

FUNDING REQUEST APPLICATION FORM

Full Review

SUMMARY INFORMATION			
Applicant			
Component(s)			
Principal Recipient(s)	1. National AIDS and STD Control (NASC) (former NASP). 2. Save the Children 3. icddr,b		
Envisioned grant(s) start date	1 st December 2017	Envisioned grant(s) end date	30 th November 2020
Allocation funding request	US\$ 21,495,375	Prioritized above allocation request	US\$ 9,471,995

IMPORTANT:

To complete this funding request, please:

- Refer to the accompanying **Funding Request Instructions: Full Review**;
- Refer to the Information Note for each component as relevant to the funding request, and other guidance available, found on the [Global Fund website](#).
- Ensure that all mandatory attachments have been completed and attached. To assist with this, an application checklist is provided in the Annex of the *Instructions*; - Ensure consistency across documentation.

Applicants are encouraged to submit a joint funding request for eligible disease components and resilient and sustainable systems for health (RSSH).

Joint TB/HIV submissions are compulsory for a selected number of countries with highest rates of co-infection. See the related [guidance](#) for more information.

This funding request includes the following sections:

- Section 1:** Context related to the funding request
- Section 2:** Program elements proposed for Global Fund support, including rationale
- Section 3:** Planned implementation arrangements and risk mitigation measures
- Section 4:** Funding landscape, co-financing and sustainability
- Section 5:** Prioritized above allocation request

SECTION 1: CONTEXT

This section should capture, in a concise way, relevant information on the country context. Attach and refer to key contextual documentation justifying the choice of interventions proposed. To respond, refer to additional guidance provided in the *Instructions*.

1.1 Key reference documents on country context

List contextual documentation for key areas in the table provided below. If key information for effective programming is not available, specify this in the table (“N/A”) and explain in Section 1.2 how this was dealt with within the context of the request, including plans, if any, to address such gaps.

Applicant response in table below.

Key area	Applicable reference document(s)	Relevant section(s) & pages nb.	N/A
Resilient and Sustainable Systems for Health (RSSH)			
Health system overview	Program Implementation Plan (PIP), Volume-1, HPNSDP	Page 13, 15, 17, 27, 33	<input type="checkbox"/>
Health system strategy	Bangladesh Demographic and Health Survey, 2014	Page 15, 201, 206, 209,	<input type="checkbox"/>
	Bangladesh Demographic and Health Survey, Policy Brief, 2014.	Page 3-4, 8, 11	
	Mapping Study and Size Estimation of Key Populations in Bangladesh for HIV Programs 2015-2016	Page 10, 45-46	
	Gender Equity Strategy 2014.	Page 5	
	4th National Strategic Plan for HIV and AIDS Response, 2018-2022.	Page 6	
Human rights and gender considerations (cross-cutting)			<input type="checkbox"/>
Disease-specific			
Epidemiological profile (including interventions for key and vulnerable populations, as relevant)			<input type="checkbox"/>
Disease strategy (including interventions for key and vulnerable populations, as relevant)	Mapping Study and Size Estimation of Key Populations in Bangladesh for HIV Programs, 2015-2016	Page XV, XVI, XVIII	<input type="checkbox"/>
	Population Size Estimates for Most at Risk Populations for HIV In Bangladesh 2009	Page 6	
	PIP, 4 th HPNSDP, Government of	Page 385-	

	Bangladesh	386,	
	UNAIDS Investment case report	Page 14	
Operational plan, including budgetary framework	Program Implementation Plan (PIP), Volume-1, HPNSDP		<input type="checkbox"/>
Program reviews and/or evaluations			<input type="checkbox"/>
Human rights and gender considerations (disease-specific)			<input type="checkbox"/>
<i>Add rows as relevant, for any additional key area as relevant to the funding request</i>			

1.2 Summary of country context

To complement the reference documents listed in Section 1.1 above, provide a summary of the critical elements within the context that informed the development of the funding request. The brief description of the context should cover disease-specific and RSSH components, as appropriate, as well as human rights and gender-related considerations.

(maximum 2 pages per component)

[Applicant response]:

1.2 Country Context: HIV

Epidemiological profile

The country context is described based on different sources of data including passive case reporting, a size estimation exercise of 2015, HIV and behavioural surveillance survey (BSS) conducted among female sex workers (FSWs), people who inject drugs (PWID), male sex workers (MSWs), males having sex with males (MSM) and transgender women (locally known as hijra) in Dhaka and Hili between 2015-2016, as well as different studies and surveys that were conducted since 2010.

Between 1989 (when the first HIV case was detected in Bangladesh) to 2016 a total of 4,721 HIV cases have been detected and the estimated number of people living with HIV (PLHIV) is 9,636 (NASP and UNAIDS, 2015). In 2016 of those found to be HIV positive 578 were new cases (NASC 2016, World AIDS Day, slide # 8) most of whom were concentrated in Dhaka (37.5%), Chittagong (23.5%), Khulna (17.0%) and Sylhet divisions (14.0%) (NASP 2016, World AIDS Day slide# 13 and 12). The size of key populations (KPs) was estimated in 2015 (ref: Bangladesh Mapping and size estimation 2015). The estimated sizes of the KPs are 102,260 for FSWs, 101,260 for MSM, 29,777 for MSWs, 10,199 for hijra and 33,067 for PWID.

The key findings from the 2015-16 BSS showed that 53.1% PWID in Dhaka shared used needle/syringes in the last week (NASP 2016, unpublished) compared to 60.7% during the last BSS conducted in 2006/07 (NASP 2009, page-22). In 2016 fewer male PWID bought sex from FSWs in the last year since BSS of 2002 (31.2% and 57.2% respectively, $p < 0.05$). More FSWs reported using condoms use with clients over the years of BSS since 2002. In 2016, consistent condom use was 39.4%, 36.9% and 42.5% in brothels, streets and hotels of Dhaka respectively. Consistent condom use by MSM also

Funding Request: Full review

increased over the years since 2002 with 34% and 46.6% reporting this with non-transactional and transactional partners respectively in last month (NASP 2016, unpublished). Similarly for MSWs and hijra in the last week this increased significantly over the years; in 2015 43.7% and 39.9% MSWs used condoms consistently while 24.8% and 22.8% hijra did so with new and regular clients respectively. As before, the highest HIV prevalence was found among male PWID in the A1 neighbourhood of Dhaka (27.3%), while in A2 it was 8.9%. In female PWID in Dhaka the prevalence was 5%. Till now, the prevalence of HIV among FSWs, MSM, MSWs is less than 1%. No HIV was detected among male PWID in Hili but of 46 Hijra sampled in Hili two were positive for HIV (4.3%) while 0.9% were positive in Dhaka. The prevalence of risk behaviours of HIV positive PWID is of concern as 64.3% lent their used needles/syringes to others in the last week, 33.1% bought sex from FSWs in the last year and 30.4% were married. The low prevalence of HIV among MSM cannot be neglected because MSM in Dhaka city are highly networked (Lisa, RDS paper in BD, 2008, page-301; 20 years of HIV, page-xvi).

The prevalence of sexually transmitted infections (STIs) was determined through surveillance where active syphilis rates were measured and through a research study conducted in Dhaka among FSWs, female PWID, MSWs and hijra where active syphilis, gonorrhoea and chlamydia were tested for from different anatomical sites (Khanam et al, STD 2016 and AAC 2015). Surveillance data of 2015-16 show that rates were 2.6% and 2.4% in male PWID from Dhaka A1 and A2 respectively, 5.8% in female PWID in Dhaka, 0.9% in male PWID from Hili, ranging from 0-3.2% in FSWs from different sites in Dhaka, Hili and nationally from brothels. In MSW and MSM the rates around 1% in Dhaka and Hili while in hijra it was 5% in Dhaka and 0 in Hili. When different STIs were considered the overall rates of having any STI among FSWs from streets and residences in Dhaka were 10% and 12.5% respectively, 20.7% in MSWs, 21.3% in hijra and 7.3% in female PWID (Khanam et al, STI report, page-80 and FSW paper, 2016).

Information on HIV among general population in Bangladesh is limited. Only 10.9% of 15-49 women (NIPORT 2016, page-179) and 16.8% of 15-49 men had comprehensive knowledge of HIV (NIPORT 2011, pages-203). Migrants have been considered to be a potential KP because of the high percentage newly detected among the reported cases (33% in 2016, NASP 2016, World AIDS Day Slide#12). A recent small study in a rural area of Bangladesh detected one HIV positive case among 297 randomly sampled returnee migrants using an oral fluid based HIV testing kit (Alam et al 2015, page-S54).

Diseases strategies

The strategy for addressing HIV in Bangladesh is based on the HIV epidemiological context, National Strategic Plan (NSP) for HIV and other documents such as the Investment Case. The 4th NSP for HIV and AIDS Response, 2018-2022 has been drafted to guide implementation of services to prevent new HIV infections ensure universal access to prevention services, provide universal access to treatment, care and support services for people infected and affected by HIV, strengthen the coordination mechanisms and management capacity at different levels to ensure an effective multi-sector HIV/AIDS response and strengthen the strategic information systems and research for an evidence-based response [Page 6, 4th National Strategic Plan for HIV and AIDS Response, 2018-2022.]. Geographical prioritization is the basis for selecting intervention sites, but field and program experience obtained over the more than 10 years of GF support in Bangladesh is also considered. 23 priority districts are mainly targeted where the size of PLHIV and KPs is higher than other districts. Case detection by HTC in communities and service centres has been emphasised. Since some treatment, care and support service components for PLHIV are covered by the health sector program; community-based activities to be implemented by community based organisations (CBOs) to complement the government program are considered under the GF. Strategies linked to better coordination and management capacity for an effective national multi-sector HIV response under the leadership of the GoB and specifically under NASC have

Funding Request: Full review

been included such as strengthened strategic information systems for evidence based interventions, knowledge management and enhancing capacity in line with strategies and activities for the fast track responses (NSP 2018-2022 page #. 4th HPNSP 2017-2022 page#).

In line with the 4th NSP activities proposed in the funding request will focus on increasing case detection among KPs and linking them to services from public health facilities for general health concerns. ICT will be introduced in selected groups and gradually expanded using the ever-improving government systems with the aim to establish a “Digital Bangladesh”. Efforts will be intensified for case detection in a coordinated fashion with selected NGO driven and the TB and hepatitis programs and among cross-border migrants through existing GOB infrastructures. Community support will strengthen the monitoring of adherence to ART and coordinated efforts with the new health sector program will ensure viral load testing of KPs as per protocol.

Operational plans (OP)

Under the government health sector program from 2017-2022 activities are expected to encompass prevention interventions for KPs and migrants. Also, HIV testing, treatment, care and support for PLHIV will be provided. The OP also includes activities around HMIS, mass awareness raising, surveillance and surveys, research studies, capacity building and coordination between different actors. The TB, leprosy and AIDS/STD program belong to a single OP, the TB,L &ASP, where activities of three diseases are detailed (HNPSP 2017-2022 page 375).

Program reviews and/or evaluations

A modelling /projection exercise using the AIDS Epidemic Model (AEM) was carried out which demonstrated the effectiveness of ongoing prevention programs among KPs and the impact if these were discontinued (Figs. attached). On discontinuation from 2018, the current estimate of about 9,600 PLHIV would become 183,191 by 2030 and the HIV prevalence would rise among all the KPs across the nation with male PWID at more 12% and FSWs, hijra, female PWID at more than 5%. In Dhaka, almost all KPs would have a concentrated epidemic (Fig, attached).

Disease specific human rights and gender considerations

Human rights and gender issues are historically the core of HIV prevention approaches in Bangladesh (GoB 1996 page#1). The National AIDS/STD Control (NASC) has developed a Gender Strategy for five years (2017-2021) aimed to address gender based violence (GBV) among KPs, Emerging & Vulnerable Groups (EVA), PLHIV & Affected Family members to provide a gender transformative HIV response. The main objectives are to enhance information and understanding of the actual scenario; prevent all forms of GBV through empowerment; ensure service for GBV victims; build institutional capacity and create protective and favourable legal and policy environment through evidence generation [page 25-26, Gender Strategy 2017-2021.] A National Consultation on HIV and the Law arranged by the GoB, NGOs and community partners in 2013 identified legal impediments hindering smooth delivery of HIV prevention services and several punitive laws and practices [Report on the HIV and Law, page 14]. The GoB has also recognized hijra as a separate gender category beyond male-female dichotomy (Reference).

Resilient and Sustainable Systems for Health

Bangladesh’s Vision 2021, transforming the country from a developing into a middle-income country, which acknowledges that improved health is a necessity and the critical conditions for the achievement of this vision. The Program Implementation Plan (PIP) (2017-2022) of the 4th HPNSP is guided by that vision. The PIP incorporates appropriate strategies and activities for focused improvements in increasing access to and quality of health care and improving equity along with financial protection in order to meaningfully realize the objectives of universal health coverage (UHC) by 2030. [Page 13, PIP, Volume-1]. In this spirit, various innovative approaches will be explored such as public-Funding Request: Full review

private partnership, particularly for hard-to-reach areas; development of a functional referral system involving all levels of facilities; ensuring access to and utilization of quality health services by the poor and the marginalized, emphasizing equity, gender sensitivity and efficiency in resource use [Page 15, PIP, Volume-1]. During the last Sector Wide Approach for health, the country scaled up interventions for prevention and control of communicable diseases and established an effective response system across the health system [Page 33, PIP, Volume-1]. The 4th HPNSP will promote the stewardship role of MOHFW. Expansion of supply chain management portal (SCMP); establishment of a coordination mechanism for procurement between DGHS and DGFP; introduction of automated mechanism for stocking and warehouse management; introduction of routine surveillance to ensure quality of goods; and development of a database for trained staff on procurement issues, etc. will also be pursued during the 4th HPNSP [Page 27, PIP, Volume-1].

The Bangladesh Demographic and Health Survey (BDHS) 2014 generates evidence on basic national indicators of social progress including fertility, childhood mortality, fertility preferences and fertility regulation, maternal and child health, nutritional status of mothers and children, and awareness and attitude towards HIV/AIDS [Page 15, BDHS, 2014]. The BDHS 2014 examined FP service readiness by facility type and found that only 25% of the facilities that offer FP services are ready to provide quality FP services [Page 8, BDHS, Policy Brief, 2014]. Overall, 82.2 percent of the FSWs reported using any method of contraception to avoid pregnancy. [Page 45-46, Mapping Study and Size Estimation of Key Populations in Bangladesh HIV Program, 2015-2016]. To achieve the SDG goal 3.1, Bangladesh has to bring its maternal mortality rate (MMR) down to 59 from the current level of 170 [Page 11, BDHS, Policy Brief, 2014]. It is evident that the population is shifting its norm of home delivery to delivery at facilities. In the last decade facility delivery increased rapidly from 12% to 37%. Despite substantial increase in facility delivery, ultimately UHC cannot be attained if some population groups are left behind. Access to facility delivery by the poor and the marginalized groups will be possible if the public sector steps up to increase its relative and absolute share of delivery care [Page 11, BDHS, Policy Brief, 2014]. Knowledge of mother to child transmission (MTCT) of HIV is highest among women age 20-24, women living in urban areas and women's knowledge about MTCT increases with their educational level and wealth status [Page 206, BDHS, 2014]. Between 2011 and 2014, the proportion of ever-married women who knew two HIV prevention methods decreased from 37 to 34 percent. Only 11 percent of ever-married women age 15-49 have comprehensive knowledge about AIDS [Page 201, BDHS, 2014].

1.3 Past implementation and lessons-learned from Global Fund and other donor investments

- a) List recent disease-specific Global Fund grants from the 2014-16 allocation period and summarize key lessons learned from their implementation.
- b) Include lessons-learned from specific HSS grants or any HSS investments embedded in the disease-specific grant(s) from the 2014-16 allocation period as applicable.
- c) Outline lessons learned from investments by other donors as applicable.

For each of the above, explain how these lessons learned are taken into account in this funding request.

[Applicant response]:

a) HIV specific GF grants from 2014-16 allocation period

During this period Bangladesh received three GF grants for HIV:

- i) The NFM grant for HIV prevention for key populations and care and support for PLHIV between December 2015 and November 2017 for HIV.
- ii) Multi-Country South Asia GF Regional Program "Reducing the Impact of HIV on men who have sex with men and transgender populations in South Asia".
- iii) A regional study supported by GF "PLHIV response to AIDS in Asia and the Pacific – regional advocacy for treatment needs of PLHIV in Asia & Pacific" was conducted.

The key lessons learnt from these grants are described below:

1. Coverage of key populations and service modality - Current national coverage for PWID is at 35%, FSWs 25%, MSM (including MSWs) 23.6%, and hijra 39.8%. During NFM changes in the modality of service provision were undertaken so that DICs were made smaller and in some locations DICs were replaced by sub-DICs, and smaller "outlets" through which STI management and HTC were also conducted. In a smaller scale, satellite sessions were also conducted for STIs and HTC. These changes allowed access to KPs residing in more remote areas. In addition, for FSWs, condoms were distributed using two mechanisms; free and using the social marketing approach both of which worked well. For the more hidden MSM and hijra cell phones were used for communication and follow-up. However, there were many challenges faced. As the number of beneficiaries allocated to each outreach worker was increased this resulted in irregular contact which was detrimental to services especially when daily contact is essential such as with PWID for needle/syringe distribution. Many changes in the field were noted – traditional meeting spots destroyed, drives by law enforcement, fear of reprisal by society in general so that many KPs have been driven underground and reaching them with conventional methods was a challenge. Better reach to younger KPs is required.

2. HTC and link to Treatment, Care and Support Program (Treatment cascade) - The national treatment cascade shows considerable gap in the treatment and follow up to initiation of ART. Within the NFM period HTC coverage was 50% for MSM and hijra, 42% for PWID and FSWs. Changes were initiated in the modality for HTC provision including using mobile HTC teams, community based testing (e.g. using hijra guru homes for HTC), changing to whole blood versus serum for testing among PWID and FSWs, providing other tests such as blood grouping. Referrals for ART were put in place and among the

HIV positive, 64% of MSM and hijra and 80% of PWID and FSWs were referred for treatment. A challenge is the need to provide incentives for HTC. Lacking are outreach services for treatment adherence, bringing ART to the doorstep and measuring viral loads. Through the regional study designed to monitor, document and advocate for issues related to PLHIV's access to HIV treatment, care and support services it was found that PLHIV are frequently denied services by health care providers and many lack access to treatment, care and support.

3. STIs - During the NFM, STI services were provided from DICs/sub-DICs by trained paramedics and/or medical assistants. Services were available 6 days/week for FSWs and PWID and 2-3 days/week for MSM and hijra. Mobile teams were also provided. For MSM and hijra, management of oral STIs was introduced. Referrals for complicated STIs were enhanced. For FSWs and PWID, STI case management for partners was introduced but challenges remain in reaching partners especially female partners of MSM. At present the 2006 national STI syndromic management guideline (ref) is used and this needs revision as under-diagnosis and over-diagnosis with over-treatment is common (Khanam et al, AAC and STD). Occasional aetiological diagnosis, treatment follow-up and continuous capacity building for the providers is needed.

4. TB/HIV - TB screening was introduced in all DICs and accompanied referrals were provided to all those suspected of TB. TB information was introduced in BCC materials. As TB screening was restricted to DICs and sub DICs, those who did not attend these centres were not screened. Among PWID all those positive for HIV were screened for TB and overall 60% of PWID were screened.

5. GBV and Human Rights - During NFM changes were made to the design of advocacy sessions so that instead of having separate sessions for different groups, mixed group advocacy sessions involving health service providers, religious leaders, lawyers, journalists, law enforcement agency were held which allowed exchange of ideas and a more robust discussion. For FSWs, a number of special initiatives were undertaken to reduce GBV; community squads were formed to respond to harassment through a 24/7 hotline which allowed 211 different cases to be addressed between July-December 2016 of which 122 were GBV. All cases were referred to public health facilities for treatment and linked for legal aid support. Through the Multi-Country South Asia Global Fund Regional Program for MSM advocacy for policy change was conducted and networks maintained with different City Corporations, Law Enforcement Agencies, National Human Rights Commission, National Legal Aid Services Organization, Ministry of Social Welfare.

b) HSS activities embedded in the HIV grants

Several initiatives were undertaken during NFM; EQA for HIV testing with BSMMU, linkage to tertiary health facilities for delivery and early infant diagnosis for the HIV positive pregnant FSWs, wives of PWID, female PWID. The DGFP was sensitised to channel condoms at a subsidized rate from government sources. Web based MIS system was made functional at all DICs and sub-DICs with regular reports to DGHS in the national MIS platform. A pool of staff received training on program management, PSM, M&E and financial management. A system is now in place for timely procurement and smooth supply of all health/pharmaceutical products to all DICs/sub-DICs with random quality testing. Current ongoing research on readiness of health systems and community systems will be used in upcoming grant to test any approach that can be implemented for bringing sexual minority people to the public health services. Through the Multi-Country South Asia Global Fund Regional Program on MSM 25 CBOs for KPs were strengthened and networks established and maintained with Public Universities and GoB health service centres to ensure services.

c) Other donor investments on HIV

During the NFM period grants on HIV were received from UNICEF that supported GoB to improve the policy environment, address bottlenecks in accessing services, and optimizing care through development of national standards and studies. Several guidelines were developed - National PMTCT guideline, National HIV Risk Reduction Strategy for Most At Risk Adolescent (MARA) and EVA, National HIV/AIDS Counselling Guidelines for Children and Adolescents, Size estimation and mapping of Children infected and Affected by AIDS as well a national database for PLHIV. For PMTCT, UNICEF enabled HIV counselling, testing and treatment services for pregnant women in three national medical university/college hospitals. The intervention is now consolidated as a model and ready for replication. The major challenge is sustainability of these initiatives. For MARA, UNICEF supported GoB to enhance GoB capacity to design and implement high impact HIV prevention, treatment and care interventions for adolescent KPs, while sustaining general awareness/ knowledge levels on HIV through school-based Life Skills Education. An interim memo was issued by MoHFW instructing service providers to allow HIV testing, condom promotion, needle syringe exchange for MARA.

SECTION 2: FUNDING REQUEST (Within Allocation)

This section should describe and provide a rationale for the program elements proposed for this funding request. Attach and refer to completed **Programmatic Gap Table(s), Funding Landscape Table(s), Performance Framework and Budget**, and refer to national strategy documents as applicable.

To respond, refer to additional guidance provided in the *Instructions*.

Ensure that the funding request as described in questions 2.1 and/or 2.2 meets the focus of application requirement as outlined in section 2.3.

2.1 Disease-specific funding request

Not applicable if the application is a standalone RSSH request.

Given the context and lessons learned outlined in Section 1,

- a) Describe the disease-specific funding request(s), the rationale for prioritizing modules and interventions, and how these choices ensure the highest possible impact with a view to ending the three diseases and removing human rights and gender-related barriers to accessing services.

For any priority modules for which gaps are difficult to quantify in the programmatic gap tables, explain here the barriers being addressed, the proposed interventions and the population or groups involved.

- b) Explain how the funding request addresses the key funding gaps reflected in the Funding Landscape Table(s) for the disease program(s) in the current allocation cycle, and specify other actions planned to cover remaining gaps.

For funding requests including both HIV and TB components:

- c) Describe the coordination of joint TB and HIV strategies, policies and interventions at different levels of the health system, including community systems, and expected impact and efficiencies from the joint programming.

Ensure the answer appropriately reflects the separate disease programs in addition to cross cutting modules where appropriate.

(maximum 4 pages per component)

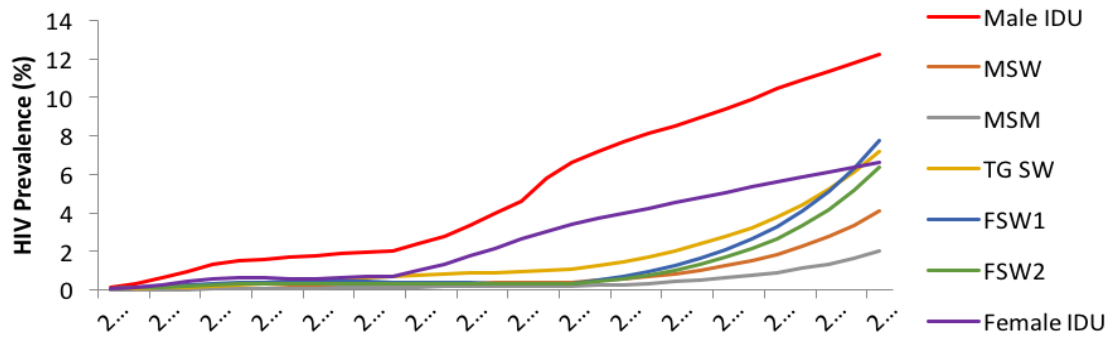
[Applicant response]:

HIV prevention services for PWID, FSWs, MSM and hijra have been chosen based on the National Strategic Plan (NSP) for HIV and AIDS 2018-2022 where the strategies, packages of services for KPs and target of coverage have been outlined. Along with NSP strategies, program experiences and lessons learned described in section 1.3 also have been taken into consideration. The potential impact of proposed intervention has been measured using the AEM exercise which has considered two scenarios with four geographical coverage areas. The scenarios include – no intervention from 2018, and interventions with proposed GF and GoB funds (NFR+GOB). The geographical areas include all of Bangladesh (Fig 1), Dhaka only (as this is the city with the highest HIV prevalence and high numbers of KPs) (Fig 2), priority districts (with next higher epidemic levels and KP numbers) (Fig 3) and remaining districts (Fig 4).

From Figures 1-4 it is projected that by 2030 without interventions most KP groups will have an HIV prevalence >5% at national levels and in Dhaka almost all the KPs will have concentrated epidemics of HIV ranging from about 10% among MSW to about 50% among PWID who are males. In case of the priority districts the HIV prevalence for all KPs will go up from 2 to 10% and in the remaining districts though the prevalence remains within 5%, the trend starts to go up in most KPs. With the planned GF and GoB interventions the national prevalence among PWID still rises, but remains half compared to no interventions. The hijra group will have a prevalence of <1% with the proposed coverage, rather than over 6% without interventions. The prevalence remains within 5% among all other KPs. In case of Dhaka, the concentrated epidemic does not appear in the KPs, except for the PWID group. Among the males who are PWID the prevalence goes to almost 40%, which is less than the 50% projected with no interventions. In remaining districts proposed interventions are projected to keep prevalence among all groups <1%.

Fig-1. All of Bangladesh

No intervention



Proposed: NFR+GOB

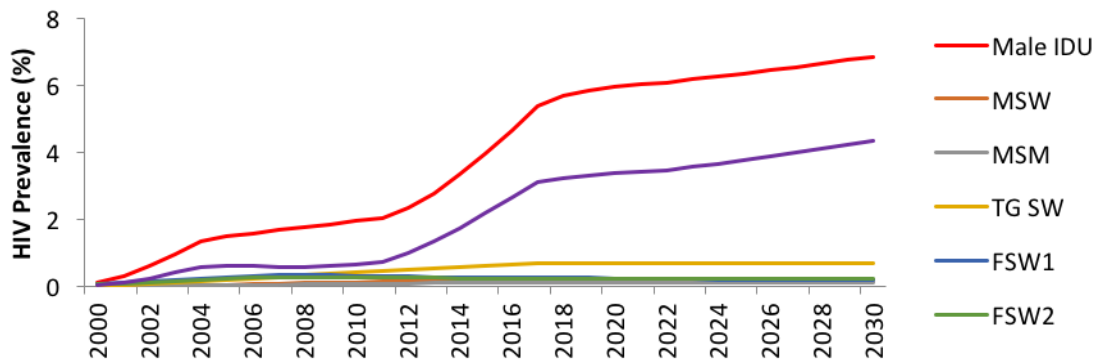
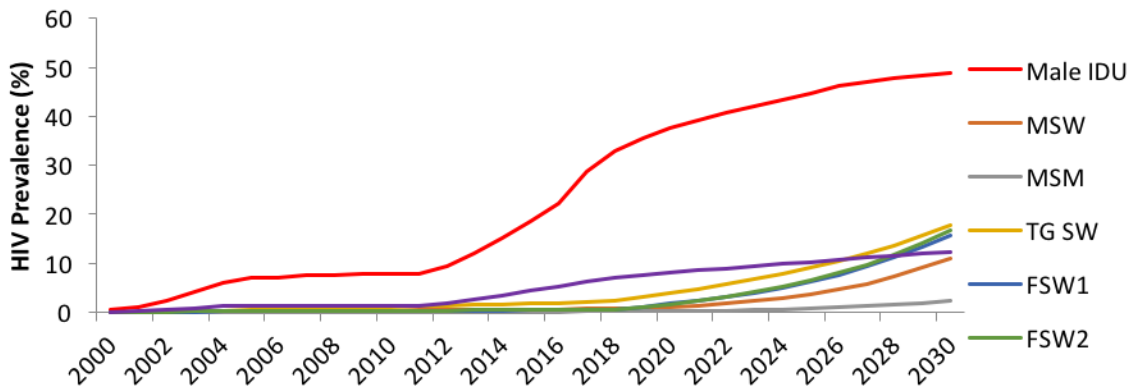


Fig-2. Dhaka
No Intervention



Proposed:
NFR+GOB

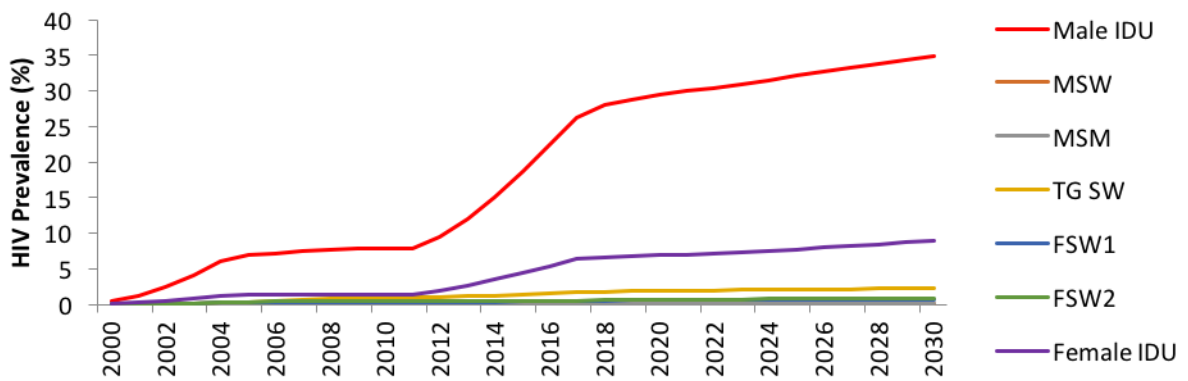
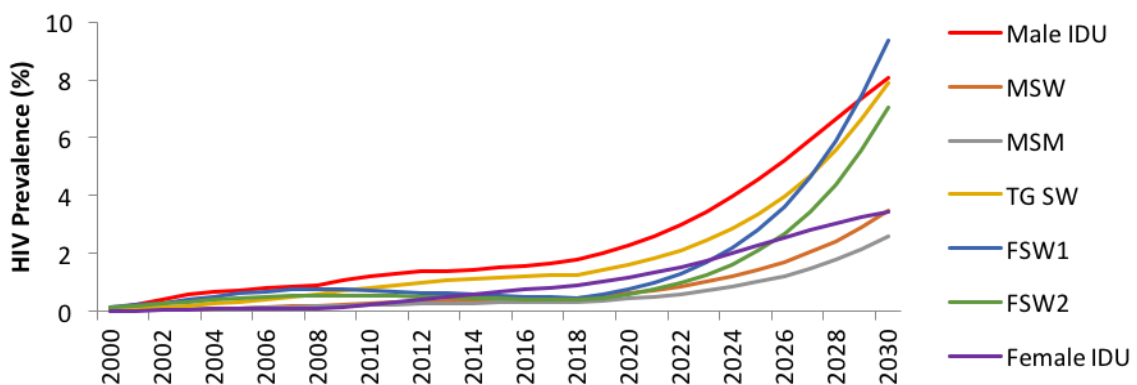
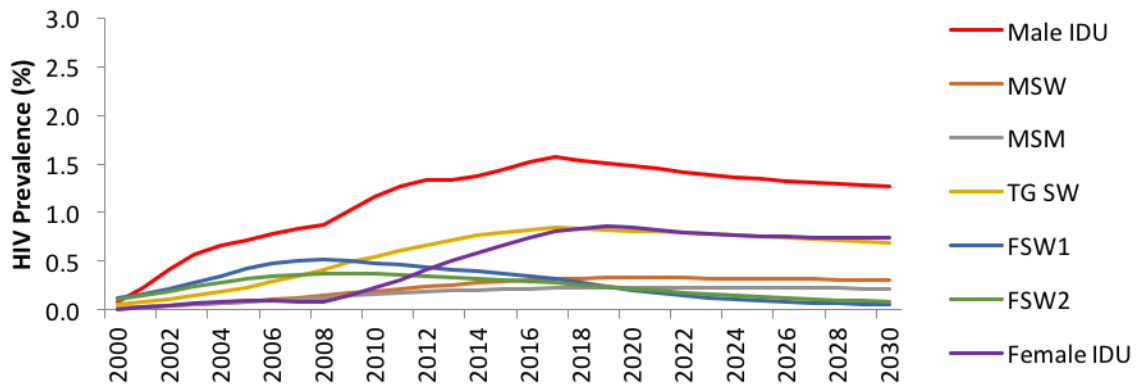


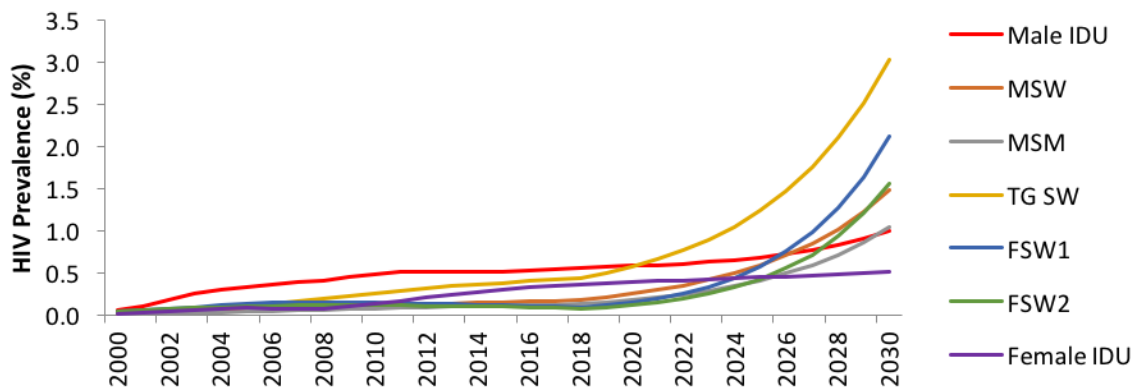
Fig-3. Priority districts
No Intervention



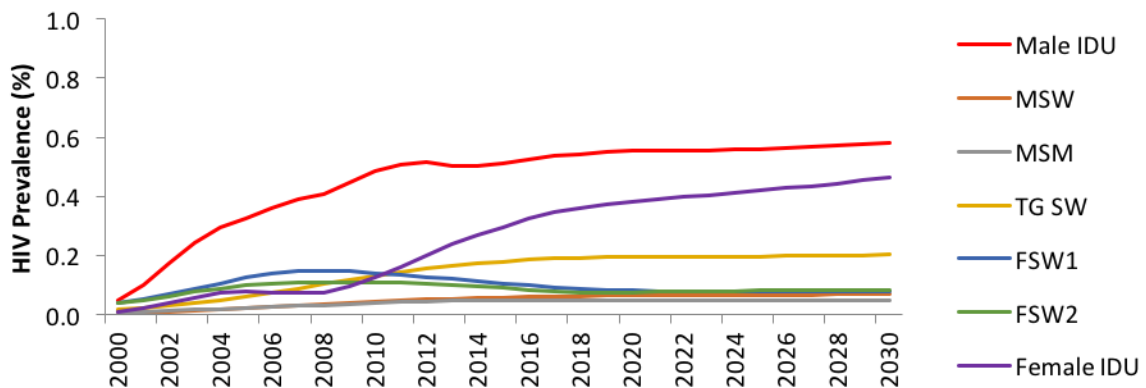
Proposed: NFR+GOB



**Fig-4. Non-priority districts
No Intervention**



Proposed: NFR+GoB



The performance indicator against each relevant intervention is considered in the performance framework (PF) following modular framework handbook. Description of each module and interventions related to each KP is described below:

Module: Comprehensive prevention programs for sex workers and their clients

The estimated number of FSW is 102,260 [P.XV, Mapping Study and Size Estimation of Key Populations in Bangladesh HIV Program, 2015-2016] Under the GoB PIP of the next HPNSP 13600 FSWs will be covered (13.2% of the estimate) for the period of 2017 to 2022. This Funding Request will cover 18,500 (18.1% of the national estimate). Among them 9,000 FSWs will be from Dhaka and 9500 will be from 10 districts selected from the prioritized 22 districts. The overall coverage against the estimate will be 31.3%, whereas, considering the in NSP 2018-2022 recommended coverage of 65% for FSWs, remaining gap will be approximately 34%.

The activities for HIV prevention, treatment care and support for FSWs, will be carried out from DICs/sub-DICs and outreach which will be enhanced through greater involvement of the community who will attempt to penetrate their network through different means. Outreach workers will be Peer Volunteers who will be selected on a part time basis and will be the primary contact for FSWs. Outreach hours will be flexible as per needs. Peer Volunteers will be supervised by Community Organizers who will also be selected from the community.

Medical assistant/paramedic will be responsible for clinical services at DICs/Sub-DICs and at satellite sessions. DIC coordinator will be responsible for overall management, monitoring, supervision and reporting. FSWs will be primarily contacted at outreach and will be provided with BCC, condom. HTS, screening for STI, TB and pregnancy will be done at satellite and will be referred to DICs/Sub-DICs or other health facilities for appropriate services. DICs/Sub-DICs will be safe place where FSWs can use the facilities for rest, recreation and interact with peers.

Community empowerment for sex workers

Sex Workers Network of Bangladesh will be capacitated to mobilize the community for ensuring sex workers' rights and empowerment. Participatory monitoring and micro-planning will be conducted by assigning CBOs/SHG. Cost sharing and DIC management by the CBOs will be explored in selected sites.

Addressing stigma, discrimination and violence against sex workers

To address the violence amongst FSWs a 'community squad' consisting of FSWs (both within and outside of CBOs) has been formed under the current grant which will be continued. This team will be available for 24 hours to respond to any harassment cases. A hotline will be continued. Lawyers, journalist, relevant NGOs and service providers will be engaged by the community squad to resolve cases. At the local level, law enforcers, religious leaders and community elites will be oriented on GBV and human rights. At district and national level regular advocacy and coordination meetings will be organized with relevant stakeholders.

Behavioral interventions for sex workers

Peer Volunteer and FSWs ratio will be 1:50. They will contact FSWs at their convenient locations and provide one to one and group services including BCC and will link them to the relevant services.

Condoms and lubricant programming for sex workers

To ensure safer sex and consistent condom use, condoms will be distributed among FSWs and their clients using both approaches i.e. free and social marketing. Condoms will be made available 24/7 through Peer Volunteers and depot holders.

HIV testing services for sex workers

70% of targeted FSW will be tested in 1st year which will be gradually increased to 80% in 2nd year and 90% in 3rd year. To increase coverage and uptake, HIV testing services will be brought to the community level. In addition to DIC based HTS, regular satellite sessions for HIV testing will be carried out for both FSWs and their partners by the trained Community Organizer and paramedics. Those screened as HIV positive, will be linked to the nearby TCS centers. External quality assurance (EQA) of HTS will be continued with reference laboratories. Community organizers will follow up HIV positive FSWs on ART for treatment adherence.

Diagnosis and treatment of sexually transmitted infections and other sexual and reproductive health services for sex workers

Considering that, 90% of targeted FSWs will be screened for STI at least twice in a year. Medical assistants/ paramedics will provide STI management services following the national guideline. FSWs who do not regularly attend DICs will be provided with vouchers by Peer Volunteers for attending an STI service centre and if necessary will be accompanied to that centre. All genital ulcer and recurrent/non-responsive cases will be referred for etiological management. Follow up of STI cases will be ensured by community organizers.

Interventions for young people who sell sex

To increase coverage and deliver customized services for adolescent FSWs and to facilitate engagement through participation and networking, a set of services will be offered which include: exclusive adolescent peer recruitment, adolescent friendly IEC/BCC material, condoms, HTS, provide hotline service for psycho-social counseling, voucher scheme for referral of STI, abortion care, pregnancy care, FP, group formation and networking, referral for vocational training and non-formal/TVET education, orientation to life skill education and leadership training. A pilot project on adolescent FSWs with the financial support of UNICEF is planned and lessons-learned will be adopted.

Module: Comprehensive prevention programs for people who inject drugs and their partners

At present, the Global Fund NFM grant is covering 35% (11,500) of the estimated (33,067) PWID. GoB has approved the Program Implementation Plan (PIP) of the 4th HPNSP, where PWID coverage will be 10,000 (30% of the estimate) for the period of 2017 to 2022. This Funding Request will cover 8,000 (24% of national estimate) PWID including 5,500 (81% of the estimated PWID in Dhaka) in Dhaka and remaining 2,500 PWID in Gazipur, Rajshahi and Chapainawabgonj, Comilla districts. Four hundred women who inject drugs (WID) (38% of the national estimate) will be covered. Considering the complexity of setting, needle sharing and increasing HIV prevalence, highest priority has been given in Dhaka and its' adjacent hot spots (Tongi, Gazipur) and around 6,000 PWID (82% of the estimated PWID in Dhaka and Tongi) including 400 WID are being targeted from these sites while 800 PWID will be covered from Comilla-another neighboring district where HIV cases been identified from PWID. Rajshahi and Chapainawabgonj districts, have been considered because of the high concentration of PWID with high prevalence of hepatitis C virus (HCV) where 1,200 PWID will be covered.

The overall coverage against the estimate will be 54% whereas, considering the in NSP 2018-2022 recommended coverage of 75% for PWID, remaining gap will be approximately 21%.

The activities for HIV prevention, treatment care and support for PWID, will be carried out from comprehensive DICs (inclusive of ART, OST), DICs and secondary channel. Extensive community led outreach focusing BCC, syringe-needle, condoms, HTS, ART, OST, and linkage to facilities for management of STI cases, HIV-TB co-infection management. Spot Leaders who will be selected on a part time basis and will be the primary contact for PWID. Outreach hours will be flexible as per needs. Spot Leaders will be supervised by Community Organizers who will also be selected from the community. Medical assistant will be responsible for clinical services at DICs/Sub-DICs and at satellite sessions. DIC coordinator will be responsible for overall management, monitoring, supervision and reporting. Additional services for female PWID will be provided such as sexual and reproductive health services, PMTCT, breast feeding counseling, pregnancy care, addressing of GBV, parenting support, legal aid, IGA, etc.

Following are the proposed implementation modalities:

Community empowerment for people who inject drugs

A set of community engagement initiatives has been planned. Outreach activity will be driven by spot leader and case worker who will be appointed from the community. SHGs/ CBOs will be involved in organizing satellite sessions for HTS, STI and abscess management at selected spots. In addition, the existing OST self help group will be strengthened. The community based detoxification and participatory assessment of community needs for program design will be operated by SHGs/ CBOs. PWID Network of Bangladesh will be capacitated to mobilize the community for reducing harassment, stigma and discrimination.

Addressing stigma, discrimination and violence against people who inject drugs

A three tier advocacy and sensitization activities are planned with SHGs. At local level, law enforcers (police, RAB, intelligence department, etc., local DNC officials) will be oriented on harm reduction and sensitization meetings will be conducted. At district level regular advocacy and coordination meetings will be organized with the health, local government and law enforcement authorities. At the national level, efforts will be given for drug policy reform through commissioning law firms and advocacy meetings in coordination with NASC.

Behavioral interventions for people who inject drugs

The outreach will be led by peers and managed at the drug spots. In every spot, 'Spot Leader' will be appointed from the drug user community and will be trained. Female spot leader will be appointed for WID. They will be responsible for 20-30 PWID for N/S distribution, motivational education to decrease sharing and linking with DIC for HTS, STI, TB, OST, ART and abscess management. Spot leader will also ensure safe injection, vein care and wound management through BCC and skill transfer. The 'Spot Leader' will be supervised by 'Outreach Supervisor'.

Condoms and lubricant programming for people who inject drugs

Condom will be provided to PWID and WID according to their need and will be made available with spot leader/medical assistant. Demand will be generated through peer education and counselling.

HIV testing services (HTS) for people who inject drugs

70% of targeted PWID will be tested in the 1st year which will be gradually increased to 80% in 2nd year and 90% in 3rd year. HTS will be provided to PWID and their partners at DICs, and satellites at community settings and will be integrated with OST and detoxification services. In addition, the PWID and their partners could also avail HTS at CST and DOTs centers of selected government health facilities.

The identified HIV positive PWID will be linked with the ART program through DICs, from where PWID will avail testing services, OST and ART. Case worker from the community will follow up the PWID living with HIV (1: 10-15) in coordination with Spot Leader and Outreach Supervisor to ensure adherence.

Diagnosis and treatment of sexually transmitted infections and other sexual health services for people who inject drugs

About 80% of targeted PWID will be screened for STI along with TB at least annually. Medical assistants will provide STI management services following the national guideline. STI management service will be provided among WID through voucher scheme and referral to FSW DICs. Recurrent/non-responsive cases will be referred for etiological management. Follow up of STI cases will be ensured by outreach supervisor.

Needle and syringe programs for people who inject drugs and their partners

Target for the Needle-Syringe (N/S) program is calculated based on global standard and current trend. PWID/WID who are enrolled in OST and drug dependence treatment will be excluded from N/S program. Considering the injection frequency and injecting behavior, 'one shot one syringe' approach will be followed and on an average 648 needle-syringe/year/PWID will be distributed.

Opioid substitution therapy (OST) and other drug dependence treatment for people who inject drugs

A total of 2,700 PWID will be covered under OST services (8% of national estimate), where 1,500 PWID will be under HPNSP and 1,200 under the funding request. SHG of OST will be used to strengthen the retention. A strong coordination will be maintained with Department of Narcotics Control (DNC) and NASC for smooth implementation of the OST services. Also, provision of community based detoxification services will be available with the engagement of CBOs/SHG of people recovering from drug misuse. It will be voluntary and client centered.

Prevention and management of co-infections and co-morbidities

Considering the susceptibility of PWID to TB, 80% of the PWID and 100% of PWID living with HIV will be screened for TB annually. All suspected TB cases will be referred and linked to DOTs center for diagnosis and management. In addition, HIV positive PWID will be screened for HCV/HBV annually and will be linked with GoB health facilities for management.

Module: Treatment, care and support (TCS) for people living with HIV

ART service delivery in government hospitals will be strengthened through active involvement of the community, i.e. people living with HIV and their network for further scale-up of the national ART program.

HIV care

The network of PLHIV will monitor the ART program for ensuring HTS; baseline and follow-up clinical and laboratory assessment; diagnosis and treatment of opportunistic infections and/or co-morbidities; rationale use of ARV and outpatient/in-patient services by the trained hospital technical staffs (e.g. medical officer, counsellor and Lab. tech). They will also monitor the involvement of national ART management committee for effective monitoring of the program.

Treatment adherence

At hospital level, the counsellor and peer community organizer will discuss adherence issues with the patient in every single visits and will identify and resolve the possible bottlenecks of drug adherence. Additional efforts will also be given to strengthen ART adherence through community ART group formation; meeting of the community ART group at regular interval; home visit and leadership & caregiver training.

Counseling and psycho-social support

The peer community organizers and community ART group members will provide counselling and psycho-social support to people living with HIV at hospital during clinical visit and at the community during home visit. Community ART group will also provide nutrition support to people living with HIV who will be referred from the hospitals based on the eligibility criteria. In addition, community ART group will take necessary initiatives for burial of the deceased. As and when required, both the peer community organizer and community ART group members will do accompanied referral with the severely ill. In addition, they will also conduct "Uthan Boithak" along with HTS to create demand for HIV testing and ART enrollment and to reduce stigma and discrimination.

Module: Comprehensive prevention programs for men who have sex with men and transgender people (hijra). The interventions related description of this module is given below.

Behavioral interventions for MSM and hijra

Behaviour change communication (BCC) will be carried out by the regular peer educators and peer associates including distribution of BCC/IEC materials, educational sessions conducted in groups at the service delivery points and one on one interaction at field sites. Furthermore, E-media will be used for providing BCC and counselling to hidden MSM.

Condoms and lubricant programming for MSM and hijra

Condoms and lubricants will be provided free of cost to prevent HIV and STI. The distribution will be done through peer to peer outreach at cruising sites, and by establishing the depots at the field sites for ensuring anonymous uptake of condoms/lubricants and availability of condoms/lubricants during holidays and weekend. Provision anonymous uptake of condoms/lubricants will be available at 63 SDPs as well. In addition, condoms and lubricants will be distributed through the gurus of hijra and kothi community so that outreach staff do not require to visit MSM and hijra every day and for

those who do not come to outreach sites regularly. E-media will be used for communicating hidden MSM for providing condoms and lubricants at their preferred sites.

HIV testing services (HTS) for MSM and hijra

HIV testing and counselling will be provided through static service delivery point (SDP) based facilities. In addition, community based HTS by going to various venues to cover the populations who do not come to service delivery centers will be available. In order to reduce time and cost, whole blood testing method will be introduced and will be linked to HIV care and treatment by accompanied referral. E-media will be used for communicating hidden MSM for providing HIV testing at their preferred venues.

MSM and hijra who will be diagnosed as HIV positive will be referred to care, support and treatment centers by accompanying them to the centres. Periodic social gathering and home visits for mental and social support and counseling for ARV adherence in collaboration with government and other stakeholders will be conducted.

Diagnosis and treatment of sexually transmitted infections and sexual health services for MSM and hijra

Diagnosis and treatment of STIs will be continued through syndromic management of STIs along with management of basic general health complaints. Trained paramedics-cum-counselor will be placed at some SDPs who will cover 2-3 centers. Clinic sessions will be arranged in the service delivery points and through satellite sessions. In addition, recurrent, non-responsive and complicated STI cases among MSM and hijra will be referred to GoB healthcare facilities. E-media will be used for communicating hidden MSM for providing STIs related services at their preferred venues

Addressing stigma, discrimination and violence against MSM and hijra

To create enabling environment mixed group advocacy events will be conducted at the interventions areas with various groups of people such as religious leaders, influential people, members of law enforcement agencies and journalists.

Interventions for young MSM and hijra

Special attention will be provided to provide HIV prevention services to MARA MSM and hijra population in the service coverage areas. MSM and hijra Peer Educator (PE) and Peer Volunteer (PV) from MARA population will be deployed in each SDP to provide condom, lubricant and conduct BCC session. Moreover, a separate day will be dedicated in each month will be set for them to provide STI and HTS services for MARA MSM and hijra. Age specific BCC materials will also be developed and distributed. A separate reporting line item will be used at SDP reporting format to report on MARA MSM and hijra related activities.

Providing services to substance user MSM and hijra

A training module will be developed for DIC and Sub-DIC level counselor to provide counseling to substance using MSM and hijra. All counselors will receive training on counseling based on the module. In addition to that, PWID MSM and hijra will be referred to nearby PWID service centers.

Module: TB/HIV

TB screening will be done using standard national TB screening guideline for all the MSM and hijra who attend the clinic sessions at SDPs (e.g. DICs, Sub-DICs, outlets) for health care. All the suspected patients will be referred to the existing national platform (i.e. NTP) for TB diagnosis and management.

Funding Request: Full review

Module: HSS Health Information system and M&E

NASC website will be updated regularly and maintained with performance data, different policy guidelines and information of the NASC. Trainings, basic and refresher, on M&E, Data Triangulation and data analysis tools and techniques for 4th health sector implementing organizations and hospital personnel positioned in HTC and ART centers on DHIS2 for maintenance of six monthly data uploading. Meetings will be held for M&E and SI technical working group and sub groups and quarterly coordination meetings with stakeholders. Coordination to ensure regular reporting to the DMIS2 for all the reporting entity managed by HIV PRs and 4th health sector program will be done. Joint monitoring visits will be carried out for the program by NASC, DGHS/ MoHFW and NAC members as well as regular program monitoring and supervision visits and RDQA. An annual HIV report on the epidemic trends and updates will be written and disseminated. An operations research will be carried out.

Module: HSS Health and Community Workforce:

Trainings will be conducted on clinical services on STI, ART & OIs management for doctors in public health facilities by engaging relevant department and ensuring logistic support in selected districts. Trainings, basic and refresher, will be conducted in selected prioritized districts on HTC for GOB staff working will be conducted, on BCC for doctors/ administrator of public health facilities and on counseling for treating KPs, migrants, etc. Development of relevant modules and materials will be undertaken and training of master trainers will be conducted. Orientation on HIV/ AIDS will be conducted for instructors of TTC, BMET and GAMCA and for instructors of nursing training center. Curriculum will be updated and teaching aid developed for TTC- BMET and Nursing Training Center (books, flipchart, etc.). Support will be provided for organizing events by STI/ PLHIV/ KPs networks to mobilize support for IGA, NSSS and other livelihood support for the KPs.

Module: HSS Policy and Governance

Advocacy with key/relevant Ministries including of Home, Education, Social Welfare, Women and Children Affairs, Ministry of labor and Overseas Employment etc. will be continued by engaging HIV focal persons and addressing annual plans. This will also be continued with national and local journalists and human rights organizations. Advocacy with district health administration/Civil Surgeons in selected priority districts for a coordinated response will be initiated. Coordination meetings with HSM, TBLC, CDC, CBHC of DGHS and MCH services of DGFP, BMET and DNC for establishing effective referral services at the field level will be conducted. Relevant advocacy and BCC materials including fact sheets/ policy briefs will be developed as well as HTC guidelines, SOP for KP programs. Annual meetings for the NAC will be coordinated and assistance provided to execute decisions. Support will be provided to policy makers, higher officials of NASC/DGHS and project staff for attending regional/international conferences on HIV/ AIDS and GF events for experience sharing and exposure to new developments. Initiatives will be undertaken to link KPs through SHGs/networks to special programs such as the National Security of Social Safety net (NSSS) and the One Stop Crisis Center located at hospitals to address GBV.

Funding sources and gaps: Funding for HIV prevention services for KPs will be from the GF and the HPNSP of GoB. For treatment, care and support services for PLHIV HPNSP will provide most of the funds with GF providing complementary funds. In addition, bilateral and multilateral donors are also supporting areas of advocacy, capacity building, systems strengthening, and coordination. Interventions with brothel-based FSW, PMTCT; interventions with male and female migrant populations and their spouses; treatment, care and support for PLHIV (including HTC), interventions with MARA and SRH for young

Funding Request: Full review

key and vulnerable populations are addressed or planned through other funding sources such as Government of Bangladesh, UNICEF, Netherlands Government, etc. Thus, in this funding request these interventions will be addressed only to link to and complement the services already being provided by others if applicable.

The resource requirement as per the revised NSP for 2018-2022 is approximately USD 291m. Of this approximately USD 78.9m (previous and expected allocations inclusive of proposed budget in the funding request); i.e. approximately 27% of the required budget is available through the above mentioned sources. Thus, approximately an additional USD 212m is required to fulfil the entire national demand. (funding landscape table, programmatic gap table and Costed Implementation Plan (IP) for NSP. The Funding landscape further elaborates the funding sources. The allocations for different services are as follows: In the above section major gaps are described which include HTC coverage among KPs and other emerging groups; scaled-up services for KPs increased case detection and coverage of ART; HIV/TB integration; interventions for migrant workers, MARA and other vulnerable young people; and systematic interventions to reduce stigma and discrimination.

Though these gaps may be somewhat addressed by health sector funds, Global Fund, UNAIDS, UNICEF, UNFPA, WHO, EKN and other bilateral and multilateral donors for the 2017-2022 period the expected allocations for prevention interventions will cover only 27% of the required funds as outlined by the NSP; i.e. an additional USD 212m is needed to reach the NSP targets for optimum prevention efforts for KPs. In the BCCM meeting it was discussed that BCCM should find out a way to negotiate with the Global Fund to increase future funding allocations for HIV interventions for Bangladesh including securing funding support from other donors. Initiatives will be taken by Ministry of Health and Family Welfare (MoHFW) to increase budget for HIV in the mid-term review of HPNSP.

Tuberculosis program and NASC both are now under one Operation Plan (OP) in HPNSP 2017-2022. However, activities of each program and budgetary allocation are detailed out separately for each of the programs. It is planned that under NASC number of HTC centers will be established for increasing HTC among all populations including KPs. In these centers will also be open for TB patients. For TB/HIV, the main source of funding will be through the tuberculous grant application to GF and in this funding request the TB/HIV related activities will complement those activities. KPs covered for HIV prevention under this proposal will be screened for TB and suspected cases will be referred to the nearby TB clinics. Furthermore, all KPs who are HIV positive will be referred to TB centers for TB testing and treatment.

2.2 RSSH funding request

The Global Fund strongly encourages funding requests for RSSH investments to be submitted within a **single** application, and preferably to be requested in the first submission.

Does this funding request include an RSSH component?

Yes✓

No

If yes, describe the request below and how it is strategically targeted.

Referring to the national health strategy, gaps and lessons learned outlined in the previous section, describe the funding request for RSSH and how the investment is strategically targeted to strengthen systems for health and achieve greater impact on the diseases. In your explanation, refer to the Funding Landscape Table on 'government health spending', Performance Framework and Budget as appropriate. Note that it is optional to complete a Programmatic Gap Table for RSSH. **(maximum 3 pages)**

If no:

- a) Indicate when the RSSH funding request was/will be submitted; and,
- b) **If the RSSH funding request has not yet been submitted**, highlight below the elements of the planned RSSH investment that will directly support the disease program in this funding request.

(maximum ½ page)

[Applicant response]:

The following RSSH activities have been planned under this funding request. To implement these activities budgetary allocation is considered in the funding request (Budget template and PF). The activities will be carried out in the framework of GO-NGO collaboration with a focus on capacity development and long-term programmatic and financial sustainability. The modules of RSSH and intervention activities are provided below.

Module: Community responses and systems

A greater involvement of community members has been envisaged in this funding request so that the HIV program will be implemented through a peer-centered approach. Community members will be recruited as Peer Volunteers, Community Mobilisers, Peer Educators who will have a better understanding of the dynamic nature of the field and can help in ensuring better reach to KPs and a more relevant intervention. Their engagement will be diverse: participatory assessment for program design and M&E, regular monitoring, periodic spot identification and strengthening spot based service delivery, outreach based HTS services, satellite HTS at their preferred locations, ART, maintaining adherence, appropriate referral linkage with government health facilities and strengthening initiatives for CBOs/SHGs/Networks.

To address cross-cutting issues of the structural intervention component, such as GBV, sexual and reproductive health rights (SRHR) and human rights issues, community representatives and CBOs/SHGs will be directly involved in advocacy activities with government and non-government health service providers, religious leaders, lawyers, journalists and representatives from law enforcement agencies. Thus they will also be engaged in advocacy efforts at the local, district and national levels with key stakeholders. This activity will function as a platform where the community will get the opportunity to talk about HIV and AIDS related issues as well as sharing their needs related to SRHR and gender-based violence. Moreover, to strengthen the capacity of the community, training

will be provided to CBOs on financial management. Community system strengthening initiatives will contribute to SDGs-1, 3, 5, 6, 16 & 17.

Supporting reproductive, women's, children's, and adolescent health platforms for integrated service delivery and better epidemic control

In this funding proposal integration of HIV prevention services with other relevant platforms such as MNCH, adolescent health and other communicable diseases is planned. FSWs and female PWID will be referred to health facilities for their sexual and reproductive health need, such as abortion care and FP. To ensure PMTCT, pregnant FSWs, female PWID and female partners of male PWID will be initially screened for HIV at DICs and will be linked to tertiary hospitals for pregnancy care, ARV, breast feeding counseling, EID, etc. An intervention to provide SRH services to female partners of married MSM will be piloted. The piloting will first take place at two DICs where DIC staff will receive training on SRH to enhance their capacity on SRH and ways to address the SRH needs of the female partners of married MSM. Based on the experience of the pilot, an intervention to serve the female partners of MSM may be scaled up in 23 priority districts. The program will also explore opportunities to link young KPs with adolescent friendly health service of DG-FP at their locality. Recurrent, non-responsive and complicated STI cases will be linked with GoB health facilities for etiological management.

Module: Strengthening procurement and supply chain systems

At NASC, a central PSM committee will be formed to manage supply chain of HIV commodities (ARV, HIV testing and reagent for CD4 and viral load testing). The committee will have a specific ToR to review the forecasting, quantification, requisition and timely procurement of HIV commodities. A well-established procurement and supply management system (PSM) has been setup. This will be strengthened by more functional web based LMIS. Requisitions will be submitted through LMIS and procurement and supply chain will be ensured. A PSM calendar will be developed for effective supply chain and circulated at all levels. To avoiding stock out of health products this approach is being followed and will be continued in the upcoming phase. A technical working group for PSM will be continued. Quality assurance mechanism for medicine, condom, needle/syringe and other health products will be done. This funding request includes human resource and capacity building initiatives for supporting PSM of PRs and SRs.

Module: Human resources for health including community health workers

Activities include leveraging critical investments in human resources for health and reducing GBV and stigma. In this funding request, capacity building of human resources for health has been proposed. Trainings will be provided on health screening for early detection of STI and TB, syndromic management of STI, abscess management, HTC to Medical Assistant/Paramedics to provide services to KPs and to explore whether these services can be integrated to make it sustainable. Community representatives (peer volunteer and outreach workers, etc.) will be trained for HTS services and TB screening at community level. Capacity and skill building activities are also planned for DIC and Outreach staff for implementing HIV prevention program.

In addition, training will be given to the government health system service provider's in order to create better access to the services for the KPs and PLHIV without stigma and discrimination. Training will be given on HTS in public health facility in the prioritized district for detection of HIV cases and enrolling new PLHIV for care and treatment. Training will be provided on Gender, Human Rights, BCC and ART counseling for KPs at public health facilities and to reduce the Stigma and Discrimination by Service Providers to the KPs and PLHIV.

In addition, findings from an ongoing study will be adopted for an evidence-based transition for providing health related services to MSM and hijra from government healthcare facilities. A model for piloting has been developed from an ongoing study titled 'Are the public health facilities ready to provide HIV prevention services to key populations at risk (KPs) in Bangladesh: Current situation and way forward'. Based on the preliminary findings of the study a possible model for piloting has been proposed. Piloting will be done in government health centers in two districts. The activities include sensitization and capacity development of health care providers to provide health care services particularly STIs and HIV prevention related services for MSM and hijra. If the program is successful, scale-up of interventions will be done in 14 priority districts.

Module: Health management information system and monitoring and evaluation

The following activities will be performed under this module. These include maintenance and strengthening of national health MIS under DGHS and IMIS will be continued. to generate data and analyze for programmatic reporting. National level working team for M&E will be made functional and coordinated regularly to review and analyze country and global data and provide strategic information for appropriate intervention design and implementation. Required human resources and capacity building initiatives on participatory monitoring, data management and local level data analysis are planned for SHGs/ CBOs, SSRs, SRs and PRs. For MSM and hijra, a web based real-time monitoring and reporting system will be established for HTS.

Training will be provided to various level of M&E staff on DHIS2 for maintaining six monthly web based data collection to ensure the national data base for national reporting and for policy decisions (Funding landscape Table). Orientation/training on monitoring and coordination for district health administration/CS for monitoring the GoB health facility centers will be conducted.

A total of three operations research studies have been planned in this funding request. The topics of the operation research studies will be identified during implementation of the program.

Module: National health strategies

In the 'National Health Strategy' and 'National Disease Specific Strategic Plan', HIV prevention and TCS services will be positioned appropriately through structural interventions with policy makers. NASC will be supported through logistics and human resources to enable effective national level coordination. To ensure aid effectiveness, this funding request will collaborate and coordinate with HPNSP to provide similar intervention approach for KPs.

Module: Financial management and systems

For strengthening financial management necessary infrastructural support and human resources are planned for PRs, SRs and SSRs. Capacity building activities on financial management and oversight are also planned for relevant staff members. Financial monitoring and audits mechanism for PRs, SRs and SSRs are considered in the funding request.

Module: Integrated service delivery and quality improvement

To implement HIV prevention interventions, TB screening and SRH services static Service Delivery Points (SDPs) will be rented to ensure service delivery among KPs. Four modalities of SDP have been designed: DIC, sub-DICs, outlets and satellite center. The

rooms allocated for each DIC has reduced, and small SDPs have increased including the introduction of satellites as part of the cost-efficient approach. These centers will be used for STI and HTS, storage (and distribution where possible and required) of health products such as condoms, lubricants, HTS kits and medicines. Furthermore, all centers will perform as a reporting unit where intervention related documents will be preserved for verification purposes and other uses.

2.3 Focus of application requirement ¹

This question is required for Lower-Middle Income (LMI) and Upper-Middle Income (UMI) countries. It is not applicable for Low-Income (LI) countries. To respond, refer to guidance provided in the *Instructions*.

For LMI countries:

- Does the funding request focus at least 50% of the budget on: disease specific interventions for key and vulnerable populations; programs that address human rights and gender-related barriers and vulnerabilities; and/or highest impact interventions?
- For RSSH, does the funding request primarily focus on improving overall program outcomes for key and vulnerable populations in two or more of the diseases, and is it targeted to support scale-up, efficiency and alignment of interventions?

Yes No

Yes No

For UMI countries:

- Does the funding request focus 100% of the budget on interventions that maintain or scale-up evidence-based approaches for key and vulnerable populations, including programs that address human rights and gender-related barriers and vulnerabilities?

Yes No

Ensure that the funding request as described in questions 2.1 and/or 2.2 meets this focus of application requirement.

SECTION 3: OPERATIONALIZATION AND RISK MITIGATION

This section describes the planned implementation arrangements and foreseen risks for the proposed program(s). Applicants are encouraged to **attach an updated Implementation Arrangements Map**. To respond, refer to additional guidance provided in the *Instructions*.

3.1 Implementation arrangements summary

Do you propose major changes from past implementation arrangements, e.g. in key implementers, flow of funds or commodities?

Yes No

If **yes**, provide an overview of the new implementation arrangements and elaborate how these changes affect the operationalization of the grant.

If **no**, provide a summary of high-level implementation arrangements focusing only on lessons learned for the next period.

In **both cases**, detail how representatives of women's organizations, key populations and people living with the disease(s), as applicable, will actively participate in the implementation.

Include a description of procurement mechanisms.

(maximum 1 page)

¹ Refer to the [Global Fund 2017 Eligibility List](#) for income level. LMI and UMI countries have specific requirements in terms of the focus of applications as set forth in the Global Fund [Sustainability, Transition and Co-Financing Policy](#).

[Applicant response]:

This application has proposed some changes although not major in nature comparing to the past implementation arrangement. This application meets the criteria of dual-track financing. The BCCM has decided to continue with existing three PRs [i.e. Government PR: National AIDS and STD Control (NASC) and NGO PR: Save the Children (SC) and icddr,b] for their grant rating A1 which was also recommended by the Global Fund as reflected in the allocation letter. The activities of the three PRs are separated from each other, thus no duplication will take place. Rather complementarities will be ensured through regular coordination meetings among 3 PRs.

NASC, the national nodal and central coordination body on HIV and AIDS of the Government of Bangladesh, under MoHFW, will conduct national coordination and structural advocacy to create an enabling environment and capacity building of the implementers. Along with National HIV MIS, NASC will monitor HIV programs including global funded interventions. Since no intervention for any KP will be implemented by NASC, they will not select any sub-recipient, however, if they require, NASC will follow the government procurement policy. NASC may also sign MOU with relevant government or non-government entities and/or with competent agencies/technical partners for any particular work. Most of the existing positions under the GF grant will continue with provision of upgrading few posts considering lesson learnt; in addition few new positions have been proposed in the grant for smooth implementation.

SC will implement HIV interventions for FSWs and PWID, community linkage component complementary to the health sector supported Care Support Treatment Centre (CSTC) program for PLHIV. icddr,b will implement HIV interventions for MSM and Hijra and operate research projects. All prevention services are described in section 2.1 of this application.

SC and icddr,b will continue with existing Sub-Recipients (SRs) as they are well-performing and familiar with global fund norms and practices. Thus, SC and icddr,b will sign formal sub-award agreement with the existing SRs. Regarding SSRs under SC, because of change in geographical focus, some changes are anticipated and respective SR will be responsible re-form the consortium based on needs. For both SC and icddr,b, several CBOs and other Civil Society Organizations (CSOs) will directly implement interventions and Networks of PWID, FSWs and PLHIV will receive support. The STI/AIDS Network will receive support from the grant as previous years.

The major procurement such as health products will be performed by PRs since beginning of this project to ensure quality of the product and prevent stock-out situation, and value for money. However, non-health products will be procured by the SRs. The procurement will be performed by procurement policies of each entity.

The Technical Working Group on HIV nominated by the BCCM, responsible for endorsing the technical aspects of the application, has representatives from a women's organization, PLHIV network and MSM CBO, sex workers' and PWID network and KP representatives. This application proposed interventions for KPs where CBOs and other CSOs will implement HIV intervention services.

3.2 Key implementation risks

Using the table below, outline key risks foreseen, including those that were provided in the *Key Program Risks* table shared by the Global Fund during the Country Dialogue process. You can also add key operational and implementation risks, which you identified as outstanding over the previous implementation period, and the specific mitigation measures planned to address each of these challenges/risks to ensure effective program performance in the given context.

Applicant response in table below.

Risk Category (Functional area)	Key Risk	Mitigating actions	Timeline
AID Effectiveness and sustainability	<ul style="list-style-type: none"> Alignment with national systems and cycles Delaying in start of 4th health sector program Co-financing and partner financing for moving towards sustainability. 	<ul style="list-style-type: none"> Higher level advocacy with Ministry of Health and Family Welfare (MOHFW), Directorate General of Health Services and relevant bodies to align with national systems, reporting cycle and indicators, and to avoid delay in implementation National Pool Funding and other multi-lateral and bi-lateral donor funds need to be explored to meet up any transition and funding gaps in key priority areas by well coordination with the donor consortium. 	Ongoing, and will be continued with more focused advocacy by NASC
Finance	<ul style="list-style-type: none"> Non-compliance with existing policies and guidelines by SRs/SSRs For NASC, only 1 person is designated to maintain the accounts. 	<ul style="list-style-type: none"> Routine financial monitoring visits and on-job capacity enhancement training will be ensured during program implementation For NASC, a Financial Consultant position has been considered under the 4th health sector program. 	Ongoing and will be continued. With beginning of the sector program, a Financial Consultant will be recruited.
Human Resources	<ul style="list-style-type: none"> Limited human resource for program management Dropout and delay of recruitment due to transition from 	<ul style="list-style-type: none"> Recruitment of efficient and skilled human resource and completion of all necessary new recruitment process Increase the level of effort (LOE) for the partial staff members or engage relevant staff of the organization. 	Necessary steps will be taken in the last quarter of current grant, so that recruitment is done on time

Governance and program management and strengthening M&E	<ul style="list-style-type: none"> • Because of recent restructuring of the OP, implementation of HIV interventions under all donors might be hampered. • Ensuring data quality/reporting 	<ul style="list-style-type: none"> • NASC will coordinate with relevant departments to explore the strategies for smooth implementation in the changing context. • Refresher training and ongoing on-job training on data quality and reporting will be continued during monitoring visits conducted PR and SRs/SRs 	<p>Ongoing.</p> <p>The training will be completed at the initial quarter of the grant and on the job training is an ongoing process.</p>
Program	<ul style="list-style-type: none"> • Frequent drop out of peer educators may hinder routine outreach services. • Peer educators and beneficiaries ration higher hindering quality outreach. • Frequency of rade, harassments by the law enforcing agencies can make the KPs more hidden , 	<ul style="list-style-type: none"> • Adequate peer volunteers will be recruited in the respective service deliver points (SDP) for providing outreach services. The number of outreach staff has been revised. • Continues advocacy and sensitization with the law enforcing agency to reduce the risk of rade and harassment 	<p>The approach will begin in 2018.</p>
Procurement and supply management	<ul style="list-style-type: none"> • Price hike of HPs • Interruption of procurement and supply due to any unanticipated incidents. • Ensure health products available on time. 	<ul style="list-style-type: none"> • Long term contract with the vendors will be implemented. • Adequate buffer stock will be maintained • All PRs will ensure to prepare a PSM planning before hand with detailed action plan in order ensure health products are procured on time. 	<ul style="list-style-type: none"> • By March 2018. • The approach is ongoing and will be continued. • By January 2018

<p>Adherence to treatment protocols and guideline</p>	<ul style="list-style-type: none"> • Chance of not following national and international protocol of clinical and prevention guideline. Patients' non-adherence to regimens, monitoring of adverse effects or other related quality of health services and rational use of 	<ul style="list-style-type: none"> • Providing training to clinical service providers and in case of drop-out, and conduct on-job refresher training to ensure they are able to provide proper management aligned with national (international where applicable) protocol/guideline. 	<p>Ongoing and budgeted as well.</p>
<p>Punitive Laws</p>	<ul style="list-style-type: none"> • Several punitive laws exist in Bangladesh which hamper HIV interventions with various KPs. 	<ul style="list-style-type: none"> • NASC along with two PRs and other stakeholders will organize advocacy meetings ranging from one to one and groups and national consultation meetings/workshops and capacity enhancement activities will be implemented. Some activities are ongoing; however, these activities will be modified based on current experiences and innovative approaches will be designed and implemented with an expectation that punitive laws will be rethought and/or at least an enabling environment will be created. • A National Task Force (NTF) will be formed under the leadership of NASC with high level policy makers from various Government and Non-Government stakeholders. Coordination meeting will take place with NTS to address emerging issues related to violation of human and gender rights, violence, and to deal with punitive laws in a systematic manner. 	<p>January 2018 onwards. Funding has been allocated for formation of NTF and related activities.</p>

SECTION 4: FUNDING LANDSCAPE, CO-FINANCING AND SUSTAINABILITY

This section details trends in overall health financing, government commitments to co-financing, and key plans for sustainability. Refer to the **Funding Landscape Table(s)** and supporting documents as applicable. To respond, refer to additional guidance provided in the *Instructions*.

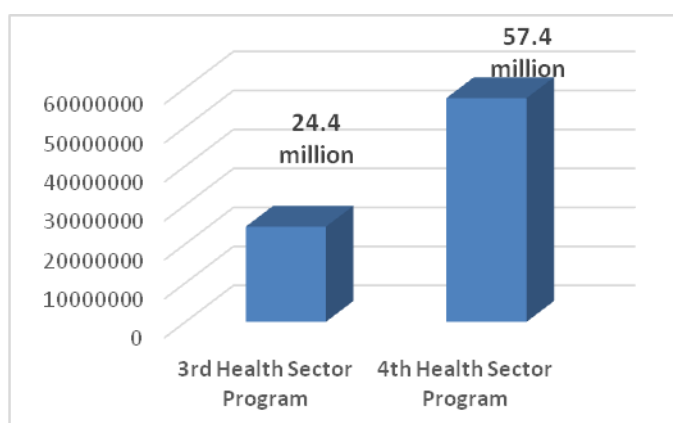
4.1 Funding Landscape and Co-financing

a) Are there any current and/or planned actions or reforms to increase domestic resources for health as well as to enable greater efficiency and effectiveness of health spending? If yes , provide details below.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
b) Is this current application requesting Global Fund support for developing a health financing strategy and/or implementing health financing reforms? If yes , provide a brief description below.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
c) Have previous government commitments for the 2014-16 allocation been realized? If not , provide reasons below.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
d) Do current co-financing commitments for the 2017-19 allocation meet minimum requirements to fully access the co-financing incentive, as set forth in the Sustainability, Transition and Co-financing Policy? ² If not , provide reasons below.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
e) Does this application request Global Fund support for the institutionalization of expenditure tracking mechanisms such as National Health Accounts? If yes or no, specify below how realization of co-financing commitments will be tracked and reported.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
(maximum 2 pages)	

[Applicant response]:

a). Under this funding request, there are specific structural interventions proposed with Ministry of Health and Family Welfare, Ministry of Social Welfare, Ministry of Women and Children Affairs for increasing availability and accessibility of government mainstreaming services including universal access to health coverage, government social safety-net program, access to legal support, etc.

Government of Bangladesh (GoB) has increased investment for HIV/AIDS Prevention and focused targets under the Sustainable Development Goals (SDGs). Data shows that in the 3rd Health Sector Program NASP was allocated 24.4 million for while in the 4th Health Sector Program 57.4 million has been allocated which is 2.35 million higher than the previous allocation.

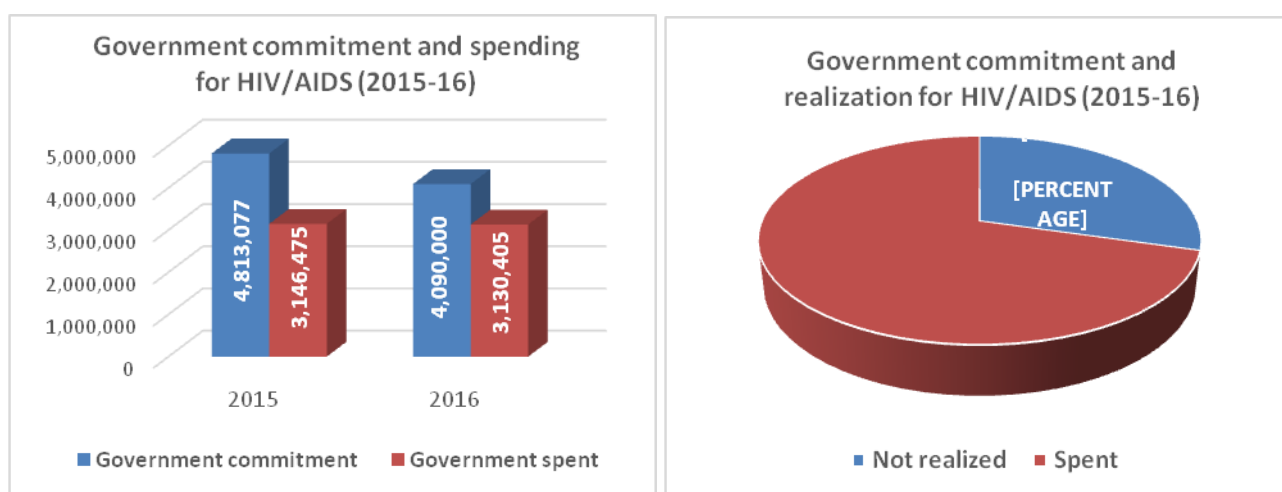


Funding Request: Full review

The Funding Landscape Table and program gap table shows that there will be a significant proportion of KPs who will not receive services during 2018-2020. NASC will coordinate with other bilateral donors for addressing this gap.

b). No.

c). Yes, previous government commitments for the 2014-16 allocation was realized. Government of Bangladesh committed to NASC USD 8.9 million for HIV/AIDS program during 2015 and 2016. During this time period GoB spent USD 6.27 million which was 71% of the committed amount.



d) Yes.

e). Government of Bangladesh (GoB) has its own Implementation Monitoring and Evaluation Division (IMED) under Ministry of Planning. This division collects quarterly program implementation and spending status from all ministries, departments and divisions, including NASC. According to the collected data, IMED analyzes the program implementation and spending progress and provide necessary feedback to concerned ministries, departments and divisions (<http://www.imed.gov.bd>). Beside this, Program Management and Monitoring Unit (PMMU), under the Planning Wing of Ministry of Health and Family Welfare regularly monitors progress (Program and Financial). A bi-annual and annual report are also produced and disseminated.

Apart from the GoB mechanism, the country has two mechanisms for tracking the response and health expenditure; the Global AIDS Response and Progress Report (GARPR) report is produced annually and periodic National AIDS Spending Assessment (NASA) is produced every two years.

² Refer to the [Sustainability, Transition and Co-Financing Policy](#).

4.2 Sustainability

Describe below how the government will increasingly take up health program costs, and actions to improve sustainability of Global Fund financed programs. Specifically,

- a) Explain the costs, availability of funds and the funding gap for major program areas. Specify in particular how the government will increasingly take up key costs of national disease plans and/or support health systems; including scaling up investments in programs for key and vulnerable population, removal of human rights and gender-related barriers and enabling environment interventions.
- b) Describe actions to improve sustainability of Global Fund financed programs. Specifically, highlight key sustainability challenges of the program(s) covered by the funding request, and any current and/or planned actions to address them.

(maximum 1 page)

[Applicant response]:

The total costs of the National Strategic Plan (NSP) for HIV of Bangladesh for the year 2018-2022 are estimated to USD \$291 M. Under the upcoming Operational Plan (OP) under the Health Sector Program, a total amount of USD\$ 57.4M has been allocated for HIV interventions, treatment and care for five and half years, i.e., 2017-2022. The Global fund has provided an amount of USD \$ 21.5m for three years (i.e., 2018-2020). Therefore, it is evident that for 2018-2020, there is a clear gap of USD\$ 209 M for implementing various components of the NSP. A portion of this gap supposed to be covered by various other sources. Therefore, a funding gap is anticipated from 2018-2022 including the period under the upcoming Global Fund grant (2018-2020). Although not clear, however, it is anticipated that the Global Fund may continue to provide fund at similar or larger scale even after 2020. Bangladesh expects such continuation of the Global Fund for HIV sector as historically with the Global Fund support, over the years, Bangladesh has shown an impressive progress in terms of keeping low HIV prevalence even among most of the KPs beside PWID in Dhaka. By looking at increasing trend of allocation under the OP of the Health Sector over the years of the Government of Bangladesh (GoB), it can be safely concluded that GoB has demonstrated its political commitment to increase domestic funding for HIV prevention, treatment, and care and support services.

HIV prevention, treatment, care and support activities in Bangladesh have combined efforts of the government, NGOs and development partners. It is expected that domestic funding will be increased in-line with enhanced economic growth of Bangladesh as documented over the last several years. In addition, the capacity of the National AIDS/STD Control (NASC) wing under the Directorate General of Health Services (DGHS) has been enhanced for which NASC has re-established as the PR of the Global Fund. This is considered a milestone in terms of rendering sustainable national leadership in the field of HIV and AIDS in Bangladesh in coming years.

Unfortunately, service gaps (as reflected the programmatic gap table) in terms of coverage of KPs still remain. However, it is predicted that with increasing government funding, this service gap will be eventually reduced. Most importantly, few issues have been considered under the proposed funding request under the Global Fund grant, keeping in mind about sustainability of HIV interventions. For example, sensitization and training of health care providers on STIs, HIV and AIDS at the government health care Funding Request: Full review

settings. The government of Bangladesh has taken some activities related to HIV and AIDS program in a sustainable manner such as providing care, support and treatment for PLHIV, serological and behavioral surveillances, training of health care providers on STIs, HIV and AIDS. Inclusion of HIV and AIDS related information in secondarily level education text book.

It has to be noted with caution that public health systems of Bangladesh and overall infrastructure, required institutions and resources of Bangladesh now are not fully prepared for making HIV intervention, treatment and care support program to be operated through a sustainable framework. The unpleasant truth as reflected from various other countries of the world that unless and until HIV and AIDS appear as a big disease burden and threat to development, it is less likely that HIV interventions will be taken-up by the government to its fullest. However, we have started the effort of transition of transferring HIV and AIDS related activities to be integrated with government systems, but it will take time and proper planning. However, we believe the Global Fund will be able to play a critical role in this process.

SECTION 5.1: PRIORITIZED ABOVE ALLOCATION REQUEST

All applicants are requested to detail a prioritized above allocation request. To respond, refer to guidance in the *Instructions* and fill in the table below.

Provide in the table below a prioritized above allocation request which, following the TRP review, could be funded using savings or efficiencies identified during grant-making or put on the register of UQD to be financed should additional resources become available. The above allocation request should include clear rationale and should be aligned with programming of the allocation for maximum impact. In line with the Global Fund's Strategy to maximize impact and end the epidemics, the prioritized above allocation request should be ambitious (for example, representing at least 30-50 percent of the within allocation amount). Applicant response in the table below.

[Component] – Copy table as needed, if your funding request includes more than one component

	Module	Amount requested [Specify US\$ or EUR]	Brief Rationale, including expected outcomes and impact (how the above allocation request builds on the allocation)
	NASP		
1	RSSH Digital data management system for 150 service delivery points for KPs under 4 th health sector program including data center set-up and management, provide equipment and relevant training to the DIC/ HTC	US\$ 450,000	Under the 4 th Health Sector Program, there are provision for establishing 150 service delivery points (DIC, HTC, ART) throughout the country. Through this digital data collection and management system, NASC will receive regular data from service delivery point which will help to monitor the progress of program implementation and helps for further decision making.
	icddr,b		

1	RSSH	US\$ 1,149,805	<p>PrEP demonstration project for MSM Rationale: Despite a decade of operation of HIV intervention in Bangladesh, consistent condom use among MSM remains low for diverse and complex reasons. Behavioral intervention alone may not be successful. Thus, it is required to utilize biomedical interventions with behavioral interventions. Demonstration projects on PrEP were undertaken in various countries with success. Till date, no project on PrEP has been conducted in Bangladesh. Hence, understanding the enablers and barriers to PrEP implementation in the context of Bangladesh is urgently required. Thus, a PrEP demonstration project in Dhaka has been proposed within the framework of implementation science with a quasi-experimental design in selected DICs for sexual minority people. Expected outcomes: The study is expected to offer a scientifically sound and feasible PrEP intervention model for expansion in other priority districts of Bangladesh. Impact: Keeping Low HIV prevalence in sexual minority people.</p>
2	RSSH	US\$ 100,110	<p>Scale-up of providing STI related services from government healthcare facilities Rationale: Activities decided from piloted districts within grant money will be scaled-up in priority districts through which government health facilities of a district will be sensitized and capacitated to serve health problems particularly STI of sexual minority; and on the other hand, sexual minority people will be encouraged to uptake services from government health facilities through the framework of implementation science. Expected Outcomes: More sexual minority people will start receiving STI related services from government health facilities. Impact: The scale-up of activities will facilitate the evidence based transition strategy for using the model at the national scale.</p>
3	Prevention program for MSM and TG	US\$ 1,500,340	<p>Scale-up of essential HIV prevention services for MSM Rationale: Scaling up services to MSM and hijra in Bangladesh may not be possible through government health sector funding alone. Therefore, it is important to increase program coverage and HTC services as well. Expected outcomes: 15% increased for both population and HTC coverage for MSM and hijra Impact: To maintain low HIV prevalence among MSM and hijra.</p>

4	RSSH	US\$ 504,150	<p>A study on oral STI and antibiotic sensitivity among MSM and hijra</p> <p>Rationale: There is a paucity of scientific information about the drug sensitivity of oropharyngeal gonorrhoea among MSM and hijra. Moreover, over diagnosis of STIs in syndromic approach may contribute to the drug resistance. This proposed study wants to see current prevalence of oropharyngeal STI as well as drug sensitivity of oropharyngeal gonorrhoea. Moreover, the current trends of prevalence and drug sensitivity pattern of other STIs.</p> <p>Expected outcomes: Prevalence of oro-pharyngeal STI among sexual minority people measured and antibiotic sensitivity of N. gonorrhoea determined.</p> <p>Impact: Appropriate antibiotic regimen for STI will be updated and prevalence of STI among sexual minority will be reduced.</p>
5	Prevention program for MSM and TG	US\$ 350,100	<p>A pilot study for promoting saliva based HIV self testing among partners of MSM and hijra</p> <p>Rationale: HIV testing rate among the male and female partner of MSM and Hijra are low in Bangladesh. As a result, they remain at risk of HIV infection and unaware about their HIV status. Thus, a need to introduce HIV self-testing approach to increase coverage among particularly female partner of sexual minority. A study on HIV self-testing (HIVST) will be conducted to assess the feasibility of saliva based self-HIV testing among partners of sexual minority people and to develop a model to scale-up this approach.</p> <p>Expected outcomes: One scientifically feasible and tested model for implementing saliva based HIV self-testing among partners of sexual minority people in Bangladesh.</p> <p>Impact: HIV testing coverage among partners of sexual minority will be increased.</p>
	Save the Children		
1.	Comprehensive prevention programs for sex workers and their clients	US\$ 1,606,633	<p>Scale-up of Essential HIV Prevention Services for Female Sex Workers</p> <p>The national FSWs coverage with HIV prevention services is made 16% in funding request which stands at 28% with HPNSP. The coverage will be 47% in Dhaka and 43% in other selected districts (outside Dhaka). In the above allocation, additional 6,000 FSWs will be covered with essential HIV prevention services which will increase the national coverage up to 37% considering the epidemiological trend, STI prevalence, and high concentration of FSWs in priority districts, border vulnerability and concentrated epidemic among PWID in Dhaka. The coverage in both Dhaka and outside Dhaka will reach up to 60%.</p>
2	Comprehensive prevention programs	US\$ 325,039	<p>Scale up of comprehensive care and protection for children of sex workers</p> <p>NASP report indicates that 66% of female sex workers have reported to live with a</p>

	for sex workers and their clients		permanent partner/husband and children (NASP & Save the Children in 2011). Children of FSWs experience insecurity, discrimination and they have vulnerability and risk towards HIV. At present no formal child protection structure or mechanism is in place for the welfare of marginalized children group at community level. Save the Children is running a comprehensive care and protection program for 1000 children of sex workers (ChSW) in selected areas of 5 districts: Dhaka, Chittagong, Sylhet, Khulna and Rajbari. In the above allocation, another 5,00 CHsW will be brought under the coverage providing with the support of nutrition supplement, education and general health.
3	Comprehensive prevention programs for sex workers and their clients	US\$ 96,913	Focused HTS intervention for MARA and FSWs who are not availing HTS HTS rate is less among MARA and FSWs. Study shows that 77.5% FSWs (below 20 years of age) know where HTS is available but only 48.3% avail the services. 31.1% of adolescent FSWs have not used condom in their last sex act while consistent condom use rate is only 9.1% [Mapping Study and Size Estimation 2015-2016]. More than 10% (10-18%) of new HIV cases in 2016 are among young people (10-24 years) [NASP, 2016]. MARA have high demand among clients but been less empowered in condom negotiation skill. Also their scattered and hidden nature, less service seeking behavior, unaware of self-vulnerability and unwillingness to come at the DICs, enhance chances to get HIV infection. To conduct HTS among 500 MARA and hard to reach FSWs, self-testing with saliva will be an option to bring the service and ART at their doorsteps. This options will also lead to achieve the global target of 90-90-90.
4	Comprehensive prevention programs for people who inject drugs and their partners	US\$ 96,913	Scale-up of focused HIV testing services for regular sex partners of people who inject drugs During NFM implementation, significant changes were made for HIV testing service both by target and modality. Introduction of whole blood HIV testing and integration at all DICs and Sub-DICs increased the uptake from 15% in RCC to 42% in NFM (2016) among PWID and FSWs. But testing of partners still remains as a major challenge, since they are scattered, hidden in nature, not aware on self-vulnerability and also many of them are afraid of testing. Only 7% of regular sex partners of PWID tested for HIV; among them 6 found HIV positive. Besides proposed HTS in funding request, provision of self-tests for 500 regular sex partners of PWID & WIDs of Dhaka city with saliva would be an additional option for regular sex partners of PWID to prevent further spread of HIV transmission and ensure timely linkage to ART.

5	Comprehensive prevention programs for people who inject drugs and their partners	US\$ 935,188	<p>Scale-up of oral substitution therapy (OST) in Dhaka, Comilla, Rajshahi and Chapainawabgonj for people who inject drugs</p> <p>OST has been proven as one of the most effective interventions to prevent HIV among PWID. In the funding request (2018-20), 1,200 PWID will be provided OST in Dhaka. GoB has also targeted to provide OST to another 1,500 PWID in HPNSP (2017-2022). However, the total national OST coverage will be 8% (40% in Dhaka) by 2020. Therefore, considering the HIV and HCV epidemic, another 1,000 PWID will be targeted for OST in Dhaka, Comilla, Rajshahi and Chapainawabgonj districts by 2020, which will increase the national coverage to 11%.</p>
6	Comprehensive prevention programs for people who inject drugs and their partners	US\$ 941,945	<p>Scale-up of HIV, HCV and Harm Reduction Services in the Prison for People Who Inject Drugs</p> <p>Despite the growth of support around the world, harm reduction remains unavailable to one particularly key population: prisoners (Cook C, Phelan M, Sander G, Stone K, Murphy F. The case for a harm reduction decade: progress, potential and paradigm shifts. London: Harm Reduction International; 2016). Although the incarcerated PWID inject less frequently, they are much more likely to share injecting equipment and with a greater number of people (World Health Organization. Prisons and Health. Geneva: World Health Organization; 2014). For these and other reasons, including overcrowding, poor sanitation and inadequate health care, prisons represent high-risk environments for the transmission of HIV, HCV and TB. This makes the prison as important settings for the provision of harm reduction services, including NSPs, OST, ART, opioid antagonists (e.g. naloxone), condoms and education and information on harm reduction. Therefore, the above allocation is proposing to scale-up harm reduction services for 400 imprisoned PWID of the Central Jail at Keranigonj, Rajshahi and Comilla.</p>
7	Treatment, care and support (TCS) for people living with HIV	US\$ 332,408	<p>Piloting an ART service delivery model for key and general population</p> <p>In 2008, NGO run ART program was scaled-up nationwide through NGOs/SHGs, under the Global Fund Round 6 and continued till 2013. In 2014, GoB incorporated ART service delivery in the government health facilities through GO-NGO collaboration and till now is provided by NGO/CBO. GoB in its' 4th HPNSP has planned for scale-up of HTS in 50 districts along with 5 ART centers in selected hospitals during the period of 2017 to 2022. However, ART service delivery model to provide HIV care to key and general populations is yet to be concluded. Therefore, above allocation funding request is proposing to develop an ART service delivery model through installation of ART centers in Comilla and Cox's Bazar district general hospitals for responsive public health system through active and functional</p>

			involvement of the community.
8	Treatment, care and support (TCS) for people living with HIV	US\$ 940,181	<p>Scale-up of PrEP as part of comprehensive HIV prevention package for key populations and sero-discordant couple</p> <p>On the basis of the effectiveness and acceptability evidence of PrEP, WHO has now broadened the recommendation to include all population groups at substantial risk of HIV infection (WHO reference number: WHO/HIV/2015.48). In funding request, Bangladesh has proposed for HIV prevention service packages for FSW, PWID, MSM, TG and Hijra that includes HIV testing, counselling, male condoms and harm reduction interventions for people who use drugs. PrEP shall be an additional prevention choice in the existing HIV prevention program of Bangladesh. Therefore, the above allocation funding request is proposing to introduce oral PrEP containing tenofovir disoproxil fumarate (TDF) as an additional prevention choice of combination HIV prevention approaches for 1,000 people at substantial risk of HIV infection (i.e. adolescent FSW, sex partners of PWID, MSM and serodiscordant couple).</p>
9	HSS Health Information system and M&E	US\$ 142,272	<p>Scale-up ICT based data collection system in HIV/AIDS program to integrate with national Health Management Information System (HMIS)</p> <p>A pilot initiative has been planned under the funding request to introduce ICT based data collection system using tablet with mobile apps by community organizer in two selected areas. It will record service delivery status at real time or immediately after providing the services and generate report for different level of users. Under above allocation, the ICT based data collection system will be scaled up for entire program and to be integrated into MIS system of HIV/AIDS program contributing to national HMIS.</p>
TOTAL AMOUNT		US\$ 9,471,995	