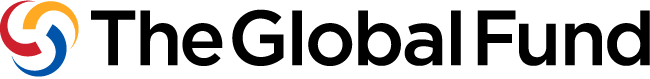
|  |  |
| --- | --- |
| |  | | --- | | **Funding Request Form**  **Allocation Period 2020-2022** |   Tailored for National Strategic Plans (NSPs) |

*Refer to the “Tailored for National Strategic Plans (NSPs)” Instructions to complete this form.*

Summary Information

|  |  |
| --- | --- |
| **Country(s)** | Bangladesh |
| **Component(s)** | Malaria |
| **Planned grant(s) start date(s)** | 1 January 2021 |
| **Planned grant(s) end date(s)** | 31 December 2023 |
| **Principal Recipient(s)** | External Resource Division (ERD), MoF& BRAC |
| **Currency** | USD |
| **Allocation Funding Request Amount** | 20.10 million |
| **Prioritized Above Allocation Request (PAAR) Amount[[1]](#footnote-2)** |  |
| **Matching Funds Request Amount[[2]](#footnote-3)**  (if applicable) |  |



# Section 1: Context Related to the Funding Request

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

## Context Included in NSPs and Other Reference Documents

Check relevant contextual areas included in NSPs, as applicable. For areas not included in NSPs, provide reference to other relevant document(s) with respective page numbers or provide a narrative in Section 1.2.

|  |  |  |  |
| --- | --- | --- | --- |
| Key area | Check the box if in NSP | Relevant section(s) and/or page(s) in NSP | If not in NSP, refer to another document (specifying page numbers) or refer to Section 1.2 |
| **Cross-cutting** | | | |
| Health system overview |  | 2.1.3 & 2.10 |  |
| Health sector strategy |  | 2.1.4 (includes a summary version relating to malaria) | 4th HPNSP Operational Plan (OP) for Communicable Disease Control 2017 – 2022, Ministry of Health and Family Welfare, Government of the People’s Republic of Bangladesh |
| Community responses and systems |  | 2.8 |  |
| Role of the private sector |  | 2.9 |  |
| Human rights-related barriers/inequities in access to health services |  | 2.5 |  |
| Gender and age-related barriers/inequities in access to health services |  | 2.6 |  |
| Economic, geographic and other barriers/inequities in access to health services |  | 2.2 |  |
| Role of community groups in the design and delivery of programs |  | 2.8 |  |
| Linkage between disease specific NSPs and sector strategies |  | 2.1.7 |  |
| Other |  |  |  |
| **Disease-specific** | | | |
| Key stakeholders of NSPs and operational plan development |  | 1.3 |  |
| Epidemiological profile |  | 3.3 |  |
| Analysis of key, vulnerable and/or underserved populations |  | 3.2.4 |  |
| Lessons learned from past program implementations |  | 3.3 |  |
| Disease-specific national policies and guidelines |  |  |  |
| Summary budget, including costing methodology and assumptions |  |  |  |
| Program’s prioritization approach |  | 4.5 |  |
| Monitoring & evaluation plan |  | 8.1-8.3; Annex |  |
| Operational plans |  |  |  |
| Other |  |  |  |

## Contextual Information not Included in NSPs

For the gaps in question 1.1, provide information below.

|  |
| --- |
| Contextual information included in the NSP 2021-2025. |

# Section 2: Funding Request and Prioritization

To respond to the questions below, refer to the *Instructions,***NSPs,** **Programmatic Gap Table(s), Funding Landscape Table(s), Performance Framework, Budget and Essential Data Table(s)**. Include narrative only if these documents omit required information.

## Overview of NSP Strategic Areas

Complete the table below, referring to the relevant NSP page numbers, whenever possible. Ensure information is consistent with NSP cost details and analysis provided in **Funding Landscape Table(s)**.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NSP strategic areas | Key interventions  (refer to NSP page numbers) | Baseline and targets  (refer to NSP page numbers) | NSP funding need  In the grant currency for implementation period of this funding request (in USD) | Anticipated funding gap as % of need  for implementation period of this funding request  (before Global Fund contribution) (in USD) |
| Early Case Detection  (To achieve and sustain universal coverage by case detection and prompt and complete treatment of all confirmed cases through 2025) | 1.1.1 Strengthen and expand RDT based diagnostic services  1.1.2 Strengthen and expand microscopy-based diagnostic services  1.1.3 Screen pregnant women in high transmission areas/communities  1.1.4 Provide diagnostic services at select district and international border-crossing points  1.1.5 Case detection by mobile teams in special situations and in underserved hard-to-reach areas/populations  1.1.6 Introduce G6PD testing to improve management of vivax malaria  1.1.7 Provide follow-up testing for Pf cases where feasible  1.1.8 Screen members of the armed forces, BGB, Police and other law enforcement agencies pre- and post-deployment to endemic areas  1.1.9 Quality Assurance (QA) in malaria diagnosis (Ensure Quality Assurance (QA) in Microscopy; Ensure Quality Assurance (QA) in RDTs) | - Confirmed malaria cases (microscopy or RDT): rate per 1000 persons per year  Baseline: 0.92 (2019)  Target: 0.32 (2023)  - Annual parasite incidence: Confirmed malaria cases (microscopy or RDT): rate per 1000 persons per year (Elimination settings)  Baseline: 0.0428 (2019)  Target: 0.0054  - Annual Blood Examination Rate (ABER)  Baseline: 8%(2019)  Target: 8% | 1,341,721  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) | 1,341,721  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) |
| Prompt and Effective Treatment  (To achieve and sustain universal coverage by case detection and prompt and complete treatment of all confirmed cases through 2025). | 1.2.1 Strengthen community-based treatment  1.2.2 Strengthen prompt and effective case management, including management of severe malaria in public sector health facilities  1.2.3 Provide treatment services in remote areas and at select district and international border-crossing points  1.2.4 Provide case management within the armed forces, BGB, Police and other law enforcement agencies  1.2.5 Provide standby treatments in special circumstances  1.2.6 Introduce Mass Drug Administration (MDA) in special circumstances  1.2.7 Strengthen and monitor private sector case management services  1.2.8 Quality Assurance (QA) in malaria treatment | - Confirmed malaria cases (microscopy or RDT): rate per 1000 persons per year  Baseline: 0.92 (2019)  Target: 0.32 (2023)  - Inpatient malaria deaths per year: rate per 100,000 persons per year  Baseline: 0.04 (2019)  Target: 0.01 (2023) | 7,404,883  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) | 7,404,883  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) |
| Malaria Prevention with Appropriate Vector Control Measures  (To achieve and sustain universal coverage of population at risk with appropriate preventive interventions through 2025) | 2.1.1 Provide free LLINs for all groups at risk of contracting malaria  *2.1.1.1 Provide LLINs for established communities*  *2.1.1.2 Provide additional LLINs for use in forest/forest farms*  *2.1.1.3 Provide additional LLINs to pregnant women*  *2.1.1.4 Provide LLINs to select employers to provide to their workers*  *2.1.1.5 Provide LLINs to protect seasonal agricultural workers, fishermen, mine worker night guards, tea garden workers*  *2.1.1.6 Provide LLINs to protect people in new settlements*  *2.1.1.7 Provide LLINs for forest workers in the informal sector*  *2.1.1.8 Continuous distribution to address any LLIN attrition in-between mass distribution*  *2.1.1.9 Provide LLINs in the event of disasters and in response to outbreaks and confirmed transmission foci*  *2.1.1.10 Provide LLINs for armed forces, BGB, police, and other law-enforcing agencies*  2.1.2 Conduct focal responsive IRS as appropriate  2.1.3 Conduct larval source management (LSM)  2.1.4 Implement novel vector control and personal protection measures as appropriate  2.1.5 Develop vector management strategy and monitor changes in entomological indicator | - Proportion of population that slept under an insecticide-treated net the previous night  Baseline: 91% (2019)  Target: 92% (2023)  - Proportion of children under five years old who slept under an insecticide-treated net the previous night  Baseline: 96% (2019)  Target: 96% (2023)  - Proportion of pregnant women who slept under an insecticide-treated net the previous night  Baseline: 96% (2019)  Target: 96% (2023) | 24,011,465  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) | 24,011,465  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) |
| Epidemiological Surveillance  (To strengthen context-specific surveillance in all malaria settings and outbreak preparedness and response through 2025) | 3.1.1 Strengthen surveillance systems in different settings (transmission reduction, elimination)  3.1.2 Expand and strengthen the malaria information system  3.1.3 Active Case Detection (proactive case detection)  3.1.4 Case-based surveillance, transmission focus investigation and response  3.1.5 Outbreak preparedness, investigation and response  3.1.6 Epidemic Prediction/Forecast/Estimation  3.1.7 Initiate cross–border surveillance  3.1.8 Drug Resistance Monitoring  3.1.9 Strengthen Pharmacovigilance System  3.1.10 Verbal autopsy of malaria death cases  3.1.11 Malaria Elimination Database | - Confirmed malaria cases (microscopy or RDT): rate per 1000 persons per year  Baseline: 0.92 (2019)  Target: 0.32 (2023)  - Annual parasite incidence: Confirmed malaria cases (microscopy or RDT): rate per 1000 persons per year (Elimination settings)  Baseline: 0.0428 (2019)  Target: 0.0054  - Annual Blood Examination Rate (ABER)  Baseline: 8%(2019)  Target: 10% | 6,108,235  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) | 6,108,235  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) |
| Entomological Surveillance  (To strengthen context-specific surveillance in all malaria settings and outbreak preparedness and response through 2025) | 3.2.1 Establish and strengthen Entomological surveillance and insecticide resistance monitoring  3.2.2 Develop guidelines on public health insecticide management  3.2.3 Establish entomology laboratory and insectaries |  | 1,259,065  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) | 1,259,065  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) |
| Community Awareness and Participation  (To achieve universal coverage by Advocacy, Communication and Social Mobilization (ACSM) activities for uptake of preventive and curative interventions, optimal community engagement for malaria elimination and enabling environment through 2025) | 4.1.1 Develop Communication Strategy for malaria elimination  4.1.2 Enhance Community Awareness and Community Participation | (Proxy indicators)  - Confirmed malaria cases (microscopy or RDT): rate per 1000 persons per year  Baseline: 0.92 (2019)  Target: 0.32 (2023)  - Annual parasite incidence: Confirmed malaria cases (microscopy or RDT): rate per 1000 persons per year (Elimination settings)  Baseline: 0.0428 (2019)  Target: 0.0054  - Annual Blood Examination Rate (ABER)  Baseline: 8%(2019)  Target: 10%  - Proportion of population that slept under an insecticide-treated net the previous night  Baseline: 91% (2019)  Target: 92% (2023)  - Proportion of children under five years old who slept under an insecticide-treated net the previous night  Baseline: 96% (2019)  Target: 96% (2023)  - Proportion of pregnant women who slept under an insecticide-treated net the previous night  Baseline: 96% (2019)  Target: 96% (2023) | 3,265,040  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) | 3,265,040    (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) |
| Programme Communication  (To achieve universal coverage by Advocacy, Communication and Social Mobilization (ACSM) activities for uptake of preventive and curative interventions, optimal community engagement for malaria elimination and enabling environment through 2025) | 4.2.1 Development of BCC materials  4. 2.2 BCC Implementation through channel-mix  4.2.3 Strengthen management and M&E of BCC | Same as above | 149,721  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) | 149,721  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) |
| Advocacy for Strengthening Enabling Environment  (To achieve universal coverage by Advocacy, Communication and Social Mobilization (ACSM) activities for uptake of preventive and curative interventions, optimal community engagement for malaria elimination and enabling environment through 2025) | 4.2.1 Advocacy at different levels [national, district, division, Upazila, peripheral levels (union, ward, communitylevels)] | Same as above | 4,627,044  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) | 4,627,044    (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) |
| Programme Management, Capacity Buiding and Strengthening  (To strengthen program management, monitoring & evaluation and coordination through 2025) | 5.1.1 Human Resources Development and Management  5.1.2 Infrastructure (development, maintenance)  5.1.3 Procurement and related Quality Assurance  5.1.4 Procurement of health and non-health products  5.1.5 Supply Chain Management  5.1.6 Financial Management |  | 14,869,534  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) | 14,869,534  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) |
| Programme Progress Review and Planning, Monitoring & Evaluation, Policy & Strategy Development  (To strengthen program management, monitoring & evaluation and coordination through 2025) | 5.2.1 Monitoring Progress  5.2.2 Annual, mid-term, end-term review  5.2.3 Development of Strategies, Guidelines, Operational Plans and SOPs  5.2.4 Update malaria risk stratification periodically |  | 12,351,884  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) | 12,351,884  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) |
| Partnership and Coordination  (To strengthen program management, monitoring & evaluation and coordination through 2025) | 5.3.1 Partnership Building and Coordination  5.3.2 Technical Assistance (UN and International Agencies)  5.3.3 International Exchange and Cooperation and cross-border collaboration |  | 5,246,563  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) | 5,246,563  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) |
| Expand Research  (To strengthen supporting elements for research, innovation through 2025) | 6.1.1 Identify and expand operational research  6.1.2 Conduct Annual Review of Research |  | 745,034  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) | 745,034  (NSP 2021-2025 costing is still being revisited drawing from further discussions; comments from WHO mock review; possible integration under RSSH, etc.) |
| TOTAL AMOUNT | | | 93,455,683 | 93,455,683 |

## Funding Request to the Global Fund

Fill in questions a) and/or b) as relevant for your country funding request approach(es):

**a)** for funding requests using the traditional, Performance Based Funding approach

**b)** for funding requests using the Payment for Results modality

All applicants should fill in questions **c)**, **d)** and **e)**.

**a)** For a funding request using the Performance Based Funding approach:

Use the table below to list and provide the rationale for **each intervention** prioritized for Global Fund funding.

|  |
| --- |
| **COMPONENT:** *Malaria* |

|  |  |  |
| --- | --- | --- |
| NSP Strategic Area #: Early Case Detection  (To achieve and sustain universal coverage by case detection and prompt and complete treatment of all confirmed cases through 2025) | | |
| Intervention | Rationale for prioritization for Global Fund funding | Amount requested  from the Global Fund  (in USD) |
| - Strengthen and expand RDT based diagnostic services;  - Screen pregnant women in high transmission areas/communities at ANC centres;  - Screen key populations (viz. mobile and migrant populations) at select district and international border-crossing points; and in underserved hard-to-reach areas by mobile teams and (and in special situations)  *[Funding Request Module:*  *Case Management; RSSH: Human resources for health, including community health workers]*  *[Funding Request Intervention:*  *Integrated community case management; Community health workers: Remuneration and deployment]* | Early diagnosis and prompt, complete treatment (EDPT) is priority towards reducing disease burden and transmission. This is in line with the WHO GTS 2016-2030 and Regional Action Plan 2017–2030. Towards 0. Malaria-Free South-East Asia Region, as well as RBM Partnership’s Action and Investment to defeat Malaria 2016-2030 – for a malaria-free world. In addtion, 2017 ministerial declaration also highlights key strategic areas:  - universal access to quality-assured prompt diagnosis and treatment, effective prevention to all vulnerable and at-risk populations (including the disadvantaged communities, communities in border and conflict areas, and refugees and undocumented migrants); and  - provision of adequate quality-assured supplies for malaria diagnosis, treatment (and vector control) through effective procurement and supply management.  RDT-based diagnostic services is prioritized for EDPT especially at community level towards reducing disease burden and transmission. Since most endemic areas are located in complex geographies and fraught with communication and health systems and various other challenges, it is proposed that 80% case detection will be done using RDTs to ensure EDPT at point of care at community level in 13 endemic districts.[[3]](#footnote-4)  Currently, 3 CHT districts are categorized as high burden districts (targeted for accelerated transmission reduction) and 10 non-CHT districts are categorized as elimination districts (phased local transmission interruption). The 51 'non-endemic' districts will be targeted for determining its status towards nationwide elimination.  Bangladesh has free community-based case management malaria services delivered by Community Clinics (CCs) [which is the first basic level of government heatlh facility where community members first engage with health care providers. 1 CC is established for 6,000 population approximately across the country. At respective CC, the community health care providers (CHCP) are responsible for provision of basic general health care services six days a week]. In addition, the GoB has recently introduced multipurpose health volunteers (MHVs) in selected districts towards bridging the community and CCs, and who will be part of malaria services.  CCs and MHVs will be the first level in provision of case management. MHVs will be trained and equipped for RDT testing of suspected malaria cases. The positive cases will be treated according to the national malaria treatment guideline. The severe cases will be referred to the nearest UHC.  It is envisaged that the MHVs will be involved progressively to support EDPT after training. The partner NGOs will continue to complement and extend the reach of health services through their health workers & volunteers in 03 CHT districts and Chattogram and Cox's Bazar districts. This will facilitate addressing the needs of key and vulnerable populations, and also maximize returns of the investments through achievement of desired impact in terms of reduction in transmission, disease burden.  Health wokers and volunteers of NGOs will diagnose and treat confirmed malaria cases, follow up as well as refer the cases, as required (in addition, they will facilitate community engagement, disseminate preventive messages, distribute LLIN to the targeted households).  In 03 CHT districts and Chattogram and Cox's Bazar, RDTs will be done by health workers/health volunteers associated with public health systems and partner NGOs.[[4]](#footnote-5) In other districts, where number of malaria cases have reduced considerably (Mymensingh and Sylhet zones), health workers/health volunteers associated with GoB Community Clinics (CCs) will use RDT to screen all fever cases and transmit reports to the UHC every month. Need based trainings (for new ones) and retrainings (for existing ones) for health workers/volunteers with partner NGOs will be done. The NMEP will lead the intial training for both MHVs and NGO volunteers. RDTs will be part of their kit. The supervisory and feedback system to monitor performance of community health volunteer network will be strengthened.  In addition, non-cash incentives to the NGO health workers/volunteers will be provided for optimal motivation, performance recognition and retention. These efforts will contribute to RSSH in terms capacitated community cadres as well as community systems strengthening.  Early case detection with RDTs will be ensured for pregnant women at identified ANC centres at Upazila levels and through household visits by GoB/NGO health workers/volunteers.  Further, mobile teams (of GoB, NGO) will strengthen outreach operations with prompt diagnosis with RDTs especially to serve key and vulnerable populations including ethnic minorities, mobile and migrant populations in high endemic hard-to-reach areas in 03 CHT districts. The GoB and NGO mobile teams will expand outreach through special health camps especially during peak transmission season. Such health camps will also cover key migration transit points (including formal district and national border crossings), forest-fringe markets. Support will be requested from the armed forces, BGB, Police and other law enforcement agencies to access the most hard-to-reach communities especially along border areas. For settled populations, mobile services will be a temporary measure to fill any gap during monsoon and post-monsoon season. The mobile and migrant populations living within/near villages will be served primarily through community-based service providers.  Rohingya refugees (~1 million in no.) - referred as Forcibly Displaced Myanmar Nationals - FDMNs) in Cox’s Bazar pose additional burden to country’s health system. Bangladesh is supporting this group with various service provision thereby addressing issues relating to human rights. This group will continue to be covered by diagnostic services [by RDTs (80%) or microscopy (20%)] through public health system/partner NGOs. [The partner NGO laboratories are responsible for both malaria and TB and hence, will be costed under TB grant]. Coordination with other international/national agencies will be strengthened for early case detection (& sharing of reports). Quality assured RDTs will continue to be provisioned for FDMN camps.  Quality assured RDTs will be procured by GoB with GF Allocation and supplied to GoB, NGO health workers and volunteers and facilities (where microscopy services exist (at health facilities), RDTs will only be used in case the microscopy services are not functional for some reason, e.g. absenteeism, off-duty hours, emergencies, etc.). Timely procurement of quality assured RDTs through the GF PPM mechanism will be priority. For RDTs, 25% buffer has been included. It is envisaged that deployment reserve will be considered for hard to reach areas including border areas facing constraints relating to timely replenishment for uninterrupted services especially during monsoon/post monsoon period (that coincides with peak transmission season). RDTs for 51 'non-endemic' districts will be procured with GoB resources.  Following activities are prioritized under GF Allocation: procurement of RDTs for 13 endemic districts; special health camps in 03 CHT districts; and remuneration of NGO field/health worker and non-cash incentives for health volunteers, their training/refresher training in 03 CHT districts and Chattogram and Cox's Bazar.  [The IEC/BCC (advocacy, communication, social mobilization - ACSM) package of activities related to universal equitable access to case management of malaria, enhancing awareness and responsive behavior, community mobilization, etc. is reflected later under Strategic Area – prompt and effective treatment].  In view of limited allocation amount, many activities/commodities are proposed under PAAR or will be attempted through GoB resources. Whilst funding for certain interventions will be explored from partner agencies like WHO and others, many interventions will continue to remain unfunded. All interventions for FDMN population except RDTs and ACTs are proposed under PAAR. Most interventions for 51 'non-endemic' districts will be covered by domestic resources; although additional resources will also be explored from partners including the GF. | 6,331,806  (being updated) |
| - Strengthen microscopy-based diagnostic services  *[Funding Request Module:*  *Case Management; RSSH: Human resources for health, including community health workers]*  *(Funding Request Intervention:*  *Facility based treatment; Remuneration & deployment of existing/new staff (excluding community health workers))* | Quality assured microscopy-based diagnostic services is prioritized for case detection at facility level. Such services will be provided in the 13 endemic districts, through a network of GoB health facilities (at tertiary, district and upazila level, GoB hospitals).  Bangladesh health system already have integrated diagnostic service provision at many district/Upazila health facilities. Medical technologists (MTs) for malaria microscopy also perform other laboratory tests. Few MTs in 03 CHT districts and their trainings will be supported with GF Allocation. Such efforts will contribute to RSSH. Partner NGO laboratories are part of malaria microscopy network. In 03 CHT districts and Chattogram & Cox's Bazar, NGO laboratories will provide complementary support for malaria microscopy. In addition, 47 NGO Lab facilities (25 in 25 Upazilas in 03 CHT districts and rest in endemic Upazilas of Chattogram and Cox's Bazar will provide diagnostic support. These will be positioned away from GoB facilities). Positioning of those laboratories will be based on mapping of GoB laboratories, availability of power supply, etc. towards coordinated and harmonized services. Going forward, a national laboratory and QA plan will be updated that will include public, NGO and even private laboratories (where feasible) with clear articulation of populations served and roles and responsibilities towards increasing access to diagnostic services through progressively integrated approach. It may be noted that few NGO laboratories within FDMN camps are providing integrated laboratory services for both malaria and TB (and will be supported under TB Allocation).  New microscopists will be trained and existing microscopists will receive need-based refresher training. Microscopes (as needed), supplies and consumables for GoB facilities will be procured with GoB funding. Supplies and consumables for NGO labs will be requested under Allocation.  [In 2019, the ABER was ~8% (in 13 endemic districts). Going forward, at least 8-10% ABER will be maintained to maximize case detection (considering tests by both RDT and microscopy) in 03 CHT districts and Chattogram and Cox's Bazar; and case based surveillance will be strengthened in Mymensingh & Sylhet zones].  Following activities are prioritized under GF Allocation: Salary for few MTs in 03 CHT districts; training of MTs in 13 endemic districts; and NGO laboratories in 03 CHT districts and Chattogram and Cox's Bazar (laboratory technicians, supplies/consummables, premises).  In view of limited allocation amount, many activities/commodities are proposed under PAAR or will be attempted through GoB resources. Whilst funding for certain interventions will be explored from partner agencies like WHO and others, many interventions will continue to remain unfunded. All interventions for FDMN population except RDTs and ACTs are proposed under PAAR. Most interventions for 51 'non-endemic' districts will be covered by domestic resources; although additional resources will also be explored from partners including the GF. | Included under above (being updated) |
| - Quality Assurance (QA) in malaria diagnosis (Ensure Quality Assurance (QA) in Microscopy; Ensure Quality Assurance (QA) in RDTs)  *[Funding Request Module:*  *RSSH: Laboratory systems]*  *[Funding Request Intervention:*  *Quality management systems and accreditation]* | Laboratory diagnostic capacity and QA of microscopy are particularly crucial in the elimination phase. High-quality diagnosis will be ensured by strengthening QA for laboratory diagnosis nationwide. Collaboration and coordination between the NMEP, Central Malaria Reference Laboratory (CMRL) will be strengthened at district and upazila levels. The laboratories with partner NGOs will be under the purview of national QA system. It will support improving the efficiency, cost-effectiveness and accuracy of test results systematically. Efforts will continue for microscopy services by competent, motivated staff, which is (and will be) supported by training/refresher training and supervision as well as regular internal and external competency assessments. Accredited Senior Medical Technologists of CMRL will conduct regular supervision visits to district/Upazila laboratories on rotation basis. Also, improvement in logistics system will continue with adequate, continuous supply of good-quality reagents, other supplies (slides, etc.) [by the GF for NGOs; and the rest by GoB].  Technical assistance will be provided by the WHO for external competency assessment and related preparedness as well as updating QA guidelines and SOPs. Internal competency assessment will be carried out periodically by the GoB. Besides, internal QA system (cross checking) will continue with representative sample of slides cross-checked at higher levels with GoB resources.  Following activities are prioritized under GF Allocation: External and internal competency assessments and preparedness; technical assistance; and supervision by CMRL.  In view of limited allocation amount, many activities/commodities are proposed under PAAR or will be attempted through GoB resources. Whilst funding for certain interventions will be explored from partner agencies like WHO and others, many interventions will continue to remain unfunded. All interventions for FDMN population except RDTs and ACTs are proposed under PAAR. Many interventions for 51 'non-endemic' districts will be covered by domestic resources; although additional resources will also be explored from partners including the GF. | Included under above (being updated) |

|  |  |  |
| --- | --- | --- |
| NSP Strategic Area #: Prompt and Effective Treatment  (To achieve and sustain universal coverage by case detection and prompt and complete treatment of all confirmed cases through 2025) | | |
| Intervention | Rationale for prioritization for Global Fund funding | Amount requested  from the Global Fund |
| - Strengthen community-based treatment  - Provide treatment services in remote areas and at select district and international border-crossing points  *[Funding Request Module:*  *Case Management]*  *[Funding Request Intervention:*  *Integrated community case management]* | As mentioned above, EDPT at point of care at community level remains priority. Prompt, complete and effective treatment will be ensured by treating all confirmed malaria cases according to the national treatment guidelines.  Trained health workers/health volunteers associated with Community Clinics (CCs) will be responsible for prompt and effective treatment at community level nationwide. In 03 CHT districts and Chattogram and Cox's Bazar, treatment services at point of care will continue to be provided by trained health workers/health volunteers of partner NGOs. Efforts will continue by service providers to ensure complete treatment adherence by the patients, which will be supported by persistent IEC/BCC. Support will be requested from the armed forces, BGB, Police and other law enforcement agencies to access the most hard-to-reach communities especially along border areas [for strengthening treatment services through outreach operations, please refer to previous strategic area]. Going forward, as number of cases declines to a few per facility in a month even in peak transmission season, supervised treatment through DOT and/or admission of all cases will be initiated, where possible to ensure full compliance with treatment and prevent onward transmission (starting with Mymensingh and Sylhet zones and later others). Further, in the event complications are noticed in a patient, timely referral will be arranged.  Quality assured antimalarials will be procured and supplied to GoB, NGO health workers and volunteers. Timely procurement of quality assured ACTs (& inj. Artesunate) [including 100% buffer] through the GF PPM mechanism will be priority. These antimalarials are not manufactured in Bangladesh and requires minimum 6 months to complete the international procurement process.  Possibilities of non-availability of these antimalarials at the right time at the right place (especially in the periphery) and/or shortages during the transmission seasons or contingencies are high. This situation can affect performace of malaria treatment services and subsequently may adversely affect malaria transmission. Adequate deployment will continue to be considered for the peripheral levels (hard to reach areas, border areas) facing constraints relating to timely replenishment for uninterrupted services especially during monsoon/post monsoon months (that coincides with peak transmission season). ACTs for FDMN camps will be sought under GF Allocation (to be provided through NGO laboratories). Other antimalarials (CQ, PQ) will be procured by NMEP with GoB resources.  Following activities are prioritized under GF Allocation: Procurement of ACTs; training/refresher training of health workers/volunteers.  [The IEC/BCC - ACSM package of activities related to universal equitable access to case management of malaria (as well as vector control), enhancing awareness and responsive behavior, community mobilization, etc. is reflected later under Strategic Area – Programme communication].  In view of limited allocation amount, many activities/commodities are proposed under PAAR or will be attempted through GoB resources. Whilst funding for certain interventions will be explored from partner agencies like WHO and others, many interventions will continue to remain unfunded. All interventions for FDMN population except RDTs and ACTs are proposed under PAAR. Most interventions for 51 'non-endemic' districts will be covered by domestic resources; although additional resources will also be explored from partners including the GF. | 283,896  (being updated) |
| - Strengthen prompt and effective case management, including management of severe malaria in public sector health facilities  *[Funding Request Module:*  *Case Management]*  *[Funding Request Intervention:*  *Facility-based Treatment]* | Prompt and effective treatment of confirmed malaria cases will continue to be provided at GoB facilities at district, Upazila levels.  As severe malaria is potentially fatal, any patient considered at increased risk will be provided parenteral Artesunate without delay. Provision of inj. Artesunate is proposed under GF Allocation that will be made available at district and Upazila level facilities; whilst progressive strengthening of facilities including availability life-saving support systems will be pursued for management of severe malaria cases with GoB resources.  Following activities are prioritized under GF Allocation: Procurement of inj. Artesunate.  In view of limited allocation amount, many activities/commodities are proposed under PAAR or will be attempted through GoB resources. Whilst funding for certain interventions will be explored from partner agencies like WHO and others, many interventions will continue to remain unfunded. All interventions for FDMN population except RDTs and ACTs are proposed under PAAR. Most interventions for 51 'non-endemic' districts will be covered by domestic resources; although additional resources will also be explored from partners including the GF. | Included under above (being updated) |
| - Strengthen and monitor private sector case management services  *[Funding Request Module:*  *Case Management; RSSH: Health sector governance and planning]*  *[Funding Request Intervention:*  *Private sector case management; Policy and planning for national disease control programs]* | Private sector providers, viz. qualified private practitioners/registered clinincs/tea garden or other corporate health facilities (formal) and pharmacists/drug vendors/traditional healers/indigenous medicine practitioners/unqualified village doctors, etc. (informal) play an important role in case management. In Bangladesh, private providers are often the first port of call/filter for many patients (including those having fever). Since the involvement and role of the private sector in malaria case management is still poorly understood, an assessment of private sector role, readiness and performance for malaria elimination has recently been carried out by an independent agency commissioned by WHO for the NMEP. The assessment provided a glimpse of current situation. Private sector are using RDT and anti-malaria drugs. Whist some are quality assured commodities some are not. Many private health care providers in private sector expressed high interest of collaboration with NMEP. The assessment recommended that: further research needs to be conducted with large sample size including more hard to reach forest areas, tea gardens and traditional healers besides considering qualitative approaches for in-depth information from the malaria hot-spots; private service providers especially at local level need to be trained regarding malaria diagnosis, treatment, and prevention according to national guidelines; identification of the private facilities and individual service provider in the high risk areas is needed for collaboration/stakeholder mapping.[[5]](#footnote-6) Drawing from several guidance, recommendations including this assessment, a private sector engagement strategy will be developed for systematic expansion of collaboration and increasing access to quality malaria case diagnosis and treatment. The strategy will be developed through a consultative process with key partners, potential partners from private sector, non-health Ministeries and development partners. Additionally, other relevant public health programmes will also be brought to the consultation process for sharing their previous experience, lesson learned and success.  The NMEP in coordination with partner NGOs has initiated trainings/orientation for formal and informal providers (‘village doctors’) on malaria case management according to national guidelines and respective recording and reporting procedures. However, systematic engagement will begin with a mapping exercise of formal and informal providers. ‘Village doctors’ constitute a significant service provider in rural Bangladesh. Yet, 98% of this segment did not have any guideline for management of malaria according to the above-mentioned assessment. Orientation of village doctors will be further pursued under GF Allocation, whilst trainings of formal private sector providers including those with tea gardens, etc. will be carried out with GoB resources. With this, case management through public, NGO, private sector is expected to maximize impact. Provision for RDTs and antimalarials for the private sector in pilot mode will be decided later.  Following activities are prioritized under GF Allocation: TA and workshop for development of private sector engagement strategy; orientation of ‘village doctors’.  In view of limited allocation amount, many activities/commodities are proposed under PAAR or will be attempted through GoB resources. Whilst funding for certain interventions will be explored from partner agencies like WHO and others, many interventions will continue to remain unfunded. All interventions for FDMN population except RDTs and ACTs are proposed under PAAR. Many interventions for 51 'non-endemic' districts will be covered by domestic resources; although additional resources will also be explored from partners including the GF. | Included under above (being updated) |

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| NSP Strategic Area #: Malaria Prevention with Appropriate Vector Control Measures  (To achieve and sustain universal coverage of population at risk with appropriate preventive interventions through 2025) | | |
| Intervention | Rationale for prioritization for Global Fund funding | Amount requested  from the Global Fund |
| - Provide free LLINs for all groups at risk of contracting malaria  [Provide LLINs through mass campaign to established communities]  [Provide additional LLINs through continuous distribution to pregnant women, mobile and migrant populations (forest goers/workers, seasonal agricultural workers, mine workers, night guards, tea garden workers), refugees, new settlements, and in the event of disasters and in response to outbreaks and confirmed transmission foci]  *[Funding Request Module: Vector Control]*  *[Funding Request Intervention: Long-lasting insecticidal nets (LLIN) - Mass campaign – Universal; Long-lasting insecticidal nets (LLIN) - Continuous distribution - Community-based]* | LLINs remain the principal intervention for reducing human-vector contact by personal protection and contributing to impact. The GF support for universal coverage of priority areas and all groups at risk of contracting malaria with free LLINs is well appreciated. Endemic villages will continue to receive periodic mass distribution. The LLINs remain effective at field level for at least three years. Universal coverage by LLINs to entire population (1 LLIN per 1.8 persons) in high endemic 03 CHT districts after an interval of every three years is considered as ‘absolute’ priority. In Chattogram and Cox's Bazar (adjacent to CHT), a village-level stratification will be carried out for prioritizing and targeting LLINs instead of a blanket coverage with increased focus on effective and efficient distribution to end beneficiaries. The villages will be prioritized for LLINs depending on number of years a village reported cases in the last three years: 3/3 – ‘high priority’; 2/3 – ‘medium priority’ and 1/3 – ‘low priority’. Due to limited Allocation amount, only ‘high & medium priority’ villages (from where cases were reported in last two and or three years) will receive universal coverage by LLINs with GF Allocation. LLINs for villages with cases in any of the last three years but not last year, is proposed under ‘PAAR’. [Although it would be critical to cover rest of the ‘endemic’ villages reporting indigenous cases, yet the LLINs for those villages is proposed under ‘PAAR’ so that the limited allocation is utilized for other priority interventions like surveillance & M&E, etc.]. ‘Endemic’ villages in the Mymensingh and Sylhet zones (having cases in any of the last three years) will be covered in 2020 following UQD approval by the GF. LLINs for FDMN camps is proposed under PAAR and/or will be explored from development partners.  Village based micro-planning will be done for coordination between PRs and local stakeholders, arranging logistics, warehousing, distribution, communication, training, recording/reporting, supervision & monitoring, etc. The LLIN distribution will use multiple delivery channels (public health system and/or partner NGOs) coupled with locally appropriate and gender sensitive IEC/BCC for high and correct LLIN usage. Post-mass campaign LLIN coverage assessments will be conducted in a representative sample of sites every year besides periodic LLIN utilization surveys.  Additional free LLINs will be provided through ‘continuous’ distribution targeting high-risk groups to:   * Pregnant women (delivered through ANC centres and/or during household visits by health workers/volunteers). * Forest/forest farms, forest workers/ forest goers. * Mobile and migrant populations (jhum cultivators, seasonal agricultural workers, fishermen, mine workers, tea garden workers, etc.). * People in need in areas affected by disasters, outbreaks or confirmed transmission foci. * New settlements; and to households with LLIN attrition in-between mass distribution (lost or damaged LLINs).   [The IEC/BCC - ACSM package of activities related to universal equitable access to case management of malaria (as well as vector control), enhancing awareness and responsive behavior, community mobilization, etc. is reflected later under Strategic Area – Programme communication].  Following activities are prioritized under GF Allocation: LLINs for mass and continuous distribution and related costs.  In view of limited allocation amount, many activities/commodities are proposed under PAAR including LLINs for ‘endemic’ villages reporting 1-2 cases in last three years and FDMN camps. Whilst funding for certain interventions will be explored from GoB resources and or partner agencies like WHO and others, many interventions will continue to remain unfunded. LLINs for FDMN population except RDTs and ACTs are proposed under PAAR. Many interventions for 51 'non-endemic' districts will be covered by domestic resources; although additional resources will also be explored from partners including the GF. | 5,665,854  (being updated) |

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| NSP Strategic Area #: Epidemiological Surveillance  (To strengthen context-specific surveillance in all malaria settings and outbreak preparedness and response through 2025) | | |
| Intervention | Rationale for prioritization for Global Fund funding | Amount requested  from the Global Fund |
| - Strengthen surveillance systems in different settings (transmission reduction, elimination)  - Expand and strengthen malaria information system  - Active Case Detection (proactive case detection)  - Case-based surveillance, transmission focus investigation and response  - Outbreak preparedness, investigation and response  - Cross-border surveillance  - Drug Resistance Monitoring  *[Funding Request Module: RSSH: Health management information systems and M&E;* *Case Management; ]*  *[Funding Request Intervention: Routine reporting; Analysis, evaluations, reviews and transparency; Program and data quality; Active case detection and investigation (elimination phase); Therapeutic efficacy surveillance; Epidemic preparedness]* | Drawing from the WHO guidance and based on lessons learned, the surveillance systems will continue to address the heterogeneity of malaria context in Bangladesh from high burden 03 CHT districts to other districts progressing towards elimination.  The current malaria MIS will continue monthly aggregated case reporting from 03 CHT districts; but will also include modules to support real-time case-based reporting, case investigation, focus investigation and focus response. A case-based surveillance and response system has already been initiated in Mymensingh and Sylhet zones which will be be refined and updated in line with the WHO guidelines and reinforced in these zones and Chattogram and Cox's Bazar. Data collection tools/reporting formats/registers will be revisited for standardization and capturing case-based reporting.  Currently, the system is paper-based up to Upazila level and electronic/web based from Upazila level, which is working well. It is expected that the malaria MIS will transition to DHIS2 based system with linkages to MoHFW DHIS2 subsequent to development and piloting through TA in 2020 (the maintenance will be the responsibility of NMEP from 2021 and accordingly is proposed under GF Allocation). During the current grant, smart phones/tablets are provisioned for health workers/volunteers of partner NGOs. The GoB already provides tablets to CCs. Subsequent to installing appropriate DHIS2 based reporting application with necessary linkages as well as capacity building, it is expected that malaria MIS will eventually transition and transform to real-time reporting of individual cases even from peripheral level. Maintenance/strengthening of programme website will also continue to be extremely important for timely data/information dissemination.  Thus, progressively, real-time case reporting (individual cases) and ‘zero-reporting’ will be ensured from Mymensingh and Sylhet zones, and Chattogram and Cox's Bazar (in that order) with reduction in caseload. As yet, there has been no systematic reporting from 51 'non-endemic' districts. With trainings/orientation and deployment of a minimum package of RDTs and antimalarials at district and Upazila levels, the updated/transformed malaria MIS will also begin capturing reports from those districts (including ’zero reporting’). Besides, malaria MIS platform will be revisited/redesigned to support data analysis and interpretation including but not limited to indices/summaries, graphics. Whilst central and district teams will lead in-depth data analysis and provide timely and strategic feedback to Upazila & peripheral levels, those at local levels will also be capacitated for data analysis to maximize the usefulness of data for planning and actions.  The NMEP and partner NGOs will follow ‘one’ surveillance and M&E system comprising data recording, collection, processing, analysis and transformation into strategic information for use. The system will cover all levels, including community based volunteers/health workers as well as private sector providers (after mapping and training) [through private sector engagement strategy]. Malaria is notifiable disease under the Infectious Disease Act 2018. Steps will be taken through persistent communication nationwide to notify malaria cases by all relevant sectors.  A surveillance (and M&E) manual will be updated through TA for guidance on systems and processes along the continuum of malaria transmission settings with special emphasis on elimination-specific case-based surveillance, data analysis for planning and action. SOPs for case investigation, focus investigation and focus response will be developed for guidance to district and sub district levels elimination districts and capacity building will be carried out through integrated training. Supportive supervision for all levels, staff and volunteers is detailed later under Programme management and M&E.  Quality and optimal implementation of interventions and optimal supervision and monitoring will increase the workload of the NMEP manifold. As recommended by the JMM, adequate and appropriately skilled staff, aggressive capacity building will be extremely critical. More so, because the PR2 Consortium will concentrate their complementary support in 03 CHT districts and Chattogram and Cox's Bazar districts, whilst the capacitated central, district and Upazila staff as well as those positioned at community clinics will be responsible for implementation of interventions and case-based surveillance in other endemic districts and 51 'non-endemic' districts. Therefore, few additional HR (02 SMOs, 01 M&E Officer) is proposed under GF Allocation and few under PAAR (due to limited Allocation amount) in addition to the existing team (which needs additional support). More so, because such paradigm shift has been previously envisaged to evolve gradually (in phased manner) in elimination districts, and drastic reduction of complementary support by PR2 staff/peripheral workers especially at Upazila/peripheral levels at one go may affect implementation of interventions.  The GoB and partner NGOs are responsible for surveillance and M&E. Starting from health workers/volunteers, other NGO staff viz. field/programme organizers, laboratory technicians, ditstrict and Upazila teams, etc. to those associated with public health system from CC and upwards will be capacitated through trainings/refresher trainings. Such trainings will be integrated with overall malaria management trainings. Capacity building will be done for DHIS2 based system, GIS at all levels, as appropriate. Use of data for strategic planning and effective & targeted implementation, monitoring progress will be emphasized. Front-line/peripheral staff as well as Upazila levels involved in case detection, recording and reporting of cases will be trained in analysing and interpreting data.  Effective supply systems remain one of the critical elements for uninterrupted implementation of interventions. Capacity will also be strengthened through training, supervision and LMIS system updates, as appropriate. Workshops on LMIS will be held periodically. The LMIS will especially track RDT/ACT until the last distribution points and will minimize the risk of stock-outs, maximize appropriate utilization, and strengthen the supply response to outbreaks and transmission foci, thereby facilitating progress towards programmatic targets.  Efforts will be initiated for cross-border collaboration at district levels (with emphasis on district-to-district collaboration) starting with strengthening of case detection and reporting within national boundaries as well as exchange of malaria information with counterparts in the neighbouring countries. Alliances will be formed with the Armed Forces, Bangladesh Border Guards and other security agencies and others (as appropriate) in this endeavour.  Robust case based surveillance will review and assess every malaria case detected and reported by trained public health system/partner NGOs in elimination districts. Every case will be investigated and linked to the village (or focus) and household of origin, where further case detection, treatment, classification will be undertaken, as appropriate. If a transmission focus is suspected, the upazila and district malaria focal points will initiate prompt investigation, management and clearance of foci of transmission. A focus investigation report will be submitted to the district Civil Surgeon and to central level immediately and entered into the MIS. In the event of a confirmed transmission focus, a tailored response, involving RACD and LLINs or IRS as appropriate, will be initiated by district RRT and supported by central team.  PCD will be strengthened nationwide starting from community clinics through tertiary hospitals. ACD (proactive case detection – PACD) will be important for detecting symptomatic cases especially in hard to reach areas and that are not reached through PCD. ACD surveillance systems, with case detection, notification and investigation will be strengthened in elimination areas but will not substitute PCD. Further, mobile and migrant populations are a key risk group and in order to improve the targeting of these groups, information on population movements in endemic districts will be collated by NMEP and partners through network of service providers and community contacts (training for this will be integrated into case management and other training). Any unusual influx will be investigated and responded with ACD, LLINs, etc., as appropriate. A multi-sectoral group (different ministries, NGOs, private companies, UN agencies etc.) will be constituted to tap into information on population movements in high risk areas. This support is expected to significantly improve the delivery of case management and prevention services amongst mobile and migrant populations, thereby reducing the risk of transmission and emergence of drug resistance and facilitating progress towards impact. PACD will also be conducted intermittently by doctor, paramedics, health workers/volunteers, etc. through special health camps especially during peak transmission season targeting hard to reach areas, which are proposed to ensure EDCT during transmission season in coordination with District VBDCPs, PHC/CHC, etc. The health camps will be conducted jointly by NMEP and partner NGOs and will involve a team of doctor, paramedics, etc. in coordination with District/Upazila levels.  Going forward, ACD may involve parasitological examination of everyone in a targeted population (mass testing) including symptomatic/aymptomatic cases and treatment or mass drug administration (MDA) in consultation with WHO.  Continuous assessments of program and/or data quality and monitoring of quality improvement activities or interventions will be critical. Such efforts will include but not limited to, data quality assessment and validation, on site data verification, etc. by central team and SMOs together with partner NGO’s central team on site as well as through review of online/electronic reports. This will continue to further strengthen correct, complete & timely data reporting for using such quality information for strategic planning/decision-making. Data triangulation relating to reports submitted by district level and those available on ground will be regularly conducted.  Outbreaks have been recorded in Bangladesh due mostly to climatic factors, systemic and socio-economic factors. Variations in rainfall pattern, disruption of surveillance leading to delayed detection and inadequate response, population movement, behaviour relating to late evening activities/LLIN use, etc. were contributing factors. As transmission is reduced, the risk of epidemics increases. Hence, data will be analysed frequently to ensure early detection of a potential outbreak. SOPs for outbreak response will be updated defining thresholds and roles and responsibilities. Outbreak detection capability will be maintained and strengthened through integrated training and supportive supervision for all staff and volunteers involved in case management. Each district has a Rapid Response Team (RRT). Such RRTs will be part of this integrated trainings and will be provided with equipment and supplies, as needed. Surveillance Medical Officers & NMEP will remain on full alert especially during June-July[[6]](#footnote-7), with preparations for additional manpower, drugs and commodities, as required[[7]](#footnote-8). If an outbreak is suspected, the health worker responsible will send message to their upazila and district malaria focal points. Prompt investigations, including ACD, will be carried-out by a team from district and upazila level. An investigation report will be submitted to the district’s Civil Surgeon and to central level immediately and entered into the MIS. In the event of a confirmed outbreak a tailored response will be initiated by RRT, involving ACD and LLINs or IRS as appropriate. Further, the surge in Rohingya refugees entering endemic areas of Bangladesh from endemic areas of Myanmar necessitates establishing emergency measures to address the malaria risk in these refugees (e.g. screening and LLIN provision), and thereby minimize the risk of importation of dangerous new parasite strains.  Monitoring of therapeutic efficacy of recommended first line antimalarials for treatment of Pf cases will continue (in 03 sites by NMEP with GF Allocation and in additional 02 sites with WHO core support) in line with WHO guidelines). The TES data will ensure evidence-based treatment and constant watch on Artemisinin resistance. Artemisinin resistance monitoring site in FDMN camp is needed and is included in the FDMN package of interventions (for seeking additional funding).  The package would include site related costs including visits, etc., trainings and information dissemination, etc. too and would be implemented through the National Institute of Malaria Research (NIMR), a premier institution of the Indian Council of Medical Research (ICMR), GoI. The funding is requested from the allocated amount.  Following activities are prioritized under GF Allocation: Case investigation and related supervision; focus investigation, response and related supervision; outbreak investigation and response; Surveillance Medical Officers and related costs; DHIS2 maintenance; surveillance and M&E trainings; TES; cross-border meetings; TA for updating surveillance manual and SOPs.  [For other activities relating to RSSH: Health management information systems and M&E, please refer to NSP Strategic Area #: Programme Progress Review and Planning, Monitoring & Evaluation, Policy & Strategy Development].  In view of limited allocation amount, many activities/commodities are proposed under PAAR including LLINs for ‘endemic’ villages reporting 1-2 cases in last three years and FDMN camps. Whilst funding for certain interventions will be explored from GoB resources and or partner agencies like WHO and others, many interventions will continue to remain unfunded. All interventions for FDMN population except RDTs and ACTs are proposed under PAAR. Most interventions for 51 'non-endemic' districts will be covered by domestic resources; although additional resources will also be explored from partners including the GF. | 1,447,997  (being updated) |

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| NSP Strategic Area #: Entomological Surveillance  (To strengthen context-specific surveillance in all malaria settings and outbreak preparedness and response through 2025) | | |
| Intervention | Rationale for prioritization for Global Fund funding | Amount requested  from the Global Fund |
| - Establish and strengthen entomological surveillance and insecticide resistance monitoring  *[Funding Request Module: Vector Control]*  *[Funding Request Intervention: Entomological monitoring]* | LLINs and focal responsive IRS are currently the core vector control interventions. Entomological surveillance therefore remains critical; and will emphasize more on epidemiology led interventions for problem solving and linked to programme decisions. Entomological survey for new vector incrimination and re-confirmation of established malaria vectors in endemic areas will be carried out. Although planning includes 20 sites in 13 districts - twice in 5 years), only survey at 5 sites in 03 CHT districts is proposed under GF Allocation (and the rest in other endemic areas and 51 'non-endemic' districts remains unfunded quality demand). Entomologists will conduct needs-based assessments for problem solving (e.g. where incidence unexpectedly rises or fails to fall). Such entomological data analysis and interpretation will support characterization of receptivity, risk assessment, and guide planning, implementation, M&E of vector control interventions. Every year insecticide resistance monitoring will be carried out in sentinel sites as a basis for choosing insecticides. Coverage and quality of interventions and LLIN utilisation in different risk populations will also be monitored. Further, monitoring the efficacy of LLIN (bio-assay) in 03 sentinel sites 03 CHT districts every alternate year is proposed. Training on basic and advance malaria entomology for entomologists and technicians at central & districts levels will be conducted as well.  Following activities are prioritized under GF Allocation: Entomological survey; insecticide resistance monitoring; Training on Basic and Advance malaria entomology.  In view of limited allocation amount, many activities/commodities are proposed under PAAR. Whilst funding for certain interventions will be explored from GoB resources and or partner agencies like WHO and others, many interventions will continue to remain unfunded. Many interventions for 51 'non-endemic' districts will be covered by domestic resources; although additional resources will also be explored from partners including the GF. | 320,056  (being updated) |

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| NSP Strategic Areas #: Community Awareness and Participation; Programme communication; Advocacy for Strengthening Enabling Environment  (To achieve universal coverage by Advocacy, Communication and Social Mobilization (ACSM) activities for uptake of preventive and curative interventions, optimal community engagement for malaria elimination and enabling environment through 2025) | | |
| Intervention | Rationale for prioritization for Global Fund funding | Amount requested  from the Global Fund |
| - Develop & launch Communication Strategy for malaria elimination  - Enhance Community Awareness and Community Participation  - Development of BCC materials  - BCC Implementation through channel-mix  - Strengthen management and M&E of BCC  - Advocacy at different levels [national, district, division, Upazila, peripheral levels (union, ward, communitylevels)]  *[Funding Request Module: Case Management; Program Management]*  *[Funding Request Intervention: IEC/BCC (Case management); Coordination and management of national disease control programs]* | Behaviour change communication (BCC) - one of the supporting elements of NSP (2017-2021) will be planned & implemented to enhance awareness, mobilize community for uptake for LLINs, case management. The BCC activities will be harmonized by NMEP and partner NGO through channel-mix including community level group communication (household discussions, courtyard meetings; and message dissemination at community gathering areas such as tea stalls, markets/shops, etc. through public announcements, drum beating) and inter-personal communication. In the past, courtyard meetings has helped in consolidating community level linkages, collaboration and coordination for enhancing community awareness and participation especially in terms of adoption/reinforcement of responsive behaviour.  Aggressive BCC will be applied for promoting LLIN use, case management through evidence-based and locale- and context-specific BCC channel-mix. Focus would be on responsive behaviour as well as removing human rights- and gender-related barriers. Language/dialect, socio-cultural elements, etc. will be kept in mind. The entire package of IEC/BCC will comprise development and dissemination of appropriate materials/kits aligned to local socio-cultural norms and practices of the target audience and appropriate channel-mix; sensitization and mobilization events targeting the key audience for sustained community ownership at various levels. Community engagement for empowered participation especially in remote tribal areas will be intensified with an emphasis on involving communities in planning & implementation as well as monitoring.  School orientation aiming to reach to students, teachers as well as guardians to raise knowledge on malaria diagnosis, treatment, prevention and referral will continue. It is advantageous that teachers and guardians are also reached through the programme. Thus, wider community outreach will be attempted by adopting ‘Child-to-Child/Child-to-Family’ educational intervention. This is expected to educate the community at large by creating change agents (school children) in the short- to long term for dissemination of messages in fostering knowledge & awareness and responsive behavior among peer groups and family besides being cost-effective too. Alignment with the GoB ‘Little Doctors Program’[[8]](#footnote-9) will be attempted.  Advocacy (political, administrative, media, corporate) is limited. Whilst some advocacy activities will continue to be carried out by GoB and partner NGOs with GF Allocation. On World Malaria Day, various events for multi-sectoral advocacy and community mobilization will be organized until Upazila level, in endemic districts viz. discussion session, street play, folk music, health camp at selected sites (comprising malaria microscopy/RDT, exhibition on LLIN, IRS, other malaria related BCC materials), etc. Advocacy for and coordination with political leaders, decision makers, local governments, municipalities, corporate sectors, and village/community leaders, religious leaders, etc. will be prioritized. Media people will also reached through Round Table Discussion. Socialization of malaria will be supported by encouraging religious, civil-social and charitable organizations, NGOs outside PR2 Consortium to be fully involved in malaria elimination.  Different IEC/BCC materials with malaria messages such as sticker, calendar, brochure, folders, signboards, traveller’s guidance, etc. will continue to developed and disseminated widely to support IEC/BCC activities. In order to cover hard to reach areas, message dissemination at the time of mobile clinics will be initiated. In last few years, progress has been made to collaborate with print and electronic media to support malaria elimination and create mass awareness. Appropriate materials will also be designed keeping in mind illiterate sections and tribal groups. All health facilities (GoB, partner NGO) will display anti-malaria messages. The MoU between Bangladesh Betar & NMEP will be revived for designing & content development, producing, and airing innovative audio contents; ensuring engagement & feedback of the listeners and sensitizing them in local languages.  M&E of ACSM activities will go beyond data collection on outputs and writing basic report in registers. Specific reporting formats will be created. Recall of messages will be gauged during supervisory visits, amongst others.  Following activities are prioritized under GF Allocation: Ward level consultations; orientation of community volunteers/leaders on BCC; some IEC/BCC materials and mid-media activities (public announcements); commemoration of World Malaria day; round table discussion with media and key stakeholders.  In view of limited allocation amount, many activities/materials are proposed under PAAR. Whilst funding for certain interventions will be explored from GoB resources, many interventions will continue to remain unfunded. Many interventions for 51 'non-endemic' districts will be covered by domestic resources; although additional resources will also be explored from partners including the GF. | 315,432  (being updated) |

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| NSP Strategic Areas #: Programme Management, Capacity Buiding and Strengthening; Programme Progress Review and Planning, Monitoring & Evaluation, Policy & Strategy Development; and Partnership and Coordination  (To strengthen program management, monitoring & evaluation and coordination through 2025) | | |
| Intervention | Rationale for prioritization for Global Fund funding | Amount requested  from the Global Fund |
| - Human Resources Development and Management  - Infrastructure (development, maintenance)  - Procurement of health and non-health products  - Supply Chain Management  - Financial Management  - Monitoring Progress  - Annual, mid-term, end-term review  - Development of Strategies, Guidelines, Operational Plans and SOPs and update malaria risk stratification periodically  - Partnership Building and Coordination  - Technical Assistance (UN and International Agencies)  - International Exchange and Cooperation and cross-border collaboration  *[Funding Request Module: Case Management; Programme Management; RSSH: Health management information systems and M&E; RSSH: Financial management systems; RSSH: Human resources for health, including community health workers]*  *[Funding Request Intervention: Facility-based treatment; Integrated community case management (ICCM); Grant management; Coordination and management of national disease control programs; Routine reporting; Program and data quality; Analysis, evaluations, reviews and transparency; Routine grant financial management]* | Successful malaria elimination depends on effective programme management, resilient and sustainable health systems including appropriate policy, strategy, guidelines and planning, as well as skilled, motivated, and well supported staff and service providers at all levels. Ensuring programme and data quality are extremely important and therefore, supervision and monitoring, analysis and review will be strengthened. It will be ensured that the NMEP policy/strategy/guidelines are available at all levels and accordingly fully implemented, besides timely and accurate routine reporting and regular data quality audits. The NMEP will need to be responsive to the evolving needs in line with phased elimination to accelerate programmatic impact.  NMEP will take initiative to recruit new staff and fill-up the vacant posts. Specialized training/re-training will be organized at central, district and upazila level on epidemiology, entomology, case detection & treatment, follow-Upazila, quality assurance, surveillance and M&E, and ACSM. NMEP will make efforts to retain experienced staff. Accordingly, a Human Resources (HR) Development Plan will be developed, which will be updated on an annual basis. Additional support will also be required for strengthening training and M&E, BCC and advocacy. Knowledge and competence of health workforce will be enhanced through training/retraining including in-service training on a periodic basis. Subsequent to nationwide training needs assessment especially in-line with elimination requirements. The NMEP will continue to provide sound financial/grant management. Programme M&E will focus on monitoring the operational aspects of the Programme, and measuring impact, outcome and process indicators; appropriately interpreting results and informing revisions in policies or strategies, when needed, to help ensure progress; and documentation. The NMEP will monitor progress and provide supportive supervision for public sector providers (including community-based volunteers) as well as partner NGOs and others who are providing complementary support. There will be regular sessions of progress of the programme review, strategy development and programme planning. Mid-term review of the programme will be carried out by an independent expert under technical assistance every three years. Both the annual and mid-term review findings will be shared to all programme personnel and implementing partners by organizing and conducting workshop. Strategies, guidelines, operational plans and SOPs will be reviewed periodically and developed and revised as appropriate with TA. The NMEP will conduct risk and vulnerability analysis, ensure effective and comprehensive micro stratification, and update the stratification of malaria risk on an annual basis.  Strong partnership and coordination is instrumental for malaria elimination. Strtategic multi-sectoral collaboration at all levels will be priority for harmonized collective action. Robust programme will have all malaria stakeholders to adhere to three-one principles (One NSP, one coordination and one M&E plan). Partners will provide support covering a broad range of programme areas and will work with the NMEP to strengthen the leadership and management capacity.  As already mentioned, TA will be sought WHO and other development partners/academia/research organizations, as necessary. A dedicated WHO technical support will be available for NMEP.  The NMEP will develop cross-border operational framework involving WHO; organize and conduct district level cross-border meeting at endemic areas; and develop joint action plan with emphasis on provision of LLINs and case management, malaria information sharing.  Following activities are prioritized under GF Allocation: Salaries for staff, health workers; incentives for health volunteers; establishment costs abnd necessary repair/maintenance, office supplies, etc.; few replacement non-health products; trainings/refresher trainings on grant & financial management, M&E; audits; supervision and monitoring; review and planning; printing and dissemination of reporting formats; participation in national/international seminars/ conferences/meetings including GF and technical meets, etc. for exchanging best practices, lessons learned.  In view of limited allocation amount, many activities/commodities are proposed under PAAR. Whilst funding for certain interventions will be explored from GoB resources and or partner agencies like WHO and others, many interventions will continue to remain unfunded.. Many interventions for 51 'non-endemic' districts will be covered by domestic resources; although additional resources will also be explored from partners including the GF. | 10,792,165  (being updated) |

*(Add additional tables as relevant)*

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| **TOTAL AMOUNT requested from the Global Fund** | 25,157,206  (being updated) |

Explain the prioritization approach used to select interventions for Global Fund funding.

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| The Funding Request draws from upcoming NSP 2021-2025; which is in-line with GTS 2016-2030 (2016), Framework for malaria elimination (2017), Regional Action Plan Towards 0. Malaria-Free South-East Asia Region (2017), besides the commitments made by Bangladesh for Sustainable Development Goals (SDGs) as well as key strategic areas in 2017 Ministerial declaration on Accelerating and Sustaining Malaria Elimination in South-East Asia Region. The NSP 2021-2025 also draws from the 2019 JMM recommendations, Bangladesh health sector strategy/policy, and stakeholder consultation.  The strategy prioritizes progressive transition of high-burden areas to low- burden and low-burden areas to elimination besides determining ‘non-endemic’ status of rest of the districts. Based on these considerations, the priorities are set as follows:   * Accelerated reduction of malaria burden in 03 ‘endemic’ districts (03 CHT districts: Rangamati, Khagrachari and Bandarban). * Phased elimination of malaria from remaining 10 ‘endemic’ districts and maintain the status. * Determination of rest 51 districts as ‘non-endemic’ and maintain the status.   Successful elimination vision requires a distinction between a transmission reduction phase, where a combination of interventions is applied in endemic areas, and an elimination phase, where these measures are targeted to remaining foci and case-based surveillance intensified with measures to rapidly detect and cure every case. Drawing from prioritization, programme phasing is envisaged, since malaria burden must be lowered before it is possible (and rational) to investigate and treat every case and because premature application of the elimination approach might be prohibitively demanding. Thus, drawing from the above-mentioned prioritization, the programme phasing comprises the following components:   1. Transmission Reduction Phase: aims to bring malaria incidence to below 1 case per 1,000 population at risk[[9]](#footnote-10)). Interventions aim to reduce transmission and have an impact on morbidity and mortality. This involves aggressive scaling-up of effective preventive and curative interventions to achieve universal coverage in three high transmission districts. If a high-burden area is located near a low-burden area, then early reduction of transmission in the high-burden area will likely to make it easier to achieve elimination in both. 2. Elimination Phase: aims to reduce incidence to zero. Malaria case and entomological surveillance become the core interventions – every case is investigated and managed to avoid onward transmission. Based on the investigation, the foci of transmission is identified, appropriate vector control and antimalarial drug-based interventions are deployed to rapidly interrupt transmission in 10 low transmission districts. In addition, ‘non-endemic’ status of the rest 51 districts is determined indicating no reported indigenous case from these districts for three consecutive years through appropriate & strengthened surveillance system and capacity building. 3. Prevention of Re-introduction Phase: Even after locally acquired malaria cases have been reduced to zero, the health system and malaria case and entomological surveillance operations remain fully capable of preventing re-establishment of malaria transmission. At this stage, maintenance of malaria-free status will become the responsibility of the general health services, as part of their normal function in communicable disease control, in collaboration with other relevant sectors.   Appropriate implementation of interventions will be packaged for a particular phase tailored to the local epidemiology. Factors such as the past and current intensity of transmission in an area, and the size and mobility of affected populations will also be considered.  Stratification (district level); transmission status and programme phase 2021-25: Burden reduction and elimination.   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Stratum** | **Criteria** | **Transmission status** | **Programme Phase** | **Zone (with number of districts)** | **Pop. at risk (2019)** | **% at-risk pop.** | | 3 | API >1/1,000 pop.;  similar eco-epidemiology | High | Accelerated transmission reduction | CHT (03 CHT districts) expecting reduction of API<1 by 2025 and local transmission interruption by 2030) | 2,159,612 | 1% | | 2 | API <1/1,000 pop. | Low | Elimination | Mymensingh (04 districts) expecting local transmission interruption by 2021 | 2,080,972 | 1% | | Elimination | Sylhet (04 districts); and Chittagong and Cox’s Bazar (02 districts) expecting local transmission interruption by 2025 | 14,504,219 | 8% | | 1 | API=0; Receptive or Receptivity unknown | Potential | Elimination (status to be determined) | ‘Non-endemic’ (51 districts) status to be determined by 2023 | 156,983,230 | 89% | |  |  | **Total** |  |  | **175,728,033** | **100%** |   **Programme Phasing: NSP 2021-2025**   |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Districts** | | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** | **2029** | **2030** | | **3** | |  |  |  |  |  |  |  |  |  |  | | **4** | |  |  |  |  |  |  |  |  |  |  | | **6** | |  |  |  |  |  |  |  |  |  |  | | **51** |  |  |  |  |  |  |  |  |  |  |   **Programme Phasing Key:**   |  | | --- | | High transmission  API > 1 case per 1,000 pop. | | Low transmission  API < 1 case per 1,000 pop. | | | Status to be determined | | Interruption of local transmission  API = Zero case per 1,000 pop. | |

**b)** If an aspect (or the entirety) of this funding request uses the Payment for Results modality:

Use the table below to list and provide the rationale for selection of the **proposed performance indicators or milestones** for Global Fund funding.

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| --- | --- | --- | --- | --- | --- | --- |
| Performance indicator or milestone | Target | | | | Rationale for selection  of the indicator/milestone | |
| Baseline | Y1 | Y2 | Y3 |
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|  |  |  |  |  |  | |
| *Add rows as relevant* |  |  |  |  |  | |
| **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] |

Explain the prioritization approach used to select performance indicators and/or milestones as results for Global Fund funding.

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| [Applicant response] |

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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| The proposed activities have taken into account possible opportunities for health and community systems strengthening under the broader health system umbrella towards improving outcomes (example, strengthening national laboratory system that is expected to increase the diagnosis component bringing more people under treatment and ultimately better disease outcomes); program sustainability (example, investment in Health Management Information System – through DHIS2 may strengthen the national system); as well as generateing efficiencies (example, deploying health workers/volunteers in the same communities with integrated trainings for all components will generate efficiencies that can be reinvested in increasing coverage for key services). Several RSSH modules have been considered, viz. RSSH: Human resources for health, including community health workers; RSSH: Health management information systems and M&E; RSSH: Laboratory systems; RSSH: Financial management systems.  However, there are strategic components that will require disease specific systemic focus and investments, and integration will not be the best solution at this juncture. |

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

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| Bangladesh is categorized as lower lower-middle-income country. Hence, at least 50% of allocation amount needs to be invested for disease-specific interventions for key and vulnerable populations and/or highest impact interventions. With available resources, this Funding Request emphasizes focus on universal coverage for populations at risk with core malaria interventions (LLINs, case management) and surveillance that will achieve maximum impact. |

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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| NSP 2021-2025 already has in-built cost-effectiveness, in addition to technical soundness. Efforts will continue to ensure value for money while maintaining quality of services through one or more of the following options:   * Possible integration with the wider health systems under RSSH. * Utilize services of health workers/health volunteers for service delivery across disease programmes. * All GoB cadres at central, district, Upazila and below levels have multiple responsibilities. Utilize public health infrastructure and HR for programme implementation, supervision and monitoring. * The CCs, Multi-Purpose Health Volunteers will provide malaria services in addition to others. * Utilize national and subnational venues for trainings/retrainings, workshops. * Community based BCC activities as well as IPC are being effective used instead of relying on resource-intensive mass media. |

## 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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| The programmatic and financial conditions, as outlined in the allocation letter are being met. However, the GF has been requested to consider additional USD 7 million through BCCM. |

# Section 3: Operationalization and Implementation Arrangements

To respond to the questions below, refer to the *Instructions,* NSPs and an updated**Implementation Arrangement Map(s)[[10]](#footnote-11)**.

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

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| * Bangladesh will continue with dual-track financing arrangement. As with the current grant, PR1 will be MoF, which will provide financial support to the NMEP through the MoHFW. PR2 will be BRAC, which leads the NGO consortium that supports the national malaria elimination effort. The NMEP-BRAC partnership, which started in 2005, has been recognized both nationally and internationally as an example of best practice in government and NGO sector partnership. This has optimized outputs and outcomes and has maximized impact in terms of reducing the disease burden and paving way for malaria elimination. * The PR1 will be mainly responsible nationwide for the strategy, guidelines, SOPs, QA/QC, planning and implementation of interventions, procurement of health products/pharmaceuticals and supply (to public health system and PR2) besides leading, M&E/MIS, oversight and coordination with PR2 and others. * Accelerated transmission reduction in 03 CHT districts and roll out of elimination phase in other endemic districts and initiation of capacity building and reporting in 51 'non-endemic' districts and multi-sector coordination and collaboration (private sector, NGOs outside BRAC Consortium, Armed forces and other security agencies, research agencies, etc.) as well as cross-border collaboration are extremely critical in the coming years. Robust case based surveillance, case identification/classification, focus identification/classification/response, progressive transition to real-time reporting including ‘zero reporting’, etc. are envisaged. Such actions will increase the workload of the NMEP manifold. As recommended by the JMM, adequate and appropriately skilled staff, aggressive capacity building will be extremely critical. More so, because the PR2 Consortium will concentrate their complementary support in 03 CHT districts and Chattogram and Cox's Bazar districts, whilst the capacitated central, district and Upazila staff as well as those positioned at community clinics will be responsible for implementation of interventions and case-based surveillance in other endemic districts and 51 'non-endemic' districts. Therefore, few additional HR, trainings/refresher trainings are proposed under GF Allocation and few under PAAR (due to limited Allocation amount). More so, because such paradigm shift has been previously envisaged to evolve gradually (in phased manner) in elimination districts, and drastic reduction of complementary support by PR2 staff/peripheral workers especially at Upazila/peripheral levels at one go may affect implementation of interventions. * As mentioned, the PR2 together with their SR-NGOs will complement PR1 efforts at community level in endemic districts. Due to roll out of elimination in phased manner (and drastic reduction in GF Allocation), the PR2 and their partner NGOs will concentrate their support in 03 CHT districts and Chattogram and Cox's Bazar districts. In Mymensingh and Sylhet zones (08 districts), the PR2 will provide coordination support to endemic Upazilas. It is envisaged that one PR2 Program Officer will support the Upazila team and concerned Surveillance Medical Officer in coordinating implementation, surveillance and M&E. * Alliances will be formed with the Army and with the Bangladesh Border Guards to maximize case detection in hard to reach endemic areas as well as border areas within national boundaries. In addition, their support will also be sought for district-to-district cross-border collaboration. * The NMEP will initiate mapping and training/orientation of private sector in malaria case management and reporting and develop an engagement plan to be implemented in collaboration with CSO partners. Both interventions are considered urgent and essential. Special interventions will be developed to address the Rohingya (FDMNs). * In addition, the NMEP will coordinate and collaborate with development partners, INGOs and NGOs outside PR2 Consortium and research agencies, who are engaged in FDMN camps and who may potentally support service delivery and coordination. Appropriate engagement is envisaged for rational case management according to national guidelines and monthly reporting subsequent to orientation sessions; possible provision for LLINs for entire FDMN population; as well as critical research and Artemisinin resistance monitoring. The NMEP has developed a costed package of interventions required under NSP 2021-2025 for FDMN camps, which will be shared with these agencies for support and coordination in harmonized manner. * The WHO will provide TA for critical areas of need. Whilst need-based short-term international and national technical assistance will be arranged with WHO core funding and a few ones with GF Allocation; one National Professional Officer (to be supported by GF Allocation) will provide dedicated technical support to the NMEP. |

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

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| As mentione earlier, the NMEP-NGO (BRAC Consortium) partnership, which started in 2005, has been recognized both nationally and internationally as an example of best practice in government and NGO sector partnership. This has optimized outputs and outcomes and has maximized impact in terms of reducing the disease burden and paving way for malaria elimination. Bottom-up planning is a key approach and has a strong influence on the design of locally appropriate implementation strategies for the programme. |

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.

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| **Key Implementation Risks** | **Corresponding Mitigation Measures** | **Entity Responsible** |
| Financial risk:  Lack of adequate and sustained funding for malaria elimination from GoB and partners, especially the Global Fund; and unsuccessful efforts in mobilizing resources (from within and outside country) commensurate with the need for malaria elimination. | * Transform political commitment in terms of adequate and sustained domestic resources for malaria elimination. * Advocate for vital support by the GF until elimination is achieved. Strong justification for sustained GF support beyond 2020 will be developed in collaboration with WHO and other regional stakeholders. * Advocate for funding for malaria elimination as an investment case for ending suffering and poverty and for achieving overall socio-economic development to in-country corporate sector and others as well as to development partners. | GoB |
| Extrinsic risk:  Natural disasters, cyclones, heavy rain and flash floods occur frequently in Bangladesh; and these affect timely implementation of interventions especially during monsoon and post-monsoon months, which also coincides with peak seasonal malaria transmission and adversely impacting malaria cases and deaths. Besides, diversion of efforts and resources to affected areas also affect implementation as per plan elsewhere. | * Buffer stock is incorporated into the procurement of key programme commodities (RDTs, antimalarials, LLINs). Deployment reserve with community level health workers/volunteers during monsoon and post-monsoon months, which also coincides with peak seasonal malaria transmission is envisaged especially in hard to reach areas. * Community level health workers/volunteers will ensure that affected population is using the LLINs effectively. | GoB; Partner NGOs |
| Extrinsic risk:  Massive influx of FDMN refugees. | * Advocate for resource mobilization for interventions from development partners including the GF. A costed package of interventions for FDMN camps has already been prepared for 2021-25. This includes prevention and case management interventions as well as buffers necessary for reponse to any outbreak; besides Artemisinin resistance monitoring. * A request will be made to the GF to consider inclusion of Bangladesh under GMS network and or regional RAI2E. Potential additional grant might be allocated to any key stakeholder/development partner engaged in service delivery/coordination, viz. UNHCR, IOM, others to minimize resource gap and joint response for FDMN humanitarian crisis. | GoB; The Global Fund; Development partners; Partner NGOs |
| Programmatic risk:  Development and spread of ACT resistant falciparum malaria in Bangladesh. | * Close monitoring of drug resistance status will be maintained through TES in sentinel sites and through molecular studies analyzing samples collected nationwide. Resulting data will be shared with WHO and technical partners. In the event of development of ACT resistance, a suitable response will be developed following the recommendations of WHO. | GoB; WHO |
| Programmatic risk:  Development and spread of operationally significant pyrethroid resistance in Bangladesh. | * Close monitoring of insecticide resistance will be carried out at sentinel sites. Resulting data will be shared with WHO and technical partners. If insecticide resistance is found, its operational significance will be assessed and a suitable response will be developed as required in consultation with WHO. | GoB; WHO |
| Programmatic risk:  Access to timely interventions remain critical risk in view of extreme remoteness of some areas that is often compounded by poor physical infrastructure and lack of staff, particularly during the rainy season. Security issues also renders access difficult in certain areas of CHT districts. | * Community level health workers/volunteers who are often recruited locally will ensure that affected population is served effectively. The timing of visits as well as special health camps in remote areas will be planned taking seasonal constraints into consideration. Deployment reserve with community level health workers/volunteers during monsoon and post-monsoon months, which also coincides with peak seasonal malaria transmission is envisaged especially in remote areas. * Coordination and linkages with community systems, networks as well as local self-governments, tribal/ethnic heads/councils, have been and will continue to be strengthened. Local knowledge and experience and community based presence of health workers/volunteers will facilitate learning to deal with such situation. For any delay/postponement of implementation of interventions that may be at times necessary in view of the local situation, efforts will made to resolve the problems locally through stakeholder discussions. | GoB; Partner NGOs |
| Programmatic risk:  The new more stringent stratification, used for targeting LLIN delivery, moving away from blanket coverage, may result in sub-optimal coverage with LLINs and possible focal resurgences of malaria transmission. | * The elimination-based surveillance system will result in a rapid response to any new transmission foci with LLIN delivery and/or IRS, as required. Buffer LLINs is proposed in the budget for the purpose. | GoB; Partner NGOs |
| Programmatic risk:  Inherent weaknesses in the health systems often limit the accesse and quality of services. | * Further emphasis on malaria services by capacitated community clinics will be a key measure. Capacity building of recently recruited multi-purpose health volunteers in endemic areas will help in minimizing the existing gap. Extensive use of volunteer networks and collaboration with the army and with border guards for malaria services in less accessible communities and areas with health system weaknesses will solve some of the issues associated with access and at the same time reduce the burden on overstretched health workers, particularly in the periphery. | GoB |
| Programmatic risk:  Supervision and monitoring for measuring progress and impact may miss out regular risk assessments and mitigation. | * Supervisory visits will be comprehensive with risk-aware focus. Trainings/re-trainings will also enhance requisite comprehension and skills. | GoB; Partner NGOs |

# 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[[11]](#footnote-12).

## 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-financing commitments 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 next allocation 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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| i) It is envisaged that the following programmatic areas will be supported by domestic co-financing:   * Core HR, establishment, infrastructure of public health systems nationwide * RRTs, CMRL staff, entomology teams, field monitoring officers, * Antimalarials (CQ, PQ) nationwide * Replacement microscope nationwide * Microscopy consummables nationwide * Internal QA (cross checking) of microscopy nationwide * Insecticide, equipment for IRS, training and spraying costs (for focal responsive IRS) * Trainings/retrainings of HI, AHI, HA and CHCP, MHV in Mymensingh and Sylhet zones * Trainings/retrainings of Armed Forces and other security force * RDTs for 51 'non-endemic' districts * Many activities relating to entomological component, surveillance and M&E, ACSM, trainings/retrainings in 51 'non-endemic' districts * Laptops and accessories for public health system cadres nationwide * TA for IVM strategy, drug quality monitoring etc. * Printing and dissemination of strategy, guidelines, SOPs nationwide   ii) Activities that are currently funded under the GF grant is planned to be covered by GoB resources: Trainings/retrainings of GoB cadres, RDTs for 51 'non-endemic' districts, many ACSM activities, Technical Committee meetings, printing and dissemination of strategy, guidelines, SOPs. |

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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| Tracking and reporting of co-financing commitments will be done through regular review and follow up of expenditure tracking together with concerned units of the MoH and MoF. |

## 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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| The NSP 2021-2025 funding need is USD ~100 million. Currently, the funding sources for malaria elimination are as under: GoB funding; GFATM funding; and WHO (for need based technical assistance only).  The GoB plans to commit increased resources to the national disease programmes and health sector each year. In order to achieve the desired goals and objectives, progressive increase in financial commitments from the GoB will play key role. Although the current HPNSP tenure will end in 2022, yet upcoming mid-term review of the HPNSP provides a opportunity for reinforcing the funding need for malaria elimination. It is envisaged that funding needs for certain components that is expected to be covered with GoB resources will be highlighted and possibility of funding under current HPNSP tenure will be explored (from efficiencies). In addition, a meeting of the key stakeholders (Divisional Heads, CSs, UH&FPOs & concerned others like the Armed Forces/BGB, other Government Departments) is being planned to inform them about the tasks ahead and funding scenario so as to maximize value for money whilst progressing in the pathway to burden reduction in 03 CHT districts and elimination elsewhere. Further, meetings with Development Partners, INGOs will be planned for exploring additional resources. Similar meets with corporate sector will be held to seek their support as part of corporate social responsibility.  However, the Global Fund funding, has and will remain one of the key external resources for achievement of impact; whilst such impact is expected to be leveraged for exploring other funding opportunities. Therefore, the GF is requested to consider this funding request (for Allocation amount) positively. In addition, the GF is also requested to positively consider funding proposed under PAAR as well. Collectively, the GoB, the GF and partner agencies will be able to realize successful elimination scenario in Bangladesh. |

* + 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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| As mentioned above, although the GoB remains committed for malaria elimination through progressive increase in domestic resources, and co-financing requirements will continue to be met, efforts will continue to maximise the efficiencies apart from overall spending for establishment, infrastructure, health systems strengthening, etc.; yet funding gap will remain with respect to ‘full expression of demand’ relating to NSP 2021-2025. Such strategic interventions that will still require funding beyond the proposed funding request (under allocation/PAAR) include: additional HR, huge capacity building needs, increased context-specific surveillance, supportive supervision and monitoring, advocacy, communication, community engagement through outreach, entomological component, multi-sector partnerships, private sector engagement, cross-border collaboration, operational research and partnership building, etc. These remain unfunded/unmet quality demand, and for which additional investments will be required.  Efforts are ongoing and will continue for efficiencies even during the current grant. In addition, options for capacity building, LLIN coverage etc., strategic planning meetings, DHIS2 initiation, etc. are being envisaged in 2020 with approved UQD funding/re-programming. This is expected to jump start interventions/ensure coverage within current grant and not consume limited Allocation of the upcoming grant period.  The GoB has moved away from the previous LLIN strategy of blanket coverage based on district level stratification. As the quality of surveillance improves, the stratification will evolve further, to distinguish between indigenous and imported cases, identify transmission foci, hot spots following granular analysis (village level), gauge cost-effectiveness of all activities. Endemic villages (considered as one indigenous case in last three years) will continue to receive periodic mass distributions, but in villages where all cases are imported, unless receptivity is considered to be high, LLINs will be provided only to ensure utilization by key populations, viz. forest goers, mobile and migrant populations, pregnant women.  Further, a recent review of resurgence in countries that successfully eliminated malaria found only four failures out of 50 successful programmes[[12]](#footnote-13). Data documenting malaria importation and onwards transmission in these countries suggested that malaria transmission potential had declined by more than 98% before elimination. This suggests that elimination is a surprisingly stable state in many settings. If this is indeed the case, then it will be possible to cut significantly the projected costs of maintaining elimination, making elimination substantially more attractive for countries acting alone, and making spatially progressive elimination a sensible strategy. The achievement of the NMEP elimination goal will contribute towards the achievement of regional and global elimination goals, which will potentially provide the ultimate sustainability solution. However, at this juncture, huge funding needs for malaria elimination as delineated in NSP 2021-2025 will require support from partner agencies. |

**ANNEX 1: DOCUMENTS CHECKLIST**

# Annex 1: Documents Checklist

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

|  |  |
| --- | --- |
|  | Funding Request Form |
|  | Programmatic Gap Table(s) |
|  | Funding Landscape Table(s) |
|  | Performance Framework |
|  | Budget |
|  | Prioritized above allocation request (PAAR) |
|  | Implementation Arrangement Map(s)[[13]](#footnote-14) |
|  | 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. PAARs can 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-2)
2. This is only relevant for applicants with designated matching funds as indicated in the allocation letter. [↑](#footnote-ref-3)
3. Currently, 3 CHT districts are categorized as transmission reduction districts and 10 non-CHT districts are categorized as elimination districts (phased local transmission interruption); and status will be determined in 51 'non-endemic' districts towards nationwide elimination. [↑](#footnote-ref-4)
4. Civil society (NGO) PR (BRAC Consortium) [mentioned as partner NGO/s in this FR]. [↑](#footnote-ref-5)
5. Report of assessment of private sector’s role, readiness and performance for malaria elimination, Bangladesh (unpublished). [↑](#footnote-ref-6)
6. June-July are particularly critical period for outbreak and epidemic detection. [↑](#footnote-ref-7)
7. 5% buffer stock of LLINs, insecticide, RDTs and ACT will be maintained at central level to deal with outbreaks and natural disasters. In addition a 100% buffer stock of ACT will be maintained at district level. Coordination with WHO will look into pre-agreed arrangements to obtain ACT from neighbouring countries in the event of a large upsurge, such as occurred in 2014. [↑](#footnote-ref-8)
8. Introduced in 2012, this programme has played an important role in child to child education on hygiene, healthy life style, and prevention of diseases like malaria and promotion of health. There are more than 100,000 educational institutes of primary level having more than 25 million students in Bangladesh. Selected students (Class III-V level) identified as ‘Little Doctors’ are engaged to provide support in health check-up of students, observance of disease/health related days and other health promotion activities. [↑](#footnote-ref-9)
9. Confirmed by population-based reporting from facilities with known catchment areas, very high and reliable case notification and, ideally, full participation of the private sector. [↑](#footnote-ref-10)
10. 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-11)
11. 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-12)
12. Smith, D.L. *et al*., (2013) A sticky situation: the unexpected stability of malaria elimination. *Philosophical transactions of the Royal Society of London. Series B, Biological sciences*, 368, (1623), 20120145. [↑](#footnote-ref-13)
13. 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-14)