Funding Request Form

Full Review

Allocation Period 2020-2022

|  |  |
| --- | --- |
| **Country(s)** | Bangladesh |
| **Component(s)** | HIV/AIDS |
| **Planned grant(s) start date(s)** | 1 December 2020 |
| **Planned grant(s) end date(s)** | 31 December 2023 |
| **Principal Recipient(s)** | 1. AIDS/STD Program, Directorate General of Health Services, Ministry of Health and Family Welfare, Peoples’ Republic of Bangladesh 2. Save the Children International 3. icddr,b |
| **Currency** | USD |
| **Allocation Funding Request Amount** | 23,000,765.00 |
| **Prioritized Above Allocation Request (PAAR) Amount[[1]](#footnote-2)** | 9,024,210.00 |
| **Matching Funds Request Amount[[2]](#footnote-3)**  (if applicable) | Not applicable |

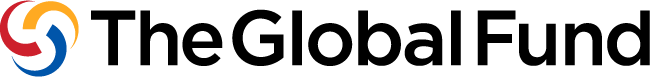
**This funding request includes the following sections:**

Section 1: Context related to the funding request

Section 2: Funding Request and Prioritization

Section 3: Operationalization and Implementation Arrangements

Section 4: Co-Financing, Sustainability and Transition



# Section 1: Context Related to the Funding Request

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

## 1.1 Key References on Country Context

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

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Reference document** | **Link or attachment** | **Relevant sections** |
| 1 | Government of Bangladesh (2017). Ministry of Health & Family Welfare. Directorate of Health Services. Planning Wing. Health-6. Bangladesh Secretariat. 4th Sector Program, TB-L&ASP/2017/247; Date 15 May 2017 | Attachment | Pages 5, 14-18, 23-25 |
| 2 | Revised 4th National Strategic Plan for HIV and AIDS Responses 2022-2023 | Attachment | Page 3, 9, 20 |
| 3 | 4th National Strategic Plan for HIV and AIDS Response 2018-2022 | Attachment | Page i, 9,10-11 |
| 4 | Government of Bangladesh (1996). National policy on HIV/AIDS and STD related issues. Directorate General of Health Services (DGHS), Ministry of Health and Family Welfare, Govt. of the People’s Republic of Bangladesh. | Attachment | Page 7, 10,12-13 |
| 5 | AIDS STD Program (2019). Annual Report 2018, AIDS/STD Program. Directorate General of Health Services, Ministry of Health and Family Welfare, Government of the People’s Republic of Bangladesh | Attachment | Page-10,11, 16, 18, 19, 21, 23 |
| 6 | AIDS STD Program (2016). Mapping study and size estimations of key populations in Bangladesh for HIV programs 2015-2016. National AIDS/STD Program (ASP), Directorate General of Health Services (DGHS), Ministry of Health and Family Welfare, Govt. of the People’s Republic of Bangladesh. | Attachment | Page xv, xvi |
| 7 | National AIDS/STD Program (ASP). 2011. National HIV Serological Surveillance, 2011 Bangladesh. 9th Round Technical Report. Directorate General of Health Services (DGHS), Ministry of Health and Family Welfare, Govt. of the People’s Republic of Bangladesh | Attachment | Page 41 |
| 8 | AIDS STD Program 2016. Behavioural and Serological Surveillance amongst Key Populations at Risk of HIV in Selected Areas of Bangladesh, 2016 Conducted by Institute of Epidemiology, Disease Control and Research (IEDCR) and icddr,b | Attachment | Page xiv, xv, 52, 54, 80, 120, 128, 130,131 |
| 9 | AIDS STD Program (2016). Behavioural and serological surveillance on males having sex with males, male sex workers and hijra, 2015: Technical Report. National AIDS/STD Program (ASP), Directorate General of Health Services (DGHS), Ministry of Health and Family Welfare, Govt. of the People’s Republic of Bangladesh. | Attachment | Page 11, 18, 34, 65, 96 60,130 |
| 10 | Government of Bangladesh (2016). National strategy on addressing gender-based violence for HIV response in Bangladesh (2017-2021). National AIDS/STD Program (ASP), Directorate General of Health Services (DGHS), Ministry of Health and Family Welfare, Govt. of the People’s Republic of Bangladesh. | Attachment | Page 1-36 |
| 11 | Government of Bangladesh (2014). Bangladesh Gazette, Registration #SKM/KM-1Sha/Hijra-15-2013- 40, January 22, 2014. | Attachment | Page 1 |
| 12 | Khosla N. (2009). HIV/AIDS interventions in Bangladesh: what can application of a social exclusion framework tell us? Journal of health, population, and nutrition, 27(4), 587–597. doi:10.3329/jhpn. v27i4.3404 | Attachment | Page 587-597 |
| 13 | Health Policy project 2016. Bangladesh how the decline in PEPFAR funding has affected key populations | Attachment | Page 2 |
| 14 | Harm Reduction International, 2019. The Death Penalty for Drug Offences: Global Overview 2018. Giada Girelli. ISBN 978-0-9935434-8-7 | Attachment | Page 33 |
| 15 | Islam, P. D. (2019). World AIDS Day 2019; HIV/AIDS Situation in Bangladesh. Dhaka, Bangladesh: AIDS/STD Program, Directorate General of Health Services (DGHS), Ministry of Health and Family Welfare, Govt. of the People's Republic of Bangladesh | Attachment | Page 4, 7, 8-10,11,16-18 |
| 16 | AIDS STD Program; UNAIDS. (2019). BANGLADESH INVESTMENT CASE FOR HIV: Sustainable Investment Options in the National HIV Response (Final Draft) | Attachment | Page viii, ix, 19, 20, 27-30, 32-37 |
| 17 | UNAIDS DATA 2019 | Attachment | Page 142,143, 156,157 |
| 18 | Alam MS, Sarker MS, Rahman M, Reza MM, Chowdhury EI, Faruque MO, Khan SI, Babar ZM, Strathdee SA, Friedman SR, Azim T. (2015). A continuing epidemic of HIV among PWID in one neighbourhood of Dhaka with high prevalence of HIV-HCV co-infection and risk behaviours among HIV positive PWID. Presented at the 12th International Congress on AIDS in Asia and the Pacific (ICAAP), 20-23 November 2015, held in Dhaka, Bangladesh | Attachment | Page 1 |
| 19 | Azim, T., & Reid, G. (2018). In Depth Review of the PWID Intervention to Identify Strategies for Quality HIV/AIDS Services and Increased Coverage EXTERNAL REVIEW REPORT. Dhaka. | Attachment | Page-12 |
| 20 | Khan, D. M., Khan, M. N., Hossain, D. M., Gourab, M. G., Reza, M. M., Rana, D. M., & Himel, D. M. (2020). Understanding the Culture of Injecting Drug Use and Analyzing the Harm Reduction Interventions Operating for People Who Inject Drugs (PWID) in Dhaka City: An Ethnographic Study. Dhaka. | Attachment | Page-32 |
| 21 | Khan, S. I., M. N. M. Khan, S. D. Irfan, A. M. Rumayan Hasan, A. G. Ross, L. M. Horng, N. Lachowsky, G. Knudson and T. Azim (2020). "The Effects of Methamphetamine Use on the Sexual Lives of Gender and Sexually Diverse People in Dhaka, Bangladesh: A Qualitative Study." Arch Sex Behav.1 | Attachment | Page-64-71 |
| 22 | Khan, S. I., M. N. M. Khan, A. R. Hasan, S. D. Irfan, L. M.-S. Horng, E. I. Chowdhury and T. Azim (2019). "Understanding the reasons for using methamphetamine by sexual minority people in Dhaka, Bangladesh." International Journal of Drug Policy 73: 64-71. | Attachment | Page-7-13 |
| 23 | UNAIDS. 2020. HIV and AIDS, Data Hub for Asia Pacific: MSM, <https://www.aidsdatahub.org/resource/men-who-have-sex-men-msm-slides> | Online link | Slide-8 |
| 24 | Sarwar G, Reza, MM, Khan MNM, Gourab G, Rahman MM, Rana AKM, Khan SM, Irfan SD, Ahmed S, Sisir R, Banu S, Khan SI. Developing and testing community-based tuberculosis to increase TB referral, case detection and knowledge among sexual minority people in urban Bangladesh: A mixed-methods study protocol. BMJ Open (In-press) | In press | In press |
| 25 | GF-UNODC Mission Report; Assessment of Bangladesh PWID programs; February 2020 | Attachment |  |
| 26 | Save the Children. Assessment of knowledge, attitude and practice of caseworkers regarding treatment, care & support services of HIV positive PWID in Bangladesh Dhaka, October 2019 | Attachment |  |
| 27 | Huq, M. N., Khan, S., Peerapatanapokin, W., Reza, M., Hossain, Z., Shams, Z., & Rahman, M. A. (2017). Modes of HIV transmissions in Dhaka city. HIV &amp; AIDS Review. International Journal of HIV-Related Problems, 16(2), 112-117. doi:10.5114/hivar.2017.66898.  <https://pdfs.semanticscholar.org/54c1/151d8dfe2856c16f2f31f0cb254f068dbef8.pdf?_ga=2.162999932.1704280239.1597840541-1537305925.1565184775> | Attachment | Page-114, 116 |
| 28 | Khanam R AD, A. M. S., Reza Md Masud, Ashraf L, Alam A, Rahman M, Khan SI, Rana AKMM, Amin M, Faruque Md O, Mayer k, Azim T. (2015). Sexually Transmitted Infections among Male and Female Sex Workers, Females who Inject Drugs and Hijras under the Global Fund Project in Dhaka. | Attachment? | Page78 |
| 29 | Reza Md Masud, Alam Md S, Khan SI, Rana AKMM, Gourab G, Azim T. A Survey of HIV, Syphilis and Risk Behaviour Among MSM, MSW and Hijra. 2014.Reza et al.2013 | Attachment | Page-29 |
| 30 | Khan, S. I., Hussain, M. I., Parveen, S., Bhuiyan, M. I., Gourab, G., Sarker, G. F, Sikder, J. (2009). Living on the extreme margin: social exclusion of the transgender population (hijra) in Bangladesh. Journal of health, population, and nutrition, 27(4), 441.  <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2928103/pdf/jhpn0027-0441.pdf> | Attachment | Page-447 |
| 31 | Gourab, G., Khan, M. N. M., Hasan, A. M. R., Sarwar, G., Irfan, S. D., Reza, M. M. Khan, S. I. (2019). The willingness to receive sexually transmitted infection services from public healthcare facilities among key populations at risk for human immunodeficiency virus infection in Bangladesh: A qualitative study. PLOS ONE, 14(9), e0221637. doi:10.1371/journal.pone.0221637.  <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6726367/pdf/pone.0221637.pdf> | Attachment | Page-10, 15 |
| 32 | Rahman, M., Janjua, N.Z., Shafiq, T.K.I., Chowdhury, E.I., Sarker, M.S., Khan, S.I., Reza, M., Faruque, M.O., Kabir, A., Anis, A.H. and Azim, T., 2019. Hepatitis C virus treatment in people who inject drugs (PWID) in Bangladesh. *International Journal of Drug Policy*, *74*, pp.69-75. | Attachment | Page-69 |
| 33 | Save the Children, “’Review of Legal Policy Environment”, July 2020 | Attachment |  |
| 34 | Save the Children, ’Situation Assessment on the Impact of Legal Policy Environment Over the Harm Reduction Intervention for PWID in Bangladesh’’, July 2020 | Attachment |  |
| 35 | Reza MM, Rana AM, Azim T, Chowdhury EI, Gourab G, Imran MS, Islam MA, Khan SI. Changes in condom use among males who have sex with males (MSM): Measuring the effect of HIV prevention program in Dhaka city. Plos one. 2020 Jul 24;15(7):e0236557. | Attachment | Page 1-15 |
| 36 | Oyewale, T.O., Shale Ahmed, F.A., Tazreen, M., Uddin, Z., Rahman, A. and Oyediran, K.A., 2016. The use of vouchers in HIV prevention, referral treatment, and care for young MSM and young transgender people in Dhaka, Bangladesh: experience from ‘HIM’initiative. *Current Opinion in HIV and AIDS*, *11*(Suppl 1), p.S37. | Attachment | Page 37-45 |
| 37 | Geibel, S., Hossain, S.M., Pulerwitz, J., Sultana, N., Hossain, T., Roy, S., Burnett-Zieman, B., Stackpool-Moore, L., Friedland, B.A., Yasmin, R. and Sadiq, N., 2017. Stigma reduction training improves healthcare provider attitudes toward, and experiences of, young marginalized people in Bangladesh. *Journal of Adolescent Health*, *60*(2), pp.S35-S44. | Attachment | Page 35-44 |
| 38 | National AIDS/STD Control [program]/Ministry of Health and Family Welfare, 2019. National guideline for community based HIV testing services. Dhaka, Bangladesh | Attachment |  |

## 1.2 Summary of Country Context

Explain critical elements of the **country context** that informed the development of this funding request. The following points should be addressed in the response:

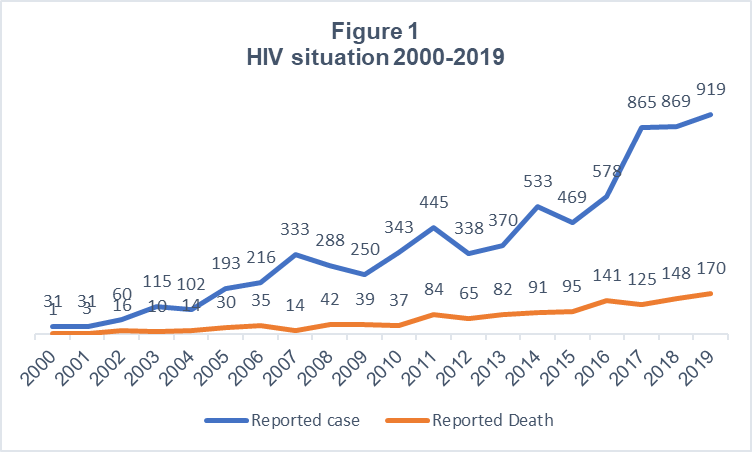
* The epidemiological context and other relevant disease-specific information;
* Information on disease-specific and the overall health systems, along with the linkages between them;
* Relevant key and/or vulnerable populations;
* Human rights, gender and age-related barriers and inequities in access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

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

Bangladesh is a lower-middle income country with an estimated population of 164.6 million in 2019 (37% urban, 63% rural) and a life expectancy of 72.5 years. Bangladesh’s GDP is growing fast at an annual growth rate of 7.9% in 2019; its gross national income was US$ 1,750 per person (in current US$). Government health spending as a proportion of total government spending is still low at 3.4%. Per capita public and private health expenditure is respectively US$ 6.1 and US$ 25 with the latter mainly out-of-pocket, with total health expenditure per person of US$ 34 in 2016 (extracted from pre-populated Essential data table).

**HIV Epidemiology**

Bangladesh has maintained a low HIV prevalence of <0.01% among its general population since the first case was detected in 1989 [2,3], however, it is one of seven countries in the region where the epidemic continues to increase [2,5]. Overall HIV incidence rose by 56% and HIV-related mortality by 110% since 2010 [17, see Figure 1].



There are an estimated 14,000 people living with HIV (PLHIV) in Bangladesh [17]. National programmatic data of the AIDS/STD Program (ASP) indicates that from 1989 to October 2019, a total of 7,374 HIV positive cases were detected (52.7%); during Nov 2018 to Oct 2019, a total of 919 new cases were detected. Most newly infected people were from Dhaka (381) followed by Chattogram (203), Khulna (90) and Sylhet (59). 105 were Rohingya people, referred to as ‘Forcibly Displaced Myanmar Nationals’ (FDMN) [15].

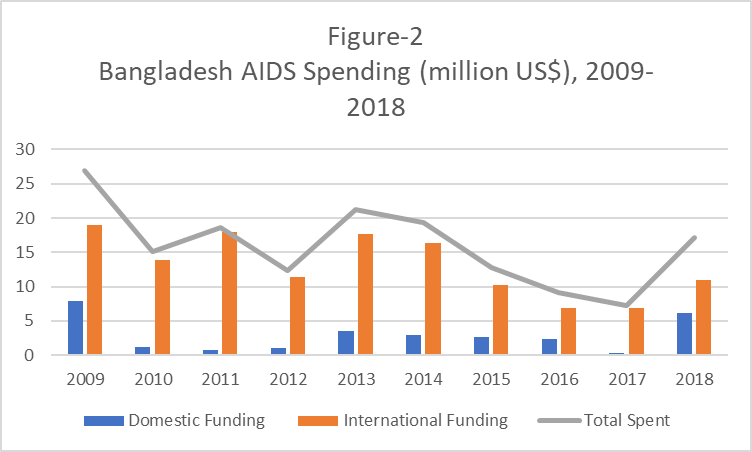
In terms of epidemiological risk factors, 37% of new cases did not belong to any key population (KP) [15] but many of these cases had experience with migration or had the status of refugee. Almost a quarter of new cases (24%) were people who inject drugs (PWID), whereas Men who have Sex with Men (MSM) and Male Sex Workers (MSW), Female Sex Workers (FSW) and *hijra* (a Bangla ‘third gender’ category, overlapping with the Western concept of ‘transgender women’ (TG or locally known as *hijra,* these two terms are used interchangeably) constituted 3%, 3%, 2% and 1% of newly identified HIV infections, respectively. Around three quarters (74.42%) of new HIV cases were aged 25-49; 6.5% of cases were children (0-18 years). About 74% of new infections were male, 25% female, and 1% were TG [15].

In the past 20 years, Bangladesh has developed from a low-level into a concentrated HIV epidemic, driven mainly by injecting drug use. The HIV epidemic’s epicentre is in the capital Dhaka. A feasibility study conducted in 2015 introducing OraQuick rapid HIV testing among male and female PWID in Dhaka found HIV prevalence among male and female PWID to be 9.9% and 4.9%, respectively [18]. In 2016, among male and female PWID in Dhaka, HIV prevalence was found to be 22% and 5%, respectively [8].

The second most HIV-affected KP are TG; two out of 46 were found positive in Hili, in Dinajpur district bordering with India; in Dhaka prevalence among TG was 0.9% and overall HIV prevalence among TG is estimated to be 1.4% [9]. Among other key populations (KP) defined in the 4th National Strategic Plan (NSP) HIV prevalence remains low: among female sex workers (FSW), men who have sex with men (MSM), and male sex workers (MSW) prevalence was found to be less than 0.5% [9, 15].

**Overview and Coverage of the HIV Response**

The 4th National Strategic Plan for HIV and AIDS Response 2018-2022 (NSP) [3] was revised in January 2020 and extended to 2023 [2]. The Operational Plan (OP) for HIV is a part of that of the TB, Leprosy & AIDS/STD Program (TB-L & ASP) under the 4th Health, Population and Nutrition Sector Program 2017-2022 (HPNSP) [1]. Bangladesh aims to contain HIV transmission and minimize its impact to end AIDS by 2030, but due to the economic evolution external aid is diminishing (Figure 2). A recent study found that there is a concentration of KP and HIV cases in Dhaka and 22 higher prevalence districts (out of a total of 64 districts), where 62.3% of KP and 79.8% of people known to be living with HIV and AIDS reside [16]; Dhaka and these 22 districts have therefore been made priorities for the national response (as well as for this grant).



The national AIDS response in Bangladesh is coordinated and managed by the National AIDS/STD Control Program (NASC) in the Ministry of Health and Family Welfare (MoHFW), which is responsible for overseeing and coordinating prevention and control of HIV and ensuring that the NSP and national policies are implemented. The ASP provides HIV testing services (HTS) in 28 HIV testing sites at GoB facilities in 23 districts, and treatment and care in 11 ART centres in 11 districts, while prevention for KP is mainly implemented by non-governmental organisations (NGOs), supported primarily by GF. HTS are available in the 23 priority districts at government and NGO-operated facilities.

Estimated coverage of differentiated prevention services in 2019 is low at 28.7% among an estimated 33,067 PWID, 39.8% among an estimated 10,199 TG, 18.1% among an estimated 102,260 FSW, and 21.3% among an estimated 131,472 MSM [17]. Table 1 shows the national size estimates of KP as of 2015-2016; HIV prevalence as of 2016 and current service coverage including coverage of HTS among KP as of June 2020:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| KP | Estimated size | HIV prevalence\* | Prevention Coverage (current grant) | HTS coverage (current grant) |
| PWID | 33,067 | 18.1% | 9,500 (28.7%) | 9,764 (29.5%) |
| TG | 10,199 | 1.4% | 4,062 (39.8%) | 2,640 (25.9%) |
| MSM/W | 131,472 | 0.2% | 28,000 (21.3%) | 18,936 (14.4%) |
| FSW | 102,260 | 0.2% | 18,500 (18.1%) | 14,808 (14.5%) |

\* Source: [17] and the GF provided essential data table with allocation letter

As of 2019, 52.7% of the estimated 14,000 people PLHIV were aware of their status, of whom 54.4% are on ART representing 28.6% of the estimated population of PLHIV in the country [6]. Out of 4,009 PLHIV on ART, 461 received viral load test (11.5%) of whom 84.6% (390 out of 461) were virally suppressed [15]. The ASP has reported in 2019 that there was a total of 51 HIV positive pregnant women enrolled for Prevention of Mother-to-Child Transmission (PMTCT) and there were a total of 47 who gave birth. Two infants were born with HIV [15].

In Dhaka, a secondary data analysis was done to examine the effect of HIV interventions among MSM. The multivariate analysis showed that the likelihood of condom use (last time and consistently) was more than double at the midline than at baseline (p<0.01 for both), highlighting that the program was successful in reducing HIV risk behaviours [35]. An investment case assessment was carried out in 2019 using the AIDS Epidemic Model (AEM). It also demonstrates the effects that ongoing HIV prevention programs among KP have had, as well as their impact on national HIV prevalence [16]. It calculated that if prevention programs among KP were to be discontinued after 2020, Bangladesh would have 81,154 PLHIV by 2030, with KP experiencing increasing HIV prevalence, especially PWID and TG. The report suggests prevention and treatment coverage need to at least reach the targets of the revised 4th NSP2018-2023 and ending AIDS by 2030 (scenario 3) [16].

**Linkages of HIV responses with the overall health system**

Ongoing efforts to increase HIV detection include strengthening linkages with the TB, Maternal Neonatal Child Health (MNCH) and Sexual Reproductive Health (SRH) programs. TB-L & ASP are considered under a single OP under the 4th HPNSP, and joint activities are planned for prevention among KP including OST and treatment for returnee migrants living with HIV [1]. The OP stipulates the implementation of a Health Management Information System (HMIS) as well as mass awareness raising activities, HIV surveillance, surveys, research studies; capacity building; and coordination [1]. Tuberculosis (TB) verbal screening is conducted in all KP prevention service delivery sites and people who screen positive have their sputum sample taken and sent to tuberculosis centres for confirmation. Out of the 919 newly identified cases in 2019, 27 (2.9%) had TB-HIV co-infection [15].

icddr,b piloted a feasibility study on HCV management among HIV negative PWID in Dhaka with Direct Acting Anti-Viral (DAA) [32]. Currently, the management of HIV-HCV co-infection is planned by the PR icddr,b (under GF) & SC (under GF-UQD). icddr,b is managing HIV-HCV co-infection among OST clients in one priority district (Narayanaganj) and is also providing technical assistance to SC on HIV-HCV co-infection management under UQD in Dhaka, Gazipur and Narayangonj.

**Key Populations (KP)** **in Bangladesh**

Officially recognized KP include FSW, MSM, MSW, TG and PWID. Their main risk behaviours are briefly reviewed below.

**PWID:** 52.4% and 53.1% of male PWID shared their used needles/syringes in the last injection episode in the last two months or within the past week respectively [8, page xiv].

**FSW**: The average age of first sex for FSW was 15 years. 61-79% and 72-81% of the FSW reported using condoms in the last sex act with new and regular clients, respectively [8].

**MSM/MSW/TG**: 46% of MSM, 46.5% of MSW and 58.9% of TG reportedly did not use condoms with clients or non-transactional sex partners during the last sex act [9]. The mean age of first sex of MSM, MSW and *hijra* was 15.7, 13.6 and 12.3 years, respectively [9].

**Human Rights, Gender and Age-related Barriers and Inequities in Access to Services**

Human rights and gender-based issues are at the core of HIV prevention in Bangladesh [4], but important legal barriers to healthcare for KP still remain, including Section 377 of the Bangladesh Penal Code, which criminalizes homosexuality, and the revised Narcotics Control Act of 2018, which expanded the applicability of the death penalty for methamphetamine possession [14]. Ambiguities in laws concerning sex work have led sex workers to face significant police harassment [12, 13]. HIV stigma further compounds social exclusion, which disproportionately affects MSM, PWID, FSW, *hijra*, people living with HIV (PLHIV) and people living in extreme poverty, which applies to many KP and PLHIV. Bangladesh lacks specific anti-discrimination legislation to protect PLHIV and sexual and gender minorities. Evidence-based prevention interventions such as needle and syringe programs for PWID are not recognized as a public health practice at the national level. Positive advances include the official recognition of *hijra* as a separate gender [11]; they were given the right to vote in April 2019, and the ASP espouses a Gender Strategy (2017-21) to address Gender-Based Violence (GBV) among KP [10]. Furthermore, a joint advocacy forum titled the ‘National Task Force (NTF) was established in June 2018 with representatives from relevant government entities, NGO stakeholders, icddr,b and UN agencies to address human rights issues in KP interventions.

**Community Responses and Engagement**

Various community networks are active, including the Network of PLHIV (NOP+); Sex Workers Network of Bangladesh (SWNoB); Network of People Who Use Drugs (NPUD); STI and AIDS Network of Bangladesh, etc. The ASP and MoHFW recognize communities as critical partners for ending AIDS by 2030. During the NSP development and updating process, planning and budgeting processes they were meaningfully engaged to ensure that national strategies and costed implementation plans address communities’ needs. Community groups also participated in country dialogues during the development of this funding request. They are engaged in implementing services as Sub-Recipient (SR), Sub-Sub Recipient (SSR) and also provide assistance to the NGOs in service delivery and advocacy initiatives. Bandhu Social Welfare Society (BSWS), an MSM-led organization, is a SR implementing MSM and *hijra* interventions. The *hijra* community-led organizations ‘Badhon Hijra Sangha’ as SSR under BSWS, and ‘Sustha Jibon’ a *hijra* CBO is implementing five and two service centres for MSM and TG respectively. Moreover, an additional five *hijra* and MSM CBOs are directly involve in program implementation. Nari Mukti Sangha (NMS), an FSW-led organization is working as a SSR for FSW interventions. APOSH, a PWID CBO and a PLHIV organization, Mukto Akash Bangladesh (MAB), are engaged in PWID interventions [5]. Ashar Alo Society (AAS) is a PLHIV CBO working as SR for Treatment, Care and Support under the GF grant since 2008. NOP+, SWNoB, NPUD and STI and AIDS Network of Bangladesh are the strategic partners of SC in the current grant to support advocacy, livelihood support and monitoring.

## 1.3 Lessons Learned from Global Fund and Other Partner Investments

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

1. Making drop-in centres more comprehensive by offering a wider array of services (NSEP, OST, ART, HTS) has led to higher case detection and more successful referral, linkage and enrolment into ART by PWID[19, 26], although questions about cost-effectiveness remain, and some negative aspects caused by ‘mixing’ OST clients with drug-dependent PWID who access for NSEP were also reported [20]. The use and cost-effectiveness of CDIC versus ‘non-comprehensive’ drop-in centres (DIC), outlets, satellites etc. to reach PWID should be further assessed [25].
2. Differentiation of HTS, including the use of lay testers and community-based testing, led to a better yield. Improved uptake of services was seen after introducing online HIV services demand generation activities; these will continue and be expanded.
3. ASP established a strong collaboration with private diagnostic centres for potential migrants and the blood transfusion program, obtaining the results of their HIV testing activities, which were not included in the national statistics in the past.
4. Operational research was conducted to assess the HIV/AIDS related knowledge, attitude and practice of caseworkers regarding ART enrolment, adherence and disclosure [26]. It found a substantial increase of knowledge among caseworkers that eventually contributed in better ART enrolment, adherence and disclosure among HIV positive PWID. This lesson will be further utilized in coming grant.
5. Services for PWID were evaluated and reviewed; the strategic approach for delivering harm reduction and HIV services to PWID needs to be redefined and the quality of services improved[19, 20, 25]. This will be further refined in the coming grant.
6. So far, there is no agreed Manual of Procedures (MOP) for how community-based HIV and harm reduction services should be managed and implemented, and how community-based HIV services (should) link to and strengthen Government-operated health services. Such a standard will need to be developed, based on the many existing SoP documents Bangladesh has, and will facilitate universal implementation to an agreed minimum national standard, better tailored to individual client needs, and also facilitate improved M&E.
7. There was a lack of capacity building / inter-stakeholder learning and discussion within the PWID program during the past grant; supervision of outreach workers should be improved and standardized. This was partly related to the point above, i.e. that there were no agreed standards in place; supervision of outreach workers and peer educators should be part of the MOP.
8. An ‘exit strategy’ should be designed in order to ‘graduate’ clients from HIV case management or peer support once they are fully treatment-adherent, freeing up space for new clients. For OST clients, more emphasis will be given to the third phase, that is treatment discontinuation or termination for those who are eligible. This will be introduced in the coming grant.
9. Stigma and discrimination (actual or anticipated) remain important barriers to KP access to public health facilities in general and HIV services in particular. Health workers in public health facilities need to be engaged in KP sensitization and stigma and discrimination reduction training, which will facilitate friendlier services from the outset and will lead to improved uptake and retention by KP clients. Several training sessions were held with health care providers in public hospitals to reduce stigma and create a KP friendly environment in selected hospitals where PLHIV are receiving ART and other health services. ART enrolment in public hospitals has been increasing every year, and stigma reduction efforts need to be continued. A client feedback mechanism to report stigma and discrimination should also be considered.
10. A study was conducted to understand the reasons for methamphetamine use, and its risk and vulnerability related to HIV, among MSM and TG in Dhaka [21,22]. Based on the findings, issues relating to use of methamphetamine among MSM and TG will be addressed in coming grant by engaging community and experts.
11. Operational research conducted by icddr,b among MSM and TGled to a new community-based TB screening model for MSM and *hijra* that can increase TB screening, presumptive TB case identification, and increase TB case detection by capacitating peer educators [24]. Relevant BCC materials were also developed. Community-based TB screening for MSM/TG will be continued in the coming grant.
12. Some innovations were introduced in the past period, which will be continued: such as

* Introduction of FSW ‘community squads’ to respond to GBV, in combination with a 24-h hotline
* Implementation of a new curriculum to improve awareness of migrants before they move abroad (without expenditure of GF funds). About 700,000 migrants are participating in HIV awareness and prevention sessions organized by the Bureau of Manpower every year, using BMET funding.
* Use of ICT based interventions (mobile apps/website) to reach out to hard-to-reach MSM and TG, this approach will continue in the coming grant cycle.

# Section 2: Funding Request and Prioritization

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

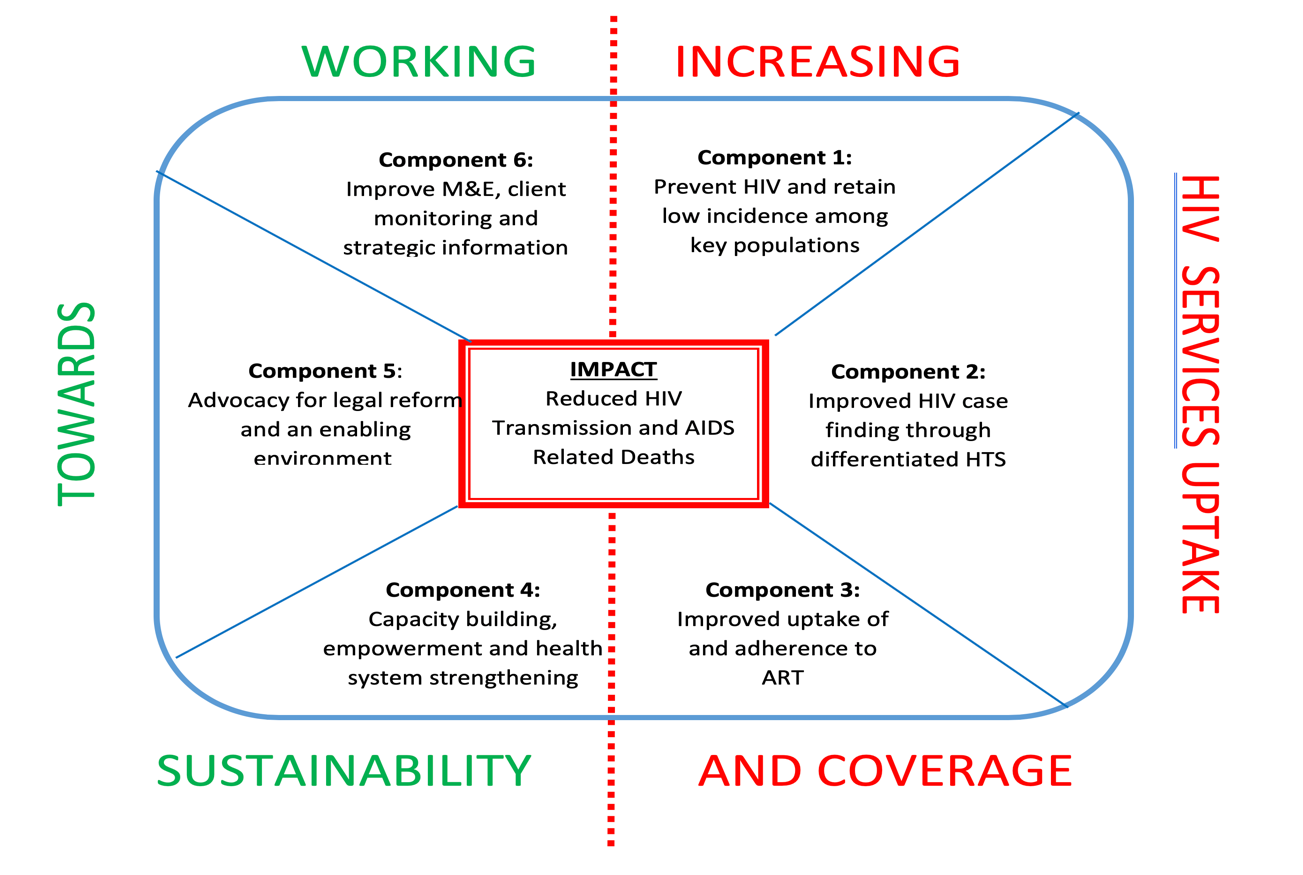
## 2.1 Overview of Funding Priorities

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

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

The investment case 2019 suggested that investing in prevention now will yield significant savings on future treatment costs. It presented four scenarios for HIV investment, of which Scenario Three was deemed the most cost-effective and most realistic (and affordable) scenario. It entails scaling up the current HIV program to reach the targets set in the NSP, i.e. achieving the 90-90-90 targets that the Bangladeshi government has signed up to, and would come very close to achieving the “Ending AIDS by 2030” target [16]. The aim is to allocate the limited resources available in prioritized interventions which maximize value for money, effectively minimize the impact of HIV and improve the health and wellbeing of KP in the program area, implementing an optimal mixture of services to improve client motivation and access, and propagate a sustained use of preventive, testing and treatment interventions. Geographically, in terms of HIV service delivery, the current proposal focuses its resources on Dhaka and 22 other priority districts where about 62.3% of all KP and 79.8% of diagnosed PLHIV live [16]. The investment case study also suggested to provide services in remaining 41 districts, but on a limited scale. Therefore, based on vulnerability of KP and programmatic experiences over the last 10 years, some other priority districts will be continued and/or included to have an effective holistic response to control HIV. In alignment with the revised 4th NSP (2018-2023) [2], the Investment Case Scenario 3 and the latest size estimation data (2015-2016) [6], scaling up of differentiated HIV interventions for KP has been made the focus of the Bangladeshi HIV program for the 2021-2023 period.

The overall goal of the joint program is **to prevent new HIV infections, reduce incidence and HIV related morbidity and mortality in Bangladesh by improving and further expanding targeted HIV interventions focusing on key populations and their partners**.



The program has six main objectives (see diagram); three are related to HIV service delivery, and three are related to creating an enabling environment. The program will:

1. Prevent new HIV infections and reduce incidence by improving and expanding access to combination HIV prevention (including comprehensive harm reduction) services for KP;
2. Increase case-finding among KP by improving and expanding access to differentiated HIV testing services (HTS);
3. Improve access, adherence to and quality of ART services for KP in need, lowering HIV-related morbidity and mortality and reducing onward transmission of HIV;
4. Strengthen community and government health systems, empower marginalized communities to claim their right to health in a stigma-free environment, and improve linkages and cross-referrals and build capacity to manage and deliver HIV services;
5. Advocate for legal reform at the policy level and advocate and engage with local gatekeepers and law enforcement agencies to reduce stigma and enable implementation of HIV services for LP;
6. Improve systems for M&E and strategic information (including updated IBBS data (ongoing under current grant), a revision of size-estimation data (using OP funds) and operations/implementation research).

The three PRs, ASP (Government), Save the Children (SC) and icddr,b (both NGOs) will jointly implement the program (see Table below), with SC focusing on PWID and FSW, icddr.b focusing on MSM, TG and PWID (particularly for OST) and ASP focusing on strengthening the enabling environment as well as gradually initiating HIV service delivery for PWID and FSW from selected government hospitals (Annex: i). Partial human resources including specialized physicians, counsellors, MT lab and relevant service logistics (drugs, condoms, lubricants, etc.) will be provided to the grant as co-financing. The targets for different coverage indicators under GF fund increased after iteration. The target for reaching PWID increased from 13,600 to 17,035 (3,435, 25.26%) and for FSW from 31,140 to 31,250 (110, 0.35%). The target for OST has also increased from 3,200 to 3,500 (300, 9.38%). The targets for HTS increased among MSM from 24,375 to 29,250 (4,875, an 20% increase), *hijra* from 3,750 to 4,500 (750, 20%), PWID from 10,350 to 15,332 (4,982, 31.18%) and FSW from 27,000 to 28,125 (1,125, 4.17%). The target for ART adherence among PWID increased from 1,160 to 1,238 (6.72%).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Table 2- Funding priorities** | | | | | |
| **KP** | **Priority Intervention** | **Targets** | **Geographic coverage** | | **Approach** |
| Dhaka | **22 Priority and 14 other districts** |
| PWID reached through comprehensive Harm Reduction  Services | Prevention, NSEP/OST, testing, treatment, care and follow-up | 17,035 (52% of national estimates, 33,067)  14,035 (SC) + 3,000 (ASP) | 6,300 (93% of Dhaka estimates, 6,788) | 10,735 [79% of 15 priority districts estimates (12,861) & 46% of two non-priority districts estimates (1,310)]; |  |
| PWID reached through needle syringe and other harm reduction services | Prevention, testing, treatment, care and follow-up | 13,535 (41% of national estimates, 33,067)  10,685 (SC) + 2,850 (ASP) | 4,200 (62% of Dhaka estimates, 6,788) | 9,335 [68% of 10 priority districts estimates (12,861) & 46% of two non-priority districts estimates (1,310)];  SC-6,485 [65% of ten priority districts estimates (9,088) and 46% of two non-priority district the estimates(1,310)]  ASP-2,850 (76% of the estimates in five priority districts, 3,773) | Peer driven differentiated community-led service; referral to govt. facilities; 8 CDIC, 2 DIC, 21 outlets (2 in GoB set-up); ASP will provide services from 5 govt. hospitals. |
| PWID reached through OST and other harm reduction services | Opioid substitution therapy for PWID and other HIV prevention services | 3,500 (11% of national estimates, 33,067); 2,600 by SC + 900 by icddr,b | 2,100 (31% of Dhaka estimates); 1,750 SC + 350 icddr.b | 1,400 (21% of the estimates in six districts, 6,816); 850 by SC in four priority districts + 550 by icddr.b in three priority districts | Peer driven outreach, OST clinics, CDIC based services and at government facilities of DNC and local government. |
| FSW | Prevention, testing, treatment, care and follow-up | 31,250 (31% of national estimates); SC - 30,000 (SC) + 1,250 (ASP from 2nd Year) | 13,500 (70% of Dhaka estimates, 15,435) | 17,750 (49% of 14 priority districts estimates and 25% of one non-priority district estimates):  SC - 16,500 [54% of 11 priority districts estimates (29,863) and 25% of one non priority district estimates (1,964)];  ASP - 1,250 (10% of the estimates in 5 priority districts;12,669) | Peer driven differentiated service; 09 DIC (one community led), 16 outlets (four community/CBO led); referral to govt. facilities. ASP will provide services from 5 govt. hospitals. |
| MSM/ MSW | Prevention, testing, treatment, care and follow-up | 32,500  (24.72% of national size estimates) | 5,530  (44.56% of Dhaka size estimation)  5,530/12,410 | 22,940 (36.3% of size estimation 63,262) in 22 priority districts and 4,030 (18.0% of size estimation 22,356) in 14 other districts | Peer-driven, community engagement,14 DIC, 18 Sub-DIC, 18 outlets and 13 satellite; In RCC phases 66 DIC were in place; then drastically reduced to 30 in NFM. In existing grant 20 DIC are in place, two public hospitals will be model of integration for clinical services on pilot basis. |
| TGW | 5,000  (49% of national size estimates) | 1,310  (88.22% of Dhaka size estimation)  1,310/1,485 | 3,183 (66.9% of size estimation 4,755) in 22 priority districts and 507 of (23.5% of size estimation 2,155) in 14 other districts) |

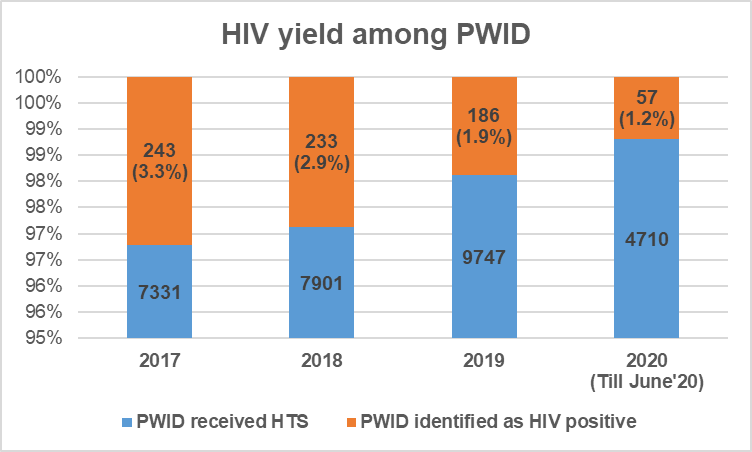
**Strategic Framework for the program (per objective)**

Objective One: Improve and expand access to HIV prevention and harm reduction services

In the coming grant, 14 drop-in centres (DIC), 18 Sub-DIC, and 18 Outlets will be operated to provide services to MSM and MSW and *hijra*; 9 DIC and 16 outlets will serve FSW and and 8 CDIC, 2 DIC and 21 outlets will serve PWID.

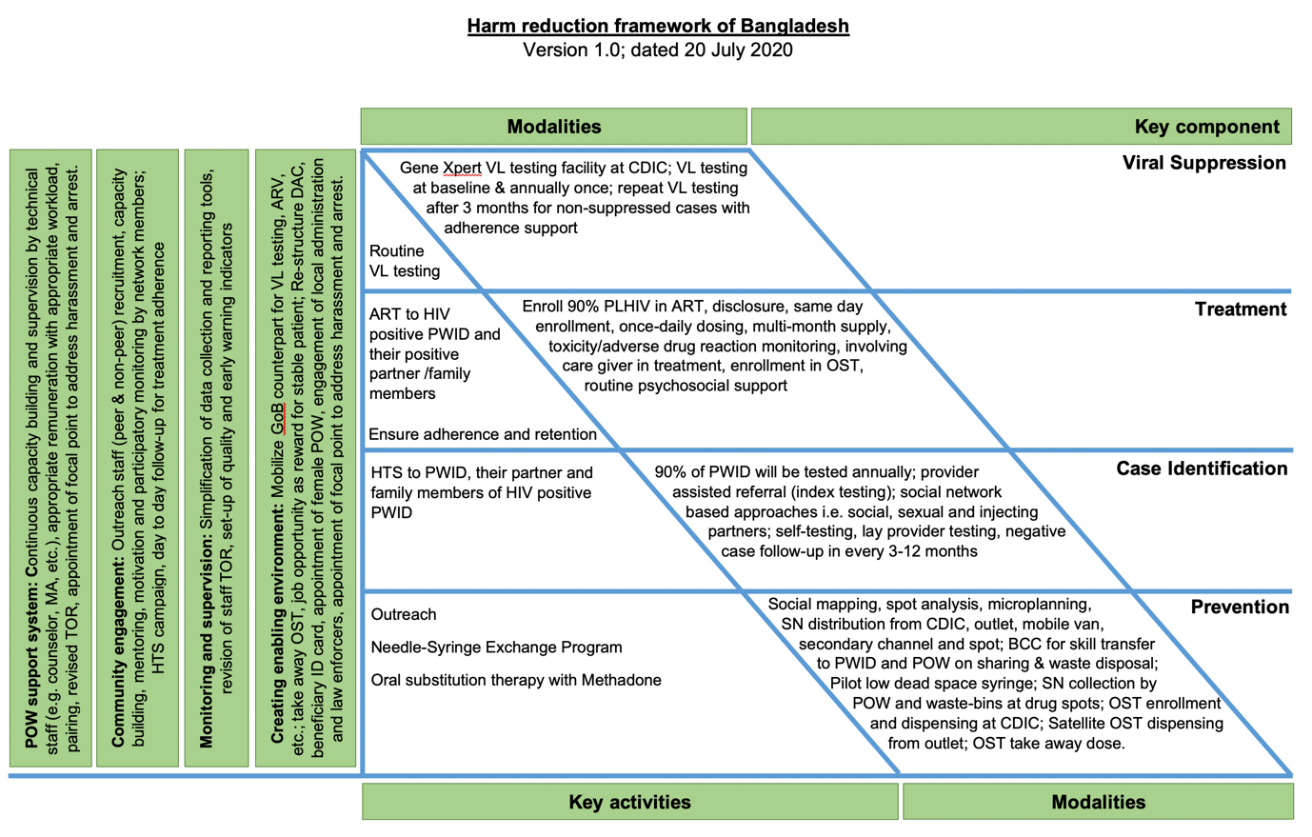
*PWID interventions*

For PWID, as was the case for other KP, many DIC have been closed in recent years in order to make the program more cost-efficient. Some have been upgraded to become more comprehensive (CDIC) and rest have (or will be) turned in to an outlet with substantially smaller space, where outreach workers operate, offering a limited package of basic services (e.g. BCC, NSEP, HTS, OST dispensing and ART adherence follow-up) to smaller groups of PWID; harm reduction stocks will also be stored there. Besides CDIC, there are stand-alone OST clinics; however, both stand-alone OST services and Outlets also provide HTS. PWID enlisted under outlet will be linked to CDIC/standalone OST clinics/public hospital for management of OST and ART. CDIC and Outlets will also operate satellite sessions in various spots/congregation areas for NESP and HTS.

After a sharp increase in HIV incidence among PWID in recent years [8], an in-depth review [19] was conducted in 2018 to identify strategies to enhance the quality of HIV services and coverage for PWID. Based on the recommendations, several initiatives were taken, such as provision of comprehensive services by converting DIC into Comprehensive DIC, deployment of case workers for ART adherence, increasing HTS coverage engaging lay providers, increased POW: client ratio and rationalization of needle-syringe distribution at outreach level. PWID coverage consequently increased in Dhaka and its adjacent district (Narayangonj). As a result, case identification, ART enrolment and retention has increased substantially (see the graphs on the left) over the period.

|  |  |
| --- | --- |
|  |  |

Based on two recent studies that found significant weaknesses in the harm reduction program in the past years [20, 25], Bangladeshi harm reduction interventions have been furher re-strategized. One key weakness was loss-to-follow-up in the OST program. To decrease loss-to-follow-up cases, the whole process of OST service delivery, i.e. client selection, preparedness, induction, maintenance and withdrawal (release) from OST program has been re-evaluated and re-designed (see below); this process is ongoing and will continue in this grant. The new strategic framework for PWID is described in the figure below:



As a result of these two studies, a number of technical assistance initiatives have been planned and launched to improve the outreach and needle exchange program as well as the quality of OST program. A hotspot analysis, contact mapping and social mapping have been conducted, based on which new spots were identified. Extended outreach hours have been piloted, through deployment of volunteer and establishment of depots in many spots to cover the early morning, late night and off-hour syringe-needle requirements of PWID and collect used syringes-needles from the field. Field monitoring and supervision have been strengthened. Written standards and IEC materials have also been updated and improved.

In the coming grant period, OST services will be increased to cover a total of 3,500 PWID. In line with gaps found in recent studies, more priority will be placed on enrolling HIV positive PWID and Women Who Inject Drugs (WWID); in order to achieve this female POW will be stationed in each of the facilities (i.e. CDIC, OST centre, and Outlet) of Dhaka, Gazipur, Narayangonj, Cumilla and Rajshahi. POW in three selected districts which include Dhaka and two of its adjacent districts under FSW intervention of PR Save the Children will be trained on dealing with drug related issues including OST to ensure services for WWID who are involved in the sex trade. FSW DIC of those districts will link WWID to CDIC (of PWID intervention) for OST and ART. WWID will have access to both FSW and PWID DIC/CDIC/Outlet to avail OST services. The uptake of OST among WWID will be monitored through gender segregated reporting.

In order to improve mental health services and reduce loss-to-follow-up in the OST program, the program will recruit clinical psychologists as counsellors in addition to qualified physicians, nurses and POW for ensuring continuous psychosocial support to OST clients. Regular follow-up for mental health support, adherence and retention will be done by clinical psychologists, following an appointment schedule. A technical committee at the CDIC has already been formed to use the updated mother-list for client selection using agreed eligibility criteria [i.e. >18 years of age, injecting for >1 years, H/O drug treatment (willingness to stop using drugs), HIV and or HCV positive, etc.] and to evaluate clients’ adherence and make treatment decisions. Before enrolment in OST program, the psychologist will check clients’ willingness and readiness following a predefined scale [circumstances, motivation, and readiness scales (CMRS]. A separate scale [clinical opiate withdrawal scale (COWS) is in place to support OST induction and maintenance.

Larger take home/away supplies of methadone have been provided to PWID considering the COVID-19 situation and to reduce loss-to-follow-up. Provision for take away/home dosage as retention and adherence reward have also been introduced as measures to reduce loss-to-follow-up. Simultaneously, satellite OST dispensing corner will be installed in outlets and spots after completing pilots in the current grant, making access to OST easier; this will also likely contribute to reduced loss-to-follow-up rates.

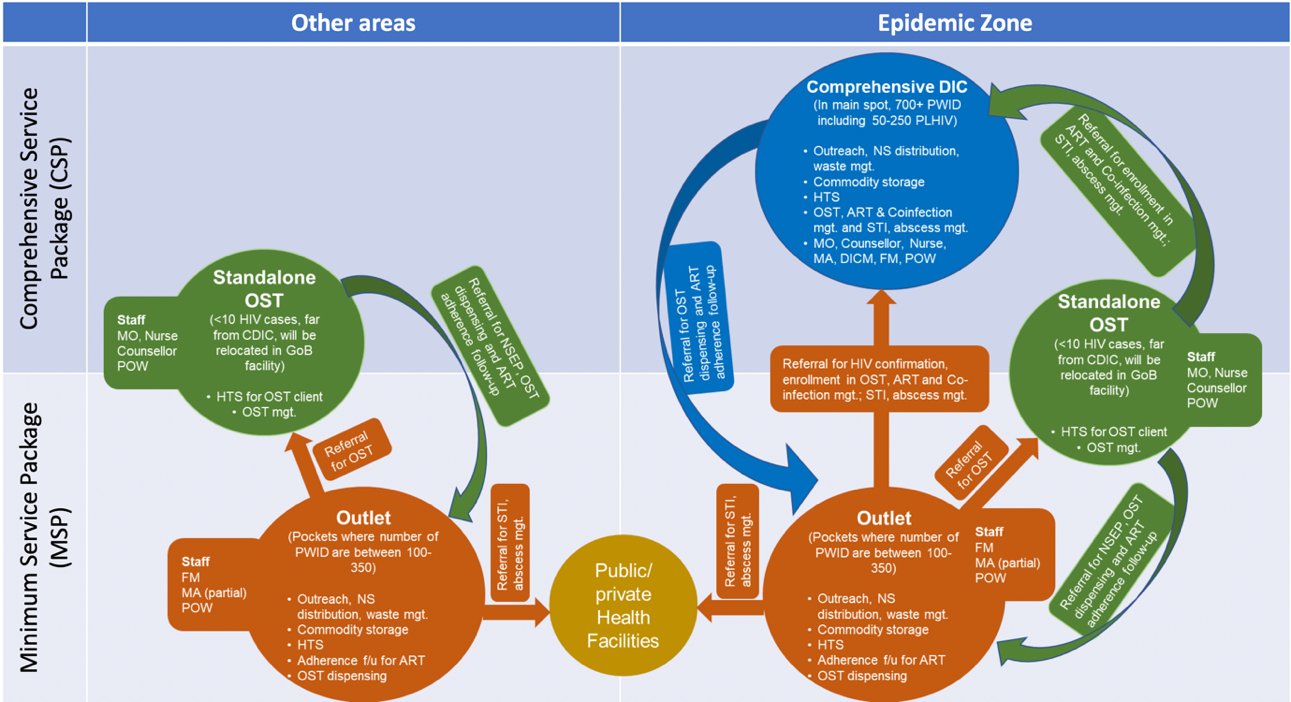
Stable OST clients, i.e. those who have been on treatment for more than one year and have >90% adherence, will have an appointment every 3-6 months; the rest will have more frequent visits. Newly enrolled clients will have twice weekly to monthly appointments based on their length of treatment. Special attention will be devoted to maintaining optimum methadone dose considering co-administered drugs and their interactions.

The collection of used needles and syringes will be further improved. POW, non-POW and peer volunteers will be engaged for this exchange program. In addition, waste-bins and collection boxes will be placed at drug spots, and with the people around the drug trade (e.g. pushers and peddlers). There will be an SOP for the collection and disposal of the needle-syringe and other medical waste. Emphasis will be placed for continuous orientation of POW, non-POW, volunteer, PWID and people around drug trade on safe injection practice and safe disposal. Similarly, routine campaigns (quarterly) around drug spots will be organized on safe injection and safe disposal. Items for aseptic precautions, such as utility gloves, forceps and puncture-proof bags, will be supplied.

For PWID, eight comprehensive drop in centres (CDIC) in Dhaka and Narayangonj will provide comprehensive harm reduction services, i.e. HIV prevention education, needle/syringe exchange (NSE), condom promotion, HTS, OST, ART, STI, abscess and general health management (with a focus on HIV, HCV and TB infection) to >700 PWID from the catchment area including >200 OST clients and 50-250 PLHIV. Sexual and drug use partners and family members of targeted PWID will also receive services as part of contact tracing. CDIC will also be the referral point for OST, ART, complicated STI, abscess and co-infection management for mother-listed clients of outlets. Each CDIC will be led by a clinical team comprising of a physician, counsellor and nurse and supported by an outreach team with different cadre. Simultaneously, four standalone OST centres (two in government facilities, namely, Rajshahi drug treatment centre under Department of Narcotics Control and Mohanagar General Hospital under Dhaka South City Corporation and two in NGO set-up in Gazipur ad Cumilla) will serve PWID with OST who will be referred (from outlets, field-based peer outreach workers or peer volunteer, other service delivery points) or access for OST enrolment by themselves. The OST centres will assess readiness and eligibility, and if they pass the assessment process, enroll, dispense OST and follow-up clients to maintain adherence. They will ensure at least one annual HTS screening to all HIV negative OST clients. There will be a physician, counsellor and dispenser to ensure OST services to the PWID.

There will be 21 outlets (mostly in other districts, barring three in Dhaka) from where PWID, their sexual and drug use partners and family members will receive a minimum package of services, i.e. syringe-needle, condom, HIV prevention education, HTS, OST (dispensing only), and ART adherence support. Clients will also receive other required services, e.g. STI and abscess management, OST and ART management (assessment, enrolment and follow-up), TB and other co-infection management from referral centres, i.e. CDIC, OST centre (OST only) and designated public and private health facilities through the accompanied referral system. Each outlet will serve around 100 to 350 PWID. Simultaneously, two mobile-vans will move within Dhaka with syringe-needle supplies, condoms, waste disposal facilities and HTS from one spot to another following a pre-fixed schedule targeting off-hours.

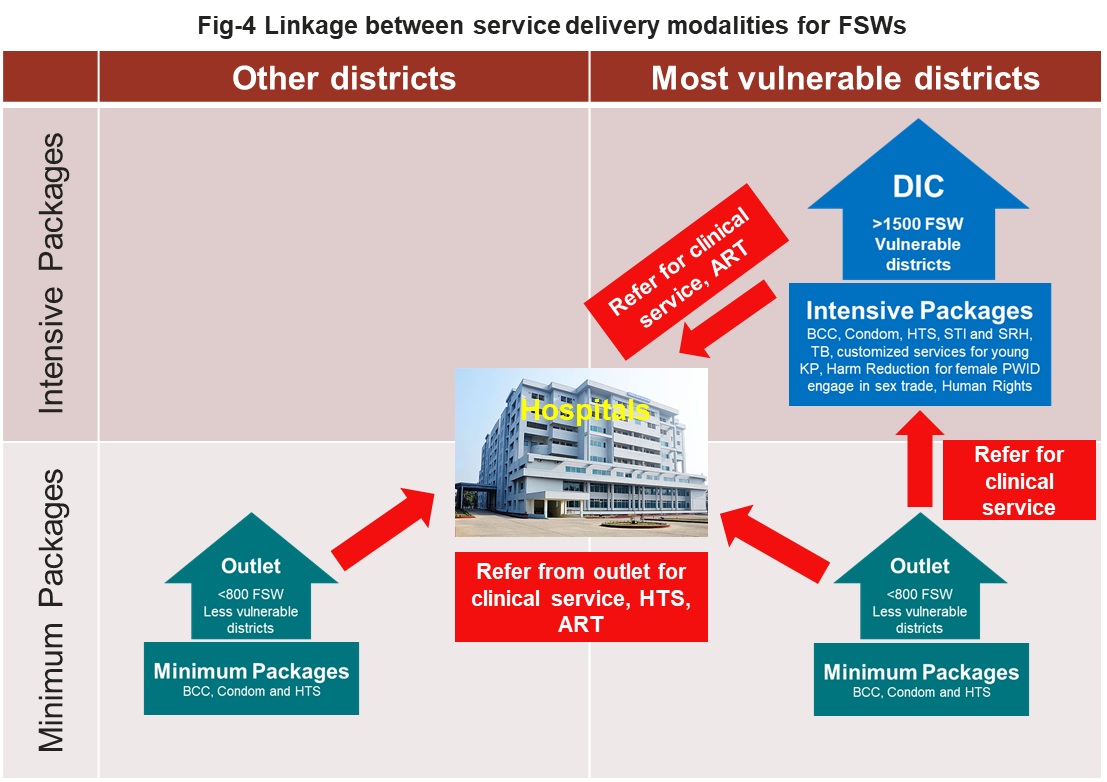
See the diagram below for an overview of PWID service delivery points and services available at the different types, as well as linkages between them.



*FSW interventions*

For FSW, a minimum service package of BCC, condoms and HTS will be ensured from outlets. Around 10% of FSW will be referred annually to public hospitals for HTS. Outlets will also refer around 25-45% of FSW to public/private hospitals for clinical services including STI and ART for HIV positive cases. The rest will receive services at NGO-operated facilities. In the most vulnerable districts (i.e. Dhaka, Gazipur, Narayangonj, Chattogram, Cox’s Bazar, Khulna and Sylhet), FSW will be offered an intensive package of services, consisting of BCC, condoms, HTS, STI diagnosis and treatment, SRH, TB screening, customized services for adolescent FSW and harm reduction services for WWID engaging in sex work from DIC, where outlets will be the extensions of DIC to cover more distant pockets (Fig-4). Outlets and DIC will also operate satellite sessions in various spots/congregation areas for HTS and STI management.

There will be 16 outlets from where FSW and their sexual partners and family members will receive a minimum package of services (e.g. BCC, condoms and HTS). Each of the outlets will serve <800 FSW. For clinical services, including STI diagnosis and treatment and ART for HIV positive cases, FSW will be linked to public/private hospitals. Around 10% of FSW will be referred annually to public hospitals for HTS. Outlets will refer a gradually increasing number of FSW to public and private hospitals, from 25% in year one to 45% in year three throughout the grant. The rest will receive services at CBO/NGO-operated facilities. In the most vulnerable districts, there will be 9 DIC to offer a more intensive package of services, containing BCC, condoms, HTS, STI diagnosis and treatment, SRH, TB screening and referral and customized services for adolescent FSW and harm reduction services for WWID engaging in sex work, where outlet will be the extensions of DIC to cover more distant pockets (Fig-4). Each of the DIC will serve >1500 FSW. Outlets and DIC will also operate satellite sessions in various spots/congregation areas for condom provision, HTS and STI management.



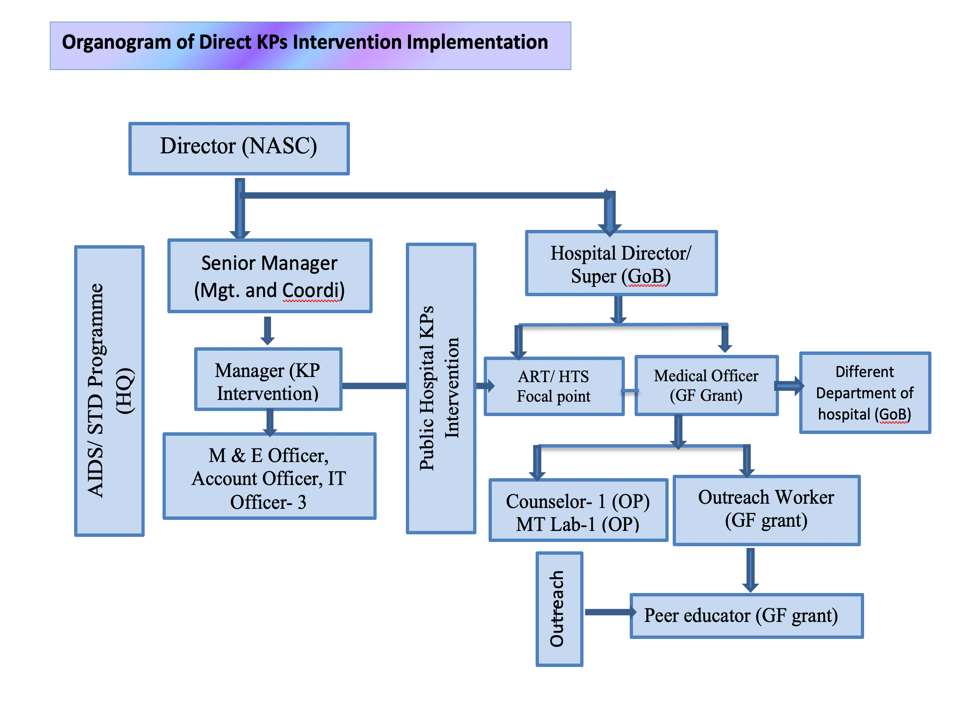
As part of mainstreaming and transition, Save the Children will relocate gradually some of the service delivery points (i.e. CDIC, DIC and outlet) to public health facilities over the grant period to avail clinical services by FSW and PWID. However, the facilities will be supported from the grant with necessary capacity building initiatives, human resources (partial), supportive supervision and reporting. The table below shows the annual relocation plan:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Population** | **Set up** | **2021** | **2022** | **2023** | **Total** |
| **PWID** | **CDIC** |  | 3 |  | 3 |
| **OST Centre** |  | 1 |  | 1 |
| **DIC** |  | 1 |  | 1 |
| **Outlet** |  | 6 |  | 6 |
| **FSW** | **DIC** |  | 1 |  | 1 |
| **Outlet** | 2 | 1 |  | 3 |
| **Total** | | **2** | **13** | **0** | **15** |

*Government-implemented interventions for PWID and FSW*

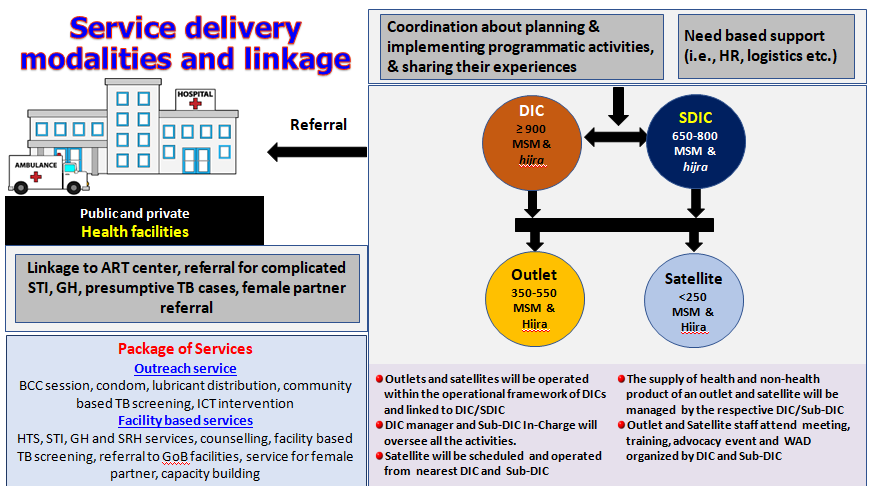
After gaining experience providing HIV prevention, testing and treatment services to KP via subcontracting NGOs, ASP is now planning to increase its role in directly implementing HIV testing and treatment services for PWID and FSW. Since 2017, ASP took over the responsibility of management of ART services which are delivered through public healthcare facilities, leading to a significantly increase in enrolment compared to the previous years when ART provision was managed by NGOs.

ASP will pilot playing the role of implementer of prevention, testing and treatment of FSW and PWID in five selected public hospitals which have been providing ART and HTS; this will be carefully documented as part of a feasibility and acceptability study (see under Objective 6) to be conducted by an independent consultant. Newly appointed medical officers and existing counsellors and MT lab staff will provide STI diagnosis and treatment, abscess treatment, general health and HTS to PWID and FSW. For treating FSW there is no additional staff at the facility, only new outreach workers have been planned to be recruited (see organogram below).

Health products like condoms, needles and syringes, and STI drugs will be provided by GoB OP fund for the KP. Only establishment costs, physical infrastructure and monthly operation cost are planned under this grant. About 3,000 PWID and 1,250 FSW are proposed to be covered; initially 3 hospital will start the services from 3rd quarter of the intervention, based on the result the other two are planned to start providing services in the 4th quarter. After getting recommendation from the assessment the approach will be revised or replanned as per need.

*MSM/MSW/hijra interventions*

Since December 2015, HIV prevention services for MSM/MSW and *hijra* have been operating through various service centre modalities such as DIC, sub-DIC, outlets, and satellites with a similar service provision (which are listed in figure 2 below). Outlet and satellite services will be operated within the operational framework of DIC and directly linked to, operated by, and reported through the respective DIC/sub-DIC where the DIC manager and Sub-DIC In-Charge will oversee the implementation and quality of the activities. Outreach staff (comprising of peer educators (PE), peer associates (PAs)) and outreach supervisor (OS)) are employed to bring in MSM, MSW and *hijra* clients to the DIC, sub-DIC, outlets and/or satellite from cruising areas and hotspots. Regular communication will be ensured with enlisted beneficiaries (physically or through telecommunication) to prevent any “loss to follow-up” and ascertain “retention in care”. ICT-based and cell phone-based communication will be strengthened for contacting infrequent and remote beneficiaries to increase retention and coverage.



To work towards more sustained responses, icddr,b will pilot clinical service delivery from two public healthcare facilities in two priority districts to explore the feasibility and acceptability of public health-facility-based services targeted towards MSM and TG. Lessons learned from this piloting exercise will be documented to strengthen public health systems.

*Cross-cutting strategies*

In order to improve the quality of prevention services, various ‘syndemic’ co-and-multi-morbidities, including TB, STIs, viral Hepatitis, and mental health, will be incorporated in the training of peer outreach workers (POW) and medical assistants as well as in the screening of clients, and referral to appropriate public healthcare facilities will be ensured. Facility-based verbal TB screening will be continued for clinical services at CDIC/DIC/Sub-DIC/Outlet/satellite for KP. Community-based verbal TB screening will also be introduced and implemented through PE in order to enhance TB-case detection and subsequent treatment among MSM/MSW/TG. Presumptive TB cases will be linked through referrals to TB clinics for further testing and treatment. To address substance use among MSM and TG, including methamphetamine, service providers will be trained to counsel clients on this issue and refer them to government and non-government healthcare facilities.

In addition, the following key strategies that are critical for community engagement, capacity building and community strengthening are proposed to achieve prevention coverage targets:

* CBOs (MSM, TG, FSW, PWID and PLHIV), self-help groups and Community Networks (SWNoB, NPUD, PLHIV network) will be engaged in daily service delivery to KP. icddr,b has worked on community systems strengthening under the Global Fund grant in 2010-2015 and formed or strengthened 20 CBOs operated by the MSM and *hijra* community. icddr,b will assess the status of these CBOs and work with them so that these CBOs can potentially contribute to HIV service delivery interventions. Save the Children and its SRs/SSRs will form strategic partnership with 3 community networks (SWNoB, NPUD, NOP+) and 6 CBOs (4 FSW CBOs and 2 PWID CBOs) in this grant; they will be linked with program implementation to ensure service for their own communities. To do so, the capacity of these networks and CBOs will be further strengthened through training, provision for human resources and institutional support.
* Community-based monitoring (CBM) will be introduced to understand and address barriers to accessing services by KP. CBM tools will be developed and KP will be trained on how to use them. In addition, participatory M&E (PM&E) will be continued for improving program implementation.
* Both icddr,b and SC, and its SRs/SSRs have been facilitating the community-led mapping of legal, policy and other barriers that hinder/limit community responses. In this process, a reporting system for GBV and human rights abuses has been developed, and data collection and analysis will be done to inform relevant stakeholders.

Objective Two: Improve HIV case finding by expanding access to HIV testing

HIV testing services have been expanded throughout the country via Government, NGO and private healthcare facilities during the past decade. In particular, HIV testing for KP has been provided via 103 NGO-operated service centres; for general population (GPs) 28 HTS centres have been operating across 23 priority districts as of 2019. By 2023, HTS centres will be expanded to all 64 districts, i.e. an additional 36 HTS centres will be established using government funding. HIV testing coverage has been extended to TB patients at DOTS centres and pregnant women at antenatal clinics (10 PMTCT centres), safe blood transfusion programs (SBTP) at various clinical settings and clinics associated with 67 Gulf Assisted Medical Centres Association (GAMCA). A total of 2,114,238 HIV screening tests were performed in these settings in 2019.

Diverse approaches for generating demand for HIV testing are in place, e.g. via outreach and BCC materials. Phone communications, text and voice SMS, and HIV self-risk assessment through mobile and web-based applications (including linkages to HTS facilities) are in place, particularly for MSM and *hijra*. Transportation costs to visit HTS centres are being provided to encourage uptake of testing. Counsellors/medical assistants and DIC manager/in-charge motivate KP through counselling and group education sessions, primarily in-service delivery points, though they also occasionally provide home-based and family counselling. Existing approaches for demand creation will be continued and intensified. Community-based organizations (CBOs), self-help groups and community networks (SWNoB, NPUD) will also be engaged to help foster KP mobilization (including their clients) and create demand for HTS.

Until 2017, facility based HTS was done among PWID and FSW with relatively low coverage. In 2018, SC and its SRs/SSRs introduced differentiated HTS following WHO guidelines. Lay providers (POW, Field Monitors) were trained and equipped for HTS. Consequently, a “National guideline for community-based HIV testing services” [38] was developed, led by ASP with technical support from SC and endorsed in December 2019. As a result, HTS coverage has increased (see graph below):

|  |  |
| --- | --- |
|  |  |

Improving HIV case finding is a top priority in the revised funding request. Following WHO guidelines, creating different options for HIV testing will increase demand and access to HIV testing, and hence increase the number of diagnosed PLHIV in Bangladesh. This is because the different modalities are likely to appeal to and provide easier access to different (additional) sub-groups of the key populations.

The following seven differentiated HIV testing strategies will be promoted and employed during the next grant:

1. **Facility-based HIV testing services**

**Prioritization:** Facility-based (HTS) is a preferred modality among all KP due to familiarity and the perception that DIC is a “safe space” where privacy and confidentiality are ensured. Moreover, NGO operated facilitates can also efficiently and conveniently establish linkages to care. In contrast, GoB operated HTS centres are servicing the general population, though KP can also be tested there. In order to create a KP friendly environment at GoB facilities, ASP will work on sensitization, orientation and training of GoB service providers with the help of the other 2 PRs. The aim is that GoB HTS facilities become KP-friendly and can that they also provide services to KP. NGO HTS service providers will also be trained periodically, especially if and when national HTS guidelines are updated.

For KP, outreach staff [peer educators (PE)/outreach workers (OW)] motivate and refer KP for facility-based service uptake through BCC sessions or ICT approach. Moreover, many KP access facility-based HTS without referral.

In the current grant, trained MA/MT of the respective HTS centres provide HTS following standard procedures (i.e., consent, pre-test information, HIV testing and post-test counselling) while maintaining privacy and confidentiality. As per the national HIV testing algorithm, the WHO-recommended HIV rapid testing approach will be followed, where whole blood is collected by finger stick and three rapid tests are performed. Oral fluid-based self-testing will also be available for those who refuse to partake in blood-based testing (detailed in the self-testing section). All clients will receive their test results through post-test counselling on the same day of testing.

1. **Community-based HTS**

**Prioritization:** Community-based HTS can reach most KP with impeded access to facility-based testing, especially MSM, male clients of FSW, street-based PWID and some *hijra*. Community-based HTS is currently available at convenient community-based locations and settings (i.e., residences of *hijra guru* or influential community members; hotels, residences and congregation sites for FSW, drug spots frequented by PWID, etc.), following the standard procedures of HTS [38].

This includes targeted HIV testing campaigns focusing on KP that will periodically be organized at CDIC as well as Sub-DIC and Outlets, congregation spots and other public gathering spots (e.g., bus terminals, ferry terminals (ghats), big markets (Bazars), etc. to maximize HTS coverage by reaching KP who generally do not visit such service centres. Community leaders will be enlisted to help in these efforts. Demand-based HTS sessions and satellite HTS sessions will be conducted during weekends/holidays for full-time working beneficiaries and remote populations, respectively, after assessing the demand and prior mapping exercises.

KP will be informed about HTS session schedules by the PE/OW beforehand. KP will attend the session for HTS through peer referral or self-referral and receive HTS following a similar format to facility-based HTS.

1. **Provider-assisted referral** (also called index testing or assisted partner notification)

**Prioritization:** Despite differing contexts for each KP, Index testing is equally crucial for all KP. HIV Index testing involves providing HTS to family members of known PLHIV (index clients). It will be offered to spouses, biological children, and regular partners. This approach will not only increase identification of previously undiagnosed HIV cases, but also increase linkage to care and treatment services. HTS service providers will be trained on index testing strategies (including partner counselling and linkage strategy) by the respective PRs during HTS training to properly implement this strategy.

Currently, the trained service providers (i.e., MA/MT/Lay provider) directly assist all PLHIV (index clients) by reaching out to their sexual and/or drug injecting partner(s) from the past year, as well as spouses and biological children. If the index client provides their consent, each listed spouse, partner, and child are contacted, informed of their HIV exposure, and offered HTS, upholding the conventions of social and cultural sensitivity. This approach will be enhanced in the next grant and conducted either at service centres, community settings or through referral to Govt. HTS centres.

HIV rapid testing approach will be used, following the national HIV testing algorithm. Moreover, self-testing method will also be considered for index-testing or partner notification (detailed in the “self-testing” section). The case management team will link positive index cases to the ART centres for treatment, care, and support services. Index testing will be consensual, confidential, and include counselling, correct test results, and connections to prevention and treatment. A set of tools will be used for data collection and reporting.

.

1. **Social network-based approaches**

**Prioritization:** This approach is more suitable for MSM, *hijra* and FSW and their sexual partners, who maintain extensive social and sexual networks. This approach can also apply to PWID and their injecting networks. This approach could be effective in situations where KP are reluctant to uptake provider-assisted referral out of fear of identity disclosure or stigmatization/discrimination/prosecution.

WHO guidance suggests that untested KP are more likely to ascent to HIV testing if a trusted member of their social network suggests it. Social network-based HIV testing approaches are an extension of HIV partner service. Based on network analysis, trained service providers (i.e., MA/MT/lay providers) will ask KP (HIV+ and HIV- alike) to encourage and invite individuals within their social contact networks in addition to their sexual and/or drug-injecting partners at risk of HIV to come forward and access HTS of their preferred modality. Various strategies will be used to enhance this approach such as engaging peer educators and navigators, and outreach workers and fostering self-referral through referral coupons. Participants undertaking social network based HTS will receive a monetary incentive in the form of a conveyance allowance. This approach will also be linked with HIV self-testing services (see below) as clients may distribute HIV self-testing kits to their partners and contacts.

1. **Self-testing (HIVST)**

**Prioritization:** HIVST can be provided to all KP since it is possible to distribute through diverse channels, and is complementary to other HTS models. This can help optimize coverage for obscure populations, such as unreached KP and sexual partners of KP. It can also be a convenient and safe tool to access HTS during the COVID-19 era.

An operational research study on self-testing among **MSM and *hijra*** is ongoing in the current grant, which will end by 2020. If the study finds that there is demand among MSM and *hijra* that may add value to the HIV response and possibly reach KP who would otherwise remain untested, HIVST will be added to the comprehensive package of HIV services for MSM and *hijra*. Meanwhile, guided self-testing will be piloted for 1000 **FSW and their partners**. FSW reached through virtual spaces will be offered anonymous self-testing. To reach adult women who may suspect their husbands to be MSM, PWID or clients of FSW and who might be interested in HIVST, PR-SC will create a Facebook page with online IEC/BCC. Potential clients will be able to contact the project via inbox messaging, and risk behaviours will be analysed; if there is significant HIV risk they will be referred and connected to an outreach worker through confidential one-to-one channels for follow-up HIV testing, STI management, condom promotion, and other required services. For 500 **PWID and their partners** and family members, guided self-testing will also be piloted during the coming grant.

As per the national HIV testing algorithm, all positive self-testing results will be confirmed by three HIV rapid tests. Clients will be referred for a confirmatory test at the respective service centres (for male/*hijra* partners) or GoB operated HTS/ART centres (for female partners) through the support and supervision of MA and case management staff. HIV self-testing has already been included in national HTS guideline but this will be further elaborated based on the findings from the operational research for wider implementation among KP. A set of data collection and reporting tools and will be developed to facilitate client tracking and monitoring.

1. **Lay provider HIV testing**

**Prioritization:** Lay providers with the same risk exposure or socio-cultural bracket of KP can significantly increase enrolment into HTS, contingent on adequate training and competent supervision. Lay-provider testing is therefore a task-shifting and cost-effective method for KP who are reluctant to uptake facility-based services or find HTS schedules inconvenient.

Besides the facility-based approach, Bangladesh has phased in a community-based approach for PWID and FSW either by lay providers or community health workers who are trained and supervised to administer rapid diagnostic tests. Community based HTS by lay providers will be continued into outreach modalities for KP. These services will be directly linked to facility-based HIV testing sites which can provide a confirmatory HIV diagnosis in case of a reactive screen-test result.

1. **Couple testing**

**Prioritization:** Partner or couple-based HIV testing and counselling can foster additional support and safe disclosure. It can also increase willingness to uptake HTS if one member of the partnership is already availing HTS and knows their HIV status.

The provider (MA/MT) will counsel the couples together, test both of them and receive their results together, upon receiving consent from both parties. Couple testing services will be confidential. They should unanimously decide whom they can disclose their results with. Appropriate and high-quality pre-test information and post-test counselling will be ensured, including the provision of effective referrals to appropriate follow-up services such as long-term prevention and treatment support. Prevention, treatment and care decisions can be made together, as well as decisions about family or child testing, and family planning. Quality assurance mechanisms and supportive supervision systems will be in place to ensure the provision of high-quality counselling to couples and partners.

Implementation barriers

Potential barriers/implementation challenges of differentiated HTS are:

1. Challenges impeding HTS uptake by MSM and *hijra* populations include fear of blood tests, social stigma attached to male to male sex and HIV, and fear of negative social implications if tested HIV positive. FSW also fear testing positive, which they perceive would affect their ability to engage in sex work. Though access and utilization of HIV testing among PWID has increased over the years, stigma, criminalization and human rights violations still deter HTS uptake.
2. Status disclosure of parents and testing children remains a challenge in index testing due to fear of potential emotional trauma. Moreover, many women fear GBV, intimate partner violence, loss of relationship or other adversities due to status disclosure.
3. Clients may perceive oral fluid based self-testing less reliable compared to conventional blood-based testing. MA may perceive the follow-up process as an additional burden. It is also challenging to ensure consent for partner testing and to bring positive cases (partners) for a confirmatory test.
4. It will be a challenge to appropriately select suitable lay providers for the people they serve. Clients may raise issues of confidentiality as their sero-status may be disclosed around the community. Lack of accredited training curriculum for lay providers and lack of structured system for remuneration and recognition for lay providers’ services are potential implementation challenges.
5. Providing HIV testing for negative partners within sero-discordant relationships will be a challenge.

Some strategies are planned for the upcoming grant to overcome the possible barriers/ implementation challenges of differentiated HTS:

1. Demand creation and awareness raising strategies for HTS (described above);
2. The capacity of counsellors providing services to HTS clients will be strengthened, focusing mostly on higher standards for client privacy and confidentiality;
3. Coordination with relevant stakeholders and PLHIV networks will be improved, in order to create a friendly and accessible environment at the facility and community, free of stigma and discrimination;
4. Training and capacity building will be continued for HTS providers to deliver high quality counselling and minimize mistrust, conflict and violence between partners. To improve service delivery, monitoring and evaluation will be in place;
5. For index testing, the case management team will conduct home visits (if required) and provide intensive counselling (including family counselling). Index client and their partner will be prioritized. Positive couples will also have linkage provisions to family planning and childcare services;
6. Instruction leaflets and videos on HIV self-testing will be developed in the local language, that are user-friendly, visually attractive and contain clearly understandable instructions and information. Self-testing will be advertised and disseminated to build trust among users. Structured follow-up and linkage mechanism will be established for confirmatory testing and linkages to care;
7. Standard selection criteria will be followed to recruit lay providers as per the national guideline/MOP. A system for quality assurance, including external quality assessment, will be adopted for HTS provided by trained lay providers. The HTS by lay provider approach will be closely monitored and supervised. Based on local contexts and population dynamics, a training manual will be developed for lay providers.

Young and adolescent KP are deterred from accessing HTS by social stigma, fear of identity disclosure to older KP and the general population, low risk perception, and inconvenient opening hours of HTS facilities. The MoHFW issued a Circular to provide prevention interventions, including HTS, for vulnerable adolescents and young KP without needing consent from their legal guardian. PRs will employ focused initiatives to increase coverage for young KP. In particular, initiatives will be taken such as recruiting young and adolescent PE/POW at every service delivery point, engaging young CBO members for community mobilization, increasing awareness among young KP about HTS, using ICT platforms, introducing youth-friendly testing schedules, (i.e. weekends and beyond conventional office hours), making counselling services youth-friendly, staff capacity building (orientation/ training), arranging differentiated HIV testing strategies including HIVST, satellite HTS session at preferred venues, e.g. at *dera*, youth clubs, other comfortable locations, etc.. In addition, group education sessions will be arranged with young KP to increase HTS uptake.

Applying these multiple HTS modalities, it is expected that the target of reaching 90% of KP in intervention areas with HTS can be achieved by 2023. Among targeted PWID and FSW under SC, 90% will be tested for HIV each year; similarly, 90% of targeted MSM and *hijra* will be tested for HIV each year, with retesting provisions. Moreover, 90% of PWID and 70% of FSW will be tested for HIV who enlisted in 5 district hospitals under direct intervention of ASP. Criteria for selection of these five hospitals included whether there were dedicated human resources available, vulnerability and size of the KP in the district, whether it was a priority district as indicated by the Investment Case study, and the past efficiency of their current HTS/ART program. ASP also plans to conduct biannual HTS campaigns in more than 4 districts where interventions are absent for KP, especially PWID.

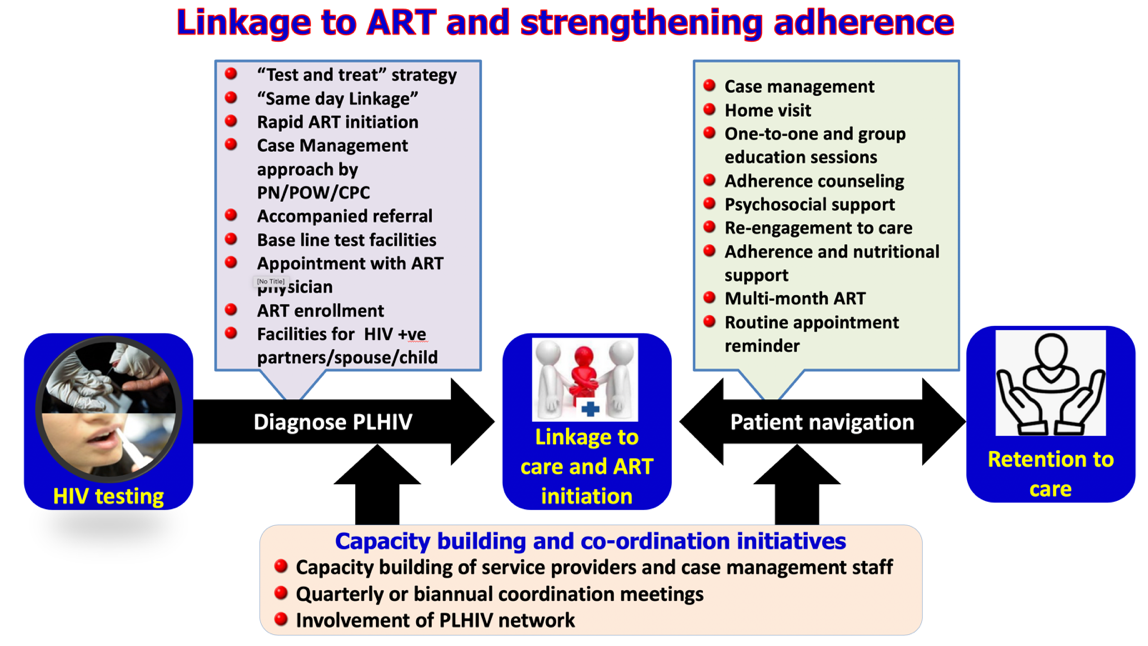
Objective Three: Improve access and adherence to ART services

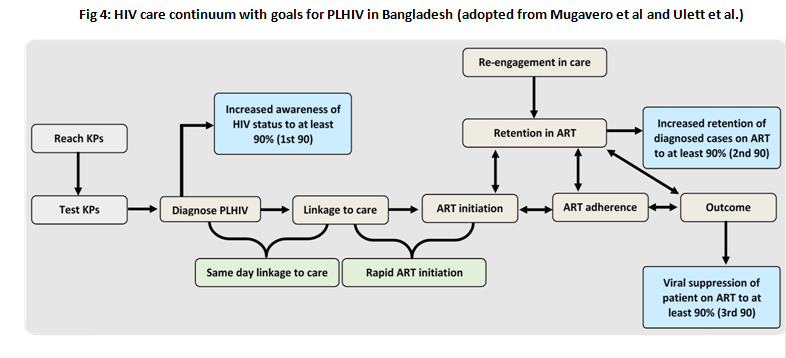
Early linkage to HIV care is a vital step within the HIV care continuum. Therefore, the “Test and treat” strategy recommended by WHO will be strengthened to ensure timely linkage and early initiation of ART. The program will prioritize linkages to ART centres / CDIC preferably on the “same day” their HIV positive status is known (if conducted in the evening, this may need to be linked on the following day) at NGO service centres/GoB ART centres and ART will be initiated as soon as the patient is ready, preferably within a 7-day window. Case management staff [Peer Navigator (PN)/Peer Outreach Worker (POW) or Community Peer Counsellors (CPC)] will be key actors of patient navigation or case management. For KP, as soon as an HIV positive client will be identified in the DIC/ SDIC/ Outlet/ Satellite, MA will immediately communicate with case management staff. The case management staff will accompany the identified PLHIV to the GoB ART centres or linked to CDIC for ART. To facilitate linkage from testing to treatment, various activities are planned such as: i) accompanied referral with conveyance allowance support; ii) ensuring baseline testing; iii) booking appointment with ART physicians; and iv) ensuring prompt treatment enrolment. Similar services at the same facilities (if possible) will also be available for HIV positive partners/spouses/children of PLHIV. Programmatic experiences indicate that these selected linkage and case management activities improved enrolment and adherence outcomes. ART retention among MSM and TGW increased from 47.7% to 86.2% since the case management program started in 2018; the remaining 13.8% were, for various reasons, not ready to start, but were in touch with PNs; no case was lost to follow-up since the case management program started. No data is available on how many of them were linked to ART within a week.

Despite the positive outcomes of the case management program, several challenges remain. Firstly, due to limited number of ART centres, PLHIV often have to travel long distances for consultation and medication. Given their poor financial circumstances and lack of stable housing, they cannot afford travel and base line diagnosis costs. Secondly, PLHIV refrain from HIV status disclosure due to anticipatory fear of multifaceted stigma, discrimination and exclusion from service providers and the mainstream community. It was also challenging to find available physicians in the ART centres who were adequately motivated to provide ART services to PLHIV. Thirdly, PLHIV were often lost to follow up in absence of adequate adherence support. Many PLHIV suffer from co and multi morbidity, forgetfulness, depression, anxiety and other mental health problems. ARV side effects and inadequate nutritional support have also hindered ART retention. Fourthly, capacity of PN/POW/CPC is a constant issue that will be enhanced through several capacity enhancement initiatives and supportive supervision. Fifth, tracking lost to follow up cases and monitoring progress of PLHIV has been a challenge. Lastly, miscellaneous issues including lack of appropriate environment for counselling services at service delivery points, and mismatch of ART office hours with clients’ personal schedules served as retention barriers. Besides, inadequate capacity and knowledge of ART among service providers to work with PLHIV and lack of protection of privacy and personal information posed as challenges. In the above and subsequent paragraphs, we elaborated the strategies to address these challenges.

Case management staff assigned for PLHIV will coordinate their tasks with the MA of respective service centres to ensure linkage, follow-up and retention within care, by maintaining PLHIV confidentiality and privacy. To ensure quality of care, community counsellors for respective KP will oversee treatment, care and support.

See the diagram below for an overview of interventions and actions that together will ensure improved linkage to and adherence to ART treatment and care.





Under the counsellor’s supervision, case management staff (Case Manager/PN/POW/CPC) will conduct one-to-one and group education sessions for treatment literacy, and provide ART adherence counselling both in-person and over the phone. Nutritional support will be available for PLHIV and monthly adherence support will be provided for PLHIV and their family members. The linkage and subsequent ART prescriptions will be followed up so that any loss to follow up (LTFU) cases will be notified early.

ART coverage for PWID will be revised/increased from 1,160 to 1,238. As part of case management, they will conduct intensive outreach visits (including home visits) to situate missing clients and bring them back under care with continuous motivational and psychosocial support to maintain adherence. Special focus i.e. deploying specific PN/case manager will ensure ARV retention of homeless PLHIV. Case management staff will remain in close contact with the PLHIV and remind them of their appointments for ART refill and/or clinical/psychosocial consultation and provide ART stock reminder phone calls to ensure uninterrupted ART support. Stable clients will refill their ART from outlets to reduce loss to follow up and improve adherence. During delivery of ART, standards of care will be maintained along with privacy and confidentiality.

The existing government-operated ART centres and HTS centres will continue to provide services for initial scale-up at priority districts. ART refill centres will be established, following the successful model of community-located ART centres, keeping in mind the PLHIV’s convenience, thus scaling up treatment coverage and facilitating retention in care. In addition to ART services, baseline and periodical investigation facilities and viral load monitoring services will be provided from ART centres to sustain a 90% viral suppression rate. Moreover, with support from PRs/stakeholders/ART management team, ASP will update the Standard Operating Procedure (SOP) which includes planning for CD4 testing, viral load optimization, multi-month ART prescription for stable cases, care of non-viral load suppressed cases, etc. ASP, in collaboration with DGMIS, will further strengthen the national PLHIV database to track and follow-up PLHIV regarding their ART intake. In this context, ASP recently appointed counsellors and MT labs in each ART centre who will provide daily updates and input services provided to PLHIV in the database. In year one, this approach will be piloted in three ART centres and, if successful it will be gradually increased to 10 centres by the end of the period.

Case management initiatives for PLHIV via PNs/POW/CPCs recruited from the respective KP communities will be strengthened through capacity development efforts.

Clients with stable ART intake who are living in remote locations will be provided with multi-month ART. In combination with prevention and treatment initiatives, community engagement communications, functional involvement of peers, SHGs, CBOs and other social mobilization initiatives will be combined to foster KP friendly services and ‘peer-to-peer support’. Retention in ART will be considered as a quality indicator, which will be included in the Performance Framework (PF).

Under the national ART guidelines, each (100%) PLHIV need to be tested for viral load at the baseline, 6 and 12 months after the initiation of ART, and on a yearly basis to follow-up the treatment and early detection of treatment failure. CM/PN/POW/CPC will ensure that the viral load test is conducted for all PLHIV at the recommended time through the accompanied referral system. An indicator on viral load suppression will be included in the PF. In the event that any PLHIV has a high viral load (>1000 copies/ml), they will be followed up with a repeat viral load test, evaluated for non-adherence, and an ARV drug resistance test will be performed if indicated (subject to availability). Based on the report of the ARV drug resistance test, the necessary treatment regimen (2nd line) will be provided. PN and PLHIV coordinator/POW/CPC will be in touch with PLHIV under close supervision of the counsellor, assigned medical assistants and medical doctor of the program.

Since 2019, ASP has been implementing viral load testing for PLHIV through the GeneXpert machine, an innovative and cost-effective approach, especially for a resource-limited setting like Bangladesh. Viral load testing and monitoring facilities are currently available at seven ART centres. ASP will expand this facility to all 11 ART centres in order to ensure all PLHIV have access to viral load testing and to increase viral load coverage among PLHIV. To optimize the use of GeneXpert machines and reduce the cost (compared to rt-PCR), they are only used for viral load testing, not for HIV testing. A portion of the viral load testing kits is planned under this grant; the remainder will be available under OP fund.

Objective 4: Capacity building, health system strengthening, empowerment

Outreach staff (including PE and OW) are the backbone of prevention efforts and play a pivotal role in spreading awareness about HIV, distributing condoms and lubricants, building HIV prevention skills and linking marginalized populations to HIV testing services. In the forthcoming program, outreach will be ‘professionalized’ with a clear vision on professional growth. A new job description, as well as clearly defined processes for their recruitment, their training, expected work procedures, knowledge and skills, expected reporting tasks, and the supervision they should receive will all be stipulated in the planned Manual of Procedures (MOP) and will be standardized across the program.

For the PWID program, both POW and non-POW volunteers/peers will be recruited from a pool based on recruitment criteria defined in the MOP (which will include an SOP for outreach). The PWID network will be actively engaged in the process. At the most vulnerable locations of Dhaka (A1), 1:1 pairing of peer and non-peer outreach workers will be deployed to assume shared responsibilities Better remuneration is planned to uphold their morale, considering national standards. Outreach activities of POW will technically be supervised and mentored by Field Organizer, Medical Assistant and Counsellor. A detailed training plan will be rolled out. Before deployment in the field, each POW and non-POW will receive basic training followed by seven days’ placement in the field under the joint supervision of PWID network and designated staff of CDIC. The current Outreach training module will be revised by national and international experts and training will emphasize active participation and skill transfer.

Training programs will be organized by ASP and other PRs for both case management staff and public health care providers either centrally or at ART distribution points to provide differentiated HIV treatment services within a KP friendly environment without discrimination. Quarterly or biannual coordination meetings will be organized with all relevant stakeholders involved in the treatment and care process to analyse the barriers to care, remove bottlenecks and strengthen coordination to facilitate linkage to and retention in care. Throughout all steps, community members such as people in the PLHIV network will be closely engaged and their feedback will be considered.

For PWID programs, three tier capacity building, i.e. written guidance note, virtual/physical training sessions and hands-on orientation will be continued to capacitate staff on OST. On the other hand, each CDIC will routinely (quarterly) organize orientation sessions and sensitization meetings at their catchment areas to enhance knowledge of the local law enforcers on drug, drug use, OST, criminal justice system and HIV.

Service providers of the HIV program will be trained on TB-related services to capacitate them to administer TB-related services. Similarly, some providers from the TB program will be trained on issues pertaining to HIV screening. National Tuberculosis Program (NTP) and its partners (PR, SR) will be coordinated for better implementation of these activities at the district levels and below. An indicator will be included in the PF to assess the progress of TB/HIV related activity.

TB-HIV service integration: The National Tuberculosis Program (NTP) and its implementing partners have been providing TB services in 68 prisons since 2014. This platform will also be utilized to render HIV services. Under the leadership of a National Working Group, a coordinated effort will be made between ASP, NTP, UNODC and Save the Children attempting to scale-up HIV/TB services in prison and other closed settings in Bangladesh. The program will follow set guidelines and protocol for prison intervention, originally developed by UNODC for its member states. The intervention at the prison setting includes establishing a national technical working group on HIV and TB consisting of officials from both Home and Health Ministries, and an assessment to identify the needs, challenges and opportunities in developing and implementing HIV intervention programs in prisons. UNODC/UNAIDS will mobilize resources to provide the required technical assistance.

Advocacy workshops will be conducted at the national level to sensitize key stakeholders on harm reduction and human rights pertaining to HIV interventions in prisons, and capacity building of NTP partners and health staff in persons will be done to deliver HIV services in selected prisons. This initiative will be orchestrated by ASP. There will be provision of combined HIV/TB messages, HTS, and HIV screening for TB patients and other high-risk groups in prisons and through mobile vans, ARV and OST dispensing among prisoners. This will be done by ASP in collaboration with NTP, Save the Children and its SRs. Dialogue regarding the next steps will be initiated, such as establishing a strategic information system on the epidemiological situation, behavioural factors, modes of transmission, availability, quality and coverage of relevant healthcare services in prisons.

Outside the prison setting, some national and PR specific activities have been planned. ASP will ensure HIV testing among people with TB through DOTS centre by supplying HIV test kits and relevant training of the staff and through 28 HTS centres. 19-35% of the newly diagnosed TB and relapse TB cases will be tested under this grant. Each year, approximately 292,000 TB cases are diagnosed in the country, of whom 19% is targeted in year 1 for HIV testing, which will gradually be increased. A strong collaborative link will be established with the DOTS centre of the TB program. PLHIV who have symptoms of TB, will be screened for TB using GeneXpert technology. Detected TB cases among KP and PLHIV will be linked with the DOTS centre. Further TB treatment follow-up and routine linkages will be performed by DOTS centre and POW at the CDIC/outlet levels. Quarterly coordination meetings will be organized between the stakeholders representing both disease components for better coordination and planning, and optimal utilization of resources. NTP has recently been supporting drugs and capacity building initiatives for initiation of Isoniazid preventive therapy (IPT) for PLHIV who are not TB positive, which will be expanded to all ART centres. NTP has procured and supplied GeneXpert machines across the country, thus also ensuring its availability at all ART centres. To reduce stigma and discrimination towards TB and HIV, ASP has been facilitating campaign programs through mass media including electronic and print under OP fund which will continue till 2023. TB-L and ASP Operational Plan is organizing seminars and workshop at different levels under 4th OP, where both diseases are discussed with participants.

Objective 5: Advocacy for an improved enabling environment

A National Working Group on Drug Policy and Harm Reduction will be formed to provide overall guidance and strategic direction to undertake specific advocacy actions. UNODC Bangladesh office will be supporting the Government of Bangladesh in leading the process of developing a training curriculum for police as well as institutionalize the curriculum in academic courses of the Bangladeshi Police Training Academy, in coordination and collaboration with other UN bodies. SCI will invest in orientation, sensitization and advocacy for law enforcers on HIV and harm reduction program in all harm reduction sites.

A recently established National Task Force (NTF) will be utilized to advocate against legal impediments against male-to-male sex and against male sexual health programs in Bangladesh. Gender and human rights remain at the core of the overall program approach with continued advocacy efforts conducted at the field- and central government level.

The coming grant will also work towards initiating HIV services in prisons, starting with Dhaka prison, in collaboration with the National TB Program and UNODC. The NTF will provide advocacy support for these challenging efforts, which will be carefully documented in order to be useful for future policy and intervention design development. UNODC will support the develop the training curriculum for the law enforcing agency especially for police, based on the developed training module, TOT will be imparted by ASP and few beaches training will be conducted under this proposed grant in collaboration with Bangladesh Police by signing a MOU.

Objective 6: Improving M&E, client tracking and operations research

For M&E data collection, monitoring, reporting and further use in decision making, a set of simplified and effective tools will be developed for use in the new grant. The number of forms/formats/tools and number of variables in each tool will be reduced to a more feasible level, especially for POW. Thus, the existing M&E framework will be further revised and simplified. Training on data analysis and its use will be organized and continuous data use will be conducted.

ASP will provide support to conduct a capacity assessment by the local funding agency (LFA) in terms of its ability to conduct oversight, procurement, HR experience, financial management capacity and provision of differentiated service to KP by the selected health facilities and community workers, in preparation for ASP’s enhanced role in implementing HIV service interventions for KP.

A routine surveillance system involving program, M&E and internal control personnel is in place and will be continued to monitor any diversion of HIV commodities, i.e. needles, syringes, condoms, ART medications, etc. The ongoing initiatives to penalize those who are involved in these practices will be continued, strengthened and reinforced. Moreover, communication will be enhanced towards local pharmacies and diagnostic centres to prevent them from buying needle and syringes from the respective outreach staff.

There is paucity of data about gender-specific barriers to HIV and harm reduction services. This necessitates an assessment to better understand the gender-specific barriers in implementing interventions with WWID, female and transgender sexual partners of men who use drugs, and transgender people who use drugs and ensure that a tailored set of prevention and care interventions adequately address these barriers. UNAIDS will provide technical assistance and mobilize resources for this assessment.

A feasibility study will be conducted to assess the direct contracting of outreach workers versus contracting community-based organizations (CBOs) which have pre-existing relevant experience with KP. This study is aimed to measure the cost-effectiveness, quality, acceptability, workload impact and ability to achieve a standardized quality service package consisting of both options before finally deciding the contracting modality. A dissemination session will be facilitated with relevant stakeholders, especially considering the inputs of KP, in order to finalize the report. Based on the report findings, ASP will decide the subsequent intervention steps. The cost of the study is budgeted in this grant.

Several sessions of dialogue will be conducted with KP to understand their willingness and recommendations to uptake services from hospital, and sessions will be conducted by consultant, seeking assistance from KP networks. The dialogue will be in Dhaka and other major cities. Around 15 KP will attend each session, and an enabling environment will be constructed so that KP can non-hesitantly express their opinions. These sessions will also constitute part of the assessment.

To promote an enabling environment, greater understanding of KP, readiness of service delivery points ASP will conduct meetings/workshops at those selected hospitals with hospital departments, existing ART/ HTS/ PMTCT program, which will also be attended by DNC, law enforcement agencies, NGO PRs, and local CBOs. A strong referral system will be developed within the hospital’s different departments to ensure that critical STI, HTS. HCV and other services are made available for KP clients.

## 2.2 Funding Priorities

1. Based on the [Global Fund Modular Framework,](https://www.theglobalfund.org/media/4309/fundingmodel_modularframework_handbook_en.pdf) use the table below to detail **each** **prioritized module** proposed for Global Fund investment for the relevant disease component(s) and/or Resilient and Sustainable Systems for Health (RSSH).

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

|  |  |
| --- | --- |
| **Module # 1** | **Prevention - MSM and TG (*hijra*)** |
| **Intervention(s) & Key Activities** | **Intervention**: Condom and lubricant programming  **Activities**: Peer outreach staff who include the Peer Educators (PE) and Peer Associates (PAs) will promote and distribute condoms and lubricants to 32,500 MSM and MSW and 5,000 TG (*hijra*), free of cost at cruising sites, from drop-boxes of service delivery points (SDP) [14 DIC, 18 Sub-DIC, 18 Outlets and 13 Satellites], and community-based depots. For cost-efficiencies and to move closer to the community, differentiated service modalities have been deployed to ensure continued and expanded coverage. In each of the 14 DIC, more than 900 MSM, MSW & *hijra* will be served. Additional services, such as referral linkages for coinfection and comorbidities will be done via the DIC. Besides the 14 DIC, 18 sub-DIC will serve 650-800 respective KP per sub-DIC. In addition, 18 outlets will be serving 350-550 KP per outlet. Furthermore, 13 satellites spots will be selected near the community and each satellite spot will provide services to smaller groups of fewer than 250 MSM, MSW & *hijra*. Information Communication Technology (ICT) based interventions (i.e., mobile app, web application, SMS, voice-SMS) will be used to communicate to hitherto unreached groups, including unreached groups of the upper class of MSM, to ensure they also receive services either from the SDPs or from their preferred settings.  **Intervention**: Behaviour change interventions  **Activities**: PE and PAs will conduct individual- and group-level behavioural change communication (BCC) activities at various outreach locations. BCC consists of the promotion of consistent condom use, the importance of regular HIV testing and STI services, how to have safer sex etc. PE will use ICT based interventions to strengthen outreach activities and routine communications with their clients as well as to contact unreached MSM, MSW and *hijra* operating online services. Various ‘syndemic’ co-and-multi-morbidities, including STIs, TB, Hepatitis, and mental health, will be incorporated in the training of PE and in the screening of clients, and referral to appropriate public healthcare facilities will be ensured. To address substance use, including methamphetamine, service providers will be trained to counsel clients on this issue and refer them to government and non-government healthcare facilities.  **Intervention**: Sexual and reproductive health services, including STIs  **Activities**: The treatment of sexually transmitted infections (STIs) will be continued using the syndromic management approach as per the National STI management guideline, alongside management of basic general health complaints. Recurrent, non-responsive and complicated STIs will be referred to government healthcare facilities for etiological management. Clients’ risk will be assessed by PE, MA/OS but if they are embarrassed, they can also use a mobile app and website to do a self-risk assessment for STIs. In the coming grant, linkages with SRH services will be strengthened for diagnosis, treatment, and counselling of female partners of MSM. On a pilot basis, two public healthcare facilities in two different districts will be utilized to explore the feasibility and acceptability of public health-facility-based health services targeted towards MSM and *hijra* (including STI,HTS, Reproductive Health and HIV services); PE or DM/SDIC-in-Charge will be based and operate from these two ‘KP-friendly government hospitals’ to help clients navigate the services. The aim of this pilot is to assess to what extent a KP-friendly hospital approach can be scaled up in the near future.  **Intervention**: Interventions for young KP  **Activities**: Young key-populations and most at-risk adolescent MSM and *hijra* will receive free-of-cost preventive services including condoms and lubricants, BCC, STIs, HTS and other SRH services, using language appropriate to their age.  **Intervention**: Addressing stigma, discrimination, and violence  **Activities**: Advocacy sessions with various groups of stakeholders (i.e., religious leaders, local influential people, members of law enforcement agencies, journalists, GO/NGO officials, round table meeting with media etc.) will be conducted at intervention sites to facilitate program implementation. Stigma, discrimination, and violence-related issues will be addressed via group education sessions and life-skill education trainings. Referral/linkages will be established with service providers for providing medico-legal and psychosocial support services to address GBV and Human Rights violations. The National Task Force, established under the leadership of the National Human Rights Commission and ASP, will continue to safeguard KP’s human rights through providing relevant services.  **Intervention**: Harm reduction interventions for illicit drug use  **Activities**: A recent study conducted by icddr,b uncovered significant HIV risks and vulnerabilities associated with methamphetamine use among KP [21,22]. Based on the findings, in the coming grant, services for meth-using MSM, MSW and *hijra* will be enhanced by making service providers in the service centres more capacitated and equipped to handle and provide counselling about issues relating to methamphetamine use. Meth use will also be incorporated into the training module for PE and other health care providers. Peer support groups will be arranged regularly to disseminate educational information about the risk of methamphetamine use. Referrals and linkages to relevant mental health services will also be established. Moreover, a national guideline will be developed for managing people who use methamphetamine, with particular emphasis on socially marginalized populations.  **Intervention**: Prevention and management of co-infections and co-morbidities  **Activities**: A recent study conducted by icddr,b [24] demonstrated that community based TB screening by PE may increase presumptive TB case identification, TB case detection and TB related knowledge. Based on the findings, a community-based TB screening model will be implemented alongside verbal TB screening at facility in order to enhance TB-case detection and subsequent treatment among MSM/MSW/*hijra*. Presumptive TB cases will be referred to DOTS Centres for diagnosis and treatment. Management of co-infection and co-morbidities of PLHIV such as Hepatitis B & C will be provided through accompanied referrals to government hospitals at the 37 districts where interventions will be in place. Accompanied referrals for anal cancer, mental health problems and non-communicable disease (NCDs) will also be initiated at government health centres. Advocacy initiatives, such as regular coordination with Civil Surgeons and orientation and training workshops with the government. physicians on KP related issues will be conducted to facilitate the availability of KP friendly services from the public healthcare facilities.  **Intervention**: Community empowerment  **Activities**: Community partnership linkage and coordination will be maintained and safe spaces will be maintained for community members. Most of the field level staff will be community members. Besides, icddr,b will involve more capacitated CBOs in program implementation and in organizing community advocacy meetings. CBOs will continue to be involved in the treatment, care and support for PLHIV. Community members and CBOs will also be involved in advocacy with local and national stakeholders. It is important that CBO representatives are trained in leadership skills, public speaking skills, negotiation skills and that they are assisted to build their self-confidence.  **A PrEP implementation research and intervention has been proposed in PAAR due to limitation of funding in the current grant.** |
| **Priority Population(s)** | Men who have sex with men (MSM), including male sex workers (MSW), and TG (*hijra*) (i.e., all kinds of *hijra*, who sell sex or live on traditional *hijra* occupations) |
| **Barriers and Inequities** | Bangladesh Penal Code (BPC 377) criminalizes male-to-male sex to the harshest degree (i.e., ten years jail or life imprisonment). Moreover, due to socio-cultural constructs, religious prohibition and gender norms, sexual practices of MSM and *hijra* are stigmatized. Feminized MSM (*kothi*) and *hijra* are socially excluded and subjected to human rights violations. Their access to health and other services remains limited and because of internalized and enacted stigma and discrimination associated with their sexual practices. |
| **Rationale** | This module has been particularly prioritized because of the high epidemic potential in MSM and *hijra* populations. In several neighbouring countries, significant HIV epidemics have been reported among MSM, MSW and transgender populations [23].  This is primarily attributed to their engagement in unprotected male-to-male sex, as projections from epidemic modelling exercises have demonstrated that male-to-male sex will account for 54% of the new HIV infections in Dhaka by 2020 even if the current intervention coverage remains stable and current behaviours such as condom use, management of sexually transmitted infections are sustained at current levels [27]. *Hijra* also warrant prioritization since they were found to have the highest rates of active syphilis and oral STIs, particularly an ~10% prevalence of oral gonorrhea [28, 29]. Further, programmatic data for the last three years (2017 to 2019) alluded to an increase in HIV infection among MSM and *hijra* (p=0.02)*.* Surveillance data and research studies have indicated inconsistent condom use among both MSM and *hijra* [7, 8, 9].They remain in the sphere of vulnerability due to violence, sexual abuse, criminalization of male-to-male sex, and fundamentalist attacks from bodies which condemn same-sex behaviours [30]. Recent research depicted their concerning use of methamphetamine, which predisposed them to risky sexual behaviours [21, 22]. Moreover, MSM and *hijra* have expansive socio-sexual networks, which provide avenues for HIV transmission, e.g. to via spouses, transactional sex clients, drug-injecting partners, etc (9, 27). Furthermore, these populations are resistant or reluctant to seek care from public healthcare due to discriminatory and antagonizing behaviours from healthcare providers [31]. |
| **Expected Outcome** | Improved safer sex behaviour to reduce HIV and STI incidence among targeted MSM, MSW and *hijra*. |
| **Expected Investment** | US $ |

|  |  |
| --- | --- |
| **Module # 1** | **Prevention- Female Sex workers and their clients** |
| **Intervention(s) & Key Activities** | **Intervention:** Condom and lubricant programming  **Activities**: *PR-SC* will provide free condoms and lubricants in 13 districts for 30,000 FSW. Condoms and lubricants will be distributed at spots by peer outreach workers (POW), and also from DIC, outlets and depots. To ensure off-hour condom availability, depot holders (e.g. shopkeepers, pimps, madams, etc.). will be engaged. POW will be recruited from the community and their work area will be defined based on concentration and modality of sex trade, settings, e.g. street, hotel or residence.  Considering the high HIV prevalence among the WWID, who mostly are female sex workers in specific pocket of Dhaka, the ratio of POW to street based FSW will be 1:60, whereas it is 1:70 and 1:90 in remaining parts of Dhaka and other districts respectively.  For hotel and residence based FSW, one POW will be responsible for reaching FSW in seven hotels and ten residences on average, respectively. They will be paired with hotel boys and residence madams.  In addition to the free condoms, multiple brands of condoms will be available for purchase among the hotel and residence based FSW for those who have ability to buy these. A proportion of required condom will be procured from the grant but gradually it will be collected from the government sector programs.  *PR-ASP* will provide HIV services from public hospitals to 1250 FSW in 5 district hospitals by engaging FSW outreach workers or peer educators at a ratio of 1 PE per 60 FSW from the middle of year 1 (3rd and 4th quarter) of the grant cycle. In association with hospital authority and network, Apart from PE, FSW will also receive condoms from the hospitals as per their requirement. Condoms will be supplied from OP fund.  **Intervention:** Behaviour change interventions  **Activities**: *PR-SC* will implement three approaches for BCC: 1) One to one and group sessions using appropriate IEC materials; 2) Social interaction with friends, family and the community through games, theatre, creative works (e.g. developing products), social networks (offline and online), and local level sensitization and advocacy. 3) Development of life skills to support business development and marketing to ensure rehabilitation and livelihood for FSW. Capacity will also be developed so FSW may access social justice and public facilities especially for health care. For hard-to-reach / unreached FSW virtual space-based BCC will be designed. Online assessment of risk behaviour will be introduced.  *Under PR-ASP* hospital-based counsellor will have sessions with the FSW to help them reduce their HIV risk during hospital visits. Also, PE will conduct one to one and group sessions at the field level using IEC/ BCC materials.  **Intervention:** Sexual and reproductive health (SRH) services  **Activities**: *Under PR-SC*, comprehensive SRH services will be offered to FSW. Shifting of SRH services from community set-up to government facilities will be gradually increased from 25% in year one to 45% in year three throughout the grant period. MA will provide counselling, pregnancy test and enhanced syndromic management of STIs either at DIC/Outlet, or at satellite spots. On the other hand, pregnancy care, cervical cancer screening, and etiological management of STIs will be linked with government/semi-government/NGO health facilities. Referral linkage will also be available with private practitioners through voucher schemes. Continuous capacity building and clinical supervision of the service providers will be ensured through formal and on-the-job training and mentoring.  *Under PR-ASP*, hospital-based SRH services will be provided for FSW when necessary. Health checkups will be offered to them, including HTS, (6-monthly) STI screening (6-monthly), as well as hepatitis B and C screening, and addressing other reproductive health problems. FSW will get psychosocial counselling during health check-ups. An enabling environment will be ensured for KP in participating hospitals.  **Intervention:** Interventions for young KP  **Activities**: Bangladesh has adopted the UN definition of adolescents (10-19 years of age). There is limited information regarding services for street children who are involved in sex work. Almost a fifth (17.4%) of FSW are between 10-19 years and 35.4% are aged 20-24 years. More than half (55.8%) of the FSW reported to have their first sex before the age of 15 years. Considering the importance of providing services to adolescent sex workers, MOHFW issued a Circular to provide prevention interventions and HTS to them without needing consent from their legal guardian. PR-SC will reach adolescent FSW with a customized, age-appropriate package of services, including the recruitment of adolescent POW in every DIC. An adolescent network will be formed to link young FSW with national social safety nets and alternative schemes; this can include support to obtain birth registration enabling them to apply for national ID card, passport, driving license, bank account, etc.  **Intervention:** Addressing stigma, discrimination, and violence  **Activities**: ‘Community Squads’ and ‘DIC-based Community Group’ will be utilized to respond to sexual violence and social harassment by *PR-SC*. A hotline number will be operational through Sex Workers Network of Bangladesh (SWNoB). The SWNoB and CBOs will be engaged for advocacy with local religious and political leaders, and law enforcement agencies for social support and combating violence. Functional linkages will be established between human rights organizations and SWN/CBOs. Strategy documents, manuals, guidelines, training modules, BCC materials, etc. will be developed or updated for advocacy in association with ASP. A systematic recording, reporting and response mechanism will be built within the intervention.  *PR-ASP* will arrange workshops, orientations and meetings at the hospital premises with hospital-based service providers and other relevant departments including district social welfare, law enforcement, district administration etc. officials under the leadership of Hospital Superintendent or Civil Surgeon to reduce stigma and discrimination of KP. Violence and discrimination reports will be shared in the meetings to discuss improvements in service quality.  Ensuring Gender based violence services: In each hospital there are one stop crisis (OCC) centres to address GBV under the joint implementation of Ministry of Home Affairs and the Ministry of Health and Family Welfare. Through establishing referral systems violence cases will be referred for necessary services to OCC. This referral system to OCC will be strengthened by organizing workshops between OCC and other hospital departments. PEP will also be provided through OCC if required.  **Intervention:** Prevention and management of co-infections and co-morbidities  **Activities**: Verbal screening for TB will be done at CDIC, DIC, Outlets, satellites and by POW by *PR-SC* and suspected cases will be referred to DOTs centre at Govt./ NGO facilities under the National TB Program (NTP) for further investigation and management. Functional referral networks will be established with relevant public and private facilities. IEC/BCC materials specific to TB will be used. Co-morbidities, mainly with TB, will be referred to relevant departments (e.g. NTP TB centre) in the same compound (by *PR-ASP)*.  **Intervention:** Community empowerment  **Activities**: FSW and their community will be empowered with rights and law literacy by *PR-SC* in order to foster an environment where FSW can raise their voice. It is important that FSW representatives are trained in leadership skills, public speaking skills, negotiation skills and that they are assisted to build their self-confidence. CBOs and FSW networks will be part of these efforts. For their economic freedom, cooperatives will be formed. Necessary initiatives, such as training on program and financial management; support for organizational policy review and update and leadership development will be taken for the SWN and CBOs. The SWN will lead and implement outreach team mentoring and community-based monitoring. A set of guidelines, policy documents, tools and form/formats will be adapted or newly developed for this. All the initiatives of community empowerment will be done in close collaboration with ASP.  **Intervention:** Harm reduction interventions for FSW using drugs  **Activities**: All outreach staff under *PR-SC* intervention will be trained on harm reduction interventions to ensure services for WWID who are involved in the sex trade. POW of DIC of Dhaka, Narayangonj and Gazipur will facilitate services required for WWID. These DIC will have provision for NSE and linkages with CDIC (of PWID intervention) for OST and ART. WWID will have access to both FSW and PWID DIC/CDIC/Outlet to avail services.  **Intervention:** Pre-exposure prophylaxis  **Activities: Activities related to PrEP has been planned in PAAR.** |
| **Priority Population(s)** | Female Sex Workers and their clients |
| **Barriers and Inequities** | Generally, sex work is considered a delinquent act. FSW are frequently victims of GBV. Municipal ordinances against soliciting place them at high risk for police harassment [12, page 2]. There are some punitive laws which trigger legal harassment, though the penal code does not criminalize sex work. Abuse of punitive laws hinders the program implementation for FSW and disrupts consistent availability of condoms. In addition, there are instances, when FSW are compelled to do sex without condom. FSW themselves neglect SRH issues including HIV testing due to self-stigma, and discrimination from the service providers. |
| **Rationale** | Though condom use rate has increased among the FSW over the period; younger FSW have riskier behaviours with a greater number of clients and less access to HIV prevention programs [8, page 80, 120]. Also, there are knowledge gaps on HIV, STI and safer sex practice with consistent condom use. The investment case 2019 reported, if the current prevention programs among KP discontinued after 2020, the estimated PLHIV in Bangladesh would reach 81,154 by 2030 (Table 13) and among the most affected groups would be the ‘clients’ of sex worker [16, page 39, table 13]. The clients are a bridging population. The geographical prioritization has been done based on FSW concentration and prevailing sex trade. |
| **Expected Outcome** | Safer sex behaviour increased among FSW; reduced number of new HIV infections and STIs among targeted FSW and their clients. |
| **Expected Investment** | US $ |

|  |  |
| --- | --- |
| **Module # 1** | **Prevention - People who inject drugs** |
| **Intervention(s) & Key Activities** | **Intervention:** Needle and syringe programs  **Activities**: 24/7 availability of syringes and needles, especially in early morning, late night and other off-hours, will be ensured through a duty roster among POW and peer volunteers. In addition to primary distribution channels of needle syringes in the spot through POW (50%), secondary channels (10% by pharmacy, grocery shop, rag pick shop etc.) and fixed facilities (20% by CDIC, DIC and outlet) will be utilized, following a pre-determined plan. The use of vending machines and mobile vans (15%) will be piloted to reduce the distribution loads on POW. Though there are challenges regarding willingness, storage, recording, reporting, monitoring and diversion, the current program has learned important lessons which will be utilized in the coming grant. There will be an SOP for the collection and disposal of the needle-syringe and other medical waste. Emphasis will be placed for continuous orientation of POW, non-POW, volunteer, PWID and people around drug trade on safe injection practice and safe disposal. Similarly, routine campaigns (quarterly) around drug spots will be organized on safe injection and safe disposal. Items for aseptic precautions, such as utility gloves, forceps and puncture-proof bags, will be supplied. In addition, waste-bins and collection boxes will be placed at drug spots, and with the people around the drug trade (e.g. pushers and peddlers). The collected needles and syringes and other medical waste will be handed over to ‘PRISM Bangladesh’ for incineration according to the current mechanism.  *PR-ASP* will provide service to 3,000 PWID in five districts (Chattogram, Jessore, Sirajgang, Pabna and Barisal). The target will be 80% of NSP targets for PWID of those four districts. NSP will be conducted at outreach as well as from the government district hospitals through Peer Educators (PE). Other outreach services will also be offered by Peer Educators (PE to PWID ratio 1:60). Needles and syringes will be procured with funds under the OP.    **Intervention:** Opioid substitution therapy (OST) and other medically assisted drug dependence treatment  **Activities**: A total of 3500 PWID will receive OST services from NGO-PRs. *PR-SC* will provide OST services to 2,600 PWID from 8 CDIC, and 4 standalone OST centres (2 in government facilities and 2 in NGO set-up). Priority will be placed on enrolling WWID as well as those who are HIV positive. Appointment of clinical psychologists as counsellors in addition to qualified physicians and nurses, ensuring take home dosage, setting up satellite OST dispensing corner in other facilities, etc. will in place. Regular follow-up for mental health support, adherence and retention will be done by clinical psychologists, following an appointment schedule.  *PR-icddr,b* will provide OST services to 900 PWID. Among them, 500 PWID will be continued from current grant period, 100 PWID will be enrolled during 2020 and 300 PWID during April 2021-June 2022. To provide OST services among 300 PWID, two centres will be established in Chattogram and Khulna at the Divisional Narcotics Treatment Centres, under the Department of Narcotic (DNC), GoB which will later take over these centres under government health sector program from July, 2022 after the necessary transfer of skills. icddr,b will continue providing OST services to 600 PWID after July, 2022. PR-icddr,b will provide methadone under the supervision of an experienced team of a doctor, psychologist nurse to assure quality of care in all of its settings.  Major factors contributing in loss-to-follow-up in the OST program are a lack of patient readiness, distance to OST distribution spots, inadequate methadone dosage, and absence of take away/home doses. In this grant, standard operating procedure will be updated and relevant team members will be oriented and provisions will created to prepare patients, enhance satellite dispensing and introduce take-away/home doses. Required quantity of methadone hydrochloride, general health drugs, and clinical consumables will be procured by respective PRs. PRs will provide services from different locations. Furthermore, overlapping will be minimized through regular coordination between PRs.  **Intervention:** Overdose prevention and management  **Activities**: IEC/BCC materials will be produced by *PR-SC* to inform PWID on opioid overdose and its prevention. In addition, outreach staff, partners of sharing networks and their family members will receive orientation on causes and signs of overdose and how to manage it. A referral network with nearby government health facilities will also be strengthened for overdose management.  *Under PR-ASP* hospital-based physicians and counsellors will be trained on overdose management to provide services to the PWID. Naloxone to manage overdose will be procured from OP fund.  **Intervention:** Condom and lubricant programming  **Activities**: Free distribution of condoms will be continued and expanded as per the needs of PWID through peer outreach workers, mobile vans and from DIC/CDIC and outlets by *PR-SC*. Most WWID are involved in sex trade; they will be provided lubricants as well.  *Under PR-ASP* free condoms will be available at the hospitals and, through peer educators, at outreach sites for PWID. Procurement will be under OP funds. Promotional activities using IEC/ BCC tools will also be conducted to promote condom use.  **Intervention:** Behaviour change interventions  **Activities**: *PR-SC* will apply the following three approaches for behavioural change of PWID around using of sterile needles-syringes; reducing sharing; exchanging used needles-syringes; using condoms; and availing OST, HTS, ART, co-infection management, overdose management, and SRH services – 1) One to one and group sessions using appropriate IEC materials; 2) Social interaction with friends, family and the community through games, theatre, creative works (eg. developing products), social networks (offline and online), local level sensitization and advocacy; 3) Life skill development for better quality and healthy living.  *Under PR-ASP* hospital-based counsellors will counsel PWID to help them reduce their HIV risk, e.g. needle-syringe sharing, promoting safer sex, avoiding overdosing, etc. In association with hospital authorities, peer educators will be recruited who will conduct one to one and group sessions at the field level using IEC/ BCC materials.  **Intervention:** Addressing stigma, discrimination and violence  **Activities**: *PR-SC* will engage PWID communities and its network in advocacy with local leaders and law enforcers for reduction of violence. In addition, efforts will be continued to strengthen the harm reduction network, which was formed during the current grant to develop ToR, expand members’ enrolment, organize routine meetings to take strategic decisions. They, along with the NTF, will work to reduce the impact of NCA 2018. To support victims of harassment or in case of arrest of PWID, linkages will be established with human rights organizations both at central and district level. Strategy document, manual/ guidelines, training modules and BCC materials will be developed to build staff capacity on how to address stigma, discrimination and violence.  *PR-ASP* will arrange workshops, orientations and meetings at the hospital premises (at intervention sites) with hospital-based service providers and officials from other relevant entities including social welfare, law enforcement, DNC, rehab centres, district administration etc. under the leadership of the Hospital Superintendent/Civil Surgeon to reduce stigma and discrimination. Violence and discrimination reports (as recorded by NGOs or CBOs) will be shared and addressed in these meetings.  Furthermore, ASP as nodal body will coordinate advocacy initiatives taken by SCI and its SR CARE-B, NPUD along UNODC, UNAIDS using the NTF platform and other relevant settings.  As per UNODC plan, a training curriculum will be developed for police/ law enforcement agency. based on the developed training module, TOT will be imparted by ASP and few beaches training will be conducted under this proposed grant in collaboration with Bangladesh Police signing a MOU.  **Intervention:** Community Empowerment  **Activities**: PWID and their community will have better access to basic rights, such as, shelter, health and livelihood. Job opportunity for OST receivers will be created through linkage with corporate agencies under its’ corporate social responsibility or government social safety-net schemes. Community network and its member organizations will be engaged in issue-based advocacy to reduce stigma and discrimination and to address human rights issues with regional and national policymakers. To do so, it is important that PWID representatives are trained in leadership skills, public speaking skills, negotiation skills and that they are assisted to build their self-confidence. PWID network and their member organization will be supported. DIC Advisory Committee (DAC) at CDIC/DIC and Outlet level will be reformed which will be headed by law enforcers, to support harm reduction interventions.  **Intervention:** Prevention and management of co-infections and co-morbidities  **Activities**: Emphasis will be given for screening, diagnosis and treatment of HIV-TB/HBV/HCV co-infection by PR-SC. Initial verbal screening for TB will be done at CDIC/DIC/Outlet and suspected cases will be referred to Govt./NGO facilities for further investigation and management. Similarly, screening for HBV and HCV among HIV positive PWID will be done at CDIC/DIC/Outlet and confirmation will be done at referral centres i.e. at selected public/private facilities. After confirmation, necessary management will be done at CDIC level. IEC/BCC materials specific to TB/HBV/HCV will be used developed and used.    *PR-ASP* will be screening for co-morbidities including TB and HCV among PWID and refer cases to respective departments for treatment. Hospital-based MO will ensure follow up services for referred cases. Treatment for the HCV will be ensured through CDC, and TB with TDC, NTP, DGHS while the testing kits and VL-HCV are planned under the proposed grant  **Interventions:** Sexual and reproductive health (SRH) services, including STIs  **Activities**: Comprehensive SRH services will be provided to PWID, specially to WWID by *PR-SC*. Syndromic management of STIs will be provided. Etiological management of STIs will be linked at government/semi-government/NGO health facilities. PWID with psycho-sexual disorders (sexual problems, e.g. loss of libido, that are psychological in origin, rather than physiological) will be counselled and referred to government facilities. Continuous capacity building and supportive supervision of the service providers on SRH will be ensured through formal and on-the-job training.  *Under PR-ASP* hospital-based centres will provide SRH services for PWID. At least once in the year health check-ups will be conducted. Medical officer, counsellor and officials of other departments (if required) will ensure the health services for the PWID. Enabling environment will be ensured for the KP in hospitals. Required drugs will be made available using the OP fund. |
| **Priority Population(s)** | People who inject drugs and their partners |
| **Barriers and Inequities** | Injecting drug-use is considered a socially-deviant behaviour in Bangladesh. Stigma associated with this practice has a negative impact on the social acceptance and job opportunities for PWID; hindering their rehabilitation and reintegration into the community. [12, page 591]. According to the Narcotics Control Act (NCA) 1990, possession of tools used for taking drugs is punishable with a minimum imprisonment of six months. The newly amended law in the NCA 2018 imposes the death penalty or life-term imprisonment on drug traders, restricting their release from punishment for such crimes. However, a specific set of activities, i.e. the planned inclusion of drug and harm reduction topics in police training curricula, training and sensitization of law enforcers, local and national level advocacy, high level meetings, formation and support of a national level harm reduction working group should help to overcome some of the barriers mentioned above. |
| **Rationale** | The programmatic data of 2019 shows that, among the KP, PWID share the major proportion of newly detected HIV infections, i.e. 24% of the newly detected 919 cases in 2019 [15]. HIV is now no longer restricted to MWID within a pocket in southern part of Dhaka but has spread to MWID in other areas of Dhaka and to WWID as well. MWID in have risky behaviours and there may be further spread in the immediate future [7]. Therefore, to provide prevention services to PWID is crucial. |
| **Expected Outcome** | All types of risk behaviours of PWID including sharing of needles-syringes and paraphernalia reduced and quality of life improved among PWID |
| **Expected Investment** | US $ |

|  |  |
| --- | --- |
| **Module # 2** | **Differentiated HIV Testing Services - MSM and TG (*Hijra*)** |
| **Intervention(s) & Key Activities** | **Intervention**: Facility-based and community-based HIV testing services  **Activities**: Annually, 90% of reached MSM and *hijra* will be tested for HIV of whom some will be repeat cases based on their vulnerability (no data available but from the program experience, it is assumed as ~2%) and high-risk behaviour, and others will be new. HTS uptake was initially only 30% and took several years to reach 65%. According to WHO guidelines (2019), six differentiated HTS delivery approach will be employed for MSM and *hijra:* Facility-based HTS, community-based HTS, index testing, HIV self-testing, social network-based approaches and couple testing. It is anticipated that 83% of the HIV testing will be done through facility-based HTS; 12% through community based HTS, 2% each through HIV self-testing and social network-based approaches, and 1% each through index testing and couple testing. This is an assumption based on programmatic experiences; this percentage may vary. Linkages to HIV treatment and care to nearby public facility for PLHIV will be ensured by peer navigators (PNs). As a pilot, two government operated HTS centres in two different districts will be used for HIV testing for KP to examine the feasibility and acceptability of HTS offered to the KP along with clients from the general population. This is to be mentioned that increased coverage of HTS will be achieved by adopting different approaches. Such as, HTS team will be increased, community led mapping will be done within and beyond catchment area to identify KP and encourage for HTS, number of satellite sessions (including demand-based satellite sessions for full-time working beneficiaries and remote populations) will be increased. In the proposed grant the average operational cost of each DIC is USD 223.49, Sub- DIC USD 157.72, Outlet USD 47.17 and Satellite is USD 17.69. The average unit cost of all SC is USD 116.89 per month which is USD 165.34 in current grant. Therefore, we have reduced the SC operational cost drastically in the proposed grant. |
| **Priority Population(s)** | Men who have sex with men and TG (*hijra*) |
| **Barriers and Inequities** | Issues that hinder HTS uptake by MSM and *hijra* populations include fear/phobia of giving blood for HTS, the social stigma attached to male to male sex and HIV, and fear of social and economic consequences and perceived feelings of double stigma if tested HIV positive. These issues will be overcome by education and counselling by peer educators and counsellors and health providers. |
| **Rationale** | HTS need to be strengthened among KP as they are more vulnerable to HIV infection. Differentiated HTS delivery strategies will be performed for MSM and *hijra* for maximizing the detection of HIV infection. |
| **Expected Outcome** | HTS coverage increased for early detection and initiation of treatment to reduce HIV transmission to others and reduce morbidity and mortality of MSM and hijra PLHIV. |
| **Expected Investment** | US $ |

|  |  |
| --- | --- |
| **Module # 2** | **Differentiated HIV Testing Services - Female Sex Workers and their clients** |
| **Intervention(s) & Key Activities** | **Intervention**: Facility-based testing and community-based testing  **Activities**: Annually, around 90% of the targeted FSW (30,000) will be tested. Among them 36% will be tested at DIC/Outlets, 10% at Govt. HTS centres through referral and 54% via outreach. A provision has also been created for annual HTS of 10% of FSW’s partners. FSW and their clients will be mobilized for HTS from the community by the peer outreach workers, community groups, CBOs, network and through online. Index testing is already being introduced and will be continued. Spouses, children and regular partners of FSW who are in their drug and sexual networks will be tested via this approach. In addition to DIC/Outlet catchment areas, other sites such as FSW’ residence, congregation spots and other public gathering spots, like bus terminals, launch ghat and big bazars will be used for targeted HIV testing campaigns in order to bring unreached FSW into the service. Service providers will be trained accordingly.  PR ASP, is providing HTS from selected government hospitals (28 centres) for all population including TB patients, vulnerable populations and KP under OP fund through different approaches, e.g. facility and community based (among those are the five ASP proposed FSW intervention hospitals). It will conduct HTS for all populations including TB cases through its hospital-based HTS centres. At least 90% of listed FSW will also be tested from the 2nd year onwards from these facilities.  PR ASP is providing HTS service for FDMN population by providing HIV test kit to implementing NGOs in camp areas.  **Intervention**: Self-testing  **Activities**: In this grant, self-testing, either guided and or anonymous, will be piloted among 1,000 FSW and their partners. FSW reached through virtual spaces will be offered self-testing anonymously. A Facebook page with online IEC/BCC will be created. After successful piloting, further scale-up will be planned. |
| **Priority Population(s)** | Female Sex Workers and their clients |
| **Barriers and Inequities** | Fear of testing positive is an important barrier to testing for FSW. Further, there is a perceived risk of losing energy and strength if one draws blood. These barriers will be overcome by education and information provided by outreach staff and counsellors. |
| **Rationale** | HTS coverage need to be increased for early detection and initiation of treatment among FSW and its clients to reduce HIV transmission to others and reduce morbidity and mortality of PLHIV and to reach 90-90-90 targets. |
| **Expected Outcome** | HTS coverage increased for early detection and initiation of treatment to reduce HIV transmission to others and reduce morbidity and mortality of PLHIV among FSW and its clients. |
| **Expected Investment** | US $ |

|  |  |
| --- | --- |
| **Module # 2** | **Differentiated HIV Testing Services - PWID and their partners** |
| **Intervention(s) & Key Activities** | **Intervention:** Facility-based (CDIC/DIC/Outlet) testing  **Activities**: Annually, around 90% of the targeted PWID (14,035) will be tested. Among them 45% will be tested at CDIC/DIC/OST centre/Outlet, 5% at Govt. HTS centres through referral and 50% via outreach. A provision also been created for annual HTS of 15% of PWID partners. Mobilization for HTS will be done involving POW, non-POW and volunteer.  PR ASP will conduct HTS from the hospital for general population special emphasis will be given to test at least 90% of listed PWID through the 5 selected district hospitals. Besides this facility-based testing, ASP has the plan to conduct a biannual testing campaign in 4 selected non-intervention districts for PWID, in collaboration with local CBOs.  **Intervention:** Community-based testing  **Activities:** HTS will be offered to PWID at their residence and congregation spots by lay providers. Mass HIV testing campaigns will be organized at CDIC/DIC/Outlet catchment areas and public gathering spots to bring more unreached KP in contact with HIV services. Index testing will be strengthened for spouses and children, and regular partners of PWID (in their drug using and sexual networks). Demand generation will be done by community groups, CBOs and drug user network. MA will provide training to lay providers and supervise HTS.  PR ASP is providing HTS service for FDMN population by providing HIV test kit to implementing NGOs in camp areas.  **Intervention**: Self-testing  **Activities**: In this grant, self-testing will be piloted among 500 PWID and their partners in Dhaka A1 to assess acceptance among them. After successful piloting, further scale-up will be planned. |
| **Priority Population(s)** | People who inject drugs and their partners |
| **Barriers and Inequities** | Though access and utilization of HIV testing among PWID has increased over the years, partner disclosure and testing coverage is inadequate. Injecting and sex partners and children of PWID are often out of HTS. Many drug users do not disclose their drug use status and HIV positive status to their spouse/sex partners/family members due to fear of relationship break up. Thus, new case identification and linked HIV care is still a challenge. This can be overcome by building the capacity of outreach workers and counsellors, as well as case managers. To overcome the challenges, index testing among injecting and sex partners and children of PWID will be scaled-up. Similarly, psychologists (counsellor) of CDIC will give more emphasis on partner disclosure. |
| **Rationale** | HTS needs to be diversified among PWID for improved early detection and immediate initiation of treatment to reach the 90-90-90 targets. |
| **Expected Outcome** | HTS coverage increased for early detection and initiation of treatment to reduce HIV transmission and reduce morbidity and mortality of PLHIV. |
| **Expected Investment** | US $ |

|  |  |
| --- | --- |
| **Module # 3** | **Treatment, care and support** |
| **Intervention(s) & Key Activities** | **Intervention:** Differentiated ART service delivery and HIV care  **Activities:** A differentiated ART service delivery framework will be updated by PR-SC in coordination with ASP and icddr,b which will be implemented to support the national program. Afterwards, ASP will set-up necessary ART and ART refill centres closer to where most PLHIV reside. Following the framework and other national guidelines, all HIV patients will be educated during HTS, enrolment in ART on the importance of ART and the different service delivery models (ART and ART refill centres) to make an informed choice. Strategies like ‘same day linkage’ and ART preferably within 7-days will be implemented. Standards of care will be maintained along with privacy and confidentiality in the delivery of ART. Support groups of PLHIV (Networks, CBOs, SHG) will recruit, second and build capacity of Community Peer Counsellor (CPC) to conduct one-to-one and group education sessions to newly diagnosed PLHIV for treatment literacy, keeping patient appointments/ appointment reminder system and strengthen ART adherence through engagement with the caregiver, routine reminder phone calls and through home visit for those who missed consecutive appointment dates. PLHIV who are stable on ART and live in remote locations will be provided with multi-month ART and will be followed up by case management staff. CPC also navigate patients within the hospital premises for other required services including nutrition support. For KP living with HIV, especially FSW will be linked to government run ART centres through accompanied referral for chronic care. PWID who are HIV positive will be linked to Comprehensive Drop-in-Centres (CDIC) through accompanied referral for enrolment into ART, clinical and immunological monitoring and for adherence and psychosocial support. Peer navigators from PR-icddr,b will refer PLHIV-MSM and hijra to respective government ART centres.  The above initiatives will support the national ART program, where ASP will build capacity of the service providers for ensuring standard services including ART, management of opportunistic infections, side effects, co-infections and other co-morbidities; clinical, virologic and immunological monitoring and HIV counselling support and understanding of the importance of maintaining privacy and confidentiality of PLHIV and their shared information. As per the framework, all ART centres will be equipped with viral load, CD4 and other necessary testing facilities for laboratory monitoring of PLHIV.  **Intervention:** Treatment monitoring - ARV toxicity  **Activities**: Currently, most of the Govt. ART centres are new and not fully equipped with laboratory investigation facilities. Thus, National program will be supported through provision of investigation cost to monitor ARV toxicity.  **Intervention:** Counseling and psycho-social support  **Activities**: Psychosocial support to PLHIV, their partners, families and caregivers will be provided by involving self-help groups (SHG)/CBOs at community level for HTS, caregiver meetings, and training of the CPCs. PLHIV Network will be involved in strengthening ART services by using its CPC to collect routine data on patients’ satisfaction and share with national program for further improvement of ART services.  **Intervention:** Treatment Monitoring – Viral load  **Activities:** PR-ASP will procure viral load reagents / cartridge for GeneXpert and conduct testing through all 11 ART centres, drug resistance survey will be conducted through single sourcing contract.  **Intervention:** Treatment monitoring - Drug resistance  **Activities:** Surveys of acquired HIV drug resistance (ADR) in adults and children receiving ART. |
| **Priority Population(s)** | All people living with HIV (PLHIV) including KP ( PWID, FSW, MSM/MSW and TG) |
| **Barriers and Inequities** | * Major challenges related to ART access are long distance to ART centres and inconvenient opening hours. * Many PLHIV have other health problems/side effects and lack nutritional support. * Capacity of service providers to understand and work with PLHIV is limited. * Requirements for identification, documentation, and registration limit uptake of health services by PLHIV and partners. * The lack of protection of privacy in health service delivery, is prominent among KP, who can suffer significant consequences, including bodily harm, if their personal information is inappropriately shared.   The Government of Bangladesh has already taken initiatives to increase the number of ART and ART refill centres to overcome the barriers related to distance following the framework for ‘Differentiated ART service delivery” [Ref.]. The PLHIV database will be upgraded. Counsellors and MT Lab technicians have already been deployed under the OP fund. Training and exposure visits have been planned for ART centres staff under OP to increase their knowledge and skills. |
| **Rationale** | Effective ART improves longevity and prevents OIs in PLHIV. Since 2017, ART delivery is fully implemented by ASP. However, counselling, psychological support and follow-up, and viral load measurement need to be strengthened. A strong follow-up needs to be ensured for treatment adherence. Peers will work in the community, to ensure linkage with ART services, track beneficiaries, and ensure treatment adherence to reach the 90-90-90 targets. Viral load testing has been piloted in ART sites with GeneXpert and this need to continue to understand the treatment success. |
| **Expected Outcome** | PLHIV including KP will be linked with ART and adherence will be ensured to reduce HIV transmission and increase life expectancy of PLHIV. |
| **Expected Investment** | US $ ‬ |

|  |  |
| --- | --- |
| **Module # 4** | **TB/HIV** |
| **Intervention(s) & Key Activities** | **Intervention**: Collaborative activities with other programs and sectors  **Activities**: Verbal TB screening will be conducted for all KP visiting any of the SDP (DIC, sub-DIC, outlets, satellites etc.). In addition, community-based TB screening will be conducted by peer approach. Presumptive TB cases will be referred to appropriate public health facilities through effective referral systems for further diagnosis and treatment. Service providers of HIV program will be trained on TB related services. Similarly, some providers from TB program will be trained to address HIV screening. National Tuberculosis Program (NTP) and its partners (PR, SR) will be coordinated for better implementation of this activities at district and below level.  **Intervention:** Screening, testing and diagnosis  **Activities:** HIV testing among people with TB (People with presumptive TB), ASP will be ensuring HIV testing through 28 HTS centres; 19-35% of newly diagnosed case will be tested under this grant. A strong collaboration will be established with the TB program and its DOT centres. Simultaneously, screening of PLHIV for TB using GeneXpert will be done at all ART centres. Detected TB cases among the KP and PLHIV will be linked with DOTS centres. NGO PRs and its SRs will put additional efforts towards screening, diagnosis and TB treatment for PLHIV. |
| **Priority Population(s)** | Men who have sex with men (MSM), including MSW, TG/*hijra*, Female sex workers (FSW), People who inject drugs (PWID), people living with HIV and people with TB. |
| **Barriers and Inequities** | Due to stigma and discrimination, KP are fearful to attend TB treatment centres. Some KP receive HIV prevention services only via outreach; TB/HIV related cases remain often undetected. |
| **Rationale** | People living with HIV are 15-22 times more likely to develop TB than persons without HIV. TB is the most common presenting illness among people living with HIV, including among those taking antiretroviral treatment, and it is the major cause of HIV-related deaths. Therefore, the aim is to create collaboration between the national TB and HIV programs, in line with WHO guidelines, to reduce the burden of TB among people living with HIV and the burden of HIV among TB patients. In each year about 292,000 TB cases are diagnosed, of whom 19% will be targeted in year 1 for HIV testing; this will gradually be increased. This activity will complement NTP’s interventions to reduce HIV burden among TB patients. |
| **Expected Outcome** | TB/HIV cases are detected among KP and other TB patients referred to TB treatment centres and reduced TB/HIV related burden, morbidity and mortality. |
| **Expected Investment** | US $ |

|  |  |
| --- | --- |
| **Module # 4** | **TB/HIV** |
| **Intervention(s) & Key Activities** | **Intervention**: KP - Prisoners  **Activities**: The National Tuberculosis Programme (NTP) and its implementing partners have been providing TB services in 68 prisons since 2014. This platform will also be utilized to render HIV services. Under the leadership of National Working Group, a coordinated effort will be made between ASP, NTP, UNODC and Save the Children attempting to scale-up HIV/TB services in prison and other closed settings in Bangladesh. The programme will follow set guidelines and protocol for prison intervention, originally developed by UNODC for its member states. The intervention at the prison setting includes establishing a national technical working group on HIV and TB consisting of officials from both Home and Health Ministries, and an assessment to identify the needs, challenges and opportunities in developing and implementing HIV intervention programs in prisons. UNODC/UNAIDS will mobilize resources to provide the required technical assistance. Advocacy workshops at the national level to sensitize key stakeholders on harm reduction and human rights pertaining to HIV interventions in prisons will be conducted, and capacity building of NTP partners and health staff in persons to deliver the HIV services in the selected prisons. This initiative will be orchestrated by ASP. There will be provision of combined HIV/TB messages, HTS, and HIV screening for TB patients and other high-risk groups in prisons and through mobile vans, ARV and OST dispensing among prisoners. This will be done by ASP in collaboration with NTP, Save the Children and its SRs. Dialogue regarding the next steps will be initiated, such as establishing a strategic information system on the epidemiological situation, behavioural factors, modes of transmission, availability, quality and coverage of relevant healthcare services in prisons. |
| **Priority Population(s)** | People in prisons including Men who have sex with men (MSM), including MSW, TG/hijra, Female sex workers (FSW), People who inject drugs (PWID), people living with HIV and people with TB. |
| **Barriers and Inequities** | Accessing prisons and providing HIV prevention, testing and treatment services are challenging because drug use and HIV positivity may be an issue of further stigmatization and harassment. Prison authorities might also deny that drug use happens in prisons. These access barriers will be overcome via high-level advocacy by ASP, the harm reduction working group and UNODC. |
| **Rationale** | Prisons continue to represent high-risk environments globally for the transmission of blood-borne infections. It may also true for Bangladesh. When incarcerated, prisoners who have a history of drug use are denied access to harm reduction services, creating significant HIV risks. |
| **Expected Outcome** | TB/HIV cases are detected among KP and other TB patients in prisons and reduced TB/HIV related burden, morbidity and mortality. |
| **Expected Investment** | US $ |

|  |  |
| --- | --- |
| **Module # 5** | **Reducing human rights-related barriers to HIV/TB services** |
| **Intervention(s) & Key Activities** | **Intervention**: Stigma and discrimination reduction  **Activities**: In order to reduce stigma-related barriers to TB-HIV, campaigns and workshops will be held with religious leaders as well as with celebrities and media people through round table conferences. This will lead to development and integration of non-stigmatizing messages into TV and radio shows and print and social media. Anti-discrimination programs and policies will be organized in the workplace, health- and education settings in association with districts health managers and NGO PRs in 28 districts. Mass campaigns will be conducted to reduce stigma and discrimination on TB-HIV by providing messages through mass media. Policy makers, media people and religious leader also be educated through updated messages by organizing workshop, round table etc. Once participants become advocates this group will play a vital role to reduce stigma in society. Most activities are planned under the OP while a few workshops and round table conferences are budgeted in the proposed grant. |
| **Priority Population(s)** | All people living with TB/HIV and PLHIV including all KP- MSM, TG, PWID and FSW |
| **Barriers and Inequities** | TB/HIV affected people are stigmatized both in health facilities and society. Health care providers might not have sufficient knowledge about TB, HIV and KP. Similarly, local leaders, policy makers and social influencers/religious/celebrities might have limited knowledge and information on TB/HIV coinfection. |
| **Rationale** | A stigma-free enabling environment is a prerequisite for infection prevention. Policy makers, religious leaders, teachers, media professionals and celebrities can play vital roles to change the social and cultural perception on TB/HIV. Providing quality information, updates on the disease through workshop/ orientation, ASP in association with NGO-PRs will combine efforts to enhance knowledge on TB/HIV for reducing societal stigma and health sector stigma. |
| **Expected Outcome** | Rights awareness and enabling environment will be created to support TB/HIV reducing stigma and a group of public advocates will be mobilized. |
| **Expected Investment** | US $ |

|  |  |
| --- | --- |
| **Module # 6** | **Resilient and Sustainable System for Health (RSSH): Health Management Information Systems and M&E** |
| **Intervention(s) & Key Activities** | **Intervention:** Routine reporting  **Activities**: ASP will lead quarterly reporting to DHIS2 across all facilities and entities (GO-NGO); currently, ASP is reporting for 6 entities covering ART/ HTS of government facilities, it is proposed to add 16 entities in this proposed grant. A total 23 reporting entities will ensure proper quarterly reporting to DHIS 2. It will report on HIV testing services, antiretroviral therapy (ART), tracking loss-to-follow-up, viral load testing, distribution of commodities such as condoms and lubricants, sterile injecting equipment, routine reporting of TB/HIV collaborative activities, analytical capacity building- training, mentoring and supervision of subnational staff on data analysis and use. Further, ASP will review data quality and will do assessments and validations systematically. Data collected through these activities will be utilized to improve the implementation of HTS and ART services.  **Intervention:** Analysis, evaluation, reviews and transparency  **Activity:** Annual / six monthly workshop for program review at national level involving all stakeholders, development and sharing periodic reports (quarterly newsletter); also data collected in the new reporting system will be disseminated and discussed.  **Intervention**: Program Review  **Activities**: NGO PRs will conduct a program review under the Global Fund project. Also, Participatory monitoring and evaluation (PM&E) will be continued. PRs will report pragmatic progress quarterly to the Global Fund and National HMIS after data verification. |
| **Priority Population(s)** | All KP and health care providers |
| **Barriers and Inequities** | The current capacity of human resource is a barrier for quality data gathering and its reporting. The KP-focused OR and national reporting of health issues of KP are inadequate. |
| **Rationale** | Disease specific RSSH is important for HIV/AIDS data gathering and quality monitoring. Recently, ASP has expanded HTS to 28 facilities including 23 priority district hospital. All centres reports are required to verify the performance, trend of the epidemic through case detection. The management information is the key to program implementation and it monitoring and evaluation to measure 90-90-90 targets. Program review, need-based OR and programmatic progress reports are essential parts of program implementation to enhance the program and remove bottlenecks of the implementation. |
| **Expected Outcome** | 28 HTS facilities will submit monthly report to DHIS2; Enhanced service delivery through evidence-based decision making |
| **Expected Investment** | US $ |

|  |  |
| --- | --- |
| **Module # 7** | **RSSH: Human resources for health, including community health workers program management** |
| **Intervention(s) & Key Activities** | **Intervention:** Remuneration & deployment of existing/new staff (excluding community health workers)  **Activities**: ASP will provide salaries, monetary and non-monetary incentives to existing grant-supported staff based on an annual performance review. Few additional staff will be recruited; retention schemes and salary payments of current and new staff will be addressed.  **Interventions**: In-service training (excluding community health workers)  **Activities**: training will include provision of quality treatment, care and support, preventive and related social services for HIV; training on leadership and management; supportive supervision to health workers; and updating, revision or new development of training curricula. |
| **Priority Population(s)** | Staff working at ASP and Service providers in government and NGOs sector |
| **Barriers and Inequities** | Less number of staff against sanctioned posts in government system for optimum operationalization of interventions with relevant skills and frequent transfer of the government trained service providers from particular hospital to other places |
| **Rationale** | Ensuring universal access to public facilities for the KP and improving the quality of care for the KP including general population is necessary on HIV. |
| **Expected Outcome** | Increase accessibility of the health and HIV services for the KP in govt hospital |
| **Expected Investment** | US $ |

|  |  |
| --- | --- |
| **Module # 8** | **RSSH: Integrated service delivery and quality improvement** |
| Intervention(s) & Key Activities | Intervention: Service organization and facility management    Activities: ASP will pilot; playing the role of implementer of prevention, testing and treatment; interventions for FSW and PWID in five selected public hospitals which have been providing ART and HTS services since 2017. These tertiary public hospitals will act as the HIV programme hub for the respective districts. PLHIV, including all groups of KPs, are receiving ARV drugs, counselling, condoms (if required), and follow-up services from the ART centres in an environment free of stigma and discrimination. HTS has been conducted regularly for all the populations, including KPs, and HIV positive cases are referred to ART centres. These hospitals are gradually becoming more capacitated to deal with KPs and other marginalized populations. This process will be carefully documented as part of feasibility and acceptability studies (see below). ASP will also increase monitoring and supervision visits to the facilities and districts for improving HIV service delivery and for integration of services with SRH and MNCH at public hospitals. More number of people including the KPs will access public facilities for HTS. An enabling environment will be created through sensitization, orientation and training to public sector staff and providers, deployment of dedicated counsellors, trained laboratory technicians and community peer counsellors (CPC) at public health facilities for PLHIV. The process has started with government budget and staff have been trained and deployed as counsellors, laboratory technicians and CPCs. Quality of care will be improved through continuous capacity building of physicians, nurses, counsellors and CPCs. Through coordination with NGO-PRs a functional referral linkage from community to public facilities will be established. The peers and CBOs will receive orientation on integrated service delivery. The quality and continuum of care will be monitored according to guidelines and SOPs.    Intervention: Service delivery infrastructure  Activities: GF fund will support ASP to work in five hospitals within priority districts for upgrading service delivery infrastructure for clinical services for PWID and FSW, which will be attached with existing HTS/ ART centres. The facilities will need to be refurbished with furniture and other equipment and logistic supports for developing an enabling environment for KPs to ensure privacy and confidentiality.  Prior to the upgrading of the facilities and training of the personnel, an assessment will be conducted to understand the expectations of the service providers and the beneficiaries and the most feasible strategic approach to ensure that the KPs access clinical services from the public health facilities.  Another assessment will be conducted to assess the best mode of community outreach, which will complement the clinical services to ensure that HIV prevention interventions are in place at all outreach (hot spot) points within the catchment area of the hospitals where the KPs reside or work or are exposed to the high risk behaviours. This feasibility study will test approaches by the direct contracting of outreach workers versus contracting community-based organizations (CBOs) which have pre-existing relevant experience with KP. This study is aimed to measure the cost-effectiveness, quality, acceptability, workload impact and ability to achieve a standardized quality service package consisting of both options before finally deciding the contracting modality. A consultation session will be facilitated with relevant stakeholders, especially considering the inputs of KP, in order to finalize the report. Based on the report findings, ASP will decide the subsequent intervention steps.  ASP is planning for start the interventions in the 3rd quarter through piloting and gradually increasing the service uptake  A package of comprehensive services, including STI and abscess management, condom promotion, NSEP, HTS, and BCC will be offered, and linkages to hospitals will be available for other health services. Health products for KPs such as condoms, needles and syringes, and STI drugs will be provided by the OP fund. HTS will also be administered through the attached HTS centres under the support of the government fund. Only establishment costs, physical infrastructure and monthly operation cost will be covered under the GF grant. It is expected that 3000 PWID and 1250 FSW will be reached with services under the grant implemented by ASP, implemented over the 3rd and 4th quarters of 2021, after the proposed assessments have been completed and recommendations from those have been followed up upon. The unit cost per PWID will be USD 69 and USD 12 per FSW, in comparison to the existing unit cost as per NSP of USD 95 and USD 88, respectively. |
| Priority Population(s) | 1.    Staff working at ASP  2.    (Government) Service providers in the selected hospitals  3.    KP within the catchment area of the selected hospitals |
| Barriers and Inequities | Government facilities may not be ready for providing services to PWID and FSW and HIV testing, treatment and care. The infrastructure is not always enabling to provide quality-care. The already over-burdened district hospitals may not be friendly for KPs. Hospital management has many priorities in terms of disease burden and service providers are not well oriented about KPs. This will be a challenge for an creating an enabling environment |
| Rationale | ASP has been extending its services to 28 facilities in 23 districts and five selected facilities among these need to be upgraded to ensure quality of care for HIV prevention, testing, treatment and care of PWID and FSW. The current facilities do not address the overall health needs of KPs and are not linked to community outreach for HIV prevention. The health care providers in the public sector need to be trained along with an improvement of infrastructure of the facilities.  Increased monitoring and supervision is required for quality improvement. |
| Expected Outcome | More number of people including KP will access public facilities for HTS. Enabling environment will be created through advocacy, sensitization and capacity building initiatives at public health facilities for PLHIV and KP and the quality of care will be improved. |
| Expected Investment | US $ |

|  |  |
| --- | --- |
| **Module # 9** | **RSSH: Community systems strengthening: MSM and TG (*Hijra*)** |
| **Intervention(s) & Key Activities** | **Intervention**: Community-based monitoring  **Activities**: Community-based monitoring (CBM) will be performed to understand and address the barriers to accessing services by KP. Tools will be developed for CBM and KP will be trained on the CBM system. In addition, Participatory M&E (PM&E), implementing by icddr,b from RCC Phase-1 (2010), which had been appreciated by TRP before, will be continued for improving the program implementation and process monitoring.  **Intervention**: Community-led advocacy and research  **Activities**: icddr,b and it’s SRs/SSRs have been facilitating the community-led mapping of legal, policy and other barriers that hinder/limit community responses. In this process, the reporting system of GBV and human rights issues had been developed, and data collection and analysis will be done to inform relevant stakeholders.  **Intervention**: Institutional capacity building, planning and leadership development  **Activities**: icddr,b has worked on community systems strengthening under the Global Fund grant in 2010-2015 and formed/strengthened 20 CBOs operated by the MSM and *hijra* community. icddr,b will assess the status of these CBOs and work with them so that these CBOs can potentially contribute to HIV service delivery interventions. A workshop will be organized and a plan of action will be developed. A few training sessions with the CBOs and KP will be arranged so that they can be linked with the SRs/SSRs to be involved in rendering services to its own community**.** |
| **Priority Population(s)** | Men who have sex with men and TG (*hijra*) |
| **Barriers and Inequities** | Due to predominantly hetero-normative gender norms, criminalization of male-to-male sex, marginalization and harassment by local hoodlums and law enforcement agencies, MSM and TG experience barriers to health services [12]. Further, many health care providers (HCP) in public health facilities coin their behaviours as “immoral” and “abnormal”. They also face deleterious, disrespectful, humiliating, neglectful and judgmental behaviours from HCP. Their resistance/reluctance to visit public health facilities is also fuelled by a lack of privacy for treating STIs (i.e. lack of closed or secluded space/room for physical check-up), long waiting times in queues, and teasing or bullying from general patients [31]. |
| **Rationale** | Both management and field level staff of implementing SR/SSRs will be trained on strategies to overcome service access barriers and optimize reach of MSM and TG.  Support will be provided to STI/AIDS network for organizational development and networking with community people. In addition, the following activities will be implemented under Module Five which will actively alleviate access barriers and lessen inequities among this population: Sensitization meetings, advocacy events and workshops will be organized at both national and local levels with public health care providers, law enforcement agencies, lawyers, religious leaders, eminent journalists, print and electronic media, and CBO representatives to overcome access barriers and inequities. Counseling and legal support will be provided to MSM and TG whose human rights are violated. |
| **Expected Outcome** | Enhanced HIV related service uptake among KP and reflect voices and expertise of the community in research, advocacy and program implementation |
| **Expected Investment** | US $ 321,541 |

|  |  |
| --- | --- |
| **Module # 10** | **RSSH: Community systems strengthening: FSW, PWID and PLHIV** |
| **Intervention(s) & Key Activities** | **Intervention:** Community-based monitoring  **Activities**: Community Networks (PWID, FSW, PLHIV) will lead and implement community-based monitoring. *PR-SC* will take appropriate capacity building initiatives, i.e. development or adaptation of guidelines/Manual of Procedures, implementation tools and reporting mechanisms; orientation and training of networks and their members. There will be joint monitoring visits by the Community Networks  **Intervention:** Community-led advocacy and research  **Activities**: Community-led mapping of legal, policy and other barriers that hinder/limit community responses will be conducted to develop or improve program strategies.  **Intervention:** Social mobilization, building community linkages and coordination  **Activities**: Social mapping, spot analysis and contact mapping by engaging KP communities will also continue in this grant to deliver differentiated service based on the individual need of PWID and FSW.  **Intervention:** Institutional capacity building and leadership development  **Activities**: *PR-SC* will lead capacity building initiatives for community networks, including the National Network of People Use Drugs (NPUD), the Sex Workers Network of Bangladesh (SNOWB)] and PLHIV Network and their members. Proposed key activities include training on program and financial management; support for organizational policy review and update, and leadership development; supporting human resources; conducting meetings including annual general meeting and cross learning visits. The main purpose is to develop the institutional capacity. |
| **Priority Population(s)** | Female Sex Workers and their clients; People who inject drugs and their partners; All people living with HIV |
| **Barriers and Inequities** | The spot scenarios change frequently due to mobility and hidden nature of KP. Thus monitoring of the service delivery by the NGO staff can be challenging, which will be overcome using participatory monitoring by the community. Appropriate record keeping and reporting mechanisms on human rights issues for KP are absent even when such incidents are reported, they are often not followed-up. Community square /group, that represent communities themselves, could act as a first response. Nevertheless, due to lack of capacity, community networks and CBOs are not in a position to properly negotiate with stakeholders for their needs and rights. This will be addressed via continued advocacy and capacity building efforts. |
| **Rationale** | Community based monitoring will help create understanding for community needs and their human rights status. *PR-SC* has built partnerships with community networks under existing Global Fund grants. Each of the DIC is attached with a community group/management group and this DIC based ‘Community Group’ will be involved in community mobilization for receiving services, identifying new KP in the community using snow-ball technique and will do coordination between community and the project staff. |
| **Expected Outcome** | Functional engagement of community networks and organizations will lead to sustainability of some activities for KP for reducing HIV transmission. |
| **Expected Investment** | US $ |

|  |  |
| --- | --- |
| **Module # 11** | **RSSH: Program Management** |
| **Intervention(s) & Key Activities** | **Intervention:** Coordination and management of national disease control programs  **Activities**: ASP will coordinate and manage the national disease control program by via oversight, monitoring and supervision and technical assistance from national to sub-national levels, including to DIC and other implementation modalities. It will help coordinate between district / local authorities and DIC. At the central level ASP will organize quarterly coordination meetings among stakeholders.  **Intervention**: Grant management  **Activities**: ASP will provide oversight to supervision of SRs/SSRs by the NGO PRs, timely submission of reports and related grant documents, oversight and technical assistance related to effective and efficient Global Fund grant implementation and management. Human resources for program management, training for the staff of SRs/SSRs, PRs and community members will be organized if needed. PRs will incur overhead costs. Regular coordination between ASP, district and local authorities, regular coordination meetings with SRs/SSRs/CBOs, quarterly meetings, office rent and costs related to office management, IT and other procurement of equipment for PR, SRs/SSRs will be procured by the PRs. |
| **Priority Population(s)** | All KP, service providers and all stakeholders |
| **Barriers and Inequities** | District health manger/ civil surgeons’ engagement is challenging due to its multiple works and involvement at the district and other priority areas. Ensuring engagement of the national and sub national level health manager is important for coordination. |
| **Rationale** | Program management is mandatory to ensure grant compliance in terms of program, M&E, finance and administration, governance, and Procurement and Supply Chain Management (PSM). Operation and management of GF supported intervention in ASP needs some specific designated persons from GoB side because all existing government staff have their own responsibility for managing revenue and OP activities. ASP proposed a few positions in the grant for managing the proposed intervention. This is crucial to achieving the agreed grant outputs, outcomes and impact. It is important to note that under program management, besides the HR cost category, many other costs are included as per Global Fund guidelines. |
| **Expected Outcome** | Ensured smooth implementation of the Global Fund program as part of the National HIV program; achievement of the agreed outputs, outcomes and impact; improved program quality and increased accountability of the implementers. |
| **Expected Investment** | US $ |

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

☐ Yes ☒ No

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

**TB/HIV collaborative activities**: ASP has effective collaboration with the NTP; there have been collaborative TB/HIV activities since GF Round 5. The TB, leprosy and AIDS/STD programs (TB-L & ASP) are considered under a single entity in the government OP and single management in the 4th health sector program, which allows for better coordination. However, activities of each program and budgetary allocation are distinct. This funding request has proposed a TB-HIV module similar as earlier grants where TB case detection is expected to be enhanced among KP, who will, upon diagnosis, be referred to the public health system for further treatment. Similarly, under NTP, TB patients are to be screened for HIV from selected DOTS centres. In addition, TB patients can access government operated HTS centres for HIV testing. Coordination with the NTP, BRAC, WHO, USAID and other relevant stakeholders will be continued. The National TB/HIV Coordination Committee is functional. Strengthening of the collaboration between ASP and NTP is well addressed under one operational plan and one Line Director. There is a national TB/HIV guideline in place.

**HIV/STI treatment and care in Government settings**: ASP is currently operating 11 ART centres based in medical colleges and district hospitals. Among these, three centres are working under the Department of Medicine, two under Skin/VD, three centres are under the residential medical officer of district hospitals, one under a university and one under Upazila (sub district) Health complex. In contrast to the situation in the past, ART centres have now been fully integrated into existing health facilities and do not operate as ‘stand-alone’ services anymore. There is also plan to establish more ART centres based on need, of which two will be ART centres and two refill-centre. At this moment there are 28 HTS running in public hospital facilities in the 23 priority districts. ASP is planning to expand HTS services to 27 additional districts. Within the current OP period, a total 50 districts will therefore be covered with HTS services for all populations. PMTCT services are being provided as part of the MNCH system. SRH issues including complex STIs are also being addressed and there are referral linkage with government facilities.

**Laboratory system**: ASP has planned to link with all DOTS centres in 28 districts and all laboratories for better coordination for HTS, in order to use those laboratories’ capacity for viral load testing using gene-expert machines. Seven GeneXpert machines have been prepared to expand access to viral load testing; the software and necessary training has been imparted. Up to June, 2020 ASP conducted viral load tests for 800 PLHIV. ASP is planning to install software for the remaining three GeneXpert machines as well, so that all 10 ART centres will be ready for viral load testing using GeneXpert.

**Health Management Information Systems (HMIS) and M&E:** The government already has an established and well-run DHIS2 system to capture service statistics of GF funded KP interventions. However, system strengthening is being proposed towards a monthly reporting system to capture data from government and NGO facilities where KP take services. OST and ART data are yet to be reported in the national HMIS; this gap will be addressed in the coming grant with its planned PLHIV database, which will be linked to HMIS.

**Integrated service delivery and quality improvement**: Differentiated HTS and ART services will be expanded to 27 more districts, bringing the total to 50 districts that will have fully government funded HTS/ART services by the end of the OP period. Capacity building of DGHS staff will be required for integration and for quality improvement, funded by the GF grant; this will also help the sustainability of the program.

**Health products management system:** ASP will take the lead for strengthening the health product management system, including procurement of condom, needles and syringes, methadone and ARV from government OP budget to integrate with the program.

**Coordination**: Coordination with other ministries, directorates, DNC as well as decentralized district-level coordination will be conducted. Joint activities with the other HIV PRs will be taken to execute effective differentiated ART services; ASP will implement all the activities from central level with the active engagement of district health managers and hospital superintendents/directors where needed, with the cost of ART fully supported with government funding.

**Human Resources** (HR): Health care providers in the national system will be trained to provide quality services to KP and to address their medical and SRH need within the existing health system. ASP aim to ultimately integrate different HIV interventions into the national health system, which will lead to sustainability; KP will eventually be counted as mainstream service recipients, able to access health care in a non-stigmatizing, welcoming environment.

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

The proposal for coming grant (2020-2023) has been developed based on evidence of the HIV epidemiological context, current and anticipated HIV disease burden, KP’ risks and vulnerabilities to HIV and geographical variations in this, the need for community system strengthening, the country’s financial status as a lower lower-middle-income country thus support is needed for Resilient and Sustainable System for Health (RSSH).

**Key populations**: This application is very much disease specific and KP (i.e., PWID, FSW, MSM including MSW and *hijra*) focused. The proposed interventions will address the entire HIV prevention and treatment cascade. The HIV prevention cascade consists of three key domains, i.e. motivation, access, and effective use of services by the KP for preventive services. Differentiated HIV testing modalities will be further rolled out; treatment and care coverage will be maintained or improved to close the gaps towards fulfilling the 90-90-90 targets. In order to make the HIV response more sustainable and cost-efficient, interventions have been extended to the community level creating outlets and satellite services at community settings during the current grant, a process that will continue in the coming grant to achieve higher cost-efficiency. Outreach and harm reduction interventions will be expanded beyond office hours to provide services during the times that KP are most in need. A total of 69% of the grant is proposed for prevention, testing and treatment and care interventions for KP; 58% for prevention (including harm reduction interventions), 3% for HIV testing, 4% for treatment and care and 3% for TV/HIV co-infection management, 2.73% community systems strengthening; 2.26% for health management information systems and M&E; 3.49% for human resources for health, including community health workers contains and 0.40% for integrated service delivery and quality improvement.

**Prisons:** There are 68 prisons in the country, with a significant number of TB patients incarcerated. The National Tuberculosis Program (NTP) has implemented interventions for TB control in prisons for many years, via the existing health system of prisons and with support from NTP partners. In this proposed grant ASP has included some activities to integrate HIV services, especially testing and treatment, with TB services in prisons. Training of TB and prison health staff on HTS and ART dispension has been planned for ten divisional based prisons so that they can conduct HTS during TB testing. There is also a plan to dispense ART drugs to prisoners where necessary. A high level advocacy workshop has been planned to introduce ART services with the Ministry of Home Affairs and the Prisons Authority. Furthermore, UNODC is planning to deliver a comprehensive service delivery guideline for prisons soon following its global protocol and guidelines developed for members states.

**Community systems**: KP communities and local community leaders have been involved since the beginning of the development of the NSP as well as for the development of this proposal. Investment in community systems will be made as part of the grant. KP will participate fully in the implementation of the grant at the community level via different approaches including peer to peer, community care, community monitoring, activities to increase accessibility and efforts to reduce stigma and discrimination for the entire program period. Both the NGO-PRs and ASP will directly work with communities both at health facilities and outside facilities in order to maximize meaningful participation a total of 2.73% of the grant budget is proposed for community system strengthening.

**Investment in health system**: The proposal emphasizes the development and improvement of the national HMIS to capture authentic and timely data of high quality. HIV service quality improvement and better linkages between different services in a continuum of care are an integral part of this. There will be a focus on integration of HIV services for KP within DGHS and DGFP facilities; this will require training, sensitization, stigma reduction and capacity building of public sector health care providers. ASP will adopt a co-financing policy in different areas of the health system. A total of 28% of the budget is proposed for investment in the health system, including program management costs for the entire program cycle. The Government will co-finance these health system strengthening activities.

**Investments in human rights and gender:** The Bangladeshi government has played a proactive role for addressing human rights and gender issues in many instances, including in its recent approval of voting rights for *hijra* as the third gender. However, much more needs to be done in this regard. The National Task Force (NTF), which was established under the leadership of the National Human Rights Commission and ASP to safeguard the human rights of KP, will continue to provide a platform for advocacy. Under the Operational Plan budget, several workshops and capacity building activities have been done with the One-stop Crisis Centres (OCC), which are managed jointly by the Ministry of Home Affairs and the Ministry of Health, and are based in the district and medical college hospitals. All GBV cases (physical torture, rape, etc) are reported to the OCC. After managing the injury of the victims, OCC staff ensure victims have access to legal support. All OCC centres are skilled for HIV testing and provision of post-exposure prophylaxis (PEP).

KP communities need to be strengthened to raise their own voices more effectively. Several activities are planned to build the capacity of KP networks and CBOs, as well as to addressing human rights and gender related issues with law enforcement agencies, journalists, lawyers, round table meetings with media, psychological and legal support for the victims etc. The NTF is expected to respond to the emerging needs and play a role in analyzing existing legal barriers with the help of ASP, SCI, UNDP and UNAIDS. An integrated and inclusive approach is promoted throughout the proposal, which ensures access to rights and services including health and psychosocial support. Advocacy initiatives will be taken for policy reform (Narcotics Control Act 1990). Public awareness will be raised and mobilized in society at all levels, including family, community and faith-based leaders to create a supportive and non-discriminatory environment for protecting the human rights of PWID and other KP. Confidentiality of all information of HIV positive PWID will be maintained. Meaningful involvement of PWID and MSM, *hijra* will be ensured through engaging them in planning, designing and implementing the program where needed. Thus, these approaches will reduce stigma, discrimination and violence towards PWID. A total of 1% budget is proposed for investment in human rights and gender.

Criminalization hinders the accessibility of HIV prevention and harm reduction services by PWID who are often arrested and harassed by law enforcers. Based on the recommendations from the legal environment review, a set of advocacy tools and a joint action plan will be developed in coordination with ASP, DNC, UNODC, UNAIDS, SCI, icddr.b and CARE-B.

**Co-financing**: GoB has demonstrated its commitment to increase domestic funding for HIV prevention, treatment, and care and support services over the years. HIV prevention, treatment, care and support activities in Bangladesh have combined efforts of the government, NGOs and development partners. It is a fact that domestic funding has been increased in-line with enhanced economic growth of the country. The co-financing commitment of the previous grant has been realized. Government anticipates using US $ **23.9 million** from 2021-2023 as its co-financing policy to support HIV program along with donors, which is 100%% of GF allocation from 2020-2023.

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

To ensure value for money (VfM), all principles of the Global Fund guideline related to VfM have been applied. It is anticipated that the following approach will generate a greater impact on each of the components of VfM outlined in the Global Fund guideline:

**Economy**: To have positive impacts on VfM, coverage of KP has been scaled-up without no additional costs. Instead, beneficiaries will be able to access appropriate services closer to their communities via outreach activities, using a peer-to-peer approach. For procurement, the global standard policy of a competitive bidding system will be followed to get quality products at a reasonable price. The best quality product will certify in terms of price, functions, endurance/life, warranty, delivery, distribution, after-sale services, disposal cost etc. Bulk procurement will be done to achieve suppliers’ economies of scale; procured products will be chosen that have long expiry dates to ensure longer life and enable for the products to be used until the end of the project period. Long-term fixed-price contracts will be considered to assure supplies at the best possible price and at just in time delivery. Integrated or combined procurement will be done for SRs and SSRs by the respective PR to reduce transaction costs and increase value for money by ensuring lower costs. Health products are distributed to the beneficiaries from the service centre level.

**Efficiency:** NGO-PRs have planned to reduce management cost but to increase coverage. In the coming grant it will be studied and piloted to what extent public health services can be utilized to fulfill all KP’s health needs by providing capacity building to public health care providers and creating an enabling environment in public health facilities**.** The number of DIC has been reduced from current grant to focus on a smaller scale, peer driven approach by both the PRs. PR-icddr,b will operate 14 DIC, reduced from the current 20 DIC; PR-SC reduced DIC from 29 to 9 for FSW and 12 to 2 for PWID, but is still increasing program coverage. The interventions will be delivered via satellite service delivery points, outlets, cruising points and peer-based approaches at close vicinity to KP communities. While STI management continues to be provided by NGO operated service centres, with the ongoing capacity building efforts of public health service staff and efforts to improve the enabling environment for KP using public health services, it is expected that public health facilities can increasingly be utilized for alternative SRH and complicated STIs management services for KP and SRH/STI services for their partners. Peers and community platforms will be further strengthened so they can deliver meaningful behaviour change communications (BCC) helping KP to achieve long-term safer sexual and drug injecting behaviours. ASP will coordinate KP interventions at public facilities. Use of ICT and virtual space will be optimized as a cost-effective way to reach to unreached KP. Participatory monitoring and evaluation will be conducted for efficient service delivery. Capacity-building activities will be organized to improve efficiency by improving the skills of staff. Logistic Management Information System (LMIS) will be continued to maintain the ability to view stock positions at a glance, to assess demand, forecast demand, avoid stock-outs and provide emergency supplies if needed, in order to increase efficiency of the supply chain.

**Equity**: The program will try to reach all segments of the target populations including MSM/MSW, transgender, female and male partners of male, female and *hijra* sex workers, FSW and its clients and both male and female PWID and its injecting and sexual partners. It will place special focus on segments of KP who have previously been under-served, in particular WWID and adolescent KP. It will also focus on previously unreached MSM; such potential clients will be assisted to access necessary services in government facilities on a pilot basis. Hence, the project will strive to provide services to the most vulnerable and marginalized of KP. Human rights, in particular the right to healthcare and the right to live a life free of stigma, discrimination and violence, will be overarching principles for all beneficiaries, both at national and district level. Continued advocacy activities will be going on to assure these principles are upheld.

## Matching Funds (if applicable)

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

# Section 3: Operationalization and Implementation Arrangements

To respond to the questions below, refer to the *Instructions* and an updated**Implementation Arrangement Map**[[3]](#footnote-4).

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

For the coming grant, the Bangladesh Country Coordination Mechanism (BCCM) has decided to continue with the three current PRs: i) AIDS/ STD Program (ASP) ii) Save the Children (SC) and iii) icddr,b. Under Dual-track financing, GF recommends to have both GO and NGO PRs for optimum efficiency, with clearly defined tasks and roles, to support the implementation with better coordination and efficiency. The activities of the three PRs are defined without overlap, either by focusing on different geographical areas or on different KP (Figure 4 and 5). Figure 4 portrays Dhaka, 22 priority and other districts.



ASP emphasizes working with the mainstream government system for HTS at 28 HTS in 23 districts, for treatment at 11 ART centres. With an eye on future sustainability, ASP will pilot prevention for FSW and PWID in 5 districts, under the leadership of the hospital superintendent, the outreach work will be coordinated with local CBOs. Furthermore, ASP addresses TB/HIV co-infection and other co- and multi-morbidities via joint actions with NTP and other relevant departments. HMIS and M&E will be key areas where ASP will confirm data extraction and reporting in an accurate and timely manner. ASP do not have any provision of SR/SSR in the proposed grant; however, a few components, including the proposed survey/ assessment will be sub-contacted following government procurement policy as well as GF guidance. ASP will decentralize its activities by engaging district health managers / superintendents. Existing staff will be continued based on the performance evaluation and a few new positions will be recruited as per standard policy.

Figure 4 depicts the all three PRs implementation arrangement for different KP. PR-SC will work for FSW in 13 districts (annex: i) a total of 9 DIC (one community-led) and 16 outlets (two community led and 2 CBOs run) will be set up, following differentiated service delivery approaches. Intensive service packages will be run in 7 districts (annex: i) based on the HIV vulnerability of FSW residing in those locations. In other districts, basic service packages (Condom, HTS and linked clinical services with government/semi-government/NGO facilities) will be offered for FSW. Further, PR-SC will work for PWID in 13 districts (Annex: i), considering the concentrated epidemics and mobility among PWID in Dhaka and adjacent districts, and concentration of people who use opiate-based drugs and has Hepatitis-C prevalence. Differentiated service delivery approaches for PWID will be provided through 8 CDIC, 4 OST centres, 2 DIC and 21 outlets (including 2 in GoB facilities). OST will be provided to 3,500 PWID. The PR-SC proposes creating a virtual space for unreached KP for conducting BCC initiatives and increasing service uptake. In order to strengthen the treatment, care and support services for PLHIV and enhance the community component, community peer counsellors (CPC) will be deployed at government-operated ART centres. PLHIV Network will also be actively engaged to enhance ART service delivery. PR-SC will continue with the existing Sub-recipients (SRs): Care Bangladesh, Light House and Ashar Alo Society (AAS). The respective SR will be responsible for reformulating the consortium based on geographical locations and population-based needs. The modality would also be redesigned to foster community engagement and enhance integration with government facilities.

As plotted in figure 4, PR-icddr,b will provide peer-driven services to MSM, MSW and *hijra*, with engagement of CBOs. A total of 14 DIC, 18 sub-DIC, 18 outlets, and 13 satellites will be in place to deliver services in all 23 priority districts, and 14 other districts (Figure-4). As pioneer in the field of OST, PR-icddr,b will continue to provide OST services to 900 PWID. Among them, 500 PWID are continued from existing three clinics during the current period and 100 PWID will be enrolled during 2020-2021. Two new clinics will be established to provide OST services to 300 PWID during April 2021-June 2022. PR-icddr,b has also proposed to continue ICT-based approaches to contact unreached MSM and MSW for providing prevention and follow-up services. PR (icddr,b) will continue with two existing Sub-Recipients (SRs) i.e., Bandhu Social Welfare Society (Bandhu) and Light House. Separate sub-grant agreements will be signed with them for implementing services in their respective geographical areas with support and community engagement of Sub Sub-Recipients (SSRs) i.e. Khulna Mukti Sheba Sangstha (KMSS) and Badhon Hijra Shangho (BHS). Besides, SRs may include community based strategic partner for better engagement and participation of the community. The PR will decide if any strategic partner will be required to be added with any SR or SSR. No SR or SSR will be allowed to include any NGO or CBO with the Global Fund program unless PR approves.

The major procurement will follow the respective procurement policies of each entity by ensuring quality and VfM. The Technical Working Group on HIV, nominated by the BCCM, is responsible for endorsing the technical aspects of the application.

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

CBOs representing and led by each of the KP groups will be central to the grant implementation.

Under PR SC, two PLHIV CBOs Ashar Alo Society (AAS) and Mukto Akash Bangladesh (MAB), one FSW CBO Nari Mukti Sangho (NMS), and one PWID CBO (APOSH) will be working as SR and SSR at different geographical locations. In addition, 2 PWID CBOs and 3 FSW CBOs [Swanirvar, Akhoy, Bachte Chai] will also be implementing HIV prevention interventions with SR and SSR as strategic partner (SP). PR-SC and SRs/SSRs will engage CBOs and networks to strengthen outreach activities through social mapping, spot analysis and contact mapping. Participatory monitoring and mentoring of outreach team will be led by CBOs and networks. A ‘Community Squad’ will respond to GBV and harassment of PWID and FSW. A systematic community monitoring (i.e. recording, reporting and response) mechanism will be carried out by CBOs and Networks for effective advocacy.

PR-icddr,b is working with the MSM-led organization BSWS (initially formed as a CBO and now considered the biggest community-led organization working with MSM and transgender in Asia) as an SR in the implementation of HIV prevention, diagnosis, linkage to treatment and other related interventions. One *hijra* operated organization named BHS is contracted as an SSR. In addition to these, six *hijra* and MSM CBOs [i.e., Sustha Jibon- Dhaka, Diner Alo Hijra Sangha- Rajshahi, Shurjer Alo Hijra Sangha- Chattogram, Bikoshito Manab Kollayan Sangothon Cox’sbazar, Shapla MSM Unnayan Songothon-Bogura and Swapno Hijra Unnyaon Sangho- Rajbari] will be implementing HIV prevention and other services along with PR-icddr,b.

PR- icddr,b and SRs/SSRs have been facilitating the community-led mapping for identifying legal, policy and other barriers that hinder/limit community responses, a process that will be continued. In this process, a reporting system for GBV and human rights violations have already been developed from the current grant, which will be continuing to collect data and to analyse and use findings in order to inform relevant stakeholders for necessary actions.

Since the proposed funding request concentrates on effective community engagement and espousing with public facilities, the PRs will follow GF guidelines and transparent procedures for strategically engaging additional CBOs for program implementation. Overall, the technical and financial capacity of Bangladeshi CBOs needs to be strengthened. Community-based monitoring (CBM) will be facilitated in association with CBOs to understand and to address the barriers for accessing quality services and for continuum of care. User-friendly tools will be developed for CBM. The CBOs of MSM and *hijra*, FSW and PWID and PLHIV will be trained on the CBM with technical guidance from PRs and SRs. In addition, Participatory M&E (PM&E), which had been appreciated by TRP before, will be continued for improving implementation and monitoring.

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

☐ Yes ☒ No

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

|  |  |  |
| --- | --- | --- |
| **Key Implementation Risks** | **Corresponding Mitigation Measures** | **Entity Responsible** |
| **Program Quality**: Poor quality of prevention services leads to poor results in terms of condom use and uptake of harm reduction services | Follow national/international SOP/ guidelines for HIV prevention service delivery; report poor service by strengthening community-based monitoring systems with feedback to health care providers; conduct regular capacity building activities with outreach workers, and with other HIV and harm reduction service providers. | PRs, SRs and SSRs, LFA and CCM |
| **Program Quality**: Inadequate quality of HIV/STI treatment services leading to lack of adherence to treatment. | Follow national treatment guidelines for STIs and ART, regular update of guidelines based on national and global evidence, ensure ART adherence and follow up, regular capacity building of service providers with updated information, ensure rational use of antibiotics and conduct laboratory based STI and HIV surveillances. | PRs, SRs and SSRs, LFA and CCM |
| **Monitoring and Evaluation**: M&E data not (sufficiently) used to improve service delivery | Introducing participatory M&E systems and low-cost training of staff responsible for reporting and M&E; continue refresher trainings on data collection, management, supervision and interpretation. | PRs SRs and SSRs, LFA |
| **Procurement and in-country supply chain**: Delays and mismanagement lead to stock-outs and interrupted access of ART, STI drugs | Follow standard pre-qualification criteria for procurement, procure in bulk and buy products with long expiry dates at comparatively lower price, develop procurement and health product supply framework agreement, develop back-up and contingency arrangements. | PRs and SRs, |
| **Grant-Related Fraud & Fiduciary**:  Funds are not used properly as per agreed workplan and budget within the organizational policies. | Jointly develop approved implementation plans between PR and SRs/SSRs strictly following organizational policies and GF accounting standards. Where such policies do not exist, develop and introduce these. Implement financial monitoring strictly with regular reporting and documenting requirements. | All PRs |
| **Accounting and Financial Reporting**: Global Fund funds are not properly recorded, accounted for, or reported by PR or SRs | Use a tally-based accounting software and institute a process for regular verification of the accuracy of the figures of submitted reports to be aligned with the software-based financial reports. PRs are submitting PUDR to GF semi-annually. All figures are supported by the ERP Microsoft navigation system. Therefore, chance of inaccurate data recording and reporting is minimal. | All PRs |
| **National Program Governance and Grant Oversight**: Dysfunction, conflicts, conflicts of interest or corruption within the CCM lead to poor program oversight. | Under the guidance of GMS consultants, BCCM was restructured following GF guidelines. Elections for membership were held. Meetings are taking place, COI polices were signed by Individual CCM members and as such, decisions are made transparently, the oversight committee of BCCM is functional and conducting regular oversight visits, PR selection was conducted following GF guidelines, and civil society and other stakeholders’ representation in BCCM have increased. | BCCM and BCCM oversight committee |
| **Risks related to human rights and gender**: GBV and human rights issues may create problems in rendering services to KP. | Routine advocacy and sensitization meetings with relevant stakeholders including local police, district administration will be part and parcel of program implementation. Advocacy, round table meetings with media, government- and non-government organizations, psychological and legal support for the victims of human rights and GBV have been built into the program. Furthermore, the NTF will function as an important advocacy platform and voice to protect the program. | National Task Force (NTF), BCCM, All PRs and SRs |

# Section 4: Co-Financing, Sustainability and Transition

To respond to the questions below, refer to the *Instructions*, the domestic financing section of the **allocation letter**, **the** [Sustainability, Transition and Co-Financing Guidance Note**,**](https://www.theglobalfund.org/media/5648/core_sustainabilityandtransition_guidancenote_en.pdf) **Funding Landscape Table(s), Programmatic Gap Tables(s)**, **and a sustainability plan and/or transition work-plan**, if available[[4]](#footnote-5).

## 4.1 Co-Financing

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

☒ Yes ☐ No

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

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



The Government of Bangladesh has met the co-financing commitments in the current grant cycle through the 4th sector program budget and operational plan for ASP. Figure 6 and 7 show that 82% of committed domestic resources have been spent (supporting document attached).

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

☒ Yes ☐ No

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

The total estimated cost in the 4th revised NSP for the year 2020-2023 for HIV is USD $ 223,973,040. In the OP under the 4th health sector program, USD$ 14,747,110 has been allocated for HIV interventions, treatment and care during the same period. The GF will provide USD $ 23 m for 37 months (i.e. Dec 2020 Dec 2023). Therefore, in the period of 2020-2023, there is a gap of USD$ 209,225,930 for implementing various components of the NSP. It is expected that efficient utilization of domestic funding will be optimized in line with the higher expected economic growth of Bangladesh as documented over the last several years after mid-term revision of 4th HPNSP in March-April 2020 (although the impact of the Covid-19 epidemic may dampen economic growth in the medium term). Unfortunately, service gaps (as reflected the programmatic gap table) in terms of coverage of KP still remain. However, it is predicted that with better utilization of government funding, this service gap will eventually be reduced. In terms of sustainability, integration of STI/SRH services, HTS, treatment and care services to government healthcare settings are planned in 28 government facilities in 23 districts. In these facilities, KP, immigrants and the general population including PLHIV will get the same services that other people get.

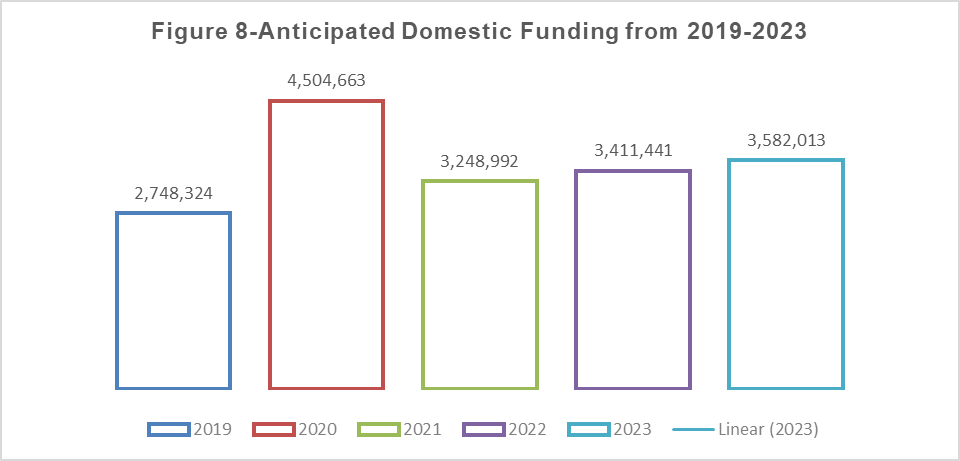
ASP has been supporting serological and behavioural surveillance, and training of health care providers on STIs and HIV. Figure 8 shows that the anticipated funding for HIV from 2019-2023 from the 4th sector program is US $ 17,495,433 under the OP of Tuberculosis-Leprosy & AIDS/STD Program, which amounts to 76% of the upcoming allocation from GF for the 2020-2023 period. Government has pledged to achieve 100% coverage of PLHIV for ART from the OP budget. These efforts will be enhanced gradually through the public health system of Bangladesh.

Summarize the **programmatic areas** to be supported by domestic co-financing in the next allocation period. In particular:

* 1. The financing of key program costs of national disease plans and/or health systems;
  2. The planned uptake of interventions currently funded by the Global Fund.

**The financing of key program costs of national disease plans and/or health systems**

The national AIDS/STD Program is implementing HTS and ART services through 28 government hospitals in 23 priority districts since 2017. Each of the hospital authorities has deployed one medical officer, one nurse as a counsellor and a Medical Technologist (MT) for the laboratory (a total of 84 persons) for continuing HTS and ART services. The hospital director/superintendent coordinates and supervises on a regular basis. As of January 2020, ASP recruited 28 full time counsellors cum administrators, and MT lab at all those centres. ASP also recruited three program coordinators to coordinate and monitor ART and HTS services in the 28 hospitals. HTS and ART logistics including ARV, testing kits are supporting by OP budget. 13 senior level officials from government OP are in regular organogram including Line Director, Director, Deputy Director, Program manager, Deputy Program managers, Medical officers who oversee the implementation as part of the national response and are being paid by government revenue. Under the 4th HPNSP operational plans, ASP has plans according to the NSP objectives, as follows:



**Objective 1** of NSP: Prevention services for KP

1. ASP is planning to implement a prevention program for KP, including 3600 brothel-based FSW (already started), 5000 hotel- and street-based FSW, 10,000 PWID and 5000 MSM and TG. Costs for condoms, needles and syringes and methadone are also provided, funded from the OP fund.
2. ASP has started its HIV testing services at 28 government hospitals in 23 priority districts since December 2018 in order to improve HIV case detection. Centrally, ASP has been procuring HIV testing kits and accessories and supplying to these hospitals, and relevant staff has been recruited (see above).
3. Mass awareness programs have been airing via social media, Bangladesh television (BTV) and other popular media under the HPNSP OP funded from the sector program.

**Objective 2**: Universal access to treatment and care

1. In order to improve ART coverage, ASP has established 12 ART re-fill centres in alignment with the geographical presence of the PLHIV population. Respective public hospitals have arranged space, physicians, nurse and other relevant staff to provide services. ASP procures ARVs using the OP fund and supplies these on a regular basis. Hospital authorities support the costs of drugs for opportunistic infection management.
2. PMTCT program: with the support from UNICEF, ASP has been implementing a PMTCT program in 11 hospitals in priority districts.

**Objective 3**: coordination and capacity building

1. Training and capacity building activities are continuing under OP fund for the different level of health care providers including doctors, nurses, MT lab technicians and other relevant staff.

**Objective 4**: Strategic information

1. ASP is implementing the STI surveillance (2019- 2021) through IEDCR to understand the prevalence and factors associated with STI transmission.

Currently, the government uses only a minimum amount of GF funding (i.e. a total of US $1,074,700 for three years 2017-2020). ASP has been implementing its own OP but has been using GF resources to complement government efforts, in agreement with the GF Country Team, which is part of its co-financing strategy. The following interventions that are currently supported by GF will be taken up by OP budget in the next implementation period:

1. The IBBS and operations research are planned under sector program funding from the upcoming implementation which has started already under the current GF grant.
2. ASP has been working to strengthen HIV routine reporting and the MIS system of DGHS. HIV programmatic data are being incorporated in national DHIS2 in cooperation with NGOs. The DHIS2 will be run using government funding.
3. The government staff of ASP has been conducting routine monitoring and supervision visits to DIC to support the NGO-implemented HIV program; this will continue in the next period, using OP funds;
4. The district managers and facility managers in 23 districts are supporting the program, which will continue into the next OP period. ASP has established functional linkages between district health managers and DIC and NGO-PRs staff for integration of services; this will also continuing with funding from OP
5. Care, support and treatment for PLHIV is already taken off by government funding. STI services for FSW and female drug users will be gradually provided from the government health facilities.
6. Specify how co-financing commitments will be **tracked and reported**. If public financial management systems and/or expenditure tracking mechanisms require strengthening and/or institutionalization, indicate how this funding request will address these needs.

The GoB has its own Implementation Monitoring and Evaluation Division (IMED) under the Ministry of Planning. This Division collects quarterly program implementation data and information on the spending status from all ministries, departments and divisions, including ASP. Based on the collected data, IMED analyses the state of implementation of the program as well as spending progress, and provides necessary feedback to concerned ministries, departments and divisions (http://www.imed.gov.bd). In addition, the Program Management and Monitoring Unit (PMMU), under the Planning Wing of the MOHFW regularly monitors progress (Program and Financial). Bi-annual and annual reports are produced and disseminated. Apart from the GoB mechanism, the country has two mechanisms for tracking the HIV response and health expenditure; the Global AIDS Monitoring (GAM) report is produced annually and periodic National AIDS Spending Assessments (NASA) are produced every two years.

## 4.2 Sustainability and Transition

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

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

Considering the updated NSP 2018-2023 target to reach [2, page 35] and to attain the targets of 2030, there is a gap in funding for program implementation. According to NSP and investment care 2019, it requires an average of USD 21.7 million a year to adopt the targets set in the NSP; new HIV infections could then be reduced to 338 per year by 2030 to achieve the 90-90-90 targets [15, see table 15]. In the next allocation period around USD 65.1 million is needed to achieve the targets of NSP [15, see table 15]. Of this, USD 23 million will come from the Global Fund, the government has committed to provide around USD 23.9 million and USD 2.8 million is committed by the UN agencies. Therefore, in the next allocation period, the funding deficit is around 24% for three years. Figure 9 and figure 10 show the funding gap without the current funding request and with the funding request below:

The gaps of funding are primarily in the HIV prevention areas, ASP will mobilize some resources from other ministries and external donors, and it has planned to consolidate government funding and to maximize utilization of existing resources.

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

Bangladesh, as a UN member state, is a signatory of the 2016 Political Declaration to end AIDS by 2030. A major mandate of the ASP as the nodal body for the national response is therefore to lead and coordinate the national HIV response, engaging relevant government departments and ministries, UN agencies and civil society under the guidance of DGHS. ASP is implementing HIV/AIDS programs through a coalition of three functionaries:

1. National AIDS Committee (NAC);

2. Ministry of Health and Family welfare (MOHFW);

3. Directorate General of Health Services (DGHS)

The mentioned functionaries are key parts of the government to support the HIV program irrespective of donor funding support. Considering the concentrated character of the HIV epidemic in Bangladesh, interventions are focused on KP. ASP is aware that CBOs and community people need to play leading roles to reach KP, who are often marginalized and stigmatized in society. Service delivery models are designed to increase the uptake of services by KP effectively, and the aim is to gradually integrate these services within public facilities—this will require sensitization, stigma-reduction training and capacity building of HIV and other health care providers working in public facilities. For this, the support of KP-led NGOs and CBOs is also pivotal.

The challenges for HIV program are compounded both in financial and programmatic management. Considering the low overall population prevalence of HIV, it attracts less attention from in-country policy makers than other health problems. On the other hand, the continued rise of HIV infections among KP illustrates the need for additional resources beyond those provided by the GF. Bangladesh has low public expenditure on health: in FY 2018-2019, public health expenditure was only 5% of the total budget, which is the foremost challenge for the sustainability of HIV financing.

A modular approach has been implemented for HIV interventions as a parallel approach of integration through peers at community level and through referral and linkage at public facilities within a sustainable government system. To strengthen the services for KP in the government health system, regular meetings, sensitization and capacity building seminars and in-person communications between KP and health workers will be organized regularly.

ASP along with DGHS and MOHFW play a key role to ensure sustainability by optimizing use of OP. The government is well-aware of the activities and the target groups and their needs; which will facilitate the sustainability of the donor funded program. Moreover, several activities are operated using the government budget such as treatment of PLHIV, skills development training for transgender people, the inclusion of HIV related issues in secondary school curricula, operating HMIS through government web portal and extension of the social safety net program for KP. ASP has engaged 16 different Ministries, numerous Development Partners and civil society organizations in attempts to facilitate a sustainable future for the HIV program. ASP has been jointly working with Department of Narcotics Control (DNC) to prevent HIV among the PWID. Also, in partnership with ASP, Bureau of Manpower, Employment and Training (BMET) and Bangladesh Overseas Employment and Services Limited (BOESL) pre-departure education is provided about HIV for overseas migrants though their training centres. ASP also has established close collaboration with Gulf Assisted Medical Centres Association (GAMCA) for HIV, TB and other communicable disease detection. Under the leadership of MOHFW and UNAIDS, ASP has been working with Ministry of Law, Justice and Parliamentary Affairs (MOLJPA), The National Human Rights Commission (NHRC) and other ministries in reviewing laws and policies to improve the human rights situation of KP. ASP also has an active partnership with Ministry of Information and Bangladesh Television to improve social awareness on HIV/AIDS gives programmatic sustainability [5, page 18-19].

# Annex 1: Documents Checklist

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

|  |  |
| --- | --- |
| **☒** | Funding Request Form |
| **☒** | Programmatic Gap Table(s) |
| **☒** | Funding Landscape Table(s) |
| **☒** | Performance Framework |
| **☒** | Budget |
| **☒** | Prioritized above allocation request (PAAR) |
| **☒** | Implementation Arrangement Map(s)[[5]](#footnote-6) |
| **☒** | Essential Data Table(s) (updated) |
| **☒** | CCM Endorsement of Funding Request |
| ☒ | CCM Statement of Compliance |
| **☒** | Supporting documentation to confirm meeting co-financing requirements for current allocation period |
| **☒** | Supporting documentation for co-financing commitments for next allocation period |
| ☐ | Transition Readiness Assessment (if available) |
| **☒** | National Strategic Plans (Health Sector and Disease specific) |
| **☒** | All supporting documentation referenced in the funding request |
| **☐** | Health Product Management Tool (if applicable) |
| ☒ | List of Abbreviations and Annexes |

1. PAARs can only be submitted with the Funding Request. To complete a PAAR, fill-in the Excel template that you will receive from the Global Fund Secretariat. [↑](#footnote-ref-2)
2. This is only relevant for applicants with designated matching funds as indicated in the allocation letter.

   [↑](#footnote-ref-3)
3. An updated implementation arrangement map is mandatory if the program is continuing with the same PR(s). In cases where the PR is changing, the implementation arrangement map may be submitted at the grant-making stage.

   [↑](#footnote-ref-4)
4. Note that information derived from the supporting documentation provided in response to the questions below, including information on funding landscape or domestic commitments, may be made publicly available by the Global Fund. [↑](#footnote-ref-5)
5. An updated implementation arrangement map is mandatory if the program is continuing with the same PR(s). In cases where the PR is changing, the implementation arrangement map may be submitted at the grant-making stage. [↑](#footnote-ref-6)