, e.g. the Chittagong Women Chamber of Commerce and Industry, or the Islamic Foundation in order to address HIV/AIDS on a broader basis.

Another contribution to reach this new complementary outcome may consist in linking the NGOs working in the field of Legal Aid and awareness-raising on human rights for the poor with those working for PLWHA. The project may start in Chittagong with bringing together the “Bangladesh Legal Aid and Services Trust (BLAST)” and the “Ashar Alo Society (AAS)”, eventually to document or file court cases of particular harsh cases of discrimination, police misbehaviour, refusal of treatment by public health services etc. Of course, each and every possible case has to be assessed properly in order to avoid unwanted repercussions for those HIV+ (or IDU!) plaintiffs that dare to come out in this way. In a longer perspective, cooperation between health and human rights organisations could include a more systematic documentation of discrimination cases, which could be used for advocacy at regional (City Corporation) and national level.

In terms of the *ex-ante* PIA-methodology (cf. ch. 1.1 above) these recommended additional outcomes and activities are used in the analysis of the “transmission channels” (PIA module 3) that otherwise can only be done *ex post* using existing results chains of the project, which are not explicitly poverty or human rights oriented. Although this may not be a major contribution, we present this *ex post* – analysis of “transmission channels”, too, in ch. 4.2.1.

4.2 Identifying result chains through the transmission channels

“Transmission channels depict the pathway via which the intervention triggers results at different levels and time horizons, which influence the stakeholders.” (OECD-DAC PIA-Guideline, 2007, p.36).²⁰

The overall thematic “transmission channels” or processes the project should promote and pursue in future should be the following in order to add a more explicit human rights based approach and poverty orientation:

1. Improving the capacity and coordination / cooperation of HIV/AIDS service providers and other stakeholders at City Corporation level to provide services to high risk and vulnerable groups and relaying the experience to the central level (=“supply side”, to be continued).
Results to be expected: Long term. (Cf. ch. 4.2.1)
2. Community mobilisation and information to break the HIV/AIDS taboo and reduce discrimination, starting in slums where most at-risk-groups and many bridging population groups live. Approach to be developed in cooperation with UNDP-Urban Partnerships for Poverty Reduction project. Complementary approaches through other networks like the Women Chamber of Commerce and Industries, Garment Factories (as already started) (= mobilising the “demand side”).
Adequate funding in the project budget is needed for field work etc.!
Results to be expected: Mid term. (Cf. ch. 4.2.2)
3. Facilitating the flow of available funding (GFATM through NASP) to the target groups and supporting agencies and NGO (= promoting effectiveness of “supply” from the central / international level).
Additional ad-hoc / emergency funding (local contributions) for limited support of NGO, Self-help groups etc. (e.g. for DU treatment, provision of ARV-medicine etc.) should be foreseen to increase the immediate effectiveness, visibility, and reputation of the project. Even subsidies to expand existing or building new facilities like e.g. DIC for sex workers or DU or the Detoxification Unit of the Department of Narcotics Control might be considered. The immaterial value of such visible actions for the standing of any project should not be underestimated.
Results to be expected: Short term (but eventually not sustainable) (Cf. ch. 4.2.3).

4.2.1 Transmission channels of the current project design

Note: For the description of the current approach, please see chapter 1.2 above.

Methodological notes: The project support to establishing a data base on HIV/AIDS has been assigned to the “authority” channel, being the closest fit of the six channels for this output. The “Access” and “Assets” channels are re-interpreted as the access and assets of the stakeholder organisations the project is working for and with, instead of its original interpretation as of the target groups’ access and assets. These changes appeared necessary to avoid assigning all elements of the official statement on the results chain (in the GTZ-offer to BMZ) in one line only (“Authority, formal organisations”).

²⁰ In the OECD-DAC PIA guideline, the term “stakeholder” is used sometimes as a generic term for responsible cooperating partners of the project AND target groups, sometimes meaning the former only and NOT the latter.

Transmission Channels & Details		Details of the change initiated by the intervention	Results by Transmission Channel			Information - Sources and quality
		Details & risks that may influence the effectiveness of this channel for intervention	Short Term (+/-)	Med. Term (+/-)	Details of results & risks that the results will not be achieved	
(1)		(2)	(3)	(4)	(5)	(6)
Prices	Production					
	Consumption					
	Wages					
Employment	Public formal					
	Private formal					
	Informal					
Transfers	Taxes					
	Public welfare/ subsidy					
	Private remittances					
Access	Public services	Lobbying and publications for decision makers and representatives of public life on the project approach	0	0	Decision makers and public personalities support and promote the concept of combating HIV/AIDS through target group friendly, competent, and cooperating services.	
	Other				Leaders/entrepreneurs in the private sector use the information provided to contribute to preventing HIV/AIDS in their enterprises.	
Authority	Formal organizations	Database on HIV risk profiles and municipal health services' system. Coordination of all actors combating HIV/AIDS, coordination committee Surveillance of the epidemiological process STD, HIV Evaluation and improvement of activities Documentation of project experience for NASP and MoLGRDC	0	+	Stakeholders in public health services and NGOs improve their methods and standards of prevention and treatment and cooperate in mutual patient referral systems. NASP and MoLGRDC align their strategies/policies and coordinate other interventions in the sector according to experiences made and useful innovations introduced.	
	Informal relations					
Assets of the partner organisations	Physical					
	Natural					
	Human	Counselling and training of staff, complementary equipment	+	+	Staff of health services, NGOs etc. better answer the needs of their clients and patients and provide adequate services in prevention, diagnosis, advising on and treatment of sexually transmitted diseases (STD) and	

					HIV/AIDS.	
	Social					
	Financial					

KEY	Strength/ direction of impact	++	+	0	-	--
		Very positive	positive	not relevant	Negative	very negative

The difficulties to accommodate the current results chain description in the PIA-Matrix reveal that the project design is

- almost exclusively focussing on the public stakeholders; the only other party mentioned are “leaders/entrepreneurs in the private sector”;
- is only indirectly target group oriented;
- is not poverty (or human rights) oriented.

We acknowledge that in reality the project management has started to “trespass” this narrow conceptual confinement by directly approaching some target groups, working towards raising their awareness and changing their behaviour regarding the HIV/AIDS menace. We suggest that the project should become ever more “action oriented”.

4.2.2 Transmission channels of the proposed additional outcome

The proposed additional outcome (cf. ch. 4.1 above) “**Public and social acceptance of vulnerable groups, including PLWHA, is improved**” may be specified by the following indicators (still to be quantified, cf. ch. 7):

- Increased use of STI and HIV/AIDS-related services by high risk and vulnerable groups.
- Public Health services of the City Corporations, medical doctors, and hospitals treat HIV-patients in a non-discriminatory manner like all other patients (measured by interviewing a sample of such patients in intervals of one year).
- Within the neighbourhoods / living quarters of vulnerable groups, voluntary advocates / local leaders / health workers assist vulnerable groups in denouncing social discrimination (measured by interviewing samples of vulnerable groups in their living quarters).
- Gainful employment of members of vulnerable groups is increased (measured by interviewing samples of vulnerable groups and of employers).

As mentioned in ch. 4.1, the overall related activities of the project are social mobilisation and advocacy in the living quarters of the vulnerable groups; in the first approximation these quarters are the slum areas of the four cities the project is targeting. The activities need to be detailed and the related processes (information campaigns and monitoring their effects) carefully planned and implemented by experienced social and health workers.

The following PIA-matrix shows the analysis of the related result chain in some elements of the six areas the project may influence (“transmission channels”) in order to arrive at the new outcome. The prospects of success are hard to predict; however, this cannot be a justification of not trying this approach. Of course, it needs persistence and patience – a long staying power.

Transmission Channels & Details (1)		Details of the change initiated by the intervention Details & risks that may influence the effectiveness of this channel for intervention (2)	Results by Transmission Channel			Information - Sources and quality (6)
			Short Term (+/-) (3)	Med. Term (+/-) (4)	Details of results & risks that the results will not be achieved (5)	
Prices	Production					
	Consumption					
	Wages	(see cell below)		+	Income is generated for few employed members of vulnerable groups, slide into poverty for them is prevented	This is a marginal result (maybe ~20 people in Chittagong)
Employment	Public formal	Advocacy to employ more ex-DU and PLWHA in public & private health services for VCT. Risk: Prejudice, no funds, no vacancies	0	+	Public health services set example that members of vulnerable groups are employable.	
	Private formal		0	+		
	Informal					
Transfers	Taxes					
	Public welfare/ subsidy	Assisting in securing regular ARV-medical supply. Risk: Funds cannot be mobilised	++	++	Regular supply of ARV to PLWHA may prevent the outbreak of AIDS and other diseases for years and secure the employability, prevent poverty.	Request of PLWHA and AAS
	Private remittances					
Access	Public services	Support of services targeted at high risk and vulnerable groups and sensitisation of duty bearers to avoid stigma and discrimination	+	++	Increase of trust in public health services, increase of demand for their services; better information about incidence of HIV can be gained; more effective limiting of the epidemic's spread.	
	Other	Provide migration agencies with information about HIV risks for migrant workers, link them with NGO for sensitising migrants before they leave the country	0	+	Migrant workers are informed about the risks of getting HIV infections and how to avoid them before departure to their workplaces abroad. Risk: informal and profit-oriented structures at local level hinder effective information	Proposal of HIV+ migrant workers returned from their host countries
Authority	Formal organizations	Linking legal aid NGO with NGO caring for PLWHA, DU etc.	0	+	Test cases of human rights violations / discrimination may strengthen the position of vulnerable groups. Risk: Exposure of plaintiffs to more discrimination; biased judiciary.	
	Informal relations	Identifying and motivating local change agents (e.g. in slum areas) to promote inclusion of DU, PLWHA etc.	0		DU, PLWHA etc. experience less discrimination and exclusion by their communities and know their advocates. Increased general awareness helps in limiting the spread of the HIV/AIDS epidemic.	

Assets	Physical					
	Natural					
	Human	Sensitisation and training of health staff and local change agents in HIV epidemiology, on risk groups, human rights and social behaviour as it is and as it should be	0	+	Health staff and local change agents may turn into multipliers / “spear headers” of changing discriminatory behaviour and fear of DU, PLWHA etc. Risk: No courageous health staff and local change agents with leadership qualities can be found; too strong adverse social prejudices and fears.	
	Social	Promoting gender specific networking of vulnerable groups within their living quarters (slums)	0	+	Vulnerable groups (DU, PLWHA etc.) are gradually empowered and can engage in self help activities, organise demand etc.	
	Financial					

KEY	Strength/ direction of impact	+ +	+	0	-	- -
		Very positive	positive	not relevant	Negative	very negative

4.2.3 Provisions for more immediate results

Another initiative of the HIV/AIDS project along the “Access” and/or “Transfer” transmission channels should be the facilitation in collecting, screening and forwarding meaningful requests for funding of NGO, SHG etc. in Chittagong (and the other targeted cities) that are engaged in preventing HIV infections and drug addiction or caring for PLWHA and drug addicts. Such requests, recommended by GTZ, could be submitted by the HIV/AIDS Coordination Committee(s) of the City Corporations to the National AIDS/STD Programme (NASP) for further scrutiny and possible funding from the GFATM and/or other sources.²¹ Intermediate supply of ARV-medicine would be but one example (in the table above mentioned in the “Transfer”-channel) until the current hindrances for regular supplies are removed.

Apart from such possibilities that require further exploration before implementation, the GTZ project budget should earmark some limited lump sum funds for emergency humanitarian assistance for self help activities that may be triggered by social mobilisation and for support of CBO, e.g. in the slum areas.

As such activities cannot be well planned in advance, a limited discretionary fund at the disposition of the project manager should be foreseen. Criteria for its use may be formulated in order to be able to refuse undue requests on a rational and systematic basis.

However, the project should not engage in other poverty alleviating activities than working against the socio-cultural stigmatisation and discrimination dimension. The project would overstretch its mandate and capacities if it was taking up other “classical” poverty reduction activities such as income generating activities, micro-credits, savings-and-loans-associations etc.

²¹ This proposal was made on 28 Apr. 2008 by the Deputy Programme Manager NASP, Dr. Shamsul Hoq Gazi.

5. Assessment of capabilities (PIA module 4)

The information available to the PIA team was too vague and incomplete for it to adequately complete the PIA Matrix 4: Assessment of Stakeholder and Target Groups' Capabilities. Neither outputs nor their use can be clearly enough identified to define whose capabilities would be positively impacted in what ways and in which time frames. Nonetheless, a rough assessment is provided in the matrix below, with the recommendation that it should be redone when more information is available.

In the PIA-matrix 4, we have omitted the original column (13) "Information-sources and – quality" because its contents is identical with the respective column in the previous PIA-matrix 3.

5.1 Target groups

The assessment of capabilities as presented here refers only to the recommended additional objective of the next phase of MSHAP: **"Public and social acceptance of vulnerable groups, including PLWHA, are improved"** (cf. ch. 4.1 and 4.2 above). It depends very much on the details and the intensity of the activities the project can engage in and the outputs it may deliver and on how these outputs will be used by which target groups, intermediaries and stakeholders. In particular in a task such as reducing habitual stigmatisation and discrimination of such minorities like MARP and PLWHA that are a priori perceived with contempt in basically all societies, it is quite presuming to assert the outcome of such endeavours that nevertheless should be tried (and eventually focussed to fewer target groups and intermediaries as mentioned here).

Even if it was achieved that vulnerable groups are no longer discriminated to an extent that causes their slide into poverty and oblivion (socio-cultural dimension of poverty), another outstanding question remains open, namely how the target groups could improve in the four other dimensions of poverty.

We are not in the position to give more than speculations to these questions (see rating in matrix). Our main assumption is that an increase in the public and social acceptance of vulnerable groups will not only improve their human rights situation but also increase their demand for and use of services. Therefore, besides the additional objective, we recommend that the project continues and possibly expands its support to provide sexual health and harm reduction services to high risk and vulnerable groups. The scope and range of these necessary services (e.g. outreach or/and in-service) should be assessed by the PPR, but in any case they should be designed and developed in such a way that they are affordable and acceptable to the target groups.

Table 4: Rough Assessment of target groups' capabilities

Target Groups	Outcomes in terms of capabilities										Details & risks	Mitigating or reinforcing measures
	Economic (+/-)		Human (+/-)		Political (+/-)		Socio-cultural (+/-)		Protective Security (+/-)			
(1)	short term (2)	medium term (3)	short term (4)	medium term (5)	short term (6)	medium term (7)	short term (8)	medium term (9)	short term (10)	medium term (11)	(12)	(13)
Female Sex Workers	0	0	0	+	0	+	0	+	+	+	Safer environment. Gain more control over their sexual health and their lives. Capacity to protect oneself against HIV-infection risk increased. Risk: forced entry into sex work can not be influenced by project	None as mitigation of risk would overstretch capability of project
Men who have Sex with men	0	0	0	+	0	+	0	+	0	+	as above	
Drug users	0	0	0	0	0	+	0	+	0	+	Safer environment. Gain more control over drug practices and sexual health. Ex-DU may change their life, and support others. Risk: DU may still remain addicted.	Besides harm reduction, provide better treatment and rehabilitation services,
Female Drug Users	0	0	0	0	0	+	0	+	0	+	as above	as above
People living with HIV/AIDS	0	+	+	++	+	+	0	+	0	+	Access to treatment. Safer environment. PLWHA may become included as valuable members of family and society and support others.	
Internal migrant workers	0	0	0	+	0	+	0	+	0	0	Should be primarily addressed as clients of sex workers. Increased capacity to protect oneself against HIV-infection risk and to change behaviour towards sex workers.	
Unmarried young people (urban)	0	0	+	++	0	0	+	++	0	+	As above (internal migrants)	
External migrant workers	0	0	0	+	+	+	0	+	0	+	Should be primarily addressed as potential clients of sex workers in destination countries. Increased capacity to protect oneself against HIV-infection risk. Risk: No influence on living situation in destination countries.	None as project does not have possibility to influence situation in other countries

	Outcomes in terms of capabilities										Details & risks	Mitigating or reinforcing measures
	Economic (+/-)		Human (+/-)		Political (+/-)		Socio-cultural (+/-)		Protective Security (+/-)			
Target Groups	short term	medium term	short term	medium term	short term	medium term	short term	medium term	short term	medium term		
Street children	0	0	0	+	0	0	0	+	0	+	Number unknown, difficult to address and influence them	Problem should be assessed in the course of project activities conducted in slum areas.

KEY	Strength/direction impact	++	+	0	-	--
		very positive	Positive	not relevant	negative	very negative

5.2 Intermediaries and Stakeholders

The assessment can only refer to the enhancement of the intermediaries' and stakeholders' capabilities to support their clients more effectively (also in avoiding poverty or working themselves out of it) that may be achieved if the latter were better accepted and integrated in society. The result is more or less uniform: Intermediaries and stakeholders would spare time, resources and (and too often futile) endeavours to work for and with their clients.

As far as project activities and outputs are concerned, one particular case needs to be emphasised: It appears to be necessary to continue to work proactively in and with the public and private health service organisations against discrimination and turning down of MARP and PLWHA patients seeking counselling and treatment. In human rights terms, this means that the gap between duty bearers and rights holders has to be reduced.

Using the PIA-Matrix 4 for intermediaries and stakeholders in this particular case appears to be of very limited use. We therefore refrain from trying it.

6. Assessment of contributions to strategic goals (MDGs) (PIA module 5)

This assessment is made under the assumption that at the end of the MSHAP, the project will have achieved its objectives that in four cities the municipal health services together with other service providers are in a position to work effectively in combating the spread of HIV-infections and that stigmatisation and discrimination of MARP and PLWHA is reduced to a level that gives these groups a chance of avoiding the slide into poverty and/or to escape from it. It is further assumed that an explicit human rights-based approach of the project from the 2nd phase onwards will have significantly increased its relevance and effectiveness. The fact that there are only few impacts at an aggregate national level does not lessen the relevance of the project approach. If it does contribute to contain the HIV/AIDS epidemic in Bangladesh and if it does strengthen the human rights of high risk and vulnerable groups, it is in our view relevant.

Matrix 5: Aggregate impacts in terms of the MDGs, and other strategic goals

Strategic Development Goals	Impacts		Details & risks
	Short term (+/-)	Medium term (+/-)	
(1)	(2)	(3)	(4)

MDG 1. Eradicate extreme poverty and hunger	0	0	Each HIV-infection prevented (or adequately treated) avoids the risk to slide into poverty or remain there. Reduction of discrimination of MARP and PLWHA is a precondition to reduce poverty. But due to the low HIV prevalence this has at an aggregate level no significance for the achievement of the MDG targets 1) halve the proportion of people whose income is less than 1\$ a day and 2) halve the proportion of people who suffer from hunger
MDG 2. Achieve universal primary education	0	0	
MDG 3. Promote gender equality empower women	0	0+	Reduction of the particularly harsh discrimination of female MARP and PLWHA contributes to improving their social status and empowerment. But probably very low impact at aggregate level.
MDG 4. Reduce child mortality	0	0	Reducing the transfer of HIV-infections from mothers to children contributes to reducing child mortality. But due to low HIV prevalence this has no significant impact.
MDG 5. Improve maternal health	0	0	
MDG 6. Combat HIV/AIDS, malaria, other diseases	+	++	The impact of the MSHAP will be a limitation of HIV/AIDS-cases to HIV-MARP in four cities in Bangladesh. Contribution to target 7: have halted by 2015 and begun to reverse the spread of HIV/AIDS Progress indicator 19a: Condom use at the last high-risk sexual intercourse is particularly relevant.
MDG 7. Ensure environmental sustainability	0	0	
Pro-poor growth	0	0+	Negligible impact if prevalence of HIV/AIDS remains low.
Protecting the vulnerable	0	+	Reduction of discrimination of MARP and PLWHA increases their protective capabilities.
Peace, security and disarmament	0	0	
Human rights, democracy and good governance	0+	++	The additional outcome strengthens the human rights of the target groups (rights holders) The project approach to strengthen good governance of local HIV/AIDS-related services should raise the accountability of duty bearers and lead to sustainable structural capacity at the City level to cope with the HIV/AIDS-problem. Risks: (1) MARP and PLWHA may remain marginalised groups. (2) Capacity building of responsible Local Authority units remains ineffective.
Protecting the global environment	0	0	

KEY	Strength/direction impact	++	+	0	-	--
		very positive	positive	not significant	negative	very negative

7. Recommendations for indicators and milestones and their monitoring

We recommend an additional outcome / objective of the MSHAP from its 2nd phase onwards (cf. ch 4.1 and 4.2 above):

“Public and social acceptance of vulnerable groups, including PLWHA, is improved”

In order to avoid loosing the focus and overstretching the capabilities of the project, we recommend being selective in the groups targeted, in the areas where they live, in the measures to be taken and in the intermediaries and partners chosen to implement the measures. The choices to be made should be flexibly guided by the strategic orientation (“impact”) the project is following, i.e. the prevention of a general epidemic of HIV/AIDS in Bangladesh. The choices should also be guided by a healthy degree of opportunism, i.e. the likelihood to be effective and efficient in having success. In other words, the project should start the new activities wherever it finds situations as favourable as possible, i.e. suitable partners, intermediaries, and access to people who are willing or most likely can be convinced to cooperate actively.

We suggest to start with the approach that is generally used in rural and urban development, i.e. approaching target groups in their living environment through community based organisation (CBO) structures. We do not suggest that MSHAP should engage in building such structures where they do not exist (that may take up to 3 years) but to use those that exist in those (slum) communities in Chittagong that have benefited from the UNDP/DFID-sponsored UPPR-project. To begin with the approach, MSHAP should establish close cooperation with that project that has declared its interest and readiness to do so to the PIA-mission. MSHAP should also use the experience of NGO’s already engaged in community development and human rights awareness raising.

7.1 Indicators

Possible indicators may be:

- Increased use of STI and HIV/AIDS-related services by high risk and vulnerable groups.

Explication: This indicates better accessibility and acceptability of services to target groups; still to be specified which services and which groups will be observed and which measuring approach will be used, e.g. number of high-risk persons reached by peer educators or outreach workers, number of PLWHA visiting the service providers in the base year compared to the target year.

- Public Health services of the City Corporations, medical doctors, and hospitals treat HIV-patients in a non-discriminatory manner like all other patients (measured by interviewing a sample of such patients in intervals of one year).

Explication: This indicates the perception of clients of health services about the professional and human behaviour of health service staff; still to be specified which services will be observed, how many patients will be interviewed for the base year and how many in the target year (preferably the same people, in any case the same number of people). Gender specification is to be considered.

- Within selected neighbourhoods / living quarters of vulnerable groups, voluntary advocates / local leaders / health workers assist vulnerable groups in denouncing social discrimination (measured by interviewing samples of vulnerable groups in their living quarters).

Explication: This indicates the perception of members of vulnerable groups about

support by trustworthy people / advocates they find in their living environment; still to be specified which living quarters will be observed, which members and how many of which vulnerable groups will be interviewed in the base year and in the target year. Gender specification is to be considered.

- Gainful employment of members of vulnerable groups is increased (measured by interviewing samples of vulnerable groups and of employers).

Explication: This indicates whether members of vulnerable groups improve their income situation (or not). In order to cover closely the “non-discrimination-issue” of the objective, only cases of employment (preferably formal employment) by employers should be considered, not self-employment or any informal survival activity. Still to be specified which members and how many of which vulnerable group will be interviewed in the base year and in the target year. Gender specification is to be considered. Complementary interviews of employers may or may not be done; they will only be informative if a change in their attitude occurs and if they are willing to inform interviewers about this change. These difficult preconditions are to be considered and eventually interviews with employers may be dropped.

7.2 Results chain

A summarised “gtz-style” results chain is presented here; for more detail in “PIA-style” cf. ch. 4.2.

Impact	Rights and abilities of vulnerable groups to be included and to participate in social and economic relationships, networks and activities are improved (= their socio-cultural and their protective-security vulnerabilities are reduced).
(Attribution gap)	
Outcome (Objective)	Public and social acceptance of vulnerable groups, including PLWHA, is improved.
Use of outputs	<ol style="list-style-type: none"> 1. Members of vulnerable groups find more people accepting them in their living quarters. 2. Vulnerable groups support each other and start voicing their interest, their worries. 3. Members of vulnerable groups start claiming their rights. 4. More members of vulnerable groups find gainful employment. 5. Emigrating workers are made aware of risks of HIV/AIDS before their departure abroad. 6. Members of vulnerable groups receive affordable and acceptable services according to their needs and rights.
Outputs	<ol style="list-style-type: none"> 1. Local change agents promote inclusion and protection of vulnerable groups (DU, PLWHA etc.) in their living quarters. 2. Gender specific CBOs of vulnerable groups within their living quarters are informed and sensitised on HIV/AIDS. 3. Legal aid NGOs, NGOs working for vulnerable groups and their CBOs are networking. 4. The same NGOs and CBOs are advocating employment of members of vulnerable groups and exert social control within their groups regarding their members’ attitude to regular work. 5. Migration agencies and NGOs working for PLWHA are networking. 6. Staff of public and private health services controls discriminatory behaviour in their respective organisation units / work environment.
Activities	(to be planned)
Inputs	(to be defined and budgeted)

7.3 Monitoring

Basically, the monitoring method of the four indicators of the outcome / objective is described in ch. 7.1 above. The PIA-team is not in a position to suggest more detail than that. The result monitoring requires specific project activities that need to be planned in the Plan of Operations; in this case the indicators need to be specified and quantified, a project officer or consultant be nominated to design the necessary surveys, interviews etc., test them and implement them at the beginning and at the end of the monitoring period. The details of monitoring must be determined after the activities and inputs are defined and the indicators, possibly also the results chain, are adjusted and finalised accordingly.

In preparing the Plan of Operations (i.e. the activities producing to the outputs), it is useful to define “milestones” and to set deadlines for their achievement (i.e. the results of certain parts of the “production”-processes such as “target groups, target areas, intermediaries identified” or “contracts concluded” or “trainings implemented” etc.) The project management needs to monitor the achievement of such milestones to remain in control of the processes of the project and to be able to adjust and change them as necessary. All milestones taken together should constitute the related “output”.

This kind of process monitoring should not be confounded with the results monitoring of the indicators of the project outcomes / objectives. (For further detail, cf. the related GTZ-guidelines on monitoring, management of the BMZ-commission, and “Capacity Works”).

Project title: „Multidisciplinary HIV/AIDS Program in Chittagong, Rajshahi, Khulna and Sylhet”

Project number: 2001.2503.9-001.00

Time of travelling: April 2008

Contract number: 81102832 (Dr. Reichenbach)

Terms of Reference

1. Background for the Assignment

The HIV and AIDS epidemic in Bangladesh is in its early stages (<1% amongst most of the other vulnerable population groups other than Intravenous Drug Users (IDUs) but all factors that may allow rapid spread of infection leading to an epidemic at large scale are present. The factors are high-risk behavior of most at risk populations (MARPs), high prevalence of Sexually Transmissible Infections (STIs), lack of awareness among the general population, mobile populations (internal and external migrants) plus being surrounded by high prevalence areas of Myanmar and Northeast India, a high degree on stigmatization and discrimination of MARPs and women and the absence of laws protecting human rights of people living with HIV and AIDS.

With funding from German Government (BMZ) and technical assistance from German Technical Cooperation (GTZ), the Health Departments of Chittagong, Rajshahi, Khulna and Sylhet City Corporation are implementing a ‘Multidisciplinary HIV/AIDS program’ primarily focusing on improving preventive, care and support services for both, general population and MARPs. The project includes local authorities from the health, education and business sectors. Key components of this project include supporting the local authorities in developing and institutionalizing an effective HIV/AIDS response strategy focusing on coordination of various HIV/AIDS activities and aiming at synergetic harmonization of these activities and more effective utilization of resources. In order to improve the quality of services the project builds capacity on HIV/AIDS and STI management among service providers and establishes a customer-oriented referral network for HIV/AIDS and STI related issues. It also supports local authorities and other stakeholders in coping with drug related harm aiming at reducing the vulnerability towards HIV/AIDS.

The project started its activities first in Chittagong in 2004 and only recently it was decided to expand to Rajshahi, Khulna and Sylhet. The current project phase ends by 31 December 2008. In order to prepare the next project phase, a Project Progress Evaluation is planned to be completed by June 2008. Part of the Evaluation process is an ex ante Poverty Impact Assessment, which also focuses on human rights aspects.

The ex ante Poverty Impact Assessment will inform about the expected intended and unintended consequences of the project’s interventions. It provides an assessment of the well-being of People living with HIV/AIDS and Intravenous Drug Users based on secondary

data. A multi-dimensional approach to poverty, including a human rights perspective, is taken. It will provide:

- I. An understanding of the relation of the intervention to national development or poverty reduction strategies, as well as relevant human rights obligations.
- II. An analysis of dimensions and causes of poverty among People living with HIV/AIDS and Intravenous Drug Users in Chittagong. This includes the assessment of the five dimensions of poverty for both groups which are related to political and social human rights (economic, human, political, socio-cultural and protection) as well as the identification of underlying reasons for the different dimensions of poverty for both groups. Identified dimensions of poverty and underlying reasons should be briefly prioritized according to their contribution to poverty and human rights violations.
- III. Hypotheses on how the project can reduce poverty within its scope and limits. Based on the identified dimensions of poverty among People living with HIV/AIDS and Intravenous Drug Users in Chittagong and underlying reasons an assessment of possibilities of the project to influence underlying reasons or to contribute to reducing poverty and improving human rights otherwise within the project's scope and limits shall be done.
- IV. An understanding of stakeholders (disaggregated into important groups by income, gender, age, etc.) and of institutions that influence and are influenced by the project's interventions.
- V. An understanding of the importance and inter-relationship of individual transmission channels through which changes are transmitted to the stakeholders.
- VI. An assessment of likely qualitative and/or quantitative outcomes for the stakeholders, with particular emphasis on the target population, taking into account the multi-dimensionality of poverty and an assessment of the intervention's implications in terms of the OECD/DAC capabilities framework.
- VII. An estimation of the potential impact on MDG # 6, and the strategic goals: a) protecting the vulnerable; b) human rights, democracy and good governance derived from the Millennium Declaration as well as relevant objectives from the national PRSP, HNPSP and National AIDS/STD Program.
- VIII. An assessment of key assumptions and identification of potential risks.
- IX. An assessment of the reliability of data/information used in the exercise and identification of key knowledge gaps.
- X. A framework for improving baseline data, and monitoring the impact hypotheses during implementation and as an input for facilitating ex post evaluation exercises including indicators.
- XI. Recommendations on how the project's interventions might be improved to increase its pro-poor and human rights impact or to mitigate negative impacts.

2. Objective of the assignment

- 2.1 To conduct an ex ante Poverty Impact and human rights Assessment of the 'Multidisciplinary HIV/AIDS Project' in Chittagong according to the 'Practical Guide to

ex ante Poverty Impact Assessments' (OECD DAC guidelines) and the ToRs. Deliver a detailed report including recommendations for the project to improve the pro-poor/humans rights approach in the second phase including a poverty and human-rights sensitive monitoring and evaluation system.

- 2.2 To use the ex ante Poverty Impact and human rights Assessment as channel for sensitizing partners and other stakeholders on the relevance of poverty in its five dimensions and human rights in the context of reducing the vulnerability of HIV/AIDS and the importance of streamlining the project towards reducing poverty and protecting human rights.
- 2.3 To hold a training for GTZ staff on issues related to poverty reduction (i.e. international discussion on poverty and poverty reduction, analysing poverty impacts, measuring poverty, etc.) and a human rights based approach.

3. Specific tasks

3.1 To assess the poverty situation and relevance to national strategies and plans

- Analyse the overall poverty situation in the country based on available secondary data, with particular focus on the HIV/AIDS sector and people covered, broken down by poor and non-poor, men/women, young/old and MARPs/no MARPs as they are relevant to the intervention.
- Given the multidimensional nature of poverty, the political, economic, socio-cultural, human and protective dimensions shall be analysed. Special emphasis shall be given to the political context (legal situation), gender inequality, discrimination and stigmatization.
- Asses the causes of poverty of People living with HIV/AIDS as well as the impact of HIV/AIDS on people's poverty situation.
- Assess the alignment of the project with the Bangladesh PRSP (national poverty reduction strategy plan), the HNPSP (Health, Nutrition and Population Sector Program), and the NASP (National AIDS/STD Program) highlighting the priority given to areas addressed by the project, and with the UPHCP (Urban Primary Health Care Project) supported by ADB, DFID, SIDA.

3.2 To analyze stakeholders including primary and intermediary target groups, and institutions who influence the intervention, are influenced by the intervention

- Identify stakeholder's characteristics, their interests, and the nature and degree of their influence on the project.
- Analyse concerned institutions applying 'organizational mapping' (static mapping, process tracing and process mapping) aiming at understanding the "rules of the game" that mediate the implementation of the project. Focus should be given to understand the motivation for change and the institutional "architecture" that is framing the project design.

3.3 To identify transmission channels and overall results by channel

- Identify and analyse primary and secondary transmission channels by which the project triggers results at different levels and time horizons, which influence the stakeholders.

3.4 To assess stakeholders' and target groups' capabilities

- Assess the five capabilities using OECD DAC Capability Framework (economic, human, political, socio-cultural and protective-security related capabilities) required by the target groups to escape from or to avoid poverty.
- Based on the existing capabilities of the target groups assess the expected outcome and impact of the project on those target groups.

3.5 To assess likely results on MDG # 1, 3, 6, UN strategic goals such as protecting the vulnerable; human rights, democracy and good governance, as well as national level strategic goals as determined in the PRSP, HNPSP and NASP

- Focusing on higher level objectives, assess the likely contributions of the project to strategic level goals as mentioned above.

3.6. To develop suggestions for a poverty-and human rights sensitive M&E System

- Use the findings and the knowledge gained by the PIA to recommend an M&E System that is poverty and human-rights sensitive.

3.7. Conduct a training for GTZ Staff on Poverty Reduction and Human Rights

- Conduct a one day workshop on poverty related issues such as PRSP, MDGs, poverty impact methods, poverty-sensitive M&E Systems, etc. as well as key elements of a human rights based approach to development.

3.8. Conduct a briefing for the PFK-Mission

- Conduct a briefing of the PFK Mission leader to explain major findings and aspects to be considered in the PFK-Mission

4. Report in English

The report shall outline the entire process of the PIA, detailed descriptions of the various assessments (specific tasks 1 to 5) including visualization of findings using attached matrices and recommendations set out clearly so as to guide project relevant decision makers. The report should reflect/describe the following:

- i) the type of the intervention: project, program, policy advice
- ii) the stakeholders, target groups and institutions and how they are influenced by and influence the project;
- iii) the key benefits of the project and underlying impact hypothesis on the basis of the analysis of the transmission channels;
- iv) potential threats and risks that can not be mitigated in the design of the project, but should be monitored and whether any additional information/systems are required to those that are already in place to provide this monitoring;
- v) a framework for monitoring the impact including indicators, which can be used to facilitate ex post evaluation exercises

- vi) any mitigating measures that should be included to help protect weaker stakeholders who may be hurt by the project, with some indication of how long these measures may be required;
- vii) overall assessment of the quality of the data available and identified information gaps
- viii) key issues that need to be included in the monitoring of the project;
- ix) recommendations and any proposed modifications to the design in the second project phase to strengthen the pro-poor approach (reinforcing measures) and address potential risks;
- x) recommendations for specific consideration of the PFK Mission

5. Duration and Implementation Arrangements

Working days:

Poverty and Urban Development Expert

Preparation: 4 days (incl. 1 day briefing at GTZ HQ)
 Field Work: 15 days (incl. travel) (9 to 23 April 2008)
 Report Writing: 5 days (incl. briefing of PFK-Mission)

Total: 23 days

Human Rights Expert

Preparation: 4 days (incl 1 day briefing at GTZ HQ)
 Field Work: 15 days (incl travel) (9 to 23 April)
 Report Writing: 5 days (incl. briefing of PFK-Mission)

Total: 23 days

The experts coordinate among themselves an appropriate division of labor. The Poverty and Urban Development Expert is responsible for the overall coordination of the responsibilities during the mission and report-writing.

Schedule of the PIA mission “Multidisciplinary HIV/AIDS Programme in Chittagong, Bangladesh”

ANNEX 2

Team members: Dr. Ernst Reichenbach, Mrs. Ilse Worm.

Date	Activities	Location	Resp./Support	Regarding Topic
Wed, 16.04.08 11:30am-12:30pm	Meeting with HIV Project Staff <ul style="list-style-type: none"> Welcome and official introduction with the project team members. Informal discussion about objectives of PIA mission with team members. 	GTZ Office, Dhaka	Parvez Mallik Shahnaz Begum Humayun Kabir Zubair Shams	PIA Mission
12:30pm-1:50pm	Lunch break			
2:00pm-2:30pm	Meeting / Briefing with Peter Palesch, GTZ-Director	GTZ Office, Dhaka		
3:00pm-4:30pm/5:00pm	Final preparation for Introduction Course for GTZ staff in Bangladesh – <i>“Human Rights, Gender and Poverty Orientation in Developing Cooperation”</i>		Roland Hackenberg Humayun Kabir, if required	
Thur, 17.04.08 09:00am-5:15pm	Introduction Course for GTZ Staff in Bangladesh – <i>“Human Rights, Gender and Poverty Alleviation in Development Cooperation”</i>	Lake Castle Hotel, Dhaka.		
Fri, 18.04.08 10:00am-12:30pm	Preparation meeting for the PIA mission for Chittagong	GTZ Office, Dhaka	Humayun Kabir, Zubair Shams	PIA Mission
3:00pm-4:30pm	Interview with Asma Parvin, Program Manager, (AAS)	Ashar Alo Society (AAS) Office, Dhaka	Zubair Shams	Overall situation of PLWHA

Date	Activities	Location	Resp./Support	Regarding Topic
Sat, 19.04.08 11:00am-1:00am	Meeting with Dr. Susanne Grimm	GTZ Office, Dhaka		PIA Mission
4:10pm-5:00pm	Flight Dhaka to Chittagong with 4H525 (United Airways)		Ilse Worm Dr. Ernst Reichenbach	
Sun, 20.04.08 10:00am-5:15pm	Workshop for the multi-sectoral HIV/AIDS Programme in Chittagong City, Bangladesh <i>“Poverty and Human Rights Impact Assessment”</i>	AMBROSIA Hotel, Chittagong.	Dr. Ernst Reichenbach, Ilse Worm, Humayun Kabir, Zubair Shams	
Mon, 21.04.08 10:00am-11:30am	Interview with Mr. Barbeza Parvez Ahmed, Founder and sponsor of ARK Mr. Shahjahan Siddique (Shamim), Programme Coordinator	ARK Office	Humayun Kabir, Zubair Shams	
11:45am-1:30pm	FGD with IDUs (Ex)	ARK Office	Zubair Shams	Overall situation of IDUs
3:00pm-4:00pm	Prof. Dr.A.Q.M.Serajul Islam Clinical Care Specialist (HIV/AIDS), CMC & Chairperson, TWG for training (Coordination Committee)	Ashar Alo Society (AAS)Office, Chittagong	Zubair Shams	Overall situation of PLWHA in Chittagong
Tues, 22.04.08 10:00am-11:30pm	Interview with Mr.Arifur Rahman, Chief Executive	Young Power in Social Action (YPSA) Office	Zubair Shams	Different dimensions of poverty

Date	Activities	Location	Resp./Support	Regarding Topic
10:00am-11:30am	Mr.Md. Harun, Focal Person	YPSA Office	Humayun Kabir	Human rights issues of PLWHA
11:45pm-1:30pm	FGD with Female Street based Sex-workers	DIC,Chittagong	(Ilse Worm only)	
2:45pm-3:30pm	Mr.A.K.M.Kamruzzaman, Divisional Director	Islamic Foundation Bangladesh, Chittagong Division	IFB Chittagong Divisional Office	Socio-cultural dimensions of poverty for PLWHA and IDUs
Wed,23.04.08 10:00am-11:30am	Interview with Mr.Khabir Uddin Ahmed, Additional Director(Chittagong & Sylhet Division) Dr. Sarfaraj Khan Chowdury, Medical Superintendent, Drug Addiction Treatment Clinic Chittagong	Dept. of Narcotics Control (DNC) Office	Humayun Kabir, Zubair Shams	Overall situation of IDUs
12:30pm-2:00pm	Observation –Theatre performance on HIV/AIDS for workers	DAF CTG. Accessories Ltd. (Garment Factory)	UTSA (United Theatre for Social Action)	
3:00pm-4:00pm	Interview with Syed Nur Ahmed Babar, Town Manager, UNDP-UPPR	UPPR-office (Urban Partnerships for Poverty Reduction Project)	Zubair Shams	Project approach of slum upgrading in Chittagong, general situation of slum dwellers
4:00pm-5:30pm	Visit of slum area, meeting women leaders	Community building	S.N.A. Babar, Zubair Shams	Basic Health Service
Thur,24.04.08 10:00am-11:15am	Interview with Mr.Monir Helal, Director	Community Development Centre	Humayun Kabir, Zubair Shams	Overall poverty situation

Date	Activities	Location	Resp./Support	Regarding Topic
		(CODEC) office		Tights based development approach
11:30am-1:00pm	Ms. Halima Akhtari, Deputy Director Mr. Md. Nurul Amin Chowdury, Ass. Director, Social Services Office	Office of the Department of Social Services (Min. of Social Welfare)	Zubair Shams	Overall poverty situation and social services of the State
2:00am-3:30pm	Prakash Chandra Sarker, Program Officer, IDU Intervention	CARE Bangladesh, Chittagong Office	Zubair Shams	Overall situation of IDUs
3:45pm-4:30pm	Advocate Tezaul Karim Chowdury, Coordinator, Chittagong Unit	BLAST office (Bangladesh Legal Aid and Services Trust)	Zubair Shams	Legal aid to poor, mediation
Fri,25.04.08 10:00am-11:00am	Interview with Ms.Muna Chowdhury, Peer Counselor Mr. Kourshedul, Advocacy Officer	Ashar Alo Scoiety (AAS) Office Chittagong.	Humayun Kabir, Zubair Shams	Overall situation of PLWHA
11:30am-1:30pm	FGD with PLWHA (Female) FGD with PLWHA(Male)	AAS-office	(Ilse Worm only) (Dr. Ernst Reichenbach)	Situation, experience of f/m PLWHA
Sat,26.04.08 09:15pm-10:00pm	Visit of an Urban Health Centre of the CCC (supported by ADB-project)		Zubair Shams	Impression of helth service provision

10:30am-11:45am	Interview with Ms. Monowara Hakim Ali, President.	Women Chamber of Commerce & Industries, Chittagong Office	Zubair Shams, Humayun Kabir	
12:30pm-1:30pm	Dr. Shahana Perveen, Health Officer, CCC and Project Director ,MSHAP	GTZ-Chittagong office	Zubair Shams	Situation of the CCC Health Dept.
2:00am-3:00pm	Mr. Wahid Mahmood Tuhin, Chief Executive	Addiction Life Overcome (ALO) – Office	Zubair Shams	SHO of ex-DU and IDU, general situation
3:00pm-4:00pm	FGD with IDU (Practicing)	ALO Office (courtyard)	Wahid Mahmood, Zubair Shams	Experience of active IDU
Sun,27.04.08 08:05am-08:55am	Flight Chittagong to Dhaka with 4H522 (United Airways)		Ilse Worm & Dr. Ernst Reichenbach	
DHAKA: 10:00am-1:00pm	Time to prepare feedback/debriefing	Hotel Lakeshore	Ilse Worm & Dr. E. Reichenbach	
03:00pm-06:00pm	Debriefing of the PIA-mission members to Dr. Susanne Grimm	GTZ-Office	Roland Hackenberg	Preliminary findings of the PIA-mission
Mon,28.04.08 10:00am-11:30am	Interview with Dr. Shamsul Hoq Gazi, Dep. Program Manager Dr. Hassan Mamul, Dep. Program Manager	NASP Office.	Zubair Shams	NASP and GFATM contributions to combating HIV/AIDS

12:00pm-1:30pm	Dr. Baquirul Islam Khan, Project Manager Grameen Shayesto Seba Prokalpo, Mr. Md. Shahid Hossain, Adviser	Management & Resource Development Initiatives (MRDI) Dhaka Office	Zubair Shams	Overall situation of female IDUs and treatment by CREA (Centre for Rehabilitation, Education, and Awareness)
1:30pm-2:45pm	Lunch			
3:45pm-4:30pm	Mr. Md. Jahangir, Joint Chief (Joint Secretary) Health Economics Unit, Ministry of Health & Family Welfare	Topkhana Road, Dhaka Office	Zubair Shams	Pro-poor health service provision, in particular for PLWHA
Tues, 29.04.08 07:30am 10:15am	Departure from Hotel for Ilse Worm to go to airport departure EK 583 to Dubai (-FRA)	Hotel Lakeshore	(ER joins the car up to GTZ-office)	
8:00am-09:30am	Interview with Mike Slingsby (UNDP), Project Director UPPR	GTZ-Office	(Dr. Ernst Reichenbach) Zubair Shams	Possibilities cooperation GTZ-HIV/AIDS and UNDP-UPPR
11:15am-12:30pm	Brother Ronald Drahozal, C.S.C., Executive Director	Ashkti Punorbason Nibash (APON) ; Addiction Rehabilitation Centre, Dhaka	Zubair Shams	Overall situation of female & children DU and IDU, in particular street children
01:00pm-03:45pm	Lunch with Dr. Susanne Grimm and personal debriefing	German Club	(Dr. Ernst Reichenbach)	
04:00pm-04:45pm	Debriefing about main results of the PIA-mission to Peter Palesch, GTZ Director for Bangladesh	GTZ-Office	(Dr. Ernst Reichenbach)	

Wed, 30.04.08 07:30am	Departure from Hotel to airport	Hotel Lakeshore	(Dr. Ernst Reichenbach)	
10.15am-07:20pm	Return flight with EK 583 and EK 047 to Dubai and Frankfurt			

List of persons met

GTZ Headquarters

Name	Organisational affiliation
Mr. Wolf-Michael Dio	OE 4215 – Combating structural poverty
Mrs. Claudia Gottmann	OE 4215 – Combating structural poverty
Mrs. Juliane Osterhaus	OE 4201 – Realizing Human Rights in Development Cooperation
Mrs. Evi-Kornelia Gruber	OE 4313 – Health and Social Security
Dr. Matthias JP Vennemann	International Health Consultant, PPR-mission for MSHAP
Mr. Stefan Bauer-Wolf	Organisation Development Consultant, PPR-mission for MSHAP

GTZ Bangladesh

Name	Organisational affiliation
Mr. Peter Palesch	GTZ Director Bangladesh
Mrs. Dr. Susanne Grimm	Programme Manager Multisectoral HIV/AIDS Programme (MSHAP)
Mr. Humayun Kabir	Project Officer Chittagong (MSHAP)
Mr. Parvez Sazzad Mallick	Senior Adviser, Research and M&E (MSHAP)
Mrs. Dr. Shahnaz Begum	Senior Training Adviser (MSHAP)
Mr. Dr. Zubair Shams	Intern (MSHAP)
Mr. Roland Hackenberg	Associate Expert (GTZ)

Civil servants of partner organisations in Chittagong and Dhaka

Name	Organisational affiliation
Mrs. Dr. Shahana Perveen	Health Officer of Health Division of CCC, MSHAP-Project Director
Mr. A.K.M. Kamruzzaman	Divisional Director of Islamic Foundation Bangladesh, Chittagong
Mr. Khabir Uddin Ahmed	Additional Director, DNC, Chittagong Zone
Mr. Dr. Sarfaraj Khan Chowdury	Medical Superintendent, Drug Addiction Treatment Clinic, DNC Chittagong
Mrs. Halima Akhtari	Deputy Director, Dept. of Social Services, Min. of Social Welfare, Chittagong
Me. Md. Nurul Amin Chowdury	Assistant Director, Dept. of Social Services, Min. of Social Welfare, Chittagong
Mr. Dr. Shamsul Hoq Gazi	Deputy Programme Manager, NASP, Dhaka
Mr. Dr. Hassan Mamul	Deputy Programme Manager, NASP, Dhaka
Mr. Md. Jahangir	Joint Chief (Joint Secretary), Health Economics Unit, MoHFW, Dhaka

Representatives of NGO and other development projects in Chittagong and Dhaka

Name	Organisational affiliation
Prof. Dr. A.Q.M. Serajul Islam	Dermatologist, Clinical Care Specialist for HIV/AIDS; Chairman of AAS Executive Committee (retired from Chittagong Medical College)

Mrs. Asma Parvin	Program Manager, AAS Dhaka
Mr. Khourshedul	Advocacy Officer, AAS Chittagong
Mrs. Muna Chowdury	Peer Counsellor, AAS Chittagong
Mr. Barbeza Parvez Ahmed	CEO of ARK, Chittagong
Mr. Shahjahan Siddique	Programme Coordinator of ARK, Chittagong
Mr. Arifur Rahman	Chief Executive, YPSA, Chittagong
Mr. Md. Harun	Focal Person for Human Rights issues, YPSA, Chittagong
Mr. Munir Helal	Director, Education & Training Programme, CODEC
Mr. Prakash Chandra Sarker	Programme Officer CARE, HIV&AIDS targetted intervention (HATI), Chittagong
Mr. Rezaul Karim Chowdury	Advocate and Coordinator of BLAST Chittagong Unit
Mr. Wahid Mahmood	Chief Executive, ALO, Chittagong

ANNEX 3

Mr. Mostafa Kamal Jatra	Executive Director, UTSA
Mr. Syed Nur Ahmed Babar	Town Manager, UNDP-UPPR-Project
Mr. Dr. Baquirul Islam Khan	Project Manager, Grameen Shayesto Seba, CREA-founder, Dhaka
Mr. Md. Shahid Hossain	Adviser, Planning and Development, MRDI
Brother Ronald Drahozal	Executive Director, APON Addiction Rehabilitation Residence, Dhaka

Representatives of the private sector in Chittagong

Name	Organisational affiliation
Mrs. Monowara Hakim Ali	President Chittagong Women Chamber of Commerce & Industry
Mr. Abul Bashar	Secretary, CWCCI
Mr. Shekar Sen Gupta	Executive Director, DAF CTG. Accessories Ltd. (garment factory)

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In addition to the following sources, project documents and written material (leaflets, project presentations) forwarded to the team by the interviewed stakeholders were viewed for the assessment.

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