

# FUNDING REQUEST APPLICATION FORM

## Full Review

SUMMARY INFORMATION			
<b>Applicant</b>	Bangladesh		
<b>Component(s)</b>	Malaria		
<b>Principal Recipient(s)</b>	Ministry of Finance and BRAC		
<b>Envisioned grant(s) start date</b>	1 January 2018	<b>Envisioned grant(s) end date</b>	31 December 2020
<b>Allocation funding request</b>	US\$ 26.8 million	<b>Prioritized above allocation request</b>	US\$ XXX

**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
<b>Resilient and Sustainable Systems for Health (RSSH)</b>			
Health system overview	Health Bulletin 2016, Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh. <b>Health Care Financing Strategy 2012-2032.</b>	Chapter 2 P iv-v (plus)	<input type="checkbox"/>
Health system strategy	<b>XXX</b>		<input type="checkbox"/>
Human rights and gender considerations (cross-cutting)	National Human Rights Commission (JAMAKON) Bangladesh, Annual Report 2015.	Chapter 2	<input type="checkbox"/>
<b>Disease-specific</b>			
Epidemiological profile (including interventions for key and vulnerable populations, as relevant)	Sean Hewitt (2016) 'A review of the epidemiology of malaria in Bangladesh', unpublished report for NMCP, 8 December 2016 (includes 'Annex 1. The 2014 malaria outbreak in Bangladesh' and 'Annex 2. Data anomalies due to the misinterpretation of Pf/Pan-specific rapid diagnostic tests in Bangladesh between 2014 and 2016').  National Strategic Plan for Malaria Elimination - <i>A path to the phased elimination of malaria from Bangladesh, 2017-2021</i> , 19 January 2017.	P 2-21.  P 10-19.	<input type="checkbox"/>
Disease strategy (including interventions for key and vulnerable populations, as relevant)	National Strategic Plan for Malaria Elimination - <i>A path to the phased elimination of malaria from Bangladesh, 2017-2021</i> , 19 January 2017.	P 26-54.	<input type="checkbox"/>
Operational plan, including budgetary framework	National Strategic Plan for Malaria Elimination - <i>A path to the phased elimination of malaria from Bangladesh, 2017-2021</i> , 19 January 2017. <b>'Bangladesh NSPME budget.xlsx'</b>	P 30-54  Whole	<input type="checkbox"/>

		workbook	
Program reviews and/or evaluations	'Joint Monitoring Mission 3 (JMM3) of National Malaria Control Programme Bangladesh' 19 December 2016. JMM3 - PowerPoint presentation - 5 December 2016.	Complete document Slides 34-63	<input type="checkbox"/>
Human rights and gender considerations (disease-specific)	National Strategic Plan for Malaria Elimination - <i>A path to the phased elimination of malaria from Bangladesh, 2017-2021</i> , 19 January 2017.	P 20-21	<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)**

In the past decade, Bangladesh has made significant progress in reducing malaria morbidity and mortality. Since 2008, malaria burden had been declining each year, but in 2014 there was an upsurge in the Chittagong Hill Tracts (CHT), which saw overall falciparum caseload increase by 109% relative to the previous year. Annual caseload has again been falling since 2014, but it has not yet reached the low levels of 2013. The number of malaria deaths dropped by 79% between 2007 and 2009 (down from 228 to 47) reflecting major improvements in access to early diagnosis and appropriate treatment. Since then there have been an average of 26 deaths per year. Despite these recent advances, malaria remains an important cause of morbidity and a cause of limited mortality in Bangladesh, particularly in the event of an upsurge.

Over the next five years Bangladesh aims to eliminate malaria in less endemic areas, while accelerating control efforts in more endemic areas to reduce cases to a low level. Post 2021, it is expected that all areas will either be targeted for elimination, or for prevention of reintroduction, so that by 2030 Bangladesh will be malaria free. The timelines and geographic targets for elimination are presented in Figure 9 and 10 of the NSP. The strategy is in-line with both the *Strategy for Malaria Elimination in the South East Asia Region (2017–2030)* and the *Global Technical Strategy for Malaria 2016-2030*, and takes into account lessons learned from successful implementation of malaria control efforts in Bangladesh during the past decade. The strategy also reflects all of the recommendations of the recent Joint Monitoring Mission.

The epidemiology of malaria in Bangladesh is highly complex, varying from location to location and from one population group to another. The different situations require different malaria control strategies, adapted to suit specific risk groups and vector behaviours, and adjusted to take into consideration local infrastructure and health service coverage. Intense malaria transmission is largely restricted to hilly, forested and forest fringe areas of the Chittagong Hill Tracts (CHT) as the most efficient vectors cannot survive without dense shade and high humidity. The behaviour of malaria vectors in Bangladesh varies depending on climatic and other environmental factors. Both indoor and outdoor biting occurs, but primary vectors are characterised, at least seasonally, by their early outdoor biting habit. Nevertheless, long-lasting insecticide treated bed nets (LLINs) continue to play a critical role in reducing malaria transmission.

Malaria is becoming an increasingly focal disease in Bangladesh. In 2015, just 4 districts had an Annual Parasite Incidence (API) greater than 1, compared to 13 in 2008. In 2015, the 3 Chittagong Hill Tract districts (Khagrachari, Rangamati and Bandarban) together accounted for 90% of confirmed malaria cases. Just 13 of the 64 districts in Bangladesh are considered to be 'endemic', although data to substantiate this view is currently lacking. This situation will be rectified with the introduction of nationwide surveillance including zero reporting by 2018.

The wide variety of population groups at risk of malaria in endemic areas of Bangladesh is summarized in table 1. These groups are discussed in detail in the NSPME. The level of malaria risk for each of these groups is dependent on a number of location-dependent factors including degree of endemicity, and accessibility to and strength of health system services. Poverty is a key issue that limits access to malaria related services and hence increases risk. Rohingya refugees remain a significant problem in Bangladesh, especially since the recent influx. Of the 232,000 refugees (or refugee-like populations) reported by UNHCR in November 2016, 200,000 were scattered through a number of southeastern districts, while just 32,000 were based in camps. These populations generally have less access to health services and hence are less well protected from malaria than other

populations in the same areas. A malaria outbreak amongst this group could upset the recent gains in malaria control in Bangladesh

Migrants, who may be found in most of the situations described in table 1.2, are a particular concern as they could potentially contribute to the spread of artemisinin resistant malaria parasites from neighbouring Myanmar and beyond.

**Table 1.2. Population groups at risk of malaria in endemic areas of Bangladesh.**

<i>Static populations*</i>	<i>Mobile and migrant populations</i>
<ul style="list-style-type: none"> <li>• Established villages (ethnic minority groups [EMGs] and ethnic majority).</li> <li>• Rohingya refugee camps.</li> <li>• New settlements.</li> <li>• Camps associated with large-scale construction projects (dams, bridges, mines, etc.).</li> <li>• Rubber plantations.</li> <li>• Tea gardens.</li> </ul>	<ul style="list-style-type: none"> <li>• ‘Jhum’ (traditional slash-and-burn) and paddy field farming communities visiting their forest farms (commonly EMGs).</li> <li>• Seasonal agricultural labourers (particularly those moving between low-endemic plains areas and high-endemic forested foothill areas).</li> <li>• Defence services.</li> <li>• Forest workers in the formal sector (police, border guards, forest/wildlife protection services).</li> <li>• Forest workers in the informal sector (hunters, people gathering forest products such as precious timber, construction timber, rattan or bamboo).</li> <li>• Rohingya refugees.</li> <li>• Transient or mobile camps associated with commercial projects (road construction, large-scale logging).</li> <li>• Formal and informal cross-border migrant workers (legal and illegal workforces) e.g. Netrakona residents mining coal in India.</li> <li>• Pilgrims (religious individuals/groups spending extended periods at mosques and temples in endemic areas)</li> <li>• Tourists travelling from urban areas to endemic forested foothills.</li> </ul>

\* Static for >1 year.

Providing malaria related services to high-risk static populations is relatively straightforward, at least theoretically. The location of settlements, plantations, construction sites and development projects can be mapped, populations can be quantified and plans for delivering interventions can be formulated. The challenges to service delivery among mobile populations are more complex. Mapping is often not possible, there may not be any actual houses or other structures in which to suspend an LLIN, the population size may vary from day to day making quantification of needs difficult, and in the case of illegal migrants and individuals involved in illegal activities, fear of punishment often prevents any contact with official groups or groups that are perceived to be official. Providing a comprehensive package of services to these high-risk *mobile population groups* will be crucial as Bangladesh moves towards elimination.

Malaria is a focal disease and to ensure effective use of limited resources it is therefore essential to identify the areas and populations at highest risk, which must be prioritized for the various programme interventions. An API based stratification at district-level is being used to select programme phase:

Burden reduction; Elimination; or, Prevention of reintroduction. In addition, the programme has adopted a two-tier approach to stratification for LLIN targeting, which takes into account the unique epidemiology of malaria in the CHT districts. The approach also prioritizes areas based on risk, in case funds for LLIN procurement are limited.

Bangladeshi women still face gender related barriers and disadvantages in various aspects of their lives, including some that affect access to health services. Efforts are underway to reduce gender inequality and raise awareness about the positive impacts of empowering women and girls. There have been very significant improvements in women's health over the past three decades. Women's life expectancy, for example, increased from 54.3 years in 1980 to 73.1 years in 2015, one of the largest increases in the region.

The Constitution of the People's Republic of Bangladesh ensures that "Health is the basic right of every citizen of the Republic" as health is fundamental to human development. Bangladesh is committed to achieving the SDGs by 2030 and has been pursuing various programmes to translate the SDGs into reality. The 'Health, Population and Nutrition Sector Development Programme' provides special focus on improving priority health services including Communicable Diseases in order to accelerate progress. The 'Essential Services Package' will be provided in difficult to reach areas through appropriate arrangements with NGOs and community based organizations (CBOs) to overcome the shortage of public sector human resources on the basis of comparative advantages. The partnership between NMCP and the BRAC led NGO consortium has been recognized both nationally and internationally as an example of best practice in collaboration between government and NGO sectors, strengthening and enhancing the malaria control programme.

The NMCP needs additional technical support to strengthen programme planning and implementation at central level. 'Human resources' (HR) is also a critical issue, especially in remote areas of the highly endemic CHT districts. Staff shortages and rapid staff turnover pose a serious threat to programme quality. This will be exacerbated by the increased demands associated with malaria elimination. Staff motivation is low in some instances due to poor career plans, limited incentive packages, and sub-standard residential facilities. The Entomology Department is particularly weak. Existing vacancies for medical officers, staff nurses, laboratory technologists, entomologists and entomology technicians, as well as supervisory personnel in general, all need to be filled on an urgent basis. Community Clinics and Union Health Centres in hard-to-reach areas need to be strengthened to improve provision of malaria control services.

### **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.

**(maximum 1 page per component)**

*[Applicant response]:*

**Table 1.3. Recent GFATM grants for malaria in Bangladesh.**

SI	Grants	Period	Grant number – PR1 MoF	Grant number – PR2 BRAC
1	Round 6	May / June 2007 – Jun 2010	BAN-607-G07-M	BAN-607-G06-M
2	Round 9 SSF	Jul 2010 – Jun 2015	BAN-S10-G14-M Later on, BAN-M-NMCP	BAN-S10-G15-M <i>Later on, BAN-M-BRAC</i>
3	NFM	Jul 2015 – Dec 2017	BGD-M-NMCP	BGD-M-BRAC

a). Recent malaria grants are presented in table 1.3 above. Many lessons have been learned during this period. Those most pertinent to the development of this funding request are summarized as issues and recommendations in slides 34 to 59 of the annex 'JMM3 - PowerPoint presentation - 5 December 2016'. They relate to a broad spectrum of programme activities. In summary:

- Staff are generally motivated and committed.
- Prevention, diagnosis and treatment practices are well followed at all levels.
- Collaboration with local stakeholders is strong and this will greatly facilitate the introduction of elimination related interventions, particularly in hard-to-reach areas.
- Outside of the upsurge affected CHT, the malaria situation has improved steadily in recent years (down 80% since 2008) and with the exceptions of CHT and Cox' Bazaar (imported cases), all sub-districts now have an API<1. Elimination is thus feasible, given additional elimination-specific capacity development.
- Case Fatality Rate has dropped by 80% between 2007 and 2009, and since then has fluctuated between 0.2 and 0.8/1,000.
- Roll-out of 1,500 community clinics and NGO managed CHWs has been a major advance for malaria case management and surveillance.
- There are 210 functional microscopy centres in the 13 most endemic districts.
- There is strong leadership and commitment at national, district and sub-district level.
- Activities of GoB officials, BRAC and its local implementing partners are well harmonized.
- There is strong stakeholder involvement in local level planning, implementation and reporting.
- Improved targeting of LLINs will maximize the cost effectiveness of vector control operations.
- Continuous LLIN distribution channels are required to target mobile populations and migrants.
- Vector profiling and mapping needs to be updated to support cost-effective targeting.
- Microscopy quality assurance and the Central Malaria Reference Laboratory need strengthening in-line with the stringent requirements for elimination.
- Systematic testing of suspected cases must be introduced in so-called 'non endemic' districts.
- Further expansion of community clinics and NGO managed case-management is needed to ensure all endemic communities are adequately covered.
- Stand-by treatment should be introduced for forest goers.
- Malaria screening should be introduced as part of ante-natal care for malaria in pregnancy in all highly endemic communities.
- A minimum package of RDTs and antimalarials should be made available to sub-district level even in non-endemic districts.
- Private sector malaria case management providers must be engaged in support of malaria elimination, and private sector pharmaceutical surveillance and regulation must be strengthened.
- Surveillance (with the paper-based reporting of aggregate data up to upazila, and web-based reporting starting from upazila) is working well. But to allow in-depth analysis and maximize the usefulness of data for action, the system needs to be upgraded to allow case-based reporting and 'zero-reporting' from peripheral level.
- Coordination and leadership needs to be adjusted in-line with elimination targets.
- Broader collaboration with local stakeholders is needed to facilitate the introduction of elimination related interventions, particularly in hard-to-reach areas.

- HR must be strengthened in-line with the increased demands associated with elimination.
- Domestic contributions (financial and other) must increase steadily in-line with the country's commitment to elimination.
- Measures must be introduced to support cross-border district-to-district coordination and action.
- Emergency measures must be established to address malaria risk in Rohingya refugees.
- The advocacy, communication and social mobilization approach needs to be revised in support of elimination, with materials and methodologies specifically targeting each risk group.
- Outbreak and focus preparedness and response capacity needs to be strengthened.

All of the issues identified above have been addressed in the newly developed NSPME 2017-21, including those relating to the priority activities covered by this funding request.

b). Bangladesh did not receive any HSS-specific grant during 2014-16, but some HSS investments were embedded in the NFM grant.

Community clinics are a relatively new concept of the Bangladesh Government. They were designed to provide healthcare services at community level. With GF support, the Programme has established malaria cases management services at community clinics through training and through the provision of diagnostics and antimalarials. This intervention has significantly improved access to services in the periphery.

In parallel to the government referral system, BRAC has built a unique referral system for malaria patients using the current grant. During the first 2 years of this grant, more than 100 severe or complicated malaria patients were referred from community level to upazila, district or tertiary level public health facilities. NGO workers were directly involved in the transportation of patients referred from hard-to-reach areas. All related costs were born by the grant. This system has undoubtedly had a high impact in terms of saving lives.

c). There has not been any investment by other donors during the period in question.



## 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 4pages per component)**

[Applicant response]:

a) *Funding request*. This application for funding covers activities grouped under 18 *interventions* spanning 4 modules as presented in table 2.1 below. A total of \$26,800,000 is requested from the within allocation amount.

**Table 2.1. GF Request by Module and Intervention.**

XXX

'NFM2' funding will make a very significant contribution towards the goal of the NSPME. NFM2 activities have been selected based on a robust prioritization process (details below). The NFM funding will support high impact activities that are currently unfunded. Some of these activities are a continuation of the high impact activities supported by GF under the current NFM grant. Others are innovations developed to address the issues currently undermining progress towards programmatic goals (described in section 1.3 a above). A list of intervention is presented below. The page limit for this section does not allow for a detailed description of each the activities included in this request. For more information on each the activities and the rationale behind selecting them, please refer to the NSPME, 2017-21 (see pages 30-53) using the activity and sub-activity numbers [presented in square brackets below] for reference.

## **Module 1 - Case management**

Ensuring universal early<sup>1</sup> diagnostic testing will reduce the over-use of ACTs and reduce drug resistance selection pressure on parasites. The detection of malaria infections will be based primarily on blood examination by RDTs or, where facilities exist, on microscopy.

The annual blood examination rate (ABER) for the population at risk in the 8 low endemic districts will be increased from 4.7% (2015) to 6% in 2018 rising to 8% in 2020. This increase is in-line with the increased case detection requirements and increased accessibility to treatment associated with the move towards malaria elimination.

Treatment for falciparum and non- falciparum malaria will be based on national treatment policies, which are in-line with WHO guidelines. Currently, all medicines recommended for the treatment of uncomplicated falciparum malaria are ACTs. Treatment will include single-dose, low-dose primaquine to eliminate gametocytes, which are responsible for infecting mosquitoes with malaria and thus continuing transmission. Where possible, supervised treatment will be used to support patient adherence to radical treatment for vivax malaria, which requires a 14-day course of treatment. This will entail follow-up by a health worker or volunteer on days 4 and 15. Directly observed treatment (DOT) for ACT, which has a 3 day regimen, may be applied, but only in the final stages of elimination when the number of cases falls to a point at which DOT becomes manageable. Until then, efforts will be made to maximize patients' adherence to their full treatment regimen through advocacy delivered by healthcare providers (inter-personal communication). The importance of this 'adherence advocacy' will be emphasized in all clinical training sessions in future.

Achieving universal coverage with case-management requires three channels of service delivery: public, community based and private. While malaria incidence remains high, the Programme will maximize coverage through all three channels while making efforts to improve quality (a minimum package of RDTs and antimalarials will be made available down to upazila level in non-endemic districts). In order to ensure optimal case-management, surveillance and reporting during the elimination phase, selected private sector providers will be allowed to test and treat patients according to the National Treatment Guidelines for Malaria, but will be required to notify all positive cases to the local health authorities within 24 hours of diagnosis.

*Facility-based treatment*[\$X – X% of Allocation]. The funding request covers: Strengthening and maintaining existing microscopy-based diagnostic services through training of newly recruited malaria microscopists as well as routine periodic and needs-based refresher training of existing microscopists [1.1]; Strengthening and expanding RDT-based diagnostic services through the procurement of RDTs for the public sector(see programmatic gap table)[1.2]; Supporting case management, including the management of severe malaria, in public sector health facilities by training of trainers and training and refresher training of public sector service providers on malaria case management and programme reorientation for malaria elimination districts [1.3]; Strengthening microscopy quality assurance (QA) in support of elimination through support for internal QA/QC of malaria microscopy (cascade system) and supervision visits by senior lab technicians from central to district/upazila level [1.16.2]; Strengthening QA for case management through support for clinical reviews of death cases by central level staff (field visits) and special needs-based refresher training for clinical staff; Strengthening and expanding case management services through the procurement of ACT and other antimalarials for the public sector (see programmatic gap table)[1.17];

*Integrated community case management* [\$X – X% of Allocation]. The funding request covers: Strengthening and expanding RDT-based diagnostic services through the procurement of RDTs for the NGO sector (see programmatic gap table) [1.4 & 1.17]; and, Strengthening and expanding case management services through the procurement of ACT and other antimalarials for the NGO sector (see programmatic gap table) [1.4 & 1.17];

*Private sector case management* [\$X – X% of Allocation].The funding request covers: Strengthening and monitor private sector case management services [1.14] through data collection using national forms (including zero reporting) implemented either through Community Health Care Providers or managed through some form of incentivised text messaging arrangement.

*Ensuring drug quality* [\$X – X% of Allocation]. The funding request covers: Optimizing the quality of antimalarial drugs by supporting central and level meetings of the Drug Administration Department on

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<sup>1</sup>Ideally diagnosis should be within 25 hours of onset of symptoms.

removal of monotherapy and inappropriate antimalarial medicines as well as facility visits by enforcement teams [1.16.1].

*Epidemic preparedness and response* [\$X – X% of Allocation]. The funding request covers: Maintaining preparedness for outbreak response by supporting training for District Rapid Response Teams in transmission reduction districts [3.3].

*Active case detection (elimination phase)* [\$X – X% of Allocation]. The funding request covers: Maintaining preparedness for focus response by supporting training for District Rapid Response Teams in elimination districts [3.7]; Conducting case investigations, transmission focus investigations [3.8] and focus responses [3.9].

*Therapeutic efficacy studies* [\$X – X% of Allocation]. The funding request covers: Drug resistance monitoring through support for therapeutic efficacy studies [3.11].

*IEC/BCC* [\$X – X% of Allocation]. The funding request covers: Support for IEC/BCC technical working group meetings [SE2.12.1]; TA for the development of a communication strategy for malaria elimination [SE2.12.3]; A large-scale community mobilization event on World Malaria Day [SE2.12.4]; and, Orientation meetings to promote community involvement in malaria elimination [SE2.12.4].

## **Module 2- Vector control.**

The selection of vector control interventions will be guided by an eco-epidemiological assessment informed by malaria case and entomological surveillance data. Implementation will be within the framework of 'Integrated Vector Management' (IVM)<sup>2</sup> to ensure optimal use of resources. Use of insecticidal interventions will follow technical recommendations provided in WHO's 'Global plan for insecticide resistance management in malaria vectors'.

LLINs treated with synthetic pyrethroids have been shown to reduce malaria incidence by around 30% in forested areas of Southeast Asia despite the local malaria vectors in some areas being characterized by early outdoor biting. LLINs are a core malaria prevention measure in Bangladesh, where they are widely used to reduce transmission and provide personal protection.

The LLIN programme will use multiple delivery strategies to maximize coverage of insecticide treated bed nets in target areas. Urban areas will be excluded except where forest cover is high, as in the CHT districts and part of Cox's Bazar. The target coverage rate for large sized LLINs will be 1.8 people per net (in-line with WHO standards to achieve 100% coverage). As the quality of surveillance improves, the stratification will evolve to distinguish between indigenous and imported cases and thereby between endemic villages and villages where all cases are imported. Endemic villages will continue to receive periodic mass distributions, but in villages where all cases are imported, LLINs will be provided only to ensure utilization by forest goers. The Programme will thus move away from blanket LLIN coverage and move towards increased focus to maximize cost effectiveness and sustainability. Distribution of LLINs will be coupled with locally appropriate and gender sensitive BCC to ensure community mobilization and high and correct LLIN usage.

*LLIN – Mass campaign* [\$X – X% of Allocation]. The funding request covers: Procurement of LLINs for *established communities* and post-campaign LLIN coverage assessments in a representative random sample of targeted sites [2.1.1] (see programmatic gap table for details).

*LLIN – Continuous distribution* [\$X – X% of Allocation]. The funding request also covers: Procurement of supplementary LLINs *targeting users in the forest and forest farms* [2.1.2], pregnant women [2.1.3], employers (for them to provide to their workers) [2.1.4], seasonal agricultural workers [2.1.5], new settlers [2.1.6], forest workers in the informal sector [2.1.7], community-based healthcare providers [2.1.8], disaster victims and those affected by outbreaks and transmission foci [2.1.9] and, armed forces personnel [2.1.10] (see programmatic gap table for details).

*Indoor residual spraying (IRS)* [\$X – X% of Allocation]. The funding request covers: Support for focal responsive IRS as appropriate [2.2] including training of NMEP field staff on IRS, training of IRS teams (spray-men and squad leaders), operational costs for IRS, and, monitoring the coverage and quality of IRS operations.

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<sup>2</sup>IVM is a rational decision-making process for the optimal use of resources for vector control. The approach seeks to improve the efficacy, cost-effectiveness, ecological soundness and sustainability of disease-vector control [[http://www.who.int/neglected\\_diseases/vector\\_ecology/ivm\\_concept/en/](http://www.who.int/neglected_diseases/vector_ecology/ivm_concept/en/)].

*Other vector control measures* [\$X – X% of Allocation]. The funding request covers: Novel vector control and personal protection measures in the form of procurement of mosquito repellents to prevent outdoor transmission [2.4].

*Entomological monitoring* [\$X – X% of Allocation]. In-line with the recommendations of the last two programme reviews, the funding request covers extensive support to revitalize insecticide resistance monitoring and entomological surveillance [3.14] including: Set-up, running and maintenance costs for three insectaries; training on malaria entomology at central level and in selected districts for entomologists and technicians; Monitoring of insecticide resistance in sentinel sites; Longitudinal surveys of vector distribution, abundance and bionomics; Vector incrimination surveys in 3 sentinel sites; Monitoring the residual efficacy of LLIN; and, LLIN utilisation survey in different risk populations.

### **Module 3 - HSS - Health information systems and M&E**

For districts in the transmission reduction phase, the basic system of surveillance, which involves monthly reporting supplemented by outbreak monitoring, will be maintained and strengthened where necessary. For districts in the elimination phase, standard surveillance will be replaced with 'case-based' surveillance whereby effectively every case is treated as an outbreak.

An expert review will be undertaken in association with MoHFW in 2018 to prepare a roadmap for the development of an elimination-specific case-based reporting system. The review report will define the new system's relationship to the MoHFW's HIS, identify data aggregation levels and clearly articulate how data will be used for decision-making.

Essentially similar strategies will be used to investigate suspected outbreaks and suspected transmission foci. Essentially similar strategies will also be used to deal with confirmed outbreaks and confirmed transmission foci.

In-line with guidance from the 'Strategy for Malaria Elimination in the South East Asia Region (2016–2030)', malaria related surveillance and response mechanisms will be integrated into the broader health sector approach. Malaria response efforts will be implemented by the Rapid Response Teams (RRTs) (also associated with other epidemic prone diseases).

*Routine reporting* [\$X – X% of Allocation]. The funding request covers expanding, modernizing and strengthening the malaria information system through support for: Upgrading the information system; expanding the reporting system; technical support for a computerised malaria elimination database; training on database, data entry and analysis as well as the (logistics management information system) at central and peripheral levels [3.1 and SE2.11]; and, technical assistance to support strengthening of stratification and migrant and mobile population mapping [SE2.2.2].

*Analysis, review and transparency* [\$X – X% of Allocation]. A comprehensive package of needs-based operational research will be supported as far as funding permits. NMEP will work in collaboration with WHO and national and international experts and institutes to develop research capacity and improve the quality and relevance of research outputs. Research will aim to address bottlenecks in operations and find innovative ways to address residual malaria transmission (RMT) and effectively deliver services to hard-to-reach populations. Research will only be carried-out following approval by the Bangladesh Ethics Review Committee.

The funding request covers support for an annual review of research through the development of an open access research website [SE1.2]. The funding request covers progress review and strategy development [SE2.2.1] in the form of support for an annual review meeting at central level. The funding request also covers measuring progress and impact through support for a Malaria Programme Review [SE2.14].

### **Module 4 - Program management**

*Policy, planning, coordination and management* [\$X – X% of Allocation]. Representatives from various sectors (governmental and non-governmental) will be involved in the planning and implementation of malaria control and elimination efforts. The funding request covers Partnerships [SE2.5] through support for coordination meeting among partners at central, district and upazila levels.

The funding request covers International exchange and cooperation [SE2.6.] through support for participation in international seminars/conferences/workshops/learning visits to other countries.

The funding request covers human resources (HR) [SE2.8] through support for GoB staff salaries; Development and production of training materials [SE2.8.2]; Infrastructure development, maintenance

and running costs in the form of fuel and maintenance costs for selected programme vehicles and costs for communications and stationary [SE2.9]. The funding request covers programmatic supervision and monitoring and evaluation (surveys) [SE2.13] through support for: Performance sharing meetings at central, district and upazila levels; Supportive supervision, mentoring and routine monitoring by central level teams; Routine M&E visits by central, district and upazila level teams; Field visits by central level medical technologists (lab) from to upazilas; and, Overheads [SE2.15].

*Grant management* [\$X – X% of Allocation]. The funding request covers financial management in the form of support for Annual Grant Audits for all IPs [SE2.3].

*Supporting procurement and supply management* [\$X – X% of Allocation]. The funding request covers Quality assurance (QA) for programme commodities [SE2.10.2.] in the form of support for insecticide testing costs and for the transport of samples for batch testing.

*Prioritization.* A detailed prioritization of activities has been carried-out as part of the NSPME development process. Activities have been identified as ‘absolute’, ‘high’, ‘medium’ and ‘low’ priority based on an analysis of a combination of various factors including ‘expected impact’, ‘cost’ and ‘malaria risk’. The prioritization process was carried out by a panel of experts from NMEP, BRAC, WHO and partners following stakeholder approval of the final draft of the NSPME. The prioritization itself was then fine-tuned in consultation with various stakeholders including members of the GF Country Team before the final version of the NSPME budget was prepared and disseminated. The results of the prioritization process are presented in column X of worksheet ‘Budget’ in the workbook ‘BAN Malaria NSPME Budget 170130.xlsx’ (Annex X). The within allocation component of this request is restricted to support for absolute priority activities.

*Impact.* At the impact level, the annual parasite incidence is expected to fall from the 2016 baseline of 1.68 per 1,000 to 0.67 per 1,000 in 2020 and the number of inpatient malaria deaths per year is expected to fall from the 2016 baseline of 17 to 6 in 2020. At the outcome level the proportion of the population that slept under an insecticide-treated net ‘the previous night’ is expected to be maintained at above 90%.

This increased programmatic impact is expected due in part to the consolidation of recent gains (e.g. maintaining and where necessary strengthening routine case management services at health facilities and in communities and maintaining periodic mass distribution of LLINs, and in part to the innovative new strategies/delivery mechanisms described herein which target high burden hard to reach groups especially mobile groups and migrants (e.g. scale-up of community based and private sector case management approaches and introduction of carefully targeted continuous LLIN distribution channels). In addition to these efforts, which aim primarily to reduce the burden in higher incidence areas/groups the programme will re-orientate towards eliminating malaria in less endemic areas by focusing on elimination specific surveillance and associated case investigation and focus response operations.

The above allocation amounts will result in additional gains allowing the programme to extend its focus beyond just the absolute priority areas, characterized by higher incidence, to cover all endemic areas and support the programme as it moves towards its ultimate goal of malaria elimination.

b). While this funding request addresses the key funding gaps reflected in the Funding Landscape Table, significant gaps still remain. The overall gaps by year are presented in the funding source summary table in the NSP budget workbook. Column X in the detailed budget worksheet identifies specific gaps at the activity and sub-activity levels. The most significant of these are included in the above allocation request (summarized in section 5.1 of this request below). The GoB will lobby potential additional funding partners for support to fill all of the funding gaps identified. Particularly after TRP comments have been satisfactorily addressed, this funding request itself, and the associated fully-costed national strategic plan, will provide valuable frameworks with which to approach other potential funding partners. In addition GoB will approach private sector stakeholders to encourage investments related to corporate social responsibility. NMEP partners may also apply for project-based additional funding as opportunities arise.

## 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)

[Applicant response]:

**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]:

a). The RSSH component of Bangladesh's NFM2 application will be incorporated into the TB funding request, which will be submitted to Global Fund in time for the 20 March 2017 deadline.

b). The elements of the planned RSSH investment that will directly support the malaria program are:

*Improve the quality of microscopy services.* The grant will support retraining of upazila staff and experienced quality assurance technicians to become good laboratory supervisors who provide supportive, problem-solving supervision. The strategy will also ensure adequate internal quality control by reference laboratories.

*Improve the performance of the laboratory network.* Several activities will be carried-out to improve the overall performance of the laboratory network. Regular supervision and monitoring to all laboratory sites will be ensured.

*Ensure regular maintenance of all diagnostic equipment.* The grant will support regular maintenance of all diagnostic equipment.

*Restructure CDCs to support a focused program of training, supervision and planning activities in addition to clinical tasks.* The grant will support strengthening the planning capacity of CDCs to enable their effective participation in the MOH planning/budgeting cycle at peripheral levels, thus ensuring adequate funding and effective coordination with MOH activities. A strategy paper for the redesigned role of CDCs (with detailed description of office and staff requirements, ToRs, activity schedule, etc.) will be developed. CDCs will be renovated as required and office equipment and transport facilities will be procured as necessary. Technical posts will be upgraded as required and additional administrative posts will be established as per the strategy paper.

*Develop management capacity at central and peripheral levels.* The grant will support strengthening of collaboration and coordination between different directorates in MOH, as well as other relevant ministries and local government. Management capacity at local level, including local level planning, budgeting, monitoring and evaluation and capacity to strategically plan to address identified gaps will be improved.

*Strengthen support to HMIS.* This grant will support the countrywide introduction of a standard electronic recording and reporting systems, ensuring inter-operability with the broader DHIS2 system.

<b>2.3 Focus of application requirement<sup>3</sup></b> This question is required for Lower-Middle Income (LMI) and Upper-Middle Income (UMI) countries. It is <u>not</u> applicable for Low-Income (LI) countries. To respond, refer to guidance provided in the <i>Instructions</i> .	
<b>For LMI countries:</b> <ul style="list-style-type: none"> <li>- 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?</li> </ul>	<input checked="" type="checkbox"/> <b>Yes</b> <input type="checkbox"/> No
<ul style="list-style-type: none"> <li>- 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?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>For UMI countries:</b> <ul style="list-style-type: none"> <li>- 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?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Ensure that the funding request as described in questions 2.1 and/or 2.2 meets this focus of application requirement.</b>	

As described in section 1.2 above, malaria in Bangladesh is closely associated with poverty. Mobile and marginalized migrant populations and minority groups working or living in the forest and on the forest fringes often carry the greatest burden of both poverty and disease. These are the key populations of concern in the national malaria control and elimination effort. Well-targeted malaria control efforts by their nature therefore cater to the needs of some of the least privileged. This, together with the rigorous activity prioritization process employed in the development of the NSP budget and the subsequent careful selection of activities for inclusion in this request (described in section 2.1 above) mean that at least 90% of the proposed budget will go towards supporting what can be considered to be ‘highest impact’ interventions focused on underserved and key populations.

<sup>3</sup> 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](#).

## 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>If <b>yes</b>, provide an overview of the new implementation arrangements and elaborate how these changes affect the operationalization of the grant.</p> <p>If <b>no</b>, provide a summary of high-level implementation arrangements focusing only on lessons learned for the next period.</p> <p>In <b>both cases</b>, detail how representatives of women's organizations, key populations and people living with the disease(s), as applicable, will actively participate in the implementation.</p> <p>Include a description of procurement mechanisms.</p> <p><b>(maximum 1 page)</b></p>	

[Applicant response]:

Bangladesh has adopted a dual-track financing arrangement. As with the current grant, the first *Principal Recipient* (PR1) will be the Economic Relations Division of the Ministry of Finance, Government of Bangladesh (GoB), which will provide financial support to the National Malaria Elimination Programme through the Ministry of Health and Family Welfare. The second *Principal Recipient* (PR2) will be the Dhaka-based international non-governmental organization BRAC, which leads the NGO consortium to support the national malaria elimination effort.

Adopting the successful model applied under the current NFM grant, PR1 will be mainly responsible for planning, procurement and supply of health products and pharmaceuticals (for both PRs), implementation, M&E, review, and oversight of PR2 activities. PR2 will complement PR1 activities at community level in endemic districts. The major modules/interventions for the two PRs are presented in table 3.1. All 21 sub-recipients (SRs) of PR2 will be responsible for implementation of communication, case management and LLIN delivery related activities at community level.

The national malaria control effort has gained momentum through the creation in 2005 of the special NMCP-BRAC partnership, which has been recognized both nationally and internationally as an example of best practice in collaboration between government and NGO sectors. The focus of the NGO consortium has been on strengthening and enhancing the malaria control programme (table 3.1). The partnership created synergies, which strengthened implementation by each of the partners, improved both the quality and the timeliness of programme outputs and ultimately optimized outcomes and maximized impact. Mutual understanding among the various partners, brought about by frequent communication for problem solving and by sharing ideas and experiences, has been key to the success of the partnership.

**Table 3.1: Areas and responsibilities in NMEP-NGO collaboration.**



Area	Government (NMCP)	NGO Consortium
Policy, planning and capacity building	National guidelines, technical training, performance review, coordination	Additional HRs, local training, peripheral lab services, civil society mobilisation
Diagnosis and treatment	Diagnosis and treatment at facility	Diagnosis & treatment at facility and households; community based service through community health workers
Diagnostics and drugs supply	Procurement and distribution	Transportation, supply at facilities and community
Prevention: LLIN/ITN	Procurement and supply to NGOs	Transportation and distribution at community, behaviour change communication (BCC)
Monitoring, supervision, Operation Research	Overall monitoring, supervision, Operation Research	Local monitoring, supervision, reporting, Operation Research

Although the implementation of previous grants has been highly successful, the roll-out of elimination in less endemic districts and the increased emphasis on transmission reduction in more endemic districts will considerably increase the programme's workload. As recommended in the recent JMM, the capacity of the programme will need to be increased through hiring additional staff and through training.

The development of the NSPME 2017-21, on which this funding request is based, was a consultative and transparent process of meetings and discussions. National and international experts, SRs and other partners who have had extensive exposure to field-level implementation as well as representatives of communities-at-risk were involved. This broad range of stakeholders have worked to ensure that programme activities target the populations most at risk of malaria, which include mobile populations, migrants, ethnic minorities and women living in the most endemic communities. The vast majority of health workers and volunteers, especially those associated with the PR2's consortium are women, and almost all are employed locally from malaria endemic areas. Community meetings conducted by health workers mostly deal with women and girls. Furthermore, women are well represented on the CCM, which ensures their participation in programme oversight.

PR1 is responsible for procurement of health products and pharmaceuticals under GF grants. PR1 uses automated accounting software that can correctly and promptly record all transactions. Payments and other transactions are made through bank accounts to minimize risk. Supporting documents for all transactions are preserved and variances are cross-checked for appropriate corrective measures. PR1 has formed a PSM working group with members from both PRs and WHO to aid proper forecasting and planning of procurement and supply of these products up to end user level. Coordination is maintained at all levels, which includes port authorities, district civil surgeons and managers associated with the NGO consortium to ensure smooth transportation of goods. PR1 has a central level warehouse, the 'Central Medical Stores Depot' (CMSD), as well as district level warehouses and Upazila Stores at all districts and upazilas. These warehouses are designed to store drugs and other medical and health products with compliance to good storage practices, including proper ventilation and air-conditioning, with trained staffs and appropriate security measures. An SOP for health product management is in place and is followed [see SOPs for managing drugs and supplies for malaria control - Annex X]. Stock registers are maintained at all store facilities. Central and local level coordination is maintained to anticipate stock outs and manage responsive redistribution of goods. A web based LMIS has been introduced, which aims to track the stock status of health products.

Samples of pharmaceutical products will be collected from all levels in the supply chain and sent to a WHO qualified laboratory for testing. Bio-assay tests on LLINs will be carried-out by the entomology unit of CDC with support from WHO.

As in recent years, the procurement of LLINs will be through GF's Voluntary Pooled Procurement (VPP) mechanism. This system meets the minimum standards prescribed by GF.

### 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
Programmatic/monitoring and evaluation risks	(e.g. data quality and program quality, access and promotion of equity and human rights, sustainability, etc.)	Funding for technical assistance that is being requested to strengthen implementation capacity could also be mentioned in this section.	
Procurement and supply management risks (e.g. forecasting and quantification, procurement, storage and distribution, last mile delivery, commodity prices higher than international prices, etc.)			
Financial risks (e.g. risk of fraud, corruption or theft, financial inefficiency, etc.)			
Governance and program management risks (e.g. CCM coordination and oversight of programs, PR coordination with national entities and partners, PR performance and/or oversight of sub-recipients, meaningful involvement of communities, etc.)			
Macroeconomic factors, including unexpected rises in commodity prices, inflation and average exchange rate in relation to local market currencies;			
Instability of the country in terms of significant political changes or social unrest, ongoing conflicts, humanitarian crises, poor physical infrastructure, natural disasters, corruption; and			
<i>Add rows for additional key risks as necessary</i>			

- i. Natural disasters. Cyclones and flash-floods occur frequently in Bangladesh and these may jeopardize implementation of planned activities both indirectly affected areas and in other parts of the country due to diversion of efforts and supplies to affected areas. Proposed mitigation. Buffer stocks have been incorporated into the procurement of all key programme commodities (RDTs, drugs and LLINs).
- ii. Development and spread of ACT resistant falciparum malaria in Bangladesh. Proposed mitigation. Close monitoring of drug resistance status will be maintained through TES in sentinel sites and through molecular studies analysing samples collected nationwide. Resulting data will be shared with WHO and technical partners and in the event of development of ACT resistance a suitable response will be developed following the recommendations of WHO's Malaria Policy Advisory Committee (MPAC).
- iii. Development and spread of operationally significant pyrethroid resistance in Bangladesh. Proposed mitigation. Close monitoring of insecticide resistance will continue to be carried out at sentinel sites. Resulting data will be shared with WHO and technical partners. If insecticide resistance is found it's operational significance will be assessed and a suitable response will be developed as required in consultation with WHO.
- iv. Financial issues. Fluctuations in exchange rates have negatively affected the purchasing power of the budget in the past. While the exchange rate appears now to be becoming more stable, inflation remains an issue and commodity prices are on the rise. Proposed mitigation. An inflation rate of 10% for human resources and 5% for everything else has been built into the NSPME budget. Where necessary shortfalls will be addressed during periodic reprogramming of GF funds.
- v. Access. The extreme remoteness of some areas is often compounded by poor physical infrastructure making access limited, particularly during the rainy season. Proposed mitigation. The timing of visits to remote areas will be planned taking seasonal constraints into consideration. Additional funds for accessing hard to reach target communities have been incorporated into the budget.
- vi. Health system weaknesses. Inherent weaknesses in the health systems often limit the quality of services. Proposed mitigation. Malaria related health system strengthening activities have been incorporated into the TB application (see section 2.2.above). Extensive use of volunteer networks and collaboration with the army and with border guards to provide malaria related services in less accessible communities will solve some of the issues associated with access and at the same time reduce the burden on overstretched health workers, particularly in the periphery.
- vii. Lack of sustained political commitment for malaria elimination and failure of the Government of Bangladesh to deploy increased domestic and foreign investment for malaria control and elimination. Proposed mitigation. A strong advocacy strategy will be put in place to obtain political commitment at all levels.
- viii. Global Fund support fails to continue at existing levels. Proposed mitigation. Strong justification for the continuation of GF support beyond 2020 will be developed in collaboration with WHO and other regional stakeholders.

These risks will be monitored in partnership with WHO during implementation and will be reported on by the PRs, regularly reviewed by the LFA, and assessed by GF during periodic grant appraisal sessions.

## 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? <b>If yes</b> , provide details below.	<input 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? <b>If yes</b> , provide a brief description below.	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Have previous government commitments for the 2014-16 allocation been realized? <b>If not</b> , provide reasons below.	<input type="checkbox"/> Yes <input 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? <sup>4</sup> <b>If not</b> , provide reasons below.	<input type="checkbox"/> Yes <input 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, <b>specify</b> below how realization of co-financing commitments will be tracked and reported.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>(maximum 2 pages)</b>	

[Applicant response]:

a). GoB has adopted a healthcare financing strategy to support the move toward Universal Health Coverage (UHC) by 2032 in the context of the Sustainable Development Goals (SDGs). The Health Care Financing Strategy 2012-2032 provides a framework for developing and advancing health financing in Bangladesh. The framework is aimed at increasing the level of funding for health, ensuring an equitable distribution of the health financing burden, improving access to essential health services, reducing the incidence of impoverishment due to catastrophic healthcare expenditures and improving quality and efficiency of service delivery. At the same time the strategy outlines actionable mechanisms to capture private spending and channel it efficiently in prepayment and pooling arrangements. It puts emphasis on extending financial protection to all segments of the population.

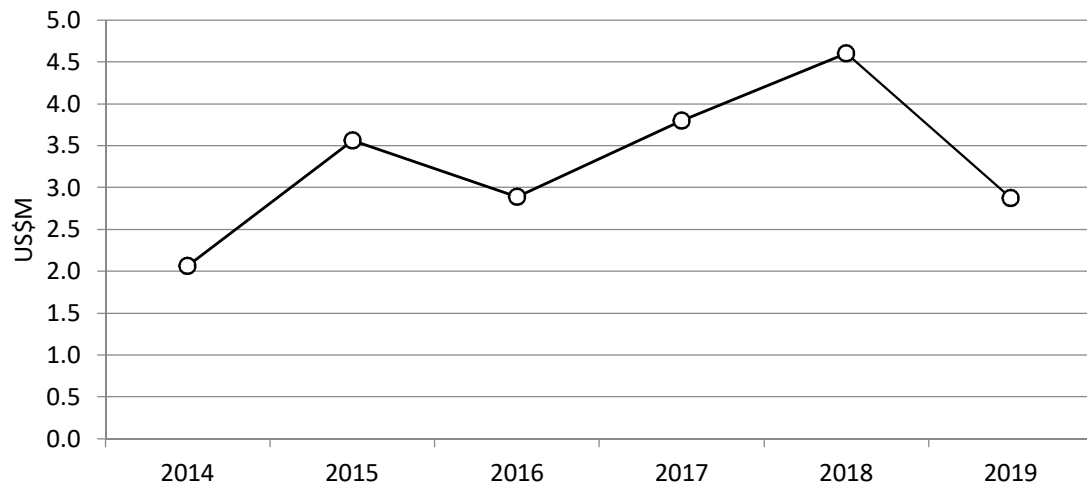
c). I

d). Planned GoB financial support for the NSPME will fluctuate over the coming years according to programmatic requirements (figure 4.1 below). Overall financial support will increase by 32% during 2017-19 relative to the previous 3-year period (up from US\$8.5M to US\$11.3M).

e). Realization of co-financing commitments will be tracked by NMEP's Finance Department (based on the annual progress report of the CDC Operational Plan) and reported to the Global Fund on an annual basis.

<sup>4</sup> Refer to the [Sustainability, Transition and Co-Financing Policy](#).

**Figure 4.1. Government resources for the NSP (previous current and anticipated).**



## 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]:

- a). Costs, availability of funds and the funding gap for major program areas.
- b). As described in section 3.2, a lack of sustained political commitment for malaria elimination and failure of GoB to deploy increased domestic and foreign investment for health as a whole, and for malaria control and elimination in particular, is a risk. NMEP and its partners BRAC and WHO will develop a strong advocacy strategy to ensure political commitment at all levels.

The programme is also working hard to maximise the cost-effectiveness of all its activities in an effort to improve sustainability. For example, the current NSPME 2017-21 has moved away from blanket coverage with LLIN based on a district level stratification irrespective of receptivity. Urban areas will be excluded except where forest cover is high. In case funding is limited, target areas will be divided into 'absolute', 'high', 'medium' and 'low' priority based on the stratification described in the NSPME (page 21, annex X). As the quality of surveillance improves, the stratification will evolve to distinguish between indigenous and imported cases and thereby between endemic villages and villages where all cases are imported. Endemic villages will continue to receive periodic mass distributions, but in villages where all cases are imported, unless receptivity is considered to be high, LLINs will be provided only to ensure utilization by forest goers.

The achievement of the NMEPs elimination goal will contribute towards the achievement of regional elimination goals and ultimately towards global eradication, which will provide the ultimate in sustainability.

## 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.

**N.B.** Please refer to the NSP for rationale using the activity and sub-activity numbers [provided below in square brackets] for reference. All of the activities presented below are considered a high priority unless specified otherwise. Please refer to section 2.1 of this funding request for an overview of the prioritization process. Please refer to the detailed budget worksheet in the budget workbook for the complete prioritization by activity and sub-activity.

	Module	Amount requested [Specify US\$]	Brief Rationale, including expected outcomes and impact (how the above allocation request builds on the allocation)
1	Case management		Support 'community case management' through provision of training, VHV kits, quarterly supervision for VHVs, transport allowances for VHVs to attend monthly meetings [1.4]. Support 'facility-based treatment' through intensified case detection by mobile teams (pending expansion of VHV network) [1.6], rollout of G6PD testing [1.11 – <b>medium priority</b> ], strengthening QA of diagnosis [1.16.2] including establishment of a QA database and provision of external competency testing [1.16.2 – <b>medium priority</b> ] and case management [1.16.3]. Support efforts to 'ensure drug quality' by strengthening role of Drug Administration Department (DAD) in antimalarial surveillance and control of inappropriate drugs [1.15.2 & 1.16.1]. Support 'epidemic preparedness and response' by funding outbreak investigations [3.4] and outbreak

			responses[3.5].
2	Vector control		Support mass campaigns for the distribution of LLINs through provision of funds for micro-planning at Central, GO-NGO, district ( <b>medium priority</b> ) and upazila ( <b>low priority</b> ) levels [2.1]. Support 'entomological monitoring' through TA [3.14] and provision of a training microscope [3.14 - <b>medium priority</b> ].
3	HSS - Health information systems and M&E		Support 'routine reporting' through procurement of GIS software [3.1 - <b>medium priority</b> ] and training costs associated with pharmacovigilance strengthening by DAD [3.12]. Support 'analysis, review and transparency' through the procurement of PCR machine [SE1.1 - <b>low priority</b> ].
4	Programme management		Support 'policy, planning, coordination and management' through provision of funds for quarterly meetings at district level, printing documents (guidelines, SOPs etc.) [SE2.2.1], TA for NSP development [SE2.2.3], coordination meetings [SE2.5], HR development planning [SE2.8.1], elimination induction workshop (and associated training - ToT[SE2.8.3] and in-country MMFO courses [SE2.8.4 - <b>medium priority</b> ]), procurement of vehicles (and associated running costs)( <b>medium priority</b> ), equipment maintenance, procurement of furniture ( <b>medium priority</b> ) and office equipment [SE2.9], and quarterly supervision by central teams ( <b>medium priority</b> ), six-monthly supervision by district teams, quarterly supervision by district and upazila teams ( <b>medium priority</b> ) (including by laboratory technicians - <b>medium priority</b> ).
<b>TOTAL AMOUNT</b>			