The Global Fund
To Fight AIDS, Tuberculosis and Malaria

STANDARD CONCEPT NOTE

Investing for impact against HIV, tuberculosis or malaria

A concept note outlines the reasons for Global Fund investment. Each concept note should describe a strategy, supported by technical data that shows why this approach would be effective. Guided by a national health strategy and a national disease strategic plan, it prioritizes a country's needs within a broader context. Further, it describes how implementation of the resulting grants can maximize the impact of the investment, by reaching the greatest number of people and by achieving the greatest possible effect on their health.

A concept note is divided into the following sections:

Section 1: A description of the country's epidemiological situation, including health systems and barriers to access, as well as the national response.

Section 2: Information on the national funding landscape and sustainability.

Section 3: A funding request to the Global Fund, including a programmatic gap analysis, rationale and description, and modular template.

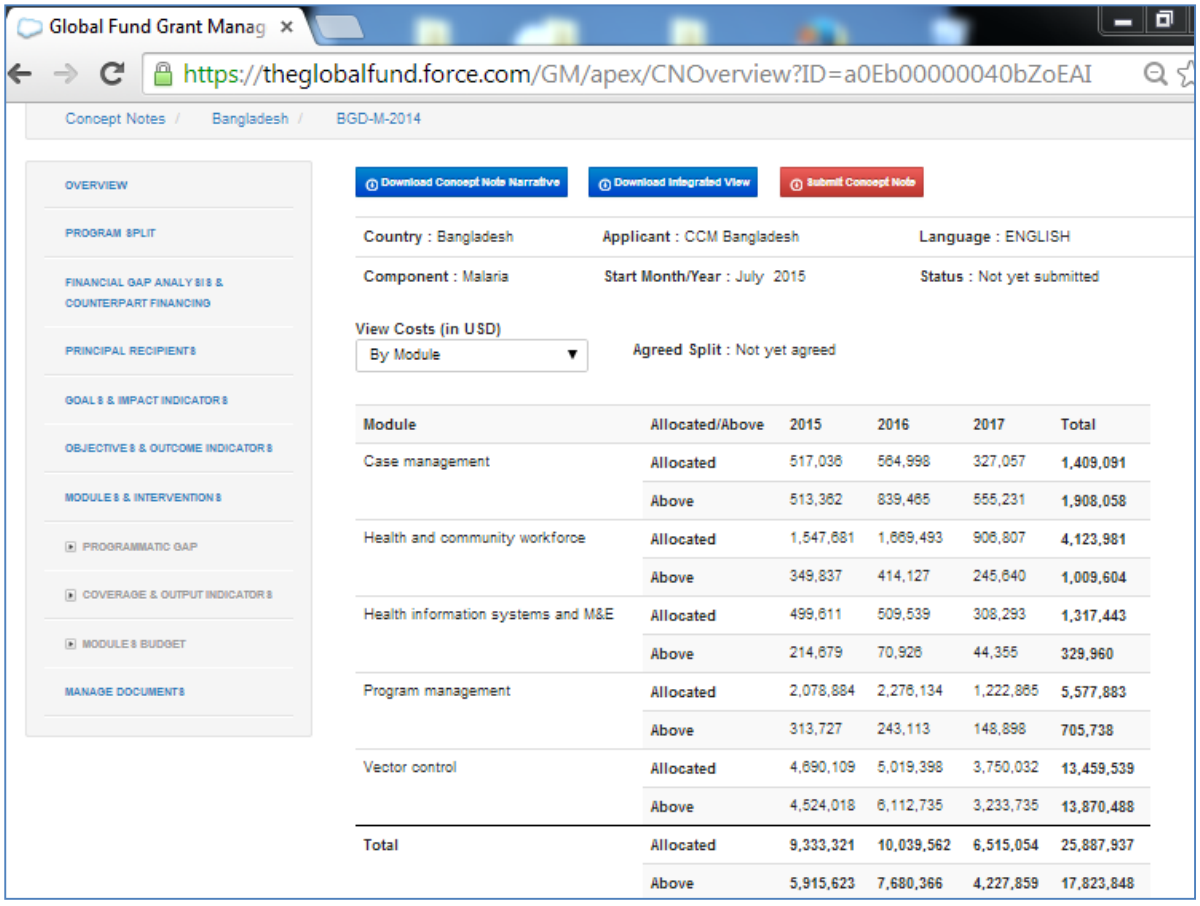
Section 4: Implementation arrangements and risk assessment.

IMPORTANT NOTE: **Applicants should refer to the Standard Concept Note Instructions to complete this template.**

SUMMARY INFORMATION			
Applicant Information			
Country	**Bangladesh**	**Component**	**Malaria**
Funding Request Start Date	**2015 (July)**	**Funding Request End Date**	**2017 (December)**
Principal Recipient(s)	**PR1: The Economic Relations Division, Ministry of Finance, The Government of the People's Republic of Bangladesh (NMCP, MOH&FW).** **PR2: Bangladesh Rural Advancement Committee (BRAC).**		

Funding Request Summary Table

A funding request summary table would be automatically generated in the online grant management platform based on the information presented in the programmatic gap table and modular templates.



Module	Allocated/Above	2015	2016	2017	Total
Case management	Allocated	517,036	564,998	327,057	1,409,091
	Above	513,362	839,465	555,231	1,908,058
Health and community workforce	Allocated	1,547,681	1,669,493	906,807	4,123,981
	Above	349,837	414,127	245,640	1,009,604
Health information systems and M&E	Allocated	499,611	509,539	308,293	1,317,443
	Above	214,679	70,926	44,355	329,960
Program management	Allocated	2,078,884	2,276,134	1,222,865	5,577,883
	Above	313,727	243,113	148,898	705,738
Vector control	Allocated	4,690,109	5,019,398	3,750,032	13,459,539
	Above	4,524,018	6,112,735	3,233,735	13,870,488
Total	Allocated	9,333,321	10,039,562	6,515,054	25,887,937
	Above	5,915,623	7,680,366	4,227,859	17,823,848

SECTION 1: COUNTRY CONTEXT

This section requests information on the country context, including the disease epidemiology, the health systems and community systems setting, and the human rights situation. This description is critical for justifying the choice of appropriate interventions.

1.1 Country Disease, Health and Community Systems Context

With reference to the latest available epidemiological information, in addition to the portfolio analysis provided by the Global Fund, highlight:

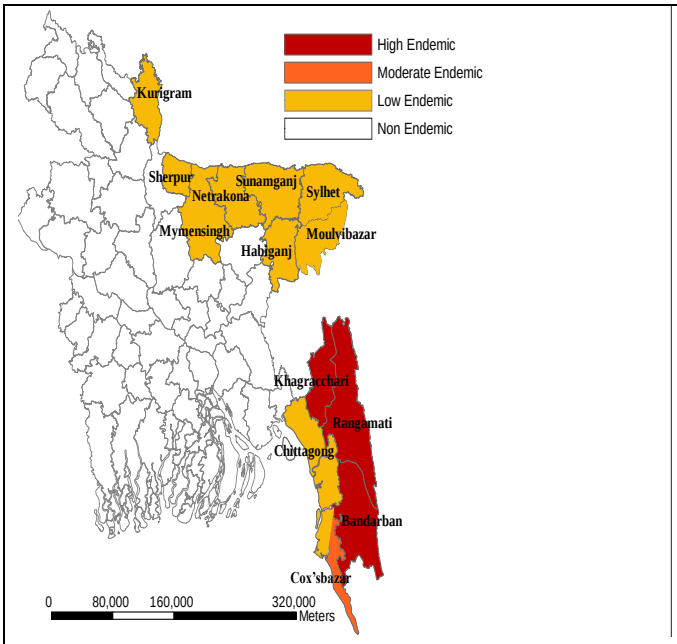
a. The current and evolving epidemiology of the disease(s) and any significant geographic variations in disease risk or prevalence.

b. Key populations that may have disproportionately low access to prevention and treatment services (and for HIV and TB, the availability of care and support services), and the contributing factors to this inequality.

c. Key human rights barriers and gender inequalities that may impede access to health services.

d. The health systems and community systems context in the country, including any constraints.

In Bangladesh, malaria is endemic in 13 eastern and north-eastern border belt districts of the country with variable transmission potentials (high, moderate and low). A total of 13.25 million people are at risk of malaria inhabited in those districts. In 2013 the prevalence rate of malaria was found to be 0.9% in these districts [Malaria Prevalence Survey, 2013 (Annex 16)]. Over 90% of the total cases are reported from the three Chittagong Hill Tract (CHT) districts (Rangamati, Khagrachari and Banderban) including Chittagong and the coastal district Cox's Bazar. The CHT districts have perennial transmission throughout the year due to the geo-physical location in the hilly, forested and the foot-hills, climate, and other favourable conditions for the vector species *An. baimaii (dirus), An. minimus and An. philippinensis.* The map of Bangladesh shows the malaria endemic areas (high, moderate, low endemic districts, and malaria free) based on available epidemiological data illustrated in the figure below.



Key Information (2013):
Area-147,570 sq.km
Population-156.27 million
Population at risk-13.25 million

Total endemic districts-13
High endemic districts-3
Moderate endemic district-1
Low endemic districts-9

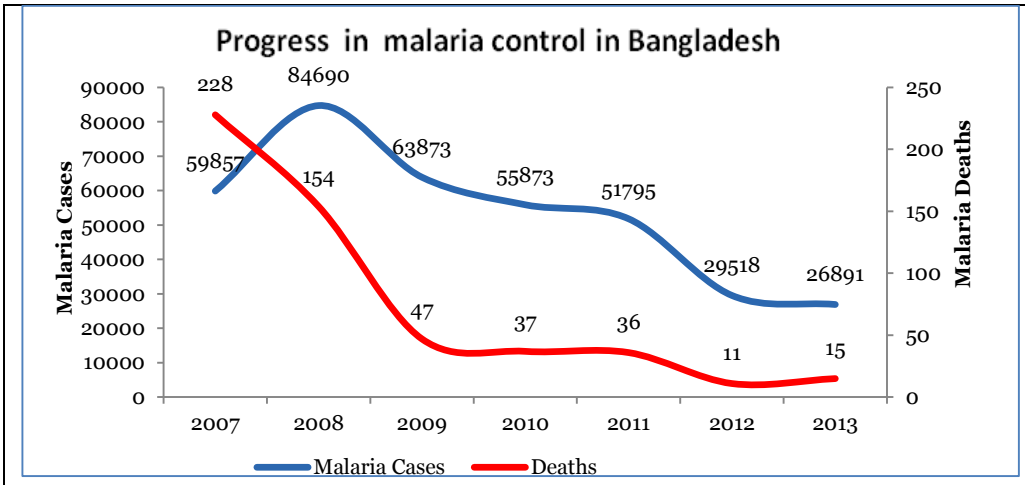
Cases in 2013:
Total-26,891 (P. falciparum-25,815; P.vivax-983; Mixed-93)
Death-15

Cases in 3 CHT & Cox's Bazar districts:
Total-24,783 (P. falciparum-23,918; P.vivax-787; Mixed-78)
Death-12

Principal vectors:
An. baimaii, An philippinensis, An. minimus, An. sundaicus

There is significant achievement in malaria control in Bangladesh during the period from 2008 to 2013 showing a progressive decline in total cases and deaths. The graph below shows the epidemiological trend of case incidence and deaths 2007-2013.

Figure: Malaria cases and deaths from 2007 to 2013 (Source: MIS, NMCP)



The NMCP had the GFATM support since 2007 and there was an increase in number of cases in 2008 due to scaling up of interventions; introduction of RDT for diagnosis and ACT for treatment of *P. falciparum* cases. Thereafter, a steady decline is noted from 84,690 cases in 2008 to 26,891 cases in 2013, having nearly 68.2% reduction. The total deaths came down to 15 as against 154 in 2008 showing a reduction of 90.2%. The table below shows district-wise epidemiological data of the 13 endemic districts for three consecutive years for a comparison based on total cases and API of malaria in the country.

District-wise Epidemiological data (13 Districts) : 2011-2013 (Source: MIS, NMCP)

District	Population	2013		2012		2011	
		Total Cases	API	Total Cases	API	Total Cases	API
Sherpur	420,100	43	0.102	73	0.174	69	0.162
Mymensingh	486,327	74	0.152	168	0.345	244	0.502
Netrokona	496,785	199	0.401	285	0.574	270	0.543
Kurigram	269,790	64	0.237	101	0.374	168	0.623
Sylhet	887,254	360	0.406	436	0.491	444	0.500
Hobigonj	580,134	34	0.059	72	0.124	65	0.112
Sunamgonj	1,623,839	488	0.301	540	0.333	461	0.284
Moulvibazar	1,744,700	198	0.113	421	0.241	448	0.257
Chittagong	3,296,471	648	0.197	1,095	0.332	1,415	0.429
Khagrachari	613,917	4,096	6.672	5,997	9.768	12,952	21.097
Rangamati	595,979	7,976	13.383	7,981	13.391	13,676	22.935
Bandarban	388,335	9,459	24.358	8,461	21.788	16,111	41.451
Cox's bazar	1,843,493	3,252	1.764	3,888	2.109	5,472	2.968
Total	**13,247,124**	**26,891**	**2.030**	**29,518**	**2.228**	**51,795**	**3.908**

There is a variation in malaria cases across the sex and age groups. During the 2008-2013, males consistently had more positive diagnoses than females; adult age group suffered more than the other age groups but the incidence of cases in three age groups (0-4yr, 5-15yr and 15+ yrs) were almost same.

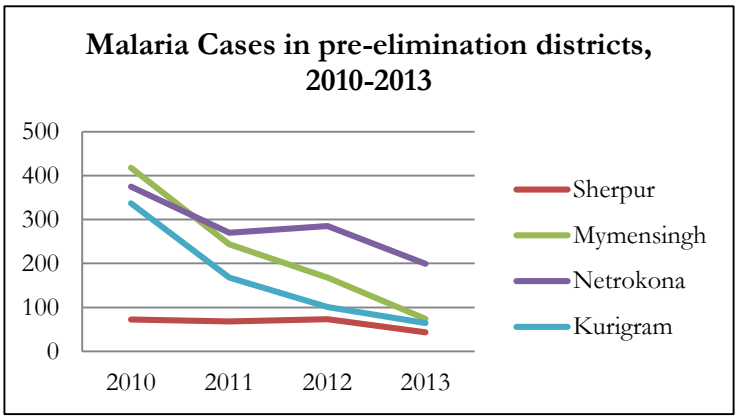
Further, the Millennium Development Goals (MDGs) that were established to focus international efforts on addressing critical issues related to health, poverty and equity wherein malaria features

prominently. Bangladesh is also on track to achieving the malaria MDGs and targets. The Table below shows the status of MDG and targets related to malaria in 2012-13 as compared to baseline 2008.

Malaria MDG Goals and Targets (Source: MIS, NMCP)

Indicators	Baseline 2008	Current Status (2013)	Target 2015
Prevalence of Malaria per 100,000 population	776	203	310
Deaths of Malaria per 100,000 population	1.4	0.1	0.6
Proportion of children U-5 sleeping under insecticide treated bed nets	81%	90.1%	90%
Proportion of children U-5 who are treated with appropriate anti malarial drugs	60%	96%	90%

Buoyed by the promise of declining trend of malaria in high and moderate endemic districts and very few reported cases and deaths in selected areas in 09 low endemic districts, the GoB is confident on embarking upon the paradigm shift from control to phased elimination by 2020. Such ambitious vision would be made possible by the full commitment and a mission mode that entails intensified and multi-pronged application of locale-specific interventions in the next six years for reducing number of locally acquired cases to zero and number of active foci to zero. The endeavour is initiated by interruption of local transmission of malaria in the four low endemic districts of the country and progressively expanding to other districts. Four districts (Mymensingh, Netrakona, Sherpur and Kurigram) with eight endemic upazilas have low transmission of malaria and have shown <5% malaria positivity rates (RDT and Microscopy) over last three years. The declining trend in these four districts over the last four years is shown below.



Population at Risk; key population

The total population at risk of malaria in the 13 endemic districts is approximately 13.25 million (Census, 2011) [Upazila/union-wise population is appended as Annex 17).

Key populations are groups that face an increased burden and/or vulnerability due to a combination of biological, socioeconomic, and structural factors combined with lower access to services. Malaria affects all age groups and both males and females; however, adult males are commonly affected mainly due to occupations and behavior that put them at risk of being bitten by malaria vectors. Pregnant women and children <5 yrs are biologically at higher risk and they tend to develop more severe malaria due to low level of immunity. Thus, in high transmission areas, these groups should be given priority for interventions. High risk populations (key population) includes:

- Settlers, Jhum cultivators and forest goers
- Refugees and mobile population
- Armed Forces, Border Guards and Police Force members from non-endemic areas working in the hill tracts
- Travelers from non-endemic areas
- People from endemic areas residing in non-endemic areas for a long time and returning home
- People with HIV/AIDS
- Young children, particularly under <5 yr children

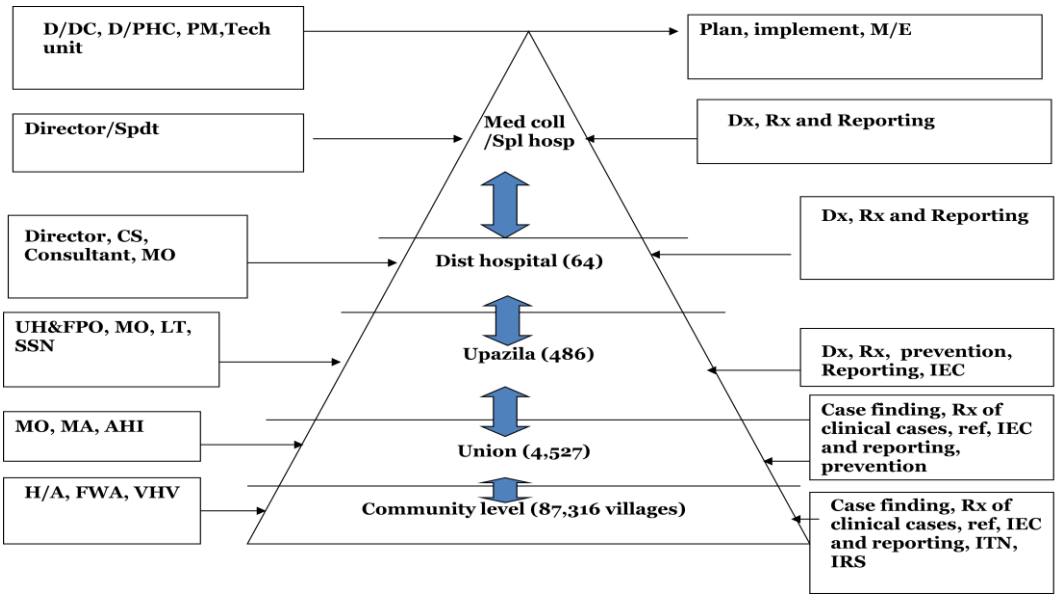
- Pregnant women

Most malaria cases and deaths probably occur among these key populations, as malaria transmission is intense in areas inhabited/frequented by them. Hence, they remain central in the fight against malaria.

The indigenous population constitutes about 50% of the total population in CHT districts. The tribal hamlets are in clusters in the remote hills and foothills. Most of the houses are thatched built with indigenous material e.g. bamboo, wood etc. and these houses seldom have any protection against the vector mosquitoes. The aggregation of laborers for development work sometimes further aggravates the malaria situation in these areas. Settlers coming from the plain areas of the country in the hill district are non-immune and more prone to get malaria infection. Seasonal workers such as Jhum cultivators, forest goers etc. are at high risk group due to staying overnight in open spaces in the forest and hill. There are higher than average levels of malaria in border areas which may be due to migration to and from endemic areas of neighboring India and Myanmar. The Cox's Bazar district remains particularly vulnerable especially in view of such scenario and possible emergence and spread of Artemisinin resistance that is already noted in parts of Myanmar.

Women and girls are at particular risk for malaria during pregnancy with an associated increased risk of death or adverse birth outcomes. Human rights and gender inequalities are being addressed well through universal access to health care services at all levels. Gender inequalities that sometimes hinder effective responses to malaria and health vulnerabilities for both women and men ('jhum' cultivators, wood cutters, other travelers) are addressed by the National Malaria Control Programme by strengthening/orienting the program implementation to ensure right to health of women and girls as well as men and boys. Women are able to utilize insecticide treated nets (ITNs), to receive antenatal care, or to take their malaria-stricken children to health services without any inhibition. In addition, men who are at higher risk if they work in mines, fields or forests at peak biting times, are also having access to health care services and effective tools. The NMCP and BRAC have integrated gender indicators and gender-responsive monitoring and evaluation into the NSPs. The outcome indicator is 'Proportion of pregnant women who slept under an ITN the previous night'; in addition to collation of age- and sex-disaggregated routine data, amongst others. LLIN/ITN usage among high-risk pregnant women and children under 5 has reached to desired level (Malaria Indicator Survey, Annex 18). Beneficiaries report high levels of satisfaction with the services offered through the programme [Client Satisfaction Survey-NMCP, 2010 (Annex 19)].

An overview of health systems in Bangladesh is as under:



The main weaknesses of and/or gaps in the health system that affect malaria outcomes are:

- Inadequate access to treatment especially in hard-to-reach, border areas and tribal population areas.
- Inadequate referral services and severe malaria management in hospitals.
- Vacancies /under staffing especially at the hard to reach areas; inadequate trained personnel and frequent turnover.
- Issues related to timeliness and incomplete health and disease surveillance

- Inadequate monitoring and evaluation of health system and health programs regarding output, outcome and impact.
- Inadequate linkages with private health providers
- Inadequate linkage between different health departments and programs and other development sectors

The Government of Bangladesh is now implementing the sector wide Health, Population and Nutrition Sector Development Program (HPNSDP), July 2011 - June 2016 for strengthening the health systems. These services aim at improving priority health services in order to accelerate the achievement of the health related MDGs. Increased attention is given to Maternal, Neonatal, Child, Reproductive and Adolescent Health; Communicable and non-communicable Diseases; Climate Change and Health Protection; Disease Surveillance; and Behavior Change Communication (BCC) related programmes. The Malaria Control Program activities are integrated with HPNSDP and the primary health care services delivery.

The GoB is addressing the weaknesses/gaps with the support of the Global Fund and government's HPNSDP budget (PIP of HPNSDP is Annex 20). Access to diagnosis and treatment with effective diagnostics and antimalarials has been expanded; 204 microscopy centres operating; and RDT for malaria has been provided in the community. Treatment with ACT has been extended up to the community level by both GoB and NGOs. Union Sub centre, Health & Family Welfare centres, Community Clinics are being envisaged to be increasingly integrated for improving outreach services for diagnosis and treatment. Health workers and volunteers have been recruited and trained to carry out the activities by NGOs. Multi-sectoral coordination and partnership is being strengthened between the GoB, Development Partners, NGOs, Private Sector Organizations as their participation at all stages are required for successful implementation of HPNSDP. The PSM improvement is being done to ensure un-interrupted supply of LLINs, drugs, diagnostics and logistics. Program management capacity is being improved by recruiting human resources. Capacity building with training and re-training of health workers and managers at different levels were carried out by both GoB and NGOs. In addition to the government and partner NGO health set up, private clinics and practitioners, village doctors and traditional healers are providing health care, who are being oriented on rational treatment. Timely, accurate and complete reporting of programmatic activities is being done. M&E strengthening is focused on tracking of outputs, outcome and impact. Micro-stratification and micro-level planning (i.e. targeted programming for specific localities and populations) are being emphasized to ensure equitable and context-specific approach for effective malaria control.

The WHO provides technical support for the areas related to Monitoring and Evaluation, Drug Resistance Monitoring; and capacity development at the national level. Institution/groups like Malaria Research group (MRG); Bangladesh Institute of Tropical and Infectious Diseases (BITID); Institute of Epidemiology, Disease Control and Research (IEDCR); National Institute of Preventive and Social Medicine (NIPSOM); and International Center for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) are collaborating in the areas of research and training and supporting to address identified gaps in implementation of the malaria program.

1.2 National Disease Strategic Plans

With clear references to the current **national disease strategic plan(s)** and supporting documentation (include the name of the document and specific page reference), briefly summarize:

a. The key goals, objectives and priority program areas.

b. Implementation to date, including the main outcomes and impact achieved.

c. Limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints described in question 1.1 are being addressed.

d. The main areas of linkage to the national health strategy, including how

implementation of this strategy impacts relevant disease outcomes.

e. For standard HIV or TB funding requests[1], describe existing TB/HIV collaborative activities, including linkages between the respective national TB and HIV programs in areas such as: diagnostics, service delivery, information systems and monitoring and evaluation, capacity building, policy development and coordination processes.

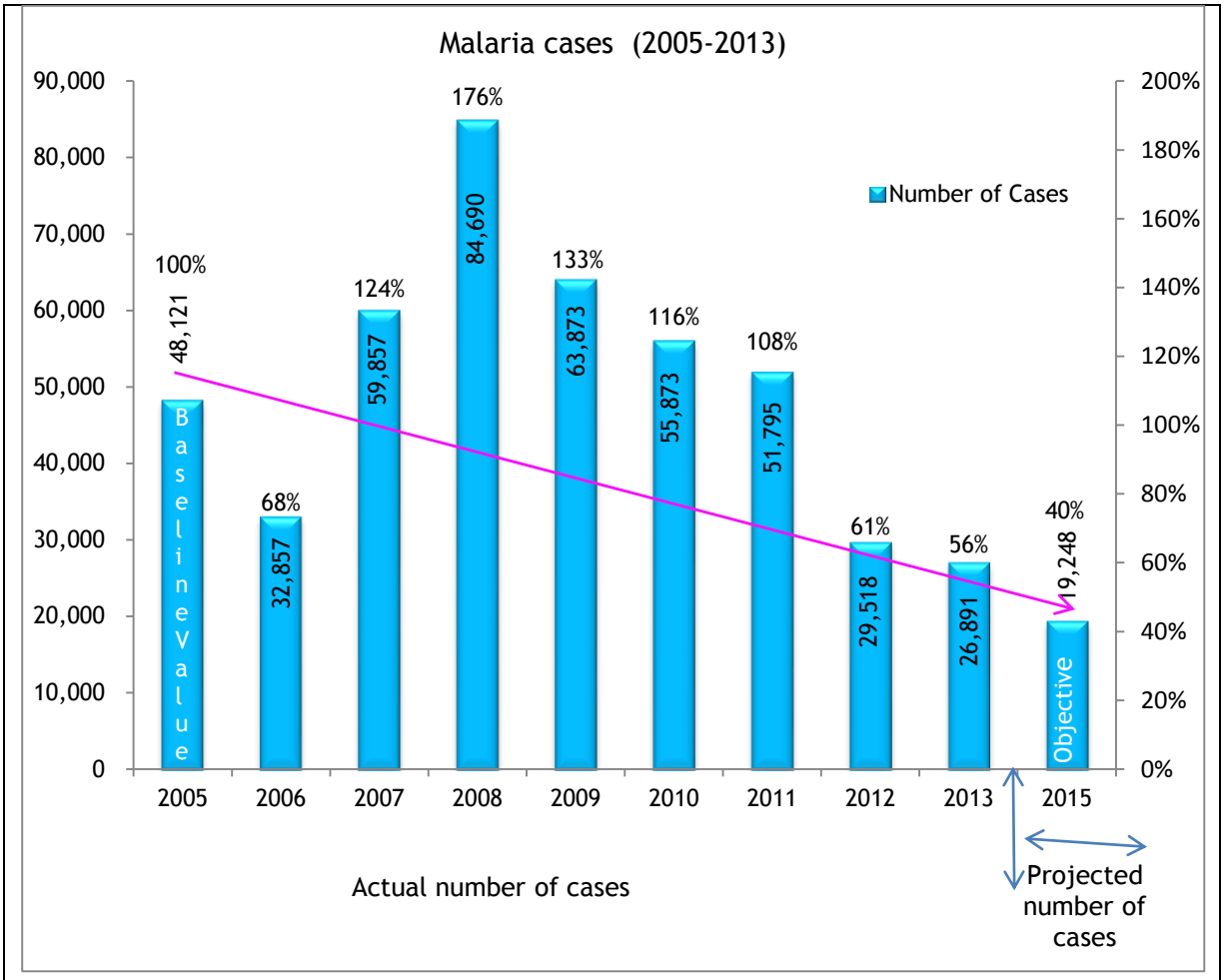
f. Country processes for reviewing and revising the national disease strategic plan(s) and results of these assessments. Explain the process and timeline for the development of a new plan (if current one is valid for 18 months or less from funding request start date), including how key populations will be meaningfully engaged.

The existing National Strategic Plan (2008-2015) envisaged 60% reduction of malaria morbidity and mortality (compared to baseline 2005) by 2015 with the specific objectives of: i) providing early diagnosis and prompt treatment (EDPT) with effective drugs to 90% of malaria patients; ii) ensuring effective malaria prevention to 100% population at risk in five high endemic districts and 80% in the remaining eight districts; iii) providing pre-referral treatment and timely referral of 90% of severe malaria cases; iv) strengthening surveillance, establishing Rapid Response Team (RRT) for containment of outbreaks; vi) promoting community participation, partnership with NGOs and private sector and vi) strengthening management capacity, M&E and Procurement and Supply Management (PSM) systems in the National Malaria Control Programme (NSP 2008-2015 is appended at Annex 21).

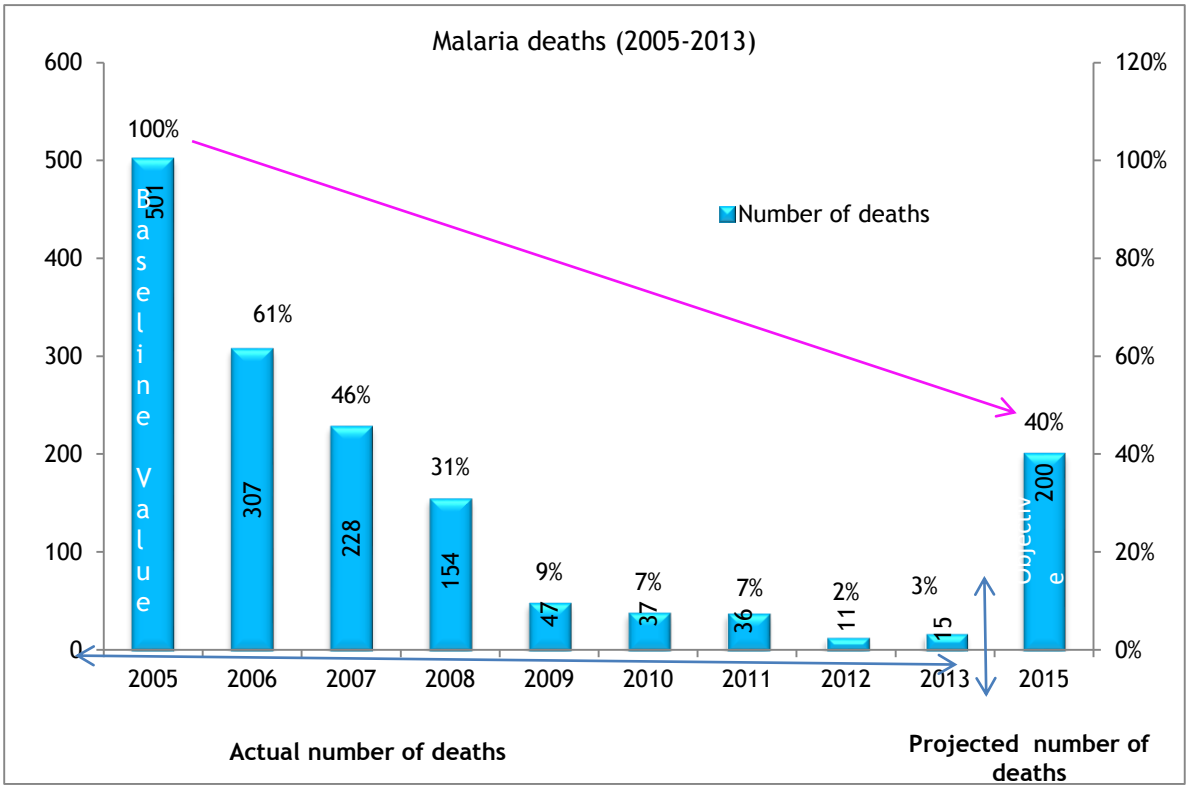
Largely, National Malaria Control Programme has been successful in achieving the set objectives and targets of NSP. The case incidence has a progressive decline and deaths due to malaria have been reduced remarkably over last a few years compared to baseline (2005). However, these gains need to be sustained and enhanced by NMCP and the programme warrants a major shift towards embarking on a stratified phased elimination to eventually achieve the goal of a malaria free Bangladesh, in near future. This is the background of the **National Strategic Plan (2015-2020)** [Annex 22] for Malaria Control (described later).

Achievements towards the Goal of Malaria Control Programme is presented in the figures below:

[1] Countries with high co-infection rates of HIV and TB must submit a TB and HIV concept note. Countries with high burden of TB/HIV are considered to have a high estimated TB/HIV incidence (in numbers) as well as high HIV positivity rate among people infected with TB.



Achievement (number of cases) by the target year 2015



Achievement (number of deaths) by the target year 2015

Although malaria diagnosis remained a key intervention per the NSP, with the application of RDT under the GF Round 6, a total of 2,854,150 fever cases were examined nationally by RDT and/or

microscopy (May 2007-Dec 2013). The number of confirmed malaria cases (by RDT and microscopy) was 363,694 of which 306,005 were falciparum malaria cases during the same period. Around 3,500 health workers from GoB and 2,500 *Shasthya Kormi* and *Shasthya Shebika* (community based service providers of BRAC) provided malaria diagnose and treatment services.

The achievement in terms outcomes include: utilization of LLIN/ITN by under 5 children the night before is 90.1% and the same in pregnant women is 85.4% (Distribution and Utilization of insecticidal bed nets among rural people in malaria endemic districts Bangladesh 2013, Annex 18). The percentage with at least 2 LLINs/ITNs is 58.1 and that with at least 1 LLIN/ITN is 76.5. BCC activities contributed to the outcomes and being continued to ensure that people use those nets.

The obstacles or limitations to the implementation of the NSP 2008-2015 are provided below:

- Geographical inaccessibility; socio-economic barriers
- High endemicity of malaria in border areas
- Reported insecticide resistance
- Drug resistance particularly ACT in neighboring countries
- Asymptomatic malaria, G6PD prevalence

Further, the Malaria Programme Review (MPR) in June 2011 and the Mid-Term Review (MTR) in April 2014 also highlighted programmatic achievements, strengths, weaknesses and gaps to address for creating a sustainable impact in malaria control through stratified micro-planning based on evidences that would support further reducing disease burden in low malaria endemic districts as against a blanket approach to implementation of malaria interventions, countrywide.

The Mid Term Review of the Malaria Program conducted in April 2014 highlighted the following findings (Annex 23):

- Diagnosis of uncomplicated and severe malaria and treatment sometimes are not according to the national guidelines. Private sector, other governmental sectors and civil society organizations are to be involved more effectively.
- Epidemiological and entomological surveillance and M&E need to be strengthened. Therapeutic efficacy study is ongoing and so far no evidence of resistance is found.
- Vacancies of medical and paramedical cadres and rapid turnover especially in hard to reach areas pose a threat to program implementation.
- Effective cross-border collaboration is yet to be established for addressing malaria problems.
- Quality assurance and quality control system for malaria microscopy/RDT is in place but needs further improvement.
- Certain areas with increased risks of transmission and high vector prevalence ("Hot-Spots") require focused interventions.

Salient recommendations from the Mid Term Review are as under:

- Given the achievements, phased elimination may be adopted with immediate effect.
- Further establish and enhance the existing community health unit structures and functions, especially in remote areas.
- Focused results driven cross border activities to sustain elimination should be undertaken jointly with India and Myanmar.
- Entomological capacity building to support a well-informed, scientifically driven elimination strategy.

National Health Strategy linkages: The sector programme (HPNSDP) provides more focus on improving health services and strengthening Health Systems which are interdependent and mutually reinforcing. These services aim at improving priority health services in order to accelerate the achievement of the health related MDGs. These components add increased attention to Maternal, Neonatal, Child, Reproductive and Adolescent Health; Communicable and non-communicable Diseases; Climate Change and Health Protection; Disease Surveillance; and Behavior Change Communication (BCC) related programmes.

Malaria control is one of the priorities under sector programme and has coordination and synergies in implementation with other programmes implemented through PHC approach. At the community level programme activities are delivered through multipurpose health workers and have shared values in related fields of training, job-orientations and responsibilities. The Ministry of Health & Family Welfare collaboration with other relevant ministries and organizations including NGOs and the private sector. Internal coordination among programmes for mainstreaming gender, equity and value for the voices of the people living with diseases, are always emphasized. Where ever possible,

HIV, TB-Leprosy, Visceral Leishmaniasis, and Lymphatic Filariasis elimination programmes are considered for synergistic interventions along with malaria elimination interventions at various levels.

As mentioned previously, the GoB is undertaking and plans to ensure the following interventions and activities towards strengthening/expansion of the linkages:

- Overall health system Strengthening– strengthening of community clinic, referral linkage, PPP;
- Strengthening of community participation in malaria prevention, early care seeking and vector management
- Identifying and targeting hot spot and its management
- Innovative initiative for targeting hard to reach areas including but not limited to, strengthening of multi sectoral collaboration (e,g; inclusion of regimental forces)
- Cross border collaboration (especially in view of possible emergence of Artemisinin resistance as well as to tackle malaria in migrant/IDPs, refugees, etc.); climate change issues and its potential impact on increasing malaria incidence further emphasizes the need for collaborative efforts across the borders;
- Strengthening surveillance by improving data quality through supportive supervision and by involving private hospitals and practitioners
- Orientation of private practitioners to follow the malaria national treatment regimen and report the malaria cases in national MIS; sensitization of hotel owners targeting tourists coming from non-endemic areas
- Increasing diagnosis and treatment facilities
- Conducting operational researches to generate evidences for malaria elimination.

The paradigm shift due to epidemiological changes and the gradual shrinking of the malaria map in low transmission districts created the need for re-orientation of the malaria control programme towards stratified and phased elimination of malaria in Bangladesh. Hence, a new **National Malaria Strategic Plan (2015-2020)** [Annex 22] has been formulated with the goal of "By 2020, to have achieved 'zero indigenous transmission' and 'zero death' aiming malaria elimination in Bangladesh". The objectives of the strategy are i) To achieve 100% coverage of 'at risk' population with appropriate malaria preventive interventions by 2018; ii) To have 100% malaria patients receiving early and quality diagnosis (RDT or Microscopy) and effective treatment by 2018; iii) To continue strengthening of programme management towards elimination by 2020; iv) To continue strengthening of disease and vector surveillance, Monitoring and Evaluation towards malaria elimination; v) To intensify Advocacy, Communication and Social Mobilization (ACSM) for malaria elimination. National Malaria Control Programme would have systematic programme reorientation and action planning (Business Plan) to achieve set objectives, targets and the goal for elimination.

The **National Strategic Plan (2015–2020)** has been developed by an expert committee with the support from a consultant fielded by JDTAF (DFID) through a multi-stakeholder and multi-sector participatory approach in line with recommendations from the Malaria Programme Review (MPR) and the Mid-Term Review (MTR) of the National Malaria Control Programme (NMCP) conducted during June 2011 and April 2014, respectively. The process included: i) Desk reviews of documents, ii) multi-stakeholder consultation and internal meetings with experts, iii) SWOT analysis and gap analysis workshop, iv) Malaria Technical Committee meeting and v) inputs from expatriate and national experts. Finally, the Technical Committee has endorsed the NSP 2015-2020.

SECTION 2: FUNDING LANDSCAPE, ADDITIONALITY AND SUSTAINABILITY

To achieve lasting impact against the three diseases, financial commitments from domestic sources must play a key role in a national strategy. Global Fund allocates resources which are far from sufficient to address the full cost of a technically sound program. It is therefore critical to assess how the funding requested fits within the overall funding landscape and how the national government plans to commit increased resources to the national disease program and health sector each year.

2.1 Overall Funding Landscape for Upcoming Implementation Period

In order to understand the overall funding landscape of the national program and how this funding request fits within this, briefly describe:

a. The availability of funds for each program area and the source of such funding (government and/or donor). Highlight any program areas that are adequately resourced (and are therefore not included in the request to the Global Fund).

b. How the proposed Global Fund investment has leveraged other donor resources.

c. For program areas that have significant funding gaps, planned actions to address these gaps.

Currently, the funding landscape for malaria control in Bangladesh entail the following sources:

- GoB funding
- GFATM funding (current Phase2 until June 2015)
- WHO
- Others (Private sector, JICA, ACT Malaria, etc)

In order to achieve lasting impact, financial commitment from the GoB would play key role to realize the implementation of the NSP 2015-202020. While the Global Fund allocates funding to the country, these resources have and would remain additional, nevertheless critical in moving forward and scaling up various interventions, viz. procurement of LLINs through the VPP mechanism. For intensifying certain interventions like vector control other than LLINs (e.g. focal IRS), GoB funding would be made available for implementing activities relating to mapping and management of vector breeding sources, focal IRS etc. The requested funding (Allocation and Above) in the concept note as submitted by the Bangladesh-CCM, would fit within the overall funding landscape, including other donor funding, and it would be clearly highlighted how national government plans to commit increased resources to the national disease program and health sector each year.

The Global Fund remains one of the key external resources. However, the systems and processes with the funding provision have been continually strengthened, and the scaling up for impact is being noted by the wider stakeholders as well as the GoB. Going forward, such outcomes are expected to be leveraged for mobilization of additional donor resources.

The effective interventions being applied currently with the GoB and especially GF grant and achievement of desirable outcomes and impacts are also expected to be highlighted for requesting funding from the 'Above' piece too. The GF as well as other donors would thus, be provided an opportunity to partner in the journey for malaria elimination in Bangladesh.

Further, some strategic interventions that would still require funding beyond the proposed concept note funding request (with funding under allocated/above categories) include: procurement of insecticide for IRS; procurement of K-O tab for insecticide treatment of community owned bed nets; establishment of PCR laboratory for diagnosis; Technical Assistance (TA) for entomology/QA/procurement and supply chain management, etc; further intensification of ACSM; and additional operational research. These remain the unfunded quality demand, which additional donor investments can further contribute to in the pathway to malaria elimination; while GoB initiatives would be taken to mobilize resources from domestic as well as external sources (including the GF) leveraging the progress made towards impact and moving forward to elimination.

2.2 Counterpart Financing Requirements

Complete the Financial Gap Analysis and Counterpart Financing Table (Table 1). The counterpart financing requirements are set forth in the Global Fund Eligibility and Counterpart Financing Policy.

a. Indicate below whether the counterpart financing requirements have been met. If not, provide a justification that includes actions planned during implementation to reach compliance.

Counterpart Financing Requirements	Compliant?	If not, provide a brief justification and planned actions
i. Availability of reliable data to assess	☐✓Yes ☐ No	

compliance		
ii. Minimum threshold government contribution to disease program (low income-5%, lower lower-middle income-20%, upper lower-middle income-40%, upper middle income-60%)	☐✓Yes ☐ No	
iii. Increasing government contribution to disease program	☐✓Yes ☐ No	

b. Compared to previous years, what additional government investments are committed to the national programs in the next implementation period that counts towards accessing the willingness-to-pay allocation from the Global Fund. Clearly specify the interventions or activities that are expected to be financed by the additional government resources and indicate how realization of these commitments will be tracked and reported.

c. Provide an assessment of the completeness and reliability of financial data reported, including any assumptions and caveats associated with the figures.

Please find attached Table1 with financial gap analysis and counterpart financing (Annex 24) providing details of the funding landscape for the malaria component.

Past spending, as well as projections of government contribution in the next implementation period to both malaria and health shows an overall increasing trend. Total government contribution to the National Malaria Control Programme is incremental over time on account of capital expenditure budgeted in earlier year. However, Bangladesh is in compliance with counterpart financing requirements of 5%. Reliable spending data is derived from the Bangladesh government budgets that have specific line items, and captures government allocation to diseases and the health sector. The country has systems to track and routinely report spending by source of funding. In addition, the country has institutionalized National Health Accounts (NHA), including disease sub-accounts that support tracking of expenditure by source of funds and key services.

The counterpart financing based on existing Global Fund commitments and indicative financing is 25%. The counterpart financing based on existing Global Fund commitments and total funding request is 16%.

The interventions and activities by GoB would include: HR, capacity building and institutional strengthening, acquisition of assets, taxes and duties

In view of the counterpart financing share by the the GoB and expected incremental budget for NMCP, the fulfillment of willingness to pay is met to access the full allocation (additional funding and existing funding).

The financial data sources include, HPNSDP (GoB) documents, WHO and other donor sources.

SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND

This section details the request for funding and how the investment is strategically targeted to achieve greater impact on the disease and health systems**.** It requests an analysis of the key programmatic gaps, which forms the basis upon which the request is prioritized. The modular template (Table 3) organizes the request to clearly link the selected modules of interventions to the goals and objectives of the program, and associates these with indicators, targets, and costs.

3.1 Programmatic Gap Analysis

A programmatic gap analysis needs to be conducted for the three to six priority modules within the applicant's funding request.

Complete a programmatic gap table (Table 2) detailing the quantifiable priority modules within the applicant's funding request. Ensure that the coverage levels for the priority modules selected are consistent with the coverage targets in section D of the modular template (Table 3).

For any selected priority modules that are difficult to quantify (i.e. not service delivery modules), explain the gaps, the types of activities in place, the populations or groups involved, and the current funding sources and gaps.

The programmatic gap table (Table2, Annex 25) is appended with the concept note detailing the quantifiable modules (viz. prevention: LLINs; case management: RDT, ACT). In addition, gap in specific intervention like health & community workforce capacity building (medical technologists/laboratory technicians) has been included in Table 2.

Overall, the coverage levels in the modular template (Table3-Annex 26.1) are consistent with the coverage levels shown in Table2. The programmatic gap analysis is focused on program coverage. The respective coverage indicators specified in Table 2 are harmonized with those in Table 3-Modular Template (the modular template draws from budget for the period of July 2015 to December 2017, i.e. 30 months-Annex 26.2).

For each priority module, the overall need, the proportion of need already being covered, and the proportion of the need that is proposed to be covered by Global Fund funds towards positioning all of the Global Fund financing (including existing funding, the allocated amount, and the request above the allocated amount) within the national coverage gaps identified.

The modules like programme management, HIS and M&E, other interventions under the Health & Community Workforce details are in the Table3 only.

The funding is requested under both Allocated and Above Allocated categories. In addition, funding would be provided through the GoB and other external sources like the WHO (for specific interventions).

However, funding gap of USD 6,286,219 remains. The GF may kindly consider yet additional funding (beyond the Allocated and Above Allocated categories) in terms of the unfunded quality demand.

3.2 Applicant Funding Request

Provide a strategic overview of the applicant's funding request to the Global Fund, including both the proposed investment of the allocation amount and the request above this amount. Describe how it addresses the gaps and constraints described in questions 1, 2 and 3.1. If the Global Fund is supporting existing programs, explain how they will be adapted to maximize impact.

The funding request is sought towards fulfilling the desired vision and mission of malaria elimination in Bangladesh by 2020 as per NSP 2015-2020. The programmatic gaps, implementation constraints, requirements to cover the at risk and key populations, provided insights in estimating the funding request.

This concept note remains critical for the need to sustain the gains, and strengthen/scale up the ongoing efforts with the GoB and GF investments towards universal coverage with effective preventive and curative interventions and ACSM, M&E, program management, etc., as the Phase2 would conclude in June 2015 (Phase2 core elements being: Diagnosis, prompt, effective treatment; BCC: community outreach; HSS: Health Workforce/Service Delivery/Information systems–M&E; Prevention: LLIN). The implementation experience has been and would be a major cornerstone for way forward in maximizing impact.

However, recognizing the limited allocation amount of USD 30,383,639 including USD 21,823,289 as additional funding and USD 8,560,351 (as of Jan. 1, 2014) as existing funding; the applicant request has been split under 'allocated' and 'above allocated' categories. The GF is requested to positively consider the request for funding under the 'Above' category until 2017. Such consideration would present an opportunity to Bangladesh to ensure application/scale up required interventions to realize the phased elimination as envisioned in the NSP 2015-2020 and to the GF (and other possible donors) to partner in the journey.

It is worth mentioning here that a total amount of USD 327,131 is estimated to be the requirements for the PR1-MoF (GoB) until June 2015. Likewise, for the same period, the PR2-BRAC would require an amount of USD 3,817,512. Hence, a total amount of USD 4,144,643 is estimated as fund requirements for both PR1 (including the WHO) and PR2 until June 2015.

The balance amount of USD 4,415,708 (from existing funding as mentioned above-Ref. Country Allocation Letter) would therefore, be more than the amount included in the funding request under the 'Allocated' category.

In view of the above, an amount of USD 4,064,648 that would be required per proposed funding request would be sought from such savings (from the existing funding of ongoing Phase2 until June 2015), has been included under '**Allocated**' category.

However, if different scenario emerges with regard to the expected savings, viz. on the upper or the lower side, then re-prioritization would be attempted under specific modules and interventions as mentioned below.

The total funding request under the allocated and above allocated categories for 13 endemic districts is for the period of July 2015 to December 2017 for 30 months.

Funding request under '**Allocated**' category: USD 25,887,937
[PR1-MoF, GoB: 15,414,943 (60%) and PR2-BRAC: USD 10,472,994 (40%)]

Funding request under '**Above**' category: USD 17,823,851
[PR1-MoF, GoB: USD 13,961,938 (78%) and PR2-BRAC: USD 3,861,913 (22%)]

Total funding request thus, works out to: USD 43,711,787.

If funding request under the 'Above' category remains unmet, then strategic prioritization would be attempted so as to preclude slowing down/limiting application of and scaling up interventions and putting the pathway to elimination at risk.

Further, funding for certain strategic interventions that remains unmet from the overall 'full expression of demand' as detailed in the NSP 2015-2020 and that would require funding beyond the above-mentioned funding request (under allocated/above) include: procurement of insecticide for IRS; procurement of K-O tab for insecticide treatment of community owned bed nets; establishment of PCR laboratory for diagnosis; Technical Assistance (TA) for entomology/QA/procurement and supply chain management, etc; further intensification of ACSM; and additional operational research. These remain the unfunded quality demand, for which additional donor investments would be required. Initiatives would be taken to mobilize resources from domestic as well as external sources (including the GF), which too would leverage the progress made (with GoB/GF/other investments) and supporting Bangladesh in achievement of elimination by 2020.

It should be noted that even though the total number of cases has decreased, the decline is more evident in low endemic non-hill zone in comparison with high endemic hilly and coastal regions. These areas, especially the three districts of CHT and Cox's Bazar, where incidence is the highest

are hard-to-reach and yet not under universal coverage in terms of diagnosis, treatment and prevention; and transmission persists at a relatively high rate. The community-based service providers need to be sustained to ensure maximum coverage. Laboratories are needed to be established in remoter pockets deprived of health services. Further, around 54% of people living in endemic regions are aware of malaria diagnosis and treatment services (Annex 27), which need to be increased through intensifying ACSM activities. Private sector service providers are not yet properly sensitized and brought under routine reporting and surveillance system, which in itself require further strengthening. Targeted programming is needed to reach key populations at risk. Improvement in quality assurance of RDT/malaria microscopy, quality of data would need to be implemented. Other interventions required for phased elimination would be required too. Micro-stratification would be required for strategic planning and ensuring equitable approach for effective malaria control. To support the quality of service delivery, higher levels of M&E support are required. The partnership between the PRs (GoB and BRAC) have become stronger over Phase2 and catalyzed complementary facet of government and non-government sector efforts by sharing responsibilities. A major focus is on strengthening of community outreach programmes to ensure participation of different stakeholders in phased elimination of malaria; and inter-sectoral coordination & collaboration, are and would be major thrust areas. Collaborative efforts with the Armed and paramilitary forces would be needed to cater to the border areas.

The rationale for funding request are also drawn from the following:

- Malaria situation in Bangladesh during the period from 2008 to 2013 showing a progressive decline in total cases and deaths; with 04 districts are already being reaching elimination phase.
- Sustaining the gains made with GoB, GF and other donor investments and intensifying efforts for elimination by 2020.
- Achievements in malaria mortality and morbidity are very fragile. Reduction in malaria mortality and morbidity is achievable with regular interventions; yet, for elimination, sustained and more intensive efforts and resources are necessary.
- Hard-to-reach areas and high risk groups (example, tribal/ethnic groups, jhum cultivators, refugees, etc.) coupled with continuing socio-political challenges and diverse institutions, health seeking behaviour besides yet to be optimal health and community systems require urgent attention.
- Emergence of possible resistance to Artemisinin in view of the risk of possibility of importation of resistant parasite from neighbouring countries.
- Possible insecticide resistance; etc. may influence the disease burden adversely, despite the best efforts.
- Surveillance data are largely from public sector. Hence, the need to collate & integrate data from different sectors. Data quality assurance is required too.
- Multi-sectoral and cross border cooperation and coordination need to be strengthened.
- Need for ensuring rational treatment and reporting by private sector.

An overview of the funding request in line with the NSP 2015-2020 is described below.

Goal

By 2018, to have reduced malaria incidence by 80% (baseline 2013) and achieved near 'zero death' aiming at phased elimination in targeted districts.

Objectives

- To achieve 100% coverage of the people living in endemic areas of 13 districts with effective preventive intervention (LLIN) by 2018.
- To have 100% malaria patients received early and quality diagnosis (RDT or Microscopy) and effective treatment in 13 endemic districts by 2018.
- To continue strengthening of programme management, disease and vector surveillance, M&E, coordination & partnerships.

The priority modules, 05 in number in the concept note (as mentioned below) are in line with the service delivery areas outlined in the NSP 2015-2020.

- Vector control
- Case management
- Health Information System/M&E
- Health and Community Workforce
- Programme Management

Proposed investments of allocation amount and the request above this amount under each objective are described below.

Objective 1: To achieve 100% coverage of the people living in endemic areas of 13 districts with effective preventive intervention (LLIN) by 2018.

Module: Vector control

Interventions:

- **Long-lasting insecticidal nets (LLIN) – Mass campaign**

LLINs would be distributed through mass campaign in endemic areas to reach 100% coverage by 2018 following the change in strategy from household coverage to population coverage (@ 1.8 persons per LLIN). The campaign would prioritize protection of special/vulnerable sections, viz. jhum cultivators, forest goers, pregnant women and children. The procurement would be done by GoB through GF's Voluntary Pooled Procurement (VPP) and LLIN distribution would be done by BRAC led NGO consortium. Implementation approach includes planning and coordination, distribution plan, logistics, communication, training, recording/reporting, supervision & monitoring, etc. The requirement for 100% coverage of 03 CHT districts, Cox's Bazar district and coverage of high endemic pockets in rest of the 09 districts (35% population coverage) is proposed with **allocated** amount.

In view of limited allocated amount, funding request under the '**Above**' category is proposed for the rest of the requirement (45%) to ensure 80% population coverage in endemic areas of 09 low endemic districts (80% of villages fall in endemic areas in 09 districts, hence covering the same would provide 100% coverage in line with the NSP and continuity of SSF).

- **Other vector control measures**

Indoor Residual Spraying (IRS) in selected areas based on case-reporting and investigation for reducing local transmission. It is targeted in low endemic 04 districts, by spraying 60 households as and when a malaria case is reported, for transmission risk reduction. Insecticides and tools would be based on WHO recommendations and standards. Recognizing that IRS is a costly intervention, resources would be mobilized from various sources. The funding is requested under the '**Above**' category, in view of limited allocated amount, although this would be an important intervention towards phased elimination.

As an adjunct to LLINs and IRS, other vector control measures would be adopted such as limited larviciding (with chemical larvicides) and environmental management and modifications in selected areas, towns etc. in 13 districts. These would include, but not limited to, scaling up integrated vector management strategies that can reduce or eliminate vector breeding grounds (entomological survey including mapping of breeding sources and vector density, and cleaning of vegetation, filling of water holes for source reduction, etc.), targeted use of insecticide to kill vector larvae in selected areas determined by the eco-epidemiological situation of malaria in addition to case reporting, investigation and response management and ACSM. These interventions would be applied towards branding selected towns as "Malaria Free Towns" in collaboration with the local govt. (Municipality) in District Sadar Municipality areas of Khagrachari, Rangamati, Bandarban Cox's Bazar, Sunamgonj and Moulvibazar of Bangladesh (Annex 28). Further, management of 'hot spots' in Bandarban, Rangamati, Khagrachari districts by focal IRS is being strategically planned. Funding for these innovative initiatives of using the multi-pronged approach drawn from the IVM concept is requested under '**Above**' category including TA (entomologist), in view of limited allocation, although the interventions would create tangible impact.

[However, if the savings from Phase are more than the above-mentioned expectation (USD 4.06 million), the applicant would further prioritize the vector control interventions, especially relating to the 'hot spot' management and/or increasing the expansion of the initiative of 'malaria free towns'].

- **Entomological monitoring**

For routine entomological monitoring, which would continue as an important intervention as progress is made for phased elimination, capacity building of identified GoB staff (entomology technicians) in 13 districts is being proposed with the **allocated** amount. This would capacitate them to determine and characterize dominant mosquito species in the area, vector density, biting behaviour. The package would include capacity building to test mosquitoes' susceptibility to

insecticides for insecticide resistance monitoring. [Important operational researches on bio-efficacy of LLINs in 5 sentinel sites, insecticide resistance monitoring, net retention have been addressed under the intervention 'Analysis, review & transparency' under a separate module 'Health Information System and M&E'].

- **IEC/BCC.**

The IEC/BCC would ensure correct and regular use of LLINs by translating increased ownership to use to achieve universal coverage for personal protection and reducing risk of malaria transmission. IEC/BCC activities would be applied in 13 districts where LLINs are being/would be distributed. This would include dissemination of LLIN cards with appropriate messages and being proposed with the **allocated** amount.

Objective 2:
To have 100% malaria patients received early and quality diagnosis (RDT or Microscopy) and effective treatment in 13 endemic districts by 2018.

Module: Case management

Interventions:

- **Facility (and Community) based Treatment**

In order to ensure access to early and complete treatment, this intervention is selected. Includes 100% case detection and confirmation by microscopy or Rapid Diagnostic Tests (RDTs), complete treatment of cases with appropriate anti-malaria drugs per national guidelines as well as management of severe and complicated malaria cases with timely procurement through the VPP mechanism (includes buffer and additional quantities for Armed forces, BGB, and selected private providers like medicine sellers/shopkeepers/practitioners/tea garden, MNCHI). Improved microscopy including strengthening of existing laboratory and establishment of new laboratory (in new Upazila Juri), maintenance, etc. QA/QC of antimalarials, RDT/microscopy would be focused too. These interventions are requested with the **allocated** amount.

New laboratories would need to be established in 4 strategic locations to further increase early case detection and access in remote areas. Funding for establishment of these Laboratories, maintenance as well as correct treatment by care providers in identified Upazila, etc. is requested under '**Above**' category.

- **Epidemic preparedness and response**

Strengthening outbreak preparedness and rapid response strategy for early containment of outbreaks being critical, capacity building of rapid response team (in 13 districts) on management of epidemic outbreak is proposed with the **allocated** amount. Under the above-mentioned intervention, buffer stock of RDTs and ACTs has been reflected that would cater to any possible outbreak situation.

- **Active Case Detection and Investigation**

Active case detection/foci investigations to tackle/eliminate parasite reservoir through active detection especially in low endemic 04 districts towards phased elimination is included. The details are: individual case investigation; additional case searching surrounding 60 households of the confirmed indigenous cases; epidemiological survey (Mass Blood Survey) to identify reservoir and additional case, if any. The funding is requested under '**Above**' category in view of limited allocated amount, although this would be a key intervention in the pathway to phased elimination.

- **TES**

Monitoring of therapeutic efficacy of recommended first line antimalarials (AL) for treatment of Pf cases in 13 districts would continue. The study would be conducted in selected sites following the WHO protocol and expected to generate data on efficacy of recommended ACT-AL, thus, ensuring evidence-based treatment and constant watch on Artemisinin resistance. The package would include trainings and information dissemination, etc. too. The funding is requested from the **allocated** amount.

- **IEC/BCC.**

The entire package would comprise development and dissemination of appropriate IEC/BCC, advocacy materials/kits aligned to local cultural and ethnic norms and practices of the target population; sensitization and mobilization events targeting the policy makers and key players for sustained advocacy at various levels. Periodic multi-media campaigns, radio and TV instructional

series, jingles, billboards and community radio, etc. in addition to orientation/sensitization of opinion leaders at community and village level as well as non-health sectors, local governments, etc. remain important for EDPT and especially targeting key populations through channel-mix.

In addition, school-based initiatives being critical in creating change agents in the short- to long term, various programmes would continue. Child-to-Child communication ("Little Doctor" approach) for dissemination of messages as being promoted by the GoB has proven impact in fostering knowledge and awareness and responsive behaviour.

Even though IEC/BCC must be intensified further towards phased elimination in 13 districts, the funding is requested under limited **'Allocated**' as well as '**Above**' categories. While the **allocated** amount would be required to continue the current activities, additional funding under '**Above**' category would be required for intensifying and scaling up (critical need for phased elimination) as well as for resource-intensive electronic media materials and use.

[Evidence generation regarding effectiveness of IEC/BCC methods as well as behaviour change is proposed under the HIS and M&E module].

[If the savings from Phase2 are not as per the expectation and is less than USD 4.06 million, then ACSM activities would be identified as 'unfunded quality demand' and additional resources would be explored].

- **Other**

Yet another critical need is establishment of QA system for microscopy and RDT as well as establishment of molecular diagnostic facility in central and selected district malaria laboratories for phased elimination that would be done by the GoB with WHO support. Therefore, TA would be essential. In addition, special health camps targeting hard to reach areas are being proposed that would possibly ensure reaching the last case.

In view of the limited allocated amount, funding for these interventions is requested under '**Above**' category.

Objective 3: To continue strengthening of programme management, disease and vector surveillance, M&E, coordination & partnerships.

Module: Health and community workforce

Interventions:

- **Health and community workers capacity building**

Improving health workers' technical capacity in service delivery that includes pre- and in-service training with special emphasis on the goal of malaria elimination would be extremely important. Updating and dissemination of training manuals would also be required. Funding for many trainings and related activities (example, ToT, training of medical technologists/LTs and HW/HVs, printing of manuals) is being requested from the limited **allocated** amount.

However, in view of a capacitated workforce working on a mission mode for phased elimination, additional trainings remain priority (Training of field staff on EDPT including pre-referral treatment and Pan RDT; Training on severe malaria management, Artesunate use for doctors; Training on severe malaria management including Artesunate use for medical assistants & nurses; Training of the Community Volunteers on case detection of Malaria, referral and follow up of the treated patient by antimalarials; Training of Spray man, Team Leader & Supervisor), and hence funding is requested under the '**Above**' category.

- **Scaling up health and community workers**

Expansion and scaling up skilled multi-disciplinary and competent workforce would continue to be priority and hence, funding for salary of LTs, Lab Support Staff/Assistants, etc. is requested from the **allocated** amount. The funding request is based on the current grant and the need for continuation especially to further strengthen/scale up the outreach programmes in the hard to reach areas. More so, because Bangladesh is aiming at phased elimination and additional thrust is imperative.

In view of limited allocated amount, salary of staff to further strengthen program implementation especially diagnosis, etc. in additional (new) laboratories, funding is requested under '**Above**'

category.

- **Retention and distribution of health and community workers**

Improving equitable distribution and retention of skilled workforce especially in hard-to-reach areas would be emphasized. Hence, remuneration of HW; Cost for M Health (Mobile communication for HW in remote areas who are engaged with diagnosis, treatment & follow up); incentive for HVs to ensure EDPT & follow-up; and branding accessories for HWs/HVs (bag, apron & tin-signboard, etc.) for easy recognition are being requested with the **allocated** amount as continuation. However, in view of limited allocated amount, remuneration of additional HW to cover additional pockets; and branding accessories are requested under '**Above**' category.

Module: Health Information Systems and M&E

Interventions:

- **Routine reporting**

Establishment/maintenance/strengthening of MIS/LMIS for routine data collection, recording and reporting in public and NGO sector are and would continue to be extremely important. Related web-based/electronic system to support data reporting from all levels; training; reporting forms and tools; data quality assessment and validation including supervisory visit, periodic meeting on performance review at various levels would continue to further strengthen correct, complete & timely reporting by implementing locally appropriate Internet and communication technologies, such as mobile phone and web based systems, etc. These would be funded with the **allocated** amount.

However in view of limited funding, for the rest of the cache of activities, the funding is requested under the '**Above**' category as replacement IT equipment and mobility support, review and planning meetings, joint supportive supervision, monitoring by additional staff, dissemination of treatment card, etc. would be imperative for phased elimination.

- **Analysis, review and transparency**

Identification of evolving research needs and generating evidence and database especially relating to elimination would be quite important. In addition, analysis, interpretation and use of data and evidence generated through operations research for programmatic and policy decision, mid course correction, way forward, etc. would be emphasized. Hence, the funding is requested under **Allocated** category for operational research on Bio-efficacy of LLINs in 5 sentinel sites, insecticide resistance monitoring and net retention. Additional OR would be funded from the GoB and other donors.

- **Surveys**

Periodic program evaluation remains the foundation for guiding the programme policy, strategy and interventions. In addition, surveys/studies (Malaria Indicator Survey and others) related to assessment of morbidity, mortality, service coverage and behavioral surveys/studies in general population or in key populations would continue. These components would be conducted with the **allocated** funding.

- **Other**

Documentation and dissemination of information products, viz. Annual Report, guidelines, SOPs, M&E Plan, etc. are requested with **allocated** funding.

As progress is made towards phased elimination, establishment of elimination data base of cases and development of data base on foci; strengthening malaria surveillance system, especially at lower levels would be extremely important. Further, as part of ensuring that resource-intensive media like TV and Radio airing is monitored for effectiveness, the same is proposed to be strengthened. However, in view of limited allocated finding, the request for funding is proposed under '**Above**' category.

Module: Program management

Interventions:

- **Policy, planning, coordination and management**

As part of this intervention, the Technical Committee comprising technical experts and stakeholders, partner organizations would discuss policy, strategies, implementation,

analysis/review of performance and evidence, etc., for providing guidance on all aspects including going forward with the phased elimination agenda. Technical consultation on micro-stratification would also be incorporated in such agenda. Another significant component, coordination at the local, district, regional and national levels aimed at harmonized planning, budgeting and financing and programme implementation towards reinforced partnership with NGO, Technical and Development agencies and research/academic institutions, and other agencies like Armed forces, Border Guard Bangladesh, Police, etc. Further visibility of the programme through events like World Malaria Day, etc. would continue as major thrust area. The funding request for the HR is based on the current grant and the need for continuation especially to further strengthen/scale up the outreach programmes in the hard to reach areas. More so, because Bangladesh is aiming at phased elimination and additional thrust is imperative.

These components are requested to be carried out with the **allocated** funding.

In view of limited allocated funding, capacity building for optimal programme planning, management through management training is proposed under the '**Above**' category besides advocacy meetings, etc. (with leaders/stakeholders especially at local levels) to sustain commitments and realize the vision and mission of the NSP.

- **Grant management**

Global Fund grant management related activities at PR/SR level, including but not limited to, development and submission of grant documents; development/strengthening of operational plans (OP)/budgets; Global Fund grant implementation and management; human resource for program, finance, procurement and administrative assistance, M&E assistance; etc. would continue apart from mobility support, office maintenance, and overheads. Likewise, training/re-training of Managers on management of malaria and programme oversight, etc. for phased elimination would carry on too. In addition, few new positions: Programme Coordinator, Store Assistant, Entomology Technicians are proposed as per felt-need based on paradigm shift in strategy. Participation in International Seminar/Conference/Workshop would be central for cross-learning and coordination within/across national program, sub national authorities and with various other stakeholders in and outside the country. These components are requested with the **allocated** amount.

Certain HR positions (example, night guard for warehouses; driver; staff of support departments); additional fuel and maintenance; office rent, etc. and replacement vehicles are proposed under '**Above**' category, considering the requirement of augmenting the programme implementation.

- **Other**

Towards phased elimination, it is vital that the travelers (in-country/outside) to and from endemic areas are provided guidance on appropriate malaria prevention and treatment, as necessary. In this background, workshop with relevant experts would be held. (Subsequently, the guidelines would be disseminated widely). However, in view of limited allocated funding, the request is proposed under '**Above**' category.

A summary of the funding request for the above-mentioned modules and interventions are as under:

For PR1-MoF, GoB:

Modules	**Sum of Total Y1**	**Sum of Total Y2**	**Sum of Total Y3**	**Total (30 months: Jul '15-Dec '17)**
Vector Control	8,718,410	10,575,281	6,621,745	25,915,435
Above	4,345,628	5,856,127	3,091,150	13,292,905
Allocation	4,372,782	4,719,154	3,530,594	12,622,530
Case Management	430,893	458,589	316,549	1,206,030
Above	102,628	111,041	67,722	281,391
Allocation	328,265	347,547	248,826	924,639
Health and Community Workforce	68,640	89,989	60,167	218,797
Above	51,263	76,903	60,167	188,333
Allocation	17,377	13,087	-	30,464
Health Information Systems and M&E	200,938	183,953	185,784	570,675

Above	12,821	14,103	10,859	37,782
Allocation	188,118	169,851	174,925	532,893
Program Management	613,038	553,885	299,020	1,465,944
Above	125,222	17,288	19,016	161,526
Allocation	487,816	536,598	280,004	1,304,418
PR1 Above Total	**4,637,562**	**6,075,461**	**3,248,915**	**13,961,938**
PR1 Allocation Total	**5,394,357**	**5,786,236**	**4,234,349**	**15,414,943**
PR1	**10,031,919**	**11,861,697**	**7,483,264**	**29,376,881**

For PR2-BRAC:

Modules	Sum of Total Y1	Sum of Total Y2	Sum of Total Y3	Total (30 months: Jul '15-Dec '17)
Vector Control	495,717	556,852	362,022	1,414,592
Above	178,390	256,608	142,584	577,583
Allocation	317,326	300,244	219,438	837,009
Case Management	599,504	945,874	565,740	2,111,119
Above	410,734	728,423	487,509	1,626,667
Allocation	188,770	217,450	78,231	484,452
Health and Community Workforce	1,828,878	1,993,632	1,092,280	4,914,790
Above	298,574	337,225	185,474	821,272
Allocation	1,530,305	1,656,407	906,807	4,093,518
Health Information Systems and M&E	513,351	396,511	166,865	1,076,728
Above	201,858	56,823	33,496	292,178
Allocation	311,493	339,688	133,369	784,550
Program Management	1,779,574	1,965,362	1,072,743	4,817,679
Above	188,505	225,825	129,882	544,213
Allocation	1,591,068	1,739,537	942,861	4,273,466
PR2-Above Total	**1,278,062**	**1,604,905**	**978,946**	**3,861,913**
PR2-Allocation Total	**3,938,963**	**4,253,326**	**2,280,705**	**10,472,994**
PR2	**5,217,025**	**5,858,231**	**3,259,651**	**14,334,907**

3.3 Modular Template

Complete the modular template (Table 3). To accompany the modular template, for both the allocation amount and the request above this amount, briefly:

a. Explain the rationale for the selection and prioritization of modules and interventions.

b. Describe the expected impact and outcomes, referring to evidence of effectiveness of the interventions being proposed. Highlight the additional gains expected from the funding requested above the allocation amount.

The modular template (Table 3) is appended as Annex 26.1 (the modular template draws from budget for the period of July 2015 to December 2017, i.e. 30 months-Annex 26.2)[2].

Rationale: The NSP 2015-2020, current and anticipated programmatic gaps, various program effectiveness that contributed to achieving the desired outcomes and impacts, besides the current, allocated and expected resource envelope from the GoB, GF and other sources, constituted the backdrop for selection and prioritization of 05 modules: viz. vector control, case management, health information system and M&E, health and community workforce, programme management as mentioned in section 3.2.

The modules and interventions are in line with the programme strategies for prevention, EDPT, surveillance and M&E, capacity building and institutional strengthening, ACSM, operational research, planning and administration, coordination and partnerships.

The funding request for the selected modules and interventions is sought under both '**allocated**' and the '**Above**' categories, in view of limited allocated funding. Further, the GF may take note that the full expression of demand per NSP 2015-2020 requirements remain critical too for phased elimination.

An outline of prioritized modules and interventions under each objective is presented below:

Objective 1: To achieve 100% coverage of the people living in endemic areas of 13 districts with effective preventive intervention (LLIN) by 2018.

Module: Vector control

Interventions (please refer to the overview of the funding request for rationale for the selection and prioritization in section 3.2)**:**

- Long-lasting insecticidal nets (LLIN) – Mass campaign (funding request under both 'Allocated' and 'Above' categories)
- Other vector control measures (funding request under 'Above')
- Entomological monitoring (funding request under 'Allocated')
- IEC/BCC. (funding request under 'Allocated')

Expected output/coverage:

- Number of LLINs procured
- Proportion of population at risk potentially covered by long lasting insecticidal nets distributed

Objective 2: To have 100% malaria patients received early and quality diagnosis (RDT or Microscopy) and effective treatment in 13 endemic districts by 2018.

Module: Case management

Interventions (please refer to the overview of the funding request for rationale for the selection and prioritization in section 3.2)**:**

- Facility (and Community) based Treatment (funding request under both 'Allocated' and 'Above' categories)

[2] Cost assumptions are appended as Annex 26.3 and 26.4.

- Epidemic preparedness and response (funding request under 'Allocated')
- Active Case Detection and Investigation (funding request under 'Above')
- TES (funding request under 'Allocated')
- IEC/BCC. (funding request under both 'Allocated' and 'Above' categories)
- Other (funding request under both 'Allocated' and 'Above' categories)

Expected output/coverage:
- Number of suspected malaria cases that receive a parasitological test
- Proportion of confirmed malaria cases that received first-line 24ntimalarials treatment according to national policy
- Proportion of confirmed malaria cases that received first-line 24ntimalarials treatment according to national policy
- Number of Rapid Response Team members trained on Management of Epidemic Out-break
- Number of village doctors oriented on malaria management
- Proportion of health facilities of PR1 without stock-outs lasting >1 week of nationally recommended anti-malarial drugs at any time during the past three months
- Proportion of health facilities of PR3 without stock-outs lasting >1 week of nationally recommended anti-malarial drugs at any time during the past three months

Objective 3: To continue strengthening of programme management, disease and vector surveillance, M&E, coordination & partnerships.

Module: Health and community workforce

Interventions (please refer to the overview of the funding request for rationale for the selection and prioritization in section 3.2)**:**
- Health and community workers capacity building (funding request under both 'Allocated' and 'Above' categories)
- Scaling up health and community workers (funding request under both 'Allocated' and 'Above' categories)
- Retention and distribution of health and community workers (funding request under both 'Allocated' and 'Above' categories)

Expected output/coverage:
- Number of Medical technologist trained/re-trained on malaria microscopy
- Number of laboratory technicians of PR2 trained in malaria microscopy

Module: Health Information Systems and M&E

Interventions (please refer to the overview of the funding request for rationale for the selection and prioritization in section 3.2)**:**
- Routine reporting (funding request under both 'Allocated' and 'Above' categories)
- Analysis, review and transparency (funding request under 'Allocated')
- Surveys (funding request under 'Allocated')
- Other (funding request under both 'Allocated' and 'Above' categories)

Expected output/coverage:
- Percentage of routine reporting units submitting timely reports according to national guidelines
- Percentage of routine reporting units submitting timely reports according to national guidelines

Module: Program management

Interventions (please refer to the overview of the funding request for rationale for the selection and prioritization in section 3.2)**:**
- Policy, planning, coordination and management (funding request under both 'Allocated' and 'Above' categories)
- Grant management (funding request under both 'Allocated' and 'Above' categories)
- Other (funding request under 'Above')

Expected output/coverage:
- Number of meeting for malaria technical committee held
- Number of management staff trained on malaria management

Commitment and commensurate intensification of control efforts and M&E, multi-sectoral partnerships yielded results so far, as demonstrated by existing impact/outcome indicators by overcoming challenges and more importantly envisioning the phased elimination. The impact and outcomes until 2012-13 are presented below:

	Baseline (2008)	Achievement			
		2009-10	2010-11	2011-12	2012-13
Case per 1000 population	7.77	5.22	4.72	3.85	2.00
Death per 100,000 population	1.41	0.40	0.27	0.24	0.09

Therefore, with judicious and scaling up intervention-mix, the goals and objectives as laid out in the concept note are expected to be achieved. However, appropriate resources need to be pledged for the paradigm shift to phased elimination as already mentioned.

The expected impacts and outcomes (relating to goal and objectives) are as under:

Impact

Impact indicator	2012-13 (Baseline)	2015-16	2016-17	2017-18
Confirmed malaria cases (microscopy or RDT) per 1000 persons per year	**2.00 (26,524)**	1.20 (15,914)	0.80 (10,610)	0.40 (5,305)
Malaria deaths per 100,000 population	**0.09 (12)**	0.05 (6)	0.03 (4)	0.02 (2)

The above-mentioned impact in terms of confirmed malaria cases (microscopy or RDT) per 1000 persons per year has been estimated on the basis of the assumption that there would be decline @20% in each year from 2013. The trend of decline is estimated based on the previous three years decline trend (the declining trend from 2010-11: 10%; 2011-12: 19%; 2012-13: 37%; which averages around 20%). Malaria deaths per 100,000 population is expected to reach 'near zero' by 2018.

It is assumed that with intensifying efforts for EDPT, application of LLINs & other vector control methods, BCC, supervision & monitoring, and other elimination interventions, etc. the targets would be achieved. However, it may change with any unusual epidemiological situation or any interruption in programme implementation due to unforeseen factors.

Outcomes

Outcome Indicators	2012-13 (Baseline)	2015-16	2016-17	2017-18
Proportion of population that slept under an insecticide-treated net the previous night (disaggregated by sex)	80%	85%	90%	90%
Proportion of children under five years old who slept under an insecticide-treated net the previous night	90%	90%	90%	90%
Proportion of pregnant women who slept under an insecticide-treated net the previous night	85%	90%	90%	90%

The targets set for endemic areas where LLINs will be distributed (1 LLIN per 1.8 people) are **assumed** to be achieved with extra inputs in health/community systems strengthening measures, IEC/BCC, procurement & supply of LLINs through VPP; the knowledge and awareness about malaria, and a heightened focus on key populations, use of preventive measures are expected to improve resulting in achievement of desired outcomes. This also serves as outcome for ACSM, indicating enhancement of knowledge & awareness of people who know the cause of/mode of and effective preventive measures for malaria and responsive behaviour.

As mentioned in section 3.2, the request for funding as sought under the '**Above**' category is critical. It is submitted that the additional funding ('**Above**') would ensure application of and scaling up interventions, which would enable the programme to stay on course to achieve the desired goal of phased elimination. Otherwise, the vision and mission of the NSP would be at risk and the opportunity to all for sustaining the gains with the investments and partnering in elimination would possibly be lost. The 'Above' request would leverage the interventions to be applied/scaled up with allocated amount.

It may be noted that Allocation Efficiency workshops were conducted by the GF with technical support by LSE, Swiss TPH, and Futures Institute for looking into the cost effectiveness of various interventions using One Health Tool, Open Malaria model. However, this remains work in progress.

However, the achievements of PR1 and PR2 in existing Phase2 (2012-13) against set targets in Phase2, are presented below as an indication of programme effectiveness against the proposed modules/interventions:

Indicator	**Implementing entity**	**Target**	**Verified Result (2012-13)**	**Performance**
Module: Vector control Interventions: • Long-lasting insecticidal nets (LLIN) – Mass campaign				
Number of LLINs procured and supplied to NGO partners	PR1	612,000	612,000	100%
Module: Case management • Facility (and Community) based Treatment • Epidemic preparedness and response • TES • IEC/BCC. • Other				
Total number of fever cases examined by microscopy and RDT(in the other 10 high Malaria transmission districts)	PR1 & PR2	148,848	158,668	107%
Total number of fever cases examined by microscopy and RDT (in the 3 highest Malaria transmission districts)	PR1 & PR2	253,443	229,930	91%
Number of clinical malaria cases with positive diagnosis examined by RDTs and/or Microscopy	PR1 & PR2	44,698	26,524	59%
Number of Severe Malaria cases treated	PR1	2,079	1,302	63%
Proportion of Pv cases receiving CQ+PQ according to the national guidelines	PR1 & PR2	N: 3129 D: 3129 P: 100%	N: 1132 D: 1265 P: 89.5%	90%
Proportion of Pf cases receiving ACT according to the national guidelines	PR1 & PR2	N: 39491 D: 41570 P: 95%	N: 23401 D: 25259 P: 92.6%	97%
Number of people received malaria treatment through community service providers (in the 3 highest Malaria transmission districts)	PR2	15,176	10,292	68%
Number of people received malaria treatment through community service providers (in the other 10 high Malaria transmission districts)	PR2	6,504	5,118	79%

Percentage of health facilities with no reported stock outs lasting >1 week of nationally recommended anti-malarial drugs at any time during the past three months	PR1 & PR2	N: 203 D: 203 P: 100%	N: 181 D: 203 P: 89.2%	89%
Number of people reached through BCC orientation meetings on malaria prevention	PR2	14,200	15,148	107%
Number of rapid response team members trained/retrained	PR1	120	110	92%
Number of village doctors oriented with malaria management (in the 3 highest Malaria transmission districts)	PR2	2,875	2,889	100%
Number of village doctors oriented with malaria management (in the other 10 high Malaria transmission districts)	PR2	3,975	3,825	96%
Number of people attended advocacy meeting/ workshops	PR2	5,550	5,678	102%
Module: Health and community workforce **Interventions:** • Health and community workforce capacity building				
Number of health staff trained on diagnosis and treatment	PR1	1,350	1,335	99%
Number of nurses and doctors trained on management of severe malaria	PR1	660	549	83%
Number of laboratory technicians trained in malaria microscopy	PR2	20	20	100%
Module: Health Information System and M&E **Interventions:** • Routine reporting				
Number of health facilities reporting timely, completely and accurately	PR1 & PR2	N: 203 D: 203 P: 100%	N: 202 D: 203 P: 99.5%	100%
Module: Program management **Interventions:** Program management				
Number of managers attended in the partnership and programme management meeting	PR1	90	60	67%

[Certain additional interventions have been included in this concept note as well].

3.4 Focus on Key Populations and/or Highest-impact Interventions

This question is <u>not</u> applicable for low-income countries.

Describe whether the focus of the funding request meets the Global Fund's Eligibility and Counterpart Financing Policy requirements as listed below:

a. If the applicant is a lower-middle-income country, describe how the funding request focuses at least 50 percent of the budget on underserved and key populations and/or highest-impact interventions.

b. If the applicant is an upper-middle-income country, describe how the funding request focuses 100 percent of the budget on underserved and key populations and/or highest-impact interventions.

NA

SECTION 4: IMPLEMENTATION ARRANGEMENTS AND RISK ASSESSMENT

4.1 Overview of Implementation Arrangements

Provide an overview of the proposed implementation arrangements for the funding request. In the response, describe:

a. If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector Principal Recipient(s).

b. If more than one Principal Recipient is nominated, how coordination would occur between Principal Recipients.

c. The type of sub-recipient management arrangements likely to be put into place and whether sub-recipients have been identified.

d. How coordination would occur between each nominated Principal Recipient and its respective sub-recipients.

e. How representatives of women's organizations, people living with the three diseases, and other key populations would actively participate in the implementation of this funding request.

As in the ongoing Phase2, the PR1 is the Economic Relations Division, MoF, GoB that provides resource support to the NMCP through MOHFW. The PR2 is BRAC that leads a consortium of 20 NGOs. Under the NFM too, dual track financing would continue.

The PR1 would be mainly responsible for the planning, procurement of health products/pharmaceuticals and supply to PR2, implementation, and M&E and review/oversight of PR2 activities. The PR2-BRAC, which is leading a NGO consortium, would complement PR1 activities at community level in endemic districts.

The major modules/interventions would include: LLIN distribution; RDT/ACT use; BCC; training of community workers/volunteers and private sector care providers; M&E/MIS. Outline of PR1 and PR2 are presented below:

- Principal Recipient 1—PR1—MoF, GoB: Policy & strategy, overall programme/grant management, oversight of and technical assistance to implementation of modules/interventions, advocacy and coordination, capacity building of personnel/consultants, M&E including reporting to GFATM, and joint planning and review, etc. and additional resource mobilization, research & evaluation.
- Principal Recipient 2—PR2—BRAC : In alignment with the NMCP, strategic planning, overall programme/grant management, oversight of implementation of modules/interventions,

advocacy and coordination, capacity building of personnel, M&E including reporting to GFATM, GoB, and joint planning and review, operational research, etc. and additional resource mobilization.

In current Phase2 implementation, there are 20 SRs, who are partners in the journey, who have been and are being strengthened and capacitated over the years and are expected continue under the NFM.

All Sub Recipients are responsible for: implementation of modules/interventions (prevention, diagnosis and treatment), BCC, M&E, etc.

Ongoing coordination at all levels is the cornerstone of the GoB-NGO partnership as in Phase2. Adequate planning and coordination mechanisms and joint planning has been built into the project management structure, systems and processes for smooth functioning of inter dependent outputs and achievement of outcomes, impact.

In addition, the platforms like Joint Review meetings, Monthly meetings would remain important for addressing issues and arriving at locale- and context-specific- solutions. Besides, the PRs regularly are in day-to-day communication, for seeking inputs and validating the policy guidance as well as discussing programmatic achievements and lessons learned. Even the NSP 2015-2020 have been prepared and currently being strengthened by the PRs together.

The planning would be carried out at the central level and each PR would disseminate the same plan to the district/Upazila levels for coordination at those levels.

All training by the PR2 is also carried out under the overall guidance of the NMCP.

Advocacy and BCC meetings with the people living in malaria endemic districts would continue. The community meetings conducted by the health workers mostly addresses the women/girls. The CCM is well represented by women and key affected persons which ensures their participation in programme oversight. The PR2 consortium health workers are all-women workforce; who are employed locally from the endemic areas.

4.2 Ensuring Implementation Efficiencies

Complete this question only if the Country Coordinating Mechanism (CCM) is overseeing other Global Fund grants.

Describe how the funding requested links to existing Global Fund grants or other funding requests being submitted by the CCM.

In particular, from a program management perspective, explain how this request complements (and does not duplicate) any human resources, training, monitoring and evaluation, and supervision activities.

The funding request through this concept note is for 30-month period starting July 2015, whilst the ongoing Phase2 is concluding in June 2015.

As done through the implementation of ongoing Phase2 (ending in June 2015), the PRs would continue to have rationalized structures and systems. The program would emphasize on achieving optimal output utilizing the limited available resources and building human capacity at implementation level. The existing HR would be continuing under the NFM too. The staff is being optimally utilized and multi-task. The PRs would ensure absence of duplication of any HR, training, M&E, and other activities (the proposed funding request has been worked out together keeping such efficiencies in mind.

Community based BCC activities including IPC/mid-media activities and use of local radio would be emphasized more in terms of effective intervention instead of relying on heavily on mass media, which are mostly resource intensive towards enhancement of knowledge and awareness and behaviour change amongst targeted groups.

Further, analysis of results of previous grants and other sources of funding and need versus gap

have been done by the PRs to ensure that the proposed activities would be aligned with realistic approaches, i.e. what works and is likely to succeed. Workshops, meetings and research activities are limited to the need for phased elimination. Existing and possible GoB and/or other donor funding has been factored while finalizing the funding request under the NFM.

4.3 Minimum Standards for Principal Recipients and Program Delivery			
Complete this table for each nominated Principal Recipient. For more information on minimum standards, please refer to the concept note instructions.			
PR 1 Name	Economic Relations Division, MoF, GoB (NMCP, MOH&FW)	**Sector**	Government
Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a cross-cutting health system strengthening grant(s)?		☐✓Yes ☐No	
Minimum Standards		**CCM assessment**	
1. The Principal Recipient demonstrates effective management structures and planning		The PR1 has skilled and experienced staff members who are working in the field of malaria for a significant period of time. The national malaria control programme is under the Malaria and Parasitic Diseases Control unit of Communicable Disease Control (CDC) division under Directorate General of Health Services (DGHS) of the Ministry of Health and Family Welfare. The central team consists of Evaluators (Epidemiologists), M&E, Training, MIS, Training, PSM and Finance consultants, Epidemiologist, Entomologist, Entomology Technicians, Medical Technologist (lab) and other support staffs led by the Deputy Programme Manager and is reportable to the Director, Disease Control. All these staff are experienced in their own field with relevant technical knowledge and expertise.	
2. The Principal Recipient has the capacity and systems for effective management and oversight of sub-recipients (and relevant sub-sub-recipients)		PR1 does not have any SR.	
3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud		PR1 strictly follows all policies and procedures formulated by the Government of Bangladesh. Three types of independent audits take place periodically: departmental audit, audit by the Office of the Comptroller and Auditor General, Bangladesh and audit by FAPAD (Foreign Aided Project Audit Directorate). Appropriate mitigating measures are ensured to prevent any kind of misuse of money or fraud.	
4. The financial management system of the Principal Recipient is effective and accurate		PR1 uses automated accounting software that can correctly and promptly record all transactions. Payments and other transactions are made through bank accounts to minimize risk. Supporting documents for all transactions are preserved and variances are cross checked for appropriate corrective measures.	
5. Central warehousing and regional warehouse have capacity, and are aligned with		PR1 has central level warehouse, known as Central Medical Stores Depot (CMSD), district level warehouses and Upazila Stores at all districts and Upazilas. These warehouses are designed to store drugs and other medical	

good storage practices to ensure adequate condition, integrity and security of health products	and health products with compliance to good storage practices, including proper ventilation and air-conditioning system, with trained staffs and appropriate security measures. An SOP for health product management is in place and followed accordingly [SOP for managing drugs and supplies for malaria control is appended as Annex 29]. . [The PSM plan exists and would be updated per additional requirements of this concept note].
6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment/program disruptions	PR1 is responsible for procurement of health products under Global Fund grant. It has formed a PSM working group with members from both PRs and WHO to aid proper forecasting and planning of procurement and supply of these products up to end user level. Coordination is maintained at all level which includes port authority, district civil surgeons and managers of BRAC NGO consortium to ensure smooth transportation of goods. Stock registers are maintained at all store facilities. Central and local level coordination is maintained to anticipate stock outs and redistribution of goods. A web based LMIS has been introduced aiming tracking stock status of health products.
7. Data-collection capacity and tools are in place to monitor program performance	The National M&E Plan is in place to guide the M&E system. The indicators for routine monitoring activities have been aligned with the goals and objectives of the programme. The programmatic data are cross checked at central level. Joint programme reviews are planned and conducted periodically (last one was conducted in April 2014). . [The M&E plan exists in line with the NSP 2015-2020 and would be updated per additional requirements of this concept note].
8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	The routine reporting system captures malaria data from all public health facilities. The NMCP has introduced a web based MIS where the programme data is entered at upazila and district level. Guidelines and training have been provided to the concerned MIS persons at field level. MIS guidelines exist and would be updated as this concept note is approved and finalized.
9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	An SOP for QA/QC has been developed [SOP on QA/QC is appended as Annex 30]. Samples of pharmaceutical products will be collected from all levels in the supply chain and will be sent to a WHO qualified laboratory for testing. Bio-assay test of LLIN/ITNs will be done by the entomology unit of CDC with the support from WHO.

PR2 Name	BRAC	**Sector**	CS/PS
Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a cross-cutting health system strengthening grant(s)?		☐✓Yes ☐No	
Minimum Standards		**CCM assessment**	
1. The Principal Recipient demonstrates effective management structures and planning		Yes, PR-BRAC demonstrates effective management structure and planning in program implementation. BRAC, one of largest NGOs in world, has been successfully operating GFATM grants through establishing efficient management at wider scale for TB programme since 2004 and malaria since 2007. In malaria programme the project	

	management unit is divided into three strata – central, regional and district/field level. The central level team constitutes multidisciplinary staff including public health specialists with technical skills, M&E, PSM and finance personnel. The regional level staff supervises and manages BRAC and SR activities at field level. The field level staff is involved in programme implementation. The central team of Project Management Unit, led by Sr. Programme Manager, under the guidance of Associate Director, is responsible for overall grant management, strategic planning, M&E, SR management, supervision of filed level activities and stakeholder coordination. The central team provides technical guidance, if required, to regional and field level for smooth implementation of approved work plan. Besides, it takes support from advocacy department for sharing the information at national and district level. All strategic decisions are taken and implemented in coordination with Government at central level. The regional level staff is responsible for SR management and work under the guidance of central level SR management personnel. They ensure implementation of activities under approved work plan and supporting the SR, if required. District Managers in the BRAC areas are responsible for planning, implementation, supervision and coordination with local district health administration and other stakeholders. The staff at all level is well oriented on their job responsibilities through formal and on-the-job trainings. The programme management of BRAC is always evolving under the guidance of Director of Health, Nutrition and Population Programme (HNPP), BRAC, which would continue under new funding model.
2. The Principal Recipient has the capacity and systems for effective management and oversight of sub-recipients (and relevant sub-sub-recipients)	Yes, PR-BRAC has the capacity and system for effective management of SRs. The PR-BRAC together with the sub-recipients (SRs) complements the efforts of the NMCP (PR1) for malaria control in 13 endemic districts. BRAC conducts management oversight, ongoing capacity assessment and development, and provides support and technical guidance in the areas of both programme and finance to its 20 SRs. BRAC has an SR management team that includes central and regional level staff. As required by the GFATM, the PR conducts systematic capacity assessment of the SRs prior to the signing of grant agreement with them and the capacity gaps and other requirements identified in the assessment are addressed by the SRs within given timelines. Trainings and other necessary support as per capacity building plan is provided by the PR to provide technical updates, address capacity gaps, provide guidance and support on the implementation of project guidelines. A SR Management Manual for managing and monitoring the performance of sub-recipients has been developed in 2012 which was duly approved by the GFATM (Annex 31). Review and planning meetings with SRs are held quarterly at the central level and monthly at the regional level to assess the quality of implementation of activities, and provide support to minimize the deviation from planned output. The central and regional level SR management staff

	supervises the SRs with an action plan. Different programmatic activities are monitored and supervised at field level to ensure quality services and compliance with the approved guidelines and policies. Intensive review of programmatic and financial reports of SRs is done quarterly to ensure correct, complete and reliable data is reported for sharing with the GFATM.
3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud	The PR-BRAC has an established system of internal control within the organization through the support from other BRAC programmes, both within and outside of HNPP to ensure compliance to policies, guidelines and procedures outlined in the GFATM grant agreement, guidelines, and overall organization policy and requirements. BRAC has independent finance, monitoring, audit, HR, procurement and research departments. Policies and procedures are in place for finance and accounting, human resource, procurement etc. and compliance of those are ensured. The Internal Audit Department of BRAC conducts audit in both BRAC and SR cost centres according to their annual audit plan to verify all financial transaction, reconciliation, books and accounts, and identify gaps and deviation in comparison with agreed action plan and budget. Independent monitoring and MIS validation is also done to see the programme performance and quality of MIS data. External audit is conducted yearly with approved ToR from GFATM by reputed audit firms.
4. The financial management system of the Principal Recipient is effective and accurate	PR-BRAC has rigorous financial policy which includes financial monitoring, timely disbursement and auditing. Automated software based accounting system is in place that can accurately record all the transactions and generate reports. Dedicated staff is in place for financial management and monitoring of Global Fund grants. The financial reports are cross checked with the activities and the variances are analysed critically. Cross checking of expenditures against activities is also done during routine financial monitoring and audits. All financial transactions including fund disbursements are made through bank accounts to ensure transparency and minimise risk. In addition to regular monitoring and audits, special investigations are also conducted with the support from programme and monitoring department. Prompt corrective measures are taken in case of any variance or misappropriation which may range from reconciliation to reimbursement of money and even termination of agreement or contract.
5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products	PR-BRAC has seven regional warehouses in strategic locations across the programme areas which are equipped with adequate conditioning to store the health products maintaining their qualities. In addition there are field level stores for transitional storage of the health products before it goes to the end user level. An SOP for drugs management is in place. Warehouse staff is trained and the inventory documents are well maintained. Security and safety measures are also strengthened over the year considering the product safety. All products (e.g. drugs and RDTs) are stored in shelves with different products in different locations. A FEFO method is followed in storing and distribution. Temperature control and other standardized methods are followed along the year as part of good storage practice in all the regional warehouses.

6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment/program disruptions	PR-BRAC has demonstrated efficient distribution systems and transportation arrangements for delivering health products. A PSM working group consisting of members from both PRs and WHO is in place for forecasting and planning of procurement and distribution. The distribution of health products is done as per plan to different districts and upazilas. The PRs maintain stock register and there is a system of reporting logistics supply status on a monthly basis. This facilitates routine assessment of supply status, noting consumption, calculation of actual requirements and tracking of expiry for necessary intervention. In addition, the government has introduced the web based LMIS recently. The PRs consult each other regarding rational forecasting and timely indenting where stock-out is anticipated. The staffs engaged in supply management have been oriented adequately.
7. Data-collection capacity and tools are in place to monitor program performance	Yes, the data collection capacity and tools are in place to monitor programme performance. The GFATM approved M&E plan of PR-BRAC provides guidance on the M&E and MIS as well as to foster and institutionalize capacity for robust M&E within the PR and SRs towards steering focus on the intended 'results'. Two types of data collection tools (one for monthly disease specific data and other for quarterly activity related data) are being used. Disease specific and programmatic data are reported through these tools from Upazila and project/district office. Both NMCP and BRAC led NGO consortium use the unique format for monthly MIS. The data related to programme performances are monitored regularly through routine monitoring and supervision using specific checklists. [The M&E plan exists and would be updated per additional requirements of this concept note]. Joint programme reviews are organized by PR1 which involves all implementing partners including PR2.
8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	Yes, a functional (both computerized and paper based) routine reporting system exists for capturing the programmatic and financial performance monthly. Recording and reporting tools, timelines for submission reports and data flow are well defined for all existing cadres/structures within the consortium. An MIS guideline has been developed to aid accurate and timely reporting. . A web-based reporting system has been introduced in the government health facilities that can capture all the data from public sector. The NGO data is being entered in that system at upazila level. Routine cross checking and data quality assessment is carried out. In addition, yearly MIS validation is conducted by the independent monitoring department of BRAC.
9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	The GoB is responsible for overseeing the quality requirements pharmaceuticals and health products and monitor product quality throughout the supply chain, which includes quality assurance and control activities.

4.4 Current or Anticipated Risks to Program Delivery and Principal Recipient(s) Performance

a. With reference to the portfolio analysis, describe any major risks in the country and implementation environment that might negatively affect the performance of the proposed interventions including external risks, Principal Recipient and key implementers' capacity, and past and current performance issues.

b. Describe the proposed risk-mitigation measures (including technical assistance) included in the funding request.

No major risk has been identified as per external and internal audit reports, OSDV findings, JRM, MTR and OIG debriefing. Minor issues identified in those reports are partly met and remaining would be mitigated as per recommendations.

However, in this concept note, certain possible risks related to the efficient and effective implementation of the program and existing and proposed risk mitigation measures are outlined. Those include: external risks, programmatic, financial, health product quality & service delivery and governance & oversight risks. Drawing from the implementation experience, various interventions/activities are being embedded in the overall program design. Implementation arrangements have been revisited and the concept note focuses on those aspects that would ensure that the program runs well, key populations have access to quality health services, and there are adequate fiduciary controls and programmatic oversight up to the community level; although certain external risks (remoteness/hard to reach areas, conflict situation, natural calamities like cyclones/landslides, macro-economic conditions) may continue to pose challenges.

Many risks/issues relating to program implementation, grant management by PRs (and NGO-SRs) have been and would continue to be resolved through strengthened oversight, monitoring, capacity building as well as in extreme circumstances declaring certain expenditures as ineligible and holding the person/organization responsible. Certain risks and mitigation measures include but not limited to the following:

The socio-political and eco-geographical constraints in certain districts may pose challenges in optimal program implementation. There could be few instances when service delivery may be temporarily erratic despite continuous strengthening of community ownership of malaria control is being emphasized by way of positioning health workers, volunteers within the overall community systems strengthening portfolio, that involves local networks as well as opinion and religious leaders especially in hard to reach areas. For any delay/postponement of initiatives that may be at times necessary in view of the local situation, efforts are being and would be made to resolve the problems through stakeholder discussions for mitigation locally.

Procurement and supply of pharmaceuticals and health products are imperative for uninterrupted diagnosis and treatment service delivery. As in the ongoing Phase2, the procurement and supply would be the responsibility of the PR1-GoB. It is expected that supply-side situation would be conducive and provision of RDTs and ACTs as well as LLINs would be met.

Both PRs have and continues to strengthen the district & Upazila levels (including SRs) drawing from the lessons learned. Capacity building through trainings/re-trainings as well as on-job orientation/motivation remains key although staff turnover remains a challenge at times. Strengthening of M&E, PHPM, management of HR, finance management including but not limited to external and internal audit, etc. are being continuously done. The PRs are focusing on developing a culture of self risk assessment.

Exchange rate fluctuation may impact cash flow. In Phase2 there was an exchange loss of about BDT 5 per USD. In addition, under-spending/overspending too are risks, which would need to be appropriately tackled.

The GoB and BRAC propose to further strengthen the risk identification, assessment and mitigation through the programme/grant management cycle in a much more structured manner drawing from the Global Fund risk management approach and guidance. According to such guidance[3], the PRs would constantly monitor and assess internal and external events for uncertainty of not achieving targets and negative outcomes and impacts. The PRs would strive to rate the risks in terms of severity, materiality of the adverse outcomes and fix timelines for mitigation using the GF framework.

[3] Drawn from presentations made by the Global Fund team in the CSO Risk Forum, Bangkok, Thailand, November 2013

Overall, key elements of a comprehensive risk management approach to be taken up would continue to include, but not limited to :

- Organisational set-up : effective structure, competent staff in key positions, clear roles and responsibilities, hold people accountable.
- Governance structure, action from the top, ethics and values, etc.
- Effective internal control : policies, procedures, preventive controls (addressing identified risks) and independent monitoring, clear and transparent processes.
- Measure progress : regular reporting, and risk based monitoring and supervision.
- Ensure effective communication and information (transparency).
- Create a risk-aware culture and open dialogue (PR, SRs).

Other aspects would include: Guidelines would be used for programme management, M&E; Capacity building; HR and PSM plan; periodic assessments and necessary course correction.

CORE TABLES, CCM ELIGIBILITY AND ENDORSEMENT OF THE CONCEPT NOTE

Before submitting the concept note, ensure that all the core tables, CCM eligibility and endorsement of the concept note shown below have been filled in using the online grant management platform or, in exceptional cases, attached to the application using the offline templates provided. These documents can only be submitted by email if the applicant receives Secretariat permission to do so.

☐✓ Table 1: Financial Gap Analysis and Counterpart Financing Table

☐✓ Table 2: Programmatic Gap Table(s)

☐✓ Table 3: Modular Template

☐✓ Table 4: List of Abbreviations and Annexes

☐✓ CCM Eligibility Requirements

☐✓ CCM Endorsement of Concept Note

List of Abbreviations

ABER	Annual Blood Examination Rate
ACSM	Advocacy, Communication and Social Mobilization
ACT	Artemisinin-based Combination Therapy
ACT Malaria	Asian Collaborative Training Network for Malaria
AIDS	Acquired Immuno-deficiency Syndrome
API	Annual Parasite Incidence
BCC	Behaviour Change Communication
BGB	Border Guards Bangladesh
BITID	Bangladesh Institute of Tropical & Infectious Diseases
CCM	Country Coordinating Mechanism
CDC	Communicable Disease Control
CHT	Chittagong Hill Tract
CMSD	Central Medical Stores Depot
CQ	Chloroquine
CS/PS	Civil Society/Private Sector
DFID	Department for International Development
EDPT	Early Diagnosis and Prompt Treatment
FAPAD	Foreign Aided Project Audit Directorate
FEFO	First Expiry First Out
G-6PD	Glucose-6-Phosphate Dehydrogenase Deficiency
GF	The Global Fund
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
GoB	Government of Bangladesh
HHs	Households
HIS	Health Information System
HIV	Human Immuno-deficiency Virus
HNPP	Health, Nutrition and Population Programme
HPNSDP	Health Population and Nutrition Sector Development Program
HR	Human Resource
HSS	Health Systems Strengthening
HV	Health Volunteer
HW	Health Worker
ICDDR,B	International Center for Diarrhoeal Disease Research, Bangladesh
IDP	Internally Displaced Person
IEC	Information, Education and Communication
IEDCR	Institute of Epidemiology, Disease Control & Research
IPC	Inter Personal Communication
IRS	Indoor Residual Spraying
IT	Information Technology
ITN	Insecticide Treated (bed) Nets
IVM	Integrated Vector Management
JDTAF	Joint Donor Technical Assistance Fund
JICA	Japan International Cooperation Agency
JRM	Joint Review Mission
LFA	Local Fund Agent
LLIN	Long Lasting Insecticidal Nets
LMIS	Logistics Management Information System
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MIS	Management Information System

MNCHI	Maternal, Newborn and Child Health Institute
MOF	Ministry of Finance
MOHFW	Ministry of Health and Family Welfare
MPR	Malaria Programme Review
MRG	Malaria Research Group
MTR	Mid-Term Review
NFM	New Funding Model
NGO	Non- Governmental Organization
NHA	National Health Accounts
NIPSOM	National Institute of Preventive & Social Medicine
NMCP	National Malaria Control Programme
NSP	National Strategic Plan
OIG	Office of the Inspector General
OSDV	On site data verification
PCR	Polymerase Chain Reaction
Pf	Plasmodium falciparum
PHC	Primary Health Care
PQ	Primaquine
PR	Principal Recipient
PSM	Procurement and Supply Management
Pv	Plasmodium vivax
QA	Quality Assurance
QC	Quality Control
RDT	Rapid Diagnostic Test
RED	Research and Evaluation Division
RRT	Rapid Response Team
RSQA	Rapid Service Quality Assessment
SDA	Service Delivery Areas
SOP	Standard Operating Procedures
SR	Sub Recipient
SSF	Single Stream Funding
SWOT	Strength, Weakness, Opportunity, Threat
TA	Technical Assistance
TB	Tuberculosis
TES	Therapeutic Efficacy Surveillance
ToR	Terms of Reference
VPP	Voluntary Pooled Procurement
WHO	World Health Organization