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BANGLADESH

HOW THE DECLINE IN PEPFAR FUNDING HAS AFFECTED KEY POPULATIONS

Brief

The Issue

Due to social and political barriers, many governments have been slow to directly support HIV services for key populations (KPs)—men who have sex with men (MSM), sex workers, people who inject drugs (PWID), and transgender people (TG). This hesitation has historically led donors to provide the bulk of, or in some instances all, funding for KP-specific programs. As donor budgets for HIV have flat-lined, funding for HIV services and programming has decreased, particularly in countries with higher income status and concentrated HIV epidemics. This trend has left key populations especially vulnerable.

In Bangladesh, a low HIV prevalence among the general population led multiple donors to decrease or discontinue funding. Correspondingly, PEPFAR ended funding for HIV programming in Bangladesh in 2014, after providing a small stream of funding for HIV programming for over ten years. In 2015, in order to examine the implications for key populations of reduced donor funding in Bangladesh and to provide guidance for future transitions, the USAID- and PEPFAR-funded Health Policy Project (HPP) conducted a desk review and 20 key informant interviews with civil society, local government, and international donors. The resulting case study offers lessons learned on how donors can ensure the resiliency of HIV programming for key populations while undergoing funding transitions.

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HEALTH POLICY PROJECT

The Context

Bangladesh is the fifth most populated country in Asia. With high poverty levels and population density, HIV-prevalence in the general population is low (less than 0.1 percent), with the epidemic concentrated among key populations, including MSM, female sex workers (FSW), PWID, TG and migrants (NASP, 2012). Bangladesh is one of only four countries in Asia and the Pacific in which HIV prevalence has increased over 25 percent in the last decade (UNAIDS, 2012).

Key populations in Bangladesh face rampant stigma, discrimination, and human rights violations, both in and out of healthcare settings. A 2009 study among people living with HIV (PLHIV) reported discrimination in government hospitals, local clinics, and from healthcare providers (Hasan et al., 2012). The country's criminal code prohibits "unnatural sex," contributing to the fear of disclosure for MSM. Sex work in private is legal, though FSW are frequently the victims of gender-based violence and municipal ordinances against soliciting place them at high risk for police harassment (GoB, 2009). *Hijra,* a traditional transgender identity, is formally recognized as a third gender, yet members of this community remain highly stigmatized and subject to abuse (Khan et al., 2009). Police have been known to arrest members of many marginalized groups arbitrarily and without warrant (NASP, 2013).

Bangladesh-at-a-Glance[1]

Population: 159,077,500

GDP per capita (current US$): 1,086

HIV Epidemic type: Concentrated

Number of PLHIV: 8,600

HIV prevalence:

- Adults: <0.1%
- FSW: 0.3%
- MSM: 0.7%
- TG (hijra): 0.5%
- PWID: 1.1%

International Funding for HIV: US$18 million

Domestic Funding for HIV: US$3 million

Existence of laws criminalizing:

- Any aspect of sex work: Yes
- Consensual same-sex relations: Yes
- Drug use: Yes

[1]Population and GDP data come from World Bank, 2015; PLHIV, international HIV funding, and domestic HIV funding data and data on existing laws come from UNAIDS, 2015; Prevalence rates for adults, FSW, and PWID come from NASP, 2012 and those for MSM and TG come from Reza et al., 2014.

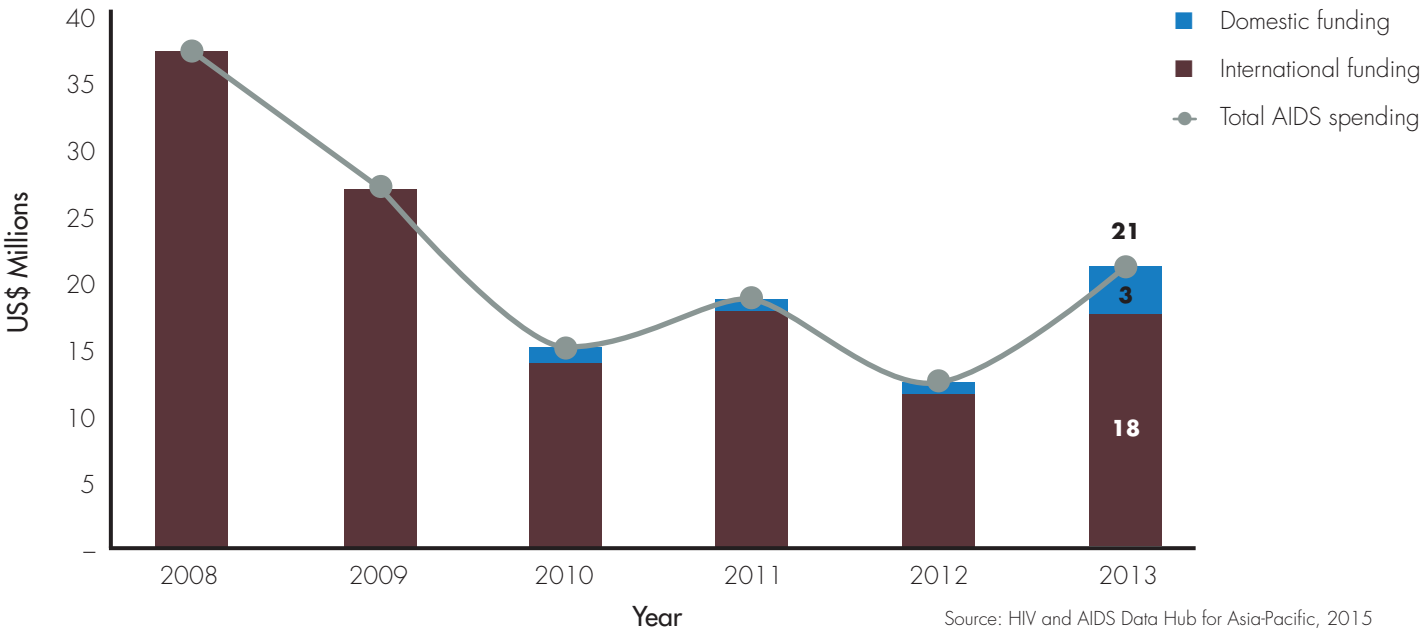
HIV Response and Funding in Bangladesh

Bangladesh's success at maintaining relative control of the HIV epidemic is, in part, due to its early recognition of HIV and openness to international aid. HIV programming in Bangladesh remains largely donor-funded, with multilateral donors contributing to both the government's program and projects implemented by civil society organizations (CSOs). In 2013, only 15 percent of the over US$21 million spent on HIV came from domestic funding sources (see Figure 1). Notably, as the country's health program is funded by a cache of pooled donor, government, and private funds, even government contributions to HIV programming include donor funds and loans.

CSOs have played a key role in successful program implementation and provide the bulk of HIV services, the majority of which are KP focused and are critical to the country's epidemic control. A 2015 modeling exercise showed that, without these interventions, within 20 years HIV prevalence among key populations would exceed 20 percent, eventually resulting in a generalized HIV epidemic (GoB, unpublished).

Bangladesh's well-coordinated network of donor-funded programs is led, in large part, by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), which has committed over US$114 million to the HIV response since 2003. The program

Figure 1. AIDS Spending by Financing Source, 2008-2013



Source: HIV and AIDS Data Hub for Asia-Pacific, 2015

works to enhance HIV prevention services for key populations and build capacity within government and nongovernmental organizations (NGOs). However, under the New Funding Model, the country's most recent grant reduces HIV funding by half. Although Bangladesh is not a PEPFAR country, USAID provided a small but steady source of funding for KP programming from 2001-2014, peaking at US$3.6 million in 2002-2003, and then ending abruptly in 2014.

PEPFAR's Modhumita Project

Modhumita (meaning "sweet friend" in Bangla) was the culmination of over a decade of HIV programming and USAID's final project in Bangladesh, running from September 2009-2014. In interviews and elsewhere it is described as a small program with impressive impact (USAID/Bangladesh, 2012; KI, 2015), having worked with Global Fund to provide complementary services that contributed a significant portion of service coverage for key populations and PLHIV.

Among Modhumita's successes was the establishment and oversight of 33 Modhumita Health Centers (MHCs) and 14 additional HIV testing and counseling (HTC) sites that provided critical KP services. HTC coverage, universally low in Bangladesh, is even more limited among key populations due to stigma and discrimination (GoB, 2014). At its peak, the project was responsible for approximately 80 percent of HIV testing in the country. Other implementers, especially those funded by Global Fund, routinely referred clients to these centers for testing, forming a symbiotic relationship that allowed the donor response to address the entire continuum of care. In interviews, CSOs spoke of the accountable, transparent, and effective service delivery provided through these centers, noting that they filled a key gap in KP-specific, high-quality services (KI, 2015).

The Transition

There were warning signs of Modhumita's impending closure as early as 2011, when funding dropped from US$2.6 to US$2.5 million, decreasing even further to US$1.5 million in 2012. The project scaled back outreach and capacity building efforts, and closed nine MHCs. Nevertheless, Modhumita continued to fund approximately 75 percent of HIV testing in Bangladesh. In 2013, the Office of the Global AIDS Coordinator withdrew all HIV assistance from Bangladesh based on the country's low HIV prevalence (KI, 2015). The project, however, was granted a one year extension of US$1 million to allow for transition planning. Many stakeholders were taken off-guard – they had assumed a follow-on project would be awarded after Modhumita's planned closure due to USAID's longstanding presence in Bangladesh and the project's pivotal role in the HIV response. Said one government representative: "We never thought [US assistance] would be 100 percent pulled (KI, 2015).

Stakeholders were concerned about the government's capacity to take over Modhumita's programming. Despite its mandate under the 2011-2016 national health sector program to provide a package of targeted, KP interventions, the government had yet to do so. Additionally, Modhumita's early attempts to integrate HTC into the public health system were largely unsuccessful due to low motivation and high HIV-related stigma among health workers (KI, 2015).

With limited time, Modhumita and USAID/Bangladesh focused on ensuring continuity of care, and meeting with government, Global Fund principal recipients, and United Nations agencies to determine where programs could be absorbed. With a strategy that depended heavily on the Global Fund, Modhumita and USAID/Bangladesh staffs prioritized the closure of MHCs where Global Fund services were available, and made significant efforts to secure Global Fund support for MHC implementing partners in other areas. The timing proved unfortunate, however, as it coincided with a drastic reduction in the anticipated Global Fund grant (KI, 2015).

The project met with their partner organizations operating MHCs—most of which were small community based organizations that relied heavily on Modhumita's funding and technical assistance—to identify alternate funding sources or strategize where else beneficiaries might access services. Those familiar with the process described it as a "stop-gap" and stressed that the approach was an emergency response, rather than a sustainable solution (KI, 2015). One respondent noted, "By the time you get to that point, you're kind of figuring out alternatives or second best."

In the end, the program consolidated the remaining resources into the MHCs that were most likely to remain in operation, ordering extra testing kits and training additional counselors and lab technicians. Meanwhile, a PEPFAR assessment of the anticipated impact of the pull-out, completed in February 2014, recommended that funding be identified to support a more strategic transition. Ultimately, this did not come to fruition and Modhumita program operations ceased at the end of September 2014.

The Challenges

The withdrawal of PEPFAR funding in Bangladesh, particularly amid a larger trend in HIV donor transitions, threatens the sustainability of HIV services for key populations, particularly in light of limited government capacity to reach and care for these populations. Through interviews with 20 stakeholders, HPP identified a number of key issues that emerged during the PEPFAR transition process and challenges confronting KP programming moving forward.

Inadequate Timing and Timeline

Uniformly, respondents expressed frustration with the short transition timeline, which did not allow for the development of sustainable government capacity or effective health delivery systems, resulting in gaps in testing and treatment coverage (KI, 2015). One CSO representative noted, "Replicability takes time…we never saw that donors were thinking of sustainability" (KI, 2015).

The withdrawal of funding was also logistically ill-timed, occurring at a critical point in the country's HIV funding and policy environment. At almost the same time as PEPFAR decreased funds, the country learned that the Global Fund would cut HIV funding

by half, while at the same time demanding greater case identification among key populations. Said one CSO informant: "You have to test a gazillion targets, you have to make all these numbers…How do you get there with such an unreasonably small amount of money" (KI, 2015)? Moreover, the National AIDS/STD Control Programme (NASP)—the agency responsible for the national HIV response—reports being unable to adjust the country's five-year operational plan to account for such a significant funding drop, as the government prescribes times at which a health area's operational plan and budget can be revisited.

Reduced Coverage and Quality of Care in Remaining Health Clinics

Through negotiations with Global Fund recipients and other funding sources, including a time-limited emergency fund from The United Nations Children's Fund, 16 of the 41 MHCs were able to remain open. The government opened an additional 20 HTC centers under the health sector program; 12 under a government set-up; and eight operated by CSOs (KI, 2015). Though this represents appreciable progress toward maintaining the number of centers open under Modhumita, interviewees noted that the quality and efficiency of these clinics is low. There are widespread reports of stigma and discrimination at government centers, and many CSOs are stretched without Modhumita's oversight and technical assistance (KI, 2015). One provider in a hospital HIV ward noted a rise in the number of key populations admitted at later stages of disease, attributing the rise to a decrease in HTC coverage and to stigma and discrimination driving key populations away from facilities (KI, 2015).

Apart from testing, Modhumita provided key social support mechanisms for key populations that have since dissolved. For example, the project supported monthly members' days on which PLHIV received reimbursement for transportation to clinics to pick-up antiretrovirals (ARVs) and allow for regular access to support networks. It also implemented a peer-led crisis management intervention—called "Flying Squads"— to address physical and legal harassment of key populations. While successful, these interventions were too expensive to survive after project close-out. "Member's day is not feasible in the government system," said one development partner, "the project was running excellently, but when you come to the reality in a poor country where HIV is very low and there's no government ownership, some realistic measures should have been in place before they decided to withdraw" (KI, 2015).

Ineffective Supply Chain Management

Another example of a system sustained by donor support was the country's supply chain for ARVs. Through 2012, the Global Fund procured ARVs and Modhumita ensured a steady supply by delivering them within centers run by community support groups. While this allowed for seamless supply chain operation during the life of the project, the efficiency was entirely dependent on technical support. One development partner recalled, "That was the main concern: that there was no in-built system of collaboration with the government to get the supply chain of drugs to the people" (KI, 2015).

In 2012, the government began taking on responsibility for procuring and providing ARVs through government hospitals in collaboration with CSOs under the national health sector program. Notably, former Modhumita staff report attempts to transfer ownership to the government for over two years before it actually occurred (KI, 2015). Despite this, interviewees stressed that the government was not prepared to take on this role, pointing to delays in medication procurement and delivery.

Impractical Procurement and Contracting Process

Though CSOs play a vital role in HIV services and programming for key populations, the government of Bangladesh is "more comfortable dealing with individual consultants and corporate agencies; they are not comfortable dealing with NGOs" (KI, 2015). Many CSOs formerly supported by Modhumita have faced difficulties obtaining and maintaining funding. This is largely due to the cumbersome contracting system currently in place under the health sector program, which contains provisions incompatible with existing CSO capacity.

A requirement on minimum bank account balances (and, some say, corrupt demands for bribes) disqualifies many CSOs from being eligible for contracts. Furthermore, the complicated and lengthy procurement and contracting process takes a minimum of eight to ten months, even when expedited, and requires significant administrative capacity. Because many CSOs are unable to navigate the procurement process, there has been a push towards single-sourced contracts for HIV programs. Only three organizations, however, had the required financial and administrative capacity to become single-sourced contractors, and "it took almost two years to get through" (KI, 2015). In the end, the lack of viable funding mechanisms for smaller CSOs is a key reason so many MHCs were forced to close.

Lack of Leadership and Capacity of Government Program

While CSOs have been critical in Bangladesh's HIV response, some stakeholders suggest donors could have done more to simultaneously build government capacity. NASP, which bears responsibility for the overall HIV response, lacks capacity for coordinating and supporting partners, and is overstretched by current programming. Owing to the relatively low priority of HIV in the mix of health problems facing Bangladesh, NASP has struggled with a succession of short-term directors, many of whom lacked direct experience with HIV or working with CSOs, and failed to secure sufficient authority within the government to advocate on the program's behalf. Capacity building by donor programs consists mainly of temporary staff being seconded to NASP, which provides only temporary leadership and neglects to impart sustainable, long-term knowledge and skills to government staff. One informant asked, "Transition to what? … You can't expect that these activities will continue on their own if there isn't something real to turn it over to" (KI, 2015). Moving forward, if NASP continues to lack political capital, there are concerns that the next health sector program, beginning in mid-2016, will lack KP-specific (or even HIV-specific) funding.

Lessons Learned

While small, the Modhumita Project represented a critical investment in the HIV response in Bangladesh, and its closing diminished the country's ability to reach and care for key populations. The Bangladesh experience presents a number of key learning opportunities for donors looking to decrease funding for KP programming, particularly in countries with concentrated epidemics. Based on interviews with a range of stakeholders in Bangladesh, HPP identified the following lessons:

1. **Develop meaningful metrics to assess and monitor KP transition readiness.** Broad readiness criteria, such as GDP and HIV prevalence, can obscure a transition's potential, negative impact on the most vulnerable populations. As such, readiness assessments must specifically consider key populations, and incorporate qualitative data collected from diverse stakeholders. One civil society member commented, "We are asking donors to assess readiness realistically" (KI, 2015).

2. **Implement a phased transition that allows for continuous KP-focused services.** The yearlong transition in Bangladesh was insufficient to develop sustainable systems, particularly within government. Diverse stakeholders agreed that an effective transition requires at least three to five years, with upfront technical assistance that diminishes over time as capacity is built. Likewise, PEPFAR should ensure that funding decreases align with both the country and other donors' budgeting, planning, and funding cycles. Additional technical assistance or bridge funding may be necessary to ensure continuity of services. As one organization implementing KP programming put it, "You have to plan in a way that there are no gaps" (KI, 2015).

3. **Improve government mechanisms to contract with CSOs.** CSOs are often best suited to deliver KP programming, as evidenced in Bangladesh by the post-transition quality of care issues, coverage gaps, and reports of stigma in government clinics. Current government contracting systems, however, are onerous and impose unrealistic requirements that effectively preclude most CSOs. As PEPFAR withdraws funding, it should ensure that domestic

contracting mechanisms are suitable for CSOs to continue to participate in the HIV response.

4. **Ensure the capacity and smooth operation of clinics and supply chains.** The closure of many MHCs—and the transition of others to government management—was associated with a reduction in KP services. Also, while the government assumed responsibility for ARV procurement, inadequate systems led to delays, risking treatment interruptions. Ensuring the sustainability of host-country health systems may require extensive capacity development, diminishing over time. Securing alternate funding and transitioning responsibilities requires sufficient time. This should be supported by PEPFAR prior to transition, and should be part of the transition readiness criteria.

5. **Ensure government leadership is empowered to effectively manage the HIV response.** A government champion with sufficient political capital is crucial to KP programs' success. In Bangladesh, HIV must compete with a variety of health concerns, and while NASP holds responsibility for addressing KP needs, it lacks authority within government. This raises particular concern as the government prepares to design its new health sector program. Throughout a program's life, PEPFAR should invest in building competent, committed local government leadership capacity.

The Project

This case study is one in a series that seeks to examine the implications for key populations of recent decreases in PEPFAR funding in four countries. Each case study is based on desk research and supplemented by key informant interviews with civil society, local government, and international donor representatives conducted in late 2015. Taken together, these case studies seek to guide PEPFAR in ensuring the resiliency of HIV programming for key populations.

For more information on how the decline in HIV donor funding is affecting key populations and to access related case studies, please visit www.healthpolicyproject.com.

Notes and References

Government of Bangladesh (GoB). Unpublished. *Report on the AIDS Epidemic Modelling (AEM) exercise conducted to support the development of the HIV and AIDS Concept Note for Global Fund funding.* Dhaka: National AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, and GoB.

GoB. 2009. *Understanding the operational dynamics and possible HIV interventions for residence-based female sex workers in two divisional cities in Bangladesh.* Dhaka: National AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, GoB, Save the Children USA and ICDDR,B.

GoB. 2014. *Revised 3rd National Strategic Plan for HIV and AIDS Response, 2011-2017.* Dhaka: National AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, and GoB.

Hasan, M.T., et al. 2012. "Experiences of discrimination among people living with HIV/AIDS in Bangladesh." *Asia Journal of Public Health* 3.2: 44-52.

HIV and AIDS Data Hub for Asia-Pacific. 2015. "Review in slides: Bangladesh." Available at: http://www.aidsdatahub.org/bangladesh-country-slides-october-2015

Joint United Nations Programme on HIV/AIDS (UNAIDS). 2012. *Regional Fact Sheet 2012: Asia and the Pacific.* Geneva: UNAIDS.

Key informants (confidential interviews with civil society, local government, and international donor representatives), interviewed by Health Policy Project staff members, October 2015.

Khan, S. I., et al. 2009. "Living on the Extreme Margin: Social Exclusion of the Transgender Population (Hijra) in Bangladesh." *Journal of Health, Population and Nutrition* 27(4), 441–451.

National AIDS/STD Programme, Bangladesh (NASP). 2012. *National Serological Surveillance 2011. 9th Round Technical Report.* Dhaka, Bangladesh: NASP, Directorate General of Health Services, and Ministry of Health and Family Welfare.

NASP. 2013. NCPI: *National Commitments and Policies Instrument.* Dhaka: UNAIDS.

Reza, M., S. Alam, S.I. Khan, A.K.M.M. Rana, G. Gourab, and T. Azim. 2014. *A Survey of HIV, Syphilis and Risk Behaviours Among Males Having Sex with Males, Male Sex Workers and Hijra: Global Fund Rolling Continuation Channel Project of ICDDR, B.* Dhaka: ICDDR, B.

USAID/Bangladesh. 2012. *A Midterm Performance Evaluation of the Modhumita Project for HIV/AIDS.* Washington, DC: USAID.

World Bank. 2015. "Data: Bangladesh, World Development Indicators." Available at: http://databank.worldbank.org/data/reports.aspx?source=world-development-indicators.

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