Country Coordinating Mechanism (BCCM)

Health Services Division
Ministry of Health and Family Welfare
BCCM Secretariat

Subject: Minutes of the 117th Meeting of BCCM

Date (dd.mm.yy)	18th May 2023
Venue of the meeting	Conference Room, Ministry of Health and Family Welfare
Meeting started	11:00 am
Meeting adjourned	01:00 pm
Meeting Chaired By	**Dr. Md. Anwar Hossain Howlader** Secretary, HSD, MOHFW & Vice Chair, BCCM
Meeting Steered by	**Md. Saidur Rahman** Additional Secretary (Admin & WH), HSD, MOHFW
Meeting facilitated by	**Manaj Kumar Biswas** BCCM Coordinator, BCCM Secretariat, HSD, MOHFW
Total number of participants	**50**
Meeting attendance	• BCCM Members and Alternate Members: 22 • Non-CCM OC Member from HSD: 02 • Observer: 04 (LFA-02) and HSD, MOHFW: 02 • PR Representative(s): 13 • BCCM Secretariat: 05 • USAID Non-CCM Member:1 • Online Participant: 1
Attendance list	Yes
Others supporting document	Yes

Agenda Items:

Agenda Item	Title of Agenda Item
Agenda Item: 1	Approval of 116th BCCM meeting minutes
Agenda Item: 2	Endorsement of Funding Request (HIV/AIDS) for the period of 2024-2026
Agenda Item: 3	Endorsement of New BCCM and BCCM Standing Committees
Agenda Item: 4	BCCM Chair, Vice-Chair Election schedule
Agenda Item: 5	Amendment of Governance and other Operational Manuals of BCCM
Agenda Item: 6	Update on C19RM Wave-II funding request submission
Agenda Item: 7	Update on BCCM Secretariat Costed Workplan
Agenda Item: 8	AOB: SEA Regional CCM Forum Pandemic Proposal

At the commencement of the meeting **Respected Secretary, HSD, MOHFW & Vice Chair, BCCM Dr. Md. Anwar Hossain Howlader** welcomed all the participants. He directed the Global Fund Bangladesh CCM Coordinator to facilitate the meeting in accordance with the predetermined agenda. The Global Fund Bangladesh CCM Coordinator facilitated the 117th BCCM meeting accordingly.

Minutes of each agenda items:

Agenda Item #1: Approval of 116th BCCM meeting minutes

Conflict of Interest: **No conflict of Interest declared.**

Discussions by the constituencies:

BCCM Secretariat: With permission of the respected Chair of the meeting, Mr. Manaj Kumar Biswas, The Global Fund Bangladesh CCM Coordinator presented the agenda items, decision points and implementation status of the 116th meeting minutes of BCCM which was held on 02nd March 2023. He informed that the draft minute of the 116th Meeting of BCCM was shared with all members, alternate members, PRs and other stakeholders for their comment & feedback. All the available feedback and comment were incorporated in final draft minutes and a signed copy was also shared with all electronically.

The BCCM OC Chair: Respected Md. Saidur Rahman, Additional Secretary (WH), HSD, MOHFW proposed to endorse the 116th BCCM Meeting minutes

Chairperson: The Chairperson of the meeting requested all participants to carefully read the decisions point at least to make their comment, if any. Since there were no further comment, the Chair of the BCCM meeting endorsed the 116th meeting minutes of BCCM.

Decision (s): The 117th meeting of the BCCM confirmed and approved the minutes of the 116th meeting of BCCM with correction of Co-financing statement in the meeting minutes.

Agenda Item #2: Endorsement of Funding Request for HIV for GC7 (2024-2026)
Conflict of Interest: **No conflict of Interest declared.**

Discussions by the constituencies:

BCCM Secretariat: The Global Fund Bangladesh CCM Coordinator discussed the process of Funding Request development for HIV Grants and interventions. He thanked the BCCM Oversight Committee, the FR Development Committee; Core Committee and stakeholders for their efforts and contribution in every step of HIV FR development. He also informed the meeting that HIV FRs have come through the FR Development Committee Chaired by Prof. Dr. Ahmedul Kabir, ADG Planning, DGHS. BCCM Submitted the TB and Malaria FRs on 20th March 2023 to catch up the 1st window of submission. TB and Malaria FRs now under the TRP Review.

Principal Recipients (HIV): Dr. Md. Mahfuzer Rahman Sarkar, Line Director of TBL & ASP, DGHS opined that the submission of the FR for HIV is on 29 May, and the draft FR was circulated among the members of BCCM for their feedback. Their feedback had been incorporated into the final FR; therefore, the FR can be endorsed. He added that diverse stakeholders, such as UNAIDS, Save the Children, and icddr,b, etc. were involved in this process. Moreover, the Chair of the Funding Request Committee Prof. Dr. Ahmedul Kabir, ADG (Planning and Development), was involved in different steps of the FR development and provided his valuable inputs during the FR development.

Dr. Md. Mahafuzer Rahman Sarkar thanked the Chairperson, and requested to allow Mr. Akhtaruzzaman, Senior Manager of ASP to make a brief presentation of the FR development process as well as a very brief outline of the FR with the summary budget.

Mr. Akhtaruzzaman presented an overview of the 'Proposed Funding Request for the Global Fund Grant Cycle 7 (GC7) Period: 2024-2026.' He mentioned that the 5th National Strategic Plan (NSP) for HIV and AIDS Response in Bangladesh (2024-2028) has been prepared, the Goal of which is "The overarching

goal is to significantly reduce new HIV infections and AIDS-related deaths, with a long-term aim of ending the HIV epidemic as a public health threat by 2030." The five specific objectives of the NSP are:

(1) To prevent new HIV infections through comprehensive, targeted interventions and active community involvement,

(2) To scale up innovative and effective HIV testing and case-finding approaches nationwide,

(3) To ensure universal access to treatment, care, and support services for people living with HIV and AIDS,

(4) To establish resilient, sustainable health and community systems for an integrated, people-centric HIV and AIDS response, and

(5) To strengthen strategic information systems and research for an evidence-based response.

He mentioned that the total allocation for the HIV component of the GF grant is US$ 25,393,719. In addition, there is a provision of matching funding of US$ 2,000,000 (1,000,000 for HIV prevention for KPs and 1,000,000 for Scaling up Programs to Remove Human Rights and Gender-Related Barriers). Thus, the total amount is US$ 27,393,719. The Prioritized Above Allocation Request (PAAR) Amount is US$ 8,700,000. The "Program Continuation" Approach is being followed for the HIV funding request, and the allocation and utilization period of the grant is January 2024 to December 2026. During the development of the FR, JMM recommendations, National strategic plan 2024-2028, Global targets (95-95-95 by 2025), Findings from IBBS 2020, Size Estimation (SE) of Key Populations 2023, Program review findings (Routine monitoring, BCCM oversight committee, PU/DR, etc.) and Global Fund's guidelines were considered.

He discussed on the proposed coverage, referring to the SE and IBBS findings it was mentioned that coverage has been increased for all the KPs, except for the female sex workers (FSW), the HIV prevalence of HIV is very low among the FSWs (i.e., 0.1%). On the other hand, the HIV prevalence among the PWID and MSM subgroups recorded the highest prevalence of 4.1% and 1.5%, respectively followed by 0.9% among transgender women (hijra). Mr. Akhtharuzzaman showed the population coverage as in the table below:

KP / Others	Current Target NFM3	Planned Target GC7	Increased/Decreased
PWID	19,187	25,704 (74.8% of Size Estimation)	34%
FSW	32,946	26,189 (24.0% of KPs SE)	<25%
MSM/MSW	40,118	67,976 (41.2% KPs SE)	69.5%
Transgender/ Hijra	6,573	6,885 (54.5% of the KPs SE)	4.7%
Prisoners	10,644	15,300	15%

It was mentioned that currently, ASP providing complementary treatment support 6,075 PLHIV under Operational Plan, GC7 targets 8,282 PLHIV as complementary support. Moreover, icddr,b piloting PrEP among 200 MSM/ MSW/ TG, will be increase to 500 in GC7 (150% +). It was mentioned that the geographical coverage has been increased (except from the FSW), which are from 18 to 38 districts for PWID, 16 to 14 districts for FSW, 37 to 36 districts for MSM/MSW and Transgender, and increase of Prison intervention from 8 to 10 district in central prison. Epidemiological data (prevalence of HIV, STIs, and Hepatitis), KP concentration, cross-border vulnerability and health indicators in general were considered to guide geographical coverage.

The Chairperson: Dr. Md. Anwar Hossain Howlader, Secretary, HSD, MOHFW mentioned that since the HIV FR had been developed and feedback had been incorporated, it can be submitted to the Global Fund on 29 May 2023. He asked to know that apart from the KPs, the existing mechanism in place to

address the migrant population–returnee migrants in particular. Respected Chair of the meeting mentioned that the FSWs have the potential to transmitting HIV. He also pointed out that due sudden decrease of the coverage of FSWs, the possibility of increase. He asked of HIV prevalence among them needs to be carefully thought about. Hence it is important to consider them with other available resources.

Finally he mentioned the potential risk of the returnee migrants of being HIV infected, and there must be a mechanism in place to bring them under HTS upon their arrival in country. Unless this is done, we cannot rule out the possibility of an HIV outbreak in future.

Principal Recipients (HIV): Mr. Akhtaruzzaman responded that The Global Fund Country Team (CT) worked with the HIV PRs during the development during 07-09 May 2023. Their guidance was considered, where the CT requested to cover PWID and the MSM/MSW populations through the GF grant. The Global Fund CT indicated that the PWID and MSM subgroups recorded the highest HIV prevalence of 4.1% and 1.5%, respectively, followed by 0.9% among transgender women (hijra), and 0.1 among FSW. Considering this scenario, the coverage of the FSW had been decreased from the Global Fund grant. He added that KPs are covered both from Operational Plan (OP) of the Government and The Global Fund Grants. He mentioned that besides the other KPs, a significant number of the FSWs will be covered through the Operational Plan.

Mr. Akhtaruzzaman mentioned that GAMCA (GCC Approved Medical Centers Association) is an obligatory medical test that any migrant must pass before traveling to seven Gulf Cooperation Council (GCC) countries. However, it was not possible to establish mandatory HIV testing for the returnee migrants.

ML/ BL Representative: Dr. Saima Khan, Country Director of UNAIDS proposed considering informing about HTS to the returnee migrants upon arrival and providing leaflets, containing information on HTS to them indicating the ethical issue and possibility of discrimination.

Oversight Committee Chair: Mr. Md. Saidur Rahman, Additional Secretary (WH) told that this is an important issue for the country, and further discussion is required for this issue. But this meeting should take note that this migrants screening issue need to be addressed in any way with discussion of other migration related ministries and stakeholders.

Funding Request Development Committee Member(s): Prof. Dr. Ahmedul Kabir, ADG (Planning and Development) added that this is a multisectoral approach, and Ministry of Expatriates' Welfare and Overseas Employment (MoEWOE) needs to be included in this process.

Prof. Dr. Ahmedul Kabir, ADG (Planning and Development) also discussed that our clinicians do not perform HTS before performing any procedure. In the meanwhile, when they cannot identify the symptoms, they go for performing HTS. The important point is that during this period, they might have transmitted HIV among several patients. HIV testing must be made mandatory in the hospital.

Principal Recipients (HIV): Mr. Akhtaruzzaman mentioned that amongst the total number of the newly detected HIV cases, around 25% are the returnee migrants. In the government hospitals, the provision of HIV testing services is available.

Mr. Akhtaruzzaman continued presenting. He mentioned that the total fund has been distributed among the PRs among the following manner: AIDS/ STD programme, DGHS (US$ 4.27m), Save the Children (US$ 11.76) and icddr,b (US$ 10.36). In the Module wise Budget of 3 PRs, he particularly highlighted the recommendations of the 'Management Cost Review Committee on Non-Government HIV PR,' that the management cost of the PRs should be 22%. He also mentioned that the Non-Government HIV PRs addressed this issue with highest importance, and the management cost of both Save the Children and icddr,b is 22% in the Module wise Budget.

The Chairperson: The Chairperson of the meeting mentioned that this issue needs to be considered with deep importance. He also highlighted the importance of maintaining the privacy, confidentiality and respect of the returnee migrant, who are being tested. He stressed on the compulsory HIV testing a protocol inclusion in the program intervention before any invasive procedure as well as during the diagnosis. He directed a detailed discussion and inclusion in the protocol. If the GF Grants not allows this screening for the workers and employees who worked in abroad, then it should be included in Operations Plan under revenue budget for the HIV programmes.

PLWD Member: Mr. Ahsanul Alam Kishore highlighted that HIV testing must be conducted maintained confidentiality and, in a stigma-free environment, the service providers must ensure these after the HIV testing. He requested to include this in the protocol.

BCCM Secretariat: Mr. Manaj Kumar Biswas, Bangladesh CCM Coordinator of the Bangladesh CCM Secretariat revisited the recommendation of the 'Management Cost Review Committee on Non-Government HIV PR,' to reduce the management cost as much as possible, and both the PRs respectfully complied with the recommendation, reducing their management cost to 22%. Moreover, the FR addressed the recommendations of Funding Request Development Committee Member(s), different stakeholders and worked with the Global Fund CT, the FR can be endorsed by the BCCM members in today's meeting.

The Chairperson: Respected Secretary, HSD, MOHFW and the Chair of today's meeting mentioned that the HIV FR has been endorsed but any changes or any corrections or any editions happen in HIV/AIDS Funding Request 2024-2026 within the allocated total budget according to the Global Fund Country Team feedback on the HIV/AIDS Funding Request, PRs would share the updated version of HIV FR with BCCM. BCCM share it with all the stakeholders before submission.

Decision(s): ***The 117th Meeting of BCCM***

- ***decided to endorse the HIV/AIDS Funding Request 2024-2026 and Malaria programme related Funding Request for C19RM Wave-2 in this meeting as presented (Attached as Annexure-A);***
- ***If there are any changes or any corrections or any editions happen in HIV/AIDS Funding Request 2024-2026 within the allocated total budget according to the Global Fund Country Team feedback on the HIV/AIDS Funding Request, PRs would share the updated version of HIV FR with BCCM to share it with all the stakeholders before submission;***
- ***decided that HIV screening for the migrants' workers at the airport, sea port and land port need to be addressed with other migration and immigration related ministries and stakeholders. DGHS and Directorate of ASP will take necessary action to include this interventions in the Operations Plan and PIP. If necessary, ASP and DGHS would communicate and meet with Immigration Authority, Ministry of Expatriate Welfare and Overseas Employment and other related stakeholders.***

Agenda Item # 2: **Endorsement of BCCM New members and alternate members and BCCM Standing Committees**

Conflict of Interest: **No conflict of Interest declared.**

Discussions by the constituencies:

BCCM Secretariat: According to the decision of 5th BCCM Evolution Taskforce Committee recommendation and 46th BCCM Oversight Committee decisions BCCM Coordinator presented the newly elected and selected (Govt) BCCM Members and Alternate Members list in the meeting

He presented the final 33 CCM members and 33 alternate members list in the meeting one by one Government, MLBL, Academia, NGO, KAP, PLWD, FBO and Private sectors. He also briefly explained the election and selection process by the CSO Constituencies. The detail and complete newly elected and selected BCCM Members and Alternate Members list attached as Annexure-B. He requested the 117th BCCM meeting to endorse newly formed BCCM and new BCCM Members and Alternate members in this BCCM meeting.

Members of BCCM Evolution Taskforce Committee: Md. Saidur Rahman, Chair of the ***BCCM Evolution Taskforce Committee*** suggested to explain about the NGO Constituency election and the raised complain by few NGO Candidates in this meeting.

BCCM Secretariat: BCCM Coordinator explained detailed about the election process again as described above. He mentioned that all CCM Constituencies election responsibilities go to the individual constituencies. BCCM Secretariat only facilitate the process. According to the BCCM NGO Constituency decisions on their 15th Consultation meeting, BCCM Secretariat only facilitate the online election process. NGO Constituency appointed three members observer committee and they observed the election on 17th April 2023 physically present in the BCCM Secretariat. Moreover, Mr. Kamal Hossain, GF Consultant from APCASO for the all CSO Constituencies election was facilitated and observed the elections presented physically there. From NGO Constituency Ms. Jahanara Hasan Panna, from NGO BASTOB was present. She also invited and observed. After that BCCM Evolution Taskforce Committee Chaired by Md. Saidur Rahman, Additional Secretary (Admin &WH) and other members examined the voting platform and casted vote in the 5th meeting of this BCCM Evolution Taskforce. Without any evidence of manipulation two candidates raised the issue that election was unfair. There was no scope to do manipulation in the election process or result of the election because it was done very cautiously and through a very secured way. Anytime anyone can apply to recheck this voting process through proper channel.

Members of BCCM Evolution Taskforce Committee: Md. Saidur Rahman, responded the Secretary, HSD's question about Oversee the election process as Chair of Evolution Taskforce Committee that the process and platform of the election was secured enough, so there was no scope to manipulation voting or result intentionally or unintentionally. He also requested to endorse the newly elected and selected BCCM members and alternate members in this 117th BCCM Meeting.

Chair of the meeting: Respected Chair of the meeting declared the endorsement of newly elected and selected 33 Members and 33 Alternate members in the 117th meeting of BCCM as there is no objection and feedback in the meeting.

BCCM Secretariat: BCCM Coordinator presented in the meeting that according to the BCCM Governance Manual, Oversight and Other Operational Manual as well as the Global Fund Evolution threshold result, the 5th BCCM Evolution Taskforce Committee recommendation - the 46th BCCM Oversight Committee formed and recommended the BCCM Standing Committees which are include:

A. BCCM Oversight & Strategy Committee

B. BCCM Ethics Committee,
C. BCCM Recruitment Committee and
D. BCCM Procurement Committee
E. BCCM Technical Committees for TB/Malaria/HIV,

Each of the committee has specific functions to contribute BCCM functioning. Among listed committees, BCCM Coordinator presented the recommended standing committee in 117th meeting of BCCM:

A) Oversight and Strategy Committee - total 21 expert members: This committee comprised by the persons with GF guided skills and expertise people He mentioned that Prof. Dr. Ridwanur Rahman regrated to be the part of BCCM Oversight Committee, BCCM Secretariat proposing to include Prof. M A Faiz as Malaria Expert in the new Oversight Committee. Proposed committee with their skills and expertise mentioned in table below:

No	Salutation	NAME	Org.	Designation	Constituency	Membership Status
Chair from HSD, MOHFW						
1	**Mr.**	**Md. Saidur Rahman**	HSD,	Addl. Secretary (WH)	GOV	**Proposed Chair, OC**
Vice Chair from -DGHS						
2	Prof.	Dr. Ahmedul Kabir	DGHS	ADG (Planning)	GOV	Proposed Vice Chair
Disease Specialist- Malaria						
3	Prof.	Dr. M A Faiz	**Former DG, DGHS**	Malaria Expert	CSO (Academia)	Member
4	Prof.	Dr. Amir Hossain	CSO	Ret. Prof. Medicine (Malaria Expert)	CSO (Academia)	Member
Disease Specialist- TB						
5	Prof.	Dr. Shakil Ahmed	Independent	TB Expert	CSO	Member
6	Prof.	Dr. Asif Mujtaba Mahmud	Independent	TB Expert	CSO	Member
7	Dr.	Samina Choudhury	USAID	PMS	ML/BL	Member
Disease Specialist- HIV						
8	Dr.	Osseni Yessifou Alladji	UNAIDS	Advisor	ML/BL	Member
9	Dr.	Tasnim Azim	Independent	HIV Expert	**CSO (Researcher)**	Member
10	Prof.	Mohammad Bellal Hossain	DU	HIV Expert	CSO (Academia)	Member
Finance Specialist						
11	Mr.	Md. Jahangir Hossain	HSD	Add. Secretary (Planning)	GOV	Member
12	Mr.	Milon Kanti Datta	BHBCOP	Pr. Member	CSO (FBO)	Member
Program Management Specialist						
13	**Ms.**	**Anjuman Ara**	HSD	Joint Secretary (WH)	GOV	Member
14	Mr.	Sadekul Islam	HSD	DS-WH2	GOV	Member
15	Mr.	Joseph Sebhatu	GAC	First Secretary	BL	Member
C19RM Expert						
16	Prof.	Dr. Tahmina Shirin	IEDCR	Director, IEDCR	GOV	Member
Procurement Specialist						
17	Dr.	S. M. Abu Zahid	MSH	Acting CPD,	ML/BL	Member
KAP						
18	Mr.	Ahsanul Alam Kishore	PLWD	PLHIV	KAP-PLHIV	Member
19	Ms.	Mitu	FSW	SWNOB	KAP-TB	Member
Gender Expert						
20	Dr.	Rahat Ara Nur	UNFPA	Gender Expert	MLBL	Member
Ethics Expert						
21	Mr.	Debashish Nag	BHBCOP	Advisor	CSO	Member
BCCM Secretariat						
22	Mr.	Mosaddeq Mehdi Imam	HSD-MOH&FW	SSA	**WH Section, HSD**	Non-Voting
23	Mr.	Manaj Kumar Biswas	BCCM Sec.	BCCM Coordinator	BCCM Sec.	Non- Voting
24	Mr.	Mohammad Harun-Or-Rasid	BCCM Sec.	Deputy Coordinator	BCCM Sec.	Non- Voting

25	Mr.	Gorkey Gourab	BCCM Sec.	Oversight Officer	BCCM Sec.	Non- Voting

B) BCCM Ethics Committee - total 09 members: Ethics Committee also constituted according to the TORs and Ethical Code of Conduct endorsed by the BCCM. Please note that Ethical Committee can not include any member or alternate member of BCCM, BCCM Oversight and Other decision-making committee. He mentioned that Dr. Zya Uddin, HIV Specialist from UNICEF regrated to be the part of Ethics Committee, BCCM can include one from MLBL constituency later. So that this meeting can endorsed the BCCM Ethics committee including the following members who are very senior professionals and not in the BCCM and other committees:

No.	Category	Title	Name	Institution	Designation	Designation in Ethics Committee
MOHFW						
1	CSO	Mr.	Md. Asadul Islam	CSO	Former Secretary (Health)	Chair of the Committee
2	Academia	Prof.	Dr. Sharfuddin Ahmed	BSMMU	VC -BSMMU	Vice Chair
3	GOVT	Ms.	Nilufer Nazneen	HSD, MOHFW	Additional Secretary (Budget) from HSD	Vice Chair
5	GOVT	Mr.	Md Mamunur Rashid	HSD, MOHFW	Joint Secretary (Admin)	Member
6	Govt	Dr.	Farida Yasmin	Director-Finance, DGHS	Director-Finance, DGHS	Member
6	CSO	Mr.	Debashish Nag	BHBCOP	Advisor-HBCUP	Member
7	CSO	Dr.	Nazneen Akhter	NSU	Director-Policy, Planning and Gender at NGH&CRI	Member
8						
BCCM Secretariat						
9	BCCM Sec.	Mr.	Manaj Kumar Biswas	BCCM Sec.	BCCM Coordinator	Non-Voting Member

D) BCCM Recruitment Committee - total 09 members: BCCM Secretariat proposed to endorse the BCCM Recruitment Committee as mentioned in the table below:

No	Category	Salut.	NAME	Organisation	Designation	Membership Status
Recruitment Committee Member(s)						
1	GOV	Mr.	Md. Saidur Rahman	HSD-MOH&FW	Add. Secretary (WH)	Chairperson
2	GOV	Ms.	Anjuman Ara	HSD-MOH&FW	Deputy Secretary (WH)	Member
3	GOV	Mr.	Md. Iqbal Hossain	HSD-MOH&FW	Deputy Secretary (Admin-1)	Member
4	GOV	Mr.	Md. Sadekul Islam	MOH&FW	Deputy Secretary (WH-1)	Member
5	MLBL	Dr.	Saima Khan	UNAIDS	Country Director	Member
6	MLBL	Dr.	Sabera Sultana	WHO	NPO	Member
7	CSO	Mr.	Milon Kanti Datta	BHBCOP	Presidium Member	Member
8	GOV	Mr.	Mosaddeq Mehdi Imam	HSD-MOH&FW	SSA	Member
9	BCCM Sec.	Mr.	Manaj Kumar Biswas	BCCM Secretariat	BCCM Coordinator	Member Secretary
BCCM Secretariat						
10	BCCM Sec.	Mr.	Md. Harun-Or-Rasid	BCCM Secretariat	Deputy Coordinator	Admin. Support

E) BCCM Procurement Committee - total 07 members: BCCM Secretariat proposed to endorse the BCCM Procurement Committee as mentioned in the table below:

No	Category	Salutation	NAME	Organization	Designation	Membership Status
Procurement Committee Member(s)						
1	GOV	Mr.	Anjuman Ara	MOH&FW	Joint Secretary (WH),	Chair
2	GOV	Mr.	Md. Sadekul Islam	MOH&FW	Deputy Secretary (WH-1)	Member
3	MLBL	Dr.	Saima Khan	UNAIDS	Country Director	Member

4	CSO	Mr.	Milon Kanti Datta	BHBCOP	Presidium Member	Member
5	CSO	Mr.	Shale Ahmed	BONDHU	ED	Member
6	MLBL	Dr.	Abu Zahid	MTaPS, MSH	Procurement Expert	Member
7	GOV	Mr.	Mosaddeq Mehdi Imam	HSD-MOH&FW	SSA	Member
8	BCCM Sec.	Mr.	Manaj Kumar Biswas	BCCM Secretariat	BCCM Coordinator	Member Secretary
BCCM Secretariat						
9	BCCM	Mr.	Mohammad Harun-Or-Rasid	BCCM Secretariat	Deputy Coordinator	Admin. Support

E) BCCM Executive Committee: According to the BCCM Governance Manual BCCM Chair, Two Vice Chairs, BCCM Oversight Committee Chair and Vice Chair are the members of BCCM Executive Committee. So, after election of BCCM Chair, vice chairs and endorsement of BCCM Oversight Committee Chair Vice Chair, BCCM Executive Committee can be structured.

F) Technical Committee(s): Disease wise technical committees will be proposed by respective Line Directors Later. Ideal Committee should be of 15-19 expert members

BCCM Coordinator also explained about the formation of recommended BCCM Standing Committees. All Members have been proposed based on their expertise, qualifications and interest to serve voluntarily and perceived knowledge (from experience and CVs) to contribute BCCM in different aspects.

Chair of BCCM Oversight Committee: Respected Chair of the BCCM Evolution Taskforce Committee opined that the BCCM Standing Committees are formed based on the GF Governance Manual and TORs of the Committees. The 117th BCCM meeting should endorse these committees as BCCM need to complete the process and CCM Evolution and Reconstitution process as soon as possible according to the Global Fund deadline.

Chair of the meeting: Dr. Md. Anwar Hossain Howlader, Respected Secretary-HSD and Chair of the meeting thanked all the members who performed in BCCM as members and alternate members, Oversight and other committee member for their intellectual and other contribution to the BCCM for making decisions and oversight the GF Grants in Bangladesh. He also welcomed the newly elected and selected BCCM members and alternate members, BCCM Oversight Committee Members, Ethics Committee Members and other committee members. He expressed his strong commitment to work with all the members and alternate members to fight TB, Malaria and HIV.

He also said that HSD and all Department under HSD will work with new members and committee as per the requirement. He declared the endorsement of newly elected and selected 33 Members and 33 Alternate members and BCCM Standing Committees recommended by the BCCM Evolution Taskforce Committee and BCCM Oversight Committee in the117th meeting of BCCM as there is no objection.

Finally, he suggested that all the Government members and alternate members should be selected as the designation according to their Ministry and divisions. If necessary BCCM should amend their Governance manual and guidelines. Elected members can be included by their name and expertise.

Decision(s): The 117th meeting of BCCM

- ***endorsed the newly elected and selected BCCM members and alternate members as attached list as Annexure-B***
- ***endorsed the BCCM Oversight & Strategic Committee, BCCM Ethics Committee, BCCM Recruitment Committee and BCCM Procurement Committee in the meeting as mentioned in the tables above.***
- ***decided to form BCCM Executive Committee after BCCM Chair & CSO Vice Chair election as well as endorsement of BCCM Oversight and Strategy Committee in BCCM***

- *decided to send letter (to be issued by WH wing of HSD) to reform TB, Malaria and HIV Technical Committee according to the GF and BCCM Guidelines before the next BCCM Meeting;*

***Agenda Item # 4*: BCCM Chair and Vice Chair Election**

***Conflict of Interest*: No conflict of Interest declared.**

Discussions by the constituencies:

BCCM Secretariat: BCCM Coordinator informed the meeting that according to the BCCM Governance Manual BCCM Chair, Two Vice Chairs from MLBL and CSO must be elected but Vice Chair from Government is by default who is Secretary- HSD, MOHFW. He also shared the BCCM Chair Election experiences last time.

He informed the meeting, during last BCCM Reconstitution, BCCM formed a 3 Members Election Commission and Election Commission published and declared the election schedule with criteria for the Chair, Vice Chairs from MLBL and CSO. Last time Only Mr. Mohammed Nasim, Minister -MOHFW submitted his candidature for the BCCM Chair Position and Vice Chair MLBL also had one candidate but Vice Chair-CSO has multiple candidates. So that BCCM Chair and Vice chair MLBL had been elected without voting. Only Election Commission had conducted election for Vice Chair-CSO position. All BCCM membership seats voted (One membership seat equal to one vote) in the BCCM meeting day with ballot papers and accordingly election commission cast the vote, calculate the vote and published result. Either member or alternate member can vote for electing Chair and Vice Chairs. So, this time also need to get endorsement from the BCCM an election commission for the BCCM Chair and Vice Chairs Election. He mentioned that BCCM Evolution Taskforce Committee recommended the three members committee including Md. Saidur Rahman, Additional Secretary (WH & Admin), HSD, Dr. Saima Khan, Country Director UNAIDS and Mr. Debasish Nag, CSO Member from HBCUC. (Commission Chair should be from HSD, MOHFW and one member should be from MLBL and one member should be from CSO).

Chair of the meeting: Dr. Md. Anwar Hossain Howlader, Respected Secretary-HSD and Chair of the meeting opined that as per BCCM Governance Manual this Election Commission can do the election process of BCCM Chair and Vice Chairs.

Decision(s): The 117th Meeting of the BCCM decided

- *that BCCM Chair and Vice Chair from MLBL and CSO would be elected as per BCCM Governance Manual;*
- *to form 3 members Election Commission including Md. Saidur Rahman, Additional Secretary as Chair of the Election Commission, Dr. Saima Khan from MLBL Organization as member and Mr. Debasish Nag from CSO.*
- *That this election commission would publish election schedule and criteria for BCCM Chair and Vice Chair from MLBL and CSO according to the Governance Manual before the next (118th) BCCM meeting.*

Agenda Item # 5: BCCM Governance Manual and other Operations manual update.

***Conflict of Interest*: No conflict of Interest declared.**

Discussions by the constituencies:

BCCM Secretariat: BCCM Coordinator informed the meeting that BCCM Governance Manual and other operations manual needs to be updated according to the new GF CCM policy & new guideline and BCCM Evolution Threshold Results and requirements by the Global Fund new CCM policy e. g. Human right experts in Oversight Committee, Ethics Committee etc. The Global Fund will provide necessary support for the update. BCCM need to decide to update the BCCM Governance Manual, Oversight Manual and Other Operations Manuals.

Chair of the meeting: The Chairperson of the meeting directed BCCM Secretariat to take necessary action in this regard communicating with The Global Fund Secretariat to update the BCCM Governance Manual, Oversight Manual and Other Operations Manuals.

Decision(s): ***The 117th meeting of BCCM***

- ***acknowledged necessity of updating BCCM Governance Manual and directed BCCM Coordinator to take necessary action;***
- ***decided to amend the BCCM Governance Manual and other Operational Manual as soon as possible after new CCM on board***
- ***decided to ask Technical Assistance from the GF CCM Hub for the amendments of BCCM Governance Manual and other Operational Manuals***

Agenda Item # 6: **Update on C19RM Wave-II funding request submission on 12th May 2023**

Conflict of Interest: **No conflict of Interest declared.**

Discussions by the constituencies:

BCCM Secretariat: BCCM Coordinator informed the meeting that according to the 116th BCCM Meeting BCCM Submitted the C19RM Wave-2 Funding Request to the Global Fund Secretariat on 12th May 2023. All the BCCM Members and alternate members were copied in the submission email. BCCM Secretariat also shared all the Funding Request for C19RM Wave-2 with all BCCM members, alternate members and stakeholders. It was supposed to be submitted on 20th March 2023 with TB and Malaria Funding Requests, but the GF Secretariat extended the submission deadline till 12th May 2023. For this reason, BCCM Secretariat submitted all PR's C19RM Wave-2 Funding Requests on 12th May 2023.

He mentioned that in the C19RM Wave-2 Funding requests were changed a little from the C19RM Funding Requests Wave-2 endorsed in the 116th BCCM meeting. As all BCCM members, alternate members and stakeholders got the updated and submitted all PR's C19RM Wave-2 Funding Requests on 12th May 2023 through email, if any BCCM members/ alternate members or stakeholders have any objection, comments, feedback, they can kindly raise objection, suggestions, comments and feedback in this meeting.

Chair of the meeting: Respected Dr. Md. Anwar Hossain Howlader, Secretary-HSD, MOHFW and The Chairperson of the meeting asked no objection vote for the all PR's C19RM Wave-2 Funding Requests which were submitted to the Global Fund on 12th May 2023 in this meeting. If there is any objection then BCCM is here to address the objection on the all PR's C19RM Wave-2 Funding Requests.

Decision(s): ***The 117th Meeting of BCCM***

- ***acknowledged update on the all PR's C19RM Wave-2 Funding Requests which were submitted on 12th May 2023***

- ***decided to endorsed changes on the all PR's C19RM Wave-2 Funding Requests which were submitted on 12th May 2023 as no one raise any objection in this meeting.***

Agenda Item # 7: Update on BCCM Secretariat budget 2023.

Conflict of Interest: **No conflict of Interest declared.**

Discussions by the constituencies:

BCCM Secretariat: BCCM Coordinator informed the meeting that BCCM Secretariat has submitted Costed Workplan for 2023 on 12th December 2022. After submission, the budget has been verified by LFA in March-April 2023 and it is for the first time that BCCM Budget verified by the LFA after CCM endorsement so far. The LFA conducted debrief meeting with BCCM Secretariat on 09th March 2023.

BCCM Secretariat received proposed costed workplan by the global fund CCM Hub yesterday (17th May 2023). In the meantime, BCCM Secretariat has sent several follow-up emails but Unfortunately GF Secretariat did not get reply. Currently BCCM Secretariat is spending in accordance with last year's budget and using cash balance from CCM Evolution Fund. However, BCCM Secretariat budget needs to discuss in details with BCCM Oversight Committee Chair what CCM Hub proposed to BCCM then BCCM Secretariat will send the feedback to CCM Hub on the BCCM Secretariat Costed Workplan/ Budget as the BCCM Oversight Committee is responsible for making the decisions on BCCM Secretariat budget and others financial and administrative issues.

The Chairperson: Respected Dr. Md. Anwar Hossain Howlader, Secretary-HSD, MOHFW and The Chairperson of the meeting suggested BCCM Oversight Committee Chair to take necessary action for the CCM Hub proposed costed workplan & budget for BCCM Secretariat.

Decision(s): ***The 117th meeting of BCCM***

- ***acknowledged the update on BCCM Secretariat's Costed workplan;***
- ***decided to review CCM Hub proposed costed workplan and budget for BCCM Secretariat by BCCM Oversight Committee Chairperson and send feedback to CCM Hub by 15th June 2023.***

Agenda Item # 8: AOB: SEA Regional CCM Forum Pandemic Proposal

Conflict of Interest: **No conflict of Interest declared.**

Discussions by the constituencies:

BCCM Secretariat: BCCM Coordinator informed the meeting that SEA Constituency formed a SEA Regional CCM Forum (SEARCMF) since 2016 and situated in New Delhi, India. SEA RCMF is responsible for addressing the cross-border issues for TB, Malaria and HIV as well as C19RM.

SEARCMF is going to submit a technical proposal for Pandemic Funding from World Bank. BCCM Secretariat shared the proposal with all BCCM Members and alternate members for their kind review and feedback. As this SEARCMF is 11 SEA Countries regional forum, this proposal needs to be endorsed in BCCM. If the proposal awarded then IEDCR from Bangladesh will implement the cross-border pandemic program and Bangladesh will get the grants Bangladesh part accordingly. This SEA RCMF is like regional CCM which is only for coordinating mechanism at regional level to coordinate regional program to address the cross-border issues.

IEDCR: Prof Dr. Tahmina Shirin, Director IEDCR informed the meeting that SEARCMF asked a authorization letter from Bangladesh. She asked to BCCM Coordinator about the letter to be signed by the HSD, MOHFW.

BCCM Secretariat: BCCM Coordinator informed the meeting that BCCM Secretariat communicated with SEARCMF Secretariat. HSD, MOHFW or BCCM does not need to issue that letter. This letter now will be issued by the Board Member, SEA Constituency of the GF Board.

The Chairperson: Respected Dr. Md. Anwar Hossain Howlader, Secretary-HSD, MOHFW and The Chairperson of the meeting stated that the SEARCMF proposal for Pandemic grants shared with all BCCM members and Alternate members and stakeholders for their review and feedback. BCCM can endorse in this meeting, if there is any comments you may share electronically with BCCM Secretariat before submission on 29th May 2023.

Decision(s): ***The 117th meeting of BCCM***

- ***acknowledged the update on SEARCMF Pandemic Funding proposal*** *(attached as Annexure-C);*
- ***decided to endorse SEARCMF Pandemic Funding proposal in the meeting***
- ***decided that BCCM Members and stakeholders could send their feedback on this SEARCMF Pandemic proposal before 29th May 2023 electronically (if any)***

Having no other issues to discuss, the Chairperson of the meeting thanked all the participants for their active participation in the meeting and wrapped up the meeting.

13/6/2023

Dr. Md. Anwar Hossain Howlader
Secretary,HSD, MOHFW
&
Vice Chair, BCCM

Annex 1

Presentation on C19RM Wave-2
National Malaria Elimination Programme

18 May 2023

Prof. Dr. Md. Nazmul Islam
Director, Disease Control & LD, CDC
DGHS, Mohakhali, Dhaka

National Malaria Elimination & Aedes-transmitted Diseases' Control Program, CDC, DGHS

Summary Information

Country(s)	Bangladesh
Component(s)	Malaria
Planned grant start date(s)	January 1, 2024
Planned grant end date(s)	December 31, 2025
Principal Recipient(s)	1. Economic Relations Division, Ministry of Finance, Government of the People's Republic of Bangladesh 2. BRAC
Currency	United States Dollar
C19RM Additional Funding Request amount	16,274,675

National Malaria Elimination & Aedes-transmitted Diseases' Control Program, CDC, DGHS

Changed proposed under NMEP, CDC

- Budget approved in CCM Oversight Committee held on 2 May 2023 for PR1: USD 4,269,68 and PR2: USD 3,388,412
- Now, IEDCR proposed a revised budget with USD 2,837,600 (previously it was 2,833,425 with an increase of USD 4,175)
- Budget proposed by National Institute of Laboratory Medicine and Referral Centre - NILMRC (Surveillance, HR, Reagent and machines for pandemic preparedness): USD 5,752,404
- Budget proposed by Planning and Research department of DGHS (establishing data management unit, research and other activities for pandemic preparedness): USD 2,860,000
- Total additional budget: USD 8,616,579
- Total Budget proposed under C19RM wave2: **16,274,675**

National Malaria Elimination & Aedes-transmitted Diseases' Control Program, CDC, DGHS

Proposed Budget by Intervention

Intervention	Amount in USD
Community Health Worker: In-Service Training	41,014
COVID-19 CSS: Social Mobilization (procurement of forest pack for high risk group)	398,527
Laboratory System (HR, Training, consumables)	357,623
Mitigation for Malaria Programme (HR, Training)	343,621
Risk Communication (Community orientation and IEC materials)	267,888
Surveillance systems (Pandemic preparedness and surveillance)	14,704,649
Grant Management	161,353
Grand Total	**16,274,675**

Proposed Budget by Intervention by PR

BRAC (Total)	**3,388,412**
Community Health Worker: In-Service Training	41,014
COVID-19 CSS: Social Mobilization (procurement of forest pack for high risk group)	398,527
Grant Management	161,353
Laboratory System (HR, Training)	106,287
Mitigation for Malaria Programme (HR, Training)	314,274
Risk Communication (Community orientation and IEC materials)	267,889
Surveillance systems	2,099,068
GoB PR	**12,886,263**
Laboratory System (HR, Training, consumables)	251,334
Mitigation for Malaria Programme (HR, Training)	29,348
Surveillance systems (Pandemic preparedness and surveillance)	12,605,581
Grand Total	**16,274,675**

Proposed Budget by PR

PR	Amount in USD
NMEP (PR1)	**12,886,263**
BRAC (PR2)	**3,388,412**
Grand Total	**16,274,675**

National Malaria Elimination & Aedes-transmitted Diseases' Control Program, CDC, DGHS

Thanks to All!

National Malaria Elimination & Aedes-transmitted Diseases' Control Program, CDC, DGHS

Annex 2

Funding Request Form

Program Continuation

Allocation Period 2023-2025

Summary Information

Country(s)	Bangladesh
Component(s)	HIV
Planned grant start date(s)	1st January 2024
Planned grant end date(s)	31st December 2026
Principal Recipient(s)	1. Economic Relations Division (ERD), Ministry of Finance of the People's Republic of Bangladesh 2. International Centre for Diarrhoeal Disease Research, Bangladesh 3. Save the Children Federation, Inc.
Currency	US dollar
Allocation Funding Request Amount	**US$ 27,393,719**
Prioritized Above Allocation Request (PAAR) Amount	**US$ 9,830,000**
Matching Funds Request Amount (if applicable)	**US$ 2,000,000** (1,000,000 for HIV prevention for KP and 1,000,000 for Scaling up Programs to Remove Human Rights and Gender Related Barriers)

AIM: Ending HIV as a public health threat by 2030 by reducing new HIV infections and AIDS-related deaths, reaching the 95-95-95 goals				
Objective 1: **To prevent new HIV infections by expanding comprehensive, targeted interventions for and with Key Populations (KP)**	**Objective 2:** **To improve HIV/STI case finding by increasing the uptake of differentiated and ethical HIV/STI testing services for KP**	**Objective 3:** **To provide universal access to HIV/STI treatment, care and support for PLHIV and KP**	**Objective 4:** **To establish resilient, sustainable health & community systems for an integrated, people-centric, HR based HIV response**	**Objective 5:** **To strengthen strategic information systems and research for an evidence-based response**
Provide a comprehensive HIV outreach & harm reduction package to KP (MSM/MSW, TGW/hijra, FSW and PWID/PUD), incl. PrEP/PEP	Expand access to differentiated HIV/STI testing services (online and offline) for KP and their partners (incl. prisoners)	Implement "Test and treat", and "Rapid ART initiation" strategies and ensure routine viral load monitoring to reduce mortality and morbidity among PLHIV.	Gradually and carefully transfer of HIV services for KP from CSO/NGO to Government facilities	Conduct comprehensive or sentinel surveillance regularly to strengthen the capacity to respond to the evolving HIV/STI epidemic
Improve targeting of HIV outreach by focusing on those most vulnerable, including young and street-based KP	Improve access to HIV self-testing and lay testing services by creating new online and offline access points	Improve the capacity of care-givers in government, NGO and private sector to provide appropriate care to PLHIV/KP	Strengthen the capacity of healthcare providers for PLHIV/KP to provide people-centred care to KP/PLHIV	Strengthen national strategic info and M&E guidelines to harmonise reporting systems and conduct program reviews
Address barriers to HIV services, using supportive supervision, CLM, advocacy (CLA) and HMIS	Make index testing of partners of newly diagnosed PLHIV both more ethical and more effective manner	Improve access to treatment for opportunistic infections and STI/Hepatitis/TB care for PLHIV and KP	Strengthen community systems, linkages to care and community-led programming to reduce human rights violations	Improve the quality and friendliness of services for KP/PLHIV by conducting CLM and regular RDQA using PM&E
Demand generation for HIV/STI services via outreach, events and virtual interventions	Ensure all pregnant women have access to HIV/Syphilis/ Hepatitis testing at ANC clinics, incl. private facilities	Strengthen linkages between government care facilities and community support systems	Strengthen supply chains and ensure quality lab and diagnostic services are available at all levels	Improve systems for knowledge management/policy translation, sharing and feedback/ consultation w. stakeholders
Cross-cutting: Address human rights incl. gender-based violence and improve monitoring and reporting practices				

Figure 1: Conceptual framework of the Funding Request (based on the NSP 2024-2028)

Section 1. Prioritised Request

For each module, provide information on the funding requested from the Global Fund and expected outcomes resulting from the Global Fund's investment.

BACKGROUND

- Since 1989, Bangladesh maintained a low national HIV prevalence of less than 0.1% among the general population. However, key populations (KP) - which encompass female sex workers (FSW), men who have sex with men (MSM), people who inject drugs (PWID), and transgender/hijra individuals (TGW) – have seen an increasing trend in terms of new HIV cases, which means Bangladesh is shifting towards a concentrated epidemic in some geographical areas. Although Bangladesh is witnessing an annual rise in the number of new HIV cases, predominately among adults aged 25-49, the national response has so far successfully averted a general epidemic.
- The latest integrated biological and behavioural survey (IBBS), conducted in 2020, revealed that the overall HIV prevalence among KP in Bangladesh stood at 2.3%. PWID and MSM recorded the highest prevalence of 4.1% and 1.7%, respectively, followed by 0.9% among TGW, and 0.1% among FSW. Among MSM aged <25 years, the HIV prevalence was 0.94% and for those aged 25 years and above, the prevalence was 2.37%; among FSW all the identified HIV cases were above 25 years; among TGW the prevalence was 1.3% among those over 25 years and 0.2% among those who were 24 and below; and among PWID the majority was over 25 years with a 2.6% prevalence. It should be noted that in Dhaka, the prevalence of HIV was as follows: PWID 5.1%, MSM 3.1%, TGW 1.2%, and FSW 0.1% [1].
- An epidemiological analysis of sentinel surveillance data spanning two decades, elaborated in Section 3, reveals an upward trend in HIV prevalence among some KP, particularly PWID, and MSM. In contrast, the HIV prevalence among transgender/hijra individuals and FSW remained relatively stable. The estimated number of people living with HIV (PLHIV) was 14,513 in 2022 [2]. From the onset of the epidemic until 2022, a cumulative total of 9,708 HIV cases have been reported in Bangladesh, including 729 cases reported in 2021 and 947 in 2022 [2]. One-third (33%) of new cases were from the general population, 18% were from migrants (overseas employees) and their partners, and 13% were found in the group of forcibly displaced Myanmar nationals (FDMN), followed by MSM and PWID [2]. There has been an increasing trend of new cases from 1996 to 2022.
- The socio-legal context is challenging, and includes penalties under the 2018 Narcotics Control Act and laws against same-sex relations and sex work. KP confront elevated HIV risk due to epidemiological factors, exacerbated by stigma, discrimination, and a range of broader socio-economic factors. Regrettably, current HIV intervention programs predominantly focus on prevention and treatment and often neglect holistic health and human rights issues.
- Bangladesh has made significant strides in HIV and AIDS prevention through innovative approaches to community involvement, transitioning treatment and support programs for PLHIV, and the gradual relocation and integration of KP interventions into government hospitals. Examples of better community involvement include three Networks (e.g. Sex Workers Network of Bangladesh, Network of People Who Use Drugs, Network of People living with HIV) as SRs and in the HIV prevention intervention for FSW,PWID and PLHIV respectively and STI Network as activity based partner; engaging sex workers and PUD networks in monitoring prevention activities, engaging a lead MSM and TGW organisation as the main SR in prevention interventions for MSM and TGW, engaging

KP in HIV testing, engaging FSW in managing GBV directly, setting up income generating options for KP in a sustainable manner, etc. These efforts have been complemented by peer-led community-based outreach.

- Bangladesh has a mixed health system encompassing four key actors: government, the private sector, non-governmental organisations (NGOs), and international development organisations. In the case of the HIV response for KP, NGOs play a major role through DICs/outlets for providing clinical services, health product storage, reporting, and recording, along with peer-led community-based outreach with outreach workers recruited from among KP. To attain sustainability and cost efficiency, DICs/outlets are gradually shifting to government hospitals.
- As a pivotal wing of the Directorate General of Health Services (DGHS) within the Ministry of Health and Family Welfare (MOHFW), the National AIDS/STD Control (NASC) serves as the nodal body, coordinating, monitoring and implementing programs for HIV and sexually transmitted infections (STIs). The NASC's mandate encompasses leading and coordinating HIV responses with a diverse array of stakeholders, executing the HIV component of the Health, Nutrition, and Population Sector Program (HNPSP), and functioning as one of the Principal Recipients (PR) for HIV grants supported by the Global Fund (GF). Within the wider context of the 4th HNPSP, the NASC is recognised as the AIDS/STD Programme (ASP). The ASP delivers antiretroviral therapy (ART) services to PLHIV through government hospitals and comprehensive drop-in centres (CDIC), provides HIV prevention services to KP, and oversees the procurement and supply chain management of essential health products. The ASP aims to mainstream interventions for KP into government health services and engage with community-led entities to implement outreach services.

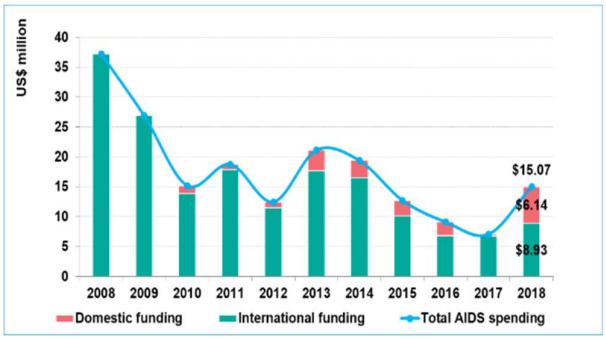


Figure 2: AIDS Spending by financing source, 2008-2018

Source: AIDS Data Hub

- The ASP collaborates with other relevant government ministries and WHO, UNAIDS, UNODC, UNICEF, NGOs, development partners (mainly the Global Fund), and the private sector at the central, divisional, district and sub-district levels. Data analysis from 2008 to 2018 reveals the government's commitment to augmenting domestic funding for the national HIV and AIDS initiative.
- **HIV continues to be a major public health challenge in Bangladesh, despite progress and achievements:** Bangladesh has experienced an unwelcome trend of increasing new infections and AIDS-related deaths that deviates from the global trajectory of progress. As of 2022, the country had only 'scored' 67-77-90 on the 95-95-95 targets. The care and support components for PLHIV need to be revigorated and made more comprehensive. Adherence monitoring, detection of side effects and drug resistance, addressing advanced HIV disease and NCDs (among PLHIV), follow-up of viral load monitoring, ensuring PEP and PrEP for all populations eligible, etc. need to be better addressed and planned for implementation. The ongoing shift from NGO-based services to government-facility-based services may impact the accessibility KP have to health services. Any shift in strategy necessitates careful and gradual considerations during the implementation of changes.

- Bangladesh proposes to refocus its interventions for KP and to scale up the implementation of interventions in key programmatic areas aligned with the defined 'programme essentials' for this funding cycle. The proposed programme essentials are:
    - HIV Primary Prevention: availability of condoms and lubricants, including focused intervention of FSW specially on Adolescent Girls and Young Women (AGYW), pre-exposure prophylaxis (PrEP) for MSM and TGW and harm reduction services including Opioid Substitution Therapy for PWID)
    - HIV Testing and Diagnosis: safe, ethical partner (index) and social network-based testing, following a three-test algorithm.
    - HIV/TB: PLHIV with active tuberculosis (TB) are started on ART early, TB preventive therapy is available for all eligible people living with HIV.
    - Differentiated Service Delivery (DSD): prevention, testing and treatment are available in health facilities, testing is available outside health facilities, including through community, outreach and digital platforms; multi-month ART dispensing is available.
    - Human Rights: HIV programs for key and vulnerable populations integrate interventions to reduce human rights- and gender-related barriers; stigma and discrimination reduction activities for KP are undertaken in health care and other settings; legal literacy and access to justice activities are accessible to KP; support is provided to reform criminal and other harmful laws, policies and practices that hinder effective HIV responses.

  The country has recently adopted a new National Strategic Plan for HIV and AIDS Response (2024-2028), and the first Joint Monitoring Mission (JMM) was held in March 2023. The new data set from the IBBS 2020 and new (2023) size estimations of KP are now available. Furthermore, a transition readiness plan has been developed. With all these foundations in place, Bangladesh is ready to raise its HIV commitments to achieve the 2030 Sustainable Development Goals and Ending AIDS targets.

  For details of the prioritisation of districts along with coverage and map, see Annex 2, page 66-70.

Prevention Package for Men Who Have Sex with Men (MSM) and Male Sex Workers (MSW) and their Sexual Partners:

Current Grant (2021-2023): HIV infection among MSM and MSW shows an increasing trend (World AIDS Day 2022 report). In 2022, among 947 newly diagnosed PLHIV, 14% were MSM, and 9% were MSW, which was higher than the previous year [2]. Program data and the latest IBBS (2020) reveal significant risk behaviours, such as unprotected anal sex, Chemsex, low uptake of STI services, lack of consistent condom use, and inadequate sexual and reproductive health care.

In the current grant**,** the program covers 40,118 out of 165,192 MSM including MSW [3] in 23 priority and 14 other vulnerable districts. There are different modalities for HIV/STI service delivery, including 14 drop-in centres (DIC), 18 Sub-DIC, 18 Outlets, and three outreach venues in rented houses and five government hospitals. From the government health facilities, only clinical services are provided, while outreach services are provided from the outreach venues through small offices operated in rented houses. All types of modalities provide a similar package of prevention services, including BCC sessions, condom & lubricant distribution, HTS, STI, GH, and SRH services, psychosocial and psychosexual counselling, TB screening, referral to public facilities, services to female partners, and capacity building of this community. To work toward a more sustainable response, clinical services are integrated into five public health facilities. Among the five health facilities, costs for three clinical services are borne from the government operational fund, and two clinics provide services paid for by revenue funds. A PrEP intervention for MSM/MSW has been piloted in Dhaka city. Legal and social barriers also slow down the progress rather than pose new risks of MSM/MSW.

Proposed Continuation Grant (2024-2026): In GC7, it is planned to provide services to 76,554 MSM, including MSW (a 91% increase from the current grant). The coverage will be around 80% in 23 priority districts [3] where concentrations of MSM/MSW and HIV/STI infection are higher. Further, interventions will continue in six other vulnerable districts (a decrease from the current 14 districts) where coverage will be around 5% (4,051) of the total MSM and MSW population. Services will be provided via 64 locations: 16 drop-in centres (DIC), 25 Sub-DIC, 20 Outlets, and three public health facilities (in three districts, i.e., Pabna, Sirajgonj & Jesshore) from where both outreach and clinical services will be provided to MSM/MSW along with other KP such as PWID, FSW and TGW (Hijra). Community engagement will be emphasised through consultation, capacity building, peer navigation, BCC activities, and virtual platforms. Online demand generation will continue to enhance safer sex, promote PrEP, and condom promotion, particularly for MSM/MSW who cannot be reached in existing venues. Standard HIV prevention services, including condoms, lubricants, HIV testing, treatment of PLHIV, STIs, and general health care services, will be provided for free.

What is different in the proposed Grant: The proposed grant aims to scale up demand generation through a peer-led approach, ICT-based platforms and promote PrEP. Service coverage will be scaled up, including HIV testing; dual HIV/Syphilis test will be used. Lay provider HTS and HIVST will be introduced and scaled up to increase HTS uptake.

The target of PrEP intervention will be increased based on the pilot project result. Strategies for PrEP demand generation, client enrolment, follow-up, adherence support, and monitoring and evaluation will be implemented. Long-acting PrEP will be piloted on a small scale under PAAR.

The Grant will expand the service provision for MSM/MSW through public facilities.

Module 1	Prevention Package for Men Who Have Sex with Men (MSM) and their Sexual Partners
Intervention 1A	**Condom and lubricant programming for MSM/MSW** Change in Programming from current grant: ☒Scale-up
List of activities	• **Prevention efforts will be scaled up to cover 80% of MSM/MSW in 23 priority districts and 23% in 6 non-priority districts** where concentrations of MSM/MSW and HIV/STI infection are high. • **Demand generation via the deployment of Peer Educators (PE)** who will generate demand, disseminate information, foster community engagement and consultation, and build community awareness. • Mobile and web applications, text messaging, and voice SMS, will be used for **online demand generation**. These tools will serve as part of the BCC strategy, promoting safer sex, TB/Hepatitis/STI awareness, self-risk assessment, and other topics. • Each PE will **provide free condoms and lubricants** to 150-180 MSM/MSW at cruising sites and community depots, including during weekends and holidays. One tube of lubricant will be distributed with every 12 condoms, which suffices according to IBBS data on their sexual behaviour. • After successful piloting, a **virtual outreach intervention, including condom and lubricant distribution**, will be expanded via dedicated Facebook pages to reach self-identified gay men who do not feel comfortable accessing DIC or other current facilities; this program will run in six to eight divisional cities. • Timely **procurement of condoms and lubricants** will be done, adhering to GF and organisational policies. The quality of condoms will undergo regular assessment, and stock-outs or product loss will be avoided. • **Professional development for peer outreach staff** is essential; on-the-job training, orientation, and refresher training will be organized to continually enhance their skills and capacity.
Amount requested	US$ 1,744,973 (6.37% of the allocated budget)
Expected outcome	• Condom use increased among MSM from 49% in 2020 to 59% in 2026. • Ensured availability of condoms/lubricants as per the requirement of MSM/MSW who do not access venue-based service points.
Intervention 1B	**Pre-exposure prophylaxis (PrEP) programming for MSM/MSW** Change in Programming from current grant: ☒Continuation
List of activities	• **700 MSM/MSW (in addition, 800 in PAAR) at risk of HIV infection will be enrolled into PrEP** services in Dhaka city, where HIV prevalence is highest. • **Procurement** of medicine for PrEP and related test / reagents. • **PrEP dispensing** following baseline tests according to the PrEP protocol. • **Follow-up of PrEP clients**, including delivery of PrEP medicine, follow-

	up tests, physical check-up, counseling etc. • **PrEP adherence support** will be provided through differentiated approaches (adherence counseling, peer-led and social media-based). Comprehensive counseling services will be provided to PrEP clients by a professional clinical psychologist. • **Integration of Harm reduction services for Chemsex**, including drug taking and mental health screening, comprehensive counselling, HTS, STI management, commodities distribution, BCC etc. in the PrEP intervention. • Conduct **advocacy with policy makers** to consider adoption of PrEP as part of the package for HIV prevention among KP in the country • Develop **national guidelines on PrEP** for providers. • **Long-acting PrEP** will be piloted on a small scale (considered **in PAAR**).
Amount requested	US$ 935,450 (3.41% of the allocated budget)
Expected outcome	• Number of MSM/MSW on PrEP increased from 168 to 700 by 2026. • At least 70% of recipients in need adhere to the prescribed PrEP.
Intervention 1C	**HIV prevention communication, information and demand creation for MSM and MSW** Change in Programming from current grant: ☒ Scale-up
List of activities	• **Prevention services demand will be generated** through peer-based and digital platforms, via consultations, peer training, awareness sessions, group discussions, outreach site visits, etc. • **BCC materials** will be disseminated by peer educators at various outreach sites and public hospitals, with a special focus on young and adolescent and married MSM, and cover topics such as consistent condom use, HIV/STI testing, safer sex practices, the importance of PrEP, and the link between HIV/STI and chemsex. • **ICT-Based Behaviour Change Activities** will be employed to strengthen outreach and routine communications with clients and reach inaccessible MSM individuals online. The existing HIV information app will be modified to provide to these specific group needs. • **Virtual outreach intervention** will be continued for self-identified gay men, who do not visit DICs. Social media will be used for providing HIV prevention services. The existing mobile app (available at the Google play store) will be upgraded to accommodate unreached MSM/MSW.
Amount requested	US$ 1,660,692 (6.06% of the allocated budget)
Expected outcome	• Comprehensive knowledge on HIV among MSM/MSW increased from 21% in 2017 to 35% in 2026.
Intervention 1D	**Community empowerment for MSM, MSW** Change in Programming from current grant: ☒ Continuation
List of activities	• **Formation of community coalitions**, roundtables and meetings to mobilize MSM/MSW communities.

	• **Engagement/employment** of capacitated MSM and MSM CBOs in program implementation. • **CBO representatives will be trained** in leadership, public speaking, and negotiation skills to build self-confidence. • **Safe spaces** will be established in 61 locations for NGO-operated areas in 26 districts while three government health facilities will be used for this intervention where services will be rendered by the government.
Amount requested	US$ 811,169 (2.96% of the allocated budget)
Expected outcome	• Continued low HIV prevalence for MSM/MSW
Intervention 1E	**Sexual and reproductive health services, including STIs, hepatitis, post- violence care for MSM, MSW** Change in Programming from current grant: ☒ Continuation
List of activities	• **STI risk evaluations** will be performed by PE, MA/OS. Clients have the option to instead use a mobile app and a website from an existing ICT-based intervention, which can facilitate self-risk assessments. • Medical Assistants will provide **free routine STI check-up and treatment, following the syndromic approach**. In three districts, these services will be provided in government hospitals by a medical doctor. Medicine costs at government hospitals will be covered by the OP budget; in other districts they are covered by the GF grant. • **Clients will be provided treatments for general health issues** such as respiratory infections, scabies, skin and soft tissue infections, rectal infections, fungal infections, fever, gastrointestinal upsets, PUD, etc. • **Etiological management of Syphilis** will be instituted at least annually using a DUO test kit (HIV-Syphilis), confirmed via VDRL (Q&Q), funded by GF. Syphilis-positive patients will receive treatment and follow-up/. • Medical assistants will offer **STI counselling services**, in addition to psycho-social, psycho-sexual, and mental health counselling. • Recurrent, non-responsive, or complicated STI cases will be **referred to government hospitals for etiological management** funded by GF. • Linkages with SRH services will be continued for **female partners of MSM through referral**. In government-operated facilities, the medical doctor (MOCM) will provide similar services to female partners of MSM. • **In SRH services through virtual interventions** the participants will be made aware of HIV/STIs through BCC and encouraged to contact for support. STI doctors provide advice and prescriptions for treatment via Whatsapp or other platforms. • **Harm reduction services for Chemsex:** (see above under PrEP) • **Sensitization meetings with SRH service providers** will be conducted with SRH service providers at local and central level. • Clinical services for MSM/MSW, including STI, HTS, Reproductive Health, and HIV services, will **be integrated into public healthcare facilities** in

	three districts beyond the current pilot sites. • **Periodic refresher training and orientation** to strengthen the capacity of service providers on SRH services, including STI management. • **Human papillomavirus (HPV)** is an emerging threat to MSM/MSW. Therefore, screening, prevention, treatment, referral, and screening for oral and anal cancers, are needed. (Requested in PAAR).
Amount requested	US$ 47,406 (0.17% of the allocated budget)
Expected outcome	• Continued testing, diagnosis, and treatment of STI for MSM/MSW. • Continued availability of trained health care providers for clinical services. • The prevalence of STI remains less than 5%.
Intervention 1F	**Removing HR-related barriers to prevention for MSM/MSW** Change in Programming from current grant: ☒ Continuation
List of activities	• Provide **counselling sessions and sensitization meetings** with SRH service providers. • **Strengthen of national information systems of GBV** among KP. • Institute a system for **reporting healthcare complaints**. • The **frequency of individual-level counselling will be increased** to mitigate internalized stigma and increase self-esteem. • **Legal and rights literacy services** will be provided for the legal empowerment of MSM/MSW. • Human rights and legal literacy issues will be **integrated into the peer educator training manual**.
Amount requested	US$ 17,724 (0.06% of the allocated budget)
Expected outcome	• Stigma and discrimination experienced by MSM/MSW dropped by 20% between 2023 and 2026, measured by stigma index and next IBBS. • Integrated legal literacy issues into the peer educator training module • Enhanced national information system on GBV of MSM/MSW

Prevention Package for Sex Workers, their Clients and Other Sexual Partners

Current Grant (2021-2023): GF-supported interventions have been implemented for street-based, hotel-based, and residence-based FSW, whereas interventions for brothel-based sex workers have been supported by government funding. Overall, 32,946 female sex workers have received support in 16 districts (15 are priority districts), through 3 hospital-based facilities and 25 drop-in centres (DICs), including outlets (Program Data, December 2022). These districts were selected based on the 2015-2016 key population mapping and size estimation (2020), IBBS data (2015), and an AIDS Epidemic Model (AEM) exercise. A total of 29,090 tests were conducted, and 3 HIV cases were identified during the current grant until December 2022, indicating strong outreach prevention, a better-differentiated service model, and excellent community engagement. Moreover, HIV testing rate is high at 86% [4];

91% of FSW take treatment for STI [4] and 87% FSW used a condom at their last sex act [4], all resulting in a low HIV prevalence of 0.2% among FSW [4]. Around a quarter (24%) of FSW had been harassed, physically harmed or coerced into sex in the previous year and 25% had been arrested [4].

Proposed Continuation Grant (2024-2026): Addressing two of the gaps in the current grant, a special focus will be on AGYW in sex work and on street-based FSW will be added in the upcoming grant cycle. Street-based FSW face higher rates of HIV/STI, substance use disorders, and mental health conditions than other FSW. A total of 25,573 FSW will be covered across 14 high-risk districts with high numbers of young, street-based FSW with 16 government and NGO set-ups. These districts have been selected based on the results of key indicators from IBBS, 2020, KP estimations (2023), and program data Syphilis and GBV case reports (Table 1). The next IBBS will need to be able to disaggregate FSW by age and type to measure progress for these two sub-populations effectively.

Table 1:List of Proposed Districts and Population Coverage

Districts	Total Size Estimates 2022		Program Data			IBBS, 2020			Target			
	Point Estimates (2023)	Estimated # of Street-based FSW, 2023	<25 years of age	Average Annual STI Cases (2018-2022)	% of FSW with STI (Dec 2022)	Positive for active syphilis	Physically Abused or Hurt due to Selling Sex	Use of Condom Every time	AGYW	Street	Rest	Total
Dhaka	15247	7186	1941	151	38%	5.3%	40.0%	45.2%	1553	5749	1224	8526
Chattogram	4802	1391	1424	50	46%	7.3%	20.9%	14.6%	1140	1113	397	2650
Gazipur	2901	2661	421	13	45%	8.9%	29.7%	12.1%	336	2129	0	2464
Narayanganj	3407	1099	688	38	52%	5.2%	32.6%	56.9%	550	879	324	1754
Cox's bazar	4264	382	672	25	90%	6.8%	21.4%	18.7%	537	0	642	1178
Narsingdi	3851	1481	-	7	-	4.7%	26.7%	41.8%	0	1185	474	1659
Tangail	2909	1119	106	8	71%	4.7%	26.7%	41.8%	84	895	-	980
Mymensingh	4519	1458	-	12	-	4.7%	26.7%	41.8%	0	1166	612	1779
Barisal	2691	405	154	4	38%	1.8%	3.0%	0.4%	123	324	898	1346
Pabna	1487	391	149	16	58%	1.6%	3.0%	0.8%	119	313	313	745
Sirajgonj	1179	237	90	18	40%	1.6%	3.0%	0.8%	72	190	328	590
Jashore	2681	865	329	5	59%	1.6%	3.0%	0.8%	263	692	386	1341
Bogura	897	423	161	4	-	1.6%	3.0%	0.8%	105	254	0	359
Kushtia	504	278	106	12	-	1.6%	3.0%	0.8%	35	167	0	202
	41900	**16777**	**5251**						***4918***	***15055***	***5598***	***25573***

The FSW program will target 80% of young FSW under 25 years of age in targeted districts and aims to maximise the use of public facilities in a strengthened government system.

What is different in the proposed Grant: The proposed grant aims to focus on doing more with fewer resources for the most vulnerable FSW, specifically targeting AGYW and street-based FSW and improving engagement with FSW communities to ensure equal access to services. Introducing a mobile van service in Dhaka city will provide HTS, STI, SRH, and condom promotion services to reach a higher proportion of AGYW and vulnerable street-based sex workers at a relatively low cost.

Two methods of condom promotion are used: free and via social marketing, with the choice based on the type of FSW and their economic status. Condoms are distributed by PE, while ensuring their availability through secondary channels such as hotel staff, residence managers, and street shopkeepers. The proportion of condoms provided for free vs. social marketing will shift to 40:60 in the next grant to improve sustainability, using available seed funds from the implementing partner organisations.

FSW capacity will be strengthened through CBOs and their networks, including improving their governance. Access to social and legal services to address human rights issues will be improved. Training, orientation, and BCC programs will sensitise FSW communities and government service providers, ensuring a smooth transition from NGO-operated DICs to government facilities and enhancing sustainable service access.

Module 2	**Prevention Package for Sex Workers, their Clients and Other Sexual Partners**
Intervention 2A	**Condom and lubricant programming for sex workers** Change in Programming from current grant: ☒ **Continuation**
List of activities	• **Condoms and lubricants** will be distributed according to demand. Each FSW requires 42 condoms per month [4]. "Free of cost" condoms and lubricants will be available through outreach, DICs, six public hospitals, and secondary distribution channels, including hotel boys, madams and shopkeepers. • **Peer Educators** will use tailored IEC/BCC materials during individual and group sessions to generate condom demand and awareness at a ratio of one PE for every 100-120 FSW. Distance outreach will be conducted from the DICs. • **Training and refresher training** will be carried out on a yearly basis for the PE. Need based on job training and orientation will be done throughout the next grant especially since there is always a high turnover. • **An online platform for HIV prevention** on Facebook will continue to raise awareness about HIV and related issues among FSW. A comprehensive mobile application helps FSW connect with necessary facilities and institutions during emergencies. A 24/7 call centre is up and running, catering to FSW who prefer not to receive services from the DIC or PE.
Amount requested	US$ 777,859 (2.84% of the allocated budget)
Expected outcome	• FSW using condoms consistently will increase from 35% [4] to 61%. • Knowledge on STI symptoms will increase from 64% [4] to 75%.
Intervention 2B	**HIV prevention communication, information, and demand creation for sex workers** Change in Programming from current grant: ☒ **Continuation**
List of activities	• **A DSD model will be implemented**, reaching out to FSW through various channels such as peer education, group discussions, one-on-one counselling, virtual platforms, and a call centre. This will involve using tailored BCC materials that focus on GBV, human rights, HIV prevention, and sexual and reproductive health (SRH). Education, support, and referral information will be incorporated into these BCC materials. • The existing web-based platform will **expand to offer virtual case management for FSW**. A specific BCC strategy will be designed for hard-to-reach FSW who work online. • A program to **reduce the HIV risk and vulnerability of young FSW** (under 25) will be launched, who represent 11% of the total FSW

	population. This program will help link young FSW with social safety nets, obtain birth registration, apply for ID cards, passports, and bank accounts.
Amount requested	US$ 1,029,101 (3.76% of the allocated budget)
Expected outcome	• Proportion of FSW using condoms consistently will be increased from 41.7% [4] to 61% for all FSW.
Intervention 2C	**Community empowerment for sex workers** Change in Programming from current grant: ☒ **Continuation**
List of activities	• Empower sex worker-led organizations by **providing training** on participatory monitoring, human rights, and leadership. • **Refer sex workers to certified Vocational Training Institutes** (VTIs) for better economic opportunities and assist them in opening and operating bank accounts. • The **current 25 DICs (providing safe spaces for rest, showers, and self-care) will be reduced to 10 centres**, with the shortfall supplemented by government hospitals and some of the community-led DICs and CBOs, ensuring no FSW is left behind. Six districts plan to close, whereas in 3 district PWID program is already integrated with Govt facilities, FSW is planning to integrate service there. It is also planned for 10,000 additional FSW to be reached with PAAR resources, if available. • Facilitation for FSW **to obtain an ID card and open a bank account** will be carried out. This step towards financial empowerment can build confidence and options for alternative livelihood. • **Engage PE in outreach activities**, including social mapping, spot analysis, and community-led HTS. • **Bolster community participation** through local advocacy efforts, ensuring human rights and mitigating stigma. • **Community-led Monitoring** will be conducted via 36 monitoring visits by the Sex Worker's Network of Bangladesh to inform strategies for expanding CLM to all KP, in collaboration with ASP. • **Advocacy** for legal protections and social integration by the SW network and CBOs.
Amount requested	US$ 12,611(0.05% of the allocated budget)
Expected outcome	• Proportion of FSW reporting harassment will be reduced from 24% [4] to 20% which will be measured by IBBS. • Continued low HIV prevalence for FSW (<0.2%)
Intervention 2D	**SRH services, including SRI, hepatitis, post-violence care for SW** Change in Programming from current grant: ☒ **Continuation**
List of activities	• **Etiological management of STIs** will be conducted, including referral of critical cases to appropriate hospital departments and STI and HIV counselling. STI management will focus on integration with government

	facilities, syndromic management of STIs at DICs, and referrals for STI management through voucher schemes. • **A mobile van initiative in Dhaka city** will provide HTS, STI, SRH, and condom promotion services, reducing the DIC/Outlet count from seven to two, cutting operational costs. • Hospital-based and DIC-based SRH services offer **comprehensive sexual health education and counselling**. • **FSW health** check-ups, STI screenings, general health screening (including TB), and referrals to government facilities for treatment. • FSW will receive **contraception and family planning counselling** and referrals to facilities providing these services. Pregnancy testing will be introduced at DICs/Outlets, and ANC/PNC referrals will be ensured. • **GBV referral services** will be provided to One-Stop Crisis Centres. SACMOs will be trained on GBV and psychosocial counselling. • The referral of children under one year to the Expanded Program on **Immunization** will continue.
Amount requested	US$ 71,669 (0.26% of the allocated budget)
Expected outcome	• STI will decrease by 10% from current prevalence (66.1%, [4]). • From year 1 (27%) to year 3 (47%) an increasing number of STI-diagnosed FSW will be linked with Govt. health facilities
Intervention 2E	**Removing human rights-related barriers to prevention for sex workers** Change in Programming from current grant: ☒ **Continuation**
List of activities	• Annual workshops will be held with the **District Legal Aid Committees**. • Training sessions will be held on human rights and stigma discrimination for the **Law Enforcement Agency** (LEA) and healthcare providers. • **Training on human rights and gender issues for CBOs** will be held under the Sex Workers Network (SWN). • **FSW in need of legal support** will be referred to legal aid organizations. • Host **advocacy and sensitization meetings** with LEA and policy makers on human rights, HIV, and gender to mitigate human rights violations.
Amount requested	US$ 4,940 (0.2% of the allocated budget)
Expected outcome	• Proportion of FSW reporting harassment will be reduced from 26.1% [4] to 20% which will be measured by IBBS.

Prevention Package for TGW (Hijra) and their Sexual Partners:

Current Grant (2021-2023): HIV infection among TGW was found to be 0.9% [4]. Program data and IBBS 2020 reveal risk behaviours such as unprotected anal sex, Chemsex, low uptake of STI services, lack of consistent condom use, and inadequate sexual and reproductive health care. Legal and social barriers also fuel the risks of TGW.

In the current grant (2021-2023)**,** the program covers 6,573 out of 12,629 TGW [3] in 23 priority and 14 other vulnerable districts. The overall coverage is around 52%. There are different modalities of service delivery points in place in rented houses, including 14 drop-in centres (DIC), 18 Sub-DIC,18 outlets and three outreach venues. Five government health facilities provide clinical services, while outreach services are provided from outreach venues established in rented houses. All types of modalities provide a similar package of prevention services, including BCC sessions, condom & lubricant distribution, HTS, STI, GH, and SRH services, psychosocial and psychosexual counselling, TB screening, referral to public facilities, services to female partners, and capacity building. A peer navigation approach is in place to ensure treatment and care support for PLHIV. To work toward a more sustainable response, clinical services are integrated into five public healthcare facilities. Among the five health facilities, the cost of three clinical services is borne from the government operational fund, and two clinics provide costs from the revenue fund. A PrEP intervention for TGW has been piloted in Dhaka city.

Proposed Continuation Grant (2024-2026): In GC7, it is planned to provide services to 6,806 TGW out of 12,629 TGW [3] in 23 priority districts (80% of the TGW will be reached there, and 526 individuals in 6 other districts. The overall coverage will be 53.8%. Services will be provided via 16 Drop-in Centres (DIC), 25 Sub-DICs, and 20 outlets. Three public health facilities will be utilised in three districts from where both outreach and clinical services will be provided to TGW along with other KP such as PWID, FSW and MSM/MSW. Community engagement will be emphasised through consultation, capacity building, peer navigation, BCC activities, and virtual platforms. Online demand generation will continue to enhance safer sex, condom promotion and HTS. Standard HIV prevention services, including condoms, lubricants, HIV testing, treatment of PLHIV, STIs, and general health care services, will be provided free of cost.

What is different in the proposed Grant: The proposed grant aims to scale up demand generation through a peer-led approach, ICT-based platforms and to promote PrEP. Service coverage will be scaled up, including HIV testing; dual HIV/Syphilis test will be used. Lay provider HTS and HIVST will be introduced and scaled up to increase HTS uptake.

The target of the PrEP intervention will be increased based on the pilot project result. Strategies for PrEP demand generation, client enrolment, follow-up, adherence support, and monitoring and evaluation will be implemented. Long-acting PrEP will be piloted on a small scale under PAAR. The grant will expand service provision for TGW through public facilities.

Module 3	**Prevention Package for Transgender People and their Sexual Partners**
Intervention 3A	**Condom and lubricant programming for transgender people** Change in Programming from current grant: ☒Scale-up
List of activities	• **Demand generation through a peer-led approach,** which entails the deployment of peer educators (PE) who will generate demand, disseminate information, foster community engagement and consultation, and build community awareness. • **Demand generation via online tools**, such as mobile and web applications, text messaging, and voice SMS, will be used. These tools will serve as part of the BCC strategy, promoting safer sex, TB, Hepatitis, STI awareness, self-risk assessment, and other topics. • PE will **provide free condoms and lubricants** to 150-180 TGW at cruising sites, hijra dera (hijra leaders' homes), and community depots, including

	during weekends and holidays. One tube of lubricant will be distributed with every 12 condoms, which should suffice according to IBBS data on their sexual behaviour and frequency. • Timely **procurement of condoms and lubricants** will be done, adhering to GF and organisational policies. The quality of condoms will undergo regular assessment, and stock-outs or product loss will be avoided. • **Professional development for peer outreach staff** is essential; on-the-job training, orientation, and refresher training will be organized to continually enhance their skills and capacity.
Amount requested	US$ 186,490 (0.68% of the allocated budget)
Expected outcome	Condom use increased among TGW from 36.9% in 2020 [4] to 50% in 2026.
Intervention 3B	**Pre-exposure prophylaxis (PrEP) programming for TGW (*hijra*)** Change in Programming from current grant: ☒Continuation
List of activities	• 100 TGW (in addition, 200 in PAAR) at risk of HIV **will be given PrEP** in Dhaka city. • **Procurement** of medicine for PrEP and related test / reagents. • **PrEP dispensing** following baseline tests according to the PrEP protocol. • **Follow-up of PrEP clients**, including delivery of PrEP medicine, follow-up tests, physical check-up, counseling etc. • **PrEP adherence support** will be provided through differentiated approaches (see under MSM, 1B). • **Harm reduction services for Chemsex**, including drug taking and mental health screening, comprehensive counselling, HTS, STI management, commodities distribution, BCC etc. will be integrated in the PrEP service. • **Advocacy with policy makers** to consider adoption of PrEP as part of the standardized package for HIV prevention among KP and development of national guidelines on PrEP for providers will be conducted • **Long-acting PrEP** will be piloted on a small scale (considered **in PAAR**).
Amount requested	US$ 103,371 (0.38% of the allocated budget)
Expected outcome	• Number of TGW on PrEP increased from 38 to 100 by 2026. • At least 70% of the recipients in need adhere to prescribed PrEP.
Intervention 3C	**HIV prevention communication, information and demand creation for transgender people** Change in Programming from current grant: ☒Scale-up
List of activities	• **Prevention services demand will be generated** through peer-based and digital platforms, via consultations, peer training, awareness sessions, group discussions, outreach site visits, etc. • **BCC materials** will be disseminated by peer educators at various outreach sites and public hospitals, with a special focus on young and

	adolescent TGW populations. Topics include consistent condom use, HIV/STI testing, safer sex practices, the importance of PrEP, and the link between HIV/STI and Chemsex. • **ICT-Based Behaviour Change Activities** aim to strengthen outreach and routine communications with clients and reach inaccessible TGW individuals online. The existing HIV information app will be modified to provide to these specific group needs.
Amount requested	US$ 146,926 (0.54% of the allocated budget)
Expected outcome	• Enhanced knowledge, attitude, and practice related to HIV and STI as measured by IBBS.
Intervention 3D	**Community empowerment for transgender people** Change in Programming from current grant: ☒Continuation
List of activities	• **Safe spaces will be established** in rented houses for NGO-operated areas at 61 locations in 26 districts while three government health facilities will be used for this intervention. • Formation of community coalitions, roundtables and meetings to **mobilize TGW communities**. Community members will be deployed as field staff. • **Engagement** of more capacitated *hijra* CBOs in program implementation. • **CBO representatives will be trained** in leadership, public speaking, and negotiation skills to build self-confidence.
Amount requested	US$ 86,602 (0.32% of the allocated budget)
Expected outcome	• Continued low HIV prevalence for TGW (~1.0%, according to PF).
Intervention 3E	**Sexual and reproductive health services, including STIs, hepatitis, post- violence care for transgender people** Change in Programming from current grant: ☒ Scale-up
List of activities	• **STI risk evaluations will be performed** by PE, MA/OS. Clients have an option to instead use a mobile app and a website from an existing ICT-based intervention to facilitate self-risk assessments. • Medical Assistants will provide **free routine STI check-up and treatment, following the syndromic approach**. In three distinct districts, these services will be provided in government hospitals by a medical doctor. The OP budget will cover medicine costs within government hospitals, while in other districts, they are covered by the GF grant. • **Clients will be provided treatments for general health issues** such as respiratory infections, scabies, skin and soft tissue infections, rectal infections, fungal infections, fever, gastrointestinal upsets, PUD, etc. • **Etiological management of Syphilis** will be instituted at least semi-annually or annually using a DUO test kit (HIV-Syphilis), confirmed via VDRL (Q&Q), funded by GF. Syphilis-positive patients will receive treatment and follow-up investigations funded by GF. • Medical assistants will offer **STI counselling services**, in addition to

	psycho-social, psycho-sexual, and mental health counselling. • Recurrent, non-responsive, or complicated STI cases will be **referred to government hospitals for etiological management** funded by GF. • **Sensitization meetings with SRH service providers** will be conducted with SRH service providers at the local and central levels. • Clinical services for MSM and TGW, including STI, HTS, Reproductive Health, and HIV services, will **be integrated into public healthcare facilities** in three additional districts beyond the current pilot sites. • **Periodic refresher training and orientation** to strengthen the capacity of service providers on SRH services, including STI management. • **PEP services** will be provided from government operated ART centres. Eligible clients will be referred to respective ART centres • **Harm reduction services** for Chemsex: (see above under PrEP) • **Human papillomavirus (HPV)** is an emerging threat to TGW. Therefore, screening, prevention, treatment, and referral, as well as screening for oral and anal cancers are needed (requested in PAAR).
Amount requested	US$ 7,655 (0.03% of the allocated budget)
Expected outcome	• The prevalence of STI among TGW in intervention areas drops from 10.7% [4] to under 5%.
Intervention 3F	**Removing human rights-related barriers to prevention for transgender people** Change in Programming from current grant: ☒ Continuation
List of activities	• **The frequency of counselling sessions with TGW will be increased** to mitigate internalized stigma and increase self-esteem. • **Sensitization meetings with SRH service providers** will be held. • **Strengthening of national information systems** on GBV among KP and instituting a system for reporting healthcare complaints. To document and report gender-based violence and human rights violations related data, relevant information will be collected from hijra that will be utilized to strengthen the national information system. • **Legal and rights literacy services** will be provided for the legal empowerment of transgender people. • Human rights and legal literacy issues will **be integrated into the peer educator training manual**, including peer human rights educators.
Amount requested	US$ 9,677 (0.04% of the allocated budget)
Expected outcome	• Stigma and discrimination experienced by TGW dropped by 20% between 2023 and 2026, as measured through stigma index and next IBBS

Prevention Package for People who inject drugs (PWID) and their Sexual Partners:

Among 947 newly diagnosed PLHIV in 2022, 11% were PWID [2]. Out of those, around 95% are currently on ART. Bangladesh faces diverse challenges in addressing the issues of PWID. The treatment and care of this marginalised community due to social, legal, human rights and environmental barriers is challenging.

A KP size estimation was conducted very recently [3]. It indicated that there are an estimated 34,370 PWID nationwide. 25,338 PWID (75% of country estimates and 91% of district estimates of 28,389) will be reached with harm reduction services in 38 districts (See Map and Table).

Interventions for people who inject drugs (PWID) are based on the mapping and size estimation reports, 2015-2016, using the higher PWID estimates of 33,067 [5]. Achievement as of December 2022 is given below:

Table 2: Current Coverage of PWID

PWID estimates (2015-16): 33,067													
Particulars	ASP			Save the Children			icddr,b			Total			
	NSE	OST	Total	NSE	OST	Total	NSE	OST	Total	NSE	OST	Total	% againt est.
GF grant	1,864	-	1,864	12,106	2,510	14,616	-	600	600	13,970	3,110	17,080	
Sector program	2,695	-	2,695	-	-	-	-	-	-	2,695	-	2,695	
Total	**4,559**	**-**	**4,559**	**12,106**	**2,510**	**14,616**	**-**	**600**	**600**	**16,665**	**3,110**	**19,775**	**60%**

The intervention is being implemented in 17 priority and 6 nonpriority districts through 49 service delivery points. Among the service delivery points, 9 are Comprehensive Drop-in Centres (CDIC), 7 stand- alone OST, 16 integrated in GoB facilities and the rest 17 are Drop-in Centres (DIC) and Outlets

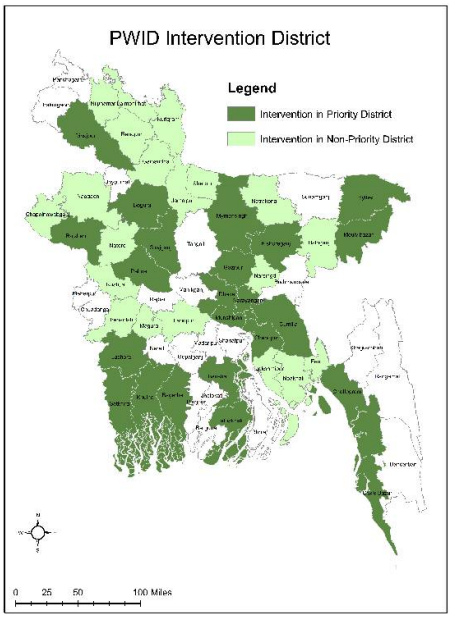


Figure 3: PWID District Coverage

Each CDIC and OST centre is led by a clinical team comprising of a physician, counsellor and nurse and supported by an outreach team. The counsellors of the OST program will counsel clients to improve mental health, and improve treatment adherence and retention. An updated mother-list has been created for OST client selection. Before enrolment, clinicians will check clients' willingness and readiness following a predefined scale (CMRS). The clinical opiate withdrawal scale (COWS), is used to support OST induction and maintenance.

226 syringes were distributed per PWID in the year 2022. Around 1% of targeted needles and syringes (N/S) are distributed from the DICs, 90% by Peer Outreach Workers (PE/PE) and 9% through secondary distribution channels, i.e., pharmacies, tea stores, etc. Vending machines and mobile vans have been planned in current grant to reduce the workload on PE; this will also enhance the distribution of N/S through secondary channels.

As of December 2022, a total of 3,110 PWID were receiving methadone from 15 centres; this number will be increased. At the end of current grant, around 3,300 PWID will be under the OST program and receive methadone from 21 service delivery points. The program will be implemented through 48 service delivery points [including 5 CDICs, 20 Outlets, 5 OST centres and 18 centres within the GoB facilities] in 19 priority (out of 23) and 19 nonpriority districts (out of 41). Out of 18 GoB facility-based centres 10 shall provide comprehensive prevention services to PWID including ART. The program will exclude four previous ‘priority districts’ due to the small number and scattered distribution of PWID.

Considering current HIV trends among PWID, the program also plans to scale up reach in nonpriority districts where at least 300 PWID are present.

Program data showed that out of a total of 247 reported deaths among drug users in 2022, 23 (9%) cases were attributed to overdose. The provision of health education and behaviour change communication (BCC) materials is the primary approach for addressing this issue.

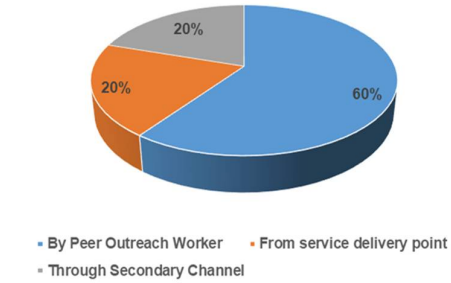
Table 3: Proposed Coverage of PWID for GC7 Grant

PWID estimates (2023): 34,370															
Particulars	ASP			Save the Children			icddr,b			Total					Remarks
	NSE	OST	Total	NSE	OST	Total	NSE	OST	Total	NSE	OST	Total	% againt national Est.	% againt district Est.	
GF grant	4,040	150	4,190	17,388	3,760	21,148	-	600	600	21,428	4,510	25,938	75%	91%	
Sector program	-	-	-	-	-	-	-	-	-	-	-	-			Target no yet finalized.
Total	**4,040**	**150**	**4,190**	**17,388**	**3,760**	**21,148**	**-**	**600**	**600**	**21,428**	**4,510**	**25,938**	**75%**	**91%**	

Program data shows that, in 2022, out of a total of 2,387 PWID with asymptomatic STIs, only 21% were managed at government facilities. Among PWID, the overall prevalence of HCV is 33.2% [4], which is far higher than the general population. PWID have a 15-times higher prevalence of leg ulceration than the general population, with a study estimating 15% of PWID have leg ulceration [6].

There are various sections in the NCA (Narcotics Control Act) that disfavour drug use and interventions. As a result, drug users often face harassment, stigma, and discrimination. It is crucial to continue efforts to remove legal barriers, stigma and discrimination towards drug use and users and work towards 'decriminalization of drug use.' Most of these efforts will be intensified in the next grant, based on the latest evidence and programme experiences.

Module 4	**Prevention Package for People Who Use Drugs (PUD) (injecting and non- injecting) and their Sexual Partners**
Intervention 4A	**Needle and syringe programs for PWID** Change in Programming from current grant: ☒ Scale-up
List of activities	• **N/S distribution will be scaled-up to 326 N/S to each PWID** each year. Availability of syringes and needles among PWID will be ensured 24/7. Secondary channels such as pharmacies, grocery shops, rag pick shops, mobile van and vending machine and SDP will be used (see diagram). • **Auto-disposable syringes** will also be distributed at various ratios throughout the grant years in selected districts. Around 25% of the required N/S will be supplied from the programme OP, the rest from GF.

	• Effective implementation of **waste management** with an emphasis on providing continuous orientation on safe injection practices and safe disposal to PWID, people involved in the drug trade, PE, and volunteers, using quarterly awareness campaigns and provision of aseptic precautions and waste bins/collection boxes. Waste collected will be properly incinerated, in line with current practices. • **The Peer Educator vs PWID** ratio will be 1:60 to 1:100 based on the injection practice and distribution of PWID in the districts. • PE will receive a **four-day training** each year. The Network of People Who Use Drugs (NPUD) will be involved in recruiting PE.  **Figure 4: Needle-Syringe Distribution Plan**
Amount requested	US$ 1,244,893 (4.54% of the allocated budget)
Expected outcome	• Scale up of PWID coverage from 60% to 75% of the country estimates. • Scale up of NS distribution from 226 per PWID per year to 326.
Intervention 4B	**Opioid substitution therapy and other medically assisted drug dependence treatment for PWID** Change in Programming from current grant: ☒ Scale-up
List of activities	• The number of **service delivery points for OST will remain 21** (some restructuring/reorganisation will take place). A total of 4,510 PWID (45% increase from NFM3) will receive methadone, mostly funded by GF. • In epidemic districts, "**one-stop-services**" from the comprehensive DICs shall offer OST to PWID. • OST **self-help/community group meetings** will be carried out to enhance retention. Remote diagnosis, treatment, and telemedicine consultation will be implemented. • An OST expert panel will provide **training to PE** with the new training module funded by GF. **Table 4: OST Coverage Plan** PR / Regular grant / PAAR / Total Save the Children / 3,760 / 300 / 4,060 ASP / 150 / - / 150 icddr,b / 600 / - / 600 **Total** / **4,510** / **300** / **4,810** • The clinic will ensure at least one **annual HTS screening** for all HIV-negative OST clients. • Priority will be given to **enrol women who inject drugs** (WWID) by adopting a "women's centre" approach as well as those who are HIV positive. Female PE will be deployed for monitoring and follow-up. • **Optimum methadone dosing** will be done considering co-administered drugs and their interactions.

	• Random and regular point-of-care (POC) **drug screening tests** will be performed (without any punitive actions if concurrent substance use is discovered) and clients using concurrent drugs will be referred for detoxification without discontinuing OST. • **Treatment for concurrent substance use** will be provided following national guidelines. • To **assess their quality of life and mental health**, periodic assessments will be conducted on a quarterly basis using the WHO Quality of Life Scale and the Depression, Anxiety, Stress Scale, followed by referrals. • **Improvement of the livelihoods of OST clients** will be addressed. The OST program will eventually be integrated into GoB facilities to increase access and government ownership of the programme. • **Take-home/away supplies of methadone** will be provided to PWID to reduce loss-to-follow-up following the national guideline recommendations, including as retention and adherence reward. • The program proposes **pilots for Suboxone and Buvidal for 300 PWID** in Dhaka city (150 participants for each pilot) in PAAR.
Amount requested	US$ 1,080,148 (3.94% of the allocated budget)
Expected outcome	• Scale up of OST from 3,110 to 4,510 PWID clients
Intervention 4C	**Overdose prevention and management for PWID** Change in Programming from current grant: ☒ **Continuation**
List of activities	• The **procurement and distribution of life-saving naloxone** services will be implemented in all implementation districts using GF funds. • CDIC/OST centres and Outlets will be utilized to prepare clients, implement satellite dispensing, takeaway/home doses **and initiate a peer-led Naloxone programme**. • **Orientation on the causes, symptoms, and management of overdose will be provided** to PE, network partners, and also their families. • Hospital-based doctors and counsellors will receive **overdose management training**. • The **referral network with nearby/adjacent government health facilities** will be strengthened. • **BCC materials** to inform PWID on opioid overdose and its prevention including information about emergency management will be continued. • Naloxone is currently listed as a Class A scheduled illicit drug under the law. **Advocacy** to change this is ongoing, and so is the referral network to government hospitals.
Amount requested	US$ 17,385 (0.06% of the allocated budget)
Expected outcome	• Overdose-related mortality reduced by 20% in 2026.

	• Access to Naloxone will be increased from 0% to 20% in 2024, 50% in 2025 and 70% in 2026.
Intervention 4D	**Condom and lubricant programming for PUD** Change in Programming from current grant: ☒ Scale-up
List of activities	• **Free distribution of condoms will be continued and expanded**. The majority (around 80%) will be distributed through PE through outreach. The rest will be distributed from facilities, incl. hospitals and mobile vans. • **Lubricants** will be provided to female PWID engaged in sex work. • **Health education sessions** on the consistent and correct use of condoms will be provided by PE.
Amount requested	The cost has been included under Intervention 2A of Module 2
Expected outcome	• Condom use among PUD will be increased from 20% to 40% by 2026. • STI prevalence among PUD will be reduced from 22% to 12% by 2026.
Intervention 4E	**HIV prevention communication, information & demand creation for PUD** Change in Programming from current grant: ☒ Scale-up
List of activities	• **Demand generation and HIV/STI awareness raising** will be implemented using one-to-one and group sessions, utilizing appropriate IEC materials, as well as social interaction strategies involving friends, family, and the community. • PE will be **recruited from the community and receive comprehensive training** on HIV, harm reduction, and SRHR. • **Life skill development programs** will be implemented to promote a better quality of life and foster healthy behaviours among PUD. • **BCC materials will be updated**, and some new online and offline materials will be developed to create demand for HIV prevention services. • The program **promotes behavioural change** in the following areas: using sterile needles-syringes, and not exchange them; using condoms; managing other non-injecting drugs with dependency; understanding the relation between drug use and risk behaviour, and availing OST, HTS, ART, co-infection management, overdose management, and SRH.
Amount requested	US$ 3,137,420 (11.45% of the allocated budget)
Expected outcome	• Knowledge among PWID about HIV will be increased from 21.3% [4] to 50% by the end of project period, measured during next IBBS.
Intervention 4F	**Community empowerment for PUD** Change in Programming from current grant: ☒ **Continuation**
List of activities	• The teams responsible for managing the service centres will collaborate with the PUD community network, and its member organizations to ensure **effective monitoring, guidance, and supervision** of the program. • PWID and their communities will experience **improved access to essential services**, including shelter, healthcare, and livelihood

	opportunities. • DIC Advisory Committee (DAC) at the service centre level will undergo **reforms to ensure meaningful community representation** and engagement, and job opportunities will be created. • The PWID network and its member organizations will be supported for **capacity development**, including issue-based advocacy to reduce stigma and discrimination, how to address human rights issues with regional and national policymakers, leadership, public speaking, and negotiation skills. • Skilled **network and network member organizations will be contacted** for program activities, e.g., issue-based advocacy, participatory monitoring, etc. using performance-based funding.
Amount requested	US$ 7,739 (0.03% of the allocated budget)
Expected outcome	• PE are trained on harm reduction.
Intervention 4G	**Sexual and reproductive health services, including STIs, hepatitis, post-violence care for PUD** Change in Programming from current grant: ☒ Scale-up
List of activities	• **Comprehensive SRH services**, including syndromic and etiological management of STI will be continued. • **Yearly health screening** will be provided to PWID. • **HCV RNA testing** will be conducted to confirm HCV infections. • **Management of hepatitis C virus infection** will be provided from the CDIC/OST centres/clinics and GoB hospitals free of cost, including the provision of Direct Acting Anti-virals. Sofosbuvir and Daclatasvir will be used as the drug of choice to avoid drug interactions with HIV ART. • **HCV medicines and necessary laboratory tests** will be procured abd funded by GF, like the previous grant. • **Management of chronic leg ulcer/abscess/ deep vein thrombosis** cases will be provided from the CDIC/OST centres/clinics free of cost. Based on the diagnosis, appropriate antibiotics, anti-coagulants will be provided free of cost from the CDIC/OST centre, including recurring care.
Amount requested	US$ 632,786 (2.31% of the allocated budget)
Expected outcome	• Incidence of STIs will be decreased from 19% (program data) to 12%. • Prevalence of leg ulcers in PWID reduced from 15% to 5% by 2026. • 80% of PWID with HCV successfully enrolled in treatment by 2026.
Intervention 4H	**Removing human rights- related barriers to prevention for PUD** Change in Programming from current grant: ☒ Continuation
List of activities	• **Advocacy with DNC and other LEA** as per the framework developed recently, in NFM3 (including an overseas tour to best practice sites by LEA/Govt officials, workshop, orientation meeting with stakeholders).

	• **Training/Orientation of CBOs under Network of People Who Use Drugs (NPUD) on the issues of human rights and gender**, especially those involved in participatory monitoring and reporting of abuses. • Contracting a **law firm to provide legal support** to KP who are often harassed or arrested due to drug use and carrying paraphernalia. • Conducting **orientation meetings with local DNC staff** to sensitize them on the need to reduce human rights violations towards PWID. • Organizing **TV talk shows and roundtable discussions** to create mass awareness and a favourable situation among policy makers regarding human rights issues related to HIV and harm reduction. • Capacity-building efforts will be undertaken to ensure that PWID can access social justice through **group discussions**. • **Pocketbooks on health and human rights** will be developed, printed, and distributed. • **Orientation and training sessions on human rights**, stigma, and discrimination will be conducted for law enforcement agencies and health service providers incl. with the district legal aid committee.
Amount requested	US$ 6,440 (0.02% of the allocated budget)
Expected outcome	• Reduced all forms of stigma and discrimination and gender-based violence, which will be measured through Stigma iIndex survey.

HIV/STI services for People in Prisons and Closed Settings:

As of November 2022, the total prison population was 81,156, encompassing pre-trial detainees and convicted prisoners. Female prisoners represented 3.9% of the total prison population [7].

Since November 2022, HIV/Syphilis/TB/Hep C testing services have been initiated in seven prisons. Since then, 1,879 prisoners have been tested for HIV of whom one tested positive. In line with the ART guidelines, any prisoner testing positive for HIV, Hep C and/or Syphilis is linked to nearby government treatment services, in coordination with the prison authority.

Unfortunately, preventive measures such as condom promotion and needle-syringe exchange programs are not covered for the prison population for the coming GC7 program. This absence stems from restrictions in the country's policies, strict jail code, safety and security, and the legal environment within prisons. Advocacy will be conducted to increase prisoner access to HIV/STI prevention services and OST.

During the coming grant, HIV and STI testing services will be extended to an additional 11 prisons, bringing the total to 19.

Module 5	**Prevention Package for People in Prisons and Other Closed Settings**
Intervention 5A	**HIV prevention communication, information and demand creation for prisoners** Change in Programming from current grant: ☒ Scale-up
List of activities	• **Individual-level and group-level behavioural interventions** will be implemented in prisons aimed at raising awareness, which include peer-

	based group sessions, one-on-one education, counselling sessions, group health education sessions on the following topics: the prevention of TB/HIV, the importance of HIV/STI testing, the importance of prevention, testing and treatment of Hep C and STI, and awareness of safer sexual practice by the peer educator selected from prisoners.
Amount requested	US$ 399,400 (1.46% of the allocated budget)
Expected outcome	A total of 10,560 (10 prisoners/session, 8 sessions/per month in 11 prisons) prisoners will be reached through group sessions, one-on-one education, counselling sessions, group health education sessions.
Interventions **5B**	**Differentiated HIV testing services in Prisons and other closed settings** Change in Programming from current grant: ☒Scale-up
List of activities	• **HIV/Syphilis/TB/Hep C testing will be conducted** in 19 selected prisons (11 regular prison hospitals, 8 satellite) by laboratory staff supported by GF. In 8 prisons without skilled prison hospital staff, trained medical personnel from nearby HTS centres will conduct satellite sessions of HIV testing twice a month. Separate time slots will be allocated for female prisoners to receive HTS services based on demand. • **Maternal and Child Health (MCH) and Sexual and Reproductive Health/Family Planning (SRH/FP) services** will be coordinated for female prisoners to provide HTS and STI services, including counselling and awareness sessions.
Amount requested	The costing has been included under Intervention 6A of Module 6
Expected outcome	• HTS will be provided to 16,223 prisoners in 19 selected prisons
Interventions **5C**	**Sexual and reproductive health services, including STIs, hepatitis** Change in Programming from current grant: ☒Scale-up
List of activities	• Prisoners diagnosed with **HIV, Syphilis and Hepatitis C will be linked to government ART centres** for treatment and care. • Prisoners will be **screened for TB and receive TB medication** from a nearby Directly Observed Treatment (DOTs) centre • The **capacity of the prison health staff of 19 prisons will be enhanced** through training on HIV, HTS, TB, Syphilis, and Hepatitis C. This will cover prevention, harm reduction/OST and HIV/STI/TB/Hep C testing methods, subject to approval from jail authorities.
Amount requested	US$ 1,165 (0.001% of the allocated budget)
Expected outcome	• Syphilis tests will be provided to 16,223 prisoners in 19 selected prisons as part of the HIV/Syphilis Duo test kit. • All (100%) confirmed TB positive prisoners will be tested for HIV.
Interventions **5D**	**Harm reduction interventions for drug use for prisoners** Change in Programming from current grant: ☒ Scale-up

List of activities	• **OST services will be expanded from the current two pilot prisons to three prisons** (Rajshahi will be added) for those who are already enrolled in OST programs when becoming detained; if successful, OST services in prisons will be expanded in the future.
Amount requested	US$ 16,802 (0.06% of the allocated budget)
Expected outcome	• Access to OST for prisoners will be expanded from the current one to 3 prisons by the end of the grant period.
Interventions **5E**	**Removing human rights- related barriers to prevention for prisoners** Change in Programming from current grant: ☒ Scale-up
List of activities	• **Capacity-building of prison management and policy-level staff** will be conducted, emphasising HIV, HTS, and human rights issues related to prisoners, thereby ensuring equitable access to HIV services (including access to HIV prevention services/condoms). • A **policy dialogue will be facilitated** with prison steering committee (senior staff of the Home Ministry, Health Ministry, Prison Directorate, HIV programme stakeholders) about the human right to HIV prevention, treatment and care at prisons, including the availability and accessibility of condoms, clean needles and HTS services for prisoners.
Amount requested	US$ 4,465 (0.02% of the allocated budget)
Expected outcome	• Three capacity building workshops will be held in GC7. • Three meetings of prison steering committee will be held in GC7.

Module 6	**Differentiated HIV Testing Services**
Intervention 6A	**Facility-based testing for key population (KP) and their partners** Change in Programming from current grant: ☒ Scale-up
List of activities	• The national program will **provide HIV test kits** for scaling up HTS. • **FSW**: 24,520 FSW will receive HIV testing services from seven public hospitals and KP facilities, which is 95% of the reach target. 60%-80% of the HIV testing will be done through a facility, i.e., hospital, DIC and outlet; 20-35% through community-based testing (depending on the district), and 5% through HIV self-testing (HIVST) annually. The national HIV testing algorithm (HIV rapid testing approach) will be followed. • **PWID**: 24,279 PWID will receive services from seven public health facilities and KP facilities annually, which is 95% of the reach target. Around 50% of the HIV testing will be done through facilities, i.e., CDIC, DIC, Outlet, and OST centres, but a little higher for GoB relocated centres (80%) and 20-46% through community-based testing, up to 3% through HIVST and 1% through a social network-based approach. Index and partner testing will be part of the HTS approach to identify HIV-positive cases among sexual partners; injecting networks and/or family members of 5% of targeted PWID will receive index testing.

	• **MSM/MSW/TGW**: A total of 81,700 MSM/MSW/TGW will be tested annually through three public health facilities and KP facilities which is 95% of the target for reach. HIV testing will be provided at least once a year for MSM, MSW, and TGW, and more often for those at high risk. • **HTS promotion and demand generation** via a peer approach and via community mobilization, one-to-one contact and online. • **Ethical Index testing** will be encouraged for KP testing positive for HIV. • **Oral fluid-based self-testing** is also available at the facilities for those who prefer this. All clients receive their test results through post-test counselling on the same day of testing as per standard protocol. • **Capacity building and training** of public health facilities staff/service providers will be organized. • Orientation workshops and capacity-building activities will be conducted with management-level staff of public facilities to create an **enabling environment for KP in public places**.
Amount requested	US$ 834,777 (3.05% of the allocated budget)
Expected outcome	• HTS coverage increased from 90% in 2022 to 95% in 2026. • The percentage of PLHIV who know their HIV status will be increased from 67% [2] in 2022 to 95% in 2026.
Intervention 6B	**Community-based testing for Key populations and their partners** Change in Programming from current grant: ☒ Scale-up
List of activities	• **Community-based HTS will be made available** at convenient community-based locations and settings (i.e., residences of hijra guru or influential community members, CBOs' places, hotels, drug spot, bust station, rail station etc). A trained provider, MA, SACMO, or government staff, will perform the test following the standard procedures of HTS. • **Demand-based HTS satellite sessions will be conducted** for full-time working and remote KP based on demand and prior mapping exercises. • **(Lay) peer educators will be trained** for each of the KP' community groups and will be assessed for quality performance. • **CBO groups will be oriented** toward encouraging community members to access community-based testing (demand generation). • **Newly found HIV cases will be swiftly referred** to the ART centre with the help of a trained provider and linked with the national programme • **Quality checks of HIV testing services** will be conducted periodically from nearby centres (public hospitals, DIC etc.).
Amount requested	US$ 368,259 (1.34% of the allocated budget)
Expected outcome	• Percentage of KP accessing CBT increased by 20% by 2026.
Intervention 6C	**Self-testing for Key populations and their partners**

	Change in Programming from current grant: ☒ Scale-up
List of activities	• **Clients of FSW and partners of MSM/MSW will be encouraged** to access self-testing. • **HIVST kits will be distributed through facility and community settings** and will also be used for index testing and couple- and social network-based peer and partner testing. • **Self-testing using oral fluid** will be conducted in DIC, CDIC, Outlet, OST centre, GoB facilities, and satellite for KP. • **Online HIVST demand creation and online orders** of HIVST kits. • **People with a reactive test result will be linked for confirmation testing** in line with the national algorithm. • Medical assistants will also ensure counselling and linkage to prevention services (including PrEP in Dhaka) **for those who test negative**.
Amount requested	US$ 156,359 (0.57% of the allocated budget)
Expected outcome	• HIVST coverage will be increased by 15% of the total HTS target for MSM, MSW, and TGW (including via online channels). • It will be 5% of the total 19,940 for FSW and 5% of 20,090 PWID in year 1, and, if feasible, it will be scaled up and continued in the upcoming grant. • FSW/MSW/TGW partner testing will be 6% of the total population coverage for MSM/MSW/TGW conducted through the HIVST approach.

Treatment, care and support for PLHIV:

The national ART guidelines, updated in Oct 2019, are followed during post-test counselling and ART initiation, management, clinical and laboratory follow-up, including WHO-recommended strategies like “Test and treat”, and rapid ART initiation. ART provision comprises a comprehensive and integrated approach involving doctors, nurses, counsellors, and community peer counsellors (CPC). It covers clinical monitoring, laboratory tests, opportunistic infection (OI) and comorbidity management, adherence and follow-up to PLHIV. HIV-positive partners/spouses/children of PLHIV are enrolled at the same centres if they reside together or in the same locality. HIV case management services are also provided by peer navigators/CPC.

All ART centres are linked with the nearest GeneXpert sites for viral load testing. In 2022, among 5130 PLHIV who were on regular ART, a total of 4,168 viral load tests were done and 85% were found virally suppressed. A viral load optimization plan and SOP were developed in NFM 3 [8, 9]. Efforts to strengthen access to viral load testing among PLHIV will continue.

There is effective collaboration between the HIV and TB programmes, lessening the burden on both PLHIV and people living with TB. In 2022, among 994 newly enrolled PLHIV, 720 were eligible for IPT, and 549 PLHIV enrolled. TB screening is conducted for PLHIV before the initiation of ART. In 2022, a total of 817 newly enrolled PLHIV were screened for TB, and 82 were found positive and linked to treatment. In 2022, 71,314 TB patients were tested for HIV, 67 become positive. In 2022, 2100 PLHIV (old and new) initiated IPT.

However, there are some challenges. Screening for TB among PLHIV and initiation of IPT need to be further strengthened. The lack of skilled and motivated staff is an issue for quality

service delivery. Stigma and discrimination remain an issue leading to demotivation and mental health problems. To address these challenges, differentiated ART service delivery is required through facility and community, outreach, mobile, and virtual services.

Module 7	Treatment, Care, and Support
Intervention 7A	**HIV treatment and differentiated service delivery – adults (15 and above)** Change in Programming from current grant: ☒ Scale-up
List of activities	• **The number of ART centres will be expanded from 12 to 28** in a phased manner during the GC7 grant period. The 7 Comprehensive DIC (CDIC) will continue to provide ART in community settings for KP. • The skills and motivation of **healthcare staff (including the case management team) at facilities will be enhanced** through training for delivering quality care to PLHIV, based on the updated national ART guidelines (2019), covering facility and community-level quality of service delivery, awareness-raising, and mobile services etc. • **Virtual training will be organised** from time to time, especially for peer providers. Capacity building on WHO-recommended Dolutegravir (DTG) first-line drug provision will be initiated for the staff physically and virtually. • **Dolutegravir (DTG) access will be increased** as the preferred first-line drug to treat PLHIV in a phased manner. • **The number of CPC at ART centres will be increased from 12 to 20** to improve ART adherence and re-enrolment, including home visits for those who missed consecutive appointment dates. Eight peer navigators will also work in KP communities to help link PLHIV to ART services and ensure follow-up and ART adherence. • **For KP living with HIV**, FSW will be linked to government-run ART centres through accompanied referral for chronic care. PWID will be linked to ART centres/CDIC through accompanied referral for enrolment into ART, clinical and immunological monitoring and adherence and psychosocial support. • **Ensure nutrition support for KP with HIV** and regular follow-up. • PLHIV who are stable on ART and live in remote locations are provided with **multi-month dispensing** (at least for three months) of ART. • **Decentralized drug distribution channels will be established** through DICs, using outreach services for delivering ARVs to PLHIV at the late evening or patients' preferred time. • Support groups of PLHIV (Networks, CBOs, SHG) will **build the capacity of Community Peer Counsellors (CPC)** • **CPC will implement SMS/virtual reminders and phone calls** to remind them to use ARVs at the right time, next appointment date for VL test, ART refill/clinical/psychosocial consultation, etc • **Peer navigation, including hiring, training, managing and supervising peer advisors**, will be designed and implemented.

	• **The case management team (PN/CPC) will conduct one-to-one and group education sessions** for treatment literacy, and provide ART adherence counselling either in-person or over the phone. • **Provide integrated adherence support for KP:** For PWID, ART/OST from the same premises (CDIC). Adherence support (monetary support) for some vulnerable PLHIV will be continued. • Post-violence counselling, clinical investigations, medical management, STI screening, testing, and treatment, clinical care, forensics management and medical-legal linkages, and psychosocial support will be provided to **support PLHIV who experience GBV**.
Amount requested	US$ 343,450 (1.25% of the allocated budget)
Expected outcome	• Percentage of PLHIV on ART increased from 87.22% (826 enrolled among 947 diagnosed cases) to 90%, 93% and 95% in 2024, 2025, and 2026. • Percentage of PLHIV on DTG increased from 32% in 2022 to 100% in 2026.
Intervention 7B	**Treatment monitoring - viral load and antiretroviral (ARV) toxicity** Change in Programming from current grant: ☒ Continuation
List of activities	• **Organize refresher for ART centre staff** on the importance of viral load testing • **Effective counselling for demand creation and treatment literacy** among PLHIV by ART physicians and counsellors • **Procurement of viral load cartridges** • Establish **EQA system for viral load**
Amount requested	US$ 397,378 (1.45% of the allocated budget)
Expected outcome	Increase of VL testing among PLHIV (90%, 92% and 95% in 2024, 2025, 2026)
Intervention 7C	**Integrated management of common co-infections co-morbidities (adults and children)** Change in Programming from current grant: ☒ **Continuation**
List of activities	• PLHIV who are on ART are **monitored and linked for diagnosis and management of co-infections** • **CD4 cell count enumeration** to determine whether a person has advanced HIV disease and requires further diagnostic investigation. • **Provision of prophylaxis** will be done, especially for PWID PLHIV. • **Provision of Hep C diagnosis and management** for PWID PLHIV.
Amount requested	US$ 335,901 (1.23% of the allocated budget)
Expected outcome	• 100% effective referrals for PLHIV with comorbidities in 2026. • 90% of Hep C-infected PWID PLHIV will be treated.

Module 8	TB/HIV
Intervention 8A	**TB/HIV - Collaborative interventions** Change in Programming from current grant: ☒ **Continuation**
List of activities	• **Six bi-annual TB/HIV coordination meetings** will be held to analyse programme data jointly; challenges, gaps and good practices at the implementation level will be analysed to improve the situation. • **12 Joint TB/HIV field missions will be organised** to interact with programme participants, clients/patients and healthcare providers.
Amount requested	US$ 652
Expected outcome	• 6 biannual meetings and 12 joint field missions held by 2026.
Intervention 8B	**TB/HIV - Screening, testing and diagnosis** Change in Programming from current grant: ☒ **Continuation**
List of activities	• **Screening of PLHIV for active TB**, including using X-rays /GeneXpert. • **Routine HIV screening among people with TB.** • Facility-based and peer-led community-based **verbal TB screening** for KP and linkage to DOTs centres if found presumptive.
Amount requested	US$ 1,206
Expected outcome	• 100% of PLHIV newly initiated on ART will be screened for TB.
Intervention 8C	**TB/HIV - Treatment and care** Change in Programming from current grant: ☒ **Continuation**
List of activities	• **Capacity building of service providers** in the TB & HIV program. • KP, TB patients, and the PLHIV network will be **oriented for better health-seeking behaviour** for accessing TB/HIV care and treatment. • Public health facilities, CDIC, and other **service delivery points will be made patient-friendly** for both TB/PLHIV to ensure treatment and care.
Amount requested	US$ 9,804 (0.04% of the allocated budget)
Expected outcome	Treatment service will be ensured for 100% of TB/HIV coinfected patients.
Intervention 8D	**TB/HIV – Prevention** Change in Programming from current grant: ☒ **Continuation**
List of activities	• **Regular counselling of PLHIV to initiate IPT** and ensure treatment completion. • **Capacity building of CPC and peer educators** regarding TB screening

	and IPT initiation.
Amount requested	No cost required
Expected outcome	Number of newly diagnosed PLHIV enrolled in IPT (76% enrolled in 2022), will be increased to 80%, 85%, 90% in 2024, 2025 and 2026).
Intervention 8E	**TB/HIV - Key populations** Change in Programming from current grant: ☒ **Continuation**
List of activities	• **Scale up active case finding of TB among KP** by conducting GeneXpert tests and strengthening TB/HIV referral systems. • Implement **community-based TB care and prevention programs** specifically for key populations to improve accessibility and appropriateness of services. • **Presumptive TB cases will be referred** to appropriate health facilities through effective referral systems for further diagnosis and treatment. • **Verbal TB screening will be conducted for KP** visiting DIC or at the community by peer educators at least once a year. • **Service providers of the HIV program will be trained** on TB-services. • **Case management** through home visits and one-to-one contact for ensuring TB treatment adherence through SACMO and PE.
Amount requested	US$ 9,229 (0.03% of the allocated budget)
Expected outcome	• Scale up TB services among KP from 70% to 90% by 2026. • 100% effective referral between the TB and HIV programs by 2026.

Reducing Human Rights-related Barriers to HIV/TB services:

Studies show that KP and PLHIV are subject to discrimination and harassment and often require societal and legal support [4, 10]. Gender-based violence (GBV) is also common, especially among KP, and is often perceived as “normative” in their life situations, thus not realised by them and goes unnoticed. KP also are either hesitant to access legal support or do not know of the existing system and where to go for support [11].

The activities planned to encounter and eliminate stigma and discrimination will focus on strengthening access of key populations, including PLHIV, to health, human rights and legal services and support by engaging with the authorities and by facilitating direct interaction of KP with the authorities and officials in these sectors. While some activities will focus on specific populations, others will address all KP and PLHIV in general for a collaborative, holistic approach. Support from the UN and legal-aid agencies will be sought when needed.

Module 9	**Reducing Human Rights-related Barriers to HIV/TB Services**
Intervention 9A	**Community mobilization and advocacy for human rights** Change in Programming from current grant: ☒ Continuation
List of activities	• **Capacity building for KP communities** under three networks (NPUD, SWN and NOP+) following existing good practices so they

	understand their rights and know mechanisms of how to access health and legal support, including training of peer human rights educators. • **Life-skills training among KP** who experienced human rights violations • **Media campaign** through development and broadcast of audio-visuals, documentaries, TV talk shows, round table discussions of TVC, street drama and folk songs. • **Continued meetings of DIC management/Advisory Committee** for creating/maintaining an enabling environment and **community level sensitization meetings** with relevant stakeholders for collaboration (including on FSW rights) • **For MSM specifically there will be revision of existing advocacy strategy** to include a media strategy and a strategy for stakeholder engagement, including with law enforcement agencies, health care providers, and religious and community leaders.
Amount requested	US$ 272,803 (1.00% of the allocated budget)
Expected outcome	• Enhanced efforts to increase access for KP to all services and support systems.
Intervention 9B	**Eliminating stigma and discrimination in all settings** Change in Programming from current grant: ☒ Continuation
	• Conduct the **3rd National Stigma Index** (PLHIV, including all KP). • Develop and disseminate a **national strategy for stigma reduction** along with an accountability mechanism based on evidence generated from consultations, including the 3rd National Stigma Index. • **Develop IEC materials on human rights** to be used by journalists, law enforcers, KP themselves, etc., on the rights of KP, people who have diseases, including communicable and infectious diseases, etc. • **Update policies, briefs and training manuals** to ensure GBV, 80-60-30 and other issues are included. • Orient **health service providers on patient rights and ethical requirements** about universal precautions for infection prevention. • Conduct **pre- and in-service training on patient rights and human rights for health care providers** (i.e., doctors, nurses, paramedics, support staff) **and authorities** of DICs, public and private health facilities and members of law enforcing agencies at priority districts. • **Conduct quarterly view exchange** meetings between hospital authorities and KP and **coordination** meetings between hospital authorities and comprehensive HIV care centres. • **Development of** a Training Module for Mental Health. • Conduct **training/orientation for journalists and social media personalities** to develop a critical mass of expertise for positive journalism and media messaging to decrease discriminatory views linked to workshops, media events, “Day” celebrations, talk shows, etc.

	• Innovations such as arranging for **Human Rights Fairs and social media events** will also contribute to advocacy efforts. • **Joint monitoring visits will be conducted** to implementation sites with stakeholders (BCCM members, ASP, NTP, PRs, UN agencies) to understand human rights related to TB/HIV and suggest actions. • **Piloting of ID cards for PUD on OST and ART** to track them properly for connecting with prison intervention (in selected areas). • **Development of two policy briefs on harm reduction and HIV** in collaboration with the regional support group, INPUD and UN agencies. • Recording and reporting systems to **record and link cases of human rights violations/GBV to legal authorities** will be developed, linked to efforts to strengthen CLM. • **Capacity building of SACMOs and network members** on mental/ psychosocial health to support post violence care, especially for FSW. • **Consultations to review advocacy strategies for KP**, including a media strategy and stakeholder engagement strategy, including law enforcement agencies, health care providers, religious and community leaders, based on learning from the existing MSM strategy. • **SOP will be developed** to address sexuality, gender power relations, access to health, UHC, and health equity and equality issues among MSM/MSW. • **Develop an App** on legal rights, human rights, and GBV issues to increase awareness of the human rights of KP. • **Set up a hotline** to address health/human rights violations/GBV of KP.
Amount requested	US$ 327,898 (1.20% of the allocated budget)
Expected outcome	• Reduced stigma and discrimination against KP as reported by CLM and the Stigma Index. • Strengthened national reporting system related to HR violations.
Intervention 9C	**Ensuring rights-based law enforcement practices** Change in Programming from current grant: ☒ Continuation
	• **Organize TOT for police** through the leadership of ASP and the Police Staff College based on the training manual on harm reduction and other HIV prevention interventions developed for the police. The manual will be updated to include GBV. Trained Police will then support orientation and training for district-level police. • **Establish working committees/ groups with KP communities and local police focal persons** to improve policing practices. DIC Advisory Committee will ensure more engagement of local people with interventions to address human rights related barriers.
Amount requested	US$ 55,426 (0.20% of the allocated budget)

Expected outcome	• Law enforcers are more supportive of KP issues and HIV prevention interventions.
Intervention 9D	**Improving laws, regulations and polices relating to HIV and HIV/TB** Change in Programming from current grant: ☒Continuation
	• **Consultation meeting with National Task Force** (NTF) and other stakeholders on legal issues of KP to support NTF in **developing medium- and long-term action plans based on the HR strategy**, and recommendations from the Human Rights Assessment and the 3rd National Stigma Index. • **Consultative workshop** with prominent lawyers and human rights experts to review punitive laws for KP. Policy level advocacy meeting with parliamentarians to pass and enact ant discriminatory law for KP. • Arrange policy dialogues, media events, round table discussions, workshops, etc. through the leadership of departments and commissions under the Ministries of Home Affairs; and Law, Justice and Parliamentary Affairs **to enhance understanding of barriers that KP and PLHIV face** and carry forward ways to overcome these barriers, including advocacy for the rapid endorsement of the Anti-discriminatory Act and further **review of punitive laws**. • **Regular meetings with human rights advisory group** members. • Activities to adequately **engage the Department of Narcotics Control (DNC) and the Police to support harm reduction** from a public health viewpoint will be conducted from the central to the district level. These activities will include continued advocacy, especially for the Decriminalization of Drug Dependency (Triple D) Framework (developed in the previous grant).
Amount requested	US$ 243,644 (0.89% of the allocated budget)
Expected outcome	• Enhanced efforts to reform punitive laws.
Intervention 9E	**Increasing access to justice (HIV/TB)** Change in Programming from current grant: ☒Continuation
	• **Divisional-level legal support and crisis management groups will be formed** in 8 divisions of Bangladesh to which critical and complex cases are referred. The divisional level groups will be supported by a central legal and human rights advisory group, formed from among human rights activists, journalists, UN partners, researchers, and policy stakeholders who will lead the activity from the national level. • **Community paralegals will be deployed and will work with human rights PE** to look after the legal issues of MSM and hijra at the field level. A legal coordinator will be recruited to support the community paralegals and link victims of abuse to district-level lawyers' groups. • Provide gender, sexuality and HIV **training** to **community paralegals**

	• Provide **training/orientation on harm reduction, gender, sexuality, and dynamics of different KP** to law enforcers, paralegals, lawyers, and human rights activists. • Good practices in **accessing pro bono services** will be expanded so all KP and PLHIV can access legal support. Law enforcers (including through the LEAHN: Law Enforcement and HIV Network), pro bono lawyers will be engaged through the DLAC.
Amount requested	US$ 219,214 (0.80% of the allocated budget)
Expected outcome	• Enhanced efforts to increase legal access for KP
Intervention 9F	**Legal literacy ("Know Your Rights") (HIV/TB)** Change in Programming from current grant: ☒ Continuation
	• **Capacity building for KP communities** on legal literacy. • **Pot Song/ Street Drama** in different districts in KP spot on Human Rights/ HIV. • Development and distribution of **booklet on human rights.**
Amount requested	US$ 74,237 (0.27% of the allocated budget)
Expected outcome	• KP have a better understanding on their rights for better access.
Intervention 9G	**Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity** Change in Programming from current grant: ☒ Continuation
	• Continue the current practices of **appointing focal persons at service delivery points to record, report and mitigate GBV, harassment and other human rights violations**. Focal persons capacity shall be enhanced through continued training. • **Participatory assessment of the gender responsiveness of programs and human rights of KP** with a particular focus on MSM and hijra across intervention districts in Bangladesh to understand intersectionality, to make interventions more acceptable and friendly. • **Orientation for lawyers** and human rights activists on gender, sexuality, and HIV. • **Rescue and referral** of FSW.
Amount requested	US$ 58,206 (0.21% of the allocated budget)
Expected outcome	• Strengthened national reporting system and mitigation related to GBV.

Resilient and Sustainable Systems for Health (RSSH):

In Bangladesh, the establishment of a Community-Led Monitoring system is at an early stage. A community-based participatory monitoring process, which is a fundamental component of CLM, is in operation under the GF grant, encompassing various KP, which began with gender and sexually diverse populations in 2010. The basic tenet of CLM is to ensure the voices of communities are systematically and meaningfully heard to change the program design to be more people-centred and people-friendly.

It is essential to resume the systematic capacity building of CBOs/networks in Bangladesh in the areas of program monitoring, implementation, advocacy, and leadership, among others. This is to assure that community-centred services are provided. CBOs and networks have demonstrated their ability and show a willingness to strengthen their capacity to comply with governance, programmatic, financial, and monitoring requirements.

Over the duration of the Global Fund HIV grants, PWID, FSW, MSM, TG and PLHIV CSOs and Networks have been partnering directly with PRs, taking part in the interventions and playing a vital role in advocacy, outreach etc. As a result, recent GF missions [12] and the JMM observed good practices and/or substantial improvements in Outreach Interventions.

According to TRP Issue-3, action Point-2, during the funding process of GC6 in Bangladesh, HIV grant PRs studied the possibility of conducting consolidated procurement for common health products (HP) through a single PR. A joint PR committee was formed in this regard, and it furnished three recommendations to GF:

- Initiate consolidated procurement of selected items by ASP using Wambo Platform (Timeline: Jan 2022)
- Inclusion of consolidated procurement of more HIV Rapid Diagnostic Test (RDT) kits, based on the success of recommendation 1 (Timeline: Jan 2023)
- Selection of a single PR based on overall cost-effectiveness for conducting in-country pool procurement for products (apart from RDTs) (Timeline: Jul 2023)

As a result, jointly-ordered HIV test kits are expected to arrive in Dhaka soon, and those will be delivered to the PRs after custom clearance. NGO PRs have already placed their six-months buffer requirements for 2024. Recommendation 3 of the committee report has not yet been started, although ASP supplied HIV test kits for both PRs from its own sources in April 2023.

Drawing from this experience, it appears that extending the procurement to include additional items like condoms and syringes could present policy issues in Bangladesh. This is because procuring domestically manufactured items, procurement through the Wambo platform becomes impossible. Therefore, ASP might continue with the consolidated procurement of Determine, Unigold, First Response, Syphilis, self-test kits, and viral load test cartridges, while other items might be procured through NGO PRs' mechanisms. Under the current grant, ASP partially supports NGO PRs with commodities from the 4th Health Sector Operational Plan (OP) fund. Condoms, syringes, and methadone are supplied upon request and are readily available in stock at the Central Medical Stores Depot (CMSD). The ASP has pledged to ensure the supply of the aforementioned items from the 5th (forthcoming) OP starting from the second year of the grant, with planned quantities already declared by the national body.

On the other hand, both NGO PRs are fully equipped with PSM professionals. They maintain separate and large procurement departments able to clear large quantities of HPs at customs quickly. In addition, PR icddr,b is exempted from VAT, tax, and import duties. Both NGO PRs possess a robust supplier network, automated logistic management system, and modern warehouses. Ordering HPs via the NGO PRs, in line with recommendation 3 of the procurement consolidation committee, will offer cost efficiency, as well as lower lead time.

Numerous training sessions were conducted under the current grant, aimed at strengthening the capacity, attitudes and friendliness towards KP of the Government of Bangladesh's health service providers. Anecdotally, this has led to an improvement in service quality and improved attitudes towards KP.

Quarterly reporting to DHIS2 occurs for all facilities and entities, including governmental and non-governmental organisations, and is led and supervised by the National program. Currently, 24 government facility entities covering ART/HTS, 115 DIC facilities implemented by PR, SR, and SSR and nine prison facilities are working on the prison intervention report to DHIS2, for a total of 148 reporting entities. The data collected is used to improve services.

A transition from combining a Community Information System (CIS) and Excel-based reporting system to a comprehensive PLHIV database reporting system has been initiated to track treatment, care, and support services and this will be continued.

Additionally, implementing an HIV Management Information System (HIV-MIS) is being considered to further improve monitoring and management. With the MIS in place, it will be possible to effectively track preventive measures and treatment care support provided to individuals affected by HIV. As the system gradually incorporates all relevant service centres, it will play a crucial role in monitoring progress in implementation and facilitating a smooth handover of responsibilities to the government.

Module 10	**Resilient and Sustainable System for Health (RSSH): Community Systems Strengthening**
Intervention 10A	**Community-led monitoring** Change in Programming from current grant: ☒ New, ☒ Continuation
List of activities	• Community monitoring systems and activities will be integrated into **one uniform CLM system for all KP** across all PRs and across the HIV and TB programs, learning from past experiences and other countries. • **Common CLM tools will be developed** in a participatory manner. • **KP/networks/ CBOs will be trained** on CLM using the tools. • **CLM focal persons will be employed in each intervention area**, responsible for reporting and sharing of CLM findings, resulting in improvements in HIV/STI/TB services, supervised by a CLM coordinator who will be responsible for the quality and implementation of CLM results. • An **annual review of the CLM system** will be conducted with stakeholders.
Amount requested	US$ 140,368 (0.51% of the allocated budget)
Expected outcome	• Enhanced HIV-related service uptake among KP. • Increased access and service uptake under universal health coverage. • KP networks/CBOs will be capacitated in CLM.
Intervention 10B	**Community-led research and advocacy** Change in Programming from current grant: ☒ Continuation
List of activities	• A **comprehensive situational analysis of existing community systems**, including community-led mapping of legal, policy, and other barriers to increased community involvement will be conducted.

	• The **reporting system for Gender-Based Violence (GBV) and human rights issues** to CBOs and Networks will be expanded. This should be supplemented with data collection and analysis. • Community led consultations will be convened about **punitive laws**, with participation from the Law Enforcement and HIV Network (LEAHN), relevant government officials, and other stakeholders based on recommendations from event described in Module 9. • **Local advocacy initiatives** will be organized to improve access to government-implemented HIV/STI prevention services, led by local support groups, community groups, and task forces.
Amount requested	US$ 11,878 (0.04% of the allocated budget)
Expected outcome	• Enhanced HIV-related service uptake among KP through strengthened evidence-based advocacy and implementation. • KP/network will be capacitated to conduct advocacy events/initiatives.
Intervention 10C	**Capacity building and leadership development** Change in Programming from current grant: ☒ Continuation
List of activities	• **Systematic capacity building will be conducted** based on the Assessment (see 10B) to strengthen CBOs, including on management, governance, and donor compliance (Finance, HR, PSM). • **Fundraising campaigns** will be conducted annually for all KP networks.
Amount requested	US$ 239,948 (0.88% of the allocated budget)
Expected outcome	• KP networks/CBOs will have sustained capacity in program monitoring and implementation and quality enhanced through community engagement. • Good governance and management practice will be established within CBOs/Networks, complementing the other modular activities under CSS for RSSH. • Due to enhancement of capacity and compliance, CBOs/Networks will be able to access new resources and support.
Intervention 10D	**Community engagement, linkages and coordination** Change in Programming from current grant: ☒ **Continuation**
List of activities	• **Coordination meetings** among Executive Committees of three networks with PR and other SRs (semi-annually). • **Semi-annual coordination meetings** among the General Committee Members of the three networks separately, to enhance good governance. • **Service centres' operational cost** to ensure safe space for KP • Meetings of Bandhu, NPUD, SWN and NOP+ and other community-based groups or **forums with local stakeholders** including LEAHN and DNC.
Amount requested	US$ 1,138,495 (4.16% of the allocated budget)

Expected outcome	• Communities will be more engaged in HIV interventions by ownership of program delivery, monitoring etc, thus improving program quality. • Enhanced coordination among CBO members, leaders and implementers.

Module 11	**Resilient and Sustainable System for Health (RSSH): Health Product Management**
Intervention 11A	**Planning and procurement capacity** Change in Programming from current grant: ☒ Continuation
List of activities	• Management of the **consolidated procurement of three major HIV RDT kits** for the program – Determine/Duo, Unigold, and First Response – as well as Syphilis and V/L cartridges via the Wambo Platform in GC7 by ASP. • PR will choose **fixed-priced LTA** to reduce the risk of price fluctuations. • **Other health products such as condoms, syringes, methadone, and STI/abscess management drugs**, among others, will be acquired through their respective NGO PRs via their PSM mechanisms. • ASP, in collaboration with the NTCP, will enhance its capabilities with a **dedicated warehouse facility** to be used by all PRs for storing HTS kits. • ASP also plans to refurbish a room in the district hospital/medical college for **the storage of prevention commodities**.
Amount requested	US$ 32,828 (0.12% of the allocated budget)
Expected outcomes	• Consolidated procurement will help implement PR to lower the unit cost due to economies of scale and minimized system losses. • The warehouse will maintain additional buffers to support during a pandemic or other disturbance in the supply chain system. • Increased control and efficiency.
Intervention 11B	**Supply chain information systems** Change in Programming from current grant: ☒ New
List of activities	• ASP will **develop an electronic Logistics Management Information System (eLMIS) and Warehouse Management Systems (WMS)**, including the development of a master data/national product catalogue, setting up systems for forecasting and supply planning, order management, transport management, and regulatory data information systems to ensure that health commodities of the right quantity and quality are consistently available. • ASP will **integrate a software-based WMS** to streamline operations across all warehouses. • ASP will hold **consultation meetings** to devise a template or comprehensive requirement outline for the LMIS with the participation of various stakeholders. ASP plans to engage an IT consulting firm to develop and maintain the eLMIS and WMS.

	• To ensure the systems' effective use, ASP will **organize training for all relevant personnel**, including Centre Managers, Counsellors (responsible for maintaining stock), Data Assistants, and the head office PSM team. • **Systems of all three PRs will be integrated** in order to create a coordinated efficient data and information system, allowing for real-time monitoring of health product stock status and distribution among PRs/KP.
Amount requested	US$ 8,574 (0.03% of the allocated budget)
Expected outcome	• Capture and distribution of accurate, timely consumption data, leading to more efficient supply chain operations. • Integration of systems leads to comprehensive management of health commodity logistics from origin to consumption, enhancing supply chain reliability. • The new systems will enable advanced demand forecasting and capacity planning, based on consumption data, facilitating strategic and efficient supply management by ASP.
Intervention 11C	**Storage and distribution capacity, design and operation** Change in Programming from current grant: ☒ Scale-up
List of activities	• Operate two warehouses in Dhaka for storing methadone and condoms. • Upgrade four storage spaces in district level hospitals (refurbishment).
Amount requested	US$ 76,532 (0.28% of the allocated budget)
Expected outcome	• **Decentralization of storage** for smooth supply chain management of health products.
Intervention 11D	**Regulatory/quality assurance support** Change in Programming from current grant: ☒ Scale-up
List of activities	• Regular **Quality testing of health products.**
Amount requested	US$ 22,699 (0.08% of the allocated budget)
Expected outcome	• Quality of health product will be ensured.

Module 12	**Human Resources for Health (HRH) and Quality of Care**
Intervention 12A	**RSSH/PP: Remuneration and deployment of existing/new staff (excluding community health workers)** Change in Programming from current grant: ☒ Scale-up
List of Activities	• The PRs will **meticulously reassess and reinstate their human resources personnel** within the Programme Management Unit, basing their decisions on comprehensive performance evaluations as per the established organisational policies.

	• A **systematic recruitment process** will be implemented to fill newly proposed positions. • **ASP will assume administrative responsibility for all incumbent DSMOs** based in the 23 HIV priority districts. It is anticipated that the whole procedure will be completed at the end of 2025, and reassignment will occur from January 2026. • **DSMOs will receive training** focusing on the implementation, monitoring, and coordination of activities within their respective districts, specifically related to TB, Malaria, and AIDS responses. • **A Regional Technical Officer** will provide technical guidance to clinical staff, to support the integration of clinical services with nearby GoB health facilities and provide technical support for health system strengthening. As part of transition, this position will be handed over the key roles to District Surveillance Medical Officer (DSMO). • **Human resources will be trained** in various areas including MT lab, Counsellors, and support staff across all 64 districts in the 5th OP. • The programme management staff, the government revenue staff of the National AIDS/STD Control (NASC), and the operational plan personnel will be equipped to **supervise and monitor interventions at the field level**, in strict accordance with the Management Implementation Plan (MIP). This includes 'supportive supervision'.
Amount Requested	US$ 697,469 (2.55% of the allocated budget)
Expected Outcome	• Continued human resources under OP along with government service providers, ensuring effective implementation of the HIV program.
Intervention 12B	**RSSH/PP: Integrated supportive supervision for health workers (excluding CHWs)** Change in Programming from current grant: ☒ Scale-up
List of activities	• Development of **guidance and plans for integrated supportive supervision**. This will involve group problem-solving sessions, mentorship, and performance data audits, informed by active community engagement. • **Development of tools and digital checklists** designed for integrated supportive supervision, in a robust, consistent approach. • **Training of supervisors on standard operating procedures** for integrated supportive supervision. This will include instruction on the use of data, group problem-solving techniques for performance improvement, and development of leadership & management skills. • **Conduct integrated supportive supervision visits**, including the supervision of supervisors in their planning and delivery capacities. Teams will include CS, law enforcement department, PRs and other experts, coordinated by DSMO.
Amount requested	US$ 16,062 (0.06% of the allocated budget)

Expected outcome	A high level of professionalism and efficacy will be maintained, making a tangible difference in the communities to be served.

Module 13	**RSSH: Monitoring and Evaluation Systems**
Intervention 13A	**Routine reporting** Change in Programming from current grant: ☒ Continuation
List of activities	• Continue strengthening the new comprehensive **PLHIV database reporting system.** • Implement an **HIV Management Information System** (HIV-MIS) to further improve monitoring and management, making it possible to effectively track preventive measures and treatment care support per individual. • On-site visits will be organised to focus on **reviewing data collection processes**, ensuring accuracy, and identifying inconsistencies. • Regular **feedback and online meetings** will be held to facilitate the improvement of data collection practices and the resolution of problems. • Program partners will sustain the existing **Routine Data Quality Assessment (RDQA) system** to monitor reporting indicators from service delivery centres. • The distribution of commodities, such as condoms, lubricants, and sterile injecting equipment, will be **recorded quarterly through DHIS2**. • **Increased oversight monitoring** will be implemented with implementing partners, aiming to enhance the effectiveness of interventions. • **Improve the IBBS**, enabling it to extract data by age and type of KP. • **Training of the relevant staff** will take place.
Amount Requested	US$ 788,122 (2.88% of the allocated budget)
Expected outcome	• Program progress can be easily tracked, enabling informed decisions. • The establishment of a PLHIV database and implementation of the HIV Management Information System (HIV-MIS) will significantly enhance the sustainability of program interventions.
Intervention 13B	**Data quality** Change in Programming from current grant: ☒ Continuation
List of activities	• Regular **data quality audits/reviews, assessments, and validation** will be conducted across implementation areas of partners through oversight visits, meetings, workshops and virtual interactions. • **Joint supportive supervisory visits** to all HTS, ART, and KP centres on a regular basis. • **Training and supportive supervision** on data collection, quality assurance, reporting, and implementing data quality improvement. • **Hands-on training to ART centre personnel** about of PLHIV database, KP database, LMIS, HIV-MIS.

	• The development of a **unique user ID for key population interventions** will be initiated as a pilot program.
Amount requested	US$ 35,096 (0.13% of the allocated budget)
Expected outcome	• Data quality ensured through effective validation. • Quality data will be accessible for decision making.
Intervention 13c	**Analyses, evaluations, reviews, and data use** Change in Programming from current grant: ☒ Scale-up
List of activities	• Conduct **participatory rapid assessments** in collaboration with community groups, management authorities, and program staff to improve planning and implementation at the sites. • Organize regular meetings (quarterly, bi-annual, annual) of various CBOs, working groups, and technical groups to **analyze information, disseminate reports and make informed decisions**, addressing community needs. • Hold (bi-)annual **coordination and performance review** meetings with hospital directors/superintendents and stakeholders at the central level. • Conduct **quarterly working group meetings** (M&E) at the central level. • Facilitate **monthly virtual meetings with ART focal points**, medical officers, counselors, MT-Lab staff, and outreach supervisors. • Conduct **program reviews** in year 2 and year 3.
Amount requested	US$ 392,326 (1.43% of the allocated budget)
Expected outcome	• Programme evidence will be generated and will be used for efficient implementation and sustainability. • Community voices will be heard and their suggestions and recommendations used in programme implementation.

Module 14	**Program Management**
Intervention 14A:	**Grant management** Change in Programming from current grant: ☒ Continuation
Activities	• PR proposes a **new organogram for programming** in the next grant. Based on performance and skill, existing staff members will be re-hired, re-designated, and will be contracted timely (before the new grant starts). • **Capacity building for SR/SSR project management** (Program, M&E, PSM, finance, etc.) will be organised. Project start-ups, annual program review workshops and partner meetings will be held to ensure high quality program implementation. • **Monthly data reviews of routine facility data** and feedback surveys at the facility level will be facilitated on the CIS dashboards. Regular monitoring visits, RDQA, and explorative reviews will guide the identification of gaps,

	challenges, and needed improvements to comply with requirements. • **A smooth supply** of health products, pharmaceutical products, consumables, etc. is essential for prevention services for KP with timely and quality products as per WHO/CE/ISO certified manufacturers. • **Financial monitoring visits** to partner organisations will be conducted to ensure financial transparency and authenticity of expenditures and also conduct timely external audits, which is integral to the grant.
Amount requested	US$ 5,695,816 (20.79% of the allocated budget)
Expected outcome	• Successful identification and mitigation of program implementation bottlenecks resulting in a well-managed program. • All targets and indicators of the approved work plan and performance framework are successfully met. • Timely submission of PU/DR and other necessary reports to the GF. • Timely and efficient completion of audits. • The HIV program achieves high-performance ratings from the Global Fund.
Intervention 14B:	**Coordination and management of national disease control programmes** Change in Programming from current grant: ☒ Continuation
Activities	• Conduct quarterly and yearly coordination **meetings** among PRs, SRs and other stakeholders, head quarter based and hospital-based staff members. • Provide **capacity building support** to GOB (field operational staff) & GF Project staff on finance, HR management, procurement etc. • **Cross learning** by attending international conferences. • Organize district **coordination workshops.** • Day observations (World AIDS Day, Human Rights Day etc).
Amount requested	US$ 82,861 (0.30% of the allocated budget)
Expected outcome	• Improve HIV program management capacity. • Sharing of best practise with regional and international forums. • Strengthen multi-sectoral coordination in response to HIV prevention.

Section 2. Matching Funds (if applicable)

If Matching Funds were designated for the 2023-2025 allocation period:

A. Describe how integrating Matching Funds will increase the impact and improve the allocation outcome for the Matching Funds area.

A.1. HIV Prevention

Developing sustainable service delivery model and cost-effective intervention: The HIV response for KP adopts a two-pronged service delivery approach: first, DICs/outlets for providing clinical services, health product storage, reporting, and recording, along with peer-led community-based outreach with outreach workers recruited from among KP, and second, substituting DICs/outlets with government hospitals to attain long-term sustainability and cost efficiency in a gradual process. A transition readiness plan is in development to integrate HIV prevention services into government centres. However, the socio-legal context, including stringent penalties under the 2018 Narcotics Control Act and laws against same-sex relations and sex work, presents formidable challenges for KP and KP NGOs/CSOs.

Scale up of HIV prevention program: Bangladesh aims to refocus its KP program and scale it up in key programmatic areas aligned with the GF 'programme essentials'.

Strengthening systems for HIV prevention: In the upcoming grant, community strengthening will be a key focus. Initiatives will include mentoring and training on leadership; participatory monitoring; various compliance issues on good management practices; in-depth understanding of the program, including legal, psychosocial, human rights and other structural barriers. It is expected that these training efforts will lead to increased capacity and engagement and higher quality of HIV services for KP and PLHIV.

In terms of outcomes, the model aims to achieve sustained behaviour change among KP, and improved services so that KP voluntarily access health services provided by the government. Community systems strengthening will empower KP to reduce HIV risk and improve health-seeking behaviours.

A.2. Scaling Up Programs to Remove Human Rights-and Gender-related Barriers to Health Services

KP and PLHIV continue to experience human rights- and gender-related barriers to health services. A rights-based approach is essential to ending the HIV epidemic. Rights-based approaches create an enabling environment for successful HIV responses and affirm the dignity of PLHIV and KP. This includes a reduction of stigma and discrimination in health settings, removing punitive laws and policies and eliminating gender inequality and GBV.

The program to improve human rights and remove gender-related barriers intends to strengthen the enabling environment, which will, in turn, support efforts to reduce HIV incidence and improve HIV case finding and treatment outcomes for PLHIV.

B. Describe how programmatic and access conditions have been met.

The matching fund requested for scaling up of programs for HIV prevention services among KP and to remove human rights and gender-related barriers aims to engage relevant government departments, legal-aid agencies, pro-bono lawyers, district-level judges, law enforcers, and policymakers in policy advocacy. Also, it aims to further expand prevention services among KP. The Government health sector programme will continue to provide treatment and care services among PLHIV and HIV testing services at the 11 ART centres and 28 HTS centres using domestic resources. Additionally, in the upcoming 5th Health

Sector Program, ASP is proposing to provide HIV/STI prevention services among KP which encompass human rights and gender rights activities, including media campaigns.

B.1. HIV Prevention

Status of the access conditions:

Strategic Priority Areas	Access Conditions	Status
HIV prevention for key populations and their sexual partners	(a) Invest a portion of the HIV allocation that is at least 1.5 times greater than the amount of available Matching Funds, in HIV prevention for key populations; and	(a) The funding allocated in the funding request is for condom and lubricant programming, SRH, HTS, human rights, community systems strengthening and ART for all KP; OST and NSE for PWID and PrEP for MSM/MSW/Hijra. The funding request for GC7 is primarily focused on prevention interventions for KP. Hence, it is expected that this condition is met.
	(b) Maintain or increase the level of investment in HIV prevention activities from the country's 2020-2022 HIV allocation in its 2023-2025 HIV allocation.	(b) The level of investment in HIV prevention activities proposed in the 2023-2025 allocation has been substantially increased compared to the country's 2020-2022 HIV allocation (from USD 13,428,283 in NFM3 to 14,198,494 in GC7).

Status of programmatic conditions:

Strategic Priority Areas	Programmatic conditions	Status
HIV prevention for key populations and their sexual partners	(a) Population size estimation for key populations	(a) This has been completed in 2023. The intervention design of GC7 is developed based on the PSE 2023.
	(b) Expansion of service delivery platforms to deliver HIV prevention program essentials	(b) Expansion of service delivery platforms such as CBOs and networks, secondary channels e.g. pharmacies, shops, syringe vending machines, mobile vans and virtual platforms have been scaled up for GC7.
	(c) Inclusion of a plan and budget for strengthened HIV prevention data systems.	(c) National online HMIS is in place, and operated using the DHIS-2 platform. Data quality is ensured through routine RDQA. It is planned to collect data related to individual HIV prevention service use for improving

	(d) Introduce, plan and budget innovative approaches for HIV prevention (e) HIV/STI prevention program stewardship and coordination that engage key stakeholders	implementation. The program also plans to implement CLM. (d) Innovations include Duo kits for HIV/syphilis testing, prioritized HIV prevention and testing and treatment for KP at government facilities, lay providers testing, virtual intervention for self-identified gay men and FSW and PrEP for MSM etc. (e) To improve HIV/STI prevention program stewardship and engagement of stakeholders, especially priority populations and relevant critical multi-sectoral key players has been ensured during country dialogue and the National Strategic Plan development (2024-2029 period) process.

B.2. Scaling Up Programs to Remove Human Rights-and Gender-related Barriers to Health Services

Status of the access conditions:

For countries receiving Human Rights Matching Funds for the first time in the 2023-2025 allocation period	Status
At least a 1:1 match of the amount of Matching Funds indicated in the Allocation Letter, from within their HIV and/or HIV/TB allocation**.**	USD 294,675. has been allocated for human rights-related activities in the upcoming grant. Alongside this allocation, an additional budget of USD 1 million has been planned from the human rights matching fund. It should be noted that due to the expansion of existing programs for MSM, MSW, and PWID, including costly interventions such as PrEP, OST, hepatitis C management, and geographical prioritizations, it was not possible to allocate 1 million from the country's regular allocated funding. However, by utilizing the matching funds, a total of 1 million USD has been budgeted strategically, taking into account a comprehensive understanding of the KP and the country's context. Recognizing that a similar amount from the country's regular allocation is unattainable, efforts are being made to secure dedicated funds for the human rights and gender agenda in the next OP funding. The OP fund is anticipated to allocate the remaining amount and address gaps and new areas identified in the human rights assessment. Attached is a letter from the Line Director of ASP, providing further information on this matter [13].

Status of programmatic conditions:

For countries receiving Human Rights Matching Funds for the first time in the 2023-2025 allocation period	Status
1. The applicant has recently undertaken an assessment of human rights-related barriers and programs to remove such barriers; has determined baseline scores for each human rights program area during country dialogue, to enable progress reporting under the Global Fund's KPI E1; has attached the assessment and baseline scores to the funding request; and undertakes to do an annual review of progress (following Global Fund guidance) to enable continued reporting under KPI E1.	1. A process of rapid assessment to determine the human rights situation towards HIV services for key population and setting baseline score has been started. In consultation with the Global Fund, consultants are currently being recruited. The assessment will be completed in August 2023. The condition will be met during the year 2023.
2. The funding request reflects the findings of the assessment of human rights-related barriers and programs, with a particular focus on advancing progress towards full implementation of all human rights program essentials, and an emphasis on reducing stigma and discrimination, removing harmful laws, policies and practices, including through community-led efforts, and on integration of human rights programs in key population programs.	2. The funding request has taken into account the human rights program essentials emphasizing the reduction of stigma and discrimination and harmful laws, policies and practices through various strategies, including community-led efforts. Strategic approaches include integration of interventions to reduce human rights- and gender-related barriers into the HIV programs for KP; stigma and discrimination reduction activities for PLHIV and KP in health care and other settings; developing legal literacy and access to justice for KP; promotion of community-led efforts reduce harmful laws, policies and practices that hinder the HIV responses.
3. The country undertakes to develop or update, within a year of the start of the grant, a national strategy or plan to remove human rights-related barriers to HIV services (and TB if the country uses Matching Funds for programs to reduce human rights-related barriers to TB), including a monitoring, evaluation and learning framework and accountability levers; and establishes a mechanism that coordinates implementation and oversight of the strategy or plan.	3. A National Strategic Plan for Human Rights for the HIV response will be developed. This will be based on the assessment report, programme data and other reference documents. Several consultations will be organized with KP networks/CBOs, health service providers, human rights organizations, law enforcement agencies, UN organizations and technical experts to finalize the strategic plan, which will have a costed result-based framework. There will be a clear strategy to monitor progress of implementing the plan. It is expected the Plan will be completed within a year of the start of the GC7 grant.

Section 3. What has changed: updates in epidemiology context and National Policies and Strategies

Have there been any significant changes to the following:

A. Country's epidemiological context since the last funding request

☐ Yes ☒ No

The first case of HIV in Bangladesh was identified in 1989 [14] and the prevalence of HIV among the general population remains less than 0.01% [15]. Data released on World AIDS Day showed that new HIV diagnoses are on the rise (Figure 5), and up until now, only 66.9% out of 14,513 estimated HIV cases in Bangladesh have been diagnosed [2]. During the last year (since World AIDS Day 2021), 947 new HIV infections were detected, and 232 have died (Figure 5, [2]. ART coverage is 77%, and 90% of PLHIV on ART are virally suppressed [2].

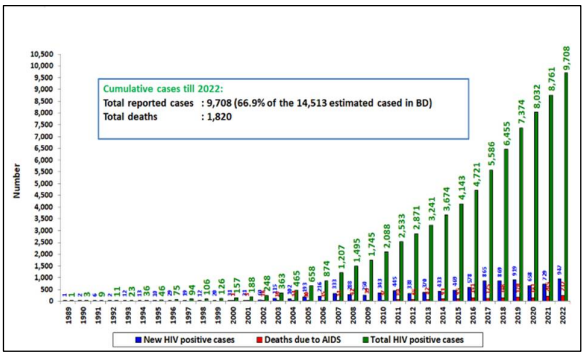


Figure 5: Cumulative and Annual Number of reported HIV cases in Bangladesh (1989-2022)

The prevalence of HIV for all KP combined in Bangladesh significantly declined from 3.9% in 2016 [16] to 1.3% in 2020 [4]. KP are defined as men having sex with men (MSM—who also include male sex workers (MSW)), female sex workers (FSW) (all types of female sex workers were combined as FSW), people who inject drugs (PWID, including males and females) and *hijra*. Although the epidemic of HIV among all KP has declined, data from the integrated biological and behavioural surveillance (IBBS, 2020), shows that the HIV epidemic is still being driven by PWID, followed by MSM (including MSW) in Dhaka and other parts of Bangladesh. In Dhaka, the prevalence of HIV among PWID has significantly declined from 20.0% in 2016 to 5.1% in 2020 (Figure 6, [16] and [4]). The prevalence of HIV among MSM (including MSW) has significantly increased in Dhaka from 0.5% in 2015 to 3.1% in 2020 (Figure 6, [17] and [4]). This increase demands special attention, the AIDS Epidemic Model (AEM) already predicted that MSM might start to play an increasing role in the HIV epidemic in Dhaka and other parts of Bangladesh [18]. It is critical to note that in several cities in the region and globally, MSM have experienced a very high HIV prevalence and increases in incidence in recent years. Significant increases were recorded over time to 43.3% in Malaysia in 2017, 27.7% in Indonesia in 2018 and 22.7% in Vietnam in 2020, Figure 6 [19]. HIV among MSM will likely be the next big wave of new infections in Bangladesh, similar to other countries in the region. On the other hand, the HIV prevalence among all types of FSW and hijra in Dhaka did not change in 2020 compared to the last HIV surveillance round conducted in 2016 (Figure 6, [16], [4], [17], [4]). However, it has to be noted that the demand for sex provided by FSW and hijra sex workers has not reduced over the surveillance rounds, and condom use also has not increased. HIV interventions need to be continued and made more effective among these groups.

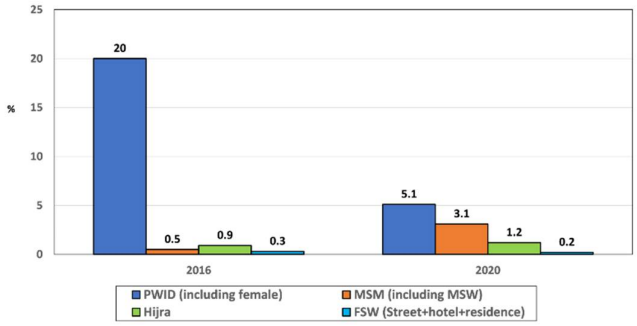


Figure 6: Prevalence of HIV among KP in Dhaka 2016 vs. 2020

Active syphilis and HCV:

In Dhaka, the prevalence of active syphilis has significantly increased among MSM (including MSW) from 1.4% in 2016 [17] to 13.9% in 2020 [4], for all types of FSW from 1.6% in 2016 [16] to 5.6% in 2020 [4] and for hijra from 2.1% in 2016 [17] to 12.8% in 2020 [4]. No significant difference was observed in the prevalence of active syphilis among PWID (male and female) between 2016 (3.0%, [16] and 2020 (4.6%, [4]), Figure 7. The combined prevalence of active syphilis for all KP in Bangladesh also increased significantly ($p<0.05$) from 2.1% in 2016 [16] to 5.7% in 2020 [4]. These increased syphilis prevalence figures are not fully aligned with HIV prevalence among KP nor with reductions in safer sex behaviours. Continued HIV surveillance is needed, critically reviewing serological and behavioural findings, examining antimicrobial resistance and programmatic gaps and literature of the other countries. All these need to be looked at in future research in Bangladesh.

HCV has always been found at an alarming rate among PWID in some areas during the HIV surveillance rounds. In 2011, the prevalence of HCV among PWID was 69.6% in Rajshahi, 89.1% in Chapainawabganj, 95.7% in Kanshat and 39.6% in Dhaka [20]. The results of IBBS 2020 showed that HCV was reported in 32.5% of male and female PWID in Dhaka [4]. The IBBS 2020 also reported a very high prevalence of HCV among male and female PWID in Narayanganj (15%), Cumilla (19.7%), Gazipur (40.3%), Rajshahi (39.3%) and Chapainawabganj (68.5%) [4]. In 2022, HCV was found among 34 OST clients (26.4%) out of 129 tested in an OST centre of icddr,b as evident in program data. Thus, more attention is needed to integrate HCV testing and treatment alongside HIV and harm reduction interventions in the coming years.

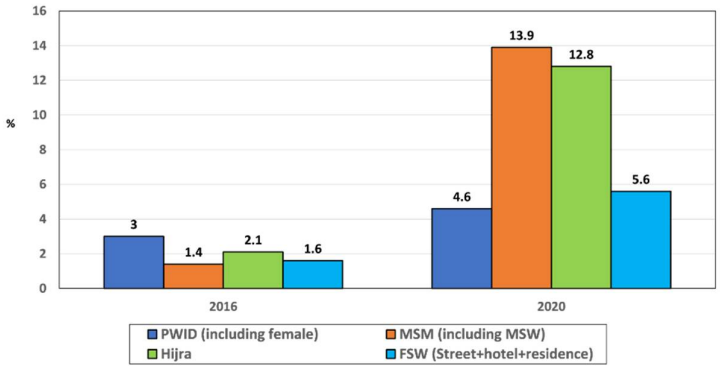


Figure 7: Prevalence of Active Syphilis among KP in Dhaka 2016 vs. 2020

B. Normative guidance or technical approaches adopted within the national policy or strategy for the program since the last funding request

☒ Yes ☐ No

Response:

Since the last funding request, the country's stakeholders, under the guidance of ASP, have generated significant new evidence to inform the policy and strategic environment for HIV/STI interventions. The country identified several gaps in strategic information and the resulting lack of standard operating procedures (SOPs) and various technical guidelines, which hampered program implementation. A list is provided below to demonstrate the extensive work that has been done during the past three years.

Name of document	Impacts
National Strategic Plan The national strategic plan of HIV and AIDS for 2023-2028 adapted contemporary guidance and approaches to strengthen the national HIV response	• NSP provides strategic direction in terms of strengthening prevention efforts, HIV case detection approaches to optimize identification of PLHIV and improve treatment, care and support services, approaches to address human rights abuses and focuses on extracting strategic information scientifically for evidence-based interventions.
Guidelines and SOP for HTS and treatment • A viral load optimization plan and SOP for viral load testing have been developed as per WHO guidelines to better assess the treatment outcomes among PLHIV. • National ART guidelines have been updated, incorporating Dolutegravir (DTG) in the first-line ARV regimen, and implementation has started accordingly. • A national SOP for HIV self-testing is under development, based on scientific evidence of the first HIV self-testing study conducted in 2020. This study and the resulting SOP will guide the implementation of HIV self-testing on a larger scale.	• Improved monitoring of the effectiveness of ART in PLHIV and earlier diagnosis of drug resistance. • Improved ART adherence due to fewer ART side effects under new regiments. • Increased HTS coverage to move closer to achieving the first 95 of the global 95-95-95 targets and to enhance intimate partner testing.
Guideline on HIV co-infections • National guidelines on the prevention of mother to child transmission of HIV, Hepatitis and Congenital syphilis (2021) have been updated to achieve services for women of reproductive age living with or at risk of HIV to maintain their own health and prevent their infants from acquiring HIV/Syphilis/Hepatitis, and strengthen the effort towards triple elimination of PMTCT of HIV, Hepatitis, and Syphilis.	• Achieved standard services for women of reproductive age living with or at risk of HIV to maintain their own health and prevent their infants from acquiring HIV, Syphilis or Hepatitis • Efforts towards triple elimination of PMTCT of HIV, Hepatitis, and Syphilis strengthened.

• Community based TB screening for KP has been incorporated in the “National guideline and Operational Manual for Tuberculosis (2021).	• Increased TB screening rate, presumptive TB case detection and TB case identification among KP.
Guideline on Drugs and OST-related interventions • The existing OST guideline has been fully revised, incorporating take-home methadone dispensing and addressing concomitant drug use among OST clients. • A new training module has been developed with the support of international and national experts on OST from Australia, Save the Children, CARE Bangladesh and icddr,b, which will be utilized for training of the new OST staff. • A National Guideline for the Management of Substance Use Disorder, Bangladesh, January 2023, has been developed by the Department of Narcotics Control (DNC), GoB	• Ensured provision of OST services following international norms and guidelines • Ensured retention in OST • Trained OST staff are available with high-quality training
Strategic information • Integrated biological and behavioural survey (IBBS) among key populations at high risk of HIV in Bangladesh was conducted in 2020. • National Size estimation exercise of KP was conducted in 2023. • The situation of concurrent psychoactive substance use among the clients of methadone maintenance treatment was assessed in Dhaka, Bangladesh, 2020 • A community-based tuberculosis (TB) screening intervention was developed and implemented to increase TB referral, case detection and knowledge among sexual minority people in urban Bangladesh	• An evidence-based HIV/TB prevention intervention were designed based on recent strategic information.

Section 4. What has not changed: continued relevance and impact:

Explain how the current program remains relevant and is on track to achieve results and impact.

The strategies in place as part of the current program have led to significant achievements in reaching target populations with HIV prevention services, including improving the uptake of testing among KP and improving treatment access and outcomes for PLHIV. Evidence shows that HIV prevalence among all KP has significantly declined from 3.9% in 2016 to 1.3% in 2020, demonstrating the effectiveness of current interventions in Bangladesh. Therefore, based on the experiences of the current grant cycle (2021-2023), the country intends to continue these prioritised interventions that have produced good outcomes and impact over the years. The programs will continue to use both traditional and innovative approaches to expand service coverage for KP and prioritise districts as per the strategic direction provided by ASP and UNAIDS. Such an expansion will not only enhance HIV case detection and establish stronger linkages to care, support, and treatment but also aim to reach the highest service coverage within the given resources.

The interventions include:

- **Prevention services:** Key population-focused differentiated service delivery (DSD) approaches such as peer-led outreach, C-DIC/DIC/sub-DIC/Outlets-based services, information, communication, and technology-based (ICT) communications and interactions for better communication with KP and virtual interventions with those who currently do not come to the service centres. Free distribution of HIV prevention commodities such as condoms and lubricants as per the need of the program participants and expanding access to PrEP for MSM/MSW/Hijra (in Dhaka only).
- **Clinical Services:** Syndromic management of sexually transmitted infections (STIs) will continue along with the provision of etiological diagnosis of STI management where needed and other basic health care services that can be dealt with at service centres with established referral linkages.
- **OST services:** The Opioid Substitution Therapy (OST) program with methadone has established itself as an impactful intervention to contain HIV among PWID. Innovative approaches like providing take-home doses and telehealth services have ensured better OST retention and outcomes in recent years.
- **Testing Services:** Differentiated HIV testing approaches, such as facility-based testing, community-based testing, index testing, partner testing, social media-based testing, and HIV self-testing using either blood or oral fluid, will be continued and expanded.
- **Treatment and Care of PLHIV:** Peer navigation/peer counsellor approaches which have been found effective, will be continued to enhance the rapid linkage of the PLHIV to the care, treatment, and support services they need.
- **Human Rights:** Activities related to addressing the human rights of KP, such as sensitisation meetings and advocacy with various stakeholders, data collection of human rights violations, analysis, and use of findings for decision-making, will be continued and further strengthened.
- **RSSH**: Routine reporting, data quality, participatory and community-led monitoring, community-led advocacy, and research and pool procurement of HIV testing kits will continue.
- **Integration of Services with Government Health Facilities:** Services, particularly clinical service integration for KP at government health facilities, will continue following the existing modalities. These modalities are now piloted, but scientific evidence is

required through applying advanced and rigorous implementation science approaches to examine which models are working (or not working) and why, later based on this scientific evidence, future scale-up can be decided at the national level. Thus, we have proposed a study to be conducted to see the implementation challenges and design of the models for identifying and recommending unique or differentiated models of integration for Bangladesh. A transition plan has been developed, which will be implemented gradually during the upcoming cycle.

However, to further strengthen the program, some adjustments have been considered, which have been described in Section 3 of the narrative. These adjustments have been made based on the recommendations of the JMM report 2023 and the Quality of Services (QoS) report 2023 done by the Global Fund. With this backdrop, and with the available resources, the continuation of the current program is relevant and on track to achieve results and impact.

Section 5. Strategic Focus Areas

The Global Fund has approved a new Strategy. Explain whether program design, implementation arrangements and budget need to adapt to fulfil the following Strategy objectives:

Strategy objectives	Already addressed within the current grant(s)?	If further effort/adaptation is needed in the 2023-2025 allocation period: summarize here
A. Maximize people-centered integrated systems for health	☒ Yes ☐ No ☐ Partially	People-centered programming has been a focus since the start of the HIV response in Bangladesh. Several CBOs actively participate in program design and implementation. Examples include the Network of People Living with HIV (NOP+), the Sex Workers Network of Bangladesh (SWNoB), the Network of People Who Use Drugs (NPUD), and the STI and AIDS Network of Bangladesh. The Ministry of Health and Family Welfare (MOHFW), ASP, and other partners are aware of the significant contributions of these organizations in achieving the 95-95-95 targets and the mission to end AIDS by 2030. During the development of the NSP 2024-2028, as well as other relevant planning and budgeting documents, the communities actively participated to ensure their specific needs were addressed. It is worth noting that community groups also participated in the development process of GC7 through national dialogues. However, additional efforts and adaptations are necessary to achieve the 95-95-95 target within the designated time frame, particularly regarding community involvement in HIV testing, care, treatment, and the reduction of stigma and discrimination against PLHIV. One-time training sessions are insufficient. The capacity of the community needs to be continuously strengthened. In the upcoming GC7 grant period, it is planned nine additional government facilities will integrate services for PWID, alongside two current public facilities. Similarly, two DICs will be transferred to public hospitals, where community-centered service delivery is emphasized. ASP will continue its efforts in GC7 to integrate two additional public hospitals, along with five hospitals from the current grant. Support will also be provided to Directorate of Prisons for integrating HIV testing and prevention services for KP and high-risk prisoners.
B. Maximize the engagement and leadership of most affected communities	☒ Yes ☐ No ☐ Partially	The national programme ensures engagement of community leaders, including network members of all KP, and Civil Society Organizations (CSOs) in programme design and delivery. In the recent NSP 2024-2028 development and the GC7 FR development the community groups and CBOs participated meaningfully They joined in nine consultation sessions and gave significant inputs. CBOs and self-help groups have been implementing interventions for the last two decades as SR/SSR along with PRs.

C. Maximize health equity, gender equality and human rights	☐Yes ☐ No ☒Partially	ASP has been integrating services for KP in different public health facilities, which will be continuing in seven public health facilities in the GC7 to ensure long-term sustainability. The NGO PRs will shift more service delivery points to government facilities during the next grant. In November 2013, the Government of Bangladesh took the policy decision to officially recognized *hijra* as the third gender. This recognition by government was hailed as a major achievement by civil society and the international community. It has improved the enabling environment for TGW and TGW-focused interventions in Bangladesh [21]. ASP has been working with the Directorate of Prisons for making services available and accessible for prisoners. However, for gender equality and enjoying full human rights, further legal, social barriers need to be removed; continued advocacy will be conducted as part of the next grant.
D. Pandemic Preparedness	☒ Yes ☐ No ☐ Partially	MOHFW, ASP and its partners worked hard for pandemic preparedness of community groups and KP via the C19RM project, which contributed resources to strengthen health and community infrastructure, with the aim of augmenting disease surveillance and addressing social and gender aspects of the pandemic. Follow up of the pandemic preparedness will continue in the next period.
E. Sustainability Are there major challenges to the sustainability of the national response?	☒ Yes ☐ No	The Health Population Nutrition Sector Programme (HPNSP) is supposed to be end by 2022. Nevertheless, due to the C19 pandemic, MOHFW has been granted a no-cost extension until June 2024 without adding additional resources. The existing allocation of funds is distinctly inadequate and not sustainable. The constraints of public funding hinder human resource deployment, the development of innovative strategies, and the implementation of multi-sectoral interventions. Besides this, the government has other priorities in the health sector, based on disease burden and epidemiological information on the ten major causes of death and top ten causes for disability adjusted life year (DALY); neither list includes HIV [22], hampering advocacy to allocated scarce resources to HIV. Despite these challenges, there are unique opportunities: • Bangladesh is on track to graduate from the UN's Least Developed Countries (LDC) list in 2026. Poverty declined from 41.9 percent in 1991 to 13.5 percent in 2016. Human development outcomes improved along many dimensions [23]. • The Government of Bangladesh has reiterated its commitment to UHC and pledged to accelerate efforts to achieve it by 2030 by expanding services, increasing resources and improving efficiency [24]. • There is a surge in efforts to address and eradicate barriers associated with human rights and gender, especially in relation to access for KP. The country has

		commenced formulating a transition strategy. The readiness process for this transition is currently underway.

Domestic Financing and Resource Mobilization

Describe how co-financing commitments for the 2020-2022 allocation periods have been realized.

The National AIDS/STD Control, DGHS is responsible for implementing the National AIDS response as part of the 4th Health Population Nutrition Sector Programme (HPNSP) through a sector-wide approach. The current Operational Plan (OP) under HPNSP began in 2017 and is scheduled to conclude in June 2022. During this phase, two separate operational plans were merged, resulting in the Tuberculosis, Leprosy, and AIDS/STD Programme (TB-L & ASP). Under the revenue department, there are two distinct organograms, each led by a Director. The initial value of the OP was 44.56 million USD, but after a revision in 2020, the amount was reduced to 27.44 million USD. The utilization rate of funds declined due to the COVID-19 pandemic and other factors. Consequently, the government decided to extend the program by one additional year until June 2024 without any additional costs.

Due to the impact of COVID-19 and other factors, the 4th Operational Plan (OP) has been extended until June 2024 using a no-cost extension approach. The Ministry of Health and Family Welfare (MoHFW) has approved only a small portion of the unspent balance and incremental funds. ASP is currently awaiting the final decision from the ministry regarding the exact amount for the extended OP. According to the co-financing commitment letter of 2020 (NFR3), ASP has confirmed its expenditure plan from the OP-GOB-RPA budget as follows:

Table 5: Government's Commitment against Co-financing

SL	2020 (million USD)	2021 (million USD)	2022 (million USD)	Total
01	6.73	12.84	5.00	24.57

Value of the OP of AIDS/ STD Programme Component as above (1 USD = TK 84.00)

The major programmatic budget heads include administrative costs, OP human resources costs, reagents and drugs, HIV prevention commodities, training/advocacy/capacity building, HIV prevention services costs among KP, awareness and advertisement, event celebrations, monitoring and evaluation (M&E), and research expenses. Over the past three years (2020-2022), implementing planned activities and work plans under the OP has been significantly impacted by the COVID-19 pandemic. Despite these challenges, the program has increased its domestic funding through various strategies. A substantial portion of the revenue budget has been allocated to human resources, such as ART physicians, medical officers, and nurses, in 23 district/medical college hospitals. The hospital revenue budget also supports service delivery space, utilities, and other necessary drugs for PLHIV.

NASC and ASP receive support from 10 higher-level government officials who are paid using government revenue funds specifically designated for the national HIV response. Therefore, the annual expenditure for the salaries and benefits of both partial and full-time government staff, as well as space and utility expenses, amounts to approximately 1.8 million USD for the period of 2020 to 2022 (Financial Year). Other ministries, such as the expatriate and overseas departments, have allocated a substantial amount of funds for HIV testing among potential migrants within the country. According to the World AIDS Day (WAD) data, a total of 955,420 tests were conducted in 2022, followed by 383,166 tests in 2021 and 311,551 tests in 2020.

The table below presents the expenditure of the OP activities implemented under the Government of Bangladesh-Revenue and Project Aid (GOB-RPA) for the past three years:

Table 6: Government's Expenditure against Co-financing Commitment

Sl	Source of the OP	2020 (July-2019- June 2020) $ in Millions	2021 (July-2020- June 2021) $ in Millions	2022 (July-2021- June 2022) $ in Millions	Total expenditure USD in Millions
01	GOB-RPA $	2.35	5.10	3.34	10.79

The mentioned expenditure is lower than the co-financing commitment made during submitting the NFR3 grant proposal in 2020. This discrepancy is primarily due to the impact of the COVID-19 situation and other unavoidable circumstances, which resulted in lower expenditure than initially anticipated. The information regarding these expenditures has been extracted from the annual expenditure statement of the AIDS/STD Programme (ASP), which was submitted to the Health Services Division of the Ministry of Health and Family Welfare (MoHFW). The expenditure report is readily available for verification purposes.

The allocated amount has been utilised across the following line items:

1. There are OP-funded positions in both the headquarters and field levels, including HTS centres, with coordinators, MT Lab personnel, counsellors, and support staff. Currently, out of the 96 positions, 85 are available.
2. The procurement of ARV drugs has been carried out to meet the needs of an estimated 5,500, 6,000, and 7,000 PLHIV in the years 2020, 2021, and 2022, respectively. These drugs were procured through the Central Medical Storage Depot (CMSD).
3. STI drugs for the department of Skin VD and ART centres, located in medical colleges and district general hospitals, have been distributed to approximately 110 hospitals. The drugs were supplied by Essential Drugs Limited (EDCL).
4. Prevention commodities such as condoms, syringes, and methadone are procured annually through the OP fund. These commodities partially fulfil the requirements of the GF-supported program and fully support the KP program under the OP.
5. The KP prevention program is implemented through NGO contracts, targeting specific groups such as brothel-based FSW (3,600 individuals), PUD (7,000 individuals), and MSM/TGW (5,000 individuals). These groups receive comprehensive HIV prevention services. However, the number of KP receiving these services has been reduced in 2022 due to procurement policy changes.
6. Testing kits, including self-testing kits, HTS kits, and viral load kits, are procured and supplied to hospitals and NGO programs.
7. Training sessions, workshops, seminars, and nationwide events focusing on health service providers are conducted and organised. These activities also include the celebration of AIDS Day.
8. Research and monitoring evaluations are conducted to gather information and assess the progress of the programs.

Describe how co-financing will increase over the 2023-2025 allocation period, and how these commitments will be tracked and reported, and planned actions to address remaining funding gaps.

The ongoing 4th Health Sector Program is scheduled to conclude in June 2024 with a no-cost extension. The budget for this extension has not yet been finalised, making it

challenging to provide detailed information about commitments. Nonetheless, it is crucial to prioritise three priority expenditures: the procurement of ARV drugs, human resources under the OP grant, and testing kits.

The upcoming 5th Health Population and Nutrition Sector Program (HPNSP) is set to commence in July 2024 and continue until June 2029. The Strategic Investment Plan (SIP) has been completed, and the operational plan is currently being drafted. It is expected that the allocation for the operational plan will be increased.

During the current OP period, the expenditure of the 4th OP was found to be below the expected level, indicating poor performance compared to the allocation. The low absorption can be attributed to delays in the service procurement process, particularly in the KP prevention intervention component. Additionally, the KP prevention services were only implemented for two years, despite the allocation being for a five-year period. To address these issues, ASP plans to increase the number of OP personnel, specifically, Deputy Programme Managers and finance staff, to enhance capacity in the relevant areas. ASP will also involve experts to execute its procurement plan for goods and services. These initiatives are expected to improve service coverage and increase the expenditure rate.

Additionally, ASP will utilise resources from other Line Directors, Directors, and department funds. In the upcoming grant period, ASP will facilitate the availability of spaces and health services in hospitals for KP interventions. STI drugs and other critical management drugs will be ensured through the hospital's OP fund and ASP's OP fund, utilising the scope of EDCL. The Maternal and Neonatal Child Health (MNCH) Department of DGHS has initially agreed to support PMTCT services in selected hospitals by providing testing kits, counselling, and other necessary resources. ASP is also advocating with CDC and DGHS to ensure HCV treatment for KP, particularly PWID, with the expectation of support from the 5th CDC OP. Several consultations have already taken place.

ASP will also take responsibility for mass awareness through the Health Education and Lifestyle Operational Plan, utilising their own allocation.

Furthermore, ASP will explore the use of resources from other departments and ministries for the HIV response, particularly in addressing the needs of the overseas migrant population.

The following table indicates that in the upcoming 5th Health Sector Program, approximately USD 84.5 million, including USD 4.3 million from the GF grant (GC7), is proposed. This allocation will be needed for various activities, including HIV prevention, community involvement, effective HIV testing, universal access to treatment, and care support for PLHIV. It will also focus on strengthening the strategic information system and establishing resilient and sustainable health and community systems to achieve an integrated and people-centric HIV and AIDS response.

Table 7: Government's Commitment against Co-financing for the Period 2024-2029

Strategic Objective	Total Amount $ in Million
1. To prevent new HIV infections through comprehensive, targeted interventions and active community involvement	20.89
2. To scale up innovative and effective HIV testing and case-finding approaches nationwide 3. To ensure universal access to treatment, care, and support services for people living with HIV and AIDS	44.95
4. To strengthen strategic information systems and research for an evidence-based response	3.58

5. To establish resilient, sustainable health and community systems for an integrated, people-centric HIV and AIDS response	15.06
Grant Total	**84.50**

During the budget preparation for the 5th OP, ASP considered the activities, interventions, and approaches stated in the 5th National Strategic Plan (NSP). Under Objective 1, there are plans to cover HIV prevention programs for KP, especially PUD (12,000), MSM/MSW and TG (5,000), Brothel-based FSW (3,700), and external migrants' intervention. There are also plans to organise a mass campaign and awareness on HIV/AIDS, co-infections, stigma and discrimination, and human rights. In the 5th OP, ASP kept HR for all 64 district hospitals based HTS centres and planned for 17 ART centres in geographical priorities, especially where the PLHIV number is high.

G. Program Essentials

Indicate if any of the Program Essentials are currently not fulfilled, explain why, and describe the proposed pathway to reach them in coming years.

The essential data table are fully filled and all programme essentials are given in this funding request.

Section 6. Implementation

Are changes needed to implementation arrangements?

☐ Yes ☒ No

If Yes: explain what these changes are, risks being addressed and expected improvements for the program.

Since this is a continuation grant, the implementation of the HIV prevention work in Bangladesh will be carried out in a similar modality as previously done. All three existing PRs (i.e., ASP, SC, and icddr,b) will continue as PRs in this GC7 grant. This decision was taken and approved by the 115th BCCM meeting and the 44th meeting of the BCCM Oversight Committee. The GC7 proposal was endorsed in the 117th CCM meeting, where this same arrangement was clearly mentioned, discussed, and further endorsed.

Targets for PWID, MSM, MSW, FSW, and TG have been realigned according to the country's epidemiological priorities, taking the 95-95-95 targets into consideration, as well as human rights dimensions. The PRs have carried out extensive internal exercises to restructure and reorganise the program to implement the program efficiently and maintain the quality of services as ensured over the last twelve years. This has led to a significant reduction in management costs; these savings have been made available for investment in program priority areas.

PR-ASP: ASP has no SRs or SSRs in the current grant. The same arrangement will be continued in the next grant. A few modular activities will be implemented by contracting out with government- and non-government entities. For the KP intervention, ASP increased from five centres in the current grant to seven in the next grant and will provide services to all KP i.e., PWID, FSW, MSM/MSW and TGW populations from three integrated centres. The implementation modality for the KP interventions will also remain the same. The prison intervention will be implemented in collaboration with the prison directorate.

PR-Save the Children Federation, Inc.: SCI will implement essential services among FSW in eight districts and a harm reduction program among PWID in 31 districts. A consortium approach has been found to be the best HIV prevention strategy. Save the Children would like to continue with existing partners. However, this arrangement will only depend on consensus on the financial and programmatic requirements. If required, consortiums will be selected via a competitive bidding process in order to reduce the management cost. Distribution of districts and populations among the partner organisations will be based on the geographical presence and organisational capacity. For the FSW intervention, the consortium will comprise one SR and one SSR. The PWID intervention will be carried out by a consortium comprised of one SR and three SSRs. The program engages community networks for capacity building, mentoring, advocacy, and participatory monitoring. Sex Workers Network of Bangladesh (SNOB), Network of People who Use Drugs (NPUD), Network of People Living will HIV (NOP+), and STI Network of Bangladesh will be engaged as partners who will be given capacity training for performance-based contracting for certain deliverables.

PR-icddr,b: To achieve impacts, icddr,b will significantly increase the coverage of MSM and MSW interventions and a small increase for coverage of TGW whilst coverage of OST for PWID remains the same in two districts. To cover this huge population in a total of 26 districts (based on geographical priority), icddr,b needs SRs, among whom the population coverage and districts will be equally distributed for efficient management and ensuring the framework of equity and quality. icddr,b will select two SRs through a competitive bidding process by following icddr,b's own SR selection policy. icddr,b will redistribute the districts and population coverage among the two SRs. Additionally, icddr,b will also implement 8 service centres directly within the framework of direct implementation. Selected capacitated

and well-performing CBOs will be involved with the SRs as strategic partners who can implement the interventions in some strategic areas depending on their locations and capacities. During the selection of SR, the engagement of CBOs and self-help groups will be made mandatory as part of the selection criteria. So that community-based organizations get capacitated with engagement with service implementation. icddr,b will work with the STI network on some activities. icddr,b will also recruit some community members to work with the icddr,b team in various capacities as part of community empowerment and engagement. Apart from this when the situation favors, icddr,b will work with authentic community networks for meaningful community networks and self-help groups, internet-based hidden groups, and so on.

Collaboration and Coordination: How the Three PRs Complement in the National Program:

In Bangladesh's national HIV response, the three PRs operate within a robust coordination mechanism that optimises their collective effectiveness. The PRs, while distinctive in serving different key populations and having a particular geographical focus and their unique strengths, foster an integrated and comprehensive response by actively collaborating and learning from each other's experiences without duplication.

The PRs convene quarterly in PR coordination meetings designed to ensure accountability and shared learning among the three organisations. This platform allows regular exchanges on implementation successes, challenges, and budgets, emphasising mutual collaboration to tackle common issues. This practice of mutual learning and collaboration will continue and be strengthened under the forthcoming GC7 grant.

Each of the PRs contributes its unique strength to the overarching national HIV response. ASP plays a crucial role, working with the prison and police sectors to facilitate interventions and managing the ART Advisory Committee. Additionally, all PRs contribute to various Technical Working Groups (TWGs), such as the TWG on Monitoring & Evaluation and Strategic Information (M&E and SI) and the TWG on HTS, which are platforms for sharing expertise to review and approve new interventions, methodologies, and guidelines.

Apart from serving as a PR, ASP operates as the national nodal body for the HIV program. This role entails identifying implementation barriers, facilitating solutions, and consistently monitoring program activities. ASP undertakes field visits and provides feedback reports to the relevant PRs and SRs, fostering continuous improvement.

Each PR, in addition to its shared responsibilities, maintains individual accountability to the Global Fund country team for finance procurement and supply management. This ensures financial transparency and accountability within each PR's operations. Furthermore, the Bangladesh Country Coordinating Mechanism (BCCM) oversight committee conducts independent monitoring visits, reinforcing accountability.

The three PRs work together to mobilise and sensitise key stakeholders towards a more multisectoral response to AIDS, involving entities such as the Department of Narcotics Control, Directorates of Social Services, Department of Prisons, district and medical college hospital authorities, police and other law enforcement agencies, HNPSP partners, and United Nations agencies, among others. In the upcoming GC7 grant, these collaborative efforts will be strengthened, further intensifying a broad-based, multisectoral response to AIDS in Bangladesh.

Annex 1: Documents Checklist

Use the list below to verify the completeness of your application package.
This checklist only applies to applicants requested to apply using the Program Continuation application approach. Refer to the Program Continuation Instructions[1] for details, applicability and resources.

Documents Reviewed by the Technical Review Panel

☒	1. Funding Request Form
☒	2. Performance Framework
☒	3. Detailed Budget
☒	4. Programmatic Gap Table(s)
☒	5. Funding Landscape Table(s)
☒	6. Prioritized Above Allocation Request (PAAR)
☒	7. Health Product Management Template
☒	8. Implementation Arrangement Map(s)
☒	9. RSSH Gaps and Priorities Annex
☐	10. Gender Assessment (if available) – CRG Plan
☒	11. Assessment of Human Rights-related Barriers to Services (if available) – GRG Plan
☒	12. Essential Data Table(s)
☒	13. National Strategic Plans
☐	14. Innovative Financing Documentation (if applicable) – not applicable
☐	15. Supporting Documentation Related to Sustainability and Transition (if available)
☒	16. List of Abbreviations and Annexes

Documents Assessed by the Global Fund Secretariat

☒	17. Funding Priorities from Civil Society and Communities Annex
☒	18. Country Dialogue Narrative
☐	19. CCM Endorsement of Funding Request
☒	20. CCM Statement of Compliance
☒	21. Additional documentation to support co-financing requirements
☐	22. Sexual Exploitation, Abuse and Harassment (SEAH) Risk Assessment (optional)

[1] Program Continuation Instructions - https://www.theglobalfund.org/media/7356/fundingrequest_programcontinuation_instructions_en.pdf

Annex 2: District-wise KP coverage in GC7 (including PAAR) along with rationale for prioritization (2024-2026)

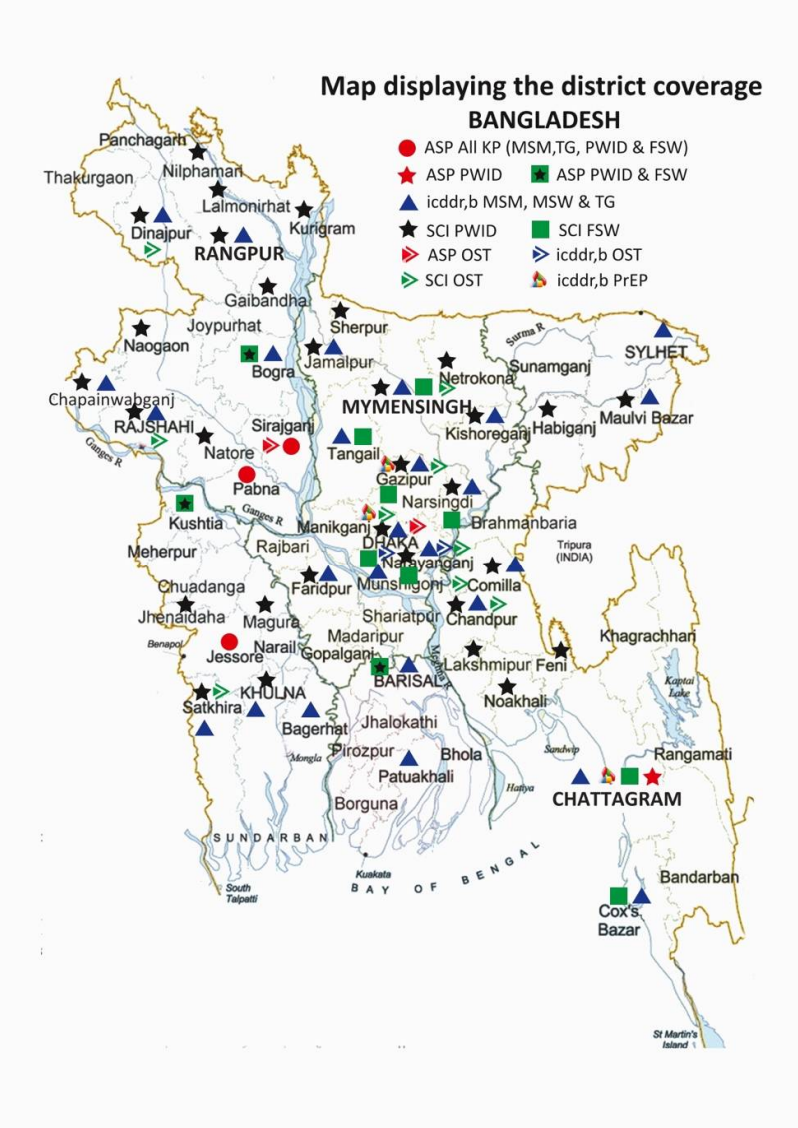
Sl. no	Name of prioritized districts	PWID Coverage target/ SE of PWID (%)	MSM/MSW Coverage target/ SE of MSM/MSW (%)	TG Coverage target/ SE TG (%)	FSW Coverage target/ SE of FSW (%)	Rational for selection of the district	Intervention packages considered
1	Dhaka*¥	6,700 /6,716 (99.8)	14,109 /17,636 (80.0)	1,748 /2,185 (80.0)	8,526 /15,347(55.9)	• High HIV prevalence among KP • High prevalence of syphilis among KP • High concentration of KP • High number of PLHIV • Street based sex trade • Mobility Young KP	• Condom programing for all KP • OST and NSE for PWID • SRH management including STI, hepatitis, etc. for all KP as needed. • Treatment, care support for PLHIV • Addressing human rights issues • PrEP for MSM/MSW/Hijra in three districts* • Abscess management
2	Chandpur¥	548 /685 (80.0)	1,629 /2,036 (80.0)	106 /132 (80.3)	-		
3	Feni	300 /375(80.0)	-	-	-		
4	Lakshmipur	306 /383 (79.9)	-	-	-		
5	Noakhali	593 /741 (80.0)	-	-	-		
6	Cumilla¥	746 /933 (80.0)	3,010 /3,762 (80.0)	298/373 (80.0)	-		
7	Gazipur*¥	632 /702 (90.0)	5,749 /7,186 (80.0)	479/599 (80)	2,464 /2,901 (85.0)		
8	Narayanganj¥	800 /1,138 (70.3)	3,640 /4,550 (80.0)	291/364 (80.0)	1,754 /3,407 (51.5)		
9	Faridpur	336 /374 (89.9)	673 /2,390 (28.2)	28/151 (18.5)	-		
10	Narsingdi	383 /478 (80.1)	263 /2,870 (9.2)	51/178 (28.7)	1,659 /3,851 (43.1)		
11	Kishoregonj¥	386 /482 (80.1)	2,367 /2,959 (80.0)	180/225 (80.0)	-		
12	Khulna¥	638 /709 (90.0)	2,269 /2,836 (80.0)	182/228 (79.8)	-		
13	Jhenaidah	292 /365 (80.0)	-	-	-		
14	Magura	270 /337 (80.1)	-	-	-		

Sl. no	Name of prioritized districts	PWID Coverage target/ SE of PWID (%)	MSM/MSW Coverage target/ SE of MSM/MSW (%)	TG Coverage target/ SE TG (%)	FSW Coverage target/ SE of FSW (%)	Rational for selection of the district	Intervention packages considered
15	Sathkhira¥	450 /562 (80.1)	2,156 /2,695 (80.0)	112/140 (80.0)			
16	Mymensingh¥	900 /1,312 (68.6)	4,194 /5,248 (79.9)	377/471 (80.0)	1,778 /4,519 (39.0)		
17	Jamalpur	450 /563 (79.9)	710 /2,702 (26.3)	122/170 (71.8)	-		
18	Sherpur	271 /339 (79.9)	-	-	-		
19	Netrakona	278 /348 (79.9)	-	-	-		
20	Rajshahi¥	1,100 /902 (122.0)	2,622 /3,278 (80.0)	178/223 (79.8)	-		
21	Natore	394 /493 (79.9)	-	-	-		
22	Naogaon	411 /514 (80.0%)	-	-	-		
23	Chapainababganj	450 /312 (144.2)	1,005 /1,914 (52.5)	153/88 (173.9)	-		
24	Dinajpur¥	1,200 /1,202 (100)	1,970 /2,463 (80.0)	130/162 (80.2)	-		
25	Gaibandha	475 /594 (80.0)	-	-	-		
26	Kurigram	362 /452 (80.1)	-	-	-		
27	Lalmonirhat	272 /340 (80.0)	-	-	-		
28	Nilphamari	311 /389 (79.9)	-	-	-		
29	Rangpur	389 /486 (80.0)	788 /2,986 (26.4)	63/225 (28.0)	-		
30	Habiganj	284 /355 (80.0)	-	-	-		
31	Maulvibazar¥	220 /275 (80.0)	1,689 /2,111 (80.0)	115/144 (79.9)	-		

Sl. no	Name of prioritized districts	PWID Coverage target/ SE of PWID (%)	MSM/MSW Coverage target/ SE of MSM/MSW (%)	TG Coverage target/ SE TG (%)	FSW Coverage target/ SE of FSW (%)	Rational for selection of the district	Intervention packages considered
32	Barishal¥	756 /601 (126.0)	2,224 /2,780 (80.0)	121/151 (80.1)	1,346 /2,691 (50.0)		
33	Pabna¥	460 /511 (90.0)	2,510 /3,138 (80.0)	132 /165 (80.0)	745 /1,489 (50.0)		
34	Sirajgonj¥	525 /583 (90.1)	2,738 /3,423 (80.0)	226 /282 (80.1)	590 /1,179 (50.0)		
35	Jasshore¥	731 /812 (90.0)	2,598 /3,247 (80.0)	156 /195 (80.0)	1,341 /2,681 (50.0)		
36	Bogura¥	456 /563 (81.0)	2,895 /3,619 (80.0)	347 /433 (80.1)	359 /897 (40.0)		
37	Kustia	497 /613 (81.1)	-	-	202 /504 (40.1)		
38	Chattogram *¥	765 /850 (90.0)	5,739 /7,174 (80.0)	516 / 645 (80.0)	2,650 /4,802 (55.2)		
39	Cox's bazar¥	-	2,243 /2,804 (80.0)	138 /173 (79.8)	1,179 /4,264 (28.0)		
40	Tangail	-	612 /4,533 (13.5)	109 /349 (31.2)	980 /2,909 (33.7)		
41	Sylhet¥	-	2,081 /2,601 (80.0)	227 /284 (79.9)	-		
42	Patuakhali¥	-	1,314 /1,642 (80.0)	75 /93 (80.6)	-		
43	Bagerhat¥	-	1,360 /1,700 (80.0)	72 /90 (80.0)	-		
44	Munshiganj ¥	-	1,393 /1,741 (80.0)	74 /93 (79.6)	-		
	Total coverage/ total SE (%)	**25,337 /34,370 (73.7)**	**76,554 /1,65,192 (46.3)**	**6,806 /12,629 (53.9)**	**25,573 /109,624 (23.3)**		

Sl. no	Name of prioritized districts	PWID Coverage target/ SE of PWID (%)	MSM/MSW Coverage target/ SE of MSM/MSW (%)	TG Coverage target/ SE TG (%)	FSW Coverage target/ SE of FSW (%)	Rational for selection of the district	Intervention packages considered
	PAAR activities related to prevention and treatment	1. Condom programming for FSW. USD: 1,000,000 2. Condom programming for MSM/MSW. USD:1,500,000 3. Facility-based testing for adolescent girls and young women (AGYW) and their male sexual partners programs. USD:1,000,000 4. Sexual and reproductive health services, including STIs, hepatitis, post-violence care for MSM. USD:500,000 5. Opioid substitution therapy and other medically assisted drug dependence treatment for PWID. USD:800,000 6. Pre-exposure prophylaxis (PrEP) programing for MSM/MSW/TG. USD:800,000 7. Sexual and reproductive health services, including STIs, hepatitis, post-violence care for PUD. USD:1,500,000					

¥: Priority districts.
* Districts with PrEP intervention for MSM/MSW/TG.
Coverage of MSM/MSW/TG is 80% in 23 priority districts as per SE and around 23% in other six vulnerable districts.
PR-ASP will provide services in 7 districts (# 6 priority + one # other districts).
PR-Save the Children will provide services to PWID in 31 districts (# 15 priority + # 16 other districts) and FSW in 8 districts (# 5 priority + #2 other districts)
PR-icddr,b will provide services in 23 priority and six other vulnerable districts


Map displaying the district coverage
BANGLADESH
ASP All KP (MSM,TG, PWID & FSW)
ASP PWID
ASP PWID & FSW
icddr,b MSM, MSW & TG
SCI PWID
SCI FSW
ASP OST
icddr,b OST
SCI OST
icddr,b PrEP
Panchagarh
Thakurgaon
Nilphamari
Lalmonirhat
Kurigram
Dinajpur
RANGPUR
Gaibandha
Joypurhat
Naogaon
Sherpur
Bogra
Jamalpur
Surma R
SYLHET
Sunamganj
Netrokona
Chapainwabganj
MYMENSINGH
Habiganj
Maulvi Bazar
RAJSHAHI
Sirajganj
Kishoreganj
Natore
Tangail
Ganges R
Gazipur
Pabna
Narsingdi
Kushtia
Ganges R
Manikganj
Brahmanbaria
DHAKA
Rajbari
Tripura (INDIA)
Meherpur
Narayanganj
Chuadanga
Faridpur
Munshiganj
Comilla
Jhenaidaha
Magura
Shariatpur
Chandpur
Madaripur
Khagrachhari
Benapol
Jessore
Narail
Gopalganj
Lakshmipur
Feni
BARISAL
Kaptai Lake
KHULNA
Noakhali
Satkhira
Bagerhat
Jhalokathi
Sandwip
Rangamati
Mongla
Pirozpur
Bhola
Patuakhali
Hatiya
CHATTAGRAM
Borguna
SUNDARBAN
Kuakata
BAY OF BENGAL
Bandarban
South Talpatti
Cox's Bazar
St Martin's Island

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Annex C

SAARC Development Fund

SOCIAL WINDOW

PROJECT DOCUMENT
BANGLADESH

Fast track malaria elimination from cross-border areas and districts adjoining the international border in some countries of SAARC Region.

SAARC Development Fund

PROJECT DOCUMENT

I. Project Contact Information	
Contact Person for application	
Name	Dr. Jigmi Singay Executive Secretary cum Coordinator South-East Asia Regional Coordination Mechanism Forum (SRCMF) Secretariate
Address	South-East Asia Regional Coordination Mechanism Forum (SRCMF) Second Floor, Plot No. 3, Sector 18A Dwarka New Delhi – 110075 India E-mail: jigmi2118@gmail.com Mobile: +919818848587
Country	
Legal Status/Year of Establishment	The SRCMF is South East Asia Regional Coordination Mechanism Forum (SRCMF) launched by the Global Fund SEA Constituency based in New Delhi, India and is governed by a board consisting of members from 11 WHO South-East Asia Region (SEA Region) countries (Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste) providing oversight and platform for the SEA GF Constituency member countries since 2016 to strengthened coordination and enhance implementation of the GF supported programs especially Malaria, TB, HIV and other programs with special emphasis on cross-border coordination towards ending the epidemics.

II. Project Summary	
Project Title	**Fast track malaria elimination from the cross-border areas and districts adjoining the international border in some of the SAARC Region**
Focus Area of Intervention	☒ **Poverty alleviation** ☐ Education ☒ **Health** ☐ Human resources development ☒ **Support to vulnerable/disadvantaged segments of the society** ☐ Funding needs of communities ☐ Micro-enterprises ☐ Rural enterprise development

Participating SAARC Countries	☐ Afghanistan ☒ **Bangladesh** ☐ Bhutan ☐ India ☐ Maldives ☐ Nepal ☐ Pakistan ☐ Sri Lanka
Duration of Project	Two years effective from singing of the Project Financing Agreement (PFA) with SDF.
Country Implementing Partners	Director, National Malaria Elimination Program (NMEP), Government of the People's Republic of Bangladesh**.** House # 442, Road # 30, 5th & 6th Floor, New DOHS, Mohakhali, Dhaka, Malaria Hotline**:** +8801787691370 E-mail: mpdc_dghs@yahoo.com
Country Project Locations	International cross-border areas/districts of Bangladesh and India

III. Project Budget	
Total amount requested from SDF by IP (in USD)	USD 60,027.83
Total contribution through co-funding (in USD)	
Amount of co-funding broken down by source (indicate 'Cash' or 'In-kind')	
Source 1 (Name/amount in USD)	
Source 2 (Name/amount in USD)	
If co-funding are yet to be mobilized, provide a short explanation of the resource mobilization strategy. Please indicate source of potential funds.	

IV. Project Description

Background and Rationale:

Bangladesh is a democratic country with multi-party system. Executive power is exercised by the government headed by Prime Minister while the legislative power is vested in both the government and parliament and the President is the constitutional head of state.

Bangladesh, with a total population of 170.7 million (2019 estimates) is one of the most-densely populated countries in the world having a population density of 1,050 per sq. km (Global Health Observatory 2012). A total of 67.3% of the population lives in rural Bangladesh, while 32.7% lives urban areas. The majority of population are Muslim (90.39%) followed by Hindu (8.54%) and other minority religions (1.07%).

The country has a total land area of 147,570 sq.km and is surrounded on three sides by India and a small part of Myanmar in the east and the Bay of Bengal in the south. Administratively, the country is divided into 8 Divisions, 64 Districts, 492 Upazilas (Sub-districts), and 4,554 Unions and wards. The country has an agriculture-based economy and agriculture sector contributes to about 33% of GDP employing about 65% of the labour forces.

The country has made significant economic progress over the past decades with the Annual GDP growth averages of 6.5% in the recent years and its per capita income brought to US$ 1,070 (BBS 2012/13).

Malaria program in Bangladesh was initiated before the independence in 1971 with Malaria Eradication Program and program nearly succeeded in eradicating the disease. However, resurgence started since mid 1980s and expanded in many parts of the country assuming an epidemic proportion in many parts of the hilly and forested areas including the foothills. Subsequently the malaria control program was initiated (1977-1994), then with Revised Malaria Control Strategies in 1994 and updated strategies until today. The country endorsed and implemented the World Declaration on the Control of Malaria and the Revised Malaria Control Strategy (RMCS) formulating the guidelines and strategies in line with Global and Regional strategies since 1994[1].

Malaria is a significant public health problem in Bangladesh and the country borders the malaria-endemic areas of India and Myanmar. The disease is endemic in 13 of the 64 districts of Bangladesh, which represent 9% of the overall population of 160 million in 2015[2].

The country has declared Rangamati, Bandarban and Khagrachori as the three highly endemic districts in the Chittagong region[3]. Cox's Bazar and the Chittagong Hill Tract districts (CHTs) (Bandarban, Khagrachhari and Rangamati) report over 90% of cases and 80% of deaths due to the disease[4]. Over 80% of cases occur in the high transmission period from May to October, when there is increased rainfall and high humidity. It is estimated that about 18.74 million (11% of the 171 million country's total population) people living in the 13 Districts (72 upazilas) are at risk of contracting malaria infection.

The fight against malaria and its elimination efforts is being undertaken jointly by the Government with the Non-Governmental Organizations. The National Malaria Elimination Programme (NMEP) collaborates with a coalition of 16 NGOs steered by BRAC, delivering a variety of interrelated community-wide intervention programmes. The BRAC-Led NGO

1 Malaria National Strategic Plan 2015-2020. National Malaria Control Programme (NMCP) Communicable Disease Control Division Directorate General of Health Services Ministry of Health & Family Welfare. Bangladesh
2 Saha, A., Sarker, M., Kabir, M. et al. Knowledge, attitudes, and practices regarding malaria control among the slash and burn cultivators in Rangamati Hill tracts of Bangladesh. Malar J 18, 216 (2019). https://doi.org/10.1186/s12936-019-2849-0. accessed 19 December 2021.
3 National Malaria Control Programme. Malaria national strategic plan: 2015–2020. Dhaka: Ministry of Health & Family Welfare; 2015. AND Ahmed S, Galagan S, Scobie H, Khyang J, Prue CS, Khan WA, et al. Malaria hotspots drive hypoendemic transmission in the Chittagong hill districts of Bangladesh. PLoS ONE. 2013;8:e69713.
4 National Malaria Control Programme. Malaria national strategic plan: 2015–2020. Dhaka: Ministry of Health & Family Welfare; 2015.

Consortium (BLNC) operates in non-urban areas as they have grass-roots connections with local populations and implements most malaria control programs.[5]

Towards the South-Eastern part of Bangladesh, out of 10 unions with the highest average annual incidence during 2013–2016, five borders with India and/or Myanmar and nine clustered in Bandarban and Rangamati. Additionally, among the 10 unions with the highest average incidence within the North-East part of Bangladesh, eight borders India[6]

Movement of people across the border areas or Cross-border migration either for short or medium distance or duration has contributed to the spread of malaria in the country. Due to common cross-border migration of people along the Bangladesh-India-Myanmar borders, it poses huge risk to spreading the disease and challenges in meeting the zero elimination target by 2030. This is further aggravated by Rohingya refugees who flees from Myanmar to Bangladesh may import or carry the diseases and spread in the country and towards India in the north.

There is challenge in undertaking effective surveillance and in having accurate data as the surveillance system underreports infections in the country. This is primarily due to the fact that primary health service providers do not report or register the cases in the national surveillance system, including private treatment and not every malaria case/access malaria care that is captured by the malaria information system like buying over the counter anti-malaria medicines from pharmacy[7].

As per World Malaria Report 2020, entire countries in the WHO South-East Asia Region were on track to achieve the 2020 GST Milestones for both mortality and morbidity. However, financial resources for the implementation of the planned interventions to meet the 2020 milestones were hampered due to fund available for support against fund required increase from USD 1.3 billion in 2017 to USD 2.6 billion in 2019.

Many countries around the world have felt the impact of COVID-19 on their country's overall economic activity as they experienced shocks in their real gross domestic product. Additionally, the United Nations predicted that due to pandemic the global economy could shrink by about 0.9%. Therefore, such an impact on the GDP could pose additional challenge towards achieving the malaria elimination goals due to reduced future funding to fight the disease.[8]

The pandemic reversed the progress made towards elimination of malaria with COVID-19 spreading to all the malaria endemic countries leading to about 22 million morbidity and 0.6 million mortality by November 2020 as per World Malaria Report 2020. The situation was

5 Noé, A., Zaman, S.I., Rahman, M. et al. Mapping the stability of malaria hotspots in Bangladesh from 2013 to 2016. Malar J 17, 259 (2018). https://doi.org/10.1186/s12936-018-2405-3

6 Noé, A., Zaman, S.I., Rahman, M. et al. Mapping the stability of malaria hotspots in Bangladesh from 2013 to 2016. Malar J 17, 259 (2018). https://doi.org/10.1186/s12936-018-2405-3

7 Reid HL, Haque U, Roy S, Islam N, Clements AC. Characterizing the spatial and temporal variation of malaria incidence in Bangladesh, 2007. Malar J. 2012;11:170.

8 World malaria report 2021. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO

further aggravated with COVID-19 prevention measures like lockdown, inadequate protection of the frontline health workers and prevention messages advising the public to stay home.

The updated global technical strategy for malaria (GST) 2021, highlights improvement of surveillance system and strengthening workforce capacity as critical, including reduced funding that hampered full implementation of the national strategic plans[9]. It has been found that that majority of global malaria burden are from countries with moderate to high transmission in sub-Saharan Africa where the surveillance system is generally weak[10]. Therefore, transforming malaria surveillance into a key intervention is one of the pillar of the global technical strategy for malaria 2021.

Therefore, since Bangladesh and India share long and porous borders, it needs to strengthen the surveillance systems, coordinate our efforts and eliminate malaria. Without such joint efforts, reaching 2030 goal of free malaria will remain a distant dream as malaria cases will keep resurfacing from each other due to shared border and high mobility of the people.

Primary beneficiaries

The primary beneficiaries are the most vulnerable/poor populations residing along the border areas or districts especially difficult, hard to reach terrain and the cross-border areas of Bangladesh and India as follows:

- Children, pregnant women, tribal/indigenous/ethnic minority groups,
- Shifting (jhum) cultivators, forest-goers/workers,
- Migrant and mobile populations, who are often poor, marginalized, and socio-economically disadvantaged.

Thus, all efforts of this project will be focused on these target population groups directly or indirectly.

Importance placed by Member State on the proposed development challenge to be addressed

- There is commitment from the highest political leader, the Prime Minister of Bangladesh to achieve Sustainable Development Goal - 3 "Good Health and Well-Being" with specific target 3.3 underscoring "end malaria" by 2030 including SDG goal – 1 "eradicating extreme poverty for all people everywhere" by 2030[11].
- Bangladesh has committed to the Ministerial Declaration on ***"Accelerating and Sustaining Malaria Elimination in the South-East Asia Region",*** when the Health Minister signed the Ministerial Declaration in 2017.

[9] World malaria report 2021. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO
[10] World malaria report 2021. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO
[11] NATIONAL STRATEGIC PLAN FOR MALARIA ELIMINATION IN BANGLADESH: 2021-2025 (FINAL DRAFT)

- Since malaria is a public health problem the government in its effort the combat malaria and eliminate from the country is collaborating with a consortium of NGOs to intensify the fight against the disease and in reaching the rural and hard to reach areas besides collaborating with other international and regional agencies.

- The country has reviewed its existing National Strategic Plan for Elimination of Malaria taking into consideration the recommendations from the joint monitoring mission (JJM4) and existing malaria stratification and will be updated to NSP 2021-2025 in line with Global Technical Strategy for Malaria 2016-2030 and Regional Action Plan 2017-2030 to provide strategic direction to achieve the goal of malaria free Bangladesh by 2030.

- The National Malaria Control Program is responsible for implementation of the program through Primary Health Care under the Directorate of Communicable Disease Control. Therefore, the urgency and importance on elimination of malaria stems from the highest level of the government and political leaders.

- The Government of Bangladesh in its effort to fight the disease and eradicate from the country seeks support, collaboration and partnership from the neighbouring country India as is also reflected in their strategic direction to initiate cross-border collaboration with India in view of geographic proximity impacting malaria transmission through population movement along the international borders[12].

Relation of the proposed projects to existing national planning and policy instruments in the Member State

The proposed project is in line with the national policy – the ***"National Strategic Plan (NSP) for Malaria Elimination 2015–2020" and National Strategic (NSP) for Malaria Elimination 2021-2025 (final draft)*** and in particular, the proposed intervention complements and supports the achievement of the following milestones and targets:

By 2021

- Robust village level epidemiological surveillance strengthened in the CHT (03 districts).
- Case-based surveillance system established at national, district, Upazila levels in all other districts going into 'elimination' in phased manner.
- Local transmission has been interrupted and no indigenous case in 04 districts of Mymensigh zone.
- System, process to determine 'non-endemic' 51 districts (considered to be malaria free) initiated.

By 2023

- 'Malaria free' status of 51 districts determined.

[12] NATIONAL STRATEGIC PLAN FOR MALARIA ELIMINATION IN BANGLADESH: 2021-2025 (FINAL DRAFT)

By 2025

- Local transmission has been interrupted and no indigenous case in 04 districts of Sylhet zone; and Chattogram and Cox's Bazar.
- Annual Parasite Incidence reduced to <1 per 1,000 in 03 CHT districts.

By 2030

- Local transmission has been interrupted nationwide.

The proposed proposal supports the GOB's emphasis on high transmission areas where majority of malaria is being reported along the cross-border areas of Bangladesh and India which are mostly hilly, tribal and forested areas with mobile migration across the international borders.

In addition, the proposal is in line with government of Bangladesh's focus on enhancing coordination and collaboration with neighbouring countries in a joint effort towards strengthening malaria interventions and elimination of malaria from the region (MNSP).

Contribution to fulfilling the objectives of the SAARC Charter, SAARC Social Charter, SAARC Development Goals, SAARC Plan of Action on Poverty Alleviation, and other relevant SAARC programmes and instruments.

Alignment with SAARC Charter/Goals/programs: The CRCFM's proposal on elimination of Malaria is aligned with the aims and priorities under the SAARC Development Funds Charter, SAARC Social Charter, SAARC Plan for Action on Poverty Alleviation and SAARC Development Goals.

The project will contribute to **SDF Charter's** focus areas of **health** and **support to vulnerable/disadvantaged segments** of society, while also **improving the coordination efforts** through better **response and treatment of the cases** essential for prevention and spread of the disease.

The project contributes towards promotion of **SAARC Charter's** objective of promoting the welfare and improve the quality of life of the people of South Asia through its continuous efforts on elimination of Malaria in the region[13].

It is also closely aligned **to SAARC's Plan of Action on Poverty Alleviation**, as the project will contribute towards enhancing social safety nets and safeguarding the marginalized and vulnerable communities in the border areas from potential infection and mortality, which can push them further into poverty.[14]

[13] SAARC Charter
[14] SAARC Plan of Action on Poverty Alleviation

It contributes towards fulfilling the **SAARC Social Charter's objective** to promote health and responding to urgent health issues and outbreaks of any communicable disease in the region through intervention to eliminate malaria in the region especially along the cross border areas of SAARC Countries[15].

This project will be contributing to multiple Goals from the **SAARC Development Goals** aiming at Reduce social and institutional vulnerabilities of the poor, women, and children (Goal 6), Maternal health (Goal 9), Child health (Goal 10), and improved hygiene and public health (Goal 12)[16].

Most importantly the project will **contribute towards cross-border collaboration** enhancing regional cooperation and integration and will specifically **fulfil SDF's primary objective** of Promoting the welfare of the people of the SAARC Region; Improve their quality of life; and accelerate economic growth, social progress and poverty alleviation in the region[17].

Description of intended activities

The proposed project will support the government of Bangladesh's National Malaria Strategic Plan 2021-2025 by supporting the cross-border efforts through the following proposed activities:

1. **Assessment and strengthening of health and community information and surveillance system in districts along the international cross border districts/ areas of Bangladesh and India**

1.1. Under this activity, the information and surveillance of the health and community system especially at the cross-border subdistricts of Bangladesh and India assessed. The community information and surveillance assessment is essential as they are the primary interface between the formal health system and the informal system in their communities. These assessments are aimed at identifying existing gaps and challenges both in terms of information, communication and its surveillance in addressing malaria in their areas and also across the borders neighbouring other countries. The findings from the assessments will be presented to the health officials, community members and other key stakeholders, have deliberations and come out with an agreed solution and way forward towards addressing those gaps and challenges, contributing towards acceleration of elimination of malaria from the region.

[15] SAARC Social Charter
[16] SAARC Development Goals
[17] SAARC Development Fund http://www.sdfsec.org/about-sdf accessed 20 Oct 2021.

2. **Assessment and initiation/strengthening of bilateral cross-border coordination between Bangladesh and India especially at subnational level**

The cross-border coordination and collaboration is essential in the fight against malaria as containment or elimination of malaria cases could be jeopardized even if one country has eliminated or maintained zero indigenous infection but cases across the immediate border areas of other country are not contained or addressed adequately. Therefore, under this activity existing cross-border bilateral coordination mechanisms and situation will be assessed and presented to government agencies including ministry of health and key stakeholders. The presentation of such findings is aimed at addressing the current challenges and gaps and initiate/strengthened cross border coordination with their full commitment.

3. **Advocacy with donors and key stakeholders for enhanced/continued support for malaria elimination in SA.**

Strengthen regional coordination, facilitating reinforcement of commitments and exploring sustained and sufficient resources.

4. **M&E**

Onsite monitoring and supervision to track progress on cross-border coordination at subnational level. The project will document the lessons learnt and best practices in the effort to fast-track elimination of malaria from the SA region. The outcomes and recommendations will be shared with all the key stakeholders especially the government agencies and key stakeholders so that they are able to provide enhanced support and provide conducive environment based on evidence and recommendation for intensifying initiative on malaria elimination and for donors to continue supporting the initiative towards fast-tracking elimination of malaria in the region.

5. End of project evaluation

The project will document the lessons learnt and best practices in the effort to fast-track elimination of malaria from the SA region. The outcomes and recommendations will be shared with all the key stakeholders especially the government agencies and key stakeholders so that they are able to provide enhanced support and provide conducive environment based on evidence and recommendation for intensifying initiative on malaria elimination and for donors to continue supporting the initiative towards fast-tracking elimination of malaria in the region.

Contribution to women's empowerment, and gender mainstreaming

The women's role in agriculture and household exposes them to the risk of malaria infection especially pregnant women and young children due to reduced immunity[18]. Similarly, the role of men/boys especially outdoor works in forestry, fishing, mining, cattle raring, jhum cultivators

18 Vulnerability to malaria in asia pacific: being gender responsive – thematic brief March 2021, APLMA.

etc. especially during the peak biting hours puts them at a greater occupational risk of contracting malaria.

Studies have found linkages between health workers gender composition and acceptance of malaria interventions where women plays an important role [19] and their involvement in prevention of malaria has resulted in enhanced awareness, service provision and in reducing malaria burden[20].

Therefore, the proposed project interventions will be undertaken with special focus on women's empowerment and gender mainstreaming. Since it requires joint effort in combating the malaria and in eliminating from the region, special attention will be given to mainstream gender in all spectrum of the project.

Potential for scaling up.

This proposed project is aligned and in line with the Global and Regional framework on elimination of malaria from the region by 2030. The Ministry of Health & Family Welfare will be working closely with other government agencies, BRAC and consortium of NGOs, communities and other key actors involved in the effort to eliminate malaria from Bangladesh. Therefore, this project will be implemented jointly with other agencies and its machineries at the subnational level especially focusing on the cross border areas and in collaboration with SRCMF India and will be intensified and expanded to other areas as well.

The challenges and gaps in interventions especially along the cross border areas shall be identified and plan appropriate support, including capacity building to deliver services to the affected areas and in designing conducive policy environment.

Alongside this project our efforts with the donors and key stakeholders will include cross-sharing of project innovations, challenges, lessons learnt etc. that can be scaled up quickly and easily by other stakeholders on elimination of malaria.

The MoH&FW will advocate with the government and stakeholders in the South-Asia region to incorporate interventions that have proven effective in contributing towards elimination of malaria in their own planning.

In addition, the MoH&FW will be proactively participating in the meetings, workshops and seminars wherever possible to advocate for scaling up their effort.

19 Directorate General of Disease and Prevention. National Action Plan for Acceleration of Malaria Elimination 2020-2024. Indonesia. 2019

[20] Pradhan S. Improved access to early diagnosis and complete treatment of malaria in Odisha, India. PLOS ONE. 2019.

Sustainability: Briefly explain how the project aims to sustain the results in the longer term after the project's termination including description of its revenue generation model.

- The Government of Bangladesh considers malaria as a public health problem, thus elimination of malaria as a priority, therefore, the proposed project supplements the ongoing initiatives and various interventions undertaken by the Ministry of Health & Family Welfare.
- The proposed project is in line with the existing and revised national strategic plan for malaria elimination in Bangladesh 2021-2025" (final draft) which aims to achieve zero indigenous malaria in Bangladesh by 2030 and to strengthen and sustain health and community system for malaria elimination and prevention of re-establishment.

- Specifically, the proposed project focuses on strengthening the health and community systems along the cross-border areas which is a focus and commitment of the Ministry of Health & Family Welfare as it is considered high transmission areas due to high mobility of migrants across the international borders.

- The Ministry of Health & Family Welfare emphasis on the coordination and collaboration with neighbouring countries in the effort to eliminate malaria from the region by 2030 will be enhanced and strengthened through strengthening of cross-border collaboration interventions under this project.

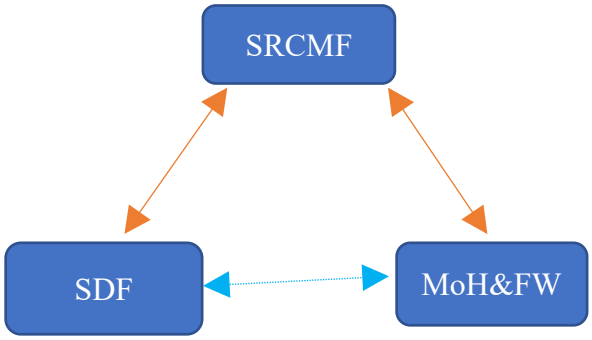
- The National Malaria Control Program, Primary Health Care under the Directorate of Communicable Disease Control, Ministry of Health & Family Welfare and the BRAC with consortium of NGOs are the main agencies implementing the malaria elimination program in the country. Thus the results achieved under this project will be taken-up and continued long after the end of this project.

The proposed project is not an economic model geared towards generating income either for the Ministry of Health & Family Welfare, NGOs or the targeted beneficiaries. This project is proposed to fast track the achievement of the malaria elimination goal of 2030 in line with Government of Bangladesh's commitment, which is a part of global and regional multi-country response. However, through this project, resource mobilization and investment in combating malaria will be pursued through engagement and advocacy with existing and potential donors like GFATM (Global Fund to Fight AIDS, Tuberculosis and Malaria), USAID and other donors either in the region or globally.

Justification for project implementation strategy and plan: Briefly describe the implementation strategy

The project will be implemented in collaboration with the SRCMF, India where the Ministry of Health & Family Welfare, Government of Bangladesh will be an implementing partner and SRCMF the Lead Implementing Agency (LIA).

Although, the project will be implemented jointly with SRCMF, all financials and expenditures for the proposed project activities will be managed and undertaken directly by SRCMF. Therefore, all budget from SDF shall be transferred to SRCMF, however, there shall be communications and interactions with the SDF on the project as shown below (blue arrow with dotted lines).



Conditions that would make the proposed project strategy the most effective approach to address the development challenge

The following conditions enables the proposed project strategy most effective approach in fast tracking elimination of malaria from the region:

- The government of Bangladesh has committed to eliminate malaria from the region by 2030. In this regard various policy initiatives and measures to combat and eradicate malaria has been undertaken guided by the National Malaria Elimination Strategic Plan.

- MoH&FW have a Country Coordination Mechanisms (CCM)[21] that play a key role in taking an aggressive approach in improving the initiative towards malaria elimination goal and enhancing the engagement of all key stakeholders in sustaining the efforts in this area.

- The Health Minister leads, directs, and guides the MoHFW in making policies, acts, strategies, rules and regulations related to the national healthcare services.

- South-South Cooperation is an important aspect of the malaria elimination program and Bangladesh participates actively in promoting the cooperation in various joint reviews and forums in coordination with the CCM of each member states especially with Government of India focussing specifically on the cross-border collaboration.

[21] Global Fund Results Report 2021

- With many member states in the region already on track to achieve zero indigenous case and proceeding towards free malaria status Bangladesh is also committed towards fast tracking elimination of malaria.

- The SRCMF has expertise facilitating harmonization of efforts between member countries and fosters partnerships and collaborations with various partners, donors and stakeholders including community and civil society towards acceleration of responses to reach the goal of ending malaria.

- There is commitment from top bureaucracy of the government on building the existing system and addressing the gaps within the surveillance system along the cross-border and making it robust towards achieving the malaria elimination target.

Added value of the IP

The malaria elimination program in Bangladesh is undertaken by the National Malaria Control Program through Primary Health Care under the Directorate of Communicable Disease Control of the Ministry of Health and Population, therefore, the program is owned and implemented by the Government of Bangladesh. The Bangladesh government has been undertaking programs proactively to address malaria in the country since independence. The Ministry of Health & Family Welfare has existing network and good working relationship with India, especially with the agencies working in the malaria elimination program.

Previous experiences of the IPs in working in this focus area

The Ministry of Health & Family Welfare under Government of Bangladesh has established the malaria control program and has been fighting the disease since their independence in 1971 and have achieved remarkable results bringing the cases from 39,719 in 2015 to 17,225 cases by 2019 and the country is confidently on track towards reducing and elimination of malaria by 2030[22]. In addition, the Ministry has wide range of expertise working on every public health issues and concerns like HIV and TB in the country.

The Ministry of Health & Family Welfare has been partnering and working with the regional and global agencies like the WHO, WB, GFATM and other agencies and donors in combating malaria and now on elimination from the country specially focusing on the cross-border.

The Ministry is a recipient of Global Fund support and have been intensively implementing interventions in the area of HIV, TB and Malaria in the country. There is a well-structured mechanism, chain of command and advisory bodies both at National and sub-national level, including consortium of NGOs led by BRAC. Therefore, the ministry has extensive experience

[22] NATIONAL STRATEGIC PLAN FOR MALARIA ELIMINATION IN BANGLADESH: 2021-2025 (FINAL DRAFT)

and expertise working both with the national partners, donors and international partners in prevention, mitigation and now elimination of malaria from the country.

Regional overview of the intervention (expected results by Member States)

The Asia Pacific Leaders Malaria Alliance (APLMA) representing 18 countries committed to the goal of a region free of malaria by 2030, subsequently endorsing the *APLMA Malaria Elimination Roadmap* in November 2015. The roadmap is in alignment with the WHO *Global Technical Strategy for Malaria 2016–2030,* and the Roll Back Malaria Partnership document *Action and Investment to defeat Malaria 2016–2030*.

From the South-East Asia region, Maldives and Sri Lanka have already eliminated malaria and have been certified by WHO since 2015 and 2016 respectively and have not reported any indigenous case. Bangladesh, India, Indonesia, Myanmar and Thailand were already implementing programs for elimination of malaria at the subnational/territorial level whereas, Bhutan, Democratic People's Republic of Korea, Nepal and Timor-Leste were already on programs aimed at elimination of malaria at the nationwide level.[23]

The "High Burden to High Impact (HBHI) approach initiated in 2018 which has four mutually reinforcing elements (Political will to reduce malaria deaths; Strategic information to drive impact; better guidance, policy and strategies; and coordinated national malaria response) has been adopted by countries (India and 10 other sub-Saharan countries) that contributed approximately 70% of the worlds malaria cases and 71% deaths[24].

In light of COVID-19 pandemic the world malaria report 2020, estimates that globally there will be prolonged economic impact as it pushes an estimated 100 million people into extreme poverty by 2020. In addition, the fight against malaria has prolonged and even stalled in some countries due to domestic and international financing amongst others in this area. There has been a resurgence of malaria cases during the COVD-19 pandemic period. In 2020 countries like South Africa (1367 additional cases), Botswana (715), Ecuador (131), Suriname (52), Saudi Arabia (45) and Bhutan (20) saw an increase in cases than the previous year (2019)[25] indicating impact of COVID-19 restriction and challenges it poses towards elimination of malaria from the region.

Enhanced local/national capacities that will be present at the end of the project

- The Ministry of Health & Family Welfare together with the National Malaria Elimination Program as the main agency will be implementing the proposed project in the country and will be collaborating with the SRCMF especially focusing on the cross-border areas. Therefore, there will be enhanced coordination and strengthened collaboration mechanisms at the end of the project period.

[23] World Malaria Report 2020. WHO.
[24] World Malaria Report 2021, WHO.
[25] World Malaria Report 2021, WHO.

- Health and community systems strengthened, improved efficiency and effectiveness of local governments and communities in preventing the spread of malaria infection in communities, schools, etc. along the border areas and enhanced efficiency of the healthcare personals and facilities in providing timely interventions.

- The ministry will be able promote south-south cooperation with lessons learnt from this project interventions shared with all key stakeholders and support resource mobilization and investment through advocacy.

Measures to ensure sustainability of results

The sustainability of the project is already covered under the same topic earlier, however, we would like to reiterate that the proposed project will be implemented by the Ministry of Health & Family Welfare in coordination and collaboration with the National Malaria Elimination Program. Therefore, interventions undertaken, and results achieved shall be taken up and continued after the end of the project period.

Targeted Beneficiaries:

The targeted beneficiaries are the most vulnerable population residing along the border areas or districts, especially hard to reach and cross-border areas of Bangladesh-India. Therefore, children, pregnant women, tribal/indigenous/ethnic minority groups, shifting (jhum) cultivators, forest-goers/workers, migrant and mobile populations, who are often poor, marginalized, and socio-economically disadvantaged will focused directly or indirectly through this proposed project interventions.

Other beneficiaries are the health professionals, frontline care service providers and the communities along the cross-border district populations.

How are their lives expected to change as a result of the project?

Studies have shown that each case of malaria cost households at least USD 2.67 an average between USD 0.37 – 7.66 indirect out-of-pocket expenses. Thus, in adult case this leads to an average of 3.4 days (between 2-6 days) of lost productivity at a minimum of additional indirect cost of USD 10.85. Mothers and other carers further sacrifice about 2-4 days each time a child or other family members is sick with malaria, further adding on to the indirect costs of the households.[26]

The female member of the households like grandmothers, mothers, daughters, sisters etc. are the ones mostly taking care of the sick[27]. Studies show that caregivers spend at least an additional two days for every sick child or younger siblings in addition to the time lost when they are sick themselves and this becomes worse in high transmission setting where children fall sick

[26] Action and investment to defeat malaria 2016-2030: for a malaria-free world. Geneva: WHO on behalf of the Roll Back Malaria Partnership Secretariat, 2015. http://www.rollbackmalaria.org/ about/about-rbm/aim-2016-2030 - accessed 20 Oct 2021.
[27] Fact sheets on malaria and the SDGs, Gender and Malaria, September 2015. Roll Back Malaria Partnership

frequently from malaria[28]. Therefore, eliminating malaria would free them from the burden of taking care of the sick and loss of time when they themselves are sick, enabling them especially women and school going age girls from entering school and completing education, contributing towards reducing gender gap in higher and tertiary education.

Through this project interventions, it is expected that the household burden due to sickness from malaria especially out-of-pocket expenses made for the diagnosis and treatment would be significantly reduced. In addition, it would enable the member of the family to attend economic activities when not sick, contributing to the household income and wellbeing of the family members.

Coordination and Management Arrangements:

The coordination and management arrangements between MoH&FW and SRCMF including SDF where relevant will be undertaken as follows:

Sl. No.	What	Purpose	Medium	Frequency	Audience
1	Monthly progress report	Project progress update and any issues requiring attention/decision.	In-person, email, phone	Monthly	Between MoH&FW and SRCMF
2	Quarterly report/meeting	Quarterly progress report/review meetings	Report and In-person	Quarterly	MoH&FW to SRCMF. SDF (where required)
3	Mid-year assessment/review	Meeting to update, review, discussion and way forward with LIA/IPs	In-person	Biannually	Between MoH&FW, SRCMF and SDF
4	End of Project Evaluation	Assess project results	Through TA	End of project	MoH&FW, SRCMF and SDF
5	Lessons learned and good practices	Documentation of lessons learnt and good practices and sharing with all relevant stakeholders and wider audiences (reports, videos, fb posts etc.)	Documentation Sharing thorough workshops, meetings, newsletters, emails, media etc.	As and when possible and required	SDF, IPs, MoH&FW, wider public, relevant stakeholders, donors etc.

Risk Analysis: The project is categorized as 'low risk' due to the following reasons:

[28] Asenso-Okyere, W. K. & Dzator, J. A. Household cost of seeking malaria care. A retrospective study of two districts in Ghana. Soc. Sci. Med. 1982 45, 659–667 (1997).

- Project design has considered the management, financial and logistic issues based on prior experience of handling projects during COVID-19 pandemic.
- Political and Pandemic related disruptions are of moderate level, but in the proposed countries, we expect stable political scenario till 2024/ 2025 (next elections in proposed countries). Most countries have vaccination levels of 80-98% and will help to mitigate any severe effects of the pandemic.
- We have set up SRCMF in close coordination with the member countries of the SE Asia region. We work closely with governments and other stakeholders and thus party to information and emergent measures that is taken in country and region. We will proactively work to address any challenges in the cross-border areas and implementation.

The detailed risk analysis provided in Annex 1

Monitoring and evaluation (M&E): *Results and Resources Framework (qualitative/quantitative; Annex 2: Results and Resources Framework)*

- *Work plan with indicative year wise activities, targets, and budgets (Annex 3: Annual Work Plan template)*

Monitoring & Evaluation (M&E) is a fundamental component of any project. Through M&E, the project's results at impact, outcome and output will be measured to provide the basis for accountability and informed decision making at both program and policy level and most importantly performance-based funding for the donors.

The Monitoring & Evaluation (M&E) framework will be developed in the beginning of the project based on the result and resource framework of this project. However, consultation and feedback will also be sought from SRCMF and SDF. Throughout the project period, monitoring shall be undertaken daily, weekly and monthly based on the M&E framework and as and when required.

On site visits to assess the progress and challenges at subnational level about cross-border coordination, health and community systems would be undertaken. The monthly and quarterly reporting would be another M&E tool of the project.

Where feasible, the SRCMF, SDF in addition to relevant partner/donor agencies will be invited to join the onsite visits (at own cost). Involvement of civil society and community representatives from national/subnational/local level within monitoring purview will be ensured.

In addition, MoH&FW shall undertake Zoom meetings with the project teams and other key stakeholders on a regular interval to monitor and address any issues and challenges. In addition, such meetings will also be convened with SRCMF and SDF to update and review project status.

An evaluation of the project will be undertaken in collaboration with SRCMF at the end of the project to gauge the achievement of the planned results, document lessons learnt and recommendations for future engagement. The same will also be shared with SRCMF and SDF and all other government, NGOs, Donors and key stakeholders to provide evidence and to garner their continued support and funding towards fast-tracking elimination of Malaria from the SA region.

Communications, Advocacy and Knowledge Management:

The Ministry of Health & Family Welfare will undertake the communication, advocacy and knowledge management as follows:
Communication: Frequent communication with the focal implementing agencies and among the project team in Bangladesh to address challenges and learn from one another. Further communication with the SRCMF and SDF will be undertaken for learning, exchange of information and as required throughout the project period.

Advocacy: Appropriate and targeted advocacy will be carried out with the government, international and national NGOs, donors, medias and key stakeholders informing them of the ground realities, progress, challenges/gaps and especially for garnering support so that elimination of malaria by 2030 becomes a reality.

Knowledge Management: Throughout the project, monitoring and assessment of the project will be undertaken and best practices and lessons learnt documented. The results achieved and lessons learnt shall be shared with the wider audience through various platforms and also used for advocacy as well.

Supporting documents to be uploaded/attached:

- Commitment/evidence of co-financing/matching fund.
- In case of in-kind co-funding, letter from co-funder stating value and how it was determined.
- Legal incorporation documents, along with the Management profiles of each IP.
- Details of similar projects undertaken by Ips.
- Balance sheet/financial status of each IP for the past 3 years.
- Details of certificate/approval from local authorities to implement the project in the proposed locations.
- Letter of undertaking from IP stating they have paid all statutory dues like income tax/sales tax/custom duty, and no other dues are pending at the time of the submission of information to SDF, supported with certification from the relevant authorities; and IPs are meeting all regulatory issues and necessary compliances to implement the SDF project; and that the IPs will comply with SDF's policies and procedures.
- Latest Know Your Customer (KYC) documents, if applicable.
- Credit rating (corporate/individual) if available (e.g. CIBIC scores in Bangladesh).
- Any other documents as prescribed by the Board of Director, CEO or any competent authority of SDF.

Annex 1: Country Risk Analysis Matrix – Bangladesh

Risk	Impact	Likelihood	How will the risk be measured?	How will the risk be mitigated?
1. Project - Delay in project implementation due to delay in approval and signing of project agreement by SDF	High	Medium	▪ Delay in project approval by SDF board ▪ Delay in signing of Project Financing Agreement	Increased follow-up and communication with SDF
2. Currency – NA	NA	NA	NA	NA
3. Financial – Funds will be managed by the SRCMF	NA	NA	NA	NA
4. Political – less support/buy-in from the Government because of competing other priorities or if it is not in their political manifesto	High	Low	Limited/no support from the Government due to competing other priorities	The MoH will advocate the commitment made by the governments for elimination of Malaria.
5. Legal - Not foreseen at the time of proposal development	NA	NA	NA	NA
6. Country – political and economy instability in Bangladesh	High	Low	Political and economic instability of Bangladesh may adversely affect the project implementation	Necessary risk mitigation measures will be put in place should there be any political and economy instability of the participating countries
7. Others … Not foreseen at the time of proposal development	NA	NA	NA	NA

Annex 2: Project Results and Resources Framework - Bangladesh

Country		**Bangladesh**
Project Outcome:		Elimination of malaria fast tracked through enhanced cross-border collaboration and health systems strengthening along the Bangladesh - India borders.
Outcome Indicator:	•	• Bilateral Cross border collaboration initiated/strengthened between Bangladesh and India. • Health information and surveillance systems strengthened along the Bangladesh and India borders
Baseline and Target:		Baseline – 0; Target - 1

Outputs	**Output Indicator**	**Indicator Baseline and Target**	**Indicative Activities**	**Source of funding (SDF/Co-financing)**	**Project Budget (USD) and Timeframe**		
					Year 1	**Year 2**	**Total**
1.1. Health and Community information and surveillance system strengthened in one district along the international cross border areas of Bangladesh and India	❖ # of Health and Community information and surveillance systems assessed. ❖ # of meetings to present the findings and way forward discussed/agreed. • Agreed outcome document shared with all.	Baseline – 0 Target – 1 district (along cross border areas of Bangladesh and India) Baseline – 0 Target – 1 (Bangladesh and India) Baseline – 0	• Hiring of TA • Development of assessment materials. • Assessment in the four countries. • Finalization of the report. • Presentation of the findings to health and other key stakeholders and way forward finalized.	SRCMF SDF	20694.50	-	20694.50

		Target – 1 (Bangladesh and India)	• Sharing of report with all the key stakeholders including SDF.				
2. Bilateral cross-border coordination initiated and progressively strengthened in one district between Bangladesh and India especially at subnational level.	• Situation of cross-border coordination assessed. • # of coordination meetings. • Report on the strengthened subnational level coordination.	Baseline – 0 Target – 1 district (along cross border areas of Bangladesh and India) Baseline – 0 Target – 4 bilateral coordination meetings. Baseline – 0 Target – 1 report	• Hiring of coordinators. • Assessment of bilateral cross-border coordination situation. • Coordination meetings with the subnational focal agencies • Documenting the strengthened subnational coordination mechanism.	SRCMF and SDF	19666.665	19666.665	39333.33
3. Advocacy with donors and key stakeholders for enhanced/continued support for malaria	•		•				

elimination in SA (common plan, please see combined proposal)							
4. M&E (common plan, please see combined proposal)	•		•				
5. End of project evaluation. .(common plan, please see combined proposal)	• # of evaluation • # of key stakeholders reached with the outcome of the project	Target – 1 Baseline – 0 Target – 100 Baseline - 0	• Hiring of TA • End of project evaluation • Presentation to share and disseminate the findings to all the key stakeholders	SRCMF and SDF			

Annex 3: Annual Work Plan
Country: Bangladesh
Year: 2022 – 2024

Outputs *including indicators and annual targets*	Planned Activities	Year 1				Year 2				Planned budget (USD)	
		Q1	Q2	Q3	Q4	Q1	Q2	Q4	Q4	Source of Funds	Amount
1.1. Health and Community information and surveillance system strengthened in districts along the international cross border areas of Bhutan and India. **Indicator:** # of Health and Community information and surveillance systems assessed. **Target: 1**(Bangladesh and India) **Indicator:** # of meetings to present the findings and way forward discussed/agreed. **Target: 1** meetings **Indicator:** The assessment report and agreement/way forward shared with all. **Target:** key stakeholders from Bangladesh and India	• Hiring of TA • Development of assessment materials. • Assessment in the Bangladesh • Finalization of the report. • Presentation of the findings to health and other key stakeholders and way forward finalized. • Sharing of report with all the key stakeholders including SDF.	**X**	**X**	**X**	**X**					**SRCMF** **SDF**	20694.50 Fund for the activity has been factored in the SRCMF proposal and will be managed/utilized directly by the SRCMF.

2. Bilateral cross-border coordination at subnational level initiated and progressively strengthened between India-Bangladesh **Indicator:** Situation of cross-border coordination assessed. **Target:** 1 **Indicator:** # of bilateral cross-border coordination initiated. **Target** – 4 (Bangladesh, and India **Indicator:** # of coordination meetings. **Target** – 4 **Indicator:** Report on the strengthened subnational level coordination. **Target** – 1 report	• Hiring of coordinators. • Assessment of bilateral cross-border coordination situation. • Coordination meetings with the subnational focal agencies and establishment of bilateral cross-border coordination. • Documenting the strengthened subnational coordination mechanism.	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**SRCMF** **SDF**	39333.33 Fund for the activity has been factored in the SRCMF proposal and will be managed/utilized directly by the SRCMF.
3. Advocacy with donors and key stakeholders for enhanced/continued support for malaria elimination in SA. (Common plan, please see combined proposal)		**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**		
4. M&E: Common plan (please see combined proposal)		**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**		

5. End of project evaluation (please see combined proposal) **Indicator:** # of evaluation. **Target**: 1 **Indicator:** # of key stakeholders reached with the outcome of the project. **Targe**t – 100 stakeholders	• Hiring of TA • End of project evaluation. • Presentation to share and disseminate the findings to all the key stakeholders								X	SRCMF SDF	

Annex C (1)

SAARC

SAARC Development Fund

SOCIAL WINDOW

PROJECT DOCUMENT(COMBINED)

Fast track malaria elimination from cross-border areas and districts adjoining the international border with systems strengthening to prevent of re-establishment of malaria in 6 countries of SAARC Region.

SAARC Development Fund

I. Project Contact Information	
Contact Person for application	
Name	Dr. Jigmi Singay Executive Secretary cum Coordinator South-East Asia Regional Coordination Mechanism Forum (SRCMF) Secretariate
Address	South-East Asia Regional Coordination Mechanism Forum (SRCMF) Second Floor, Plot No. 3, Sector 18A Dwarka New Delhi – 110075 India E-mail : jigmi2118@gmail.com Mobile : +919818848587
Country	Bhutan, Bangladesh, India, Maldives, Nepal and Sri Lanka
Legal Status/Year of Establishment	The SRCMF is South East Asia Regional Coordination Mechanism Forum (SRCMF) launched by the Global Fund SEA Constituency based in New Delhi, India and is governed by a board consisting of members from 11 WHO South-East Asia Region (SEA Region) countries (Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste) providing oversight and platform for the SEA GF Constituency member countries since 2016 to strengthened coordination and enhance implementation of the GF supported programs especially Malaria, TB, HIV and other programs with special emphasis on cross-border coordination towards ending the epidemics.

II. Project Summary	
Project Title	**Fast track malaria elimination from cross-border areas and districts adjoining the international border with systems strengthening to prevent of re-establishment of malaria in some countries of SAARC Region.**
Focus Area of Intervention	☒ Poverty alleviation ☐ Education ☒ Health ☐ Human resources development ☒ Support to vulnerable/disadvantaged segments of the society ☐ Funding needs of communities ☐ Micro-enterprises

	☐ Rural enterprise development
Participating SAARC Countries	☐ Afghanistan ☒ Bangladesh ☒ Bhutan ☒ India ☒ Maldives ☒ Nepal ☐ Pakistan ☒ Sri Lanka
Duration of Project	2-years effective from signing of the Project Financing Agreement (PFA) with SDF
Implementing Partners	National disease control and elimination programs, Ministry of Health, Government of Bhutan, Bangladesh, Nepal, India, Maldives and Sri Lanka
Project Location	International cross-border areas of Bhutan, Bangladesh, India and Nepal and entry points of Maldives and Sri Lanka. The project locations are being submitted which will be further reviewed in consultations with National Malaria Elimination Program of the individual countries upon approval of the project proposals: • Bhutan: Sarpang (Chuzanggang, Gaden, Gelephu, Taraythang, Samtenling, Sarpang Tar, Gakidling, Dargaythang) for Malria. • Bangladesh: Still in process of identifying districts, it will be communicated as soon as finalized. • India: Cross-border districts in states of West Bengal, Assam, Sikkim, Tripura, Meghalaya, Mizoram, Uttar Pradesh, Bihar and Arunachal Pradesh • Nepal: Nepalgunj, Banke for Malaria and districts will be selected after consultation with National Malaria Program • Maldives: National (Male) • Sri Lanka: National (Colombo)

III. Project Budget	
Total amount requested from SDF (in USD)	USD 596,042.00

Total contribution through co-funding (in USD) secured by SRCMF for malaria elimination from RBM/UNOPS	USD 596,042.00
Amount requested by individual Implementing Partner (IP) - NA	
IP 1 (Name of IP/amount in USD)	
IP 2 (Name of IP/amount in USD)	
IP 3 (Name of IP/amount in USD)	
IP 4 (Name of IP/amount in USD)	
IP 5 (Name of IP/amount in USD)	
IP 6 (Name of IP/amount in USD)	
IP 7 (Name of IP/amount in USD)	
IP 8 (Name of IP/amount in USD)	
Amount of co-funding broken down by source (indicate 'Cash' or 'In-kind')	
Source 1 (Name/amount in USD/equivalent)	
Source 2 (Name/amount in USD)	
Source 3 (Name/amount in USD)	
Source 4 (Name/amount in USD)	
If co-funding are yet to be mobilized, provide a short explanation of the resource mobilization strategy. Please indicate source of potential funds.	

IV. Project Description

Background and Rationale:

The countries of South Asia and SAARC make up more than a quarter of the world's population, and an even greater percentage of the global disease burden. Malaria and TB, remain major infectious disease threats in South Asia and SAARC. Malaria remains endemic and a public health concern. About a third of the global population at risk of malaria lives in the SAARC region, with India carrying the highest burden, followed by Bangladesh and Nepal. Bhutan is on the path to eliminating malaria, while the Maldives and Sri Lanka have formally eliminated malaria and are collaborating to prevent the re-establishment of malaria.
Table 1 provides an overview of malaria in these six countries.

Table 1: Overview of malaria burden in select countries

Country	Malaria cases (2020) *
Bangladesh	7,545
Bhutan	22
India	4,148,253
Maldives	0
Nepal	245
Sri Lanka	0

* World Malaria Report 2021 https://www.who.int/teams/global-malaria-programme/reports/world-malaria-report-2021;

The WHO Global Technical Strategy (GTS) for malaria 2016 – 2030 aims to reduce malarial case incidence and mortality from its initial baseline (2015) to about 40% by 2020, 75% by 2025, and 90% by 2030.

One of the main challenges in the fight against malaria is the lack of sustained international and domestic financing and regional cross-border collaboration, amongst others. In addition, as per World Malaria Report 2020, the pandemic has reversed the progress towards eliminating malaria with COVID-19 spreading to all the malaria-endemic countries, leading to about 22 million case morbidity and 0.6 million case mortality by November 2020.

The movement of malaria across international borders poses a major obstacle to achieving malaria elimination. Reducing the malaria burden in cross-border areas needs an effective cross-border collaboration and coordination and synchronization of activities, a well-structured integrated health system and programs, a high-quality surveillance system, a clear strategy to reach high-risk and hard-to-reach populations efficiently, and a timely response to detected cases early. Translating technically sound strategies and policies into the most peripheral levels of implementation is the key to success. We need to strengthen health facilities at the community and district levels along borders, particularly at points of entry. Engagement with all stakeholders in the advocacy and implementation of strategies is necessary to prevent

transmission across borders. Thus, we need to address cross-border challenges to eliminate communicable diseases.

Challenges in eliminating malaria include health system weaknesses in border districts where access to prevention and treatment is limited and a lack of integration of health and social services. Health infrastructure in the border districts is usually inadequate in terms of workforce, quality, and supply is often irregular, interrupted, and short. The information available from the surveillance may not be readily available for adequate response planning. The living conditions of mobile and migrant populations may be substandard and crowded, resulting in increased disease transmission. People's engagement may not be adequate due to missing community coherence and adequate information.

Inter-country and regional coordination and support, and information sharing are necessary to synchronize and strengthen national efforts. Cross-border regional initiatives to tackle inter-country issues are required to achieve and sustain the elimination and control, including health and community systems strengthening.

The primary beneficiaries of the proposed project are the most vulnerable/poor populations residing along the border areas, on difficult and hard-to-reach terrain in the cross-border areas of Bhutan, Bangladesh, India, Nepal and the entry points of the Maldives and Sri Lanka.

The proposed project focuses on enhancing coordination & collaboration and strengthening the health information and surveillance system along the cross-border areas of Bhutan, Bangladesh, India, Nepal, Maldives, and Sri Lanka for malaria Advocacy and outreach activities focus on strengthening the resolve and regional cooperative spirit. The project contributes toward reducing the household burden due to sickness from malaria, especially out-of-pocket expenses for the diagnosis and treatment of the most vulnerable and poor population.

In addition, it would enable the member of the family to attend economic activities when not sick, contributing to the household income and well-being of the family members.

The women and children would be freed from caring for the sick, enabling them to participate in economic activities, national workforce, public decision-making, attend school, and complete their education. Thus, further contributing towards reducing the gender gap in higher and tertiary education besides enabling them to voice their concerns and issues and claim their rights.

This project aligns with the aims and priorities of the SAARC Development Funds Charter, SAARC Social Charter, SAARC Plan for Action on Poverty Alleviation, SAARC Development Goals and the Social Window funding criteria.

The proposed project is in line with the priority and commitment made by the respective governments. The activities align with their National Strategic Plans and contribute and fast-track their respective progress towards eliminating malaria and tuberculosis. Thus, the interventions of this project utilize the existing mechanism and channels and continue after the end of the project period as part of their national strategic plan, resulting in a sustainable response.

Implementation plan: The regional effort focuses on strengthening the resilient health systems to augment the countries' efforts to eliminate/ sustain the elimination of malaria. The indicative activities include:

- Activity 1.1: Health and Community information and surveillance system assessed in districts along the international cross-border areas of Bhutan, Bangladesh, Nepal, and India.
- Activity 1.2: Situation assessment to prevent re-establishment of malaria in the Maldives and Sri Lanka, focussing on the ports of entry.
- Activity 2: Bilateral cross-border coordination initiated and progressively strengthened between India-Bangladesh, India -Bhutan, India -Nepal especially at subnational level.
- Activity 3: Advocacy with donors and key stakeholders for enhanced /continued support for malaria elimination in SA,
- Activity 4: M&E to track progress on cross-border coordination in priority countries
- Activity 5: End of Project Evaluation

Sustainability:

Our project is catalytic in nature and focus on the areas and issues that augment the country's response to eliminate/ maintain eliminated status for malaria. The project activities are part of national strategic plan and involve communities, governments, donors, and philanthropists to address issues of catalytic nature such as improving the technical competencies in border areas, facilitate data sharing for improved response, regular cross border meetings and advocacy for improved resources in the region. These are part of the project design, implementation, and evaluation.

The project results are sustained through its design and ownership by the community and countries health systems. SRCMF focuses on bringing the governments to support the cross-border response augment the national goal to eliminate malaria. The key responses are part of the national plan and funded through domestic and donor resources from the Global Fund, other donors and technical partners. Our project outcomes will continue with the support from the countries health systems, donor programs and community support working on a well-established design and implementation plan. Alongside, as part of mandate of setting up for SRCMF, we will strive to raise resources to address cross border challenges and key gaps as part of our catalytic efforts.

SRCMF use an affiliate revenue generation model, through its constituent member countries and its board. We function as a para statal agency to support the issue and focus on cross border area. This is a cost effective and value for money implementation model that enhances country's ownership and response with its neighbors.

Justification for project implementation strategy and plan: Cross border issues have been a neglected area in disease control. Our gap analysis has shown that limitation of technical, commodity and logistical resources slow down the pace of malaria elimination efforts. Cross border collaboration to address disease elimination remains a low priority issue. Our activities focus on the cross-border challenges and endeavor to bring governments to the same platform to enable improved and effective collaborative efforts for a common cause. We use a cascading approach, from national, provincial, and local levels to strengthen cross border collaboration efforts, keeping in mind that the ownership lies with the respective countries to draw the memorandum of understanding (MoU). Our RBM project has provided valuable insights how to fast track collaborative efforts across borders. We have come up with the following enablers that make the project strategy effective and timely, namely:

- Step wise planned approach with measurable milestones
- Involve communities and national health systems simultaneously. They should be part of the national level plan and implementation. Requires perseverance and continuous efforts
- Repeat the same steps for border provinces and areas among neighboring countries
- Effective monitoring to ensure implementation is on track
- Cyclic advocacy in regular and timely manner

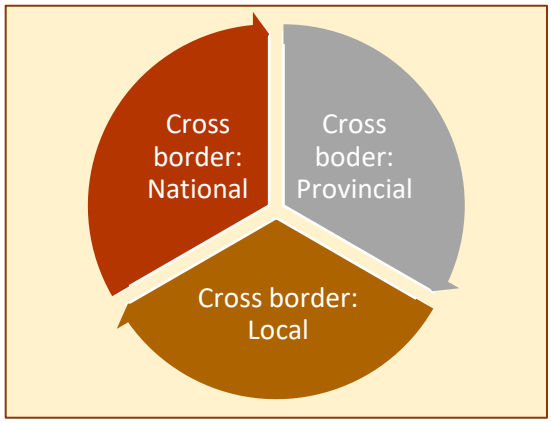


Figure 1: Cyclic advocacy with data flow

SRCMF was set up with support from 11-member country led country coordinating mechanism (CCM). In addition, we are governed by board from these constituent countries. This allows us a unique opportunity to work as regional organization with complete confidence and support from our constituent members.

We have worked for the past one year on cross border malaria elimination in four countries namely, Bangladesh, Bhutan, India and Nepal through funding support from UNOPS/RBM. We have delivered in a timely manner and have been on track. We have also successfully requested for a two-year additional funding support from UNOPS/RBM based on our good work and successful implementation of proposed activities.

The proposed project is in line with the priority and commitment made by the respective governments. The activities align with their National Strategic Plans and contribute and fast-track their respective progress towards eliminating malaria. Thus, the interventions of this project utilize the existing mechanism and channels and continue after the end of the project period as part of their national strategic plan, resulting in a sustainable response

The project interventions are designed to be sustainable as detailed in the section above. The nature of project design involving communities and health systems of cross border area, sharing of data for early detection and response and collaborative efforts from countries to implement the project makes it a sustainable response.

Targeted Beneficiaries:

The primary beneficiaries of the proposed project are the most vulnerable/poor populations residing along the border areas, on difficult and hard-to-reach terrain in the cross-border areas of Bhutan, Bangladesh, India, Nepal and the entry points of the Maldives and Sri Lanka.

The proposed project focuses on enhancing coordination & collaboration and strengthening the health information and surveillance system along the cross-border areas of Bhutan, Bangladesh, India, Nepal, Maldives, and Sri Lanka. Advocacy and outreach activities focus on strengthening the resolve and regional cooperative spirit. The project contributes toward reducing the household burden due to sickness from malaria, especially out-of-pocket expenses for the diagnosis and treatment of the most vulnerable and poor population.

In addition, it would enable the member of the family to attend economic activities when not sick, contributing to the household income and well-being of the family members.

The women and children would be freed from caring for the sick, enabling them to participate in economic activities, national workforce, public decision-making, attend school, and complete their education. Thus, further contributing towards reducing the gender gap in higher and tertiary education besides enabling them to voice their concerns and issues and claim their rights.

Coordination and Management Arrangements:

SRCMF will coordinate with the country programs to implement the proposed activities. The broad management arrangements are as follows (Figure 2):

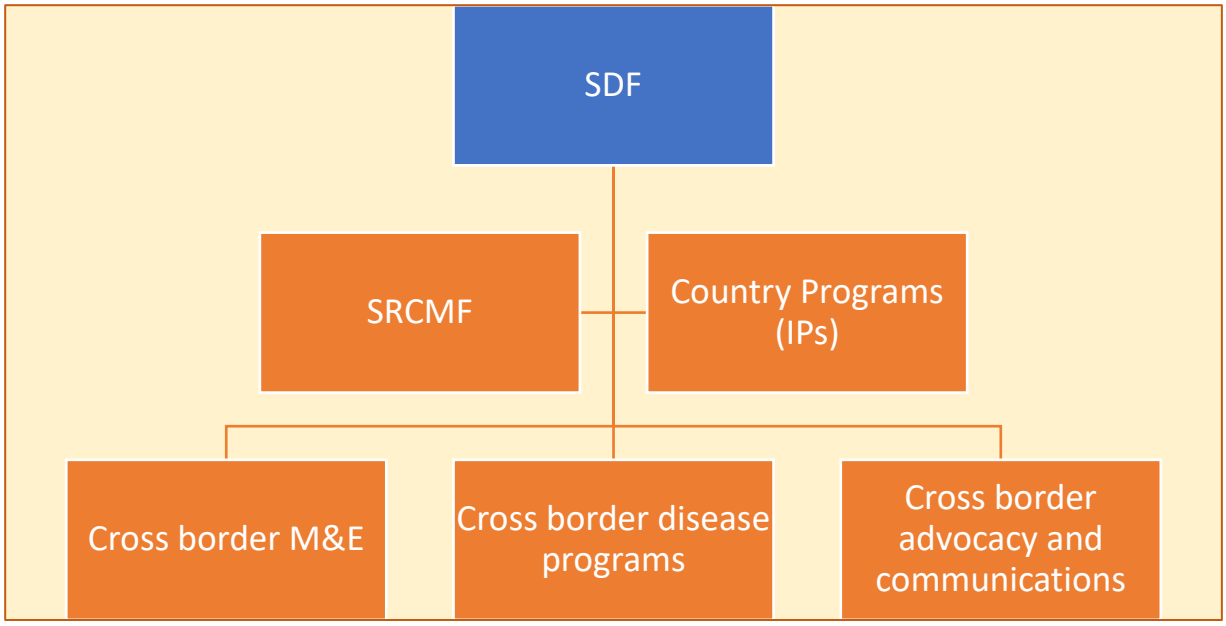


Figure 2: Management and Coordination Arrangements

SRCMF will ensure, transparent and incisive monitoring and evaluation system of the project with quality assurance of the implemented activities (Table 2). We will also use a Plan-Do-

Check-Act (PDCA) cycle to monitor the quality of the project with a defined feedback loop and reporting (Figure 3)

Table 2: Project recording and reporting

Sl. No.	What	Purpose	Medium	Frequency	Audience
1	Monthly progress report	Project progress update and any issues requiring attention/decision.	In-person, email, phone	Monthly	Between SRCMF and Ips
2	Quarterly report/meeting	Quarterly progress report/review meetings	Report and In-person	Quarterly	IPs to SRCMF to SDF and between agencies as required
3	Mid-year assessment/review	Meeting to update, review, discussion, and way forward with LIA/Ips	In-person	Biannually	Between SRCMF, IP and SDF
4	Annual Project Review Meeting	Progress update, review, discuss next year AWP and way forward with LIA/Ips	In-person	Annual	Between SRCMF, IPs and SDF
5	End of Project Evaluation	Assess project results	Through TA	End of project	SRCMF, IPs and SDF
6	Lessons learned and good practices	Documentation of lessons learnt and good practices and sharing with all relevant stakeholders and wider audiences (Reports, videos, Facebook posts etc.)	Documentation Sharing thorough workshops, meetings, newsletters, emails, media etc.	As and when possible and required	SDF, IPs, MoH, wider public, relevant stakeholders, donors etc.

We will ensure the quality of implemented activities, outcomes, documents, and reports through a PDCA cycle ensuring standards of (1) Administrative; (2) Advocacy and communication; (3) Data management; (4) Technical and (5) Cognitive processes.

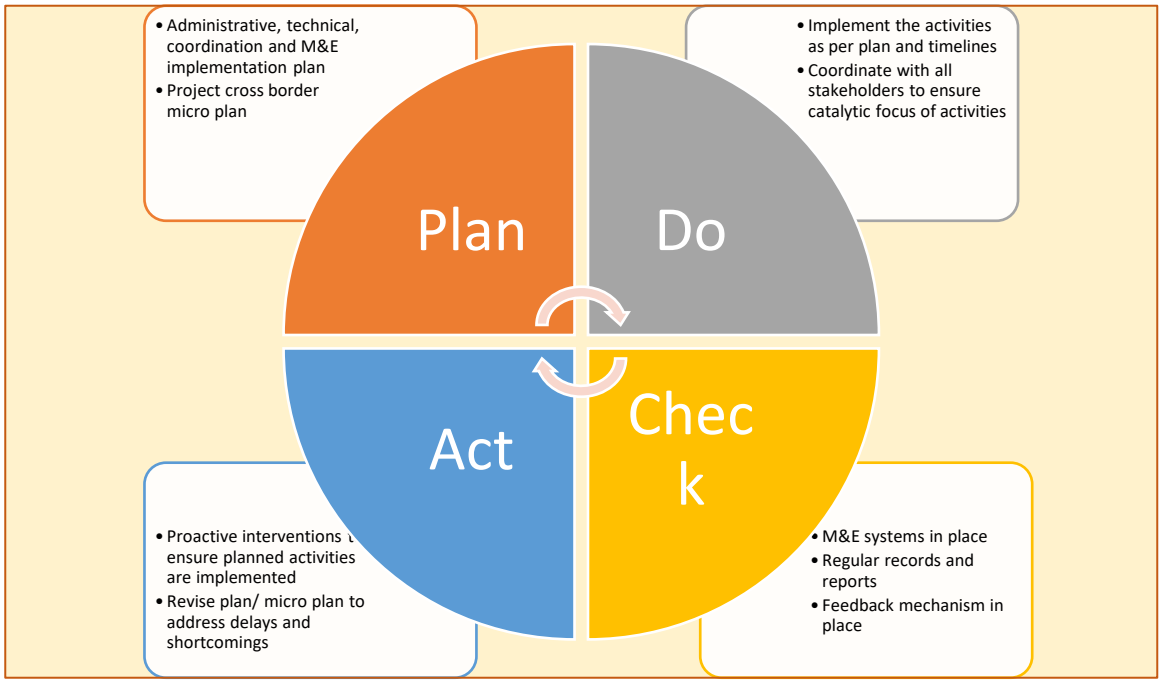


Figure 3: Quality Assurance - Project PDCA cycle

Risk Analysis:

The project is categorized as 'low risk' due to the following reasons:

- Project design has considered the management, financial and logistic issues based on prior experience of handling projects during COVID-19 pandemic.
- Political and Pandemic related disruptions are of moderate level, but in the proposed countries, we expect stable political scenario till 2024/ 2025 (next elections in proposed countries). Most countries have vaccination levels of 80-98% and will help to mitigate any severe effects of the pandemic.
- We have set up SRCMF in close coordination with the member countries of the SE Asia region. We work closely with governments and other stakeholders and thus party to information and emergent measures that is taken in country and region. We will proactively work to address any challenges in the cross-border areas and implementation.

The detailed risk analysis provided in Annex 1.

Monitoring and evaluation (M&E):

Monitoring & Evaluation (M&E) will be an important component of the project and activities will be result-oriented. We will develop an M&E framework in the beginning of the project and inputs will be sought from the GF SEA constituency, relevant others (the implementation & monitoring plan and a log frame attached to this CFP will be considered for the framework, as

appropriate). We will use the M&E guidance from the SDF, RBM[i], WHO[ii] and the GF[iii]. Multiple tools and mechanisms are proposed including but not limited to review of: record notes/minutes of meetings, visit reports, strategy documents and guidelines, impact assessment report, key performance indicator (KPI) reports, and milestone narrative reports by the GF SEA constituency, malaria technical working group (MTWG) and National Disease Control Programs (malaria) and (tuberculosis). In addition, we will conduct on site to assess progress at sub-national level about cross-border coordination. We have been conducting site visits as part of our UNOPS/RBM program in selected districts along India-Bhutan and India-Bangladesh border. Participants will include: representation from local/district level and state/provincial level, national level and select local stakeholders, MTWG members, selected experts/resource persons. Such visits will be aligned with supervisory visits of NMPs/program reviews as much as possible and involve visits on both sides of the border district. Involvement of civil society and community representatives from national/subnational/local level within monitoring purview will be ensured.

The SRCMF secretariat will be responsible for keeping all documents ready for review and will facilitate on site visits through the project period. Besides active participation in such assessments, they will themselves also carry out periodic visits to district level for monitoring progress on the ground. Utmost attempt will be made to ensure effective implementation, efficient use of resources and foster learning. Transparent communication with the GF SEA constituency, MTWG, SDF and continuous learning throughout project implementation are envisaged towards optimal accountability and performance.

The details are provided in Annex 2 and Annex 3.

Communications, Advocacy and Knowledge Management:

We are learning from our implementation of cross border malaria elimination funded through UNOPS/RBM for the region. We propose a tailored approach to implement the communication and advocacy plan for the cross-border region to fast track malaria elimination.

SRCMF uses evidence-based advocacy is one of the fundamental approaches. We continually monitor, document, and share learnings from our implementation experience and project evaluations. In addition, we will imbibe the latest technical recommendations from WHO, other technical partners and stakeholder and promote south-south collaboration

Communication: SRCMF will undertake communication at four levels throughout the project:

- With the focal implementing agencies in Bhutan, Bangladesh, India, Nepal, Maldives and Sri Lanka.
- Among the project team to learn from one another.
- With regional countries will be done frequently for learning exchange; and
- With SDF and other donors on the project

Advocacy: We will undertake proactive advocacy with the government, international and national NGOs, donors, medias and key stakeholders informing them of the ground realities,

progress, challenges and gaps. We shall especially focus on influencing them for greater support both in terms of policy and budgetary so that elimination of malaria by 2030 becomes a reality.

Knowledge Management: Throughout the project, we will be undertaking monitoring and assessment of the project, documenting the best practices and lessons learnt. Also advocacy materials and proposals will be developed. All this will be shared with all levels of Government, donors and other organizations through various platforms

Supporting documents to be uploaded/attached:

- Commitment/evidence of co-funding
- In case of in-kind co-funding, letter from co-funder stating value and how it was determined
- Legal incorporation documents, along with the Management profiles of each IP
- Details of similar projects undertaken by IPs
- Balance sheet/financial status of each IP for the past 3 years
- Details of certificate/approval from local authorities to implement the project in the proposed locations
- Letter of undertaking from IP stating they have paid all statutory dues like income tax/sales tax/custom duty, and no other dues are pending at the time of the submission of information to SDF, supported with certification from the relevant authorities; and IPs are meeting all regulatory issues and necessary compliances to implement the SDF project; and that the IPs will comply with SDF's policies and procedures.
- Latest Know Your Customer (KYC) documents, if applicable
- Credit rating (corporate/individual) if available (e.g., CIBIC scores in India)
- Any other documents as prescribed by the Board of Director, CEO or any competent authority of SDF.

Annex 1: Combined Project Risk Analysis Matrix

Risk	Impact	Likelihood	How will the risk be measured?	How will the risk be mitigated?
1. Project: Delayed start of the project due to financial, human resources and logistical issues	Delayed milestones and deliverables proposed in the project	Low	M&E of the project implementation plan with timelines of activities	This is a matching funding project, thus SRCMF will try to mitigate the implementation delays through: • Sustained advocacy efforts with donors and SDF • Project micro plan with contingency scenarios
2. Currency: Fluctuation in currency with devaluation	Cost of interventions may go up	Low	Financial tracking mechanism of the project	SRCMF will try and mitigate this risk with value for money planning with financial buffer.
3. Financial: Same as project				
4. Political: Risk of change of governments in any intervention country may lead to delay in project implementation	Delayed milestones of the project	Low	Information on countries political scenarios and election predictions	SRCMF will take a proactive approach though its secretariat and other constituent member countries support to mitigate any such risk that is likely to arise.
5. Legal: None				
6. Country: Risk of poor performance of the countries in malaria elimination	Delayed milestone of project and consequently delayed malaria elimination	Moderate	National program and CCM for each country have an M&E mechanism to track the progress for the Global Fund as well as national strategic plan for malaria. We will coordinate with in country programs to track the progress.	SRCMF will proactively interact with the national programs and other stakeholders to participate and support the national program as required to address any issues that is in our domain of expertise.

7. Others: Risk of COVID-19 like pandemic disrupting the malaria program performance	Delayed milestone of project and consequently delayed malaria elimination	Low to moderate	WHO and Country's national pandemic preparedness and response (PPR)	SRCMF will keep monitoring the current pandemic situation in coordination with WHO and other partners and follow a common agenda as decided to mitigate the effects of the pandemic as best as we can

Annex 2: COMBINED Results and Resources Framework

Project Outcome:	**Progressive strengthening of health systems in region and cross-border coordination to accelerate malaria in South Asia**							
Outcome Indicator:	**Number of countries sharing data and instituting measures to eliminate malaria in cross border areas**							
Baseline and Target:	**Baseline: 2022: 0** **Target: 2024: 6**							
Outputs	**Output Indicator**	**Indicator Baseline and Target**	**Indicative Activities**	**Country**	**Source of funding (SDF/co-funding source)**	**Project Budget (USD) and Timeframe**		
						Year 1	**Year 2**	**Total**
1.1 Strengthened health and community information and surveillance system in districts along the international cross border areas of Bangladesh, Bhutan, India, and Nepal	a. Number of cross border districts/ areas where communicable disease surveillance systems have been strengthened	Baseline: None Target: Four	i. Technical support to cross border areas on health systems strengthening (cross border workshops for both sides of border districts – local level coordination) ii. Facilitate malaria data sharing in	Bangladesh Bhutan India Nepal	SDF	124,167	-	124,167

			accordance with laws of each country. ii. Conduct coordination meetings in local cross border health authorities on a regular basis					
1.2 Situation assessment for prevention of cross border re-establishment of malaria in Sri Lanka and Maldives completed	Situation analysis reports on cross border malaria are available from both countries	Baseline : None Target: Two	i. Hire consultant to conduct the situation analysis on re-establishment of malaria in Sri Lanka and Maldives ii. Coordinate with national programs and other stakeholders (WHO, TGF, others) in both the countries iii. Develop the situation analysis	Maldives and Sri Lanka	SDF	30,000		30,000

			report on re-establishment of malaria in Maldives and Sri Lanka					
Strengthening of National Malaria Elimination Program for acceleration of malaria elimination	a. update cross-border strategy and implementing plan b. Regional meeting c. Impact of covid-19 on malaria elimination		I. Strategy and implementation plan developed ii. Regional meetings conducted iii. Impact of covid-19 pandemic on malaria elimination program report		Co-Funding support (UNOPS/RBM)	28,810	28,810	57,620
2. Bilateral cross-border coordination initiated and progressively strengthened between India-Bangladesh, India-Bhutan, India-Nepal especially at sub-national level	a. Number of coordination meetings held with reports b. Number of countries sharing data on a regular basis for cross border prevention efforts on malaria	Baseline : NA Target: two meetings per year (total of 6)	i. Facilitate the cross border strategic plan implementation (developed through co-funding support) ii. Facilitate the local cross border meetings to pave way for	Bangladesh Bhutan India Nepal	SDF	152,875	152,875	305,750

Bilateral coordination meetings, monitoring and supervision	c. Number of countries sharing a coordinated work plan on malaria elimination for cross border activities		data sharing to develop coordinated work plan in cross border areas iii. Facilitate (through TA) implementation of cross border malaria elimination activities		Co-Funding support (UNOPS/RBM)	70,080	70,080	140,160
3. Advocacy with donors and key stakeholders for enhanced/continued support for malaria elimination in SA	a. Number of advocacy meetings held to enhance/ continue support for malaria elimination in SA b. Number of cross border community support meetings of formal and informal community groups for malaria	Baseline : None Target: One meeting per year (total of three, formal larger scale) Four per year smaller scale cross border	i. Facilitate implementation of regional advocacy and resource plan ii. Facilitate private sector participation in cross border malaria elimination	Regional	SDF	10,000	10,000	20,000

Advocacy, communication and IEC	elimination in the priority countries	for both sides of border			Co-Funding support (UNOPS/RBM)	28,317.50	28,317.50	56,635
4. End of project evaluation	a. Endline evaluation of project completed	Target: one	i. Hire consultant to conduct the end of project evaluation ii. Coordinate with malaria programs to facilitate the cross-border evaluation iii. Develop end of project evaluation iv. Share the end of project evaluation report with all stakeholders	Regional	SDF		29,600	29,600

5. Set up, implement and operate project M&E system Capacity building for aiding programme implementation management and monitoring and supervision targeting key stakeholders in border districts.	a. Project M&E system set up and operating b. Data from project is available at regular intervals	Baseline : None Target: One	i. Develop project M&E systems by engaging consultants ii. Operating the project M&E through cost sharing with other programs	Regional	SDF Co-Funding support (UNOPS/RBM)	7,500 24,355	7,500 24,355	15,000 48,710
6. Program support cost	a. Program functioning at optimal level with deliverables		i. Operate program management through SRCM secretariat staff ii. Build, operate and evaluate the program at regular intervals iii. Institute indicative/ facilitate	Regional	SDF Co-Funding support	35762.50	35762.50 146,458.50	71,525 292,917.00

Program support costs			course correction measure as required for the project		(UNOPS/RBM)	146,458.50		

Annex 3: Combined Annual Work Plan Template
Country: <u>Bangladesh, Bhutan, India, Maldives, Nepal and Sri Lanka</u>

Year: <u>2023</u>

Outputs ***including indicators and annual targets***	**Planned Activities**	**Year 1**				**Year 2**				**Planned budget (USD)**		
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Imp partner/Country**	**Source of Funds**	**Amount**
1.1: **Strengthened health and community information and surveillance system in districts along the international cross border areas of Bangladesh, Bhutan, India and Nepal** Indicator: **Number of cross border districts/ areas where communicable disease surveillance systems have been strengthened** Target: **Four**	i. Technical support to cross border areas on health systems strengthening (cross border workshops for both sides of border districts – local level coordination) ii. Facilitate malaria data sharing in accordance with laws of each country. iii. Conduct coordination meetings in local cross border health authorities on a regular basis	**X**	**X**	**X**	**X**					NMEP programs MoH, Govt of Bhutan, Bangladesh, Nepal and India	SDF	124,167

Outputs *including indicators and annual targets*	Planned Activities	Year 1				Year 2				Planned budget (USD)		
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Imp partner/Country	Source of Funds	Amount
1.2: **Situation assessment for prevention of cross border re-establishment of malaria in Sri Lanka and Maldives completed** Indicator: **Situation analysis reports on cross border malaria are available from both countries** Target: **Two**	i. Hire consultant to conduct the situation analysis on re-establishment of malaria in Sri Lanka and Maldives ii. Coordinate with national programs and other stakeholders (WHO, TGF, others) in both the countries iii. Develop the situation analysis report on re-establishment of malaria in Maldives and Sri Lanka	X	X	X	X					NMP, MoH, Govt of Maldives and Sri Lanka	SDF	30,000
2: **Bilateral cross-border coordination initiated and progressively strengthened between India-Bangladesh, India-Bhutan, India-Nepal especially at sub-national level** Indicator: a. **Number of coordination meetings held with reports**	i. Facilitate the cross border strategic plan implementation (developed through co-funding support) ii. Facilitate the local cross border meetings to pave way for data sharing to develop coordinated work plan in cross border areas	X	X	X	X	X	X	X	X	NMEP programs MoH, Govt of Bhutan, Bangladesh, Nepal and India	SDF	305,750

Outputs *including indicators and annual targets*	Planned Activities	Year 1				Year 2				Planned budget (USD)		
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Imp partner/Country	Source of Funds	Amount
b. **Number of countries sharing data on a regular basis for cross border prevention efforts on malaria** c. **Number of countries sharing a coordinated work plan on malaria elimination for cross border activities** Target: **Four countries**	iii. Facilitate (through TA) implementation of cross border malaria elimination activities											
3: **Advocacy with donors and key stakeholders for enhanced/continued support for malaria elimination in SA** Indicator: a. **Number of advocacy meetings held to enhance/ continue support for malaria elimination in SA** b. **Number of cross border community support meetings of formal and informal community**	i. Facilitate implementation of regional advocacy and resource plan ii. Facilitate private sector participation in cross border malaria elimination	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	NMEP programs MoH, Govt of Bhutan, Bangladesh, Nepal and India	SDF	20,000

Outputs *including indicators and annual targets*	Planned Activities	Year 1				Year 2				Planned budget (USD)		
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Imp partner/Country	Source of Funds	Amount
Target: **One every year (formal meetings), Four smaller meetings (one every quarter cross border)**												
4. 4. End of project evaluation	i. Hire consultant to conduct the end of project evaluation ii. Coordinate with malaria programs to facilitate the cross-border evaluation iii. Develop end of project evaluation Share the end of project evaluation report with all stakeholders								**X**	NMEP programs MoH, Govt of Bhutan, Bangladesh, Nepal and India	SDF	29,600
5: **Set up, implement and operate project M&E system** **Indicator:** a. **Project M&E system set up and operating**	i. Develop project M&E systems by engaging consultants ii. Operating the project M&E through cost sharing with other programs	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	NMEP programs MoH, Govt of Bhutan, Bangladesh, Nepal and India	SDF	15000

Outputs *including indicators and annual targets*	Planned Activities	Year 1				Year 2				Planned budget (USD)		
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Imp partner/Country	Source of Funds Amount	
b. **Data from project is available at regular intervals** Target: **One**												
6: Program support cost	i. Operate program management through SRCM secretariat staff ii. Build, operate and evaluate the program at regular intervals iii. Institute indicative/ facilitate course correction measure as required for the project	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	SRCMF		71525

[i] https://endmalaria.org. Accessed 15 March 2021.

[ii] Malaria surveillance, monitoring & evaluation: a reference manual. World Health Organization. 2018. https://apps.who.int/iris/bitstream/handle/10665/272284/9789241565578-eng.pdf, Accessed 15 March 2021.

[iii] Modular Framework Handbook. The Global Fund. 2019. https://www.theglobalfund.org/media/4309/fundingmodel_modularframework_handbook_en.pdf, Accessed 1 March 2020.

Bangladesh Country Coordinating Mechanism (BCCM)

Newly Reconstituted in 2023

BCCM Members and Alternate Members list

Updated on: 06 June 2023

N.B: Not according to seniority, but according to the constituency

Seat No.	Category	Title	Name	Institution	Designation	Telephone	Email	Constituency	Member/ Alternate	Gender
HSD, MOHFW										
1	Govt.	**Mr.**	**Zahid Maleque, MP**	MOH&FW	Minister	+88029574488, +88029574422	minister@mohfw.gov.bd	GOV	Member	Male
	Govt.	**Dr.**	**Md. Anwar Hossain Howlader**	Health Services Division	Secretary	02-223357199	secretary@hsd.gov.bd	GOV	Alternate Member	Male
2	Govt.	**Mr.**	**Md. Saidur Rahman**	Health Services Division	Additional Secretary (WH)	+8801718030258	devwing@hsd.gov.bd, rahman.saidur66@gmail.com	GOV	Member	Male
	Govt.	**Ms.**	**Anjuman Ara**	Health Services Division	Joint Secretary (WH Branch)	+8801712664136	who@hsd.gov.bd, anjuman2174@gmail.com	GOV	Alternate Member	Female
3	Govt.	**Mr.**	**Md. Saidur Rahman**	Health Services Division	Additional Secretary (Admin)	+8801718030258	adminwing@hsd.gov.bd	GOV	Member	Male
	Govt.	**Mr.**	**Sadekul Islam**	Health Services Division	Deputy Secretary (WH2)	+8801761491222	samonti2009.24@gmail.com, wh1@hsd.gov.bd	GOV	Alternate Member	Male
4	Govt.	**Prof.**	**Dr. Abul Bashar Mohammad Khurshid Alam**	DGHS	Director General, DGHS	+8801711749096	alamdr2003@yahoo.com; dghsbd@gmail.com	GOV	Member	Male
	Govt.	**Dr.**	**Ahmedul Kabir**	DGHS	ADG(Planning & Devlop) DGHS	+8801720910541	ahmedul_986@yahoo.com; adgplanning@ld.dghs.gov.bd; adgplanning@gmail.com	GOV	Alternate	Male
5	Govt.	**Mr.**	**Md. Jahangir Hossain**	Health Services Division	Additional Secretary (Planning)	+8801818985545	addlsecypln.hsd@gmail.com;	GOV	Member	Male
	Govt.	**Ms.**	**Shaila Sharmin Zaman**	Health Services Division	Joint Secretary (Planning	+8801733505577	shaila_sz@yahoo.com	GOV	Alternate	Female
6	Govt.	**Mr.**	**Md. Tofael Islam**	CMSD, DGHS	Director, CMSD	+8801712577165	md.tofaelislam@yahoo.com	GOV	Member	Male
	Govt.	**Prof.**	**Dr. Tahmina Shirin**	IEDCR, DGHS	Director, IEDCR	+8801711626151	tahmina.shirin14@gmail.com; directoriedcr@gmail.com; director@iedcr.gov.bd	GOV	Alternate	Female
MOLGRD										
7	Govt	**Mr.**	**Md Jasim Uddin**	LGRD	Joint Secretary	+8801715181160	jasim6811@yahoo.com	GOV	Member	Male
	Govt	**Mr.**	**Md Mustafizur Rahman**	LGRD	Deputy Secretary	+8801711235628	lgws1@lgd.gov.bd	GOV	Alternate	Male
MOE										

Bangladesh Country Coordinating Mechanism (BCCM)

Newly Reconstituted in 2023

BCCM Members and Alternate Members list

Updated on: 06 June 2023

N.B: Not according to seniority, but according to the constituency

Seat No.	Category	Title	Name	Institution	Designation	Telephone	Email	Constituency	Member/ Alternate	Gender
8	Govt	**Mr.**	**Md. Nazrul Islam**	MOEDU	Additional Secretary	0255100490 +8801772541264	ds.admin@moedu.gov.bd	GOV	Member	Male
	Govt	**Mr.**	**Saifur Rahman Khan**	MOEDU	Deputy Secretary	0255101220 +8801718591339	ds.admin@shed.gov.bd	GOV	Alternate	Male
MOWCA										
9	Govt	**Ms.**	**Most. Ferdousi Begum**	MOWCA	Joint Secretary	+8801552397996	jsbudget@mowca.gov.bd	GOV	Member	Female
	Govt	**Mr.**	**Dipak Kumar Roy**	MOWCA	Deputy Secretary (Child and Co-ordination)	+8801710169398	dschild@mowca.gov.bd	GOV	Alternate	Male
MOSW										
10	Govt	**Mr.**	**Md. Zehsan Islam**	MOSW	Joint Secretary	8801768620970	zehsanislam@msw.gov.bd	GOV	Member	Male
	Govt	**Mr.**	**Mohammad Abdul Hamid Mia**	MOSW	Deputy Secretary	8801712053407	mianmgst@gmail.com	GOV	Alternate	Male
MOCHTA										
11	Govt	**Mr.**	**Md Jahangir Alam**	MOCHTA	Joint Secretary	+8801819597111	pd.jstp.5685@gmail.com	GOV	Member	Male
	Govt	**Ms.**	**Nasrin Sultana**	MOCHTA	Deputy Secretary	+8801720-030348	nasrin.admin@gmail.com	GOV	Alternate	Female
MOHA										
12	Govt	**Mr.**	**Md Ali Reza Siddiquee**	SSD	Joint Secretary (Immi-1 branch)	+8801886100555	bc.immi1@ssd.gov.bd	GOV	Member	Male
	Govt	**Mr.**	**Shaikh Farid Ahmed**	SSD	Deputy Secretary (Admin-1 Section and Budget-1 section)	+8801746688700	admin1@ssd.gov.bd	Gov	Alternate	Male
MOF										
13	Govt	**Mr.**	**A K M Sohel**	MOF	Joint Secretary and Wing Chief, ERD	+8801711646667	addlsecy-un@erd.gov.bd; wingchief04@erd.gov.bd	GOV	Member	Male
	Govt	**Mr.**	**Bidhan Baral**	MOF	Deputy Secretary, ERD	+8801712903630 9180715	bidhan2224@gmail.com; un4@erd.gov.bd	GOV	Alternate	Male
14	Govt	**Mr.**	**Md. Abdul Gafur**	MOF-IRD	Joint Secretary (Budget)	+8801715028118 +8801715237272	abdul.gafur@ird.gov.bd	GOV	Member	Male

Bangladesh Country Coordinating Mechanism (BCCM)

Newly Reconstituted in 2023

BCCM Members and Alternate Members list

Updated on: 06 June 2023

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Seat No.	Category	Title	Name	Institution	Designation	Telephone	Email	Constituency	Member/ Alternate	Gender
	Govt	**Mr.**	**Dipak Kumar Biswas**	MOF-IRD	Deputy Secretary (Budget-1,2)	+8801716166165	prof.dipakkumar@ird.gov.bd	GOV	Alternate	Male
ML/ BL										
15	ML/BL	**Mr.**	**Joseph Sebhatu**	Global Affairs Canada	First Secretary	+8801711218216	joseph.sebhatu@international.gc.ca	ML	Member	Male
	ML/BL	**Ms.**	**Farzana Sultana**	Global Affairs Canada	Development Advisor	+8801688103774	farzana.sultana@international.gc.ca	ML	Alternate	Female
16	ML/BL	**Dr.**	**Samina Choudhury**	USAID	Infectious Disease Team Lead, OPHNE	+8801711181297	schoudhury@usaid.gov	ML	Member	Female
	ML/BL	**Mr.**	**Sardar Munim Ibna Mohsin**	USAID	Project Management Specialist (Tuberculosis), OPHNE, USAID	+8801755648960	smohsin@usaid.gov	ML	Alternate	Male
17	ML/BL	**Dr.**	**Saima Khan**	UNAIDS	Country Director	+8801711821726	KhanS@unaids.org	BL	Member	Female
	ML/BL	**Mr.**	**Md. Abu Taher**	UNODC	National Programmme Coordinator	+8801711006369	md.taher@un.org	BL	Alternate	Male
18	ML/BL	**Dr.**	**Anupama Hazarika**	WHO	Medical Officer, Communicable Disease Surveillance	+8801318367300	hazarikaa@who.int	BL	Member	Female
	ML/BL	**Dr.**	**Sabera Sultana**	WHO	NPO	+8801713001269	sultanas@who.int	BL	Alternate	Female
NGO										
19	CSO	**Mr.**	**SM Shirajul Islam**	PDC	Executive Director	+8801711429126 +8801552399211	smshiraj@pdcbd.org	NGO-HIV	Member	Male
	CSO	**Mr.**	**Asaduzzaman Selim**	MUK	Executive Director	+8801733223299 +8801711397142	muk1995@gmail.com	NGO-HIV	Alternate	Male
20	CSO	**Mr.**	**Sharif Mostafa Helal**	BWHC	Executive Director	+8801714220183	ed.bwhc@gmail.com	NGO-TB	Member	Male
	CSO	**Prof.**	**Dr. Moazzem Hossain**	IACIB	Executive Director	+8801715038551 +8801911321781	moazzem.iacib@gmail.com	NGO-TB	Alternate	Male
21	CSO	**Mr.**	**A. T. M. Badrul Islam**	JASHIS	Executive Director	+8801713486200	jashis1997@gmail.com	NGO-Malaria	Member	Male
	CSO	**Ms.**	**Jesmin Prema**	SKUS	Chairperson	+8801712750071 +8801816251919	skus.coxsbazar@gmail.com	NGO-Malaria	Alternate	Female

Bangladesh Country Coordinating Mechanism (BCCM)

Newly Reconstituted in 2023

BCCM Members and Alternate Members list

Updated on: 06 June 2023

N.B: Not according to seniority, but according to the constituency

Seat No.	Category	Title	Name	Institution	Designation	Telephone	Email	Constituency	Member/ Alternate	Gender
22	CSO	**Dr.**	**Dibalok Singha**	DSK	Executive Director	+8801713147329	singha@dskbangladesh.org	NGO-WO&Ch	Member	Male
	CSO	**Mr.**	**Md. Hemayet Hossain**	RISDA-Bangladesh	Executive Director	+8801777765400 +8801552350687	ed@risda.org.bd; risda.bangladesh@yahoo.com	NGO-WO&Ch	Alternate	Male
PLWD										
23	CSO	**Mr.**	**Ahsanul Alam Kishore**	PLHIV	Member	+8801833104791	ahsanul.kishore@gmail.com	PLWD- HIV	Member	Male
	CSO	**Mr.**	**Hafizuddin Munna**	Network of PLHIV (NOP+)	Greneral Secretary	+8801711315557	munnadfd24@gmail.com	PLWD- HIV	Alternate	Male
24	CSO	**Ms.**	**Dr. Samnun Faruque**	NATAB	Executive Committee Treasurer	+8801711530525	natabbd@gmail.com	PLWD-TB	Member	Female
	CSO	**Mr.**	**Khairuddin Ahmed**	NATAB	General Secretary	+8801708790204	natabbd@gmail.com	PLWD-TB	Alternate	Male
25	CSO	**Mr.**	**Sing Young Mro**	BHDC	Member	+8801820187663	singyoung71@gmail. com	PLWD-Malaria	Member	Male
	CSO	**Mr.**	**Sabir Kumar Chakma**	RHDC	Alternate Member	01720693062 01818430037	subirchakam62@gmail.com cht.rhdc@yahoo.com	PLWD-Malaria	Alternate member	Male
KAP										
26	CSO	**Mr.**	**Didarul Alam Rashed**	NPUD	President	+8801818067706	npud17@gmail.com	KAP-HIV	Member	Male
	CSO	**Mr.**	**Mezbah U Ahmed (Biraj)**	CBO-Bangladesh	Coordinator	+8801711973912	masbahnatore@yahoo.com	KAP-HIV	Alternate	Male
27	CSO	**Ms.**	**Nilufa**	SWNOB	General Secretary	+8801826684387	nilufa.swnob@gmail.com	KAP-TB	Member	Female
	CSO	**Ms.**	**Rina Akhtar**	SWNOB	Member	+8801795247668	swnob2002org@yahoo.com	KAP-TB	Alternate	Female
28	CSO	**Mr.**	**Mohammad Ali**	Shining Hill	Member	+8801554335373	shininghillcht@yahoo.com	KAP-Malaria	Member	Male
	CSO	**Ms.**	**Hla Shing Nue**	BNKS	Alternate Member	+8801886742358	bnks.ed@gmail.com	KAP-Malaria	Alternate	Female
Faith Based Oranization										

Bangladesh Country Coordinating Mechanism (BCCM)

Newly Reconstituted in 2023

BCCM Members and Alternate Members list

Updated on: 06 June 2023

N.B: Not according to seniority, but according to the constituency

Seat No.	Category	Title	Name	Institution	Designation	Telephone	Email	Constituency	Member/ Alternate	Gender
29	CSO	**Mr.**	**Milon Kanti Datta**	BHBCOP	Presidium Member	+8801727 346990	milon_kanti_datta@hotmail.com	FBO	Member	Male
	CSO	**Mr.**	**Jitendra Lal (J L) Bhowmik**	BHBCOP	Presidium Member	+8801776196269	dplehnbd101@gmail.com	FBO	Alternate	Male
Academia										
30	CSO	**Prof.**	**Mohammad Abul Faiz**	Malaria Expert	Former DG, DGHS	+8801713008858	drmafaiz@gmail.com	Academia	Member	Male
	CSO	**Dr.**	**Asif Mujtaba Mahmud**	Asgar Ali Hospital	Senior Consultant, Respiratory Medicine & Tuberculosis	+8801819238333	asifmahmud60@gmail.com	Academia	Alternate	Male
31	CSO	**Dr.**	**Nadira Sultana**	Frannan International LTd.FSSP	Public Health Specialist	+8801711389606	sultanadrnadira@yahoo.com; sultanadrnadira@gmail.com	Academia	MEmber	Female
	CSO	**Prof.**	**Dr. Md. Aminul Haque**	Department of Population Sciences, DU	Professor	+8801712529264	aminul.haque@du.ac.bd	Academia	Alternate	Male
Private Sector										
32	CSO	Ms.	**Kazi Zebunnessa Begum,**	Bangladesh Girl Guides Association	National Commissioner,	+8801753422385 +8801783181774	zebun1@yahoo.com	PS	Member	Female
	CSO	Mr.	**Commodore Muhammed Farooque**	Kumudini Welfare Trust of Bengal (BD) Ltd	Adviser	+8801713197510	cdrefarooque@gmail.com	PS	Alternate	Male
33	CSO	Dr.	**Iqbal Anwar**	Prime Bank Foundation	CEO	+8801713069905	iqbalanwar@primebank.com.bd	PS	Member	Male
	CSO	Dr.	**Muhammod Abdus Sabur**	Ad-din Foundation	Chairman	+8801731629575	sabur.pso@gmail.com	PS	Alternate	Male

Bangladesh Country Coordinating Mechanism
BCCM Oversigth Committee Members

PR Representatives to BCCM (Non Voting) list

N.B Not according to seniority but according to the PRs

Update: 06 June 2023

No	Salutation	NAME	Organisation	Title (Designation)	Phone	Email	Constituency	Membership Status
NTP								
1	Dr.	Mahfuzer Rahman Sarker	TBL and ASP	Line Director	+8801712591887	directordcbd@gmail.com	HIV & TB	PR Representative
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