MONGLA: Project and Evaluation

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Précis

The focus of the Mongla HIV/AIDS Project is prevention. The emphasis of the Program is primarily to curb the spread of HIV. Reduction of the incidences of other sexually transmitted diseases (STDs) and reproductive tract infections (RTIs) is a secondary but related goal. The target area is the busy port of Mongla in Bangladesh. Target populations are commercial sex workers (CSWs), dock workers, rickshaw pullers, housewives, and youth/adolescents. All these are high-risk groups to contract HIV/STDs. Housewives are included due to the sexually promiscuous behaviour of many of their spouses.

The effectiveness of this Project may be primarily attributed to peer educators using a wealth of information, education, and communication (IEC) methods and techniques. Within a short period of time, the knowledge of transmission and prevention of HIV/AIDS rose dramatically among most of the targeted high-risk groups. So successful is the Mongla Project that the evaluation team would like to see it replicated in other high-risk behaviour areas where World Vision Bangladesh works.

Behavioural change to prevent HIV/STDs is reflected in the greater acceptance and use of condoms. Most of the praise for attitudinal modifications is due to peer educators. Some of the credit also must be given to the Project for dispersing condoms free of charge. That, of course, is also a project weakness noticed by the evaluation team. To help assure sustainability, ways must be found to sell condoms at a "nominal price" for which government subsidies may be needed.

Summary

The objectives of the evaluation were to:

- Assess Mongla Project accomplishments, both quantitative and qualitative;
- Check the progress of different HIV/AIDS prevention approaches and quality of services offered;
- Review the existing human management information systems (HMIS) and assess the appropriateness of the monitoring system in tracking progress of the Mongla Project;
- Assess the changes in attitude and sexual behaviour pattern among commercial sex workers (CSWs);
- Review the status of condom promotion and use among commercial sex workers (CSWs); and
- Determine future opportunities and strategic direction/suggestions for better performance of the programme, its extension, expansion, and sustainability.

For collecting data the evaluation team did some focus group discussions with CSWs at Banishanta brothel, peer educators working with housewives, dock workers at Mongla port, rickshaw pullers, and youth/adolescent groups. The evaluation team interviewed randomly selected persons, visited health education sessions, and observed the clinical service delivery system. Relevant Project documents, reports, and records were reviewed.

One of the Mongla Project objectives was to enhance the knowledge of HIV/AIDS target groups, including the transmission and prevention of the disease. The results indicated that the Project worked very successfully with sex workers and housewives whose knowledge of HIV transmission considerably improved. This increased awareness was mainly achieved through the development of peer educator groups who worked closely with the women by providing information and education to small groups and individuals. In contrast, dock workers' knowledge of transmission and prevention of STD/HIV did not satisfactorily increase.

Commercial sex workers and brothel clients increased their use of condoms. There also was a reported rise in the use of condoms among dockworkers and youths. The main strategy to disseminate information among the target groups was through the formation of peer educator groups and volunteers who used a variety of strategies and information, education, and communication (IEC) materials.

The common practice for both doctors who worked at the centres and pharmacists who came to the group meeting was only to prescribe and provide medication to patients. These medical professionals did not know the proper treatment of partners of patients. Due to lack of training, the doctor working at the Mongla Project out patient clinic has almost no knowledge of the syndromic management approach to reproductive tract infections and sexually transmitted infections (RTI/STD). Apparently the concerned medical providers who were linked to the Project had very little awareness regarding the importance of partner management. Providers who were met by the team during the evaluation exercise did not spontaneously mention that they informed their patients who used condoms about RTI/STD treatments. As there was no protocol, the management of RTI/STD depended solely on the judgement of the provider.

Based on the findings of the evaluation, the evaluation team made several recommendations. The first is to expand peer educator groups in all target groups but especially dock workers, youth, and rickshaw pullers. Mongla Project staff and peer educators need training in participatory learning and action (PLA) methodologies. All of the IEC materials used at the Project are more appropriate for literate people. Steps should be taken to develop specific IEC materials for each target group in co-operation with members of the group. Mongla Project staff and peer educators should visit other HIV/AIDS projects to gain more experience and practical knowledge. Peer educators and other Project members also should be involved in regular Project reviews and evaluations.

The second recommendation is to work with target groups, health centres, and commercial enterprises to develop a sustainability action plan for condom availability. The Mongla Project should take steps to initiate selling condoms at nominal prices instead of giving them away free of charge.

Third, there is an urgent need to improve the availability and accessibility of preventive and curative RTI/STD services within the existing infrastructure. The Mongla Project medical staff (doctor and nurse) and other possible providers should receive training on the syndromic approach of management of RTI/STD cases. In this connection, the Project should develop strong linkage with other health care agencies and providers working in the port area.

Fourth, steps should be taken to strengthen the practice of all universal infection prevention procedures including safe disposal of syringes and needles. Standard infection prevention workshops should be conducted for the Project doctor and nurse, pharmacists, and providers of other hospitals and clinics with whom the Project refers cases. In collaboration with the local Thana Health Complex the Mongla Project managers should consider setting up an incinerator for disposal of certain clinical wastes.

Fifth, considering the different dimensions of the Mongla HIV/AIDS Project and its satisfactory achievements, the policy makers at World Vision Bangladesh should consider replicating the Project. The rich experiences learned from Mongla should be shared with donors, service delivery organisations, and government agencies.

Introduction and background

The Mongla HIV/AIDS Prevention Project began as a small-scale operation in 1993. The Project was expanded in 1997 as World Vision Bangladesh considered the alarming HIV/AIDS situation in neighbouring countries such as India, Myanmar and Thailand; ignorance of the population at risk; social taboos about sex/reproductive health education; and risky sexual behaviour of the population at this port town.

The project is situated at the Mongla Port Municipality in Bagerhat District and at the Banishanta brothel in Khulna District. The project encompasses an area of 38 sq. km. Mongla Port is the second largest international seaport of Bangladesh. The total population of the port town is nearly 50,000. Between 50,000 and 80,000 people visit the port for business purposes every month. Approximately 10,000 mostly single men work at the Mongla docks. In addition, about 5,000-6,000 men live in this area, most of whom migrated from other districts in Bangladesh and serve as boatmen, fishermen, and rickshaw pullers.

There are around 400 registered and another 200 unregistered commercial sex workers (CSWs) living at the Banishanta brothel on the bank of the River Posur, opposite Mongla Port. Seamen from Thailand, India, Myanmar, and the Philippines, as well as a large number of dockworkers, truck drivers, businessmen, and visitors from different parts of Bangladesh frequent this brothel. In short, Mongla Port has all the conditions favourable for the spread of HIV/AIDS.

The Mongla HIV/AIDS Prevention Project began with the broad goal of reducing the spread of HIV/AIDS/STDs in the vicinity of the Mongla municipality area.

The project had these measurable, specific objectives:

- Increased condom use by different target group populations;
- Enhanced knowledge on the spread and prevention of HIV/AIDS;
- Improved STD detection;
- Case management and care-seeking behaviour; and
- Increased condom use negotiating skills by CSWs.

The Mongla Project had the following key interventions/activities as goals:

- Mass programme of STD/AIDS awareness through different media, such as local newspapers, cinema slides, brochures, billboards, folk media, and community visitations.
- Awareness and education programmes through peer educators for condom promotion and improved care-seeking behaviour.
- Networking and relationship with local power structures, government organisations, non-governmental organisations (NGOs), and the community.
- Community and staff capacity building for effective communication and program implementation.
- Development and publication of information, education, and communication (IEC) materials segmented for target group audiences.
- Capacity building of local health practitioners for STD case management, partner notification and follow-up. The Mongla Project works among seven target groups: commercial sex workers (CSWs), dock workers, adolescent/youth, housewives, rickshaw pullers, brothel clients, and people with STDs.

HIV/AIDS prevention programmes are sensitive and challenging work in Bangladesh's restricted country context. The culture greatly restricts open discussions of sex and sexuality. To operate a prevention programme among target groups required congenial relationships and co-operation with religious leaders, local elites, government agencies, NGOs, and brothel operators. HIV programmes also need a strong social commitment and must mobilise local resources and facilities. Considering all these factors, the project's programme implementation strategy needs to:

- Address the basic health care services for children and STD treatment for CSWs at Banishanta Brothel. If necessary, clients were referred for more thorough check-ups or treatment at an appropriate hospital.
- Arrange training and maximise utilisation of local resources from governmental organisations, NGOs, and the community.
- Provide cost effective service.
- Continue quality improvement in all activities.
- Develop community mobilisation through involving opinion makers, such as religious heads, schoolteachers, brothel operators, hospital managers, and community elites.
- Provide very strong monitoring system for quality assurance and quantitative achievement for all program indicators.
- Demonstrate sustainability of resources. Services and impacts through up-grading management and technical skill of program partners, such as community volunteers and peer educators, and networking with local service providers (government, private, and NGOs).
- Promote human resource development in the community and Mongla HIV/AIDS Prevention Project staff.
- Upgrade the educational level of peer educators.
- Create a supportive social and legal environment for CSWs and their children.
- Develop psychosocial recovery for the traumatised child sex workers in the brothel.

In the early days of the Mongla Project a base line survey was conducted. Data tabulation and interpretation were done separately for each of the areas affected by the project. A summary of the findings included:

- Exposure to extra marital sex was highest (92.86%) among married adolescents and youths.
- Only 31% brothel clients used a condom.
- Only 7% of men with exposure to extra marital sex used a condom during sexual intercourse with their wives.
- Village doctors and pharmacists were the most common service providers and first hand informants for STD.
- Reasons given for not using condoms were the lack of satisfaction or because people surveyed did not like to use condoms.
- 24% of dockworkers did not know how to properly use a condom.
- 41% of brothel clients were businessmen.

Objectives of the evaluation

The five primary objectives were to:

- Assess the accomplishments of the Mongla Project in view of quantitative and qualitative methodologies and techniques. Recognise the progress of different HIV/AIDS Prevention approaches and the quality of the services offered.
- Review the existing health management information system (HMIS). Assess the appropriateness of the HMIS in tracking the project's progress among different target groups.
- Assess the accomplishment of the Mongla Project and verify the changes in attitude and sexual behaviour pattern among CSWs.
- Review the condom promotion status and its use among CSWs.
- Determine future opportunities and strategic direction/suggestions for better performance of the program, its extension, expansion, and sustainability.

Methodology of the Evaluation

The evaluation/assessment was conducted from 12 to 16 December 1999. The evaluation team undertook the following activities for the evaluation:

- Focus group discussions with the following groups:
  - Commercial sex workers (CSWs) at Banishanta brothel
  - Peer educators working with housewives and dock workers
  - Rickshaw pullers
  - Youth/adolescents
- Interviews with randomly selected people, including:
  - Local government officials
  - Local NGO representatives (Mongla Port Mohila Samity)
  - Staff of St. Paul and Dock Labour hospitals
  - Project counsellors
  - Peer educators
  - Project staff
  - Community volunteers
- Observation of sessions:
  - Conduct of health education sessions,
  - Clinical service delivery.
- Review of Mongla Project documents, reports and records.

Objective-wise operational strategy for the project and achievements

Dissemination of knowledge about STD/AIDS

The Mongla Project's first objective was to enhance knowledge of target groups with HIV/AIDS, its transmission and prevention. Operational benchmarks were set out in a detailed implementation plan (DIP) following a baseline survey conducted in August 1997. Another survey was conducted in September 1999 to determine the achievements of the project over two years. Knowledge of HIV/AIDS transmission and prevention has increased in all the target groups as shown in the tables below:

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The percentage of CSWs able to name at least two specific ways that HIV/AIDS is transmitted increased

Table 1: Percentage of respondents naming at least two specific ways that HIV/AIDS is spread.

Sl. No.	Respondents	Survey '97	Expected output – 09/99	BC Survey – 10/99
1.	CSW	22%	50%	93%
2.	Dock workers	31%	50%	50%
3.	Housewives	14%	50%	97%
4.	Rickshaw pullers	2%	50%	53%
5.	Youths	29%	50%	30%

Table 2: Percentage of respondents naming at least two specific ways to prevent HIV/AIDS.

Sl. No.	Respondents	Survey '97	Expected output 09/99	BC Survey 10/99
1.	CSW	2%	50%	100%
2.	Dock workers	17%	Not determined	30%
3.	Housewives	5%	-do-	80%
4.	Rickshaw pullers	0%	-do-	37%
5.	Youths	27%	-do-	43%

from 22% in the 1997 survey to 93% in this 1999 survey. The percentage of CSWs able to name at least two specific ways to prevent HIV/AIDS increased from two percent in the 1997 survey to 100 percent in the 1999 survey! The percentage of housewives able to name at least two specific ways that HIV/AIDS is transmitted increased from 14% in the 1997 survey to 97% in this 1999 survey. The percentage of housewives able to name at least two specific ways to prevent HIV/AIDS increased from five percent in the 1997 survey to 80 percent in this 1999 survey. These increases in knowledge were facilitated through the development of peer educator groups who worked closely with the women providing information and education in small groups and to individuals. There were 13 peer educators trained to work with the sex workers and 18 to work with housewives. The data suggest that the project has worked very successfully with the sex workers and housewives to help them increase their knowledge of HIV/AIDS transmission and prevention.

As can be seen in Table 1, the proportion of dock workers and rickshaw pullers able to name at least two specific ways that HIV/AIDS is transmitted equalled (in the case of dock workers) or passed (in the case of rickshaw-pullers) the target set by the staff in the DIP. The percentage of dock workers able to name at least two specific ways that HIV/AIDS is transmitted increased by 19% between 1997 and 1999. The percentage of rickshaw pullers able to name two or more specific ways that HIV is spread increased by 51% over the same time. The percentage of dock workers able to name two or more specific ways to prevent HIV/AIDS increased by 13%. The percentage of rickshaw pullers able to name two or more ways to prevent HIV/AIDS increased by 35%.

The dock workers targeted in the program were the single under-40 years group, usually migrants from other parts of Bangladesh. This is a transient group whose irregular work patterns depend on when ships arrive in the port. The number of peer educators working among the dockworkers was three and among the rickshaw-pullers two. From observations during the evaluation visit the dockworker peer educators have been well trained and are able to conduct education session among the dockworkers.

In the 1997 and 1999 surveys, a similar percentage of youth was able to name at least two ways that HIV/AIDS is transmitted (29% and 30% respectively). However, the percentage of young people able to name at least two specific ways to prevent HIV/AIDS infection increased by 16%. A group of 40 youth volunteers work with the young people, including an entertainment group who perform dramas, sing and dance as a means to educate people about HIV/AIDS.

Regarding increase in knowledge about STD's, the survey in 1999 did not ask questions about mode of transmission and prevention, instead questions focused on knowledge of signs and symptoms and care seeking behavior. The findings are given in Table 3.

Table 3: Percentage of respondents able to name at least two signs of STD's; percentage of respondents indicating that they sought medical treatment for STD symptoms; percentage of respondents indicating that they sought treatment for their partners.

Sl. No.	Respondents	Signs/ symptoms	Care seeking behaviour	Treatment of partners
1.	Housewives	77%	62%	40%
2.	CSWs	100%	100%	NA
3.	Rickshaw pullers	30%	83%	33%
4.	Dock workers	33%	50%	NA
5.	Brothel clients	40%	83%	0%
6.	Suspected STD cases	87%	52%	64%

Knowledge of STD symptoms is highest among the sex workers, housewives and suspected cases of STD's. Seeking medical treatment is lowest among the dockworkers. The seeking of treatment for partners is low overall.

Behavioural change

The Mongla Project had an objective of increasing condom use among the various target groups. The operational benchmark for this objective was determined only for the commercial sex worker (CSW) group. The survey question asked about condom use during the last sexual act. The results are shown in Table 4.

From the results it is noted that the sex workers and brothel clients are using condoms increasingly. As can be seen in Table 4, a significantly higher percentage of dockworkers in 1999 reported condom use during their last sexual act (33% in 1999 compared to 13% in 1997). There was also a pleasing upward trend in reported condom use among youth (39% in 1999 compared to 24% in 1997).

Table 4: Percentage of respondents reporting condom use during last sexual act.

Group No.	Respondents	Survey '97	Expected output 09/99	BC Survey 10/99
1.	Brothel clients	31%	50%	67%
2.	CSWs	59%	Not determined	100%
3.	Rickshaw pullers	10%	-Do-	22%
4.	Dock workers	13%	-Do-	33%
5.	Youths	24%	-Do-	39%

Questions regarding from where condoms are procured gave us information that the source is in a changing trend (Table 5).

Sex workers now receive all the condoms from the project, whereas in 1997 they only received 65%. In 1999 rickshaw pullers received condoms from shops (60%), the health centre (20%), and from partners (20%). Dockworkers obtained condoms from pharmacies (25%), shops (50%), and partners (25%). Youth procured condoms from shops (71%), health centres (14%), and partners (14%). Brothel clients received condoms from partners (70%), shops (20 %), and the pharmacy or project (5% each).

In all groups there was an increase in the percentage receiving condoms from partners who were likely to be commercial sex workers. There was a general decrease in the percentage of condoms received from shops and pharmacies.

In 1999, rickshaw pullers received condoms from shops (20%), health centre (20%) and from partners (60%); dockworkers receive condoms from pharmacies (25%) shops (50%) and partners (25%); youth received condoms from shops (71%) health centres (14%) and partners (14%); brothel clients receive condoms from partners (70%), shops (20 %), and pharmacy or project (10%).

In all groups there has been an increase in the percentage receiving condoms from partners whom it can be assumed is the sex worker. There has been a corresponding decrease in the percentage source from the shops and pharmacies.

The Mongla Project strategy was to disseminate information and provide education through peer educators using a variety of communication strategies. The following data illustrates how the project achieved the objective of increased knowledge of HIV/AIDS and condom use.

Knowledge disseminated by:

- Peer educators: 36 (18 for housewives, 13 for CSWs, 3 for dock workers, and 2 for rickshaw pullers)
- Volunteers: 40 (50% male and 50% female, 2 volunteers per ward plus a drama team)
- Council members: 20
- Teachers: 12 (6 male and 6 female)
- Pharmacists/medical providers: 20

Table 5: Percentage of respondents reporting where they obtained condoms.

Group No.	Respondents	Hospital/clinic		Shop		Pharmacy		Partner		Project staff	
		'97	'99	'97	'99	'97	'99	'97	'99	'97	'99
1.	CSWs	0	0	19	0	0	0	8	19	65	100
2.	Brothel clients	0	0	66	20	3	5	24	70	7	5
3.	Rickshaw pullers	0	20	100	60	0	0	0	20	0	0
4.	Dock workers	13	0	50	50	38	25	0	25	0	0
5.	Youths	8	14	67	71	17	0	8	14	0	0

Knowledge disseminated to:

- Commercial sex workers: 268
- Dock workers: 2,000 (almost resided in the Mongla area their wives or they were bachelors). The average age of dockworkers was under 40 years old. It was estimated that there are over 7,000 dockworkers at Mongla Port.
- Rickshaw pullers: 3,000
- Housewives: 9,967
- Youth: 9,750 approximately (15-24 years old)
- Outpatient clients and brothel clients: unknown number

The following methods of dissemination were used in the project at the Banishanta brothel and Mongla Municipality area:

- Individual one-to-one education
- Group discussions
- IEC: posters, flip charts, video, caps, tee shirts, stickers, booklets, leaflets, calendars
- Media: cinema slides, magazine, local paper
- Cultural program and dramas
- Essay, quiz and debates for the students
- Workshops, seminars and mass gatherings.

Results of the survey conducted in September 1999 revealed the increased effect of the Mongla Project on target groups. CSW and housewife groups now have a sound knowledge of the transmission of STDs and HIV/AIDS as well as prevention. Still, among other groups such as dockworkers, rickshaw pullers, and youth only 50 % achieved a correct understanding of transmission and prevention.

The main strategies to disseminate information among the target groups were through the formation of peer educators groups and volunteers who used a variety of strategies and information, education, and communication (IEC) materials. Peer educators for CSWs and housewives, in addition to the volunteer group who worked mainly with youth, were especially active and very effective.

The number of peer educators among these groups (13 and 18 respectively) was a factor that helped to achieve this success. However, the number of peer educators for the dock workers (3) and rickshaw pullers (2) was insufficient to impact a large change in the knowledge levels among these groups.

Among the youth groups there were 40 volunteers working in the community and a special drama group that performed plays and concerts to disseminate information on HIV/AIDS. Some 12 teachers were also involved in instructing health education courses in the schools to 480 grade 9 and 10 students. These lessons helped to increase awareness of HIV/ AIDS. Project staff conducted a Family Life course for 20 adolescent girls over a six-month period.

The Mongla Project established training courses for peer educators. Educators were active in their communities in disseminating information and educating people about STDs and HIV/AIDS. From the survey results it was clear that the foundations were put in place. Yet for a wider impact there was a need to increase the number of peer educators in all the target groups, but especially among the dock workers, youth, and rickshaw pullers.

Information, education, and communication (IEC) materials were produced using a wide variety of media such as leaflets, posters, flip charts, magazines, cinema slides, video, caps, t-shirts, and stickers. A review of these materials indicated that they provided general information, but not materials that were specific to the different target groups. As happens in many projects where information was prepared by health professionals and Mongla Project staff, many of the booklets and magazines were presented in written form without many pictures. Messages should be targeted to different groups and the level of detail and technical/medical knowledge appropriate to the audience. Materials for health staff should be different to what is provided for peer educators or youth workers. Materials for the dockworkers could be made specifically for them. The development of specific materials would best be done with the assistance of the dockworkers themselves in the design and pre-testing of materials and messages.

CSWs reported that there was a policy in the brothel that condoms were to be used with every client. A client can be refused service if he does not agree to use one. Among all groups there was an increase in condom use. The sex workers received their supply of condoms from the Mongla Project. According to the surveys conducted in 1997 and 1999 there was an increasing reliance on the partner (CSW) to provide the condom. Sex workers, in turn, were relying on condom supplies from the project.

This strategy is not sustainable, and it is not helping men take responsibility for safe sex. The Mongla Project staff should work with the commercial sex workers to develop strategies for selling condoms to clients. They should also work to increase the sale of condoms through commercial outlets.

Reproductive tract infections/sexually transmitted diseases (RTIs/STDs) case detection and management

RTIs were one of the most common health problems affecting women of reproductive age in South Asia. Studies undertaken in Bangladesh revealed that more than 50% of women suffer from RTIs. Some RTIs are sexually transmitted. A 1995 report indicated a 3.8% prevalence of gonorrhoea found among women in the general urban population. This result indirectly reflected the presence of high-risk sexual behaviour. The situation was probably no different than Mongla Port, which has all the characteristics of a general population involved in high-risk sexual activities.

RTIs may be caused by unhygienic medical procedures including home deliveries and also poor maintenance of menstrual hygiene. It is clear from available health information that RTIs of all types that affect fertility, pregnancy outcome, and child survival might be a common problem in the Mongla Project area. Bacterial vaginitis, the most common RTI, can cause premature delivery and low birth weight babies

The common practice mentioned by the doctors working at the centres visited and the pharmacists who came for the group meetings was to prescribe and provide medication only to patients. Medical practitioners do not know about the proper treatment of partners of patients. Some doctors gave treatment to clients and asked their partners to come in for follow-ups. A pharmacist mentioned that he provided half-doses of drugs to the patient and asks the patient to bring the partner for treatment. The doctor who worked at the project out patient clinic had almost no knowledge about the syndromic approach to the management of RTIs/STDs. It seems that the providers had very little awareness regarding the importance of partner management. The providers who met during the evaluation exercise did not spontaneously mention telling their patients to use condoms along with RTIs/STDs treatments. As there was no protocol, the management of RTIs/STDs depended solely on providers' own judgements. About two-thirds of the doctors and pharmacists mentioned sending their STD patients for syphilis, hepatitis B, or gram stain tests. Almost all of the providers said that they ordered a urine examination and other blood tests, procedures that are not related to diagnosing RTIs/STDs.

Different aspects of project management

Community involvement in the program

Different local community groups were involved in the program implementation process. Generally the program was based on community ownership by involving different stakeholders through various workshops, seminars, training, meetings, gatherings, and collaboration activities. There were different partners from the community groups that were directly or indirectly working with the project to achieve its target. These were community volunteers (mainly college students), peer educators from different segments, counsellors (from government agencies and NGOs), school and college teachers, pharmacists, local leaders and elites, and advisor groups from every target group.

Partnership with local GOB agencies and NGOs

The Mongla Project sought the active participation and collaboration with national STD/AIDS networks, US Agency for International Development (USAID), a social marketing company, Thana Health Complex, various community organisations, and World Vision Bangladesh management. The latter included the National Health Co-ordinator and the Asia Regional Health Advisor to ensure consistency with the Government of Bangladesh's AIDS Prevention Policy. At the local level there were strong partnerships and working relationships with different local governmental organisations and NGOs, especially with those working in the health sector.

It was the Mongla Project strategy to strengthen the local institutions through training, supporting STD case detection and management, buttressing AIDS prevention services, and sustaining the program in the community. In 1999 there was a referral partnership of STD cases with St. Paul's hospital, Thana Health Centre, Dock Labour Hospital, and Mongla Port Mohila Sommity (local NGO). The project conducted health education sessions for clients in collaboration with these health organisations.

The Mongla Project established a good relationship with government agencies and NGOs. However, the project must continue to strengthen its working relationship and networks with all government organisations and NGOs, especially with local health providers in the impact area through:

- Individual contacts, discussion sessions, seminars, workshops, meetings, and gatherings;

- Being involved in different mass programmes such as AIDS Day, Health Day, and Volunteers Day;
- Sharing up-dated project activities, survey reports, and up-to-date AIDS information;
- Building up an effective referral system on STD case detection and management;
- Counsellor selection;
- Submission of regular monthly reports to the government high officials.

Project information management system

The Mongla Project carried out surveys in 1997 and 1998. In August 1997 a baseline information survey was done on the knowledge, attitude, and practice/care-seeking behaviour in relation to STD and HIV/AIDS among seven target groups. This information was used in the development of operational strategies including a systematic IEC campaign, ongoing assessment of achievement towards objectives, and for monitoring and evaluation purposes. A household enumeration survey was conducted in March 1998 to determine the demographic structure of the local population and to identify target segments in order of population density and to develop monitoring and evaluation tools.

As the baseline and household surveys provided quantitative data, a supplementary survey was made to get qualitative information in March 1998. This survey attempted to identify effective processes to bridge the gap between knowledge and practice among the target groups. Detailed reports from all the surveys were published and used by the Mongla Project to develop strategies to increase the communities awareness and knowledge of HIV/AIDS and to influence behaviour change in relation to STDs and HIV/AIDS.

A Detailed Implementation Plan (DIP) was developed for the project in June 1998 after completion of the surveys. This document developed during a workshop with staff outlined how the project was to be implemented. It was an important working tool for staff to ensure the project was executed correctly.

Monitoring and evaluation of the Mongla Project occurred at both the project and National Office levels. The project received technical and managerial inputs from the World Vision Asia Regional Office and World Vision Australia. The Mongla Project employed a monitoring and evaluation officer who tracked the input, process, output, and impact indicators directly related to the project objectives. This was achieved through the development of a project log frame and checklists for condom distribution, along with knowledge assessment tools for each of the target groups. Monthly narrative and financial reports were compiled for the National Office and quarterly reports for the National and World Vision Australia offices. The project monitoring and evaluation officer was able to enter survey data and produce basic survey reports that permitted project and National Health managers to do analyses.

Human resource development and its management

The Mongla Project provided its own staff and community partners with numerous training courses in all aspects of project operations. Training related to health included topics such as training of trainers (TOTs) on STD and HIV/AIDS counselling; TOT on adolescent family life education; reproductive health and reproductive rights; maternal and child health care; primary health care; family planning; RTI/STD syndromic management; and health and functional education. The project staff and peers also were provided with training in survey methodology, social analysis, development groups management, functional education, and participatory learning by action (PLA).

In January 1999, the Mongla Project team leader was replaced by a medical doctor who never attended a training session on syndromic management of RTI/STDs. Five Community Development Organisers (CDOs) were transferred from other World Vision Bangladesh projects. All five lacked proper training on technical details about HIV/AIDS/STDs and counselling for prevention and care.

All CDOs needed to be trained in HIV/AIDS counselling, STD care and management, and communication technology for group health education, and interpersonal communication. Recruitment of project staff was not gender balanced. At the community level the Mongla Project had only one CDO to work among the CSWs. Young male CDOs were not comfortable in message dissemination among housewives and elderly dockworkers. CDOs defined geographical areas and/or target group populations to cover. They supervised or provided necessary guidance to the activities of peer educators.

The project had 32 peer educators trained for working among CSWs, dockworkers, rickshaw pullers, and housewives. Besides peers, the Mongla Project also trained 24 teachers to support its adolescent health education program in their respective schools. Each CDO had his/her individual monthly plan of action and

reporting format. All reports are compiled by the monitoring and evaluation officer and shared among staff and partners on a regular basis.

The Mongla Project employed a training and communication officer. His role was to procure and develop IEC materials and arrange workshop for larger community participation and dissemination. From 1996 to 1999 many local and national level dissemination workshops on HIV/AIDS and several qualitative and quantitative studies were done. The Mongla Project had to train its newly recruited CDOs and develop a mechanism of withdrawing financial support to peers working among housewives. The number of peer educators working among dockworkers and rickshaw pullers had to be increased.

Overall, staff members appeared to be satisfied with their work because they knew they were addressing a great human need. Project partners appreciated what the Mongla Project was accomplishing for the community.

Lessons learned and recommendations

Peer educators

Expand the peer educator groups in all the target groups, but especially among the dockworkers, youth, and rickshaw pullers. A group of 50 dockworkers should be identified and trained as peer educators as these workers are often seasonal labourers and will migrant back to their homelands.

Project staff and peer educators need training in participatory learning and action (PLA) methodologies. Use PLA with the target groups to identify strategies that will assist in behavioural changes occurring in the community in relation to condom use and the prevention of STDs and HIV/AIDS.

IEC materials

All the information, education, and communication (IEC) materials used at the project are appropriate for literate people. Steps should be taken to develop specific IEC materials for each target group in co-operation with members of the group.

Capacity Building

Arrange for Mongla Project staff and peer educators to visit other HIV/AIDS projects and to meet people living with AIDS (PLWHA). Involve peer educators and other project members in regular project reviews and evaluations. Needs-based training should be organised for project staff and volunteers, particularly focusing on bringing behavioural changes to the customers/clients.

Sustainability

Work with target groups, health centres, and commercial enterprises to develop a sustainability action plan for condom availability. The Mongla Project should take steps to initiate selling condoms at nominal price instead of giving them away free of charge. In this connection, assistance may be obtained from a social marketing company.

RTI/STD case management

There is an urgent need to improve the availability and accessibility of preventive and curative RTI/STD services within the existing infrastructure. The project medical staff (doctor and nurse) and other possible medical providers should receive training on the syndromic approach of management of RTI/STD cases.

Improving infection prevention practices

The Mongla Project made people aware of the danger of using second-hand syringes, needles, and other sharp instruments. To stop use of the disposable syringes and needles the project has been providing free one time use plastic syringes and needles to the local Dock workers Hospital. Unfortunately no steps were taken to strengthen practice of all universal infection prevention procedures including safe disposal of disposable syringes and needles. Standard infection prevention workshops should be conducted for the Project doctor and nurse, pharmacists, and providers of other hospitals and clinics with whom the project refers cases. In collaboration with the local Thana Health Complex the Mongla Project management should think of setting up an incinerator for disposal of certain clinical waste.

Replication and wider dissemination

Considering the different dimensions of the Mongla HIV/AIDS Project and its satisfactory achievements, the policy makers at World Vision Bangladesh should start thinking of replicating the project. In the different high-risk behaviour populations where World Vision Bangladesh works, managers should think of putting into action some of the activities of the HIV/AIDS Mongla Project. The rich experiences of this project should be shared with donors, service delivery organisations, and the government.