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| Funding Request FormAllocation Period 2020-2023 |

Full Review |

*Refer to the “Full Review” Instructions to complete this form.*

Summary Information

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| **Country(s)** | Bangladesh  |
| **Component(s)** | HIV/AIDS |
| **Planned grant(s) start date(s)** | 01 December 2020 |
| **Planned grant(s) end date(s)** | 31 December 2023 |
| **Principal Recipient(s)** | AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Peoples’ Republic of Bangladesh Save the Children International icddr, b |
| **Currency** | USD |
| **Allocation Funding Request Amount** | 23,000,765 |
| **Prioritized Above Allocation Request (PAAR) Amount[[1]](#footnote-3)** |  |
| **Matching Funds Request Amount[[2]](#footnote-4)**(if applicable) | Not Applicable  |



# Section 1: Context Related to the Funding Request

To respond to the questions below, refer to the *Instructions* and**Essential Data Table(s).**

## Key References on Country Context

List key reference documents referred to in this funding requestthat provide the country’s contextual cross-cuttingand disease-specific information. A list of which types of documents can be used is included in the *Instructions*.

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| **Key focus area** | **Reference document** | **Link/Attachment**  | **Relevant section(s) and/or page(s)** |
| Health system strategies | 1. Government of Bangladesh (GoB). (2016). Health, population and nutrition sector program (HPNSP), Program implementation plan (PIP), vol-1, 2017-2022. Planning Wing, Ministry of Health and Family Welfare, Govt. of Bangladesh
 | Attachment  | Pages 375-390 |
| 1. Revised 4thNational Strategic Plan for HIV and AIDS Responses 2022-2023
 | Attachment  |  |
| 1. 4th National Strategic Plan for HIV and AIDS Response 2018-2022
 | Attachment  | PageI, 9,10-11 |
| 1. Government of Bangladesh (GoB). (1996). National policy on HIV/AIDS and STD related issues. Directorate General of Health Services (DGHS), Ministry of Health and Family Welfare, Govt. of the People’s Republic of Bangladesh.
 | Attachment  | Page 79 |
| Health system overview | 1. ASP. 2019. Annual Report 2018, AIDS/STD Program. Directorate General of Health Services, Ministry of Health and Family Welfare, Government of the People’s Republic of Bangladesh
 | Attachment | Page-10,11, 16, 19, 20, 23 |
| 1. GoB. (2011). Bangladesh Demographic and Health Survey, 2011. National Institute of Population Research and Training (NIPORT), Ministry of Health and Family Welfare, Dhaka, Bangladesh.
 | <https://dhsprogram.com/pubs/pdf/FR311/FR311.pdf> | Page 179, 209 |
| 1. ASP. (2016). Mapping study and size estimations of key populations in Bangladesh for HIV programs 2015-2016. National AIDS/STD Program (ASP), Directorate General of Health Services (DGHS), Ministry of Health and Family Welfare, Govt. of the People’s Republic of Bangladesh.
 | Attachment  | Page xv, xvi |
| 1. ASP. 2016. Behavioural and Serological Surveillance amongst Key Populations at Risk of HIV in Selected Areas of Bangladesh, 2016 Conducted by Institute of Epidemiology, Disease Control and Research (IEDCR) and icddr,b
 | Attachment  | Page 54, 120, 128, 130,131 |
| 1. ASP. (2016). Behavioural and serological surveillance on males having sex with males, male sex workers and hijra, 2015: Technical Report. National AIDS/STD Program (ASP), Directorate General of Health Services (DGHS), Ministry of Health and Family Welfare, Govt. of the People’s Republic of Bangladesh.
 | Attachment | Page 11, 18 60 |
|  | 1. World Health Organization. 2015. Bangladesh health system review (Health Systems in Transition, Vol. 5 No. 3 2015)
 | <http://apps.searo.who.int/PDS_DOCS/B5409.pdf> | page 14 |
| 1. World Health Organization. Health financing profile 2017 Bangladesh
 | <https://apps.who.int/iris/bitstream/handle/10665/259640/BAN_HFP.pdf?sequence=1&isAllowed=y> |  |
| Human rights and gender considerations | 1. Government of Bangladesh (GoB). (2016). National strategy on addressing gender-based violence for HIV response in Bangladesh (2017-2021). National AIDS/STD Program (ASP), Directorate General of Health Services (DGHS), Ministry of Health and Family Welfare, Govt. of the People’s Republic of Bangladesh.
 | Attachment  | Page 1-36 |
| 1. Government of Bangladesh (GoB). (2014). Bangladesh Gazette, Registration #SKM/KM-1Sha/Hijra-15-2013- 40, January 22, 2014.
 | Attachment  | Page 1 |
| 1. Khosla N. (2009). HIV/AIDS interventions in Bangladesh: what can application of a social exclusion framework tell us? Journal of health, population, and nutrition, 27(4), 587–597. doi:10.3329/jhpn. v27i4.3404
 | <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2928101/> | Page 587-597 |
| Disease-specific areas | 1. AIDS/STD Program. (2019). World AIDS Day presentation slides, December 01, 2019. AIDS/STD Program (ASP), Directorate General of Health Services (DGHS), Ministry of Health and Family Welfare, Govt. of the People’s Republic of Bangladesh.
 | Attachment  | The PPT |
| 1. ASP; UNAIDS. 2019. BANGLADESH INVESTMENT CASEFOR HIV: Sustainable Investment Options in the National HIV Response (Final Draft)
 | Attachment  | Page 19, 20, 27-30, 32-35 |
| 1. UNAIDS DATA 2019
 | <https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf> | Page 142,143, 156,157 |
| 1. Bangladesh Country Snapshot 2019. UNAIDS Regional Support Team for Asia and the Pacific and AIDS Data Hub. (2019)
 | <https://aidsdatahub.org/Country-Review/Bangladesh> |  |
| 1. UNAIDS. 2019. 25-27 June 2019 | Geneva, Switzerland UNAIDS Program Coordinating Board. Issue date: 13 June 2019. Delivering on SDG3: Strengthening and Integrating Comprehensive HIV Responses into Sustainable Health Systems for Universal Health Coverage, COUNTRY SUBMISSIONS
 | <https://www.unaids.org/sites/default/files/media_asset/UNAIDS_PCB44_CRP2.pdf> | UNAIDS/PCB (44)/CPR2Page 18-21  |
| 1. Health Policy project 2016. Bangladesh how the decline in PEPFAR funding has affected key populations
 | <https://www.healthpolicyproject.com/pubs/462_HPPBangladeshBriefMarchFINAL.pdf> | Page 2 |
| 1. Khanam, R., Reza, M., Ahmed, D., Rahman, M., Alam, MS., Sultana, S., Alam, A., Khan, SI., Mayer, KH., Azim, T. (2017). Sexually transmitted infections and associated risk factors among street-based and residence-based female sex workers in Dhaka, Bangladesh. Sexually Transmitted Diseases, 44(1): 22-29
 | Attachment  | Page 22-29 |
| 1. Khanam, R., Ahmed, D., Rahman, M., Alam, MS., Amin, M., Khan, SI., Mayer, KH., Azim, T. (2016). Antimicrobial Susceptibility of Neisseria gonorrhoeae in Bangladesh (2014 Update). Antimicrobial Agents and Chemotherapy, 60(7): 4418- 4419.
 | <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4914670/> | Page 4418-4419 |
| 1. Khanam, R., Ahmed, D., Alam, MS., Reza, M., Ashraf, L., Alam, A., Das, N., Ahmed, S., Rahman, M., Khan, SI., Rana, AKMM., Amin, M., Faruque, MO., Mayer, KH., Azim, T. (2015). Sexually transmitted infections among male and female sex workers, females who inject drugs and hijra under the global fund project in Dhaka. icddr,b
 | Attachment  | Page 80 |

## Summary of Country Context

Explain critical elements of the **country context** that informed the development of this funding request.

The following points should be addressed in the response:

* The epidemiological context and other relevant disease-specific information;
* Information on disease-specific and the overall health systems, along with the linkages between them;
* Relevant key and/or vulnerable populations;
* Human rights, gender and age-related barriers and inequities in access to services;
* Socio-economic, geographic, and other barriers and inequities in access to health services;
* Community responses and engagement; and
* The role of the private sector.

Refer to information provided in the key reference documents listed in **Section 1.1**.

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| [Applicant response]**3 pages****1.2 Country Context: HIV****HIV Epidemic in Bangladesh** Bangladesh though contains a low national HIV prevalence among the general population is <0.1 since first cases detected in 1989 but it is one of the seven countries in the Asia and the Pacific region where the new infections continue to increase [5, Page 10]. A concentrated epidemic has been on rise among populations identified as key populations (KPs) in the country and surveillances conducted in 2015-16, recorded high prevalence among the male PWID (People who inject drugs) in a neighborhood of Dhaka (old part of Dhaka) where the prevalence was 22% with 27.3% in one pocket. It was reported 8.9% in the rest of Dhaka. Among the female PWID in Dhaka the HIV prevalence was 5% [8, page 120].The prevalence of HIV among Female sex workers (FSWs), Men who have sex with men (MSM), Male Sex Worker (MSWs) is less than 1%. Among the transgenders (Hijra) 46 were sampled in Hili, a land port and bordering area with West Bengle, Indiaandtwo were positive for HIV (4.3%) while 0.9% were positive in Dhaka [8, page 139, 9 Page 60]. From 1989 to October 2019 a total of 7374 HIV positive cases were detected in Bangladesh. In the year 2019, a total of 919 cases were newly detected up to Octoberwhich includes a total of 105 Rohingya cases in Cox’s Bazar among the Forcibly Displaced Myanmar National (FDMN)]. Excluding the FDMN, among the newly detected 814 cases the highest concentration was in Dhaka (381) followed by Chottrogram (203), Khulna (90) and Sylhet (59). Among the newly diagnosed cases in 2019, 24% are People who Inject Drugs (PWID), 3% are Male Sex Workers (MSW), 3% are Men Sex with Men (MSM), 2% are Female Sex Worker (FSW) and 1% are Transgender women (TG, who are locally known as Hijra).[15, Slide #7, 8,10,18]. The estimated total number of People living with HIV (PLHIV) is 14,000 [15, Slide #4; 17, page 142-143, 156-157]. Figure-1 below shows the trend of HIV infection in Bangladesh since 1989 to 2019.Recent data says, 74.42% of the infected people are from 25-49 years age who are mostly sexually active and 74% of infected persons are male [15, slide # 12, 11].In terms of geographical distribution of HIVpositive cases though found highest concentration in Dhaka but it has been spread-outacross the country. The HIV surveillance 2016report showed that **active syphilis** rates were 2.4%-2.6% in male PWID at the same neighborhood ofDhaka where HIV prevalence is higher. Active syphilis was 5.8% in female PWID in Dhaka, 0.9% in male PWID from Hili. It ranges from 0-3.2% in FSWs from different sites in Dhaka, Hili and from all brothels [8, page 103, 110]. Among MSW and MSM the active syphilis rates were around 1% in Dhaka and Hili, while in hijra syphilis rate was 2.1% in Dhaka and 0% in Hili [9, page 18]. In a separate research study, etiological diagnosis for active syphilis, gonorrhea and chlamydia from different anatomical sites were measured among different KPs in Dhaka [21, pages 22-29; 22, pages 4418-4419]. The rates of having any of these STIs among FSWs from streets and residences in Dhaka were 10% and 12.5% respectively[21, pages 22-29]. Again, it is 20.7% among MSWs, 21.3% among hijra and 7.3% among female PWID [23, page 64, 46].Recently, all HIV cases are being screened for TB through GeneXpert. In 2019, 27 PLHIV diagnosed as TB-HIV coinfection and 26 patients are receiving TB treatment[15, Slide #16].In 2019, a total of 51 HIV positive pregnant women were enrolled for Mother-to-Child Transmission (PMTCT) and all are on anti-retroviral treatment (ART). Among those, total live birth was 47 but 2 children are born with HIV [15, slide #16, 17].**Disease SpecificInformation and its Linkages with Overall Health Systems** Tuberculosis-Leprosy & AIDS/STD Program (TB-L & ASP) is one of the 29 Operational Plans (OP) under the 4thHealth Population Nutrition Sector Program (HPNSP) 2017-2022. This OP is being implemented from January 2017- June 2022. The goal is to minimize the spread of HIV and the impact of AIDS on the individual, family, community, society andworking towards ending AIDS in Bangladesh by 2030. The Sponsoring Ministry is Health Services Division, Ministry of Health and Family Welfare (MOHFW).Implementing Agency is the Directorate General of Health Services (DGHS). The AIDS response in Bangladesh is primarily guided under the purview of the 4thHPNSP which is administered by the MOHFW [5,Page-10, 16]. Currently, government has been provided the anti-retroviral (ARV) drugs through selected 09 tertiary level public facilities across the country. Under the 4th HPNSP from 2017-2022activities are planned toencompass prevention for KPs and migrants; HIV testing, treatment,care and support for PLHIV are to be provided. The Operation Plan includes activities aroundHMIS, mass awareness raising, surveillance and surveys, research studies, capacitybuilding and coordination between different actors[1,page 375].Currently, HIV detection rate is 52.67%[15, slide # 9]. A total of 4009 PLHIV (up to October 2019) has been receiving ART from 09 governmentARTcenters and 05 comprehensive Drop-in Centers (DIC) of PR-SCII and CARE- Bangladesh for PWID-PLHIV. The ART coverage is 65.38% among alive PLHIV, viral suppression rate is 84.60% among the recipients of viral load testing [15, slide # 9]. It is evident that, Gene Expert machines are being used for viral load testing in the government ART centers and PR-icddr,b centers. Report showed a total of 461 viral load testing was done using the Gene Expert machine in those centers up to October 2019. Currently, one CD4 machine is working in Dhaka at the largest public medical university name Bangabandhu SheikhMujib Medical University (BSMMU). **Key and Vulnerable Populations**The number of people belonging to FSW, MSM,MSW, PWID and the TG/hijraare the key populations (KPs) considering the vulnerability and in the country contextof Bangladesh. It is estimated at around 300,000 KPs across the country. A significant part of all key and vulnerable populations are young people who often have limited knowledge about HIV/AIDS because of societal barriers [3, Page i]. Among the estimated sizes of the KPs: (i) FSW are102260 (ii) PWID are 33067 (iii)MSM are101695 (iv)MSWare 29777 and (v)TG/hijra are 10199 for [7, page xv].Other groups at increased vulnerability of infection include vulnerable adolescents, migrant workers, clients of sex workers, non-injecting drug users, partners of key populations, and these groups number in the millions.**Disease Strategy**The National Strategic Plan (NSP) has the overarching goal of minimizing HIV transmission and the impact of AIDS at all levels of the Bangladeshi society through the four pillars of prevention; treatment, care and support; management and coordination and strategic information. The strategy for addressing HIV in Bangladesh is based on the HIV epidemiological context, 4th HPNSP, NSP, and other documents such as the Investment Case of 2019 and projections from the AIDS Epidemic Model (AEM) [16, pages 20, 32-35]. Considering geographic variations, intervention strategies are prioritized in 23 districts where Dhaka is especially cogitated. HIV testing services (HTS) are available both in government and in selected NGOs facilities. There are ongoing efforts for HIV detection by linking with other relevant disease components such as TB, MNCH, etc. For treatment, care and support services for PLHIV, antiretroviral therapy (ART) and management of opportunistic infections (OIs) are provided at the public health facilities. To complement this community-based organizations (CBOs) are engaged to reach PLHIV including HIV positive KPs. Information and Communications Technology (ICT) has been used to extent for covering hidden KPs. Program evidences have been used to guide interventions and strategies. Under the respective OP of the 4th HPNSP from 2017-2022, activities are being prepared to encompass prevention for KPs and migrants. In a revised structure of the OP, TB, leprosyand AIDS/STD program (TB-L & ASP) are considered under a single entity, where activities of three diseases are detailed [1, pages 378-390]. **Program Reviews and Evaluations**The national response to HIV/AIDS guided by national strategies but relies on international funding. The interventions among key populations and their partners are being implemented through NGOs with unanimity from ASP.These programs are designed to focus on prevention initiatives, increase case detection, provide treatment, care and support services to PLHIV. **Currently, PWID coverage is 28.7% (9500/ 33067), FSW coverage is 21.6% (22100/ 102260), MSM (including MSW) coverage 21.3% (28000/131472),TG/hijra coverage is 39.8% (4062/10199) against national size estimation**[ 7, Page xv] and HIV prevention program is running within certain districts based on KP concentration. The investment case of 2019 was carried out using AIDS Epidemic Modelling (AEM) exercise showedthe effectiveness of ongoing prevention programs among KPs and the impact on HIV prevalence. AEM demonstrated that ongoing interventions have averted a total of 704051 HIV infections among adult population since 1995. The interventions also saved 76861 lives and 4486000 DALYs over the past years. In the absence of any HIV intervention programs since 1995, the total number of PLHIV could be 640859 by the end of 2018. The estimated death among PLHIV was 22323 in the year 2018.If these programs were discontinued since 1995, HIV prevalence among TG, female PWID, MSW, MSW and clients of sex workers would be on the rise between 1995 and 2018[16, page 36-40]. If the current prevention programs among KPs discontinued after 2020, the estimated PLHIV in Bangladesh would reach 81,154 by 2030 [16, page 39,Table 13,] and the most affected group would be the ‘clients’ of sex workers. Out of 16,562 new HIV infections in 2030 nearly 58% would be the ‘clients’ of sex workers [16, page 39, Figure 13]. According to the AEM exercise, almost all KPs would have a concentrated epidemic in Dhaka in 2030.If current donor support discontinues, there will be epidemics among PWID and hijra; prevalence among other KPs will increase and there will be 60,300 new infections by 2030. The same exercise suggested, considering cost-effectiveness and Ending AIDS by 2030, the most feasible option seems to scale up efforts in prevention and treatment to reach the targets of the National Strategic Plan.**Human Rights, Gender and Age-related Barriers and Inequities in Access to Services**Human rights and gender issues have been at the core of HIV prevention approaches in Bangladesh [4, page 79].The GoB has recognized hijra as a separate gender category beyond male-female dichotomy [13, page 1] and has created a specialist "third gender" category on Bangladesh's national voters list in April 2019. A joint advocacy forum ‘National Task Force (NTF)’ was formed to deal human rights issues in KP intervention, consisting all relevant GO-NGO stakeholders including ASP, icddr,b and UNAIDS in June 2018 at icddr,b. The NTF decides meeting semi-annually to review the human rights situation, legal and other barriers of HIV intervention and it also agrees to combine all the previous efforts of NGOs in regard to human rights. Meanwhile, ASP developed a Gender Strategy (2017-2021) aimed at addressing gender-based violence (GBV) among KPs, Emerging & Vulnerable Groups (EVA), PLHIV and affected family members [12, pages 1- 36].Health Sector Response to Gender Based Violence is included in the operation plan of Health Economics and Financing, Health Economics Unit, Ministry of Health and Family Welfare [19,page 18-21].In reality, the socially-excluded people in Bangladesh, in the context of HIV and AIDS are women, including sex workers, MSM, PWIDs, hijra, people living with HIV/AIDS, and the very poor. Double stigmatization occurs when MSM are diagnosed with HIV infection and have to cope with two ostracized identities. Exclusionary legal barriers with respect to HIV and AIDS in Bangladesh includes the**Section 377 of the Penal Code that criminalizes homosexuality**.A second barrier to effective HIV prevention is the ambiguity in the legal status of brothels, which are neither legal nor illegal. Sex work in all other venues is illegal. This ambiguity makes harassment of sex workers easier and their access to healthcare services harder.A third legal exclusionary barrier concerns PWIDs. The Narcotics Control Act 1990 makes possession of tools used for taking drugs punishable with a minimum imprisonment for six months [14,Page587–597]. **Socio-economic, Geographic, and other Barriers and Inequities in access to Health Services**Despite current economic growth, poverty and income inequality remain persistent challenges in Bangladesh. Simultaneously, with the demographic transition, Bangladesh is undergoing a health transition and manifesting the double burden of disease from the combination of communicable and noncommunicable diseases [10, page 14].The pluralistic health systemof Bangladesh with low public expenditure is a barrier to access health services and ensure universal health coverage. Current expenditure on health as a share of the GDP remains low, averaging 2.6%. The share of domestic government health expenditure has decreased from more than 28% to lower than 14% since 2000. [11, page 1-2]. The key population usually from poor social condition, low- or no-income status face stubbornchallenges to access health services no matter public or private throughout the country. The social taboo is against the key populations who are vulnerable for HIV/AIDS. Key populations in Bangladesh face rampant stigma, discrimination, and human rights violations, both in and out of healthcare settings. 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 [20, page 2].**Community Responses and Engagement**ASP engaged different community networks including Network of PLHIV (NOP+); Sex Workers Network (SWN); Network of People Who Use Drugs (NPUD); STI/AIDS Network; Community Forum etc. Bandhu Social Welfare Society (BSWS), the MSM community led organizations is a sub-recipient (SR) of GF grant implementing MSM and Hijra interventions under this current grant and earlier grants too. The Hijra community led organization ‘Badhon Hijra Sangha’ is acting as sub-sub-recipient (SSR) under BSWSand “Sustha Jibon” a Hijra CBO is implementing two service centers of MSM, Hijra interventionsas strategic partner.Similarly, Nari Mukti Sangha (NMS), one of the FSW led organizations is working as SSR for FWS intervention. APOSH-PWID community organization and Mukto Akash Bangladesh (MAB), one of the PLHIV organization are engaged in PWID intervention under current GF grant and earlier too [5, Page 19, 20, 23]. Since March 2018, UNFPA and UNICEF jointly engaged Light House with support from UBRAF Country Envelope (2018) to implement an integrated and comprehensive SRH, HIV and PMTCT program in Mymensingh and Tangail brothels for one year based on the situation analysis done in January 2018. The program is jointly coordinated by UNAIDS Country office, UNFPA and UNICEF. The project has designed to cover 520 brothel residents with essential services to address SRH, PMTCT, HIV and human rights issues. The goal was to enhance access to comprehensive, high-quality, effective, efficient, and sustainable SRH, HIV/AIDS and PMTCT services for Brothel based sex workers[19, page 18-21]. |

## Lessons Learned from Global Fund and Other Partner Investments

Describe how Global Fund and domestic investments, as well as those of other partners,supported national health targetsduring the current allocation period. Include the main **lessons learned**that are relevant to this funding request (for example,innovations orbottlenecks in service delivery).

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| [Applicant response]1 pageThe AIDS response is guided by the 4thHPNSP and the 4th National Strategic Plan 2018-2022. The PRs performreaching targets based on the result-based framework (RBF) with Global Fund and to contribute national targets based on NSP. There was geographical prioritization in 23 districts based on KP size and case reporting. The implementation was both atfacilities (service centers/DIC, Sub-DIC, and outlet) and at community with peer involvement for prevention, diagnosis, treatment, care and support in the 23 priority districts and beyond. In response to the 90-90-90 global target, PR-SCIIprovides services at 6 districts to 9,500 PWID, which is 38% of NSP target through conventional outreach activities from current grant but it took initiatives to provide more HTS cascading through satellite sessions at close to community with extended hours. There is concentrated epidemic of HIV among the PWID at certain geographic parts of Dhaka and it is as high as 27% among PWID at some locations. Differentiated ART delivery model was developed. SCI with its SR-CARE Bangladesh operates five comprehensive DICs at Dhaka to extended hours for providing services to PWID including ART, Opioid Substitution Therapy (OST) and DOT for TB/HIV patients and other SRH related services. Currently, 1128 PWID receive OST and among them 400 is HIV positive and 396 is under ART. Additionally, PR-SCI extends it services at 12 districts to18,500 FSW, which is 28% of NSP target through conventional outreach. HIV prevalence is still less than 1% among FSW. Similarly, PR-icddr,b provides services to 28,000 MSM, and 4062 hijra which is 21.3% and 39.8% of national targets respectively from current grant. icddr,b enhanced HTS through satellite sessions at community and holiday clinics,and activities related to care, support and treatment for PLHIV among sexual minority groups through peer navigators (HIV-positive community members).Further, PR- icddr,b has been continuing its role as an implementer and technical-assistance providing organization of OST for PWID in Bangladesh since 2010 and it has been working closely with government department of narcotics control (DNC) for implementing OST.The OST program showed 85% treatment retention rates among the PWID, which was achieved through optimal OST services and treatment environment, vigorous field activity and joint efforts between the program stakeholders [5, page 24]. Meanwhile, icddr,b started ICT based IEC/BCC services to hidden MSM and hijra, which include website and mobile app, voice short message service (SMS) to create awareness, online self-risk assessment for HIV and STI etc. apart from coordination with other PRs, ministries and relevant stakeholder, ASP engages different community networks including Network of PLHIV (NOP+); Sex Workers Network (SWN); Network of People Who Use Drugs (NPUD); STI/AIDS Network; Community Forum etc. in various initiatives taken though out the grant period. It conducts training for government providers and coordinates with all public ART centers. However, the current level of coverage supported by Global Fund among the KPs mentioned earlier makes it difficult to achieve “Ending AIDS by 2030” [ 3, page 10-11]. Therefore, the programmatic gaps are significant. Simultaneously, role of community-based organizations was insignificant in current grant and follow-up of HIV positive patients is a critical issue. The government OP budgetswere not optimally used for HIV programme and expenditure from Global Fund budgets were not timely spent. ASP built a relation with Gulf Cooperation Council (GCC) Approved Medical Centres' Association (GAMCA) for doing HTS for the outgoing Bangladeshi employees. UNICEF has been working with ASP to provide PMTCT services at 08 public health facilities. The PMTCTprogramhas made a significant result by providing ART services to the HIV+ pregnant mothers and by halting HIV infection from mother to the children. UNFPA, UNAIDS and NGO partners are working jointly at number of brothels with FSWs for increasing awareness and behavioral changes. Simultaneously, continued rise of infection among PWID indicatesstrong programmatic thrust is urgent. Still, 48% of estimated cases are hidden for HTS and out of reach. ART coverage is 65.38% among alive PLHIV. Limited number of HTS and ART facilities without trained counselor and without follow-up caused increased number patients ‘lost to follow up’. Therefore, bottlenecks for the program can be categorized:1. Low coverage: current coverage level of KPs itself is challenges to prevent infection from the large uncovered portion both in number of KPs and priority geographic locations.
2. Readiness: Large number of government health facilities are not equipped for HTS ; private health facilities and laboratories are out of HIV programs. Mainstreamed health services are lack of addressing HIV interventions even in priority districts.
3. Staff capacity: public sector staff are not trained to provide services to KPs. The health staff are not free from intruding discrimination and stigma towards KPs and PLHIV. The humanitarian approach is lacked in many instances.
4. PWID intervention and OST: needle-syringe exchange programme continuously faces challenges for drug related legal issues, PWIDs are always under police incursion and hide themselves caused needle-syringe sharing and unsafe practice. Again, OST is not available across the programme due to legal, policy and execution barrier. ASP need to work more on OST procurement and policy level to overcome the challenges
5. ART centers: A few numbers of ART centers across the country, patient’s follow-up for PLHIV is not in the expected level. One stop service for viral load testing, ARV drug resistant testing, and other co-infection (TB, Hepatitis, syphilis), standardization of HTS center and National reference lab is lacked in system.
6. Monitoring and data reporting: integrating Online reporting (real time) from HTS centers to DHIS is important with monitoring system.

Achieving the 90-90-90 target by 2020 is real challenges if all the mentioned bottlenecks exist.  |

# Section 2: Funding Request and Prioritization

To respond to the questions below, refer to the *Instructions,* as well as national strategy documents, **Programmatic Gap Table(s), Funding Landscape Table(s), Performance Framework, Budget and Essential Data Table(s)**.

## 2.1 Overview of Funding Priorities

Summarize the **approach used for prioritization** of modules and interventions (or in the case of Payment for Results, the performance indicators and/or milestones). The response should include:

* How these prioritized modules ensure the highest possible impact with a view to ending the epidemics of HIV, TB and malaria; and
* How challenges, barriers and inequities, including those related to human rights and gender, are being addressed through the modules prioritized within this funding request.

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| [Applicant response]**1page****2.1 Overview of Funding priorities**The funding priorities is based on the general objective of 4th HPNSP 2017-2022 to minimize the spread of HIV and the impact of AIDS on the individual, family, community, and society, working towards ending AIDS in Bangladesh by 2030 [1, Pages 375-390]. The funding priorities has considered both the sustainable investment options based on KP size and case reporting. The country aims to attain the national and global 90-90-90 targets. The proposed programs for KPs have designed for scale from current grant, and the entire cascade of prevention, diagnosis, treatment, and care for HIV to be taken up. The other priority health needs such as STIs, hepatitis, tuberculosis, mental health, and sexual and reproductive health issues will be addressed through integration and linkage with public health system in a cost-effective manner. However, based on latest size estimation [7, page xv], AEM exercise 2019 and NSP 2018-2023 the interventions keep dividingthe64 districts into three different geographical regions similar as the current grant: the Dhaka; priority 22 districts; and remaining 41 districts considering 62.3% of key population and 79.8% of total detected PLHIVs live in 23 districts (Dhaka and 22) [16, page 27-30].PRs will maximize its coverage at districts based on KP size estimation [7, page xv]. It will adopt dual approaches of *corporal & connect for prevention module, HTS, treatment, care and supports, PMTCT, sexual and reproductive health, TB/HIV, other co-morbidities and reducing human rights barriers by maximizing utilization of public health system.* The *corporal* approaches will be physically reached at different facilities e.g. public hospitals, DIC, Sub-DIC, service Outlet and Satellite session and/or at communities. The peers, community leaders and community-led organizations will be engaged in the entire cascade. Integrated approaches are expected to increase testing through ANC, SRH, diagnosis of TB and Hepatitis, etc. The *connect* approach will be IT enabled online interventions for rendering services in cost-effective manners to increase coverage, raising awareness, patient’s follow-up, treatment adherence, monitoring, self-assessment, community system strengthening and counseling. The veiled KPs will be the target for IT based *connect* approach. ‘Differentiated Approaches’ will be adopted for different KPs to provide HTS, treatment, care and supports. PR-SCI will outspread its coverage to 10 districts for PWID instead on 6 districts in current grant. By *corporal* approach it will be reached to 12800 with comprehensive harm reduction services including HTS, ART, OST and co-infection management and by IT based *connect* approach it will reach additional to 1200 PWIDs with selected component of harm reduction. In total, 14000 of PWID will be reached in 10 districts, which is 88% of targeted districts estimates. In regards to FSWs, SCI will apprehend 19 districts instead of 12 districts in current grant. It will cover 24000 of FSWs by using *corporal* approach and will bring another 15000 of FSWs under IT enabled *connect* approach. In total, 39000 FSWs, and 64% of targeted district estimates be accessed from upcoming GF grant. Moreover, PR SC will continue its’ community component involving CBOs and network to supplement national ART program. PR-icddr,b will approach both *corporal &IT based connect* approach side by side to reach 29000 MSM, 4500 Hijra and 600 PWID for OST services for upcoming program cycle. However, out of total proposed coverage of 33500 KPs including MSM and hijra, 81.5% (27302) will be in 23 priority districts and rest 18.5% (6198) will be from other 12 districts, which icddr,b intends to reach during 2020-2023. PR-ASP will emphasis on Resilient and Sustainable System for Health (RSSH). A central reference laboratory will be linked with network of laboratories. It will expand its strategic partnership with GO-NGO, community organizations, civil society organizations and other ministries, directorates and professional body like obstetric and gynecological society (OGSB), private sector etc. Strengthening the HMIS, integration of services like syphilis, hepatitis, TB and other co-morbidities will be taken. The differentiated ART services and PMTCT will be strengthened to 23 priority districts based in mapping exercise. ASP will coordinate the implementation and will ensure the enabling environment for KPs for accessing services without discrimination and upholding its human rights. The human rights issue will be addressed by all the PRs throughout the upcoming grant period up to 2023. According to investment case report, the scaled-up program, equal to NSP targets, expected to have impact and to ensure value for money by reducing epidemic. The expansion of coverage among the KPs both in number and geographic locations will reduce the risk of spreading infection, will increase HTS, treatment adherence and follow-up by involving community groups expected to contribute 90-90-90 targets and will direct to value for money.  |

## Funding Priorities

1. Based on the Global Fund Modular Framework, use the table below to detail **eachprioritized module** proposed for Global Fund investment for the relevant disease component(s) and/or Resilient and Sustainable Systems for Health (RSSH).

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| --- |
| **COMPONENT: *HIV*** |

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| **Module # 1** | **Prevention- MSM and transgender women** |
| **Intervention(s)& Key Activities** | **Intervention**: Condom and lubricant programming**Activities**: Condoms and lubricants will be promoted and distributed to MSM (including male sex workers) and transgender women (hijra) at free of cost (N=35,500 MSM and Hijra) in 35 districts. Condoms will be distributed at cruising sites by peer educators (PEs) and peer associates (PAs) and through establishing depots at key locations of the community and at service delivery points (SDPs). Information communication and technology (ICT) will be used to promote safer sex and condom use, and to reach hidden MSM. Around 24 million pieces of condoms and around 2.3 million tubes of lubricants have been planned to be procured and distributed following icddr,b procurement policy and ensuring Global Fund compliance on procurement and quality assurance.**Intervention**:Behavior change interventions**Activities**: Individual-level and community-level behavioral change communication (BCC) activities for MSM and hijra will be conducted. These include promoting condom use, HIV testing, safer sex, etc. Activities will be conducted through sex trading venue-based outreach and in one-on-one and group risk reduction sessions. ICT-based intervention, along with peer-based outreach services will be implemented. The mobile apps will be utilized as well to contact with the community participants for providing services.**Intervention**:Sexual and reproductive health services, including STIs **Activities**: STIs management will be continued through syndromic management approach as per national STI management guideline along with management of basic general health complaints from the SDPs and through satellite clinics. Therefore, required number of STI and General Health drugs, STI clinical equipment and STI clinical consumables have been planned for procurement complying icddr,b and GF procurement and quality assurance policies. Recurrent, non-responsive and complicated STI cases will be referred to government healthcare facilities for etiological management. ICT will be used for STI self-risk assessment of MSM and hijra through the website and mobile apps. Moreover, linkages with SRH programs for providing diagnosis, treatment, and counseling for female partners of MSM will be considered. As a pilot basis two government operated health centers in two different districts will be used for STIs and general health care services for KPs to examine the feasibility and acceptability of health care services offered to KPs along with general populations.**Intervention**:Interventions for young key populations**Activities**: Young key-population (YKP) and most at-risk adolescents (MARA) MSM and hijra will receive services such as condoms and lubricants, behavior change interventions, and sexual and reproductive health services at free of costs. **Intervention**:Addressing stigma, discrimination, and violence**Activities**: Advocacy with a mixed group (i.e., religious leaders, local influential people, members of law enforcement agencies and journalists, etc.) will be conducted at the intervention sites. Issues related to stigma, discrimination, and violence will be addressed through group education sessions and life-skill education training. Referral linkages will be established with these service providers for providing medico-legal and psychosocial support services for GBV and Human Rights violations. Also, a National Task Force (NTF), which established under the leadership of the National Human Rights Commission and ASP to safeguard the human rights of the KPs will continue to provide related services.**Intervention**:Harm reduction interventions for drug use**Activities**: MSM and hijra, who use drugs will be linked to relevant government and non-government services related to harm reduction interventions. Since the trend of methamphetamine use among hijra and MSM is increasing, it is essential to address methamphetamine-related HIV risks and complexities within the HIV prevention intervention. In this context, a guideline on the management of methamphetamine use will be developed with the collaboration of department of narcotic control (DNC), Government of Bangladesh. DIC counselors will be capacitating to provide counseling services to methamphetamine user transgender women to reduce their HIV related risk and vulnerabilities. The chief psychiatrist of DNC will provide support as a master trainer. The critical cases of meth dependence, referrals, and linkages will be consolidated with rehabilitation and detoxification centers.**Intervention**:Prevention and management of co-infections and co-morbidities **Activities**: Community-based and facility-based verbal TB screening will be conducted. Presumptive TB cases will be referred to the DOTS Center for diagnosis and treatment. Management of co-infection and co-morbidities of PLHIV such as Hepatitis B & C etc. will be provided through accompanied referrals to government hospitals.Similarly, accompanied referrals for anal cancer screening will be done at the government health centers.**Intervention**:Community empowerment: **Activities**: Community partnership linkage and coordination will be maintained. Community sensitive safe spaces (i.e., DICs) will be established for community members.  |
| **Priority Population(s)** | Males who have sex with males including male sex workers, and transgender women (hijra) |
| **Barriers andInequities** | Bangladesh has laws criminalizing male to male sexual relationship with the highest punishment (i.e., life imprisonment). In addition, due to socio-cultural constructs and gender norms, the sexual behavior of MSM and hijra are stigmatized. Feminized males (Kothi) and hijra are also socially excluded and are often subjected to human rights violations. If their gender and sexual orientations and practices become open, their access to various services including health becomes limited and to some extent restricted.  |
| **Rationale** | Health inequalities exist for MSM and hijra populations due to the non-acceptance of male to male sexual behaviors and relationships, leaving kothi (effeminate MSM) and hijra difficult to accessing HIV prevention services. The negative experiences in accessing health services from the government healthcare facilities make these populations further resistant or reluctant to seek services particularly sexual and reproductive health-related services including STI from the public healthcare facilities. The Global Fund recommends offering safe spaces for key populations at risk of STI, in countries where punitive laws exist. Hence, HIV and STI services will be provided through SDPs operated by non-government organizations. Moreover, HIV prevention services are not available for these groups at the public and any other settings  |
| **Expected Outcome** | Safer sex behavior improved causing to reduce the incidence of HIV and other STIs among targeted MSM and hijra.  |
| **Expected Investment** |  |
|  | **Activities**: PAAR**Interventions**: Pre-exposure prophylaxis for MSM and Hijra(PAAR)**Activities**: PAAR**Interventions**: Stigma reduction for MSM and transgender women (PAAR)**Activities**: PAAR**Interventions**: Mental Heath and NCD intervention  for  MSM (PAAR)**Activities**: PAAR**Interventions**: Increase HIV prevention service coverage among MSM and Hijra  (PAAR) |
| **Module # 1** | **Prevention- Female Sex workers and their clients** |
| **Intervention(s)& Key Activities** | **Intervention**: Condom and lubricant programming **Activities**: Condom and lubricant will be provided free of cost for the targeted 39,000 Female Sex Workers (FSWs) in 19 districts. Primarily condom and lubricants will be distributed from DIC/Sub-DIC/Outlet and at outreach settings through peer outreach workers of implementing partners (NGOs and CBOs). In addition, in hotel and residence settings, hotel boy and madam will act as primary contact for FSWs to get condoms. To ensure off hour condom availability, depot holder, for example shopkeeper, hotel management, etc. will be engaged. It is envisaged that gradually free condom will be available from the sector program during the grant cycle for these targeted FSWs. For social marketing, cafeteria approach with multiple brand of condoms will be available for those who have ability to buy. Moreover, vending machine will be set-up at hotel premises and/or common places on pilot basis. Information on safer sex and condom use will be delivered at community, following conventional peer approach; mobile and internet-based application.**Intervention**: Behavior change interventions **Activities**: In this grant cycle, greater emphasis will be given for behavioral change of the FSWs for condom use, HIV testing and safer sex. Three approaches will be followed – A. Approach to address personal or individual beliefs, knowledge, attitudes and skills; a) One-on-one and group risk reduction sessions using IEC materials (printed and electronic) at DIC/Sub-DIC/Outlet and at outreach b) One-on-one and group risk reduction sessions using online IEC materials at social media/using apps and web site.c) Introduce online self-assessment of risk behavior for FSWsB. Approach of social interaction with other people including friends, family and the communitya) IEC through games, theater, creative works- developing products, involving friends and family during annual gathering and/or day observanceb) IEC for family and community using social networks (printed and electronic) during local level sensitization and advocacyC. Approach to address environmental factors and contextual dynamics where an individual life and receives services a) Sustainable business development and social marketing for community networks to ensure rehabilitation and livelihood for FSWsb) Mass media campaign and advocacy on safer sex practices, condom use and HTSc) Developing contents of TOT for conducting sessions and user manuals of IEC materialsd) Reduce negative perception among service providers about KPse) Promote health seeking behavior among FSWs to receive services from public health facilities**Intervention**: Sexual and reproductive health services, including STIs**Activities**: Comprehensive Sexual and Reproductive Health (SRH) Services will be offered to targeted FSWs either at DIC/Sub-DIC or through referral and or integration of services at government/semi-government/NGO health facilities. FP counselling, pregnancy test and enhanced syndromic management of STIs will be done by Medical Assistant at DIC or Sub-DIC level. On the other hand, Antenatal Care (ANC), Postnatal Care (PNC), Cervical cancer screening, TT vaccination, Post abortion care and etiological management of STIs among FSWs will be linked at government/semi-government/NGO health facilities. Continuous capacity building of the service providers on SRH will be ensured through formal and on-the-job training. To strengthening STI diagnosis, relevant test kits and equipment will be provisioned in this grant.**Intervention**: Interventions for young key populations **Activities**: In this grant, adolescent among FSWs will be reached with customized package of services following the “most at risk adolescent reaching strategy” developed in collaboration with unicef. Other than essential service package, adolescent FSWs will also be offered with alternative livelihood options to reintegrate them in the society. Adolescent network will be formed to bring them in a platform to express their views and to link them with national social security schemes. Efforts will be given to have birth registration so that they can apply for national ID, passport, driving license, bank account, etc.**Intervention**: Addressing stigma, discrimination, and violence **Activities**: Several initiatives will be taken to addressing stigma, discrimination and violence. Community Network will be engaged for addressing these issues. For example, ‘Community squads’ and ‘DIC based community Group’ will be capacitate to respond to harassment. A hot line number will be operated through community squad with the support of Sex Workers Network. Network and CBOs will be engaged for advocating local religious and community leaders, law enforce agency for reduction of violence. Additionally, for support of the victim, functional linkage will be established with human rights organization and one stop crisis center through Sex workers network. Emphasis will be given for Mental Health and Psycho-Social Support (MHPSS) for FSWs. An advocacy strategy will be developed for addressing stigma, discrimination and violence against FSWs. A set of manual/guidelines, training modules, BCC materials will be developed to build staff capacity and its implementation. Systematic recording, reporting and response mechanism will be built within the intervention.**Intervention**: Prevention and management of co-infections and co-morbidities: **Activities**: In this grant, emphasis will be given for screening, diagnosis and treatment of TB. Initial verbal screening for TB will be done at DIC/Sub-DIC and susceptive cases will refer to Govt./NGO facilities for further investigation and management. Functional referral network will be established with relevant public and private facilities. IEC/BCC materials specific to TB will be used to aware FSWs and training will be provider to DIC staff.**Intervention**: Community empowerment**Activities**: During the grant period, targeted FSWs and their community will be empowered on their basic rights, such as, shelter, health and livelihood. DIC will be the safe space for FSWs and link them with shelter home who are in need. To promote safer sex, condom will be made available with appropriate SBCC. Health seeking behavior towards SRH services will be enhanced involving community group and peer outreach worker. Environment will be created, so that FSWs can link, coordinate and communicate with community group, member of the CBOs as well as with their networks to raise their voice.Intervention: Harm reduction interventions for drug use **Activities**: PAAR**Interventions**: Pre-exposure prophylaxisPAAR |
| **Priority Population(s)** | Sex Worker and their clients |
| **Barriers and Inequities** | Being victim of poverty, most of the FSWs came to the profession, who are mostly un-educated and isolated. Here they face high level of stigma, discrimination, violence and gender inequality in every walk of the society, dealing clients, seeking health services or raising voices for human rights. They are afraid of disclosing their identities and availing services from the health facilities. Amidst these realities, they become more hidden and mobile than staying at fixed settings by the growth of internet.Sex work is not considered as a profession, and criminalization of sex work is wide spread. There are some punitive laws which trigger legal harassment, though the penal code does not criminalize sex work. HIV program provides various services including free condom and conducts advocacy to have their rights, but abusive use of punitive laws often hinders the program implementation for FSWs. All of these factors are creating various barriers for ensuring availability and usage of condom for every sex act and behavior change. There are some circumstances when an FSW is compelled to do sex work without condom. Moreover, they often neglect their SRH issues including HIV testing due to self-stigma, and stigma from the service provider. Social inclusion of FSWs is still a challenge.  |
| **Rationale** | In Bangladesh, the estimated sizes of Female Sex Workers (FSWs) are 102,260 of different typology, i.e. street, residence, hotel and brothel based. Around half of them are aged 25 years and above and one fifth are between age 10-19 years. Three forth of them are married. [7, page xv, xvi]. In the end line survey conducted in 2017 revealed that around three quarter of FSWs earned Taka less than 20,000 in a month. The End line survey also reveal that the average number of days FSWs work per week is 5 days in Dhaka and 4.9 days in all other cities. The average number of non-paying partners was 1.3 per week among all typology. Selling sex in more than one spot was more common in other cities, e.g. Khulna and Barisal compare to Dhaka. Overall condom use rate in last sex in last 12 months by female sex workers were 50.2% and consistent condom use during vaginal, anal and oral sex in ‘last week’ with new clients among all FSWs were between 16.5% to 22.4%. Although knowledge on each of the 5 individual issues was high, a slightly more than 27% FSWs had comprehensive knowledge on HIV/AIDS transmission. Overall 63.8% FSWs reported of having any symptoms of STI in last 12 months. Overall 72.2% FSWs had their HIV tested in last 12 months and knew the result at the time of survey. Almost all FSWs, irrespective of the type got themselves tested at DICs/ HTC Center. Overall obtaining condom at the time of need from the peer educators and outreach workers by FSWs was 64.9%. Sex workers are 13 times more at risk of HIV compared with the general population, due to an increased likelihood of being economically vulnerable, unable to negotiate consistent condom use, and experiencing violence, criminalization and marginalization. It is important to reduce its vulnerability by providing condom and provide other sexual and reproductive health care including BCC interventions. The districts selected based on higher concentration of sex workers. |
| **Expected Outcome** | Safer sex behavior improved causing to reduce the incidence of HIV and other STIs among targeted FSW and its clients. |
| **Expected Investment** |  |

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| **Module #1** | **Prevention - People who inject drugs**  |
| **Intervention(s)& Key Activities** | **Intervention:** Needle and syringe programs**Activities**: Needle/Syringe Exchange Program (NSEP) consider as one of the effective components of comprehensive harm reduction approach as mentioned in WHO, UNAIDS, UNODC 2009. Thus, in this grant, total xxx Needle/Syringe will be distributed to reach PWID per year. To achieve the target, needle-syringe will be distributed at DIC, C-DIC, Sub-DIC and outlet from its’ dispensing corner, as well as through van or vending machine and by the peer outreach worker at the spots. This grant will also put emphasis to distribute needle-syringe involving drug seller, pusher, selected pharmacies, etc. The program will also encourage PWID over time to use a single-unit needle and syringe, as “attached” units.**Intervention**: Opioid substitution therapy (OST) and other medically assisted drug dependence treatment: **Activities**: PR-SCI will provide OST services to 2,200 PWID who will continue receiving OST from 10 centers located at CDIC and government facilities. More emphasis will be given to enroll female who inject drugs as well as those who are HIV positive. Provision of other replacement therapy like, oral Buprenorphine (Suboxone). will be created based on national consensus. Emphasis will be given to regular follow up of OST client to ensure adherence. Current grant also taken initiative to conduct quality assessment of OST services, develop National OST Framework, update existing guidelines and training modules and capacity building, so that service quality including mental health issues be addressed to solve burn out and concurrent drug use. There will be provision to update the framework, guidelines and modules in upcoming grants. More functional collaboration will be established with Department of Narcotics control (DNC) and other important Govt. and local Govt. departments for further scale up and future sustainability of OST program. Moreover, other options of drug dependence treatment will be explored in collaboration with Central Drug Treatment Center, tertiary hospital and NGO run drug treatment centers in NFM 3 program.Activities: PR-icddr,b operated OST clinics will be providing free of cost methadone and ancillary medical services through a team of experienced doctor, psychologist and nurses (n=600). A multidisciplinary service modality for PWID receiving OST is a prerequisite for a positive treatment outcome. Icddr,b is planning to provide all inclusive services for PWID from the OST clinic at Central Treatment Centre (CTC), a government detoxification centre under Department of Narcotics Control (DNC). The CTC will serve as an Umbrella Clinic including variety of health services from a single delivery point. PWID will be provided methadone in a supervised condition by the treatment team. Free general medical services, laboratory investigations, and medicines will be provided as required. On the spot and periodic urine tests for illicit drug use (e.g. opioids, sedatives and yaba/methamphetamine) will be conducted. PWID under OST will be provided counseling services for associated psychiatric co-morbidity. Detoxification, treatment, rehabilitation and psychiatric consultation will be provided by psychiatrists or trained addiction professional. OST clients will also receive HIV, TB, Ulcer, Hepatits, STI related health services from the same clinic. HTS will be conducted with pre and post test counselling by the clinic psychologist. ART will be availed from ASP, GoB and will be distributed in DOTS manner for HIV sero-positive OST clients. Methadone dose will be adjusted as per requirement by the clinic doctor. Adherence will be monitored by OST nurse and OW/peer navigator during daily intake of methadone. For TB related services, verbal screening will be conducted at the clinic. GeneXpert tests will be conducted in the icddr,b operated TB screening centres or nearby DOTS centre which deemed convenient. Anti-TB drugs will be obtained from NTP, GoB and will be kept in OST clinics for daily DOTS. For the management of chronic leg ulcer cases, necessary laboratory investigations like duplex venography or wound culture will be conducted in NICVD and icddr,b respectively. Treatment will be provided by the same OST clinic doctor. Initial screening for hepatitis (Anti-HCV antibody and HBsAg) will be conducted at BSMMU. Treatment will be provided from the same OST clinic after obtaining anti-viral drugs from CDC, GoB. CTC will operate seven days a week and as “Walk in Clinics” where appointment is not required to receive services.**Intervention**: Overdose prevention and management**Activities**: Overdose management will be integral part of harm reduction service for PWID. Specific IEC/BCC materials will be produced to orient the PWID on opioid overdose and how to prevent overdose. In addition, DIC based staff, peer outreach workers, partners of sharing networks and family members will also be oriented on the cause & sign of overdose and how to manage overdose at community and at home. Naloxone injection will be used to treat opioid overdose at DIC and community settings with adequate capacity building initiatives. Referral network with nearby government health facilities will also be strengthened for overdose management.**Intervention**: Condom and lubricant programing**Activities**: Condom programming is one of the components of comprehensive Harm Reduction approaches of PWID. It would be continued with more importance and according to the needs of PWID. Condom will be distributed to PWID at outreach through peer outreach workers and also from DIC/CDIC/Sub-DIC and outlet. Condom will be also made available through mobile van and vending machine at selected places.**Intervention**: Behavior change interventions**Activities**: In this grant cycle, greater emphasis will be given for behavioral change of the PWID for sterile needle-syringe use and reduce sharing, OST, HTS, ART, Co-infection, overdose management, condom use and safer sex, SRH and STI. Three approaches will be followed – A. Approach to address personal or individual beliefs, knowledge, attitudes and skills; i. One-on-one and group risk reduction sessions using IEC materials (printed and electronic) at DIC/Sub-DIC/Outlet and at outreachii. One-on-one and group risk reduction sessions using online IEC materials at social media/using apps and web site.B. Approach of social interaction with other people including friends, family and the communityi. IEC through games, theater, creative works- developing products, involving friends and family during annual gathering and/or day observanceii. IEC for family and community using social networks (printed and electronic) during local level sensitization and advocacyC. Approach to address environmental factors and contextual dynamics where an individual life and receives services i. Sustainable business development and social marketing for community networks to ensure rehabilitation and livelihood for PWIDii. Collaborative efforts for mass media campaign and advocacy on drug issuesD. Developing contents of TOT for conducting sessions and user manuals of IEC materials**Intervention**: Addressing stigma, discrimination and violence**Activities**: During this grant, several initiatives will be taken to addressing stigma, discrimination and violence. Network will be engaged for addressing these issues. A hot line number will be operated through Network. They will be engaged for advocating local religious and community leaders, law enforce agency for reduction of violence. Additionally, for support of the victim, functional linkage will be established with human rights organization. An advocacy strategy will be developed for addressing stigma, discrimination and violence against KPs. A set of manual/guidelines, training modules, BCC materials will be developed to build staff capacity and its implementation. Systematic recording, reporting and response mechanism will be built within the intervention.**Intervention**: Community Empowerment**Activities**: targeted PWID and their community will be empowered on their basic rights, such as, shelter, health and livelihood. DIC or any other government and semi government facilities will be the safe space for PWID. To address hunger of PWID, local government authority and the CBOs/Network will jointly response. Job opportunity for OST receivers will be created through linkage with corporate agencies under their social corporate responsibility or under government social safety-net scheme. PWID CBOs will be involved and capacitated and will be functionally link with Network. Capacity will be enhanced for the networks and their member’s organizations on participatory community-based monitoring. Community network and their member organization will also be engaged during issues-based advocacy to reduce stigma, discrimination and to address human Rights issues with regional and national policymakers. Institutional capacity development initiatives for network and member organization will be taken. Moreover, a taskforce at local level will be formed headed by law enforcers to support harm reduction interventions.**Intervention**: Prevention and management of co-infections and co-morbidities**Activities**: emphasis will be given for screening, diagnosis and treatment of TB. Initial verbal screening for TB will be done at DIC/Sub-DIC and susceptive cases will refer to Govt./NGO facilities for further investigation and management. Functional referral network will be established with relevant public and private facilities. IEC/BCC materials specific to TB will be used to aware PWID and training will be provider to DIC staff. Current grant also taken initiative to manage HIV-HCV co-infection. Same protocol will be followed in NFM 3 to manage additional PWID. In addition, service providers based in DIC/CDIC/Sub-DIC will be vaccinated against HBV.**Interventions**: Sexual and reproductive health services, including STIs**Activities**: Comprehensive Sexual and Reproductive Health (SRH) Services will be offered to targeted PWID, specially to Female PWID either at DIC/CDIC/Sub-DIC or through referral and or integration of services at government/semi-government/NGO health facilities. Enhanced syndromic management of STIs for PWID both male and female will be done by Medical Assistant at DIC/CDIC or Sub-DIC level. Etiological management of STIs among PWID will be linked at government/semi-government/NGO health facilities. PWID with psycho-sexual disorders will be counselled and referred to government facilities. Continuous capacity building of the service providers on SRH will be ensured through formal and on-the-job training. To strengthening STI diagnosis, relevant test kits and equipment will be provisioned in this grant.**Intervention**: Pre-exposure prophylaxisPAAR |
| **Priority Population(s)** | People who inject drugs and their partners |
| **Barriers and Inequities** | In Bangladesh, widespread persistent social norm is fabricating stigma and discrimination associated with drug use. PWID are denied in getting access to any social, legal and lifesaving health services. Their health is jeopardized due to inequality at health care settings. According to the Narcotics Control Act 1990, possession of tools used for taking drugs punishable with a minimum imprisonment for six months. Furthermore, health facility readiness is major concern for accessing services for PWID. There are also lack of sensitized and trained health care providers to treat the PWID at government hospitals. In addition, most of the family members or care givers of PWID are reluctant to provide support during hospitalization. Among PWID, who use opioids, especially among those who inject heroin/opiate drugs, overdose and associated death is very common. Factors such as younger age, unemployment, frequency of injecting, history of drug treatment and injecting heroin mixed with diazepam are significantly associated with overdose. A significant number of overdose deaths occur in people who combined opiate use with alcohol. Maintaining adequate dose of methadone is also an issue and have impact on OST adherence (Azim T, Crofts N 2015). Drug of choice for drug dependency treatment is only methadone which need to be taken in every day at OST clinics and no provision for take home doses. Absence of Naloxone for overdose management in prevention program is a barrier to prevent unwanted death among PWID. Due to chronic forgetfulness and cravings for drug, PWID are unable to remember education of the risk reduction. Even knowing the risk of sharing, they do share needle/syringe during ‘Bera’. Drug users are often arrested and harassed by the law enforces due to abusive use of law. In recent days, use of Amphetamine Type Substance (ATS) gone high and switching behavior among PWID from opioid to ATS causes disproportionate distribution of needle syringes among PWID. A good number of PWID stays in prison and the authority has denial to accept the need of them such as withdrawal management, ART, OST and TB case management.Illicit drug use is criminalized by the Narcotics Control Act 1990. The newly amended law in the Narcotics Control Act 2018 imposes the death penalty or life-term imprisonment on drug traders, restricting their release from punishment for such crimes. |
| **Rationale** | In Bangladesh around 33,067 PWID where 1,045 are female. PWID are generally divided in two types, home and street based. End line survey data showed that majority (around 85%) of the PWID are home based and 10.1% are living in street. Data also showed, 73.1% are married. The average age of the PWID was 37.7 years, 32 years for females and 38.1 years for males. The main source of income of male PWID was rickshaw/van pulling (23.7%) followed by small trade (21.8%), business (13.0%) and service (11.0%). On the other hand, sex work (33.0%) was the main sources of income of female PWID followed by small trade (16.9%) and drug peddling (15.0%). A considerable percentage of both male and female PWID depend on tokai (male 4.6; female 5.8) work and stealing/snatching (male 3.5; female 1.8) for earning money. On average, a PWID took injecting drugs twice in a day, both in Dhaka and in ‘all other cities. Both in Dhaka and ‘all other cities’, majority (87%) of PWID used more than two spots for taking injecting drugs.On average, 65.2% PWID share needle-syringe during the last 7 days with predominance among female PWID (73.8%) compare to male and more sharing was seen among the street based PWID. 44.3% of female PWID admitted that their spouse/sex partners (regular and commercial) also took drugs through injection. Myths also prevailed that needle-syringe could be sterilized by cloths, water, spit, drug and blood was also frequently reported by the PWID. Condom use among male and female PWID was reported as 18.1% vs. 12.8% in end line survey. Survey data also showed low condom use with regular partner of both male and female PWID. 86% female PWID reported having sex with commercial partners in the last one month, among male PWID, it was 38.1%. Almost all the PWID reported that they heard about HIV/AIDS. Only 15% male PWID and 18% female PWID had comprehensive knowledge about HIV/AIDS. Overall, 33.3% PWID and sex-wise, 31.8% male PWID and 55.8% female PWID reported any symptoms of STI in last 12 months. The percentage of reported STI symptoms was higher among both male and female PWID in ‘all other cities’ in comparison to Dhaka. Majority of PWID (90% male and 53.7% female) reported seeking STI management from DIC doctor/paramedic. On the other hand, overall one-third (33.2%) of the PWID reported suffering from abscess in the last three months. Knowledge of both male and female of PWID about the place where HIV testing is available is almost universal - (97.6%). Overall 76.8% of all PWID, had their HIV tested in last 12 months and knew the result. Most PWID - 98.4% males and 99.1% females got HIV tested from DIC/ HTC centers, whereas only 1% male and 0.9 female PWID got tests for HIV from government hospitals. Almost all PWID (Dhaka-98.8% and other cities-99.1%) reported participation in HIV prevention program during the past one year irrespective of age. As per end line survey report 2017, PWID in Bangladesh face huge stigma, discrimination and violence from the family, society, workplace and health care setting. Violence against PWID is mainly occurred by police (94.3%) followed by local people (38.9%). Majority (88.1%) of PWID reported that they were arrested for taking drugs. Most commonly they were beaten by officials in uniform and by local people. In the last year, 20% said they had been jailed and most commonly for taking drugs [8, page 54]. Therefore, considering the overall risk and vulnerability, NFM 3 grant will increase its’ scope and scale to cover an optimum number of PWID to generate impact. 10 districts including Dhaka will be prioritized, among those nine from priority districts and one is from non-priority districts. Districts are selected considering presence of HIV positive cases, opioid user, OST user, female PWID and also presence of other key populations.Intervention will emphasis on combined approach of both prevention and biomedical. For prevention, more comprehensive approach like peer outreach as well as mobilize secondary channels for needle exchange program and for safe injection practice. For biomedical, comprehensive DIC model as point of care for OST, HTS, ART, Co-infection management will be continued and expanded. Decriminalization of drug use will be a major focus through government ownership engaging relevant ministries including law enforcers. Community Based Organizations (CBOs) and drug user network will be greatly engaged to build capacity, participatory monitoring and advocacy. To reduce needle syringe sharing practices among PWID this OST intervention is globally recommended. Evidence show that without the OST program, it is difficult to reduce HIV related risk among PWID. Therefore, OST services need to be provided under the leadership of the Department of Narcotics Control (DNC) and ASP. |
| **Expected Outcome** | Needle syringe sharing related risk behavior reduced to prevent HIV infection and improve quality of life among PWID |
| **Expected Investment** |  |

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| **Module # 1** | **Prevention -People in prisons and other closed settings** |
| **Intervention(s) & Key Activities** | **Intervention**: Harm reduction interventions for drug usePAAR  |
| **Priority Population(s)** |  |
| **Barriers and Inequities** |  |
| **Rationale** |  |
| **Expected Outcome** |  |
| **Expected Investment** |  |

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| **Module #2** | **Differentiated HIV Testing Services-MSM and transgender women** |
| **Intervention(s)& Key Activities** | **Intervention**: Facility-based and community-based HIV testing services **Activities**: Annually 75% of MSM and hijra will be tested for HIV of whom some will be repeat cases and others will be new. Facility-based and community-based HTS will be offered to MSM and hijra. In addressing the above requirement 761 packs of Determine, 24 packs of Unigold and 18 packs of First Response HTC test kits have planned to procure as per National HTC guidelines and in compliance with related policies of icddr,b and Global Fund. Linkages to HIV treatment and care for PLHIV will be ensured. Counseling, including assisted partner notification and index testing, and treatment services for PLHIV will be continued through the leadership of ASP. As a pilot basis two government operated HTS centers in two different districts will be used for HIV testing for KPs to examine the feasibility and acceptability of HTS offered to the KPs along with general populations. |
| **Priority Population(s)** | Men who have sex with men and transgender women (hijra) |
| **Barriers and Inequities** | Issues that hinder HTS uptake by MSM and hijra populations include fear/phobia of giving blood for HTS, the social stigma attached to male to male sex and HIV, and fear of social and economic consequences if tested HIV positive. |
| **Rationale** | HTS need to be strengthen among KPs as they are more vulnerable to HIV infections for early detection of HIV and immediate initiation of treatment. Both facility-based and, community-based HTS will be performed for MSM and hijra for detection of HIV cases  |
| **Expected Outcome** | HTS coverage increased for early detection and initiation of treatment to reduce HIV transmission to others and reduce morbidity and mortality of PLHIV. |
| **Expected Investment** |  |
|  | **Activities**: PAAR**Interventions**: HIV Self Testing among MSM and Hijra PAAR |

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| **Module # 2** | **Differentiated HIV Testing Services- Female Sex Worker and their clients** |
| **Intervention(s)& Key Activities** | **Intervention**:Facility-based testing**Activities**: At the facility settings provider initiated HTS service will be offered to FSWs and their clients at DIC/Sub-DIC level by Medical Assistants and Lay Providers. FSWs and their clients will be mobilized from the community by the peer outreach worker, community groups, CBOs, network and through online. Though index testing is already being introduced, however more systematic approaches will be followed. Spouse, children and regular partners of FSWs who are in their drug and sexual networks will be tested. In addition, DIC/Sub-DIC/Outlet catchment areas and public gathering spots, like bus terminal, launch ghat, big bazar, etc. mass HIV testing campaign will be organized.Continuous capacity building of the providers will be ensured through formal and on-the-job training. In selected geographical areas, capacity of the service providers at GoB health facilities will further strengthen, where the integrated service model will be implemented.**Intervention**: Community-based testing**Activities**: At community level, HTS service will be offered to FSWs at their residence and congregation spots by the lay provider. Demand and service for HIV testing will be ensured by community group, CBOs and by the network. Medical Assistants will provide hands on training and at the same time will supervise HIV testing service at the community.**Intervention**: Self-testing**Activities**: In this grant, self-testing either guided and or anonymous will be introduced for FSWs and their partner. The FSWs reached through ICT will be offered self-testing anonymously |
| **Priority Population(s)** | Female Sex Worker and their clients |
| **Barriers and Inequities** |  |
| **Rationale** |  |
| **Expected Outcome** |  |
| **Expected Investment** |  |

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| **Module # 2** | **Differentiated HIV Testing Services- People who inject drugs and their partners** |
| **Intervention(s)& Key Activities** | **Intervention**:Facility-based testing**Activities**: At the facility settings provider initiated HTS service will be offered to PWID and their clients at DIC/CDIC/Sub-DIC level by Medical Assistants and Lay Providers. PWID and their clients will be mobilized from the community by the peer outreach workers, CBOs, network and through online. Though index testing is already being introduced, however more systematic approaches will be followed. Spouse, children and regular partners of PWID who are in their drug and sexual networks will be tested. In addition, DIC/CDIC/Sub-DIC/Outlet catchment areas and public gathering spots, like bus terminal, launch ghat, big bazar, etc. mass HIV testing campaign will be organized.Continuous capacity building of the providers will be ensured through formal and on-the-job training. In selected geographical areas, capacity of the service providers at GoB health facilities will further be strengthened, where the integrated service model will be implemented.**Intervention**: Community-based testing**Activities**: At community level, HTS service will be offered to PWID by the lay providers. Demand and service for HIV testing will be ensured by community group, CBOs and by the network. Medical Assistants will provide hands on training and at the same time will supervise HIV testing service at the community.**Intervention**: Self-testing**Activities**: In this grant, consensus will be built to include self-testing in national HIV testing algorithm. Self-testing will be either guided and or anonymous and be introduced for PWID at prison or other close settings. The IDUs reached through ICT will be offered self-testing anonymously. |
| **Priority Population(s)** | People who inject drugs and their partners |
| **Barriers and Inequities** |  |
| **Rationale** |  |
| **Expected Outcome** |  |
| **Expected Investment** |  |

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| **Module #3** | **Treatment, care and support** |
| **Intervention(s)& Key Activities** | **Intervention:** Differentiated ART service delivery and HIV care**Activities**: there will be KP specific activities. ARV drug resistance and viral load monitoring for MSM and hijra will be conducted by GoB. A comprehensive support program for MSM and hijra HIV positive including psychosocial support by Peer Navigator (PN) will be continued. Alongside, ART adherence counseling in the community and in health facilities, and counseling support for care and support services for spouses and children of PLHIV will be conducted. ART will be provided to HIV positive FSW, MSM and hijra from government ART centers by working in close collaboration with SHGs and PLHIV networks. For PWID HIV positive will include extended ART clinic hours at selected comprehensive DICs, the stable cases will be transferred to government ART center. ASP will update training, development of guidelines, policies and strategies for Differentiated ART service delivery and HIV care for KPs. Further, designing, developing and implementing a comprehensive treatment retention and adherence strategy both at the programmatic/facility level will be developed. Treatment monitoring – Viral load will be executed from government centers using gene-expert technology.  |
| **Priority Population(s)** | All people living with HIV |
| **Barriers and Inequities** | Fear of stigma and discrimination due to disclosure of HIV status, losing a partner and anticipated other negative consequences create barriers to update of ART treatment and adherence. Location and opening hours of public centers limit the ability of PLHIV to access services. The lack of concern for and protection of privacy and personal information, a general concern in health service delivery, is even more prominent in the case of key populations, who can suffer significant consequences, including bodily harm, if their personal information is inappropriately shared.  |
| **Rationale** | The appropriate regimen of ART is capable for suppression of viral replication to undetectable levels for as long as possible; it can do immune reconstitution as manifested principally by a rise of CD4 count; and able to do reduction of morbidity and mortality.Among the known PLHIV, many are out of treatment due to stigma and discrimination. Hence a strong follow-up approach needs to follow for ensuring treatment adherence, PN will work in the community, to ensure linkage with ART services, track beneficiaries, and ensure treatment adherence of PLHIV. |
| **Expected Outcome** | Detected PLHIV linked with ARV treatment and ensured ARV adherence which will reduce HIV transmission to others, and increase the life expectancy of PLHIV. |
| **Expected Investment** |  |
|  | **Activities**: PAAR**Interventions**: ARV drug resistance survey PAAR |

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| **Module #4** | **TB/HIV** |
| **Intervention(s)& Key Activities** | **Intervention**: Collaborative activities with other programs and sectors**Activities**: Verbal TB screening will be performed for all the KPs visiting any of the SDPs (DIC, sub-DIC, outlets, satellites etc.). In addition, community-based TB screening will be conducted by peer approach. Presumptive TB cases will be referred to appropriate public facilities through existing referral systems for further diagnosis and treatment. Besides, service providers of HIV program will be trained on TB related services so that they can provide TB related services. Similarly, some providers from TB programme will be trained to address HIV screening.  |
| **Priority Population(s)** | 1. Men who have sex with men (MSM), including MSW
2. Transgender women/hijra
3. Female sex workers (FSW)
4. People who inject drugs (PWID)
5. All people living with HIV
 |
| **Barriers and Inequities** | Due to stigma and discrimination, KPs remain hidden and do not attend the available TB treatment centers. Some of the KPs receive HIV prevention services only from the outreach. Hence TB/HIV related cases are not detected fully among these KPs.  |
| **Rationale** | People living with HIV are 15-22 times more likely to develop TB than persons without. TB is the most common presenting illness among people living with HIV, including among those taking antiretroviral treatment, and it is the major cause of HIV-related deaths. Collaboration between TB and HIV programs, reduce the burden of TB among people living with HIV and the burden of HIV among TB patients. |
| **Expected Outcome** | TB/HIV cases are detected, referred to the TB treatment centers and reduced TB/HIV related morbidity and mortality. |
| **Expected Investment** |  |

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| **Module # 5** | **Resilient and Sustainable System for Health (RSSH): Health Management Information Systems and M&E** |
| **Intervention(s)& Key Activities** | **Intervention:** Routine reporting**Activities**: ASP will lead the three-monthly reporting to DHIS2 and increase the entity all facilities (GO-NGO). It will report on HIV testing services, antiretroviral therapy, tracking loss-to-follow-up, viral load testing, distribution of commodities such as condoms and lubricants, sterile injecting equipment, routine reporting of TB/HIV collaborative activities, analytical capacity building- training, mentoring and supervision of subnational staff on data analysis and use. Further, ASP will review data quality, will do assessments and validations. **Intervention**: Programme Review**Activities**: NGO PRs will do the Program review, and needs-based operations research (OR) with any KPs under the Global Fund project. Also, the Participatory monitoring and evaluation (PM&E) will be operational. PRs will routinely report pragmatic progress to the Global Fund and National HMIS after data verification. |
| **Priority Population(s)** | All KPs, General population and health service providers  |
| **Barriers and Inequities** | The current capacity of human resource is a barrier for quality data gathering and its reporting. The KP focused OR and national reporting of health issues of KPs are inadequate.  |
| **Rationale** | ASP expanded to 28 HTS in 23 priority district hospital recently, all center report is required to see the performance, trend of the epidemic through case detection. The management information is the key to program implementation and it monitoring and evaluation. Program review, need-based OR and programmatic progress reports are essential parts of program implementation to enhance the program and remove bottlenecks of the implementation. |
| **Expected Outcome** | 28 HTS facility will submit quarterly report to DHIS2; Enhanced service delivery through evidence-based decision making |
| **Expected Investment** |  |
|  | **Activities**: PAAR**Interventions**: Enhancing HMIS PAAR**Activities**: PAAR**Interventions**: Tracking system of PLHIV PAAR |

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| **Module # 7** | **RSSH: Human resources for health, including community health workers** |
| **Intervention(s)& Key Activities** | **Intervention:** Remuneration & deployment of existing/new staff (excludingcommunity health workers)**Activities**: ASP will provide salaries, monetary and non-monetary incentives to existing grant supported staff. Due to programme expansion few additional staff will be recruited. Retention schemes and salary payments of current and new staff will be addressed. **Interventions**: In-service training (excluding community health workers)**Activities**: training will include provision of quality treatment, care and support, preventive and related social services for HIV; Leadership and management; Supervision of health workers; Development or revision of training curricula |
| **Priority Population(s)** | Staff working at ASP and Service providers in government and NGOs sector |
| **Barriers and Inequities** | Less number of staff against sanctioned posts in government system for optimum operationalized interventions and transfer of the government service provider from particular hospital |
| **Rationale** | Improving the quality health services for the KPs and general population and ensure accessibility at govt services center will help to accessibility of KP to public facilities |
| **Expected Outcome** | Increase accessibility of the health and HIV services for the KPs in govt hospital |
| **Expected Investment** |  |

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| **Module # 8** | **RSSH: Community systems strengthening** |
| **Intervention(s)& Key Activities** | **Intervention**:Community-based monitoring **Activities**: Community-based monitoring (CBM) will be performed to understand and address the barriers to accessing services. Tools will be developed for CBM and MSM and hijra will be trained on the CBM system. In addition, Participatory M&E (PM&E), which had been appreciated by TRP before, will be continued for improving the program implementation and process monitoring.**Intervention**:Community-led advocacy and research**Activities**: icddr,b and SRs/SSRs have been facilitating the community-led mapping of legal, policy and other barriers that hinder/limit community responses. In this process, the reporting system of gender-based violence (GBV) and human rights issues had been developed, and data collection and analysis will be done to inform relevant stakeholders.**Intervention**:Institutional capacity building, planning and leadership development **Activities**: icddr,b has worked with community systems strengthening under the Global Fund grant in 2010-2015 and formed/strengthened 20 CBOs operated by MSM and hijra community. We will assess the status of these CBOs and work with them so that the potential CBOs can contribute to the intervention program in a formal and informal manner. A national workshop will be organized and a plan of action will be developed and implemented along with ASP. We expect to train them on some organizational and other required areas, link them with SRs/SSRs so that they can directly be involved in rendering services to their own MSM and hijra community**.**  |
| **Priority Population(s)** | Men who have sex with men and transgender women (hijra) |
| **Barriers and Inequities** | MSM and hijra are disproportionately affected by heteronormative gender norms leading to gender inequalities, violence, and discrimination. |
| **Rationale** | Programmatic experiences suggest that community participation helps the beneficiaries raising their voices against any form of abuse and violence, demand their rights be protected. The reporting mechanism on GBV is first of its kind in Bangladesh, which will help in addressing challenges faced by the community-based on scientific evidence. |
| **Expected Outcome** | Enhanced HIV related service uptake among KPs and reflect voices and expertise of the community in research, advocacy and program implementation |
| **Expected Investment** |  |

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| **Module # 9** | **RSSH: Laboratory systems** |
| **Intervention(s)& Key Activities** | **Intervention:** National laboratory governance and management structures**Activities**: ASP will do mapping and optimizing lab networks in country, it will develop HIV National policies and guidelines for laboratories. ASP will do, evaluation and validation of new laboratory. It will procure HIV equipment and reagents for the laboratories and will provide national HIV proficiency testing schemes and quality laboratory interventions for HIV service providers in the country. , ASP will coordinate national partner activities in scaling up of quality HIV laboratory services in the country. It will facilitate and coordinate external quality assessments. Further, ASP will develop, national training curricula for HIV Laboratory services and conduct training, fosters national and international collaborations, improve equity and access to quality Laboratory HIV Services. Upgrading infrastructure, including refurbishing facilities, equipment to comply the standard; Training of users of equipment; Connectivity solutions for laboratory equipment Establishment of a national laboratory network for HIV |
| **Priority Population(s)** | Lab services providers/ government hospital  |
| **Barriers and Inequities** | Integration of the lab services in the government hospital and availability of national technical expertise on laboratory system is difficult. The expatriate is always expensive and difficult to get to provide supports. |
| **Rationale** | Laboratory system is key to quality diagnosis and infection control |
| **Expected Outcome** | Established a standard lab services in national and regional level |
| **Expected Investment** |  |

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| **Module # 10** | **RSSH: Program Management**  |
| **Intervention(s)& Key Activities** | **Intervention:** Coordination and management of national disease control programs**Activities**: ASP will do the coordination and management of national disease control programme by doing oversight, monitoring/ supervision and technical assistance from national to sub national levels includes DICs and other intervention sites; it will do coordination with district/ local authorities between DICs. ASP will organize Quarterly coordination meetings among stakeholders centrally. **Intervention**: Grant management: **Activities**: Supervision of SRs by the NGO PRs timely submission of the reports and related grant documents, oversight and technical assistance related to effective and efficient Global Fund grant implementation and management, human resource for program management, training for the staff of SRs and PRs and community members if needed. PRs will incur overheads cost. The regular coordination with ASP, district and local authorities, regular coordination meetings with SRs/SSRs/CBOs, quarterly meeting, office rent and costs related to office management, procure required IT equipment for PR, SRs/SSRs will be required. |
| **Priority Population(s)** | All KPs, Services provider and all stakeholders |
| **Barriers and Inequities** | District health manger/ civil surgeons’ engagement is challenging due to their huge work at the district and other priority areas.  |
| **Rationale** | Program management is needed to ensure grant compliance in terms of program, M&E, Finance, governance, and PSM, which is crucial to achieving grant outputs, outcomes and impact as agreed. It is important to note that under program management, besides the HR cost category, many other costs are included as Global Fund guidelines. Ensuring engagement of the national and sub national level health manager is important for coordination.  |
| **Expected Outcome** | Ensured smooth implementation of the Global Fund program. Improved programme quality and increase accountability of ASP and district managers |
| **Expected Investment** |  |

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| **Module # 10** | **RSSH: PMTCT**  |
| **Intervention(s) & Key Activities** | **Intervention:** Preventing vertical HIV transmission**Activities**: ASP will do campaign and capacity building of HIV testing services during ANC services through existing professional network of obstetrician and gynecologist (OGSB). Establishment of PMTCT services in the selected hospital. It will expand the HIV testing services during ANC services at selected facilities and installed provision of ARV services. ASP will ensure viral load testing for HIV positive pregnant and breastfeeding women, with mapping and optimization of laboratory systems and networks.  |
| **Priority Population(s)** | Pregnant women  |
| **Barriers and Inequities** | Facility readiness for HTS for pregnant women; stigma and discrimination for HIV positive pregnant women  |
| **Rationale** | PMTCT programs support safe childbirth practices and appropriate infant feeding, as well as providing infants exposed to HIV with virologic testing after birth and during the breastfeeding period, ART for prevention and effective treatment. |
| **Expected Outcome** | Number of women would be identified and enrolled into ARV treatment will ensure safe childbirth practice and appropriate infant feeding.  |
| **Expected Investment** |  |

*(Add additional tables as relevant)*

1. Does any aspect of this funding request use a **Payment for Results** modality?

☐ Yes ☒ No

**If yes**, in the table below, indicate the relevant performance indicators and rationale for the choice of performance indicators and/or milestones.

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| **Performance indicator or milestone** | **Target** | **Rationale for the indicator/milestone selection for Global Fund funding** |
| **Baseline** | **Y1** | **Y2** | **Y3** |
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| Add rows if necessary |  |  |  |  |  |
| **Total amount requested from the Global Fund** |  |

Specify how the accuracy and reliability of the reported results will be ensured.

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| [Applicant response]NOT Applicable  |

1. **Opportunities for integration:** Explain how the proposed investments take into consideration:
* Needs across the three diseases and other related health programs;
* Links with the broader health systems to improve disease outcomes, efficiency and program sustainability.

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| [Applicant response] 1pageThe national AIDS response is guided by the national health sector plan 4th HPNSP 2017-2022.The general objective of 4th HPNSP 2017-2022 in the operational plan is to minimize the spread of HIV and the impact of AIDS on the individual, family, community, and society, working towards Ending AIDS in Bangladesh by 2030. In the HIV programme ASP in collaboration with the NTP and it has been implementing TB/HIV collaborative activities since Global Fund Round 5. The sexual and reproductive issues including complex STIs are also being addressed through the GF supported programme and has referral linkage with government facilities. **TB/HIV collaborative activities**: TB, leprosy and AIDS/STD program (TB-L & ASP) are considered under a single entity in the OP and single management in the 4th health sector program which may allow for better coordination. However, activities of each program and budgetary allocation are distinct. Thisfunding request has proposed a TB-HIV module similar as earlier grants where TB case detection expects to be enhanced among the KPs and referred to public health system for further traetment. The 2019 data up to October shows, a total of 27 PLHIV were detected TB and 26 enrolled for treatment; One patient has completed TB treatment; all HIV cases screening for TB (GeneXpert); and preventive treatment therapy (IPD) started for all PLHIV [ 15, slide #16]. Similarly, under NTP, TB patients are to be screened for HIV from selected DOTS centres.In addition, TB patients can access government operated HTS centres for HIV testing. Coordinationwith the NTP, BRAC, WHO, USAID and other relevant stakeholders will be continued. The National TB/HIV CoordinationCommittee is functional. The country’s capacity for managing TB/HIV co-infection has beenincreased through training HIV counsellors and other staff to identify and refer TB suspected casesto designated DOTS centres. Further strengthening of the collaboration between ASP and NTP iswell addressed under one operational plan and one Line Director (LD). There is a national TB/HIV guideline is being implemented. **HIV treatment and care in Government setting**: ASP takes lead already has been providing ART services to the PLHIV from 09 public facilities from OP budget and deployed revenue manpower. It has planned to expand the ART services to 04 more centers from government budget too. The PLHIV are connected to each of the treatment and care center based on its closest locations since 2017 and it has been successfully used by the PLHIV. ASP is willing to extend its HTS services to 28 districts capturing all 23 priority districts. ASP will provide HTS and ART services both to general population and key population. For the upcoming grant cycle ASP focuses on detecting a greater number of cases and to bring them under treatment coverage. Also have plan the mobile van for HTS in different areas in the country for the both the population general and KPs.**Laboratory system**: ASP planned to establish the reference lab services centrally at BSSMU, which is the largest autonomous public medical university in this country with support from the upcoming grant. The selected medical college hospitals/district hospitals where ART services are linked will be formally networked with this reference laboratory for triple elimination (HIV, Syphilis and Hepatitis). The diagnosed cases will be reported in HMIS and will be referred to treatment for respective ART center. This strengthened laboratory system will lead to improved disease outcomes and will increase the ability to diagnose across thecountry, resulting in more people on treatment and ultimately better disease outcomes across alldiseases (and beyond) and it will leadto sustainability in long run since the laboratory system is part of national health system**Health Management Information Systems (HMIS) and M&E:**Government already has established and well run DHIS2 to capture service statistics of GF funded KP interventions. However, system strengthening is being proposed for reporting system to capture data from government and NGO facilities where KPs will go for services. The OST and ART data yet to be reported in national HMIS properly. There is a need for monthly data reporting from SDPs like other health programme. Therefore, HMIS strengthening is proposed for the upcoming grant Data from the networked hospitals and NGO reports will be reviewed periodically both online and off line. **Integrated service delivery and quality improvement**: HIV, Syphilis and Hepatitis testing will be encouraged and promoted during ANC check-up through partnership with existing OGSB networks and effective referral for the positive pregnant women to treatment center has been proposed in this grant. PMTCT services will be linked where needed; existing adolescent’s health corners at public health facilities will be coordinated through DGHS-MNCAH and DGFP for sexual and reproductive health services including STIs for adolescents and young women; differentiated ART services at 28 public facilities will be established based on concentration of PLHIV of the specific districts from proposed grant and co-financing will be adopted. Capacity building of DGHS staff will be required for integration from upcoming grant. However, for quality improvement capacity building of staff will be needed from grant money and which will be leading sustainability of the programme. ASP already appointed manpower for all 28 center from OP budget who will be trained to receive the KPs patient referred by DIC. **Health products management system:** ASP will take lead for health product management system including procurement of condom, needle-syringe, OST drugs and ARV from government OP budget to integrate with the programme. The co-financing policy will be practiced for health product management. ASP already procured those logistics for the KPs intervention from the 2019- 2020 budget under OP. **Coordination**: Coordination with other ministries, directorates, DNC and other relevant areas will be done from upcoming grants. and the joint activity with other HIV PRs will be taken to execute differentiated ART services; ASP will implement all the activities from central level with the active engagement of district health managers and hospital superintendent/ Directors where needed. **Human Resources** (HR): since the KPs are yet to be accepted and mainstreamed in the society and its need are completely different from other diseases, it will be difficult to use same field workers for KPs rather they need peer to peer interaction. On the other hand, the health care providers in the national system will be trained to provide quality services to KPs and to address its medical, SRH need from existing system. ASP and government’s active role and co-financing policy to integrate different HIV interventions in to national system will lead to sustainability and the KPs will be counted as mainstreamed service recipients.  |

1. Summarize how the funding request complies with the **applicationfocus requirements** specified in the allocation letter.

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| [Applicant response]1 PageThe proposal for upcoming grant 2020-2023 is developed based on evidences of HIV epidemiological context, disease burden, KPs’ vulnerability to HIV, need for community system strengthening, country financial status as lower lower-middle-income country and the supports need Resilient and Sustainable System for Health (RSSH).**The key populations**: this application is very much disease specific and the KP (PWID, FSW, MSM and hijra)focused. The proposed interventions will be addressed the entire HIV prevention and treatment cascade. HIV prevention cascade that consists of three key domains of motivation, access, and effective use by the key population for preventive services, differentiated HIV test, treatment and care to close the gaps of 90-90-90 targets. The interventions will be extended beyond facility boundaries to community level and at KPs’ door steps by satellite sessions, outlets, cruising points, both within hour and/or after hour. The ---% of total budget has proposed to be allocated for HIV disease and KPs to capture prevention, testing, treatment and care.**Community systems**: the community involvement of each of the KP groups has been addressed from beginning of proposal development. Investment in community system strengthening will be ensured through KPs’ participation in programme implementation at community level by different approaches e.g. peer to peer, community care, increasing accessibility, reducing stigma and discrimination for the entire period which leads to future sustainability. Both the NGO-PRs and ASP will directly work with community both at facility and out of facility to maximize its participation effectively. A total of --% budget allocated for community system. **Investment in health system**: to ensure the HIV treatment cascade of initial diagnosis, treatment, care, support and to achieving viral suppression (a very low level of HIV in the body) has been proposed by establishing reference laboratory at BSMMU and the laboratory network in the government system using the tertiary level of medical college hospitals across the country. Further, the proposal emphasizes on improving the national HMIS for capturing quality and timely data.Quality improvement and continuum of care of services is the integral part of system enhancement and which need investment under health system improvement too. Integration of services with DGHS and DGFP facilities during ANC or SRH services needs training and capacity building of the public sector service provides. ASP will adopt co-financing policy in different areas. A total of ----% budget is proposed for investment in health system for the entire programme cycle.**Investments in human rights and gender:** Bangladesh government has positive role to address human rights and gender issues in many instances including recent voting right for hijra as a third gender but there are areas to be addressed. The National Task Force (NTF), which established under the leadership of the National Human Rights Commission and ASP to safeguard the human rights of the KPs will continue to provide related services. However, the community need to be strengthened on raising its own voice and its capacity of individual members need to be promoted by training and online and offline session. A total of ----% budget is proposed for investment in human rights and gender.**Co-financing**: GoB has demonstrated its political commitment to increase domestic funding for HIVprevention, treatment, and care and support services over the years. HIV prevention, treatment, care and support activities in Bangladesh have combined efforts of the government, NGOs and development partners. It is proven that domestic funding has already been increased in-line with enhanced economic growth of Bangladesh as documented over the last several years. The previous co-financing commttment **has been realized -----%** and government has been proposed to using **----- USD** from its co-financing policy to support HIV programme along donors.  |

1. Explain how this funding request reflects **value for money**, including examples of improvement in value for money compared to the current allocation period. To respond, refer to the *Instructions* for the aspects of value for money that should be considered.

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| [Applicant response]1pageTo ensure value for money (VfM), several aspects have been considered in this proposal. This has reflected all the principles of the Global Fund guideline related to VfM. It is anticipated that the following approach will generate a greater impact on each of the components of VfM outlined in the Global Fund guideline:  i) **Economy and efficiency**: To have positive impacts on these two dimensions of VfM, service delivery modality has been revised to reach the beneficiaries through establishing more sub- DICs, outlets, satellite and integration with the community-based organizations and the government health facilities; peer associate-based service has been expanded and planned to increase dissemination of behavior change communications (BCC) cost-effectively through information communication and technology (ICT).Follow a fair and transparent system of a competitive bidding process and to have quality products with a comparatively lower price by ensuring the best quality product in terms of price, functions, endurance/life, warranty, delivery, distribution, after-sale services, disposal cost etc. against the price agreed to be paid. Establishes framework contract to minimize the risk of stock out through just in time (JIT) planning of supply. Bulk procurement is done to achieve suppliers’ economic scale; therefore, suppliers can offer a lower price than that of low volume purchase; procures products with long expiry dates to ensure longer life and enable products to use until the end of the project. Follow long-term fixed-price contracts to ensure the economy in price also it freezes the price throughout the project/contract period and ensures the sustainability of cost. Integrated or combined procurement is done to reduce transaction costs, manhour etc. and increase value for money by ensuring lower costs. Maintains good governance through implementing policies and procedures. Conduct participatory monitoring and evaluation for efficient service delivery. Capacity-building activities are done to improve efficiency by improving the skills of staff to avoid errors, mistakes and appropriate service delivery. LMIS is maintained to view stock position at a glance, to assess demand, forecast, avoid stock-outs and emergency supply etc. for increasing efficiency of the supply chain. Policy and procedures are in place to reduce confusion and misjudgment related to services.ii) **Effectiveness**: The KPs are highly venerable to HIV and other sexually transmitted infections (STIs). Considering their vulnerability and epidemiological context, interventions are directed toward KPs. To render the services effectively to KPs, the CBOs and community people would play the key-roles. The activities are prioritized based on the need of the KPs. Furthermore, service delivery models are designed in a friendly manner to increase the uptake of services effectively.iii) **Equity**: Maximize reaching all subsections of the target groups to ensure equity. The program tries to reach all segments of the target populations including MSM/MSW, transgender, female and male partners of male, female and hijra sex workers, FSW and its clients and PWID, thereby ensures the availability and access to services to the most vulnerable and marginalized populations. Services are designed for the gender and sexual diverse people (i.e., MSM and hijra) who are otherwise discriminated from existing health systems to provide them equal access to services. Furthermore, activities are designed to uphold their human rights through advocacy initiatives at various levels. iv) **Sustainability**: For the sustainability of the program, two approaches are followed: individual and structural aspects. Some services are integrated with government health centers and referral mechanisms are established with the government health facilities. To strengthen the services for the KPs in the government health systems, regular meetings, seminars and in-person communications are maintained and the National AIDS/STD Program (ASP) would play the key-roles to ensure sustainability. The government is well-aware of the activities and the target groups and their needs; which will facilitate the sustainability of the program. Moreover, several activities are operated through government revenue budget such as treatment of PLHIV, skills development training for transgender, the inclusion of HIV related issues in the secondary school book and operating HMIS through government web portal etc. Individual individual-level approach includes building awareness and capacity of the KPs to them ready to continue in preventing HIV even whenever no support is available from others. This has been further enhanced by ICT based services to enhance sustainability in terms of improving behavioral aspects of the KPs in the absence of any intervention. |

## Matching Funds (if applicable)

This question should only be answered by applicants with designated matching funds, as indicated in the allocation letter.

Describe how the **programmatic and financial conditions**, as outlined in the allocation letter, have been met.

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| [Applicant response]NOT Applicable |

# Section 3: Operationalization and Implementation Arrangements

To respond to the questions below, refer to the *Instructions* and an updated **Implementation Arrangement Map**[[3]](#footnote-5).

1. Describe how the proposed **implementation arrangements** will ensure efficient program delivery.1 page

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| [Applicant response]1 The BCCM has decided to continue with existing three PRs: i) AIDS and STD Program (ASP) ii) Save the Children International (SCI) and iii) icddr,b. This proposal has emphasized on value for money by effective and sustainable relationship with public sector health facilities and different public sector departments for the KPs both in HIV prevention and in HIV treatment cascade (initial diagnosis to achieving viral suppression) to reach 90-90-90 targets by 2030. The human rights and gender equity have been taken care throughout the programme implementation and coordination areas. All the PRs take sustainability issues in to consideration and has proposed for effective relationship with public sector for programme delivery and to uphold human rights issues and equity for KPs. The PRs has proposed for effective use of ICT for programme implementation cycle, for reaching KPs, for providing BCC services and for follow-up. Use of ICT already has been proven successful for MSM/hijra interventions by icddr,b. The ASP emphasizes on working through RSSH modules. It will implement and coordinate all the activities from central office with the active engagement of district health manager and hospital authority as required in associations with other PRs. ASP will build strategic partnership with professional networks of OGSB for integration of HTS during routine ANC check-up at selected facilities. The adolescent and young people will be tag for HIV prevention through DGHS and DGFP services. ASP will establish the reference laboratory at BSMMU (as SR) Dhaka and will activate the lab networks with public health facilities in some of the priority districts. The partnership with community-based organizations and PLHIV networks will be strengthened for accessing services and for treatment& care. The community-led organizations will work for PLHIV follow-up and treatment adherence. ASP will further lead differentiated HTS and ART services in collaboration with other PRs and PLHIV communities from health sector funding at public health facilities. The TB/HIV coordination and other co-morbidities/triple elimination will be addressed by involving expertise in respective areas. The reproductive and sexual health issues will be integrated at all PR managed service delivery points and better accessibility will be linked with public health facilities for the KPs. Through regular coordination meetings among 3 PRs, ASP will conduct national coordination and structural advocacy to create an enabling environment and capacity building of the service providers. The HMIS and M&E will be one of the key areas where ASP will confirm data gathering and reporting accurately and timely. However, improving capacity of staff and ensuring quality is important. SCI will implement the interventions for FSWs in 19 districts and for PWID in 10 districts through DIC, sub-DIC, Outlets and/or satellite sessions. The community engagement will be maximized in the programme cycle by peers, community field workers and other community staff as appropriate. Similarly, icddr,b will give major focus on 23 priority districts identified during KP size estimation, revised NSP 2020-2023 and investment case exercise 2019 for MSM, MSW and transgender women/hijra. Further, icddr,b will expands it services to another 12 districts with involving community. Both the NGO PRs will involve KP communities in the center of implementation for addressing the HIV Continuum of Prevention, Care, and Treatment Cascade and will maximize use of ICT. The PRs will continuously re-engage with HIV-negative KPs on regular HIV testing and combination prevention, including access to condoms, lubricants, needles/syringes, OST and PrEP. All proposed modules, interventions and activities are described in section 2.2 with rationale and expected investment. The barriers and inequalities will be addressed in collaboration with national bodies. For both SCI and icddr,b, several CBOs and other Civil Society Organizations (CSOs) will directly implement interventions and Networks of PWID, FSWs and PLHIV will be strengthened and will receive support for effectiveness and sustainability. The procurement will be performed by procurement policies of each of the entities by ensuring quality and value for money. The Technical Working Group on HIV nominated by the BCCM, responsible for endorsing the technical aspects of the application, has representatives from a women’s organization, PLHIV network and MSM CBO, sex workers’ and PWID network and KP representatives.  |

1. Describe the role that **community-based organizations** will play under the implementation arrangements.**1 page**

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| [Applicant response]The community-based organizations from each of the KPs will be center of the grant implementations. Currently, one MSM organization (Bandhu Social Welfare Society) is working as a SR capacity with PR-icddrb in programme implementation and there are few other community-based organizations working as SSR capacity with both of the NGO-PRs. However, the PRs will follow the GF guidelines for recruiting more community-based organizations as SR and SSR capacity for direct programme implementation according to modular approach. They will work for their own rights, to minimize stigma and to coordinates with public sectors for their own sake. However, the capacity of community-based organization needs to be strengthened. Community-based monitoring (CBM) will be performed to understand and address the barriers to accessing services. Tools will be developed for CBM. MSM and hijra, FSW and PWID community will be trained on the CBM system. In addition, Participatory M&E (PM&E), which had been appreciated by TRP before, will be continued for improving the program implementation and process monitoring. PR- icddr,b and SRs/SSRs have been facilitating the community-led mapping of legal, policy and other barriers that hinder/limit community responses. In this process, the reporting system of gender-based violence (GBV) and human rights issues had been developed, and data collection and analysis will be done to inform relevant stakeholders.PR-icddr,b has worked with community systems strengthening under the Global Fund grant in 2010-2015 and formed/strengthened 20 CBOs operated by MSM and hijra community. It will assess the status of these CBOs and work with them so that the potential CBOs can contribute to the intervention program in a formal and informal manner. A national workshop will be organized and a plan of action will be developed and implemented along with ASP. We expect to train them on some organizational and other required areas, link them with SRs/SSRs so that they can directly be involved in rendering services to their own MSM and hijra community. |

1. Does the funding request envisage a **joint investment platform** with other institutions?

☐ Yes ☒ No

If **yes**, describe specific arrangements and modalities.

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| [Applicant response]Not Applicable  |

1. Describe key,**anticipated implementation risks** that might negatively affect **(i)**the delivery of the program objectives supported by the Global Fund, and/or**(ii)** the broader health system. Then, describe the mitigation measures that address these risks, and which entity would be responsible for these mitigation measures.1 page

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| **Key Implementation Risks** | **Corresponding Mitigation Measures** | **Entity Responsible** |
| **Program Quality**: Possibility of poor quality of various prevention and treatment services, patient’s adherence to treatment, and rational use of health and pharmaceutical products | Follow national/international SOP or guidelines for programs and treatments, keeping proper records, and availability of required documents for verification. | PRs, SRs and SSRs, LFA |
| **Monitoring and Evaluation**: Lack of proper M&E systems, lack of understanding the problems of implementations and misinterpretation of results, poor validity and reliability of data | Introducing participatory M&E systems and low-cost training of respective staff and develop master trainers and continue refresher training when needed on data collection, management and interpretation.  | PRs SRs and SSRs, LFA |
| **Procurement and in-country supply chain**: Delay in procurement and price hike of products, possibility of negative health outcomes among the beneficiaries from treatment disruptions due to issues in the supply chain management. | Bulk procurement with long expiry date at comparatively lower price, framework agreement, back-up and contingency arrangements. | SRs, PRs |
| **Grant-Related Fraud & Fiduciary**: Possibility that the funds are not used properly as per agreed workplan and budget within the organizational policies. Agreed-upon reports are not submitted on time | Complying the approved work plan and spend as per budget by strictly following the organizational relevant policies, where policies are unavailable, develop without any delay. Implement financial monitoring strictly with reports and documented actions.  | PRs |
| **Accounting and Financial Reporting**: Possibility that Global Fund funds are not properly recorded, accounted for, or reported by PR or SRs | In the contract between the SRs and PR, there is an appendix of financial reporting timeline. All SRs are complying with the timeline. The reporting template is developed by the PR which is unique for all SRs. The template figures are supported by the tally-based accounting software. During the financial monitoring visit, we verify the accuracy of the figures of the submitted report is aligned with the software based financial report. Therefore, scope of inaccurate data recording and reporting is minimal. PR-icddr,b is submitting PUDR to GF semi-annually. All figures are supported by the ERP Microsoft navigation system. Therefore, chance of inaccurate data recording and reporting s minimal.  | All PRs |
| **National Program Governance and Grant Oversight**: Possibility that the CCM exhibits unmitigated conflict(s) of interest; poor multi-stakeholder and constituency representation; weak organizational structure, policies and processes; inadequate leadership and quality of CCM secretariat staff; lack of transparency; ineffective PR selection, oversight or sanctions; or insufficient engagement and coordination with program stakeholders and partners | Under the guidance of GMS consultants, BCCM was restructured by following the Global Fund guidelines. through elections, members of various constituency have now on-board. Meetings are taking place, COI polices signed by Individual CCM members and as such decisions are made transparently, oversight committee of BCCM is functional and conducting oversight visits, PR selection was conducted by following the Global Fund guidelines, Moreover, the civil society and other stakeholders also have remarkable representation in the BCCM. | BCCM and BCCM oversight committee |
| **Quality of Health Products**: low quality of health products may be procured and supplied | Routine quality check of health products by the independent agency will be done routinely. | All PRs |
| **Risks related to human rights and gender**: Gender-based violence and human rights issues may create problems in rendering services to KPs | Routine advocacy and sensitization meetings with relevant stakeholders need to done. The NTF has to be functionalized. | National Task Force (NTF), BCCM, All PRs and SRs |
| **Macroeconomic factors**: Possibility of unanticipated financial losses due to foreign exchange, price, or other market changes, including for Pharmaceutical & Health Products | Long term contract may be helpful for future procurement. An interest-bearing account for GF grant may help. | All PRs |
| **Instability of the country**: natural calamity and human made instability may take place | Train and aware PR and SR staff on disaster preparedness, strengthen internal control such as good storage with adequate stock to prevent disruption of services in such situations | BCCM and All PRs and SRS |
| **Other emerging risks (punitive laws)including potential cross border risks**: Existence of punitive law against male to male sex: According to the Bangladesh Penal Code (BPC) 377 (“Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal shall be punished with transportation for life, or with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine”) Narcotics laws 2018 clause 21 and FSW need to be added) | Advocacy meetings/workshops need to be conducted with various respective stakeholders. Security threats and attacks on minority people need to be handled by involving the NTF. These threats to some extent difficult to prevent. Therefore, to be honest mitigation for improving situation is challenging. However, we may take some security measures at PR and SRs' office. | NTF, PRs and BCCMPRs and SRs and ASP, BCCM, UNAIDS and others |

# Section 4: Co-Financing, Sustainability and Transition

To respond to the questions below, refer to the *Instructions*,the domestic financing section of the **allocation letter**, **the** [Sustainability, Transition and Co-Financing Guidance Note](https://www.theglobalfund.org/en/funding-model/applying/resources/)**,Funding Landscape Table(s), Programmatic Gap Tables(s)**, **and a sustainability plan and/or transition work-plan**, if available[[4]](#footnote-6).

## Co-Financing

1. Have **co-financing commitments** for the **current** allocation period been realized?

☒ Yes ☐ No

If **yes**, attach supporting documentation demonstrating the extent to which co-financing commitments have been met.

If **no**, explain why and outline the impact of this situation on the program.

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| [Applicant response] |

1. Do **co-financing commitments** for the **next** allocation period meet minimum requirements to fully access the co-financing incentive?

☒ Yes ☐ No

If details on commitments are available, attach supporting documentation demonstrating the extent to which co-financingcommitments have been made.

If co-financing commitments do not meet minimum requirements, explain why.

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| [Applicant response] |

1. Summarize the **programmatic areas** to be supported by domestic co-financing in the nextallocation period. In particular:
	* 1. The financing of key program costs of national disease plans and/or health systems;
		2. The planned uptake of interventions currently funded by the Global Fund.

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| [Applicant response]1. Under the 4th OP ASP is planning for the following services
* ARV drugs along with manpower
* Supplies including condom, needles/ syringes(partially)
* Methadone (partially)
* Mass awareness programme for general population
* 50 HTS center through public hospital along with manpower
* Survey/ surveillance/ operational research
* Proportion of prevention services for KPs
* Proportion of PMTCT services
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1. Specify how co-financing commitments will be **tracked and reported**. If public financial management systems and/or expenditure tracking mechanisms require strengthening and/or institutionalization, indicate how this funding request will address these needs.

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| [Applicant response]ASP submits its six monthly and annual performance report (physical and financial) to MoHFW, PMU of IMED compile the report and publish accordingly which can be utilized for tracking the co financing commitment. This tracking system is proven to be effective and utilize by different government sectors and Development Partners.  |

## Sustainability and Transition

1. Based on the analysis in the **Funding Landscape Table(s)**, describe the funding need and anticipated funding, highlighting gaps for major program areas in the next allocation period.

Also, describe how(i) national authorities will work to secure additional funding or new sources of funding,and/or(ii)pursue efficiencies to ensure sufficient support for key interventions, particularly those currently funded by the Global Fund.

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| [Applicant response] |

1. Highlight challenges related to sustainability (see indicative list in *Instructions*). Explain how these challenges will be addressed either through this funding request or other means.If already described in the national strategy, sustainability and/or transition plan, and/or other documentation submitted with the funding request, refer to relevant sections of those documents.

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| [Applicant response] |

# Annex 1: Documents Checklist

Use the list below to verify the completeness of your application package.

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| ☐ | Funding Request Form |
| ☐ | Programmatic Gap Table(s)  |
| ☐ | Funding Landscape Table(s)  |
| ☐ | Performance Framework |
| ☐ | Budget |
| ☐ | Prioritized above allocation request (PAAR) |
| ☐ | Implementation Arrangement Map(s)[[5]](#footnote-7) |
| ☐ | Essential Data Table(s) (updated) |
| ☐ | CCM Endorsement of Funding Request  |
| ☐ | CCM Statement of Compliance |
| ☐ | Supporting documentation to confirm meeting co-financing requirements for current allocation period  |
| ☐ | Supporting documentation for co-financing commitments for next allocation period  |
| ☐ | Transition Readiness Assessment (if available) |
| ☐ | National Strategic Plans (Health Sector and Disease specific) |
| ☐ | All supporting documentation referenced in the funding request |
| ☐ | Health Product Management Tool (if applicable) |
| ☐ | List of Abbreviations and Annexes |

1. PAARscan only be submitted with the Funding Request. To complete a PAAR, fill-in the Excel template that you will receive from the Global Fund Secretariat. [↑](#footnote-ref-3)
2. This is only relevant for applicants with designated matching funds as indicated in the allocation letter. [↑](#footnote-ref-4)
3. An updated implementation arrangement map is mandatory if the program is continuing with the same PR(s). In cases where the PR is changing, the implementation arrangement map may be submitted at the grant-making stage. [↑](#footnote-ref-5)
4. Note that information derived from the supporting documentation provided in response to the questions below, including information on funding landscape or domestic commitments, may be made publicly available by the Global Fund. [↑](#footnote-ref-6)
5. An updated implementation arrangement map is mandatory if the program is continuing with the same PR(s). In cases where the PR is changing, the implementation arrangement map may be submitted at the grant-making stage. [↑](#footnote-ref-7)