PROGRAM ANNOUNCEMENT

DEPARTMENT OF DEFENSE (DoD)

Defense Health Agency

Title: Department of Defense HIV/AIDS Prevention Program

Announcement Type: Initial Announcement

Funding Opportunity Number: W81XWH-21-DHAPP

Assistance Listing Number: 12.350 -- Department of Defense HIV/AIDS Prevention Program

Key Dates: This announcement will be **open to receive applications continuously** until 5:00 p.m. Eastern Time (ET), 23 September 2022, at which point all applications must be received.

Issued: September 2020

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A. Program Description

Background: The United States Government has a long history and extensive network of international collaboration and partnerships in the fight against HIV/AIDS, providing funding, technical assistance, and program support. These collaborations increase the fundamental understanding of HIV transmission and provide an evaluative basis for prevention and intervention success. The HIV/AIDS epidemic is devastating and Militaries, in particular, have been identified as a high-risk population.

DoD HIV/AIDS Prevention Program (DHAPP) works as part of the U.S. Government's effort to save lives, prevent HIV infections, and accelerate progress toward achieving HIV/AIDS epidemic control in more than 50 countries around the world. DHAPP is positioned within the Defense Health Agency (DHA) and located at the Naval Health Research Center (NHRC) in San Diego, California.

DHAPP has successfully engaged over 80 countries in efforts to combat HIV/AIDS among its respective military services. DHAPP is the Department of Defense's military to military implementing arm of the President's Emergency Plan for AIDS Relief (PEPFAR) collaborating with the U.S. State Department (DoS), U.S. Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention (CDC), the U.S. Agency for International Development (USAID), the Peace Corps, and other federal agencies. Working closely with U.S. Department of Defense, U.S. Unified Combatant Commanders, Joint United Nations Program on HIV/AIDS (UNAIDS), university collaborators, and other non-governmental organizations, DHAPP assists countries in establishing HIV/AIDS prevention, care and treatment programs in strengthening their capabilities to combat HIV.

DHAPP continues to rely upon the vital support of various partners such as local and international non-governmental organizations (NGOs) including faith-based organizations to implement HIV prevention, care and treatment programs across the globe. A customized plan is needed to assist militaries as they implement HIV/AIDS programs capable of reaching our shared goals for HIV epidemic control.

Applicants for an award should be aware of the country specific military's HIV control activities and propose a plan that builds on the country specific military's activities without duplicating efforts, creating parallel systems, or conflicting activities. The overall program manager for PEPFAR is the Department of State's Office of the U.S. Global AIDS Coordinator (OGAC). DHAPP provides support for military-specific programs. Country HIV programs supported by PEPFAR funds can be found on the OGAC website: http://www.state.gov/s/gac/

DHAPP provides technical assistance, management, and administrative support to the HIV/AIDS prevention, care, and treatment for foreign militaries through support to implementing partners. In addition, DHAPP provides HIV program execution and monitors outcomes with staff that include country specific active duty military, civil service, and contractor personnel.

Program Objective: DHAPP's objective, through the PEPFAR program, is to save lives, prevent HIV infections, and accelerate progress toward achieving HIV/AIDS epidemic control and to support the development of interventions and programs in military health systems that address these issues. DHAPP works with militaries of foreign countries to devise plans based on the following process:

- Meet with key partners in country to determine provisional major program areas and other technical assistance needs.
- Adapt DHAPP support to a country's need for prevention, care and/or treatment of its HIV/AIDS situation based on an assessment of the country's epidemic, and more specifically, in that country's military.
- Strengthen the military capacity for ownership and behavioral changes over the long term.
- Consider program design by leveraging assets with other country partners who have/had successful prevention, care, and/or treatment efforts.
- Focus on prevention, care and/or treatment impact aligned with national implementation plans.
- Implement and monitor programs to ensure accountability and sustainability.

Countries and their militaries need strong evidenced based HIV programs with measurable courses of action that demonstrate the following specific attributes. Priorities for DHAPP include the following but are subject to change.

- Support and ownership from the military sector.
- Development of plans of action and support for military policies that further HIV epidemic control.
- Alignment with PEPFAR and national strategies and priorities.
- Testing and treatment expansion to meet 2020 goals of 90-90-90 and 2030 goals of 95-95-95 for people living with HIV. (The first goal is identifying 90/95 percent of all HIV-positive individuals in the population; the second goal is linking 90/95 percent of all those identified HIV positive people to consistent antiretroviral treatment; and the last goal is reaching 90/95 percent of all those on antiretroviral treatment to attain viral suppression.)
- Care and treatment plans should use the "Treat All" approach with differentiated models of care including tuberculosis (TB), hepatitis, cervical cancer in HIV positive women, other sexually transmitted infections (STI) other opportunistic infections, and care for those with advanced HIV disease.
- Reduction of mother-to-child transmission of HIV.
- Combination prevention using biomedical, behavioral and structural support for sexual transmission of HIV and other STI.
- Prevention packages for specific populations including a comprehensive package for Key Populations (KP), Priority Populations, and prevention interventions for young people.
- Stigma and discrimination reduction associated with HIV infection.
- Program monitoring to collect and report on PEPFAR indicators, ensure quality of service delivery using clinical and laboratory monitoring tools and to take rapid corrective action based on results.

- Strengthen HIV data collection systems for improved clinical decision making and program management.
- Promoting sustainability through capacity building of the military partner.

Transition to Local Partners: **Local partners are encouraged to apply to this announcement**.

- To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and community-based and community-led organizations – regardless of current antiretroviral (ARV) coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term, local partner engagement and impact.

B. Federal Award Information

The following information applies to awards issued under this announcement:

- Funding Amount: For each country where funding is available, Attachment 1 (Country Specific Narrative) will contain a description of the work that is needed, along with the program areas and an approximation of the available funding. It should be noted that while dollar amounts are listed, this should be taken as an estimate of the funding for an effort whether a single amount or range is listed. Changes to Attachment 1 will be provided in the form of amendments to this announcement.
- Anticipated number of Federal awards: The anticipated number of awards for this program in FY21 will range from approximately 10 to 20, with the number of awards being determined based on the rigor and transformative potential of the proposals received, as well as the availability of funds. All funding decisions are final.
- The Period of Performance for these awards is 4 years
- Information regarding program funding amounts as well as total cost limitations within the application can be found in the country specific narrative outlined in Attachment 1.
- Investigators on collaborative projects should each write and submit separate, unique proposals, and provide the name and title of their collaborator's proposal within the project narrative of the application.
- Awards will be made on an open continuous basis. Refer to your country specific narrative in Attachment 1 for more details. Cooperative agreements will be awarded under this announcement.

C. Eligibility Information

Eligible Applicants: All responsible sources from academia, industry, and non-governmental organizations may submit proposals under this announcement. No grants, contracts or cooperative agreements may be awarded directly to foreign military

establishments. **All respondents must demonstrate the active support of the in-country military and the DoD representative in the corresponding U.S. Embassy in the planning and submission of their proposals.**

Other information:

- The Federal Assistance Certifications Report (completed as part of the SAM registration) is a required attestation that the entity will abide by the requirements of the U.S. laws and regulations; therefore, as applicable, you are still required to submit any documentation, including the SF LLL Disclosure of Lobbying Activities (if applicable), and informing DoD of unpaid delinquent tax liability or a felony conviction under any Federal law. If applicable, the SF LLL should be submitted with the SF 424 form. See Section F. Federal Award Information for additional information.
- DoD required certifications: By checking "I agree" in block 17 of the SF 424 (see below) and signing the application as the authorizing official, you are certifying that your institution will be in compliance with these additional requirements:
    - Institutions of higher education must certify compliance with 10 U.S.C 983, *Institutions Of Higher Education That Prevent ROTC Access Or Military Recruiting On Campus: Denial Of Grants And Contracts From Department Of Defense, Department Of Education, And Certain Other Departments And Agencies*, and 32 C.F.R. 216 *Military Recruiting And Reserve Officer Training Corps Program Access To Institutions Of Higher Education.*
    - Recipient will not require any of its employees, contractors, or sub-recipients seeking to report fraud, waste, or abuse to sign or comply with internal confidentiality agreements or statements prohibiting or otherwise restricting those employees, contractors, sub-recipients from lawfully reporting that waste, fraud, or abuse to a designated investigative or law enforcement representative of a Federal department or agency authorized to receive such information.

D. Application and Submission Information

Submitting a Proposal: DoD will only accept proposals submitted through Grants.gov on or before the date specified in the country specific narrative provided in Attachment 1. Read the instructions below about registering to apply for DoD funds. Applicants should read the registration instructions carefully and prepare the information requested before beginning the registration process. Reviewing and assembling the required information before beginning the registration process will alleviate last-minute searches for required information.

Organizations must have a Data Universal Numbering System (DUNS) Number, active System for Award Management (SAM) registration, and Grants.gov account to apply for grants. If individual applicants are eligible to apply for this funding opportunity, then you may begin with step 3, Create a Grants.gov Account, listed below.

Creating a Grants.gov account can be completed online in minutes, but DUNS and SAM registrations may take several weeks. Therefore, an organization's registration should be done in sufficient time to ensure it does not impact the entity's ability to meet required application

submission deadlines. Note: Failure to allow enough time for the systems to complete the registration is not considered a valid explanation for why grants.gov did not accept the proposals.

Complete organization instructions can be found on Grants.gov at: https://www.grants.gov/web/grants/applicants/organization-registration.html

1) *Obtain a DUNS Number*: All entities applying for funding, including renewal funding, must have a DUNS Number from Dun & Bradstreet (D&B). Applicants must enter the DUNS Number in the data entry field labeled "Organizational DUNS" on the SF-424 form. For more detailed instructions for obtaining a DUNS Number, refer to: https://www.grants.gov/web/grants/applicants/organization-registration/step-1-obtain-duns-number.html

2) *Register with SAM*: The applicant organization must also be registered in the Entity Management functional area of the SAM with an "Active" status to submit applications through the Grants.gov portal. Verify the status of the applicant organization's Entity registration in SAM well in advance of the application submission deadline. Allow several weeks to complete the entire SAM registration process. If an applicant has not fully complied with the requirements at the time the Federal awarding agency is ready to make a Federal award, the Federal awarding agency may determine that the applicant is not qualified to receive a Federal award and use that determination as a basis for making a Federal award to another applicant

Announcement of Transition to SAM-Generated Unique Entity Identifier (UEI): As published in the *Federal Register* 10 July 2019 (https://www.federalregister.gov/documents/2019/07/10/2019-14665/unique-entity-id-standard-for-awards-management), the UEI for awards management generated through SAM will be used instead of the DUNS number as of December 2020. All Federal awards including but not limited to contracts, grants, and cooperative agreements will use the UEI, and the DUNS will be phased out as the identifier within SAM. During the transition phase (July 2019 – December 2020), the DUNS number remains the official identifier. Organizations should continue to register in SAM using the DUNS number assigned by Dun & Bradstreet. As of December 2020, the SAM-generated UEI will be the official identifier for applicants. During the transition, your SAM registration will automatically be assigned a new UEI displayed in SAM. (For more information, visit General Services Administration (GSA): https://www.gsa.gov/about-us/organization/federal-acquisition-service/office-of-systems-management/integrated-award-environment-iae/iae-information-kit/unique-entity-identifier-update.)

3) *Create a Grants.gov Account*: The next step is to register an account with Grants.gov. Follow the on-screen instructions or refer to the detailed instructions at https://www.grants.gov/web/grants/applicants/registration.html

4) *Add a Profile to a Grants.gov Account*: A profile in Grants.gov corresponds to a single applicant organization the user represents (i.e., an applicant) or an individual

applicant. If you work for or consult with multiple organizations and have a profile for each, you may log in to one Grants.gov account to access all your grant applications. To add an organizational profile to your Grants.gov account, enter the DUNS Number for the organization in the DUNS field while adding a profile. For more detailed instructions about creating a profile on Grants.gov, refer to: https://www.grants.gov/web/grants/applicants/registration/add-profile.html

5) *EBiz POC Authorized Profile Roles*: After you register with Grants.gov and create an Organization Applicant Profile, the organization applicant's request for Grants.gov roles and access is sent to the EBiz POC. The EBiz POC will then log in to Grants.gov and authorize the appropriate roles, which may include the Authorized Organization Representative (AOR) role, thereby giving you permission to complete and submit applications on behalf of the organization. You will be able to submit your application online any time after you have been assigned the AOR role. For more detailed instructions about creating a profile on Grants.gov, refer to: https://www.grants.gov/web/grants/applicants/registration/authorize-roles.html

6) *Track Role Status*: To track your role request, refer to: https://www.grants.gov/web/grants/applicants/registration/track-role-status.html

Electronic Signature: When applications are submitted through Grants.gov, the name of the organization applicant with the AOR role that submitted the application is inserted into the signature line of the application, serving as the electronic signature. The EBiz POC **must** authorize people who are able to make legally binding commitments on behalf of the organization as a user with the AOR role; **this step is often missed, and it is crucial for valid and timely submissions.**

Proposal Narrative: All proposals must be submitted in English or they will be rejected.

Formatting Requirements:

- Font: Times New Roman, 12 point
- Margins: 1 inch on all sides
- Paper size: 8 ½ by 11"
- Single-spaced

Required Documents: All elements and forms listed below are required, except as stated, for a proposal to be determined complete and must be submitted in English.

Cover Page - Should include the words “Technical Proposal” as well as the following:

1) Funding Opportunity number
2) Targeted Country
3) Title of Proposal
4) Identity of Prime Respondent and complete list of subcontractors, if applicable
5) Technical Contact (name, title, address, phone, fax and e-mail)
6) Administrative/Business Contact (name, title, address, phone, fax and e-mail)

7) Duration of effort
8) Table of Contents: Section, Title and page numbers are required

Project Abstract – Concise, single-spaced abstract, not to exceed 4000 characters, summarizing the proposed program effort, including the name of the Offeror institution/organization, anticipated public benefit, type of substantial involvement by the Government objectives, assessed need, and anticipated impact and results. ***Applications with abstracts exceeding 4000 characters will be withdrawn from consideration.***

The project abstract must contain a summary of the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible, understandable to the technically literate lay reader. This abstract must not include any proprietary/confidential information.

Section I: Technical Approach. The following items shall be addressed:

Executive Summary. Brief description of proposed activities, goals, purposes, and anticipated results. Briefly describe technical and managerial resources of your organization. Describe how the overall program will be managed. State the bottom line funding request.

Background Information. Provide general background information about the host country and its military, including conditions and issues that have relevance to HIV transmission and HIV prevention programs. This information should include data on HIV prevalence. Other possible information to include: population size, economic conditions, political conditions, conflicts and border disputes, country infrastructure, and host nation military HIV program accomplishments or priorities to date and other donors, resources leveraged, etc. Information provided in this section should demonstrate awareness of the conditions and needs within the country and it's military.

Goal and Objectives. Describe (a) the overall program goal of the project, and (b) the specific objectives that are measurable and time phased, consistent with the objectives and numerical targets that are described in the program narrative. See DHAPP current Priority activities in Section II. A. Program Description for reference.

Statement of Work. In an Excel spreadsheet, provide a summary of the planned activities for each program area. Use the following column headings: Country, Offeror, Funds Requested, and Brief Activity Narrative.

Work Plan. Clearly detail the scope and plan of the effort. Describe the specific methods (e.g., surveys, interviews, surveillance, etc.) you will use to accomplish the proposed objectives. All anticipated work must be aligned with the national guidelines of the host country. If the plan includes a training/education program or other intervention, please describe these in detail. Training should be aligned with national standards where possible. It is anticipated that the proposed plan will be incorporated as an attachment to the resultant award instrument. To this end, such proposals must include a severable self-standing plan without any proprietary restrictions that can be attached to the agreement award.

Data Management Plan. Proposals must include a supplementary document of no more than two pages labeled "Data Management Plan". This supplementary document should include:

a) The types of data, guidance, physical data collections, software, training materials, and other materials to be used or produced in the course of the project;
b) The standards to be used for data and metadata format and content (where existing standards are absent or deemed inadequate, this should be documented along with any proposed solutions or remedies);
c) Data governance policies for access and sharing including provisions for appropriate protection of privacy, confidentiality, security, intellectual property, or other rights or requirements; in cases where Personal Health Information is collected, identify appropriate national/international standard to be used for data protection. Data is considered property of the military partner.
d) Policies and provisions for re-use, re-distribution, and the production of derivatives; and
e) Plans for archiving data and other information products (reports), and for preservation of access to them.
f) A valid Data Management Plan may include only the statement that no detailed plan is needed, as long as the statement is accompanied by a clear justification.

Monitoring and Evaluation. State how you will demonstrate that the proposed program will have an impact on military members and/or their families and state the specific PEPFAR Monitoring, Evaluation, and Reporting (MER) indicators of performance that will be used. Indicators of performance and associated targets need to be specific and measurable (e.g., 100 military members will receive Voluntary Counseling and Testing (VCT) counseling, 2 laboratories will be established). Also, state how you will collect this information.

Schedule and milestones. Provide a schedule and description of major milestones or tasks to be accomplished in the proposed program by quarter (e.g., by 3-month period). No set number of milestones is required; the number and nature of the milestones will depend on your program and objectives.

In-Country Participation. Describe the involvement of the host country's military and its leadership in: (a) the development of the proposal (and/or the ideas presented in the proposal), and in (b) the planned execution of the proposed program bearing in mind the long term sustainability and host country military ownership of the program.

Relevance of the Program. (a) Describe the relevance of the proposed program to the needs, priorities and circumstances of the host country's military; (b) describe how the proposed program fits into the overall HIV strategy for the country and/or the country's military. If the respondent has previously performed and accomplished HIV prevention, treatment, or system strengthening efforts involving the host country's military, it should describe its past and current efforts.

Section II: Management and Qualifications Approach

The Management Plan will provide a clear description of how the cooperative agreement will be managed, including the approach to addressing potential problems. The plan shall outline, where applicable, which organization/sub-awardee will carry out the various tasks specified in the

technical approach. The prime partner will be responsible for all technical activities regardless of the activities implemented by the sub-partner or other member of the team. The application team (including home office support and other sub-partners) needs to describe the role of each staff member named under key personnel, technical expertise, and estimated amount of time he or she will devote to the program. Given the funding limit of the award and the broad scope, applicants may want to propose innovative ways to reduce managerial costs of sub-partners such as sharing office space, vehicles, etc. It is expected that sub-partners will not set up separate offices and separate managerial units, but instead offer specialized technical support under the prime partner.

The application shall discuss proposed technical, managerial and other personnel as deemed appropriate to implement the tasks described above, inclusive of a coordination plan for other partners working in the district or sub-district. Such staff should have played important technical and country-level support roles in the past and current health and HIV and AIDS programs. The staffing plan shall elaborate what and how long-term and short-term technical and management assistance will be provided to the program to accomplish tasks and objectives.

The application shall provide summary role descriptions, responsibilities and qualifications of all key personnel relevant to successful implementation of the proposed technical approach.

In proposing the overall staffing plan, the applicant should ensure that experience in implementing similar programs of focus and scale in the country is represented. In particular, the application should consider:

a) Program Director: The applicant is required to appoint a Program Director. The Program Director should have demonstrated capabilities in management, institutional capacity building, high-level strategic visioning and leadership, and experience in working effectively with district, provincial and national government authorities. Prior experience in senior level management of similar programs is absolutely required. Demonstrated experience is required in coordination and collaboration with broad set of stakeholders, including multi-lateral and international donors and local and international Non-Governmental Organizations (NGO). The Program Director must have background and experience in more than one technical area of the program and experience or familiarity in management in an integrated, comprehensive, clinic-based program environment. Written and oral communications skills in English must be demonstrated.
b) Other Personnel: Applicant has the discretion to determine the proper number and mix of additional key personnel, short-term technical staff, and others to meet award requirements.
c) Consultants: Applicant may propose a mix of international and local advisors and specialists to cover the full range of objectives and activities. The management plan shall also demonstrate how the applicant will use in-country experts and resources. All personnel must demonstrate written and oral communications skills in English. Familiarity and demonstrated experience with the political, social, economic and cultural context of the country is required.

The application should support the organization’s effectiveness and provide partnership arrangements. The applicant should propose how they will coordinate with the host country military as well as with other district partners and/or PEPFAR partners working across program

areas. If the applicant intends to develop institutional partnerships/teaming arrangements for implementation of the cooperative agreement (sub-recipients or alliances), the application must specify the nature of organizational linkages. This includes their relationships between each other, lines of authority and accountability, and patterns for utilizing and sharing resources. Applicants that intend to utilize sub-awards should indicate the extent intended, the method of identifying sub-awardees, and the tasks/functions they will be performing. Applicants that plan to team up with other organizations, or government agencies for the implementation of the agreement should outline the services to be provided by each agency or organization and should discuss how the collaboration with these partners fits into the Applicant's proposed management plan. Applicant should state whether or not they have any existing relationships with the proposed partners and, if so, should include the Memoranda of Understanding (MOUs) in the Attachment/Annex. It is not expected at this time that offerors should include host country military letters of support or MOUs as these will be negotiated after award once district and sub-district allocation are finalized.

The Organization's Qualifications - In this section, the applicant should describe its organizational knowledge, capability and experience in managing similar programs. This includes activities in institutional capacity building, HIV and AIDS policy development and implementation, delivery of integrated, comprehensive district-based HIV-related services for care and treatment and collaborations with donors, host country governments, and NGOs to strengthen health and HIV and AIDS systems. Offeror shall also describe its organizational capability in collaborating with the host country military, donors, and NGOs to strengthen health and HIV/AIDS systems, and to improve the quality and use of data for decision making and advance organizational capacity building. The Applicant should also describe the organizational knowledge, capability, and experience of the other proposed team members (sub-contractors and/or grantees) in successfully managing similar programs.

Current and Pending Support – The applicant must provide information on all current and pending projects, including subsequent funding in the case of continuing contracts, grants and other assistance agreements and proposals that involve the proposed Technical Program Manager. All current project support from whatever source (e.g., Federal, State, local or foreign government agencies, public or private foundations, industrial or other commercial organizations) must be listed.

The information must also be provided for all pending proposals already submitted concurrently to other possible sponsors, including DHA. Concurrent submission of a proposal to other organizations will not prejudice its review by DHA. Provide the following information:

- Title of award or project title;
- Source and amount of funding (annual direct costs; provide award numbers for all current awards);
- Percentage effort devoted to each project;
- Technical contact (name, address, phone, e-mail);
- Administrative/Business contact (name, address, phone, e-mail);
- Period of performance;
- The proposed project and all other projects or activities requiring a portion of time of the proposed Technical Program Manager and other proposed senior personnel must be included, even if they receive no salary support from the project(s); The total award

amount for the entire award period covered (including indirect costs) must be shown as well as the number of person-months or labor hours per year to be devoted to the project, regardless of the source of support;
- Commitment proposed for the Technical Program Manager in terms of person-months per year for each year.

All submissions will be protected from unauthorized disclosure in accordance with applicable law and DoD regulations. You are expected to appropriately mark each page of the submission that contains proprietary information.

The following SF 424 forms and attachments, as applicable are required for all applications:

SF-424, Application for Federal Assistance - (included in the application package available on grants.gov posted with this Program Announcement). This form must be sent as the cover page for all proposals. Complete all required fields in accordance with the "pop-up" instructions on the form and the following instructions for specific fields. Please complete the SF-424 first, as some fields on the SF-424 are used to auto-populate fields on other forms.

SF424 Research and Related Budget - (available at https://www.grants.gov/web/grants/forms/r-r-family.html)

Budget Narrative Attachment Form – Attach the Budget justification to this form. Provide a separate Adobe .pdf document to provide appropriate justification and/or supporting documentation for each element of cost proposed. Click "Add Attachment" to attach.

SF-424B, Assurances - Nonconstruction Programs - (included in the application package available on grants.gov posted with this Program Announcement).
The program described in Section I above includes non-construction elements. Therefore, the mandatory forms for non-construction programs must be completed. Non-construction activity costs should be included on the SF-424A.

Project Abstract Form – The project abstract must identify the problem and objectives, technical approaches, anticipated outcome of the effort, if successful, and impact on the DoD capabilities. Use only characters available on a standard QWERTY keyboard. Spell out all Greek letters, other non-English letters, and symbols. Graphics are not allowed and there is a 4,000-character limit including spaces.

Do not include proprietary or confidential information. The project abstract must be marked by the applicant as "Approved for Public Release". Abstracts of all funded projects will be posted on the public DTIC website: https://dodgrantawards.dtic.mil/grants

Any modifications to the Project Narrative or Budget Form require submission of a changed/ corrected Grants.gov application package to Grants.gov prior to the application submission deadline.

Submission Dates and Times: Applications must be received by 5:00 p.m. Eastern Time (ET), on the date specified in the country specific narrative in Attachment 1.

Applicants are responsible for submitting their applications in sufficient time to allow them to reach Grants.gov by the time specified in this announcement. If the application is received by Grants.gov after the exact time and date specified as the deadline for receipt, it will be considered "late" and will not be considered for review. Acceptable evidence to establish the time of receipt by Grants.gov includes documentary evidence of receipt maintained by Grants.gov.

To avoid the possibility of late receipt, which will render the application ineligible for consideration, **it is strongly recommended that applications be uploaded at least 24-48 hours days before the deadline.** This will help avoid problems caused by high system usage or any potential technical and/or input problems involving the applicant's own equipment.

DHAPP cannot make allowances/exceptions to its policies for submission problems encountered by the applicant organization using system-to-system interfaces with Grants.gov. If an emergency or unanticipated event interrupts normal federal government processes so that applications cannot be received by Grants.gov by the exact time specified in this announcement, and the situation precludes amendment of the announcement closing date, the time specified for receipt of applications will be deemed to be extended to the same time of day specified in this announcement on the first work day on which normal federal government processes resume.

Application Receipt Notices: After an application is submitted to Grants.gov, the Authorized Representative (listed in Block #19 of the SF-424) will receive a series of three e-mails from Grants.gov. The first e-mail will confirm receipt of the application by the Grants.gov system. The second e-mail will indicate that the application has either been successfully validated by the system prior to transmission to DoD or has been rejected due to errors. This second email will also determine if the proposal is late based on the aforementioned receipt time. The third e-mail should be received once DoD has confirmed receipt of the application usually within 10 days from the application due date. The last e-mail will indicate that the application has been received and provide the assigned tracking number. Applicants can track the status of their applications at https://www.grants.gov/web/grants/applicants/track-my-application.html.

Funding Restrictions:

Information regarding funding restrictions can be found in the country specific narrative in Attachment 1.

Other Submission Information:

Applicant Support*:* Grants.gov provides applicants 24/7 support via the toll-free number 1-800- 518-4726 and email at support@grants.gov. For questions related to the specific grant opportunity, contact the number listed in the application package of the grant you are applying for.

If you are experiencing difficulties with your submission, it is best to call the Grants.gov Support Center and get a ticket number. The Support Center ticket number will assist the DoD with tracking your issue and understanding background information on the issue.

Timely Receipt Requirements and Proof of Timely Submission:

The AOR who submitted the application will receive an acknowledgement of receipt and a tracking number (GRANTXXXXXXXX) from Grants.gov with the successful transmission of their application. This AOR will also receive the official date/time stamp and Grants.gov tracking number in an email serving as proof of their timely submission.

When DoD successfully retrieves the application from Grants.gov, and acknowledges the download of submissions, Grants.gov will provide an electronic acknowledgment of receipt of the application to the email address of the AOR who submitted the application. Again, proof of timely submission shall be the official date and time that Grants.gov receives your application.

Applicants using slow internet, such as dial-up connections, should be aware that transmission can take some time before Grants.gov receives your application. Again, Grants.gov will provide either an error or a successfully received transmission in the form of an email sent the AOR attempting to submit the application. The Grants.gov Support Center reports that some applicants end the transmission because they think that nothing is occurring during the transmission process. Please be patient and give the system time to process the application.

Application Withdrawal: An applicant may withdraw an application at any time before award by written notice or by email. Notice of withdrawal shall be sent to the Grants Officer identified in this announcement. Withdrawals are effective upon receipt of notice by the Grants Officer.

E. Application Review Information

Review Criteria:

Proposals will be selected through a technical and business decision-making process with technical considerations being most important. The following scored criteria are listed in descending order of importance.

a. Technical Approach
   - Goals and Objectives. The proposal clearly states the overall goal(s) of the program and has specific, measurable objectives. The proposal is relevant to established DHAPP priority activities
   - Work Plan. The proposal contains sound scientific methods, an appropriate work plan described in sufficient detail and appropriate deliverables.
   - Methodology for monitoring and evaluation procedures. The proposed plan includes a description of how the program will have an impact on the country's military and clearly states the indicators of performance that will be used to

monitor effectiveness.

- Schedule and milestones. The proposed plan for HIV prevention efforts is feasible and contains concrete, achievable schedule and milestones.
- Relevance to the host country's military. The proposal clearly describes the involvement of the host country military and the relevance of the proposed program to the needs, priorities, and circumstances of the host country's military.

b. Qualifications

- Key Personnel are qualified and eligible to perform the work.

In addition, the following **unscored** criteria will also contribute to the overall evaluation of the application:

- Whether the applicant qualifies as a local partner. To be considered a local partner, the applicant must submit supporting documentation demonstrating their organization meets at least one of the three criteria listed below.
- (1) an individual must be a citizen or lawfully admitted permanent resident of, and have his/her principal place of business in the country served by the PEPFAR program with which the individual is or may become involved, and a sole proprietorship must be owned by such an individual; or
- (2) an entity (e.g., a corporation or partnership):
- a) must be incorporated or legally organized under the laws of, and have its principal place of business in, the country served by the PEPFAR program with which the entity is or may become involved;
- b) must be at 75% beneficially owned by individuals who are citizens or lawfully admitted permanent residents of that same country, per sub-paragraph (2)(a)
- c) at least 75% of the entity's staff (senior, mid-level, support) must be citizens or lawfully admitted permanent residents of that same country, per sub-paragraph (2)(a), and at least 75% of the entity's senior staff (i.e., managerial and professional personnel) must be citizens or lawfully admitted permanent residents of such country; and
- d) where an entity has a Board of Directors, at least 51% of the members of the Board must also be citizens or lawfully admitted permanent residents of such country; or

Review and Selection Process: Proposals will not be evaluated against each other but will be scored based on the criteria listed above. DHAPP's intent is to review proposals as soon as possible after they arrive; however, proposals may be reviewed periodically for administrative reasons.

The ultimate recommendation for award of proposals is made by DHAPP or other technical experts. Recommended proposals will then be forwarded to the U.S. Army Medical

Research Acquisition Activity (USAMRAA). Any notification received from USAMRAA indicating the Applicant's proposal has been recommended does not ultimately guarantee an award will be made. This notice indicates that the proposal has been selected in accordance with the evaluation criteria stated above and has been sent to the USAMRAA Grants Division to conduct cost analysis, determine the Applicant's responsibility, to confirm whether funds are available, and to take other relevant steps necessary prior to making the award.

Anticipated Announcement and Federal Award Dates: Decisions are expected to be announced by acceptance/declination letters via email. All awards are expected to be in place as specified in the country specific narrative in Attachment 1.

Recipient Qualification: The Office of Management and Budget (OMB) has issued final guidance implementing section 872 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 as it applies to grants. As required by section 872, OMB and the General Services Administration have established the Federal Awardee Performance and Integrity Information System (FAPIIS) as a repository for government-wide data related to the integrity and performance of entities awarded federal grants, cooperative agreements, and contracts. This final guidance implements reporting requirements for recipients and awarding agencies; requires awarding agencies to consider information in FAPIIS before awarding a grant or cooperative agreement to a non-federal entity; and addresses how FAPIIS and other information may be used in assessing recipient integrity.

a. Federal awarding agencies must report information to FAPIIS about any termination of an award due to a material failure to comply with the award terms and conditions; any administrative agreement with a non-federal entity to resolve a suspension or debarment proceeding; and any finding that a non-federal entity is not qualified to receive a given award, if the finding is based on criteria related to the entity's integrity or prior performance under federal awards.

b. Federal awarding agencies, prior to making award to a non-federal entity, must review information in FAPIIS to determine that entity's eligibility to receive the award.

c. Recipients of federal contracts, grants, and cooperative agreement awards with a cumulative total value exceeding $10,000,000 are required to provide information to FAPIIS on certain civil, criminal, and administrative proceedings that reached final disposition within the most recent five year period and that were connected with the award or performance of a federal award; and to disclose semiannually the information about the criminal, civil, and administrative proceedings described in section 872(c).

d. Notice of funding opportunities and federal award terms and conditions to inform a non-federal entity that it may submit comments to FAPIIS (https://www.fapiis.gov) about any information the federal awarding agency had reported to the system about the non-federal entity, for consideration by the awarding agency in making future awards to the non-federal entity.

F. Federal Award Administration Information

Federal Award Notices: Notification of selection of all applications will be e-mailed by the USAMRAA Grants Officer.

The notification e-mail regarding a successful application must not be regarded as authorization to commit or expend DoD funds. An award signed by the USAMRAA Grants Officer is the authorizing document. Applicants whose applications are recommended for negotiation of award will be contacted by a USAMRAA Grant Specialist to discuss any additional information required for award. This may include representations and certifications, revised budgets or budget explanations, or other information as applicable to the proposed award. The award start date will be determined at this time.

Administrative and National Policy Requirements: Each cooperative agreement awarded under this announcement will be governed by the general terms and conditions in effect at the time of the award that conform to DoD's implementation of OMB guidance applicable to financial assistance in 2 CFR part 200, "Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards."

Awards made under this announcement are subject to the Department of Defense Directive 6485.02E which can be found here: https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodd/648502E.pdf?ver=2018-06-01-130040-790

A. Certification

Certification of compliance with the national policy requirement regarding lobbying activities is required from all recipients of awards over $100,000. Submission of this certification is required by 31 USC 1352 and is a prerequisite for making or entering into an award over $100,000.

Complete SFLLL (Disclosure of Lobbying Activities), if applicable, and attach to Block 18 of the SF424 (Application for Federal Assistance) Form.

Certification for Contracts, Grants, Loans, and Cooperative Agreements

By signing an application, the applicant certifies, to the best of his or her knowledge and belief, that:

(1) No Federally appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, and the

making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid, or will be paid, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit SFLLL (Disclosure of Lobbying Activities), in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by 1352 USC 31. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

B. Representations

All extramural applicants are required to complete the representations below and submit with each application. The form for completion and submission is posted in eBRAP (https://ebrap.org/eBRAP/public/Program.htm). Upload the form into Grants.gov under Attachments.

Representations Regarding Unpaid Federal Tax Liabilities and Conviction of Felony Criminal Violations Under Any Federal Law

At the time of application submission, the applicant organization represents that it:

(1) Is_____Is not_____a Corporation ("Corporation" means any entity, including any institution of higher education, other non-profit organization, or for-profit entity that has filed articles of incorporation). If the organization is a corporation, complete (2) and (3) below.

(2) Is_____Is not_____a Corporation that has any unpaid Federal tax liability that has been assessed, for which all judicial and administrative remedies have been exhausted or have lapsed, and that is not being paid in a timely manner pursuant to an agreement with the authority responsible for collecting the tax liability.

(3) Is____Is not_____a Corporation that was convicted of a criminal violation under any

Federal law within the preceding 24 months.

NOTE: If the applicant organization responds in the affirmative to either (2) or (3) of the above representations, the applicant is ineligible to receive an award unless the agency suspension and debarment official has considered suspension or debarment and determined that further action is not required to protect the Government's interests. The applicant organization therefore will be required to provide information about its tax liability and/or conviction, upon request, to the Grants Officer, to facilitate completion of the required consideration before award decisions are made.

In accordance with DoD appropriations, the following representation is required. The applicant, by its signature on the SF424, represents:

Representation Regarding the Prohibition on Using Funds Under Grants and Cooperative Agreements with Entities That Require Certain Internal Confidentiality Agreements.

By submission of its application, the applicant represents that it does not require any of its employees, contractors, or subrecipients seeking to report fraud, waste, or abuse to sign or comply with internal confidentiality agreements or statements prohibiting or otherwise restricting those employees, contractors, or subrecipients from lawfully reporting that waste, fraud, or abuse to a designated investigative or law enforcement representative of a Federal department or agency authorized to receive such information. Note that (1) the basis for this representation is a prohibition in Section 743 of the Financial Services and General Government Appropriations Act, 2015 (Division E of the Consolidated and Further Continuing Appropriations Act, 2015, Public Law 113-235) and any successor provision of law on making funds available through grants and cooperative agreements to entities with certain internal confidentiality agreements or statements; and (2) Section 743 states that it does not contravene requirements applicable to Standard Form 312, Form 4414, or any other form issued by a Federal department or agency governing the nondisclosure of classified information.

C. National Policy Requirements

The recipient must comply with the following requirements, as applicable. The full text of National Policy Requirements is available at https://www.usamraa.army.mil/Pages/Resources.aspx. Awards will incorporate the most recent set of National Policy Requirements available at the time of award.

Reporting:

1) FINANCIAL REPORTING
(a) Interim Federal Financial Report (SF 425) shall be submitted within 30 days following the end of each calendar quarter and must include in the remarks the location of financial records and a point of contact for the Government to obtain access to the financial records associated with this

award. The following reporting period end dates shall be used for interim reports: 3/31, 6/30, 9/30, and 12/31.
(b) Final Federal Financial Report (SF 425) is required within 120 calendar days of the completion date for the term of this award and must include in the remarks the location of financial records and a point of contact for the Government to obtain access to the financial records associated with this award.
(d) Annual report of Implementing Partners Budget and Projected Expenditures will be required for awards funded with PEPFAR funding and will follow PEPFAR guidance for submission.
(e) Annual Expenditure Reporting will be required for awards funded with PEPFAR funding and will follow PEPFAR guidance for submission.

Financial Reporting Format Instruction:

• **Attach the Quarterly Financial Report Spreadsheet with the SF 425.** Submit in excel format along with SF425 in order to monitor expenditures according to the PEPFAR program area(s). The report template will be provided by the Government Program Office/DHA. Submit 30 calendar days after each reporting period (3/31, 6/30, 9/30, and 12/31). The Recipient shall provide the Quarterly Financial Reporting Spreadsheet in accordance with the template provided by DHA.

2) INTERIM PROGRESS: INDICATOR REPORT
This report shall summarize progress in relation to the approved Work Plan as well as monitor grant deliverables. The Grantee shall submit quarterly indicator reports in accordance with the format provided by the Program Office within 45 calendar days following the end of the reporting period: 3/31, 6/30, 9/30 and 12/31. The Recipient shall provide reports in accordance with the guidance and template provided by DHA.

DHAPP Strategic Information Reporting Requirements: The grantee is expected to promptly prepare and submit data results that accurately reflect the contributions of those involved, and all significant findings from work conducted under DHAPP awards. Data reporting deadlines and requirements are clearly communicated by DHAPP to all grantees on a routine basis.
DHAPP award recipients are required to:

• If applicable, submit routine program indicator targets and results (e.g. Monitoring, Evaluation and Reporting (MER) Indicators) that reflect expected and achieved results through activities supported by DHAPP awards. Military program indicator data at the Implementing Mechanism level (not at a military site-level) are to be submitted on a quarterly, semi-annual and annual basis into the OGAC hosted system Data for Accountability Transparency and Impact Monitoring (DATIM), within the deadlines established by OGAC. **Instructions will be provided after award.** Military program indicator data at the site-level must also be submitted to DHAPP, using the required DHAPP templates, within the deadlines established by DHAPP. DHAPP will provide all orientation and training related to the reporting of site-level data.

• Implementing Partners are responsible for ensuring the quality of data from the point of data collection through report submission, and should make every attempt to either fix or document and communicate to DHAPP data quality issues.

• Implementing Partners are responsible for following the standards defined in the Site Improvement through Monitoring System (SIMS) and are required to participate in program quality assurance and improvement activities, per guidance provided by OGAC and DHAPP.

3) FINAL TECHNICAL REPORT
Within 120 calendar days of completion or termination of this Agreement, the Recipient shall submit a Final Report addressing the technical achievements of the program. The report should provide a synopsis of the accomplishments made under the Agreement. No proprietary or classified information shall be included in the final report as it is subject to public release.

4) PROPERTY REPORT
Recipients shall submit annually an inventory listing of federally-owned property in their custody. Upon completion of the award, Title to all property and equipment acquired under this grant shall revert to the host nation at the end of the performance period.

The Award terms and Conditions will specify if more frequent or other special reporting is required. Should OGAC require additional or different reporting requirements during the award period of performance, awards will be modified to include these requirements.

Awards resulting from this Program Announcement will incorporate additional reporting requirements related to recipient integrity and performance matters. Recipient organizations that have Federal contract, grant, and cooperative agreement awards with a cumulative total value greater than $10,000,000 are required to provide information to FAPIIS about certain civil, criminal, and administrative proceedings that reached final disposition within the most recent 5-year period and that were connected with performance of a Federal award. Recipients are required to disclose, semiannually, information about criminal, civil, and administrative proceedings as specified in the applicable Representations

G. Federal Awarding Agency Contacts

Questions regarding program policy, program content, or technical issues should be directed prior to the date indicated in the country specific narrative in Attachment 1 to:

DHAPP Program Manager
Dr. Steve Wiersma
DHAPP Deputy Division Chief
steven.t.wiersma.civ@mail.mil

Questions regarding administrative issues or grant administration should be directed to:

USAMRAA Grants Officer
David Ruane
Grants Officer
david.p.ruane.civ@mail.mil

H. Other Information

Applications must not include any information that has been identified as classified national security information under authorities established in Executive Order 12958, Classified National Security Information.

Applicants are advised that employees of commercial firms under contract to the government may be used to administratively process applications. By submitting an application, an applicant consents to allowing access to its application(s) by support contractors. These support contracts include nondisclosure agreements prohibiting their contractor employees from disclosing any information submitted by applicants.

Freedom of Information Act Requests: The FOIA (5 USC 552) provides a statutory basis for public access to official Government records. The definition of "records" includes documentation received by the Government in connection with the transaction of public business. Records must be made available to any person requesting them unless the records fall under one of nine exceptions to the Act (www.usdoj.gov/oip/index.html).

When a FOIA request asks for information contained in a successful application that has been incorporated into an award document, the submitter will be contacted and given an opportunity to object to the release of all or part of the information that was incorporated. A valid legal basis must accompany each objection to release. Each objection will be evaluated by DoD in making its final determination concerning which information is or is not releasable. If information requested is releasable, the submitter will be given notice of DoD's intent to release and will be provided a reasonable opportunity to assert available action.

J-1 Visa Waiver: Each organization, including organizations located outside of the United States, is responsible for ensuring that the personnel associated with any application recommended for funding are able to complete the work without intercession by the DoD for a J-1 Visa Waiver on behalf of a foreign national in the United States under a J-1 Visa.

Note: The Federal Government will not provide funds to support scientists from countries meeting the criteria for designation as a State Sponsor of Terrorism (https://www.state.gov/j/ct/list/c14151.htm). Additional information on J-1 Visa Waivers can be located at the following Department of State website: travel.state.gov/visa/temp.

Rejection Criteria

- Missing budget
- Missing narrative
- Missing Data Management Plan
- Proposals not submitted in English
- Project Abstract exceeds 4000 characters

Attachment 1. Country Specific Narratives

Applications may be submitted in accordance with the following country specific narratives. Please note that submission deadlines vary across each narrative:

- **Multi-Country**
- **Angola**
- **Botswana**
- **Burkina Faso**
- **Burundi**
- **Cameroon**
- **Colombia**
- **Ghana**
- **Liberia**
- **Mozambique**
- **Togo**
- **Uganda**
- **Vietnam**
- **Zambia**

Multi-Country - DHAPP Partnership for Sustainable HIV Epidemic Control

NOTE: Application submissions for this narrative are due by 5pm ET on February 5, 2021. Submission received after the deadline will not be considered for funding

Introduction

The HIV/AIDS epidemic has been devastating and negatively affected many militaries and other uniformed organizations worldwide by reducing military readiness, limiting deployments, causing physical and emotional decline in infected individuals and their families, posing risks to military personnel and their extended communities, and impeding peacekeeping activities. As HIV management improves, many of these impacts are disappearing; however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries in addition to other long-term chronic disease management issues.

The U.S. Government (USG) has a long history of international collaboration and partnerships in the fight against HIV/AIDS, providing funding, technical assistance, and program support. These collaborations are all contributing to HIV epidemic control.

Over the years, the United States Department of Defense (DoD) HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries in an effort to control the HIV epidemic among their respective military services. DHAPP is the DoD implementing agency collaborating with the U.S. Department of State, the Health Resources and Services Administration, Peace Corps, U.S. Agency for International Development (USAID), and the Centers for Disease Control and Prevention (CDC), in the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). DHAPP receives funding for its programs from two sources: a congressional plus-up to the Defense Health Program (DHP) and funding transfers from the Department of State for PEPFAR. Working closely with DoD, U.S. Unified Combatant Commanders, Joint United Nations Programme on HIV/AIDS (UNAIDS), university collaborators, and other nongovernmental organizations (NGOs), DHAPP's mission is to build capable military partners through military-specific, culturally focused, HIV/AIDS cooperation and assistance.

In the Defense Security Cooperation Agency guidance, the U.S. Secretary of Defense has identified HIV/AIDS in foreign militaries as a national security issue. Pursuing HIV/AIDS activities with foreign militaries is clearly tied to security interests, regional stability, humanitarian concerns, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing societies. DHAPP employs an integrated bilateral and regional strategy for HIV/AIDS cooperation and security assistance. DHAPP implements bilateral and regional strategies in coordination with respective Combatant Commands (COCOMs) and Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the U.S. Under Secretary of Defense for Policy and by the Office of the Global AIDS Coordinator (OGAC). DHAPP provides strategic information and supports defense forces in HIV prevention, care, and treatment for HIV-infected individuals and their families.

PEPFAR adopted the UNAIDS' global 95-95-95 goals that state by 2030: 95% of people with HIV are diagnosed, 95% of them are on ART and 95% of them are virally suppressed.

DHAPP shifted with PEPFAR in how Monitoring, Evaluation, and Reporting (MER) indicators are

collected and reported to efficiently use data to drive decision-making and focus HIV programming in the right geographic areas. DHAPP collects MER indicator results on a quarterly and semi-annual basis, and data are reported at the site level. These data allow DHAPP to understand the gaps in programming and needs for shifts to reach our shared goals. Due to security sensitivities regarding military site locations and troop movement, all site-level data are analyzed at DHAPP headquarters, and summary data are collected by OGAC so each USG country team can review military program results at the national level.

To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and community-based and community-led organizations – regardless of current antiretroviral (ARV) coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term, local partner engagement and impact.

In fiscal year (FY) 2019, DHAPP supported 52 active HIV programs, mainly through direct military-to-military cooperation in addition to support from contracting external organizations and academic institutions to assist with specific aspects of proposed programs. Partners in FY19 included 35 Non-Governmental Organizations (NGO)s and universities working in 46 countries.

Local partners are encouraged to apply to this announcement.

Budget

PEPFAR activities and services and corresponding budgets and expenditures are uniformly organized into a classification structure referred to as PEPFAR Financial Classifications. In this structure, the PEPFAR funded activities and services are classified systematically as interventions, which is a combination of programs (and sub-programs) and beneficiaries (and sub-beneficiaries). Budget and program expenditures are further arrayed according to the cost classification. The below link contains the PEPFAR Financial Classifications Reference Guide and summaries of these classification definitions.
https://datim.zendesk.com/hc/en-us/articles/360015671212-PEPFAR-Financial-Classifications-Reference-Guide

The estimate budget for this program announcement in the format of the PEPFAR Financial Classifications is as follows:

Estimated Budget to be used as a Framework

	Year 1	**Year 2**	**Year 3**	**Year 4**
ASP: Human resources for Health-NSD (MIHTP)				
--San Diego MIHTP	130,000	130,000	130,000	130,000
--Regional MIHTP	300,000	300,000	300,000	300,000
ASP: Human resources for Health-NSD (PM Training)	270,000	270,000	270,000	270,000
Human resources for Health (Data Use Workshops)	290,000	290,000	290,000	290,000
TOTAL	990,000	990,000	990,000	990,000

Technical Narrative

DHAPP is seeking a Recipient to assist with event planning. The field of HIV epidemic control and the corresponding approach of the USG through PEPFAR is rapidly changing. To ensure that DHAPP-supported staff can keep up with these changes, a number of educational and training approaches are needed to support DHAPP programs across the globe. These events need to occur both in the United States and internationally, in-person and virtually. International representatives who need this updated HIV epidemic control information are DHAPP in-country Program Management staff, partner militaries staff, and implementing partners, some of whom have limited infrastructure support to conduct requisite capacity-building activities on their own. The Recipient will provide comprehensive services to successfully plan and execute meetings, training programs, workshops and other events. The Recipient will handle budgeting, venue selection, procurement, logistics and other issues as they arise. These meetings range in size from 10 to 100 attendees. The Recipient will be expected to communicate on behalf of DHAPP including but not limited to with USG officials, participants and vendors, many of whom will be internationally-based. Effective, culturally and politically sensitive, error-free communication is crucial.

The Recipient shall prepare a Project Management Plan describing the technical approach, organizational resources and management controls to be employed to meet the cost, performance and schedule requirements for this effort. The Project Management Plan shall detail the products, methods for developing the products, allocation of staff and other resources necessary to produce the products and a timeline for producing the products, if necessary. DHAPP shall receive the revised Project Management Plan in electronic form. Based on the Project Management Plan, DHAPP will provide approval to move forward on activities planned. The Recipient shall request prior approval for all activities not included in the plan or for any modifications to the plan after approval has been given. Resumes of individuals who will be coordinating these meetings must be submitted. If any substitutions are necessary after the Recipient has been awarded, persons being substituted must possess the same or higher qualification and must be approved by DHAPP.

DHAPP anticipates the yearly event requirement to include: two San Diego-based Military International HIV Training Program (MIHTP) courses; two regional MIHTP courses; one Program Manager (PM) training; and two Data Use Trainings.

San Diego MIHTP

Clinicians from militaries around the world have had the unique opportunity to visit the United States for 30 days to participate in the Military International HIV Training Program (MIHTP) in San Diego, California. Trainees experience in-depth lectures, tour U.S. medical facilities, and take part in clinical rounds and counseling sessions with HIV patients. Trainees are exposed to the most up-to-date advances in HIV epidemiology, prevention and treatment. MIHTP involves intense study, collaboration, and coordination. All participants are expected to transfer acquired knowledge to other military HIV care providers in their respective countries. DHAPP anticipates hosting two San Diego MIHTP events each year. DHAPP usually hosts 10-12 students per session, but may be more or less depending on last-minute cancellations or additions. The course is conducted in collaboration with the Naval Medical Center San Diego (NMCSD) and the University of California, San Diego (UCSD).

Regional MIHTP

To increase the impact of MIHTP, a shortened version is offered outside San Diego. DHAPP anticipates hosting two regional courses per year. These courses are each two weeks in length and are conducted at a site convenient for a region to be able to send partner military physicians. Prior locations have included Malawi, Cambodia, Estonia, Guatemala, and Tanzania. The next site is to be determined, but will likely be in Western Africa. The site is generally a hotel conference center. The participants average 20-30 in number.

Program Manager Training

The Program Manager Training is designed for DHAPP country teams and HQ agencies to review progress towards HIV epidemic control in partner militaries, engage in technical discussions in preparation for annual planning, and review financial, operational and monitoring requirements. The training has a different focus depending on the program funding of that country team (PEPFAR or DHP). It, therefore, requires both plenary and breakout sessions to allow a customized delivery of content and interactions. The training is planned to be a one-week event conducted in San Diego. There are usually between 60-100 attendees. The meeting generally occurs in January due to other calendar considerations and to PEPFAR Country Operational Plan cycles.

Data Use Training

Data Use Training addresses reporting requirement changes, data management needs, and analytic and dissemination methods. DHAPP anticipates hosting one in-person training per year. This training would be one week for all participants and two weeks for selected participants. We anticipate training approximately 30 participants with half participating in the second week. The training will be held outside the United State (the previous trainings took place in Uganda and Ghana). We also anticipate one virtual training with similar number of participants and timeframe.

To support these trainings, the Recipient will be expected to provide at a minimum:

- Working closely with the Event point of contact (POC) to address specific planning needs and ensuring the successful completion of the event;
- Venue planning including preparing proposals for various sites and costs for approval by DHAPP;
- Developing a registration system for participants;
- A deliverable schedule and timeline based on the statement of work;
- Weekly and monthly status reports (progress, budget, etc);
- Booking all participants' travel and hotel accommodations, and providing travel assistance;
- Providing transportation to hotel upon arrival and to airport upon departure for each participant;
- Procuring travel insurance for participants if the partner military has not provided it, as approved by DHAPP staff;
- Providing local transportation as required for course-related activities;
- Providing per diem (obtain participant signature upon receipt);
- Providing a Welcome Packet with conference bag, supplies, and any electronic or printed materials to participants upon arrival;
- Providing on-site coordination and logistical support;
- Providing interpretation services as needed;
- Providing translation services as needed;

- Securing appropriate audiovisual equipment for the duration of the meeting, which should include but not be limited to projectors, screens, microphones and laptop computers as necessary for each scheduled session;
- Coordinating all meeting requirements with both DHAPP and selected venue;
- Maintaining and providing a regularly updated spreadsheet to track participant data which may include: registration data, needs assessment (as required by specific course), passport copy, CV, copies of medical licenses, proof of international travel insurance (paid for by participating military), and others according to the POC;
- Selecting and administering pre- and post-test knowledge surveys as appropriate (weekly for MIHTP), providing results in a standard database and providing corresponding reports and analysis;
- Compiling and analyzing weekly and overall evaluations;
- Reproducing and distributing all electronic and print course materials (participant manual, flip chart, provider card, trainer manual);
- Ensuring that staff are on site for two to three days prior to the beginning of each course (for airport pickup, per diem distribution, troubleshooting);
- Arranging social event/graduation ceremonies;
- Providing a group photo for all participants;
- Working closely with the course coordinators and leaders to address any course-specific needs that arise;
- Provide contingency planning in the event of illness, legal issues, or elopement; and
- Preparing a post-training summary.

While all events are planned to take place in-person, the Recipient should be prepared with a virtual back-up plan in the event that an in-person course is deemed unsafe by DHAPP (due to a situation like COVID-19).

Work Plans

The Recipient must submit annual, programmatic and financial work plans to DHAPP HQ (budget breakdown per activity and for program management is required). Work plans should include an activities implementation timeline, as well as a monitoring and evaluation timeline.

Angola: DHAPP — Forças Armadas Angolanas (FAA) Partnership for Sustainable HIV Epidemic Control

NOTE: Application submissions for this narrative are due by 5pm ET on February 5, 2021. Submission received after the deadline will not be considered for funding

Introduction

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Over the years, the United States Department of Defense (DoD) HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries in an effort to control the HIV epidemic among their respective military services. DHAPP is the DoD implementing agency collaborating with the U.S. Department of State, the Health Resources and Services Administration, Peace Corps, U.S. Agency for International Development (USAID), and the Centers for Disease Control and Prevention (CDC), in the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). DHAPP receives funding for its programs from two sources: a congressional plus-up to the Defense Health Program (DHP) and funding transfers from the Department of State for PEPFAR. Working closely with DoD, U.S. Unified Combatant Commanders, Joint United Nations Programme on HIV/AIDS (UNAIDS), university collaborators, and other nongovernmental organizations (NGOs), DHAPP's mission is to build capable military partners through military-specific, culturally focused, HIV/AIDS cooperation and assistance.

In the Defense Security Cooperation Agency guidance, the U.S. Secretary of Defense has identified HIV/AIDS in foreign militaries as a national security issue. Pursuing HIV/AIDS activities with foreign militaries is clearly tied to security interests, regional stability, humanitarian concerns, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing societies. DHAPP employs an integrated bilateral and regional strategy for HIV/AIDS cooperation and security assistance. DHAPP implements bilateral and regional strategies in coordination with respective Combatant Commands (COCOMs) and Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the U.S. Under Secretary of Defense for Policy and by the Office of the Global AIDS Coordinator (OGAC). DHAPP provides strategic information and supports defense forces in HIV prevention, care, and treatment for HIV-infected individuals and their families.

PEPFAR adopted the UNAIDS' global 95-95-95 (formerly 90-90-90) goals that state by 2030: 95% of people with HIV are diagnosed, 95% of them are on antiretroviral therapies (ART) and 95% of them are virally suppressed.

PEPFAR Monitoring, Evaluation, and Reporting (MER) indicators are collected and reported to efficiently use data to drive decision-making and focus HIV programming in the right geographic areas. DHAPP uses the same program indicators for DHP and PEPFAR funded programs. DHAPP collects MER indicator results on a quarterly semi-annual, and annual basis, depending on indicator and data are reported at the site level to DHAPP. These data allow DHAPP to analyze and evaluate gaps in programming and achievement and identify needs for shifts to reach our shared goals. Due to security sensitivities regarding military site locations and troop movement, all site-level data are analyzed at DHAPP headquarters and summary data are reported to OGAC so that other USG country team agencies can review military program results aggregated at the national level.

Transition to Local Partners: Local partners are encouraged to apply to this announcement.

To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and community-based and community-led organizations – regardless of current antiretroviral (ARV) coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and to establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term, local partner engagement and impact.

All respondents must demonstrate the active support of the in-country military and the DoD representative in the corresponding U.S. Embassy in the planning and execution of their proposals.

In fiscal year (FY) 2019, DHAPP supported 52 active HIV programs, mainly through direct military-to-military cooperation in addition to support from contracting external organizations and academic institutions to assist with specific aspects of proposed programs. Partners in FY19 included 35 Non-Governmental Organizations (NGO)s and universities working in 46 countries.

Estimated Budget to be used as Framework

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Total**
Prevention	**$140,000**	**$140,000**	**$140,00**	**$140,000**	**$560,000**
PREV: Not Disaggregated	$140,000	$140,000	$140,000	$140,000	$560,000
Care & Treatment	**$750,000**	**$750,000**	**$750,000**	**$750,000**	**$3,000,000**
C&T: HIV Clinical Services	$750,000	$750,000	$750,000	$750,000	$3,000,000
Health Systems Strengthening	**$510,000**	**$510,000**	**$510,000**	**$510,000**	**$2,040,000**
ASP (above site program): Laboratory systems strengthening	$170,000	$170,000	$170,000	$170,000	$680,000
ASP: Policy, planning, coordination & management	$140,000	$140,000	$140,000	$140,000	$560,000
ASP: Health Management Information System (HMIS), surveillance, & research	$200,000	$200,000	$200,000	$200,000	$800,000

PM: Program Management	**$310,000**	**$310,000**	**$310,000**	**$310,000**	**$1,240,000**
TOTAL	**$1,710,000**	**$1,710,000**	**$1,710,000**	**$1,710,000**	**$6,840,000**

Approaches to Reaching Sustainable Epidemic Control

Proposals are requested to support the FAA to reach sustainable control of the HIV/AIDS epidemic through the pillars of transparency, accountability, and impact.

The Recipient's program should emphasize capacity building across all activities and technical areas. All proposals should detail how the Recipient will engage the partner military leadership as well as personnel at all levels in this work; and, specifically how the partner will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Within the proposal, the Recipient will need to demonstrate transition of programmatic capabilities and capacity to the military over the life of the award.

The Recipient must work in complete coordination with the partner militaries' HIV prevention and health services, as well as the DHAPP/DoD Program Manager based at the U.S. Embassies in these countries, the DoD adult and pediatric treatment program manager based at the Military Health Department, other DHAPP supported Recipients working in these countries, other bilateral and multilateral agencies with similar objectives and the DHAPP Headquarters Team.

Targets

Progress towards epidemic control will be successfully measured, in part, through an effective strategic information framework that monitors not only program outputs as compared to planned targets, but also key outcomes and programmatic impact.

Collection and use of disaggregated data that characterize the populations served in the lowest geographic areas where HIV services are being provided is critical in understanding current program performance and planning for future performance. Consequently, the MER indicators continue to evolve in order to reflect the progression of USG support and global HIV response guidelines. Measuring the impact of support at national and regional above-site levels down to direct services at the site-level is paramount to DHAPP's program implementation and monitoring approach.

MER indicators are not an exhaustive list of all metrics that should be monitored by DHAPP-supported programs. DHAPP also collects a custom indicator. All programs should continually monitor and assess any acute programmatic issues and collect additional data to inform program improvement.

The indicators listed below support a patient-centered program monitoring approach. Per the 2017 WHO Consolidated Guidelines on Person-Centered HIV Patient Monitoring and Case Surveillance, person-centered monitoring refers to a shift from monitoring measuring services (e.g., the number of individuals tested or people on treatment) to monitoring people at the center of their access to linked HIV and health services. In essence, this marks a shift to better support the clients accessing services by focusing more on their individual health outcomes.

The proposal will address approaches to reaching the following targets for military and civilian populations. Targets are listed using the associated PEPFAR MER Indicator. Please see the most recent MER Indicator Reference Guide for more detail at https://datim.zendesk.com/hc/en-us/articles/360000084446-MER-Indicator-Reference-Guides .

Prevention

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
1. PP_PREV	Number of priority populations reached with standardized HIV prevention intervention(s) that are evidence-based	21,477	NA
2. TB_PREV	Proportion of ART patients who started on a standard course of TB Preventive Treatment (TPT) in the previous reporting period who completed therapy	90%	90%

Testing

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
3. HTS_TST	Number of individuals who received HIV Testing Services (HTS) and received their test results (includes HTS_INDEX)	14,473	9,648
4. HTS_INDEX	The total number of contacts who were tested for HIV and received their results	184	1,660
5. TB_STAT	Number of new and relapsed TB cases with documented HIV status, during the reporting period	1,952	428

Treatment

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
6. TB_ART	Percentage of HIV-positive new and relapsed TB cases on ART during TB treatment	95% 444	95% 97
7. TX_CURR	Number of adults and children currently receiving antiretroviral therapy (ART)	6,167	4,112
8. TX_NEW	Number of adults and children newly enrolled on antiretroviral therapy (ART)	1,228	818

Viral Suppression

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
9. TX_PVLS	Percentage of ART patients with a suppressed viral load (VL) result (<1000 copies/ml) documented in the medical or laboratory records/laboratory information systems (LIS) within the past 12 months	95% 5,628	95% 3,752

Technical Narrative

The Recipient will address the technical approach to each area. The Recipient will be responsible for providing the following in close collaboration with other DHAPP-funded recipients and the host military:

HIV Prevention

The Recipient will ensure that the partner military is providing standardized, evidence-based interventions that are designed to promote the adoption of HIV prevention behaviors and service uptake for all military and other uniformed services as well as other priority populations served by the military health services. These priority populations (PP) should include men that have sex with men (MSM), sex workers and their clients, displaced persons, fishing communities, mobile populations, HIV discordant couples, adolescent girls and young women and illicit drug users.

The Recipient will ensure that the following interventions for adults and youth include:

- Promotion of relevant adult and youth friendly prevention and clinical services and demand creation to increase awareness, acceptability, and uptake of these services;
- Information, education, and skills development to reduce HIV risk and vulnerability; correct identification of HIV prevention methods; adoption and sustaining of positive behavior change; and promotion of gender equity and supportive norms and stigma reduction;
- Referral to or provision of HIV testing; facilitated linkage to care and prevention services; and/or support services to promote use of, retention in, and adherence to care;
- Condom and lubricant (where feasible) promotion, skills building, and facilitated access to condoms and lubricant (where feasible) through direct provision or linkages to social marketing and/or other service outlets;
- Programs targeting adults to raise awareness of HIV risks for young people, promote positive parenting and mentoring practices, and effective adult-child communication about sexuality and sexual risk reduction.

HIV Testing Services

Finding the remaining persons who are living with HIV infection is the first priority for reaching HIV epidemic control. Current epidemiology shows that most of those who do not yet know their infection status are men. The FAA HIV/AIDS program is strategically placed to reach men; therefore, the Recipient will work closely with the FAA on HIV Testing Services (HTS), particularly index testing and self-testing, in an effort to achieve the "first 95" for military personnel: 95% of all FAA personnel living with HIV know their status.

HTS will focus primarily on index testing to provide high yield testing to those most at risk for infection. The local epidemiology and situational analysis should guide the use of other testing methodologies to identify those who are living with HIV.

Where possible, a rapid test for recent infection (RTRI) should be conducted for all of those found to be newly positive. Those who test positive are classified as "probable recent HIV infections" until results of viral load are available. The index testing of these persons should receive high priority and robust efforts should be made to reach all contacts.

Provider-Initiated Testing and Counseling (PITC) will continue in the fixed sites for both the military and civilian cohorts. PITC should focus in clinical areas that have shown a high yield such as TB and STI clinics.

Ensuring that any positives identified are linked to HIV care and treatment is essential to the success of the FAA program. The Recipient should work to achieve 100% linkage of HIV+ individuals identified. The Recipient will monitor HIV testing yield; modifying strategies or locations that are not identifying and/or linking significant numbers of HIV positive persons to HIV care and treatment.

The Recipient will be responsible for:

- HTS to military bases and facilities
    - Diagnosing 2,106 People Living with HIV (PLHIV) with 95% of those diagnosed linked to HIV care and treatment services
    - Index-case testing for all sexual partners of HIV-infected military personnel and civilians
    - Index-case testing for all children under 15 years of age with HIV- infected mothers.
    - Index clients should also be offered self-testing for partners if they do not volunteer for partner notification.
- HTS to military bases and facilities, ensuring that all of those diagnosed are linked to HIV treatment services and receive same day initiation of ART.
- Self-testing should be made available for military personnel and their partners, male partners of Antenatal Care (ANC) clients, sex workers, MSM and other key and priority populations (young men and at-risk males) that face high levels of stigma and discrimination. Following self-testing, facility referral and the regular diagnostic algorithm can be used according to national standards. It is vital to engage community groups to advocate for, design, implement, and analyze the success of HIV Self-Testing (HIVST).
- Quality improvement and quality assurance for all FAA HTS including continuous training and mentoring and supervision visits, at least quarterly

- Conducting proficiency testing for all HTS sites and individuals
- Tracking PLHIV from HTS to clinical care and treatment services
- Monitoring HIV testing yield; modifying strategies or locations that are not identifying and/or linking significant numbers of HIV positive persons to HIV care and treatment

HIV Treatment

Support for treatment of HIV is an essential component of this PA. The following issues should be considered in supporting the treatment of PLHIV in military populations.

Dolutegravir (DTG)-containing regimens are the preferred first-line antiretroviral therapies (ART) due to superior efficacy, tolerability and higher threshold for resistance compared to efavirenz (EFV)-containing regimens. The fixed dose combination (FDC) of tenofovir disoproxil fumarate/lamivudine/dolutegravir (TLD) is currently priced as the least expensive FDC, and it is expected that prices will go down as generic manufacturing scales up. For these reasons, DHAPP now recommends TLD as the preferred option for ART, and further recommends that DHAPP-supported programs switch over to TLD as soon as possible in a coordinated fashion as supply becomes available.

Programs should carefully assess the risks and benefits of TLD in child-bearing age women. See published updates from WHO and PEPFAR to further understand the high benefits in the face of a potential Neural Tube Defect (NTD) signal.

Children (< 20kg) are not expected to be included in the initial roll-out of TLD. Development of pediatric DTG formulations and evaluation of appropriate DTG dosing in infants and children are underway.

A priority of HIV programs is to find, diagnose and treat people with tuberculosis (TB) disease and ensure that they become non-infectious. For all those who do not have active TB, prevention of TB is a priority using nationally approved TB preventive therapy (TPT).

TPT must be scaled up for all PLHIVs as an integral part of the clinical care package. Recipients are expected to increase the use of TB diagnostic testing within DHAPP-supported HIV care and treatment facilities and promote the use of TPT as a routine part of HIV care. In short, all newly diagnosed HIV persons should be offered TB treatment or preventive therapy and all persons assessed for TB should be tested for HIV.

Programs should have clear policies and/or guidelines for the use of TPT, and should plan for programmatic and clinical trainings, procurement and supply management, adequate diagnostic capacity (including specimen transportation) and development of appropriate data collection systems. In Global Fund high-impact countries implementing joint TB/HIV awards, Recipients should also seek opportunities to support effective joint program implementation.

Additionally, Recipients should implement TB infection prevention and control activities to minimize the risk of TB transmission and provide safe health seeking environment. This is critical in DHAPP-supported settings where clients at high risk for TB and HIV often co-mingle. It also puts the health care workers at the highest risk of contracting TB disease. Activities aimed at preventing transmission at facility-level include administrative and environmental controls, and the availability and use of personal protective equipment.

Cervical cancer screening for HIV+ women should be integrated into routine HIV treatment services in each country program. A "screen-and-treat" approach is recommended for the management of precancerous lesions to maximize opportunities for immediate cryotherapy or thermal ablation treatment for eligible women without the need for diagnostic pathology confirmation and to reduce loss to follow-up.

Viral Load (VL) Scale-up

Sustained viral suppression of all PLHIV is the key to HIV epidemic control. To this end, the Recipient will work closely with the FAA to scale-up VL testing coverage and suppression in an effort to achieve 95-95-95 goals for military personnel. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 95: 95% viral suppression among PLHIV taking ART.

The Recipient should ensure the partner military has access to timely VL testing and that capacity exists to test at least 90% of persons currently on ART annually. To ensure this capacity the appropriate use of both plasma and dried blood spots (DBS) should be considered to increase access to routine VL monitoring.

DBS are easy to collect and store under field conditions, no phlebotomist required, easy to transport to centralized laboratories, reduced cost associated with collection materials and transportation under ambient temperature. The DBS technology is applicable to both adult and pediatric populations and the small volume of blood required for preparing DBS makes it suitable for pediatric populations.

The Recipient will ensure that VL results are made available in a reasonable amount of time to both the health care provider and the client. These results should be used to ensure that those who are not virally suppressed are linked to adherence support and close follow-up leading to either suppression or ART modification as needed. Those who are suppressed should be encouraged to stay suppressed and should be offered differentiated models of care including multi-month supplies of ART and fast-tracking as an incentive and given the message that undetectable equals untransmittable (U=U).

Health System Strengthening

DHAPP is working to enhance the ability of governments to manage their epidemics, respond to broader health needs impacting affected communities, and address new and emerging health concerns. Activities include the following:

1. Laboratory capacity building

   The Recipient will be responsible for:

   - Inventory control, forecasting, and ensuring the procurement of laboratory reagents to ensure that laboratory services are uninterrupted
   - Procurement of service maintenance contracts, calibration of equipment, and training of the laboratory staff on the use of the equipment
   - Ensuring quality improvement of laboratories using Site Improvement Monitoring System (SIMS), Strengthening Laboratory Management Toward Accreditation (SLMTA) and Stepwise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA) to reach full ISO 15189 accreditation of main laboratories and quality improvement of all

satellite laboratories and HIV test sites.

- Monitoring laboratory quality and adherence to quality systems, method validation, provision of proficiency testing panels for rapid HIV testing, viral load, CD4, TB, STI and other tests critical to HIV epidemic control.
- Conducting routine visits to laboratories to assess achievements, review/evaluate activities, and provide recommendations with the development of improvement plans to resolve any identified problems.
- Linking FAA laboratory services to other laboratory resources at the district, provincial, and national levels.

The procurement of supplies, support, and equipment should use government and other donor sources when possible (Ministry of Health, Ministry of Defense, Global Fund, etc.).

DHAPP will continue to reduce its overall level of support for CD4 testing to prioritize access to VL testing. CD4 count is not needed to determine eligibility for ART (and continued CD4 testing may perpetuate the belief that CD4 count thresholds are criteria for initiating ART) and, as reflected in current WHO guidelines, CD4 is inferior to viral load for treatment monitoring.

DHAPP's priority is access to critical HIV treatment monitoring which is through use of VL and should be conducted at least once annually for stable patients and more frequently for new, unstable and pediatric patients.

Site Improvement through Monitoring System (SIMS)

The purpose of SIMS is to provide a standardized approach and set of tools for monitoring program quality at DHAPP-supported sites and entities that guide and support service delivery. SIMS assessment results are used to strengthen alignment with global and national standards and facilitate program improvement as a component of an overall quality management strategy. SIMS is also used to identify performance issues that may impact patient outcomes or the integrity of reporting for MER targets or disaggregates. Low final scores (reds and yellows) from these core essential elements (CEEs) highlight potential issues with service delivery, site performance or oversight, and/or documentation of patient results. Site-level triangulation of MER and SIMS data can be used to contextualize performance and could be useful to determine if performance challenges at a site are due to issues related to the underlying quality of service provision.

SIMS aims to: (1) facilitate improvement in the quality of DHAPP-supported services and technical assistance, (2) ensure accountability of USG investments, and (3) maximize impact on the HIV epidemic.

SIMS assessment results confirm compliance to minimum quality assurance standards and identify areas where improvements in DHAPP-supported programs can be made.

Programs should conduct SIMS assessments in accordance with DHAPP guidance and Recipients are responsible for taking corrective action for items within the Recipient SOW and per discussion with DHAPP USG staff.

Client, Patient, and Program Data Monitoring

Successful collection, evaluation, and use of client/patient level data is critical to good patient care and to the success of the partner military HIV program's ability to monitor progress towards epidemic control. The Recipient will work with the partner military and MOH or other organizations, as appropriate, to support the collection of patient-level data, the clinical and programmatic use of data, and the reporting of site-level data to DHAPP HQ and the partner military leadership.

The Recipient will be responsible for:

- Staffing, support, and mentoring of existing partner military staff for paper and electronic data entry
- Timely, accurate reporting of all indicators required by the partner military and DHAPP
- Ensuring confidentiality and security of data, in line with Ministry of Defense (MOD), Ministry of Health (MOH), and national guidelines from clinic to storage to dissemination.
- Securing all patient-level and site-level data from dissemination outside of the partner military and DHAPP without prior approval from the partner military
- Support for paper and electronic data entry, cleaning, reporting, and use

Data Quality

Measuring the success of HIV/AIDS initiatives requires strong monitoring and evaluation (M&E) systems that produce high quality data. Efforts to ensure data quality, therefore, are not singular events occurring randomly. Rather, these processes need to become institutionalized as part of routine data management processes. Once achieved, data quality helps to ensure that limited resources are used effectively, progress toward established goals are accurately monitored, and that decisions are based on strong evidence. Attention to data quality ensures that target-setting and results reporting are informed by valid and sensitive information, and that all partners are thinking about and collecting and organizing this information in the same manner. In this way, attention to data quality leads to improved program performance and to more efficient resource management.

Data quality has always been a focus of global HIV monitoring and reporting efforts. Specifically, all countries conducting programming supported by DHAPP are expected to have a data quality strategy in place. For example, data quality assessments (DQAs) should be conducted routinely and action should be taken as a result of these DQAs. If errors are identified in data, these should be remediated at the point of service delivery as well as in the DHAPP and host-country reporting systems as soon as possible. Standard operating procedures for routine data quality review should also be in place. Data should be routinely reviewed for errors before submission to ensure that the data passes the data quality checks outlined within the guidance, the DC2 validations, and the DATIM Data Review Tool

Virtual Communities of Practice

The Recipient should support the development of virtual communities of practice (vCoP). These evidence-based, virtual, face-to-face health workforce development and collaborative problem-solving platforms, serve to create ongoing dialogue and collaboration among key staff in the military health care systems. They provide a consistent platform for conducting low-dose, high-frequency learning and collaboration sessions. The goal is to build a vCoP for each partner military where DHAPP works in collaboration with DHAPP HQ, field staff and other recipients working in that country.

Key requirements are equipment and connectivity as well as personnel who can coordinate, manage

and lead regular vCoP sessions. These roles may need to be held by the Recipient until they can be transitioned to the partner military.

Work Plans

The Recipient must submit annual, programmatic and financial, work plans to the DHAPP Program Manager and DHAPP HQ (budget breakdown per activity and for program management is required). Work plans should include an activities implementation timeline as well as monitoring and evaluation timeline.

Botswana: DHAPP—Botswana Defense Force (BDF) Partnership for Sustainable HIV Epidemic Control

NOTE: Application submissions for this narrative are due by 5pm ET on February 5, 2021. Submission received after the deadline will not be considered for funding

Introduction

The HIV/AIDS epidemic has been devastating and negatively affected many militaries and other uniformed organizations worldwide by reducing military readiness, limiting deployments, causing physical and emotional decline in infected individuals and their families, posing risks to military personnel and their extended communities, and impeding peacekeeping activities. As HIV management improves, many of these impacts are disappearing, however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries in addition to other long-term chronic disease management issues.

The U.S. Government (USG) has a long history of international collaboration and partnerships in the fight against HIV/AIDS, providing funding, technical assistance, and program support. These collaborations are all contributing to HIV epidemic control.

Over the years, the United States Department of Defense (DoD) HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries in an effort to control the HIV epidemic among their respective military services. DHAPP is the DoD implementing agency collaborating with the U.S. Department of State, the Health Resources and Services Administration, Peace Corps, U.S. Agency for International Development (USAID), and the Centers for Disease Control and Prevention (CDC), in the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). DHAPP receives funding for its programs from two sources: a congressional plus-up to the Defense Health Program (DHP) and funding transfers from the Department of State for PEPFAR. Working closely with DoD, U.S. Unified Combatant Commanders, Joint United Nations Programme on HIV/AIDS (UNAIDS), university collaborators, and other nongovernmental organizations (NGOs), DHAPP's mission is to build capable military partners through military-specific, culturally focused, HIV/AIDS cooperation and assistance.

In the Defense Security Cooperation Agency guidance, the U.S. Secretary of Defense has identified HIV/AIDS in foreign militaries as a national security issue. Pursuing HIV/AIDS activities with foreign militaries is clearly tied to security interests, regional stability, humanitarian concerns, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing societies. DHAPP employs an integrated bilateral and regional strategy for HIV/AIDS cooperation and security assistance. DHAPP implements bilateral and regional strategies in coordination with respective Combatant Commands (COCOMs) and Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the U.S. Under Secretary of Defense for Policy and by the Office of the Global AIDS Coordinator (OGAC). DHAPP provides strategic information and supports defense forces in HIV prevention, care, and treatment for HIV-infected individuals and their families.

PEPFAR adopted the UNAIDS global 95-95-95 (formerly 90-90-90) goals that state by 2030: 95% of people with HIV are diagnosed, 95% of them are on ART and 95% of them are virally suppressed.

DHAPP shifted with PEPFAR in how Monitoring, Evaluation, and Reporting (MER) indicators are

collected and reported to efficiently use data to drive decision-making and focus HIV programming in the right geographic areas. DHAPP collects MER indicator results on a quarterly and semi-annual basis, and data are reported at the site level. These data allow DHAPP to understand the gaps in programming and needs for shifts to reach our shared goals. Due to security sensitivities regarding military site locations and troop movement, all site-level data are analyzed at DHAPP headquarters and summary data are collected by OGAC so each USG country team can review military program results at the national level.

Transition to Local Partners: Local partners are encouraged to apply to this announcement.
To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and community-based and community-led organizations – regardless of current antiretroviral (ARV) coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term, local partner engagement and impact.

All respondents must demonstrate the active support of the in-country military and the DoD representative in the corresponding U.S. Embassy in the planning and execution of their proposals.

In fiscal year (FY) 2019, DHAPP supported 52 active HIV programs, mainly through direct military-to-military cooperation in addition to support from contracting external organizations and academic institutions to assist with specific aspects of proposed programs. Partners in FY19 included 35 Non Governmental Organization NGOs and universities working in 46 countries.

Estimated Budget to be used as Framework

Strategic Information	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Total**
ASP: HMIS, Surveillance, and Research- NSD	**$200,000**	**$200,000**	**$200,000**	**$200,000**	**800,000**
Prevention	**$132,000**	**$132,000**	**$132,000**	**$132,000**	**528,000**
Voluntary Medical Male Circumcision-SD	$132,000	$132,000	$132,000	$132,000	**528,000**
Health Systems Strengthening	**$216,000**	**$216,000**	**$216,000**	**$216,000**	**864,000**
C&T: HIV Laboratory Services-SD	$216,000	$216,000	$216,000	$216,000	**864,000**
Program Management	**$127,000**	**$127,000**	**$127,000**	**$127,000**	**508,000**
TOTAL	**$675,000**	**$675,000**	**$675,000**	**$675,000**	**2,700,000**

Approaches to Reaching Sustainable Epidemic Control

Proposals are requested to support the Botswana Defense Force (BDF) to reach sustainable control of the HIV/AIDS epidemic through the pillars of transparency, accountability, and impact.

The Recipient's program should emphasize capacity building across all activities and technical areas. All proposals should detail how the partner will engage the partner military leadership as well as personnel at all levels in this work; and, specifically how the partner will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Within the proposal the partner will need to demonstrate transition of programmatic capabilities and capacity to the military over the life of the grant.

The partner must work in complete coordination with the partner militaries' HIV prevention and health services, as well as the DHAPP/DoD Program Manager based at the U.S. Embassies in these countries, the DoD adult and pediatric treatment program manager based at the Military Health Department, other DHAPP supported recipients working in these countries, other bilateral and multilateral agencies with similar objectives and the DHAPP Headquarters Team.

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Progress towards epidemic control will be successfully measured, in part, through an effective strategic information framework that monitors not only program outputs as compared to planned targets, but also key outcomes and programmatic impact.

Collection and use of disaggregated data that characterizes the populations served in the lowest geographic areas where HIV services are being provided is critical in understanding current program performance and planning for future performance. Consequently, the MER indicators continue to evolve in order to reflect the progression of USG support and global HIV response guidelines. Measuring the impact of support at national and regional above-site levels down to direct services at the site-level is paramount to DHAPP's program implementation and monitoring approach.

MER indicators are not an exhaustive list of all metrics that should be monitored by DHAPP-supported programs. DHAPP also collects a custom indicator. All programs should continually monitor and assess any acute programmatic issues and collect additional data to inform program improvement.

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The proposal will address approaches to reaching the following targets for military and civilian populations. Targets are listed using the associated PEPFAR Monitoring, Evaluation, and Reporting Indicator. Please see the most recent Monitoring, Evaluation, and Reporting Indicator Reference Guide for more detail at https://datim.zendesk.com/hc/en-us/articles/360000084446-MER-Indicator-Reference-Guides .

Prevention

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
VMMC_CIRC	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program	1000	
HTS_TST VMMC	Number of individuals who received HIV Testing Services (HTS) and received their test results	937	

Technical Narrative

The Recipient will address the technical approach to each area. The Recipient will be responsible for providing the following in close collaboration with other DHAPP-funded recipients and the host military.

HIV Prevention

The Recipient will ensure that the partner military is providing standardized, evidence-based interventions that are designed to promote the adoption of HIV prevention behaviors and service uptake for all military and other uniformed services as well as other priority populations served by the military health services. These priority populations (PP) should include men that have sex with men (MSM), sex workers and their clients, displaced persons, fishing communities, mobile populations, HIV discordant couples, adolescent girls and young women and illicit drug users.
The Recipent will ensure that the following interventions for adults and youth include:

- Promotion of relevant adult and youth friendly prevention and clinical services and demand creation to increase awareness, acceptability, and uptake of these services;
- Information, education, and skills development to: reduce HIV risk and vulnerability; correctly identify HIV prevention methods; adopt and sustain positive behavior change; and promote gender equity and supportive norms and stigma reduction;
- Referral to or provision of HIV testing; facilitated linkage to care and prevention services; and/or support services to promote use of, retention in, and adherence to care;
- Condom and lubricant (where feasible) promotion, skills building, and facilitated access to condoms and lubricant (where feasible) through direct provision or linkages to social marketing and/or other service outlets; and
- Programs targeting adults to raise awareness of HIV risks for young people, promote positive parenting and mentoring practices, and effective adult-child communication about sexuality and sexual risk reduction.

Voluntary Male Medical Circumcision

The Recipient will ensure that the BDF is following PEPFAR guidance, WHO recommendations

and the national guidelines for conducting VMMC. The full package of VMMC services will be offered including:

- Demand creation, VMMC education, safe sex practices and provision of condoms;
- HIV screening (*see addendum below) or testing for all clients and tracked referral to HIV treatment programs for those who test HIV positive for same-day initiation of ART;
- Examination and evaluation for active sexually transmitted infections (STI);
- STI positive persons will be deferred from VMMC and referred for immediate treatment of STI as well as counseled to return for VMMC when STI is resolved;
- Post-VMMC wound care and safe sex education including promotion of 6-week abstinence period post-VMMC; and
- Effective monitoring and reporting of VMMC program data and adverse events as well as linked STI and HIV program data.

The Recipient will follow all PEPFAR adverse event reporting protocols for any notifiable adverse events (AE) occurring during the VMMC procedure or within 30 days following surgical circumcision. This includes notifying the PEPFAR DoD POC and the Botswana PEPFAR Coordinator within 24 hours of the AE occurring. The Recipent will collaborate with other PEPFAR VMMC recipients to ensure VMMC coverage in scale up districts and populations.

The Recipient will offer surgical VMMCs, ensuring that forceps-guided method is not used for boys 10-14 years of age or clients 15 years and older with immature penile anatomy.
VMMC activities will be implemented concurrently with other component activities such as HIV Testing Services, treatment for STIs, promotion of safer-sex practices and condom distribution.

VMMC Strategy:

1. Recruits: In an effort to offer 100% VMMC coverage in the BDF in an efficient manner, the Recipient will support the BDF in their routine offer of VMMC to BDF recruits within the recruit training period.
2. Active Duty Males: The Recipient will support the BDF in holding campaigns at garrisons and camps for VMMC demand creation.
3. Civilians: The Recipient will support the national VMMC program in conducting VMMC for civilians in DoD allocated PEPFAR VMMC scale-up districts, targeting high risk-males between the ages of 15-29 years old.
4. High risk men: The Recipient will build strong referral systems to reach and offer VMMC to: a) STI patients (post treatment), b) alcohol risk reduction clients, 3) partners of HIV positive persons, 4) other men who are identified as high risk for HIV.

Testing in VMMC settings:
Testing in VMMC settings has historically produced very low HIV yields and may be replaced with screening using a validated tool. Validation should be conducted in at least one large VMMC site to determine if the screening tool is screening out the right people (HIV-negative) yet not also screening out the wrong people (HIV+ who are not yet diagnosed). Evaluation of the screening tool should include:

- Test a number of men who seek VMMC services based on established sample size calculation using appropriate HIV prevalence estimates.
- The screening tool performance should be compared with universal national HIV testing algorithm results for all persons using a standard two by two table. Screening tool sensitivity,

specificity as well as positive and negative predictive values will allow an informed decision to be made on tool performance and guide modifications.
- Test yields for universal and pre-screening should be compared.
- Technical assistance for this work is available from DHAPP.

Health System Strengthening

DHAPP is working to enhance the ability of governments to manage their epidemics, respond to broader health needs impacting affected communities, and address new and emerging health concerns. Activities include the following:

Laboratory capacity building

The Recipient will be responsible for:

- Inventory control, forecasting, and procuring laboratory reagents to ensure that laboratory services are uninterrupted;
- Procuring of service maintenance contracts, calibrating equipment, and training of the laboratory staff on the use of the equipment;
- Ensuring quality improvement of laboratories using Site Improvement Monitoring System (SIMS), Strengthening Laboratory Management Toward Accreditation (SLMTA) and Stepwise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA) to reach full ISO 15189 accreditation of main laboratories and quality improvement of all satellite laboratories and HIV test sites;
- Monitoring laboratory quality and adherence to quality systems, method validation, provision of proficiency testing panels for rapid HIV testing, viral load, CD4, TB, STI and other tests critical to HIV epidemic control;
- Conducting routine visits to laboratories to assess achievements, review/evaluate activities, and provide recommendations with the development of improvement plans to resolve any identified problems; and
- Linking BDF laboratory services to other laboratory resources at the district, provincial, and national levels.

The procurement of supplies, support, and equipment should use government and other donor sources when possible (Ministry of Health, Ministry of Defense, Global Fund, etc.).

DHAPP will continue to reduce its overall level of support for CD4 testing to prioritize access to VL testing. CD4 count is not needed to determine eligibility for ART (and continued CD4 testing may perpetuate the belief that CD4 count thresholds are criteria for initiating ART) and, as reflected in current WHO guidelines, CD4 is inferior to VL for treatment monitoring.

DHAPP's priority is access to critical HIV treatment monitoring, which is through use of viral load (VL) and should be conducted at least once annually for stable patients and more frequently for new, unstable and pediatric patients.

Seroprevalence and Behavioral Epidemiology Risk Survey (SABERS)

SABERS help militaries better understand their HIV epidemic by linking HIV testing with demographic and behavioral risk factors. There are numerous national HIV surveillance studies such as Population-based HIV Impact Assessment (PHIA), Demographic and Health Surveys (DHS), and others (e.g., Botswana AIDS Impact Survey [BAIS]). SABERS is the ONLY study to quantify HIV prevalence in military populations. SABERS also measures and captures unique features of military service and its

association with HIV infection that are not captured within the PHIA, DHIS, and BAIS.

The Recipient will be responsible for:

- Providing DHAPP and partner militaries with experienced technical assistance for a SABERS;
- Providing technical assistance in the efficient distribution of protocols and IRB documentation, surveys, and training manuals;
- Providing translation services, as needed;
- Procuring study materials, such as testing supplies and reagents, in a timely manner to ensure that research activities are completed on schedule; and
- Coordinating support communications among stakeholders and prepare meeting minutes.

Site Improvement through Monitoring System (SIMS)

The purpose of SIMS is to provide a standardized approach and set of tools for monitoring program quality at DHAPP-supported sites and entities that guide and support service delivery. SIMS assessment results are used to strengthen alignment with global and national standards and facilitate program improvement as a component of an overall quality management strategy. SIMS is also used to identify performance issues that may impact patient outcomes or the integrity of reporting for MER targets or disaggregates. Low final scores (reds and yellows) from these core essential elements (CEEs) highlight potential issues with service delivery, site performance or oversight, and/or documentation of patient results. Site-level triangulation of MER and SIMS data can be used to contextualize performance and could be useful to determine if performance challenges at a site are due to issues related to the underlying quality of service provision.

SIMS aims to: (1) facilitate improvement in the quality of DHAPP-supported services and technical assistance, (2) ensure accountability of U.S. government investments, and (3) maximize impact on the HIV epidemic.

SIMS assessment results confirm compliance to minimum quality assurance standards and identify areas where improvements in DHAPP-supported programs can be made.

Programs should conduct SIMS assessments in accordance with DHAPP guidance and recipients are responsible for taking corrective action for items within the Recipient statement of work (SOW) and per discussion with DHAPP USG staff.

Data Monitoring

Successful tracking of patient level data is critical to the success of the partner military HIV program's ability to monitor progress towards epidemic control. The Recipient will work with the respective partner militaries to support the collection of patient-level data, the clinical and programmatic use of data, and the reporting of site-level data to DHAPP HQ and the partner military leadership.

The Recipient will be responsible for:

- Staffing support and mentoring of existing partner military staff for data entry;
- Ensuring confidentiality and security of data, in line with MOD, MOH, and national guidelines;

- Timely, accurate reporting of all indicators required by the partner military and DHAPP;
- Securing all patient-level and site-level data from dissemination outside of the partner military and DHAPP without prior approval from the partner military.
- Supporting data entry, cleaning, reporting, and use.

Data Quality

Measuring the success of HIV/AIDS initiatives requires strong monitoring and evaluation (M&E) systems that produce high quality data. Efforts to ensure data quality, therefore, are not singular events occurring randomly. Rather, these processes need to become institutionalized as part routine data management processes. Once achieved, data quality helps to ensure that limited resources are used effectively, progress toward established goals are accurately monitored, and that decisions are based on strong evidence. Attention to data quality ensures that target-setting and results reporting are informed by valid and sensitive information, and that all partners are thinking about collecting and organizing this information in the same manner. In this way, attention to data quality leads to improved program performance and to more efficient resource management.

Data quality has always been a focus of global HIV monitoring and reporting efforts. Specifically, all countries conducting programming supported by DHAPP are expected to have a data quality strategy in place. For example, data quality assessments (DQAs) should be conducted routinely and action should be taken as a result of these DQAs. If errors are identified in data, these should be remediated at the point of service delivery as well as in the DHAPP and host-country reporting systems as soon as possible. Standard operating procedures for routine data quality review should also be in place. Data should be routinely reviewed for errors before submission to ensure that the data passes the data quality checks outlined within the guidance and the Data Review Tool available in DATIM.

Virtual Communities of Practice

The Recipient should support the development of virtual communities of practice (vCoP). These evidence-based, virtual, face-to-face health workforce development and collaborative problem-solving platforms, serve to create ongoing dialogue and collaboration among key staff in the military health care systems. They provide a consistent platform for conducting low-dose, high-frequency learning and collaboration sessions. The goal is to build a vCoP for each partner military where DHAPP works in collaboration with DHAPP HQ, field staff and other recipients working in that country.

Key requirements are equipment and connectivity as well as personnel who can coordinate, manage and lead regular vCoP sessions. These roles may need to be held by the Recipient until they can be transitioned to the partner military.

Work Plans

The Recipient must submit annual, programmatic and financial, work plans to the DHAPP Program Manager and DHAPP HQ (budget breakdown per activity and for program management is required). Work plans should include an activities implementation timeline as well as monitoring and evaluation timeline.

Burkina Faso: DHAPP—Armed Forces of Burkina Faso (FAN) Partnership for Sustainable HIV Epidemic Control

NOTE: Application submissions for this narrative are due by 5pm ET on February 5, 2021. Submission received after the deadline will not be considered for funding

Introduction

The HIV/AIDS epidemic has been devastating and negatively affected many militaries and other uniformed organizations worldwide by reducing military readiness, limiting deployments, causing physical and emotional decline in infected individuals and their families, posing risks to military personnel and their extended communities, and impeding peacekeeping activities. As HIV management improves, many of these impacts are disappearing, however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries in addition to other long-term chronic disease management issues.

The US Government has a long history of international collaboration and partnerships in the fight against HIV/AIDS, providing funding, technical assistance, and program support. These collaborations are all contributing to HIV epidemic control.

Over the years, the United States Department of Defense (DoD) HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries in an effort to control the HIV epidemic among their respective military services. DHAPP is the DoD implementing agency collaborating with the US Department of State, the Health Resources and Services Administration, Peace Corps, US Agency for International Development (USAID), and the Centers for Disease Control and Prevention (CDC), in the US President's Emergency Plan for AIDS Relief (PEPFAR). DHAPP receives funding for its programs from two sources: a congressional plus-up to the Defense Health Program (DHP) and funding transfers from the Department of State for PEPFAR. Working closely with DoD, U.S. Unified Combatant Commanders, Joint United Nations Programme on HIV/AIDS (UNAIDS), university collaborators, and other nongovernmental organizations (NGOs), DHAPP's mission is to build capable military partners through military-specific, culturally focused, HIV/AIDS cooperation and assistance.

In the Defense Security Cooperation Agency guidance, the US Secretary of Defense has identified HIV/AIDS in foreign militaries as a national security issue. Pursuing HIV/AIDS activities with foreign militaries is clearly tied to security interests, regional stability, humanitarian concerns, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing societies. DHAPP employs an integrated bilateral and regional strategy for HIV/AIDS cooperation and security assistance. DHAPP implements bilateral and regional strategies in coordination with respective Combatant Commands (COCOMs) and Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the US Under Secretary of Defense for Policy and by the Office of the Global AIDS Coordinator(OGAC). DHAPP provides strategic information and supports defense forces in HIV prevention, care, and treatment for HIV-infected individuals and their families.

PEPFAR adopted the United Nations Programme on HIV/AIDS (UNAIDS) global 95-95-95 (formerly 90-90-90) goals that state by 2030: 95% of people with HIV are diagnosed, 95% of them are on antiretroviral therapies (ART) and 95% of them are virally suppressed.

PEPFAR Monitoring, Evaluation, and Reporting (MER) indicators are collected and reported to efficiently use data to drive decision-making and focus HIV programming in the right geographic areas. DHAPP uses the same program indicators for Defense Health Program (DHP) and PEPFAR funded programs. DHAPP collects MER indicator results on a quarterly semi-annual, and annual basis, depending on indicator and data are reported at the site level to DHAPP. These data allow DHAPP to analyze and evaluate gaps in programming and achievement and identify needs for shifts to reach our shared goals. Due to security sensitivities regarding military site locations and troop movement, all site-level data are analyzed at DHAPP headquarters and summary data are reported to OGAC so that other USG country team agencies can review military program results aggregated at the national level.

Transition to Local Partners: Local partners are encouraged to apply to this announcement.

To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and community-based and community-led organizations – regardless of current antiretroviral (ARV) coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and to establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term, local partner engagement and impact.

All respondents must demonstrate the active support of the in-country military and the DoD representative in the corresponding U.S. Embassy in the planning and execution of their proposals.

In fiscal year (FY) 2019, DHAPP supported 52 active HIV programs, mainly through direct military-to-military cooperation in addition to support from contracting external organizations and academic institutions to assist with specific aspects of proposed programs. Partners in FY19 included 35 Non-Governmental Organizations (NGO)s and universities working in 46 countries.

Estimated Budget to be used as Framework

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Total**
Program Management	**$36,000**	**$36,000**	**$36,000**	**$36,000**	**$144,000**
Care & Treatment	**$48,000**	**$48,000**	**$48,000**	**$48,000**	**$192,000**
HIV clinical services - NSD	$48,000	$48,000	$48,000	$48,000	$192,000
HIV Testing Services	**$38,000**	**$38,000**	**$38,000**	**$38,000**	**$152,000**
Testing: Not disaggregated - NSD	$38,000	$38,000	$38,000	$38,000	$152,000
Prevention	**$15,000**	**$15,000**	**$15,000**	**$15,000**	**$60,000**
Prevention: Not disaggregated - NSD	$15,000	$15,000	$15,000	$15,000	$60,000
Above Site Programming	**$43,000**	**$43,000**	**$43,000**	**$43,000**	**$172,000**
Laboratory systems strengthening	$28,000	$28,000	$28,000	$28,000	$112,000
Health management information systems (HMIS), surveillance, and research	$15,000	$15,000	$15,000	$15,000	$60,000
TOTAL	**$180,000**	**$180,000**	**$180,000**	**$180,000**	**$720,000**

Approaches to Reaching Sustainable Epidemic Control

Proposals are requested to support the Armed Forces of Burkina Faso (FAN) to reach sustainable control of the HIV/AIDS epidemic through the pillars of transparency, accountability, and impact.

The Recipient's program should emphasize capacity building across all activities and technical areas. All proposals should detail how the Recipient will engage the partner military leadership as well as personnel at all levels in this work; and, specifically how the partner will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Within the proposal, the Recipient will need to demonstrate transition of programmatic capabilities and capacity to the military over the life of the award.

The Recipient must work in complete coordination with the partner militaries' HIV prevention and health services, as well as the DHAPP/DoD Program Manager based at the U.S. Embassies in these countries, the DoD adult and pediatric treatment program manager based at the Military Health Department, other DHAPP supported Recipients working in these countries, other bilateral and multilateral agencies with similar objectives and the DHAPP Headquarters Team.

Targets

Progress towards epidemic control will be successfully measured, in part, through an effective strategic information framework that monitors not only program outputs as compared to planned targets, but also key outcomes and programmatic impact.

Collection and use of disaggregated data that characterizes the populations served in the lowest geographic areas where HIV services are being provided is critical in understanding current program performance and planning for future performance. Consequently, the MER indicators continue to evolve in order to reflect the progression of USG support and global HIV response guidelines. Measuring the impact of support at national and regional above-site levels down to direct services at the site-level is paramount to DHAPP's program implementation and monitoring approach.

MER indicators are not an exhaustive list of all metrics that should be monitored by DHAPP-supported programs. DHAPP also collects a custom indicator. All programs should continually monitor and assess any acute programmatic issues and collect additional data to inform program improvement.

The indicators listed below support a patient-centered program monitoring approach. Per the 2017 WHO Consolidated Guidelines on Person-Centered HIV Patient Monitoring and Case Surveillance, person-centered monitoring refers to a shift from monitoring measuring services (e.g., the number of individuals tested or people on treatment) to monitoring people at the center of their access to linked HIV and health services. In essence, this marks a shift to better support the clients accessing services by focusing more on their individual health outcomes.

The proposal will address approaches to reaching the following targets for military and civilian populations. Targets are listed using the associated PEPFAR Monitoring, Evaluation, and Reporting

Indicator. Please see the most recent Monitoring, Evaluation, and Reporting Indicator Reference Guide for more detail at https://datim.zendesk.com/hc/en-us/articles/360000084446-MER-Indicator-Reference-Guides

Prevention

Technical Area Targets, Year 1		
Indicator	**Label**	**Military**
FPINT_SITE	Number of HIV service delivery points (SDP) at a site supported by PEPFAR that are providing integrated voluntary family planning (FP) services	4
PP_PREV	Number of priority populations (PP) reached with the standardized, evidence-based intervention(s) required that are designed to promote the adoption of HIV prevention behaviors and service uptake	4,500

Testing

Technical Area Targets, Year 1			
Indicator	**Label**	**Military**	**Civilian**
HTS_INDEX	Number of individuals who were identified and tested using Index testing services and received their results	42	168
HTS_TST	Number of individuals who received HIV Testing Services (HTS) and received their test results	182	727

Treatment

Technical Area Targets, Year 1			
Indicator	**Label**	**Military**	**Civilian**
TX_CURR	Number of adults and children currently receiving antiretroviral therapy (ART)	127	509
TX_NEW	Number of adults and children newly enrolled on antiretroviral therapy (ART)	27	106

Viral Suppression

Technical Area Targets, Year 1			
Indicator	**Label**	**Military**	**Civilian**
TX_PVLS	Percentage of ART patients with a suppressed viral load (VL) result (<1000 copies/ml) documented in the medical or laboratory records/laboratory information systems (LIS) within the past 12 months	95%	95%

Technical Narrative

The Recipient will address the technical approach to each area. The Recipient will be responsible for providing the following in close collaboration with other DHAPP-funded recipients and the host military.

HIV Prevention

The Recipient will ensure that the partner military is providing standardized, evidence-based interventions that are designed to promote the adoption of HIV prevention behaviors and service uptake for all military and other uniformed services as well as other priority populations served by the military health services. These priority populations (PP) should include men that have sex with men (MSM), sex workers and their clients, displaced persons, fishing communities, mobile populations, HIV serodiscordant couples, adolescent girls and young women and illicit drug users.

The Recipient will ensure that the following interventions for adults and youth include:

- Promotion of relevant adult and youth friendly prevention and clinical services and demand creation to increase awareness, acceptability, and uptake of these services.
- Information, education, and skills development to reduce HIV risk and vulnerability; correctly identify HIV prevention methods; adopt and sustain positive behavior change; and promote gender equity and supportive norms and stigma reduction.
- Referral to or provision of HIV testing; facilitated linkage to care and prevention services; and/or support services to promote use of, retention in, and adherence to care.
- Condom and lubricant (where feasible) promotion, skills building, and facilitated access to condoms and lubricant (where feasible) through direct provision or linkages to social marketing and/or other service outlets.
- Programs targeting adults to raise awareness of HIV risks for young people, promote positive parenting and mentoring practices, and effective adult-child communication about sexuality and sexual risk reduction.

HIV Testing Services

Finding the remaining persons who are living with HIV infection is the first priority for reaching HIV epidemic control. Current epidemiology shows that most of those who do not yet know about their infection are men. The FAN HIV/AIDS program is strategically placed to reach men; therefore, the Recipient will work closely with the FAN on HIV Testing Services (HTS), particularly index testing,

in an effort to achieve the "first 95" for military personnel: 95% of all FAN personnel living with HIV know their status.

HTS will focus primarily on index testing to provide high yield testing to those most at risk for infection. The local epidemiology and situational analysis should guide the use of other testing methodologies to identify those who are living with HIV.

Where possible, a rapid test for recent infection (RTRI) should be conducted for all of those found to be newly positive. Those who test positive are classified as "probable recent HIV infections" until results of viral load are available. The index testing of these persons should receive high priority and robust efforts should be made to reach all contacts.

Provider-Initiated Testing and Counseling (PITC) will continue in the fixed sites for both the military and civilian cohorts. PITC should focus in clinical areas that have shown a high yield such as tuberculosis (TB) and sexually transmitted infections (STI) clinics.

Ensuring that any clients with positive results are linked to HIV care and treatment is essential to the success of the FAN program. The Recipient should work to achieve 100% linkage of HIV-positive individuals identified. The Recipient will monitor HIV testing yield, modifying strategies or locations that are not identifying and/or linking significant numbers of HIV-positive persons to HIV care and treatment.

The Recipient will be responsible for:

- HTS to military bases and facilities
    - Diagnosing 140 people living with HIV (PLHIV) with 95% of those diagnosed linked to HIV care and treatment services
    - Index-case testing for all sexual partners of HIV-infected military personnel and civilians
    - Index-case testing for all children under 15 years of age with HIV-infected mothers.
    - Index clients should also be offered self-testing for partners if they do not volunteer for partner notification.
- HTS to military bases and facilities, ensuring that all of those diagnosed are linked to HIV treatment services and receive same day initiation of ART.
- Quality improvement and quality assurance for all FAN HTS including continuous training and mentoring and supervision visits, at least quarterly
- Conducting proficiency testing for all HTS sites and individuals
- Tracking PLHIV from HTS to clinical care and treatment services.

HIV Treatment

Support for treatment of HIV is an essential component of this PA. The following issues should be considered in supporting the treatment of PLHIV in military populations.

Dolutegravir (DTG)-containing regimens are the preferred first-line antiretroviral therapies (ART) due to superior efficacy, tolerability and higher threshold for resistance compared to efavirenz (EFV)-containing regimens. The fixed dose combination (FDC) of tenofovir disoproxil fumarate/lamivudine/dolutegravir (TLD) is currently priced as the least expensive FDC, and it is expected that prices will go down as

generic manufacturing scales up. For these reasons, DHAPP now recommends TLD as the preferred option for ART, and further recommends that DHAPP-supported programs switch over to TLD as soon as possible in a coordinated fashion as supply becomes available.

Programs should carefully assess the risks and benefits of TLD in child-bearing age women. See published updated from WHO and PEPFAR to further understand the high benefits in the face of a potential NTD signal.

Children (< 20kg) are not expected to be included in the initial roll-out of TLD. Development of pediatric DTG formulations and evaluation of appropriate DTG dosing in infants and children are underway.

A priority of HIV programs is to find, diagnose and treat people with TB disease and ensure that they become non-infectious. For all those who do not have active TB, prevention of TB is a priority using nationally approved TB preventive therapy (TPT).

TPT must be scaled up for all PLHIVs as an integral part of the clinical care package. Recipients are expected to increase the use of TB diagnostic testing within DHAPP-supported HIV care and treatment facilities and promote the use of TPT as a routine part of HIV care. In short, all newly diagnosed HIV persons should be offered TB treatment or preventive therapy and all persons assessed for TB should be tested for HIV.

Programs should have clear policies and/or guidelines for the use of TPT, and should plan for programmatic and clinical trainings, procurement and supply management, adequate diagnostic capacity (including specimen transportation) and development of appropriate data collection systems. In Global Fund high-impact countries implementing joint TB/HIV grants, Recipients should also seek opportunities to support effective joint program implementation.

Additionally, Recipients should implement TB infection prevention and control activities to minimize the risk of TB transmission and provide safe health seeking environment. This is critical in DHAPP-supported settings where clients at high risk for TB and HIV often co-mingle. It also puts the health care workers at the highest risk of contracting TB disease. Activities aimed at preventing transmission at facility-level include administrative and environmental controls, and the availability and use of personal protective equipment.

Cervical cancer screening for HIV+ women should be integrated into routine HIV treatment services in each country program. A “screen-and-treat” approach is recommended for the management of precancerous lesions to maximize opportunities for immediate cryotherapy or thermal ablation treatment for eligible women without the need for diagnostic pathology confirmation and to reduce loss to follow-up.

Viral Load (VL) Scale-up

Sustained viral suppression of all PLHIV is the key to HIV epidemic control. To this end, the Recipient will work closely with the FAN to scale-up VL testing coverage and suppression in an effort to achieve 95-95-95 goals for military personnel. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 95: 95% viral suppression among PLHIV taking ART.

The Recipient should ensure the partner military has access to timely VL testing and that capacity exists to test at least 95% of persons currently on ART annually. To ensure this capacity the appropriate use of both plasma and dried blood spots (DBS) should be considered to increase access to routine viral load monitoring.

DBS are easy to collect and store under field conditions, no phlebotomist required, easy to transport to centralized laboratories, reduced cost associated with collection materials and transportation under ambient temperature. The DBS technology is applicable to both adult and pediatric populations and the small volume of blood required for preparing DBS makes it suitable for pediatric populations.

The Recipient will ensure that VL results are made available in a reasonable amount of time to both the health care provider and the client. These results should be used to ensure that those who are not virally suppressed are linked to adherence support and close follow-up leading to either suppression or ART modification as needed. Those who are suppressed should be encouraged to stay suppressed and should be offered differentiated models of care, including multi-month supplies of ART and fast-tracking as an incentive, and given the message that undetectable equals untransmittable (U=U).

Health System Strengthening

DHAPP is working to enhance the ability of governments to manage their epidemics, respond to broader health needs impacting affected communities, and address new and emerging health concerns. Activities include the following:

1. Laboratory capacity building

   The Recipient will be responsible for:

   - Inventory control, forecasting, and ensuring the procurement of laboratory reagents to ensure that laboratory services are uninterrupted.
   - Procurement of service maintenance contracts, calibration of equipment, and training of the laboratory staff on the use of the equipment.
   - Ensuring quality improvement of laboratories using Site Improvement Monitoring System (SIMS), Strengthening Laboratory Management Toward Accreditation (SLMTA) and Stepwise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA) to reach full ISO 15189 accreditation of main laboratories and quality improvement of all satellite laboratories and HIV test sites.
   - Monitoring laboratory quality and adherence to quality systems, method validation, provision of proficiency testing panels for rapid HIV testing, VL, CD4, TB, STI and other tests critical to HIV epidemic control.
   - Conducting routine visits to laboratories to assess achievements, review/evaluate activities, and provide recommendations with the development of improvement plans to resolve any identified problems.
   - Linking FAN laboratory services to other laboratory resources at the district, provincial, and national levels.

   The procurement of supplies, support, and equipment should use government and other donor sources when possible (Ministry of Health, Ministry of Defense, Global Fund, etc.).

   DHAPP will continue to reduce its overall level of support for CD4 testing to prioritize access to

VL testing. CD4 count is not needed to determine eligibility for ART (and continued CD4 testing may perpetuate the belief that CD4 count thresholds are criteria for initiating ART) and, as reflected in current WHO guidelines, CD4 is inferior to VL for treatment monitoring.

DHAPP's priority is access to critical HIV treatment monitoring which is through use of VL and should be conducted at least once annually for stable patients and more frequently for new, unstable and pediatric patients.

2. Stigma and discrimination reduction

The Recipient will be responsible for:

- Conducting a baseline assessment using existing qualitative and quantitative assessment tools. This activity will determine the impact of stigma on prevention, testing, and treatment activities in the military health system (respondents will include: military members, military leaders, military HIV lead, health care providers, people who work in health facilities, and patients receiving services in military health systems). The Recipient will conduct analysis and disseminate findings to military leadership and military health workers. Baseline program evaluation will identify barriers to the uptake of services by military members. Once specific stigma related barriers are identified, the Recipient will work closely with the military and the DHAPP HQ SMEs to customize a multi-component comprehensive military specific program to address the barriers.
- Facilitating multi-level stigma and discrimination reduction training of trainer workshop (4-days) with military leadership, military healthcare workforce, troops, and military PLHIV. Activities will be coordinated with DHAPP. Recipient will use evidence based materials already created and adapted to the military context. Participants of the workshop will build their capacity to facilitate stigma reduction activities independently and sustainably and health facilities will provide stigma free services. Participants will develop a draft Code of Conduct and an Action Plan to be reviewed, approved, and launched by the military healthcare leaders. Participants will also review existing health related policies to determine if they are discriminating and make recommendations to military leadership for policy changes.
- Working closely with the military leadership to establish a working group/committee comprised of ministry of defense, military services (e.g. Army, Navy, Air Force), and military health care providers to review current military policies related to HIV and to steer the draft Code of Conduct and Action Plan through the appropriate review and approval process to final launch. The committee will revise and or develop non-discriminatory policies using current public health and WHO guidelines focused on human rights and stigma and discrimination elimination and steer these through the appropriate review and approval process.
- Conducting a quantitative and qualitative follow-up assessment to determine the change (reduction) of stigma and discrimination and their impact on prevention, testing, and treatment activities in the military health system (respondents will include: military members, military leaders, military HIV lead, health care providers, people who work in health facilities, and patients receiving services in military health systems). The Recipient will conduct analysis of assessment, write up final program report, and disseminate findings. The follow-up program evaluation will

identify impact of comprehensive S&D reduction interventions in relation stigma related barriers and the uptake of prevention, testing, and treatment services to military members in the military health system.
- Monitoring trainees and tracking the number of activities and persons trained and providing follow-up training as needed.

Site Improvement through Monitoring System (SIMS)

The purpose of SIMS is to provide a standardized approach and set of tools for monitoring program quality at DHAPP-supported sites and entities that guide and support service delivery. SIMS assessment results are used to strengthen alignment with global and national standards and facilitate program improvement as a component of an overall quality management strategy. SIMS is also used to identify performance issues that may impact patient outcomes or the integrity of reporting for MER targets or disaggregates. Low final scores (reds and yellows) from these core essential elements (CEEs) highlight potential issues with service delivery, site performance or oversight, and/or documentation of patient results. Site-level triangulation of MER and SIMS data can be used to contextualize performance and could be useful to determine if performance challenges at a site are due to issues related to the underlying quality of service provision.

SIMS aims to: (1) facilitate improvement in the quality of DHAPP-supported services and technical assistance, (2) ensure accountability of USG investments, and (3) maximize impact on the HIV epidemic. SIMS assessment results confirm compliance to minimum quality assurance standards and identify areas where improvements in DHAPP-supported programs can be made.

Programs should conduct SIMS assessments in accordance with DHAPP guidance, and Recipients are responsible for taking corrective action for items within the Recipient SOW and per discussion with DHAPP USG staff.

Client, Patient, and Program Data Monitoring

Successful collection, evaluation, and use of client/patient level data is critical to good patient care and to the success of the partner military HIV program's ability to monitor progress towards epidemic control. The Recipient will work with the partner military and Ministry of Health (MOH) or other organizations, as appropriate, to support the collection of patient-level data, the clinical and programmatic use of data, and the reporting of site-level data to DHAPP HQ and the partner military leadership.

The Recipient will be responsible for:
- Staffing, support, and mentoring of existing partner military staff for paper and electronic data entry.
- Timely, accurate reporting of all indicators required by the partner military and DHAPP.
- Ensuring confidentiality and security of data, in line with Ministry of Defense (MOD), MOH, and national guidelines from clinic to storage to dissemination.
- Securing all patient-level and site-level data from dissemination outside of the partner military and DHAPP without prior approval from the partner military.
- Supporting paper and electronic data entry, cleaning, reporting, and use.

Data Quality

Measuring the success of HIV/AIDS initiatives requires strong monitoring and evaluation (M&E) systems that produce high quality data. Efforts to ensure data quality, therefore, are not singular events occurring randomly. Rather, these processes need to become institutionalized as part routine data management processes. Once achieved, data quality helps to ensure that limited resources are used effectively, progress toward established goals are accurately monitored, and that decisions are based on strong evidence. Attention to data quality ensures that target-setting and results reporting are informed by valid and sensitive information, and that all partners are thinking about and collecting and organizing this information in the same manner. In this way, attention to data quality leads to improved program performance and to more efficient resource management.

Data quality has always been a focus of global HIV monitoring and reporting efforts. Specifically, all countries conducting programming supported by DHAPP are expected to have a data quality strategy in place. For example, data quality assessments (DQAs) should be conducted routinely and action should be taken as a result of these DQAs. If errors are identified in data, these should be remediated at the point of service delivery as well as in the DHAPP and host-country reporting systems as soon as possible. Standard operating procedures for routine data quality review should also be in place. Data should be routinely reviewed for errors before submission to ensure that the data passes the data quality checks outlined within the guidance, the DC2 validations, and the Data for Accountability, Transparency, and Impact Monitoring (DATIM) Data Review Tool.

Virtual Communities of Practice

The Recipient should support the development of virtual communities of practice (vCoP). These evidence-based, virtual, face-to-face health workforce development and collaborative problem-solving platforms, serve to create ongoing dialogue and collaboration among key staff in the military health care systems. They provide a consistent platform for conducting low-dose, high-frequency learning and collaboration sessions. The goal is to build a vCoP for each partner military where DHAPP works in collaboration with DHAPP HQ, field staff and other Recipients working in that country.

Key requirements are equipment and connectivity as well as personnel who can coordinate, manage and lead regular vCoP sessions. These roles may need to be held by the Recipient until they can be transitioned to the partner military.

Work Plans

The Recipient must submit annual, programmatic and financial, work plans to the DHAPP Program Manager and DHAPP HQ (budget breakdown per activity and for program management is required). Work plans should include an activities implementation timeline as well as monitoring and evaluation timeline.

Burundi: DHAPP— Burundi National Defence Force (BNDF) Partnership for Sustainable HIV Epidemic Control

NOTE: Application submissions for this narrative are due by 5pm ET on February 5, 2021. Submission received after the deadline will not be considered for funding

Introduction

The HIV/AIDS epidemic has been devastating and negatively affected many militaries and other uniformed organizations worldwide by reducing military readiness, limiting deployments, causing physical and emotional decline in infected individuals and their families, posing risks to military personnel and their extended communities, and impeding peacekeeping activities. As HIV management improves, many of these impacts are disappearing; however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries in addition to other long-term chronic disease management issues.

The U.S. Government (USG) has a long history of international collaboration and partnerships in the fight against HIV/AIDS, providing funding, technical assistance, and program support. These collaborations are all contributing to HIV epidemic control.

Over the years, the United States Department of Defense (DoD) HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries in an effort to control the HIV epidemic among their respective military services. DHAPP is the DoD implementing agency collaborating with the U.S. Department of State, the Health Resources and Services Administration, Peace Corps, US Agency for International Development (USAID), and the Centers for Disease Control and Prevention (CDC), in the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). DHAPP receives funding for its programs from two sources: a congressional plus-up to the Defense Health Program (DHP) and funding transfers from the Department of State for PEPFAR. Working closely with DoD, U.S. Unified Combatant Commanders, Joint United Nations Programme on HIV/AIDS (UNAIDS), university collaborators, and other nongovernmental organizations (NGOs), DHAPP's mission is to build capable military partners through military-specific, culturally focused, HIV/AIDS cooperation and assistance.

In the Defense Security Cooperation Agency guidance, the U.S. Secretary of Defense has identified HIV/AIDS in foreign militaries as a national security issue. Pursuing HIV/AIDS activities with foreign militaries is clearly tied to security interests, regional stability, humanitarian concerns, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing societies. DHAPP employs an integrated bilateral and regional strategy for HIV/AIDS cooperation and security assistance. DHAPP implements bilateral and regional strategies in coordination with respective Combatant Commands (COCOMs) and Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the U.S. Under Secretary of Defense for Policy and by the Office of the Global AIDS Coordinator (OGAC). DHAPP provides strategic information and supports defense forces in HIV prevention, care, and treatment for HIV-infected individuals and their families.

PEPFAR adopted the United Nations Programme on HIV/AIDS (UNAIDS) global 95-95-95 (formerly 90-90-90) goals that state by 2030: 95% of people with HIV are diagnosed, 95% of them are on antiretroviral therapies (ART) and 95% of them are virally suppressed.

PEPFAR Monitoring, Evaluation, and Reporting (MER) indicators are collected and reported to efficiently use data to drive decision-making and focus HIV programming in the right geographic areas. DHAPP uses the same program indicators for DHP and PEPFAR funded programs. DHAPP collects MER indicator results on a quarterly semi-annual, and annual basis, depending on indicator and data are reported at the site level to DHAPP. These data allow DHAPP to analyze and evaluate gaps in programming and achievement and identify needs for shifts to reach our shared goals. Due to security sensitivities regarding military site locations and troop movement, all site-level data are analyzed at DHAPP headquarters and summary data are reported to OGAC so that other USG country team agencies can review military program results aggregated at the national level.

Transition to Local Partners: Local partners are encouraged to apply to this announcement.

To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and community-based and community-led organizations – regardless of current antiretroviral (ARV) coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and to establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term, local partner engagement and impact.

All respondents must demonstrate the active support of the in-country military and the DoD representative in the corresponding U.S. Embassy in the planning and execution of their proposals. The selected Recipient is referred to as the Recipient in this document.

In fiscal year (FY) 2019, DHAPP supported 52 active HIV programs, mainly through direct military-to-military cooperation in addition to support from contracting external organizations and academic institutions to assist with specific aspects of proposed programs. Partners in FY19 included 35 Non-Governmental Organizations (NGO)s and universities working in 46 countries.

Estimated Budget to be used as a Framework

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Total**
Program Management	**$413,329**	**$413,329**	**$413,329**	**$413,329**	**$1,653,316**
Above Site Programming	**$160,000**	**$160,000**	**$160,000**	**$160,000**	**$640,000**
HMIS, Surveillance, and Research – NSD	$90,000	$90,000	$90,000	$90,000	$360,000
Human Resources for Health – NSD	$70,000	$70,000	$70,000	$70,000	$280,000
HIV Testing Services	**$546,104**	**$546,104**	**$546,104**	**$546,104**	**$2,184,416**
Community-based Testing – SD	$373,883	$373,883	$373,883	$373,883	$1,495,532
Facility-based Testing – SD	$172,221	$172,221	$172,221	$172,221	$688,884
Care & Treatment	**$430,551**	**$430,551**	**$430,551**	**$430,551**	**$1,722,204**
HIV Clinical Services – SD	$361,663	$361,663	$361,663	$361,663	$1,446,652
HIV Laboratory Services –	$68,888	$68,888	$68,888	$68,888	$275,552

SD					
Prevention	**$172,221**	**$172,221**	**$172,221**	**$172,221**	**$688,884**
Community Mobilization, Behavior, and Norms Change – SD	$172,221	$172,221	$172,221	$172,221	$688,884
TOTAL	**$1,722,205**	**$1,722,205**	**$1,722,205**	**$1,722,205**	**$6,888,820**

Approaches to Reaching Sustainable Epidemic Control

Proposals are requested to support the Burundi National Defence Force (BNDF) to reach sustainable control of the HIV/AIDS epidemic through the pillars of transparency, accountability, and impact.

The Recipient's program should emphasize capacity building across all activities and technical areas. All proposals should detail how the Recipient will engage the partner military leadership as well as personnel at all levels in this work; and, specifically how the partner will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Within the proposal, the Recipient will need to demonstrate transition of programmatic capabilities and capacity to the military over the life of the award.

The Recipient must work in complete coordination with the partner militaries' HIV prevention and health services, as well as the DHAPP/DoD Program Manager based at the U.S. Embassies in these countries, the DoD adult and pediatric treatment program manager based at the Military Health Department, other DHAPP supported Recipients working in these countries, other bilateral and multilateral agencies with similar objectives and the DHAPP Headquarters Team

Targets

Progress towards epidemic control will be successfully measured, in part, through an effective strategic information framework that monitors not only program outputs as compared to planned targets, but also key outcomes and programmatic impact.

Collection and use of disaggregated data that characterizes the populations served in the lowest geographic areas where HIV services are being provided is critical in understanding current program performance and planning for future performance. Consequently, the MER indicators continue to evolve in order to reflect the progression of USG support and global HIV response guidelines. Measuring the impact of support at national and regional above-site levels down to direct services at the site-level is paramount to DHAPP's program implementation and monitoring approach.

MER indicators are not an exhaustive list of all metrics that should be monitored by DHAPP-supported programs. DHAPP also collects a custom indicator. All programs should continually monitor and assess any acute programmatic issues and collect additional data to inform program improvement.

The indicators listed below support a patient-centered program monitoring approach. Per the 2017 WHO Consolidated Guidelines on Person-Centered HIV Patient Monitoring and Case Surveillance, person-centered monitoring refers to a shift from monitoring measuring services (e.g., the number of individuals tested or people on treatment) to monitoring people at the center of their access to linked

HIV and health services. In essence, this marks a shift to better support the clients accessing services by focusing more on their individual health outcomes.

The proposal will address approaches to reaching the following targets for military and civilian populations. Targets are listed using the associated PEPFAR Monitoring, Evaluation, and Reporting Indicator. Please see the most recent Monitoring, Evaluation, and Reporting Indicator Reference Guide for more detail at https://datim.zendesk.com/hc/en-us/articles/360000084446-MER-Indicator-Reference-Guides .

Prevention

Technical Area Targets, Year 1			
Indicator	**Label**	**Military**	**Civilian**
FPINT_SITE	Number of HIV service delivery points (SDP) at a site supported by PEPFAR that are providing integrated voluntary family planning (FP) services	8	0
GEND_GBV	Number of people receiving post-gender-based violence (GBV) clinical care based on the minimum package	43	174
PP_PREV	Number of priority populations (PP) reached with the standardized, evidence-based intervention(s) required that are designed to promote the adoption of HIV prevention behaviors and service uptake	15,000	0
TB_PREV	Among those who started a course of TB Prevention Therapy (TPT) in the previous reporting period, the number that completed a full course of therapy.	247	987

Testing

Technical Area Targets, Year 1			
Indicator	**Label**	**Military**	**Civilian**
HTS_INDEX	Number of individuals who were identified and tested using Index testing services and received their results	196	784
HTS_RECENT	Number of newly diagnosed HIV-positive persons who received testing for recent infection with a documented result during the reporting period	5	18
HTS_TST	Number of individuals who received HIV Testing Services (HTS) and received their test results	984	3,937
PMTCT_EID	Percentage of infants born to HIV-positive women who received a first virologic HIV test (sample collected) by 12 months of age	100%	100%
PMTCT_STAT	Percentage of pregnant women with known HIV status at antenatal care (includes those who already knew their HIV status prior to Antenatal Care (ANC)	100%	100%
TB_STAT	Percentage of new and relapse TB cases with documented HIV status	100%	100%

Treatment

Technical Area Targets, Year 1			
Indicator	**Label**	**Military**	**Civilian**
PMTCT_ART	Percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy	100%	100%
TB_ART	Number of TB cases with documented HIV-positive status who start or continue ART during the reporting period.	1	3
TX_CURR	Number of adults and children currently receiving antiretroviral therapy (ART)	700	2,799
TX_ML	Percentage of ART patients (who were on ART at the beginning of the quarterly reporting period) and then had no	2%	2%

	clinical contact since their last expected contact		
TX_NEW	Number of adults and children newly enrolled on antiretroviral therapy (ART)	72	288
TX_TB	Number of ART patients who were screened for TB at least once during the semiannual reporting period.	680	2,720

Viral Suppression

Technical Area Targets, Year 1			
Indicator	**Label**	**Military**	**Civilian**
TX_PVLS	Percentage of ART patients with a suppressed viral load (VL) result (<1000 copies/ml) documented in the medical or laboratory records/laboratory information systems (LIS) within the past 12 months	95%	95%

Technical Narrative

The Recipient will address the technical approach to each area. The Recipient will be responsible for providing the following in close collaboration with other DHAPP-funded Recipients and the host military.

HIV Prevention

The Recipient will ensure that the partner military is providing standardized, evidence-based interventions that are designed to promote the adoption of HIV prevention behaviors and service uptake for all military as well as other priority populations served by the military health services. These priority populations (PP) include men that have sex with men (MSM), sex workers and their clients, displaced persons, fishing communities, mobile populations, HIV discordant couples, adolescent girls and young women and illicit drug users.

The Recipient will ensure that the following interventions for adults and youth include:

- Promotion of relevant adult and youth friendly prevention and clinical services and demand creation to increase awareness, acceptability, and uptake of these services.
- Information, education, and skills development to reduce HIV risk and vulnerability; correctly identify HIV prevention methods; adopt and sustain positive behavior change; and promote gender equity and supportive norms and stigma reduction.
- Referral to or provision of HIV testing; facilitated linkage to care and prevention services; and/or support services to promote use of, retention in, and adherence to care.

- Condom and lubricant (where feasible) promotion, skills building, and facilitated access to condoms and lubricant (where feasible) through direct provision or linkages to social marketing and/or other service outlets.
- Programs targeting adults to raise awareness of HIV risks for young people, promote positive parenting and mentoring practices, and effective adult-child communication about sexuality and sexual risk reduction.

HIV Testing Services

Finding the remaining persons who are living with HIV infection is the first priority for reaching HIV epidemic control. Current epidemiology shows that most of those who do not yet know about their infection are men. The BNDF HIV/AIDS program is strategically placed to reach men; therefore, the Recipient will work closely with the BNDF on HIV Testing Services (HTS), particularly index testing, in an effort to achieve the "first 95" for military personnel: 95% of all BNDF personnel living with HIV know their status.

HTS will focus primarily on index testing to provide high yield testing to those most at risk for infection. The local epidemiology and situational analysis should guide the use of other testing methodologies to identify those who are living with HIV.

Where possible, a rapid test for recent infection (RTRI) should be conducted for all of those found to be newly positive. Those who test positive are classified as "probable recent HIV infections" until results of viral load are available. The index testing of these persons should receive high priority and robust efforts should be made to reach all contacts.

Provider-Initiated Testing and Counseling (PITC) will continue in the fixed sites for both the military and civilian cohorts. PITC should focus in clinical areas that have shown a high yield such as TB and STI clinics.

Ensuring that any positives identified are linked to HIV care and treatment is essential to the success of the BNDF program. The Recipient should work to achieve 100% linkage of HIV+ individuals identified. The Recipient will monitor HIV testing yield; modifying strategies or locations that are not identifying and/or linking significant numbers of HIV positive persons to HIV care and treatment.

The Recipient will be responsible for:

- Diagnosing 380 People Living with HIV (PLHIV) with 95% of those diagnosed linked to HIV care and treatment services.
- Index-case testing for all sexual partners of HIV-infected military personnel and civilians.
- Index-case testing for all children under 15 years of age with HIV- infected mothers.
- Index clients should also be offered self-testing for partners if they do not volunteer for partner notification.
- HTS to military bases and facilities, ensuring that all of those diagnosed are linked to HIV treatment services and receive same day initiation of ART.
- Quality improvement and quality assurance for all BNDF HTS including continuous training and mentoring and supervision visits, at least quarterly.

- Conducting proficiency testing for all HTS sites and individuals.
- Tracking PLHIV from HTS to clinical care and treatment services.
- Monitoring HIV testing yield; modifying strategies or locations that are not identifying and/or linking significant numbers of HIV positive persons to HIV care and treatment.

HIV Treatment

Support for treatment of HIV is an essential component of this PA. The following issues should be considered in supporting the treatment of PLHIV in military populations.

Dolutegravir (DTG)-containing regimens are the preferred first-line antiretroviral therapies (ART) due to superior efficacy, tolerability and higher threshold for resistance compared to efavirenz (EFV)-containing regimens. The fixed dose combination (FDC) of tenofovir disoproxil fumarate/lamivudine/dolutegravir (TLD) is currently priced as the least expensive FDC, and it is expected that prices will go down as generic manufacturing scales up. For these reasons, DHAPP now recommends TLD as the preferred option for ART, and further recommends that DHAPP-supported programs switch over to TLD as soon as possible in a coordinated fashion as supply becomes available.

Programs should carefully assess the risks and benefits of TLD in child-bearing age women. See published updated from WHO and PEPFAR to further understand the high benefits in the face of a potential NTD signal.

Children (< 20kg) are not expected to be included in the initial roll-out of TLD. Development of pediatric DTG formulations and evaluation of appropriate DTG dosing in infants and children are underway.

A priority of HIV programs is to find, diagnose and treat people with tuberculosis (TB) disease and ensure that they become non-infectious. For all those who do not have active TB, prevention of TB is a priority using nationally approved TB preventive therapy (TPT).

TPT must be scaled up for all PLHIVs as an integral part of the clinical care package. Recipients are expected to increase the use of TB diagnostic testing within DHAPP-supported HIV care and treatment facilities and promote the use of TPT as a routine part of HIV care. In short, all newly diagnosed HIV persons should be offered TB treatment or preventive therapy and all persons assessed for TB should be tested for HIV.

Programs should have clear policies and/or guidelines for the use of TPT, and should plan for programmatic and clinical trainings, procurement and supply management, adequate diagnostic capacity (including specimen transportation) and development of appropriate data collection systems. In Global Fund high-impact countries implementing joint TB/HIV awards, Recipients should also seek opportunities to support effective joint program implementation.

Additionally, Recipient should implement TB infection prevention and control activities to minimize the risk of TB transmission and provide safe health seeking environment. This is critical in DHAPP-supported settings where clients at high risk for TB and HIV often co-mingle. It also puts the health care workers at the highest risk of contracting TB disease. Activities aimed at

preventing transmission at facility-level include administrative and environmental controls, and the availability and use of personal protective equipment.

Viral Load (VL) Scale-up

Sustained viral suppression of all PLHIV is the key to HIV epidemic control. To this end, the Recipient will work closely with the BNDF to scale-up VL testing coverage and suppression in an effort to achieve 95-95-95 goals for military personnel. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 95: 95% viral suppression among PLHIV taking ART.

The Recipient should ensure the partner military has access to timely VL testing and that capacity exists to test at least 95% of persons currently on ART annually. To ensure this capacity the appropriate use of both plasma and dried blood spots (DBS) should be considered to increase access to routine viral load monitoring.

DBS are easy to collect and store under field conditions, no phlebotomist required, easy to transport to centralized laboratories, reduced cost associated with collection materials and transportation under ambient temperature. The DBS technology is applicable to both adult and pediatric populations and the small volume of blood required for preparing DBS makes it suitable for pediatric populations.

The Recipient will ensure that VL results are made available in a reasonable amount of time to both the health care provider and the client. These results should be used to ensure that those who are not virally suppressed are linked to adherence support and close follow-up leading to either suppression or ART modification as needed. Those who are suppressed should be encouraged to stay suppressed and should be offered differentiated models of care as an incentive and given the message that "undetectable equals untransmittable" (U=U).

Health System Strengthening

DHAPP is working to enhance the ability of governments to manage their epidemics, respond to broader health needs impacting affected communities, and address new and emerging health concerns. Activities include the following:

3. Laboratory capacity building

   The Recipient will be responsible for:

   - Inventory control, forecasting, and ensuring the procurement of laboratory reagents to ensure that laboratory services are uninterrupted.
   - Procurement of service maintenance contracts, calibration of equipment, and training of the laboratory staff on the use of the equipment.
   - Ensuring quality improvement of laboratories using Site Improvement Monitoring System (SIMS), Strengthening Laboratory Management Toward Accreditation (SLMTA) and Stepwise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA) to reach full ISO 15189 accreditation of main laboratories and quality improvement of all satellite laboratories and HIV test sites.
   - Monitoring laboratory quality and adherence to quality systems, method validation,

provision of proficiency testing panels for rapid HIV testing, viral load, CD4, TB, STI and other tests critical to HIV epidemic control.
- Conducting routine visits to laboratories to assess achievements, review/evaluate activities, and provide recommendations with the development of improvement plans to resolve any identified problems.
- Linking BNDF laboratory services to other laboratory resources at the district, provincial, and national levels.

The procurement of supplies, support, and equipment should use government and other donor sources when possible (Ministry of Health, Ministry of Defense, Global Fund, etc.).

DHAPP will continue to reduce its overall level of support for CD4 testing to prioritize access to VL testing. CD4 count is not needed to determine eligibility for ART (and continued CD4 testing may perpetuate the belief that CD4 count thresholds are criteria for initiating ART) and, as reflected in current WHO guidelines, CD4 is inferior to viral load for treatment monitoring.

DHAPP's priority is access to critical HIV treatment monitoring which is through use of VL and should be conducted at least once annually for stable patients and more frequently for new, unstable and pediatric patients.

Site Improvement through Monitoring System (SIMS)

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Work Plans

The Recipient must submit annual, programmatic and financial, work plans to the DHAPP Program Manager and DHAPP HQ (budget breakdown per activity and for program management is required). Work plans should include an activities implementation timeline as well as monitoring and evaluation timeline.

Cameroon: DHAPP—CDF Partnership for Sustainable HIV Epidemic Control

NOTE: Application submissions for this narrative are due by 5pm ET on February 6, 2021. Submission received after the deadline will not be considered for funding

Introduction

The HIV/AIDS epidemic has been devastating and negatively affected many militaries and other uniformed organizations worldwide by reducing military readiness, limiting deployments, causing physical and emotional decline in infected individuals and their families, posing risks to military personnel and their extended communities, and impeding peacekeeping activities. As HIV management improves, many of these impacts are disappearing; however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries in addition to other long-term chronic disease management issues.

The U.S. Government (USG) has a long history of international collaboration and partnerships in the fight against HIV/AIDS, providing funding, technical assistance, and program support. These collaborations are all contributing to HIV epidemic control.

Over the years, the United States Department of Defense (DoD) HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries in an effort to control the HIV epidemic among their respective military services. DHAPP is the DoD implementing agency collaborating with the U.S. Department of State, the Health Resources and Services Administration, Peace Corps, U.S. Agency for International Development (USAID), and the Centers for Disease Control and Prevention (CDC), in the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). DHAPP receives funding for its programs from two sources: a congressional plus-up to the Defense Health Program (DHP) and funding transfers from the Department of State for PEPFAR. Working closely with DoD, U.S. Unified Combatant Commanders, Joint United Nations Programme on HIV/AIDS (UNAIDS), university collaborators, and other nongovernmental organizations (NGOs), DHAPP's mission is to build capable military partners through military-specific, culturally focused, HIV/AIDS cooperation and assistance.

In the Defense Security Cooperation Agency guidance, the U.S. Secretary of Defense has identified HIV/AIDS in foreign militaries as a national security issue. Pursuing HIV/AIDS activities with foreign militaries is clearly tied to security interests, regional stability, humanitarian concerns, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing societies. DHAPP employs an integrated bilateral and regional strategy for HIV/AIDS cooperation and security assistance. DHAPP implements bilateral and regional strategies in coordination with respective Combatant Commands (COCOMs) and Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the US Under Secretary of Defense for Policy and by the Office of the Global AIDS Coordinator (OGAC). DHAPP provides strategic information and supports defense forces in HIV prevention, care, and treatment for HIV-infected individuals and their families.

PEPFAR adopted the UNAIDS global 95-95-95 (formerly 90-90-90) goals that state by 2030: 95% of people with HIV are diagnosed, 95% of them are on antiretroviral therapies (ART) and 95% of them are virally suppressed.

PEPFAR Monitoring, Evaluation, and Reporting (MER) indicators are collected and reported to efficiently use data to drive decision-making and focus HIV programming in the right geographic areas. DHAPP uses the same program indicators for DHP and PEPFAR-funded programs. DHAPP collects MER indicator results on a quarterly, semi-annual, and annual basis, depending on indicator, and data are reported at the site level to DHAPP. These data allow DHAPP to analyze and evaluate gaps in programming and achievement and identify needs for shifts to reach our shared goals. Due to security sensitivities regarding military site locations and troop movement, all site-level data are analyzed at DHAPP headquarters and summary data are reported to OGAC so that other USG country team agencies can review military program results aggregated at the national level.

All respondents must demonstrate the active support of the in-country military and the DoD representative in the corresponding U.S. Embassy in the planning and execution of their proposals

In fiscal year (FY) 2019, DHAPP supported 52 active HIV programs, mainly through direct military-to-military cooperation in addition to support from contracting external organizations and academic institutions to assist with specific aspects of proposed programs. Partners in FY19 included 35 NGOs and universities working in 46 countries.

Estimated Budget to be used as Framework

Program Area	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Total**
Care & Treatment	**$1,319,585**	**$1,319,585**	**$1,319,585**	**$1,319,585**	**$5,549,012**
C&T: HIV Clinical Services-NSD	$124,064	$124,064	$124,064	$124,064	$541,368
C&T: HIV Clinical Services-SD	$783,855	$783,855	$783,855	$783,855	$3,180,532
C&T: HIV Lab Services-NSD	$22,557	$22,557	$22,557	$22,557	$135,340
C&T: HIV Lab Services-SD	$191,735	$191,735	$191,735	$191,735	$812,052
HTS: Facility-based testing-NSD	$22,557	$22,557	$22,557	$22,557	$135,340
HTS: Facility-based testing-SD	$174,817	$174,817	$174,817	$174,817	$744,380
PM: IM Program Management-NSD	**$372,188**	**$372,188**	**$372,188**	**$372,188**	**$1,218,080**
TOTAL	**$1,691,773**	**$1,691,773**	**$1,691,773**	**$1,691,773**	**$6,767,092**

Approaches to Reaching Sustainable Epidemic Control

Proposals are requested to support the Cameroon Defense Forces (CDF) to reach sustainable control of the HIV/AIDS epidemic through the pillars of transparency, accountability, and impact.

The Recipient's program should emphasize capacity building across all activities and technical areas. All proposals should detail how the Recipient will engage the partner military leadership as well as personnel at all levels in this work; and, specifically how the partner will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Within the proposal, the Recipient will need to demonstrate transition of programmatic capabilities and capacity to the military over the life of the award.

The Recipient must work in complete coordination with the partner militaries' HIV prevention and health services, as well as the DHAPP/DoD Program Manager based at the U.S. Embassies in these countries, the DoD adult and pediatric treatment program manager based at the Military Health Department, other DHAPP supported Recipients working in these countries, other bilateral and multilateral agencies with similar objectives and the DHAPP Headquarters Team.

Targets

Prevention

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
1. TB_PREV	Proportion of ART patients who started on a standard course of TB Preventive Treatment (TPT) in the previous reporting period who completed therapy	90% (1,078/ 1,198)	90% (7,906/ 8,783)
2. FPINT_SITE	Number of HIV service delivery points (SDP) at a site supported by PEPFAR that are providing integrated voluntary family planning (FP) services	21	21

Testing

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
3. HTS_INDEX	The total number of contacts who were tested for HIV and received their results	226	3,539
4. HTS_TST	Number of individuals who received HIV Testing Services (HTS) and received their test results (includes HTS_INDEX)	4,140	30,359
5. PMTCT_EID		95%	95%

	Percentage of infants born to HIV-positive women who received a first virologic HIV test (sample collected) by 12 months of age	(0)	(166)
6. PMTCT_HEI_POS	Number of HIV infected infants identified	0	2
7. PMTCT_STAT	Percentage of pregnant women with known HIV positive status at first antenatal care visit (ANC1) (includes those who already knew their HIV positive status prior to ANC1)	100% (0)	100% (2,035)
8. TB_STAT	Percentage of new and relapsed TB cases with documented HIV status, during the reporting period	100% (53)	100% (387)

Treatment

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
9. PMTCT_ART	Percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy	100% (0)	100% (162)
10. TB_ART	Percentage of HIV-positive new and relapsed TB cases on ART during TB treatment	95% (13)	95% (94)
11. TX_CURR	Number of adults and children currently receiving antiretroviral therapy (ART)	2,086	8,344
12. TX_NEW	Number of adults and children newly enrolled on antiretroviral therapy (ART)	413	1,651
13. TX_TB	Percentage of ART patients screened for TB in the semiannual reporting period who start TB treatment.	100% (2,195)	100% (8,782)

Viral Suppression

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
14. TX_PVLS	Percentage of ART patients with a suppressed viral load (VL) result (<1000 copies/ml) documented in the medical or laboratory records/laboratory information systems (LIS) within the past 12 months	95% (1,738)	95% (6,952)

Technical Narrative

The Recipient will address the technical approach to each area. The Recipient will be responsible for providing the following in close collaboration with other DHAPP-funded recipients and the host military.

HIV Prevention

The Recipient will ensure that the partner military is providing standardized, evidence-based interventions that are designed to promote the adoption of HIV prevention behaviors and service uptake for all military and other uniformed services as well as other priority populations served by the military health services. These priority populations (PP) should include men that have sex with men (MSM), sex workers and their clients, displaced persons, fishing communities, mobile populations, HIV discordant couples, adolescent girls and young women and illicit drug users.

The Recipient will ensure that the following interventions for adults and youth include:

- Promotion of relevant adult and youth friendly prevention and clinical services and demand creation to increase awareness, acceptability, and uptake of these services;
- Information, education, and skills development to: reduce HIV risk and vulnerability; correctly identify HIV prevention methods; adopt and sustain positive behavior change; and promote gender equity and supportive norms and stigma reduction;
- Referral to or provision of HIV testing; facilitated linkage to care and prevention services; and/or support services to promote use of, retention in, and adherence to care;
- Condom and lubricant (where feasible) promotion, skills building, and facilitated access to condoms and lubricant (where feasible) through direct provision or linkages to social marketing and/or other service outlets;
- Programs targeting adults to raise awareness of HIV risks for young people, promote positive parenting and mentoring practices, and effective adult-child communication about sexuality and sexual risk reduction.

HIV Testing Services

Finding the remaining persons who are living with HIV infection is the first priority for reaching HIV epidemic control. Current epidemiology shows that most of those who do not yet know about their infection are men. The CDF HIV/AIDS program is strategically placed to

reach men; therefore, the Recipient will work closely with the CDF on HIV Testing Services (HTS), particularly index testing, in an effort to achieve the "first 95" for military personnel: 95% of all CDF personnel living with HIV know their status.

HTS will focus primarily on index testing to provide high yield testing to those most at risk for infection. The local epidemiology and situational analysis should guide the use of other testing methodologies to identify those who are living with HIV.

Where possible, a rapid test for recent infection (RTRI) should be conducted for all of those found to be newly positive. Those who test positive are classified as "probable recent HIV infections" until results of viral load are available. The index testing of these persons should receive high priority and robust efforts should be made to reach all contacts.

Provider-Initiated Testing and Counseling (PITC) will continue in the fixed sites for both the military and civilian cohorts. PITC should focus in clinical areas that have shown a high yield such as tuberculosis (TB) and sexually transmitted infections (STI) clinics.

Ensuring that any clients with positive results identified are linked to HIV care and treatment is essential to the success of the CDF program. The Recipient should work to achieve 100% linkage of HIV+ individuals identified. The Recipient will monitor HIV testing yield, modifying strategies or locations that are not identifying and/or linking significant numbers of HIV positive persons to HIV care and treatment.

The Recipient will be responsible for:

- HTS to military bases and facilities:
    - Diagnosing CDF PLHIV with 95% of those diagnosed linked to HIV care and treatment services;
    - Index-case testing for all sexual partners of HIV-infected military personnel and civilians;
    - Index-case testing for all children under 15 years of age with HIV-infected mothers;
    - Index clients should also be offered self-testing for partners if they do not volunteer for partner notification;
- HTS to military bases and facilities, ensuring that all of those diagnosed are linked to HIV treatment services and receive same day initiation of ART;
- Self-testing should be made available for military personnel, AGYW and their partners, male partners of ANC clients, sex workers, MSM and other key and priority populations (young men and at-risk males) that face high levels of stigma and discrimination. Following self-testing, facility referral and the regular diagnostic algorithm can be used according to national standards. It is vital to engage community groups to advocate for, design, implement, and analyze the success of HIVST;
- Quality improvement and quality assurance for all CDF HTS including continuous training and mentoring and supervision visits, at least quarterly;
- Conducting proficiency testing for all HTS sites and individuals;
- Tracking PLHIV from HTS to clinical care and treatment services

HIV Treatment
Support for treatment of HIV is an essential component of this PA. The following issues should be considered in supporting the treatment of people living with HIV (PLHIV) in military populations.

Dolutegravir (DTG)-containing regimens are the preferred first-line antiretroviral therapies (ART) due to superior efficacy, tolerability and higher threshold for resistance compared to efavirenz (EFV)-containing regimens. The fixed dose combination (FDC) of tenofovir disoproxil fumarate/lamivudine/dolutegravir (TLD) is currently priced as the least expensive FDC, and it is expected that prices will go down as generic manufacturing scales up. For these reasons, DHAPP now recommends TLD as the preferred option for ART, and further recommends that DHAPP-supported programs switch over to TLD as soon as possible in a coordinated fashion as supply becomes available.

Programs should carefully assess the risks and benefits of TLD in child-bearing age women. See published updated from WHO and PEPFAR to further understand the high benefits in the face of a potential Neural Tube Defect (NTD) signal.

Children (< 20kg) are not expected to be included in the initial roll-out of TLD. Development of pediatric DTG formulations and evaluation of appropriate DTG dosing in infants and children are underway.

A priority of HIV programs is to find, diagnose and treat people with TB disease and ensure that they become non-infectious. For all those who do not have active tuberculosis, prevention of TB is a priority using nationally approved TB preventive therapy (TPT).

TPT must be scaled up for all PLHIVs as an integral part of the clinical care package. The Recipient is expected to increase the use of TB diagnostic testing within DHAPP-supported HIV care and treatment facilities and promote the use of TPT as a routine part of HIV care. In short, all newly diagnosed HIV persons should be offered TB treatment or preventive therapy and all persons assessed for TB should be tested for HIV.

Programs should have clear policies and/or guidelines for the use of TPT, and should plan for programmatic and clinical trainings, procurement and supply management, adequate diagnostic capacity (including specimen transportation) and development of appropriate data collection systems. In Global Fund high-impact countries implementing joint TB/HIV awards, Recipients should also seek opportunities to support effective joint program implementation.

Additionally, the Recipient should implement TB infection prevention and control activities to minimize the risk of TB transmission and provide safe health seeking environment. This is critical in DHAPP-supported settings where clients at high risk for TB and HIV often co-mingle. It also puts the health care workers at the highest risk of contracting TB disease. Activities aimed at preventing transmission at facility-level include administrative and environmental controls, and the availability and use of personal protective equipment.

Cervical cancer screening for HIV+ women should be integrated into routine HIV treatment services in each country program. A “screen-and-treat” approach is recommended for the

management of precancerous lesions to maximize opportunities for immediate cryotherapy or thermal ablation treatment for eligible women without the need for diagnostic pathology confirmation and to reduced loss to follow-up.

Viral Load (VL) Scale-up

Sustained viral suppression of all PLHIV is the key to HIV epidemic control. To this end, the Recipient will work closely with the CDF to scale-up VL testing coverage and suppression in an effort to achieve 95-95-95 goals for military personnel. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 95: 95% viral suppression among PLHIV taking ART.

The Recipient should ensure the partner military has access to timely VL testing and that capacity exists to test at least 95% of persons currently on ART annually. To ensure this capacity the appropriate use of both plasma and dried blood spots (DBS) should be considered to increase access to routine viral load monitoring.

DBS are easy to collect and store under field conditions, no phlebotomist required, easy to transport to centralized laboratories, reduced cost associated with collection materials and transportation under ambient temperature. The DBS technology is applicable to both adult and pediatric populations and the small volume of blood required for preparing DBS makes it suitable for pediatric populations.

The Recipient will ensure that VL results are made available in a reasonable amount of time to both the health care provider and the client. These results should be used to ensure that those who are not virally suppressed are linked to adherence support and close follow-up leading to either suppression or ART modification as needed. Those who are suppressed should be encouraged to stay suppressed and should be offered differentiated models of care including multi-month supplies of ART and fast-tracking as an incentive, and given the message that undetectable equals untransmittable (U=U).

Health System Strengthening

DHAPP is working to enhance the ability of governments to manage their epidemics, respond to broader health needs impacting affected communities, and address new and emerging health concerns. Activities include the following:

Laboratory capacity building

The Recipient will be responsible for:

- Inventory control, forecasting, and ensuring the procurement of laboratory reagents to ensure that laboratory services are uninterrupted;
- Procurement of service maintenance contracts, calibration of equipment, and training of the laboratory staff on the use of the equipment;
- Ensuring quality improvement of laboratories using Site Improvement Monitoring System (SIMS), Strengthening Laboratory Management Toward Accreditation (SLMTA) and Stepwise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA) to reach full ISO 15189 accreditation of main laboratories;

and quality improvement of all satellite laboratories and HIV test sites.

- Monitoring laboratory quality and adherence to quality systems, method validation, provision of proficiency testing panels for rapid HIV testing, VL, CD4, TB, STI and other tests critical to HIV epidemic control;
- Conducting routine visits to laboratories to assess achievements, review/evaluate activities, and provide recommendations with the development of improvement plans to resolve any identified problems;
- Linking CDF laboratory services to other laboratory resources at the district, provincial, and national levels.

The procurement of supplies, support, and equipment should use government and other donor sources when possible (Ministry of Health, Ministry of Defense, Global Fund, etc).

DHAPP will continue to reduce its overall level of support for CD4 testing to prioritize access to VL testing. CD4 count is not needed to determine eligibility for ART (and continued CD4 testing may perpetuate the belief that CD4 count thresholds are criteria for initiating ART) and, as reflected in current WHO guidelines, CD4 is inferior to VL for treatment monitoring.

DHAPP's priority is access to critical HIV treatment monitoring which is through use of VL and should be conducted at least once annually for stable patients and more frequently for new, unstable and pediatric patients.

Site Improvement through Monitoring System (SIMS)

The purpose of SIMS is to provide a standardized approach and set of tools for monitoring program quality at DHAPP-supported sites and entities that guide and support service delivery. SIMS assessment results are used to strengthen alignment with global and national standards and facilitate program improvement as a component of an overall quality management strategy. SIMS is also used to identify performance issues that may impact patient outcomes or the integrity of reporting for MER targets or disaggregates. Low final scores (reds and yellows) from these core essential elements (CEEs) highlight potential issues with service delivery, site performance or oversight, and/or documentation of patient results. Site-level triangulation of MER and SIMS data can be used to contextualize performance and could be useful to determine if performance challenges at a site are due to issues related to the underlying quality of service provision.

Site Improvement through Monitoring System (SIMS) aims to: (1) facilitate improvement in the quality of DHAPP-supported services and technical assistance, (2) ensure accountability of U.S. government investments, and (3) maximize impact on the HIV epidemic.

SIMS assessment results confirm compliance to minimum quality assurance standards and identify areas where improvements in DHAPP-supported programs can be made.

Programs should conduct SIMS assessments in accordance with DHAPP guidance and Recipients are responsible for taking corrective action for items within the Recipient SOW and per discussion with DHAPP USG staff.

Client, Patient, and Program Data Monitoring

Successful collection, evaluation, and use of client/patient level data is critical to good patient care and to the success of the partner military HIV program's ability to monitor progress towards epidemic control. The Recipient will work with the partner military and Ministry of Health (MOH) or other organizations, as appropriate, to support the collection of patient-level data, the clinical and programmatic use of data, and the reporting of site-level data to DHAPP HQ and the partner military leadership.

The Recipient will be responsible for:

- Staffing, support, and mentoring of existing partner military staff for paper and electronic data entry
- Timely, accurate reporting of all indicators required by the partner military and DHAPP
- Ensuring confidentiality and security of data, in line with Ministry of Defense (MOD), Ministry of Health (MOH), and national guidelines from clinic to storage to dissemination.
- Securing all patient-level and site-level data from dissemination outside of the partner military and DHAPP without prior approval from the partner military
- Support for paper and electronic data entry, cleaning, reporting, and use

Data Quality

Measuring the success of HIV/AIDS initiatives requires strong monitoring and evaluation (M&E) systems that produce high quality data. Efforts to ensure data quality, therefore, are not singular events occurring randomly. Rather, these processes need to become institutionalized as part routine data management processes. Once achieved, data quality helps to ensure that limited resources are used effectively, progress toward established goals are accurately monitored, and that decisions are based on strong evidence. Attention to data quality ensures that target-setting and results reporting are informed by valid and sensitive information, and that all partners are thinking about and collecting and organizing this information in the same manner. In this way, attention to data quality leads to improved program performance and to more efficient resource management.

Data quality has always been a focus of global HIV monitoring and reporting efforts. Specifically, all countries conducting programming supported by DHAPP are expected to have a data quality strategy in place. For example, data quality assessments (DQAs) should be conducted routinely and action should be taken as a result of these DQAs. If errors are identified in data, these should be remediated at the point of service delivery as well as in the DHAPP and host-country reporting systems as soon as possible. Standard operating procedures for routine data quality review should also be in place. Data should be routinely reviewed for errors before submission to ensure that the data passes the data quality checks outlined within the guidance, the DC2 validations, and the Data for Accountability, Transparency, and Impact Monitoring (DATIM) Data Review Tool.

Virtual Communities of Practice

The Recipient should support the development of virtual communities of practice (vCoP). These evidence-based, virtual, face-to-face health workforce development and collaborative problem-

solving platforms, serve to create ongoing dialogue and collaboration among key staff in the military health care systems. They provide a consistent platform for conducting low-dose, high-frequency learning and collaboration sessions. The goal is to build a vCoP for each partner military where DHAPP works in collaboration with DHAPP HQ, field staff and other Recipients working in that country.

Key requirements are equipment and connectivity as well as personnel who can coordinate, manage and lead regular vCoP sessions. These roles may need to be held by the Recipient until they can be transitioned to the partner military.

Work Plans

The Recipient must submit annual, programmatic and financial, work plans to the DHAPP Program Manager and DHAPP HQ (budget breakdown per activity and for program management is required). Work plans should include an activities implementation timeline as well as monitoring and evaluation timeline.

Colombia DHAPP/ Colombian Armed Forces de Colombia FFMM Partnership for Sustainable HIV Epidemic Control

NOTE: Application submissions for this narrative are due by 5pm ET on February 5, 2021. Submission received after the deadline will not be considered for funding

Introduction

The HIV/AIDS epidemic has been devastating and negatively affected many militaries and other uniformed organizations worldwide by reducing military readiness, limiting deployments, causing physical and emotional decline in infected individuals and their families, posing risks to military personnel and their extended communities, and impeding peacekeeping activities. As HIV management improves, many of these impacts are disappearing, however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries in addition to other long-term chronic disease management issues.

The US Government has a long history of international collaboration and partnerships in the fight against HIV/AIDS, providing funding, technical assistance, and program support. These collaborations are all contributing to HIV epidemic control.

Over the years, the United States Department of Defense (DoD) HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries in an effort to control the HIV epidemic among their respective military services. DHAPP is the DoD implementing agency collaborating with the US Department of State, the Health Resources and Services Administration, Peace Corps, US Agency for International Development (USAID), and the Centers for Disease Control and Prevention (CDC), in the US President's Emergency Plan for AIDS Relief (PEPFAR). DHAPP receives funding for its programs from two sources: a congressional plus-up to the Defense Health Program (DHP) and funding transfers from the Department of State for PEPFAR. Working closely with DoD, U.S. Unified Combatant Commanders, Joint United Nations Programme on HIV/AIDS (UNAIDS), university collaborators, and other nongovernmental organizations (NGOs), DHAPP's mission is to build capable military partners through military-specific, culturally focused, HIV/AIDS cooperation and assistance.

In the Defense Security Cooperation Agency guidance, the US Secretary of Defense has identified HIV/AIDS in foreign militaries as a national security issue. Pursuing HIV/AIDS activities with foreign militaries is clearly tied to security interests, regional stability, humanitarian concerns, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing societies. DHAPP employs an integrated bilateral and regional strategy for HIV/AIDS cooperation and security assistance. DHAPP implements bilateral and regional strategies in coordination with respective Combatant Commands (COCOMs) and Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the US Under Secretary of Defense for Policy and by the Office of the Global AIDS Coordinator (OGAC). DHAPP provides strategic information and supports defense forces in HIV prevention, care, and treatment for HIV-infected individuals and their families.

PEPFAR adopted the United Nations Programme on HIV/AIDS (UNAIDS) global 95-95-95 (formerly 90-90-90) goals that state by 2030: 95% of people with HIV are diagnosed, 95% of them are on antiretroviral therapies (ART) and 95% of them are virally suppressed.

PEPFAR Monitoring, Evaluation, and Reporting (MER) indicators are collected and reported to efficiently use data to drive decision-making and focus HIV programming in the right geographic areas. DHAPP uses the same program indicators for Defense Health Program (DHP) and PEPFAR funded programs. DHAPP collects MER indicator results on a quarterly semi-annual, and annual basis, depending on indicator and data are reported at the site level to DHAPP. These data allow DHAPP to analyze and evaluate gaps in programming and achievement and identify needs for shifts to reach our shared goals. Due to security sensitivities regarding military site locations and troop movement, all site-level data are analyzed at DHAPP headquarters and summary data are reported to OGAC so that other USG country team agencies can review military program results aggregated at the national level.

Transition to Local Partners: Local partners are encouraged to apply to this announcement.

To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and community-based and community-led organizations – regardless of current antiretroviral (ARV) coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and to establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term, local partner engagement and impact.

All respondents must demonstrate the active support of the in-country military and the DoD representative in the corresponding U.S. Embassy in the planning and execution of their proposals.

In fiscal year (FY) 2019, DHAPP supported 52 active HIV programs, mainly through direct military-to-military cooperation in addition to support from contracting external organizations and academic institutions to assist with specific aspects of proposed programs. Partners in FY19 included 35 Non-Governmental Organizations (NGO)s and universities working in 46 countries.

Estimated Budget to be used as Framework

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Total**
Program Management	**$20,400**	**$20,400**	**$20,400**	**$20,400**	**$81,600**
Care & Treatment	**$67,600**	**$67,600**	**$67,600**	**$67,600**	**$270,400**
HTS: Facility-based testing- NSD C&T: HIV Clinical Services-NSD	**$30,600** **$34,000**	**$30,600** **$34,000**	**$30,600** **$34,000**	**$30,600** **$34,000**	**$122,400** **$136,000**
Prevention	**$30,600**	**$30,600**	**$30,600**	**$30,600**	**$122,400**
PREV: Condom	**$17,000**	**$17,000**	**$17,000**	**$17,000**	**$68,000**

& Lubricant Programming-SD PREV: Comm. mobilization, behavior & norms change-NSD	**$13,600**	**$13,600**	**$13,600**	**$13,600**	**$54,400**
Health Systems Strengthening	**$20,400**	**$20,400**	**$20,400**	**$20,400**	**$81,600**
ASP: HMIS, surveillance, & research-NSD ASP: Laws, regulations & policy environment-NSD	**$17,000** **$3,400**	**$17,000** **$3,400**	**$17,000** **$3,400**	**$17,000** **$3,400**	**$68,000** **$13,600**
TOTAL	**$136,000**	**$136,000**	**$136,000**	**$136,000**	**$544,000**

Approaches to Reaching Sustainable Epidemic Control

Proposals are requested to support the Colombian Armed Forces (FFMM de Colombia) to reach sustainable control of the HIV/AIDS epidemic through the pillars of transparency, accountability, and impact.

The Recipient's program should emphasize capacity building across all activities and technical areas. All proposals should detail how the Recipient will engage the partner military leadership as well as personnel at all levels in this work; and, specifically how the partner will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Within the proposal, the Recipient will need to demonstrate transition of programmatic capabilities and capacity to the military over the life of the award.

The Recipient must work in complete coordination with the partner militaries' HIV prevention and health services, as well as the DHAPP/DoD Program Manager based at the U.S. Embassies in these countries, the DoD adult and pediatric treatment program manager based at the Military Health Department, other DHAPP supported Recipients working in these countries, other bilateral and multilateral agencies with similar objectives and the DHAPP Headquarters Team.

Targets

Progress towards epidemic control will be successfully measured, in part, through an effective strategic information framework that monitors not only program outputs as compared to planned targets, but also key outcomes and programmatic impact.

Collection and use of disaggregated data that characterizes the populations served in the lowest

geographic areas where HIV services are being provided is critical in understanding current program performance and planning for future performance. Consequently, the MER indicators continue to evolve in order to reflect the progression of USG support and global HIV response guidelines. Measuring the impact of support at national and regional above-site levels down to direct services at the site-level is paramount to DHAPP's program implementation and monitoring approach.

MER indicators are not an exhaustive list of all metrics that should be monitored by DHAPP-supported programs. DHAPP also collects a custom indicator. All programs should continually monitor and assess any acute programmatic issues and collect additional data to inform program improvement.

The indicators listed below support a patient-centered program monitoring approach. Per the 2017 WHO Consolidated Guidelines on Person-Centered HIV Patient Monitoring and Case Surveillance, person-centered monitoring refers to a shift from monitoring measuring services (e.g., the number of individuals tested or people on treatment) to monitoring people at the center of their access to linked HIV and health services. In essence, this marks a shift to better support the clients accessing services by focusing more on their individual health outcomes.

The proposal will address approaches to reaching the following targets for military and civilian populations. Targets are listed using the associated PEPFAR Monitoring, Evaluation, and Reporting Indicator. Please see the most recent Monitoring, Evaluation, and Reporting Indicator Reference Guide for more detail at https://datim.zendesk.com/hc/en-us/articles/360000084446-MER-Indicator-Reference-Guides .

Prevention

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
7. PP_PREV	Number of priority populations (PP) reached with the standardized, evidence-based intervention(s) required that are designed to promote the adoption of HIV prevention behaviors and service uptake	100	-

Testing

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
13. HTS_INDEX	Number of individuals who were identified and tested using Index testing services and received their results	323	277

16. HTS_TST	Number of individuals who received HIV Testing Services (HTS) and received their test results	5225	4397
22. TB_STAT	Percentage of new and relapse TB cases with documented HIV status	100% (54/54)	100% (54/54)

Treatment

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
25. TB_ART	Proportion of HIV-positive new and relapsed TB cases on ART during TB treatment	89% (8/9)	89% (8/9)
26. TX_CURR	Number of adults and children currently receiving antiretroviral therapy (ART)	615	558
28. TX_NEW	Number of adults and children newly enrolled on antiretroviral therapy (ART)	203	145
29. TX_TB	Proportion of ART patients screened for TB in the semiannual reporting period who start TB treatment.	11%(28/260)	10% (24/230)

Viral Suppression

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
30. TX_PVLS	Percentage of ART patients with a suppressed viral load (VL) result (<1000 copies/ml) documented in the medical or laboratory records/laboratory information systems (LIS) within the past 12 months	95%(555/584)	95%(503/530)

Technical Narrative

The Recipient will address the technical approach to each area. The Recipient will be responsible

for providing the following in close collaboration with other DHAPP-funded recipients and the host military.

HIV Prevention

The Recipient will ensure that the partner military is providing standardized, evidence-based interventions that are designed to promote the adoption of HIV prevention behaviors and service uptake for all military and other uniformed services as well as other priority populations served by the military health services. These priority populations (PP) should include men that have sex with men (MSM), sex workers and their clients, displaced persons, fishing communities, mobile populations, HIV discordant couples, adolescent girls and young women and illicit drug users. The Recipient will ensure that the following interventions for adults and youth include:

- Promotion of relevant adult and youth friendly prevention and clinical services and demand creation to increase awareness, acceptability, and uptake of these services.
- Information, education, and skills development to: reduce HIV risk and vulnerability; correctly identify HIV prevention methods; adopt and sustain positive behavior change; and promote gender equity and supportive norms and stigma reduction.
- Referral to or provision of HIV testing; facilitated linkage to care and prevention services; and/or support services to promote use of, retention in, and adherence to care.
- Condom and lubricant (where feasible) promotion, skills building, and facilitated access to condoms and lubricant (where feasible) through direct provision or linkages to social marketing and/or other service outlets.
- Programs targeting adults to raise awareness of HIV risks for young people, promote positive parenting and mentoring practices, and effective adult-child communication about sexuality and sexual risk reduction.

Pre-exposure Prophylaxis (PrEP)

Oral pre-exposure prophylaxis with oral tenofovir or tenofovir-containing regimens has been shown to reduce the risk of HIV acquisition among numerous populations. WHO guidelines recommend offering oral PrEP to those at substantial risk of HIV infection, defined as an incidence rate of or exceeding 3 per 100 persons per year. This level of risk has been seen among sero-discordant couples with inconsistent condom use when the partner living with HIV is not virally suppressed, MSM, transgender women, sex workers (SW) of all genders, people who inject drugs (PWID), and older adolescent girls and young women (AGYW) in many parts of sub-Saharan Africa. DHAPP supports WHO guidelines on the use of PrEP as part of a package of comprehensive prevention services that includes risk reduction education and counselling, condom promotion, VMMC, and structural interventions to reduce vulnerability to HIV infection.

- The Recipient should work with the partner military to identify priority groups, set targets, and plan for PrEP implementation and implementation.
- Recipients should engage with partner militaries to advance “above-site” PrEP readiness and implementation. These activities may include: developing national policies; implementation and operational guidelines; product registration; supporting awareness-building and demand-creation efforts; testing integrated PrEP service delivery models; and exploring private sector engagement. Communication efforts will be needed to educate potential PrEP clients and to train health care providers on PrEP benefits, risks, and

procedures. Civil society groups already working with the key and other vulnerable populations should be engaged to assist in outreach. High-quality PrEP materials can be found at the following links:

- Implementation tools: http://www.who.int/hiv/pub/prep/prep-implementation-tool/en/
- Readiness materials, training materials, monitoring and evaluation (M&E) materials, advocacy materials, and demand creation materials including communications tools: www.prepwatch.org
- Training materials and M&E tools in several languages (English, French, Spanish, and Portuguese): http://icap.columbia.edu/resources/PrEP-kit

HIV Testing Services (HTS)

Finding the remaining persons who are living with HIV infection is the first priority for reaching HIV epidemic control. Current epidemiology shows us that most of those who do not yet know about their infection are men. The FFMM HIV/AIDS program is strategically placed to reach men; therefore, the Recipient will work closely with the FFMM on HTS, particularly index testing and self-testing, in an effort to achieve the "first 95" for military personnel: 95% of all FFMM personnel living with HIV know their status.

HTS will focus primarily on index testing to provide high yield testing to those most at risk for infection. The local epidemiology and situational analysis should guide the use of other testing methodologies to identify those who are living with HIV.

Where possible, a rapid test for recent infection (RTRI) should be conducted for all of those found to be newly positive. Those who test positive via RTRI are classified as "probable recent HIV infections" until results of viral load are available. The index testing of these persons should receive high priority and robust efforts should be made to reach all contacts.

Provider-Initiated Testing and Counseling (PITC) will continue in the fixed sites for both the military and civilian cohorts. PITC should focus in clinical areas that have shown a high yield such as TB and STI clinics.

Ensuring that any positives identified are linked to HIV care and treatment is essential to the success of the FFMM program. The Recipient should work to achieve 100% linkage of HIV+ individuals identified. The Recipient will monitor HIV testing yield; modifying strategies or locations that are not identifying and/or linking significant numbers of HIV positive persons to HIV care and treatment.

The Recipient will be responsible for technical assistance at 6 sites to support the FFMM in the following:

- HTS to military bases and facilities
  - Diagnosing 348 PLHIV with 95% of those diagnosed linked to HIV care and treatment services
  - Index-case testing for all sexual partners of HIV-infected military personnel and civilians

        - Index-case testing for all children under 15 years of age with HIV-infected mothers.
    - Index clients should also be offered self-testing (where available) for partners if they do not volunteer for partner notification.
    - The Recipient will provide refresher/updated training and mentoring for KP-friendly, stigma free HTS service delivery to 9621 individuals across modalities in the Colombian Military HIV/STI and TB clinics utilizing trainers previously trained in 3 sites in Bogota, and expanding to 3 additional sites in 2 new cities outside the Capital, ensuring that all of those diagnosed are linked to HIV treatment services and receive same day initiation of ART.
    - Self-testing should be made available for military personnel, adolescent girls and young women (AGYW) and their partners, male partners of ANC clients, sex workers, MSM and other key and priority populations (young men and at risk males) that face high levels of stigma and discrimination. Following self-testing, facility referral and the regular diagnostic algorithm can be used according to national standards. It is vital to engage community groups to advocate for, design, implement, and analyze the success of HIVST.
    - The Recipient will provide follow-up training for and monitor the roll-out of Index-Case testing and active partner notification in the three main hospitals and one Private Health Provider (EPS) were most military PLHIV are receiving medical care as well as continue to improve linkage to care
    - Quality improvement and quality assurance for all FFMM HTS including continuous training and mentoring and supervision visits, at least quarterly
    - Conducting proficiency testing for all HTS sites and individuals
    - Support of virtual course for HTS services and KP friendly, stigma free service delivery including mentoring in order to strength sustainability and military ownership of training for HTS providers, especially in high-rotation positions.
    - Tracking PLHIV from HTS to clinical care and treatment services.
    - Monitoring HIV testing yield; modifying strategies or locations that are not identifying and/or linking significant numbers of HIV positive persons to HIV care and treatment
    - Ensuring high quality recency testing for all newly diagnosed HIV-positive persons by well trained, certified testers using TRACE format of 3 QCs and 10 TPs (COP Section 6.3.1.6), and support reporting of MER indicator HTS_Recent and narratives.

HIV Treatment

Support for treatment of HIV is an essential component of this PA. The following issues should be considered in supporting the treatment of PLHIV in military populations:

Dolutegravir (DTG)-containing regimens are the preferred first-line antiretroviral therapies (ART) due to superior efficacy, tolerability and higher threshold for resistance compared to efavirenz (EFV)-containing regimens. The fixed dose combination (FDC) of tenofovir disoproxil fumarate/lamivudine/dolutegravir (TLD) is currently priced as the least expensive FDC, and it is expected that prices will go down as generic manufacturing scales up. For these reasons, DHAPP now recommends TLD as the preferred option for ART, and further recommends that DHAPP-supported programs switch over to TLD as soon as possible in a coordinated fashion as supply

becomes available.

Programs should carefully assess the risk and benefit of TLD in child-bearing age women. See published updates from PEPFAR to further understand the high benefits in the face of a potential neural tube defect (NTD) signal.

Children (< 20kg) are not expected to be included in the initial roll-out of TLD. Development of pediatric DTG formulations and evaluation of appropriate DTG dosing in infants and children are underway.

A priority of HIV programs is to find, diagnose and treat people with tuberculosis (TB) disease and ensure that they become non-infectious. For all those who do not have active TB, prevention of TB is a priority using nationally approved TB preventive therapy (TPT).

TPT must be scaled up for all PLHIVs as an integral part of the clinical care package. Recipients are expected to increase the use of TB diagnostic testing within DHAPP-supported HIV care and treatment facilities and promote the use of TPT as a routine part of HIV care. In short, all newly diagnosed HIV persons should be offered TB treatment or preventive therapy and all persons assessed for TB should be tested for HIV.

Programs should have clear policies and/or guidelines for the use of TPT, and should plan for programmatic and clinical trainings, procurement and supply management, adequate diagnostic capacity (including specimen transportation) and development of appropriate data collection systems. In Global Fund high-impact countries implementing joint TB/HIV grants, Recipients should also seek opportunities to support effective joint program implementation.

Additionally, Recipients should implement TB infection prevention and control activities to minimize the risk of TB transmission and provide safe health seeking environment. This is critical in DHAPP-supported settings where clients at high risk for TB and HIV often co-mingle. It also puts the health care workers at the highest risk of contracting TB disease. Activities aimed at preventing transmission at facility-level include administrative and environmental controls, and the availability and use of personal protective equipment.

Viral Load (VL) Scale-up

Sustained viral suppression of all PLHIV is the key to HIV epidemic control. To this end, the Recipient will work closely with the BNDF to scale-up VL testing coverage and suppression in an effort to achieve 95-95-95 goals for military personnel. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 95: 95% viral suppression among PLHIV taking ART.

The Recipient should ensure the partner military has access to timely VL testing and that capacity exists to test at least 95% of persons currently on ART annually. To ensure this capacity the appropriate use of both plasma and dried blood spots (DBS) should be considered to increase access to routine viral load monitoring.

DBS are easy to collect and store under field conditions, no phlebotomist required, easy to transport to centralized laboratories, reduced cost associated with collection materials and transportation under ambient temperature. The DBS technology is applicable to both adult and pediatric populations and the small volume of blood required for preparing DBS makes it suitable for pediatric populations.

The Recipient will ensure that VL results are made available in a reasonable amount of time to both the health care provider and the client. These results should be used to ensure that those who are not virally suppressed are linked to adherence support and close follow-up leading to either suppression or ART modification as needed. Those who are suppressed should be encouraged to stay suppressed and should be offered differentiated models of care including multi-month supplies of ART and fast-tracking as an incentive and given the message that undetectable equals untransmittable (U=U).

Site Improvement through Monitoring System (SIMS) and Data Use

The purpose of SIMS is to provide a standardized approach and set of tools for monitoring program quality at DHAPP-supported sites and entities that guide and support service delivery. SIMS assessment results are used to strengthen alignment with global and national standards and facilitate program improvement as a component of an overall quality management strategy. SIMS is also used to identify performance issues that may impact patient outcomes or the integrity of reporting for MER targets or disaggregates. Low final scores (reds and yellows) from these core essential elements (CEEs) highlight potential issues with service delivery, site performance or oversight, and/or documentation of patient results. Site-level triangulation of MER and SIMS data can be used to contextualize performance and could be useful to determine if performance challenges at a site are due to issues related to the underlying quality of service provision.

Site Improvement through Monitoring System (SIMS) aims to: (1) facilitate improvement in the quality of DHAPP-supported services and technical assistance, (2) ensure accountability of U.S. government investments, and (3) maximize impact on the HIV epidemic.

SIMS assessment results confirm compliance to minimum quality assurance standards and identify areas where improvements in DHAPP-supported programs can be made.

Programs should conduct SIMS assessments in accordance with DHAPP guidance and Recipients are responsible for taking corrective action for items within the Recipient SOW and per discussion with DHAPP USG staff.

Client, Patient, and Program Data Monitoring

Successful collection, evaluation, and use of client/patient level data is critical to good patient care and to the success of the partner military HIV program's ability to monitor progress towards epidemic control. The Recipient will work with the partner military and Ministry of Health (MOH) or other organizations, as appropriate, to support the collection of patient-level data, the clinical and programmatic use of data, and the reporting of site-level data to DHAPP HQ and the partner military leadership.

The Recipient will be responsible for:

- Staffing, support, and mentoring of existing partner military staff for paper and electronic data entry
- Timely, accurate reporting of all indicators required by the partner military and DHAPP
- Ensuring confidentiality and security of data, in line with Ministry of Defense (MOD), Ministry of Health (MOH), and national guidelines from clinic to storage to dissemination.
- Securing all patient-level and site-level data from dissemination outside of the partner military and DHAPP without prior approval from the partner military
- Support for paper and electronic data entry, cleaning, reporting, and use

Data Quality

Measuring the success of HIV/AIDS initiatives requires strong monitoring and evaluation (M&E) systems that produce high quality data. Efforts to ensure data quality, therefore, are not singular events occurring randomly. Rather, these processes need to become institutionalized as part routine data management processes. Once achieved, data quality helps to ensure that limited resources are used effectively, progress toward established goals are accurately monitored, and that decisions are based on strong evidence. Attention to data quality ensures that target-setting and results reporting are informed by valid and sensitive information, and that all partners are thinking about and collecting and organizing this information in the same manner. In this way, attention to data quality leads to improved program performance and to more efficient resource management.

Data quality has always been a focus of global HIV monitoring and reporting efforts. Specifically, all countries conducting programming supported by DHAPP are expected to have a data quality strategy in place. For example, data quality assessments (DQAs) should be conducted routinely and action should be taken as a result of these DQAs. If errors are identified in data, these should be remediated at the point of service delivery as well as in the DHAPP and host-country reporting systems as soon as possible. Standard operating procedures for routine data quality review should also be in place. Data should be routinely reviewed for errors before submission to ensure that the data passes the data quality checks outlined within the guidance, the DC2 validations, and the Data for Accountability, Transparency, and Impact Monitoring (DATIM) Data Review Tool.

Virtual Communities of Practice

The Recipient should support the development of virtual communities of practice (vCoP). These evidence-based, virtual, face-to-face health workforce development and collaborative problem-solving platforms, serve to create ongoing dialogue and collaboration among key staff in the military health care systems. They provide a consistent platform for conducting low-dose, high-frequency learning and collaboration sessions. The goal is to build a vCoP for each partner military where DHAPP works in collaboration with DHAPP HQ, field staff and other Recipients working in that country.

Key requirements are equipment and connectivity as well as personnel who can coordinate, manage and lead regular vCoP sessions. These roles may need to be held by the Recipient until they can be transitioned to the partner military.

Work Plans

The Recipient must submit annual, programmatic and financial, work plans to the DHAPP Program Manager and DHAPP HQ (budget breakdown per activity and for program management is required). Work plans should include an activities implementation timeline as well as monitoring and evaluation timeline.

Ghana: DHAPP – Ghana Armed Forces (GAF) Partnership for Sustainable HIV Epidemic Control

NOTE: Application submissions for this narrative are due by 5pm ET on February 5, 2021. Submission received after the deadline will not be considered for funding

Introduction

The HIV/AIDS epidemic has been devastating and negatively affected many militaries and other uniformed organizations worldwide by reducing military readiness, limiting deployments, causing physical and emotional decline in infected individuals and their families, posing risks to military personnel and their extended communities, and impeding peacekeeping activities. As HIV management improves, many of these impacts are disappearing, however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries in addition to other long-term chronic disease management issues.

The US Government has a long history of international collaboration and partnerships in the fight against HIV/AIDS, providing funding, technical assistance, and program support. These collaborations are all contributing to HIV epidemic control.

Over the years, the United States Department of Defense (DoD) HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries in an effort to control the HIV epidemic among their respective military services. DHAPP is the DoD implementing agency collaborating with the US Department of State, the Health Resources and Services Administration, Peace Corps, US Agency for International Development (USAID), and the Centers for Disease Control and Prevention (CDC), in the US President's Emergency Plan for AIDS Relief (PEPFAR). DHAPP receives funding for its programs from two sources: a congressional plus-up to the Defense Health Program (DHP) and funding transfers from the Department of State for PEPFAR. Working closely with DoD, U.S. Unified Combatant Commanders, Joint United Nations Programme on HIV/AIDS (UNAIDS), university collaborators, and other nongovernmental organizations (NGOs), DHAPP's mission is to build capable military partners through military-specific, culturally focused, HIV/AIDS cooperation and assistance.

In the Defense Security Cooperation Agency guidance, the US Secretary of Defense has identified HIV/AIDS in foreign militaries as a national security issue. Pursuing HIV/AIDS activities with foreign militaries is clearly tied to security interests, regional stability, humanitarian concerns, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing societies. DHAPP employs an integrated bilateral and regional strategy for HIV/AIDS cooperation and security assistance. DHAPP implements bilateral and regional strategies in coordination with respective Combatant Commands (COCOMs) and Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the US Under Secretary of Defense for Policy and by the Office of the Global AIDS Coordinator(OGAC). DHAPP provides strategic information and supports defense forces in HIV prevention, care, and treatment for HIV-infected individuals and their families.

PEPFAR adopted the United Nations Programme on HIV/AIDS (UNAIDS) global 95-95-95 (formerly 90-90-90) goals that state by 2030: 95% of people with HIV are diagnosed, 95% of them are on antiretroviral therapies (ART) and 95% of them are virally suppressed.

PEPFAR Monitoring, Evaluation, and Reporting (MER) indicators are collected and reported to efficiently use data to drive decision-making and focus HIV programming in the right geographic areas. DHAPP uses the same program indicators for Defense Health Program (DHP) and PEPFAR funded programs. DHAPP collects MER indicator results on a quarterly semi-annual, and annual basis, depending on indicator and data are reported at the site level to DHAPP. These data allow DHAPP to analyze and evaluate gaps in programming and achievement and identify needs for shifts to reach our shared goals. Due to security sensitivities regarding military site locations and troop movement, all site-level data are analyzed at DHAPP headquarters and summary data are reported to OGAC so that other USG country team agencies can review military program results aggregated at the national level.

Transition to Local Partners: Local partners are encouraged to apply to this announcement.

To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and community-based and community-led organizations – regardless of current antiretroviral (ARV) coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term, local partner engagement and impact.

All respondents must demonstrate the active support of the in-country military and the DoD representative in the corresponding U.S. Embassy in the planning and execution of their proposals.

In fiscal year (FY) 2019, DHAPP supported 52 active HIV programs, mainly through direct military-to-military cooperation in addition to support from contracting external organizations and academic institutions to assist with specific aspects of proposed programs. Partners in FY19 included 35 Non-Governmental Organizations (NGO)s and universities working in 46 countries.

Estimated Budget to be used as a Framework

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Total**
Program Management	**$82,000**	**$82,000**	**$82,000**	**$82,000**	**$328,000**
Above Site Programming – Non-Service Delivery	**$228,000**	**$228,000**	**$228,000**	**$228,000**	**$912,000**
HMIS, Surveillance, and Research	$70,000	$70,000	$70,000	$70,000	$280,000
Human Resources for Health	$35,000	$35,000	$35,000	$35,000	$140,000

Laws, Regulations, and Policy Environment	$123,000	$123,000	$123,000	$123,000	$492,000
TOTAL	**$310,000**	**$310,000**	**$310,000**	**$310,000**	**$1,240,000**

The beneficiary for all Above Site Programming activities is Priority Populations: Military & other uniformed services.

Approaches to Reaching Sustainable Epidemic Control

Proposals are requested to support the Ghana Armed Forces (GAF) to reach sustainable control of the HIV/AIDS epidemic through the pillars of transparency, accountability, and impact with particular focus on 37 Military Hospital in Accra as well as military medical facilities in Western Region.

The Recipient's program should emphasize capacity building across all activities and technical areas. All proposals should detail how the Recipient will engage the partner military leadership as well as personnel at all levels in this work; and, specifically how the partner will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Within the proposal, the Recipient will need to demonstrate transition of programmatic capabilities and capacity to the military over the life of the award.

The Recipient must work in complete coordination with the partner militaries' HIV prevention and health services, as well as the DHAPP/DoD Program Manager based at the U.S. Embassies in these countries, the DoD adult and pediatric treatment program manager based at the Military Health Department, other DHAPP supported Recipients working in these countries, other bilateral and multilateral agencies with similar objectives and the DHAPP Headquarters Team.

Technical Narrative

The Recipient will address the technical approach to each area. The Recipient will be responsible for providing the following in close collaboration with other DHAPP-funded Recipients and the host military.

HIV Prevention

The Recipient will ensure that the partner military is providing standardized, evidence-based interventions that are designed to promote the adoption of HIV prevention behaviors and service uptake for all military and other uniformed services as well as other priority populations served by the military health services. These priority populations (PP) should include men that have sex with men (MSM), sex workers and their clients, displaced persons, fishing communities, mobile populations, HIV discordant couples, adolescent girls and young women and illicit drug users.

The Recipient will ensure that the following interventions for adults and youth include:

- Promotion of relevant adult and youth friendly prevention and clinical services and demand creation to increase awareness, acceptability, and uptake of these services.

- Information, education, and skills development to: reduce HIV risk and vulnerability; correctly identify HIV prevention methods; adopt and sustain positive behavior change; and promote gender equity and supportive norms and stigma reduction.
- Referral to or provision of HIV testing; facilitated linkage to care and prevention services; and/or support services to promote use of, retention in, and adherence to care.
- Condom and lubricant (where feasible) promotion, skills building, and facilitated access to condoms and lubricant (where feasible) through direct provision or linkages to social marketing and/or other service outlets.
- Programs targeting adults to raise awareness of HIV risks for young people, promote positive parenting and mentoring practices, and effective adult-child communication about sexuality and sexual risk reduction.

Health System Strengthening

DHAPP is working to enhance the ability of governments to manage their epidemics, respond to broader health needs impacting affected communities, and address new and emerging health concerns. Activities include the following:

4. Stigma and discrimination reduction

   The Recipient will be responsible for:

   - Facilitating multi-level stigma and discrimination reduction training of trainer workshop (4-day) with military leadership, military healthcare workforce, troops, and military PLHIV. Activities will be coordinated with DHAPP. Recipient will use evidence-based materials already created and adapted to the military context. Participants of the workshop will build their capacity to facilitate stigma reduction activities independently and sustainably and health facilities will provide stigma free services. Participants will develop a draft Code of Conduct and an Action Plan to be reviewed, approved, and launched by the military healthcare leaders. Participants will also review existing health related policies to determine if they are discriminating and make recommendations to military leadership for policy changes.
   - Working closely with the military leadership to establish a working group/committee comprised of ministry of defense, military services (e.g. Army, Navy, Air Force), and military health care providers to review current military policies related to HIV and to steer the draft Code of Conduct and Action Plan through the appropriate review and approval process to final launch. The committee will revise and or develop non-discriminatory policies using current public health and WHO guidelines focused on human rights and stigma and discrimination elimination and steer these through the appropriate review and approval process.
   - Monitoring trainees and tracking the number of activities and persons trained and providing follow-up training as needed.

5. Trainings and meetings

   The Recipient will be responsible for:

   - Facilitating trainings and meetings for military leadership on GAF HIV policy.

- Facilitating trainings for military clinic administrators and providers on Positive Health, Dignity, and Prevention (PHDP) and Index Testing.
- Facilitating positive client support group meetings at least quarterly, with follow-up and logistical support as needed.
- Holding meetings at least quarterly with GAF staff to review and analyze data quality.

Site Improvement through Monitoring System (SIMS)

The purpose of SIMS is to provide a standardized approach and set of tools for monitoring program quality at DHAPP-supported sites and entities that guide and support service delivery. SIMS assessment results are used to strengthen alignment with global and national standards and facilitate program improvement as a component of an overall quality management strategy. SIMS is also used to identify performance issues that may impact patient outcomes or the integrity of reporting for MER targets or disaggregates. Low final scores (reds and yellows) from these core essential elements (CEEs) highlight potential issues with service delivery, site performance or oversight, and/or documentation of patient results. Site-level triangulation of MER and SIMS data can be used to contextualize performance and could be useful to determine if performance challenges at a site are due to issues related to the underlying quality of service provision.

Site Improvement through Monitoring System (SIMS) aims to: (1) facilitate improvement in the quality of DHAPP-supported services and technical assistance, (2) ensure accountability of U.S. government investments, and (3) maximize impact on the HIV epidemic.

SIMS assessment results confirm compliance to minimum quality assurance standards and identify areas where improvements in DHAPP-supported programs can be made.

Programs should conduct SIMS assessments in accordance with DHAPP guidance and Recipients are responsible for taking corrective action for items within the Recipient SOW and per discussion with DHAPP USG staff.

Client, Patient, and Program Data Monitoring

Successful collection, evaluation, and use of client/patient level data is critical to good patient care and to the success of the partner military HIV program's ability to monitor progress towards epidemic control. The Recipient will work with the partner military and Ministry of Health (MOH) or other organizations, as appropriate, to support the collection of patient-level data, the clinical and programmatic use of data, and the reporting of site-level data to DHAPP HQ and the partner military leadership.

The Recipient will be responsible for:

- Staffing, support, and mentoring of existing partner military staff for paper and electronic data entry
- Timely, accurate reporting of all indicators required by the partner military and DHAPP
- Ensuring confidentiality and security of data, in line with Ministry of Defense (MOD), Ministry of Health (MOH), and national guidelines from clinic to storage to dissemination.
- Securing all patient-level and site-level data from dissemination outside of the partner

military and DHAPP without prior approval from the partner military

- Support for paper and electronic data entry, cleaning, reporting, and use

Data Quality

Measuring the success of HIV/AIDS initiatives requires strong monitoring and evaluation (M&E) systems that produce high quality data. Efforts to ensure data quality, therefore, are not singular events occurring randomly. Rather, these processes need to become institutionalized as part routine data management processes. Once achieved, data quality helps to ensure that limited resources are used effectively, progress toward established goals are accurately monitored, and that decisions are based on strong evidence. Attention to data quality ensures that target-setting and results reporting are informed by valid and sensitive information, and that all partners are thinking about and collecting and organizing this information in the same manner. In this way, attention to data quality leads to improved program performance and to more efficient resource management.

Data quality has always been a focus of global HIV monitoring and reporting efforts. Specifically, all countries conducting programming supported by DHAPP are expected to have a data quality strategy in place. For example, data quality assessments (DQAs) should be conducted routinely and action should be taken as a result of these DQAs. If errors are identified in data, these should be remediated at the point of service delivery as well as in the DHAPP and host-country reporting systems as soon as possible. Standard operating procedures for routine data quality review should also be in place. Data should be routinely reviewed for errors before submission to ensure that the data passes the data quality checks outlined within the guidance, the DC2 validations, and the Data for Accountability, Transparency, and Impact Monitoring (DATIM) Data Review Tool.

Virtual Communities of Practice

The Recipient should support the development of virtual communities of practice (vCoP). These evidence-based, virtual, face-to-face health workforce development and collaborative problem-solving platforms, serve to create ongoing dialogue and collaboration among key staff in the military health care systems. They provide a consistent platform for conducting low-dose, high-frequency learning and collaboration sessions. The goal is to build a vCoP for each partner military where DHAPP works in collaboration with DHAPP HQ, field staff and other Recipients working in that country.

Key requirements are equipment and connectivity as well as personnel who can coordinate, manage and lead regular vCoP sessions. These roles may need to be held by the Recipient until they can be transitioned to the partner military.

Work Plans

The Recipient must submit annual, programmatic and financial, work plans to the DHAPP Program Manager and DHAPP HQ (budget breakdown per activity and for program management is required). Work plans should include an activities implementation timeline as well as monitoring and evaluation timeline.

Liberia: DHAPP – AFL Partnership for Sustainable HIV Epidemic Control

NOTE: Application submissions for this narrative are due by 5pm ET on February 5, 2021. Submission received after the deadline will not be considered for funding

Introduction

The HIV/AIDS epidemic has been devastating and negatively affected many militaries and other uniformed organizations worldwide by reducing military readiness, limiting deployments, causing physical and emotional decline in infected individuals and their families, posing risks to military personnel and their extended communities, and impeding peacekeeping activities. As HIV management improves, many of these impacts are disappearing; however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries in addition to other long-term chronic disease management issues.

The U.S. Government (USG) has a long history of international collaboration and partnerships in the fight against HIV/AIDS, providing funding, technical assistance, and program support. These collaborations are all contributing to HIV epidemic control.

Over the years, the United States Department of Defense (DoD) HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries in an effort to control the HIV epidemic among their respective military services. DHAPP is the DoD implementing agency collaborating with the U.S. Department of State, the Health Resources and Services Administration, Peace Corps, U.S. Agency for International Development (USAID), and the Centers for Disease Control and Prevention (CDC), in the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). DHAPP receives funding for its programs from two sources: a congressional plus-up to the Defense Health Program (DHP) and funding transfers from the Department of State for PEPFAR. Working closely with DoD, U.S. Unified Combatant Commanders, Joint United Nations Programme on HIV/AIDS (UNAIDS), university collaborators, and other nongovernmental organizations (NGOs), DHAPP's mission is to build capable military partners through military-specific, culturally focused, HIV/AIDS cooperation and assistance.

In the Defense Security Cooperation Agency guidance, the U.S. Secretary of Defense has identified HIV/AIDS in foreign militaries as a national security issue. Pursuing HIV/AIDS activities with foreign militaries is clearly tied to security interests, regional stability, humanitarian concerns, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing societies. DHAPP employs an integrated bilateral and regional strategy for HIV/AIDS cooperation and security assistance. DHAPP implements bilateral and regional strategies in coordination with respective Combatant Commands (COCOMs) and Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the US Under Secretary of Defense for Policy and by the Office of the Global AIDS Coordinator (OGAC). DHAPP provides strategic information and supports defense forces in HIV prevention, care, and treatment for HIV-infected individuals and their families.

PEPFAR adopted the UNAIDS global 95-95-95 (formerly 90-90-90) goals that state by 2030: 95% of people with HIV are diagnosed, 95% of them are on antiretroviral therapies (ART) and 95% of them are virally suppressed.

PEPFAR Monitoring, Evaluation, and Reporting (MER) indicators are collected and reported to efficiently use data to drive decision-making and focus HIV programming in the right geographic areas. DHAPP uses the same program indicators for DHP and PEPFAR-funded programs. DHAPP collects MER indicator results on a quarterly, semi-annual, and annual basis, depending on indicator, and data are reported at the site level to DHAPP. These data allow DHAPP to analyze and evaluate gaps in programming and achievement and identify needs for shifts to reach our shared goals. Due to security sensitivities regarding military site locations and troop movement, all site-level data are analyzed at DHAPP headquarters and summary data are reported to OGAC so that other USG country team agencies can review military program results aggregated at the national level.

Transition to Local Partners: Local partners are encouraged to apply to this announcement. To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and community-based and community-led organizations – regardless of current antiretroviral (ARV) coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term, local partner engagement and impact.

All respondents must demonstrate the active support of the in-country military and the DoD representative in the corresponding U.S. Embassy in the planning and execution of their proposals.

In fiscal year (FY) 2019, DHAPP supported 52 active HIV programs, mainly through direct military-to-military cooperation in addition to support from contracting external organizations and academic institutions to assist with specific aspects of proposed programs. Partners in FY19 included 35 NGOs and universities working in 46 countries.

Estimated Budget to be used as Framework

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Total**
Program Management	**$60,000**	**$60,000**	**$60,000**	**$60,000**	**$240,000**
Above Site Programming	**$32,000**	**$32,000**	**$32,000**	**$32,000**	**$128,000**
Laws, Regulations, and Policy Environment - NSD	$32,000	$32,000	$32,000	$32,000	$128,000
Care & Treatment	**$86,000**	**$86,000**	**$86,000**	**$86,000**	**$344,000**
HIV Clinical Services - SD	$38,000	$38,000	$38,000	$38,000	$152,000
HIV Laboratory Services – NSD	$10,000	$10,000	$10,000	$10,000	$40,000
HIV Laboratory Services – SD	$25,000	$25,000	$25,000	$25,000	$100,000
Not Disaggregated – NSD	$13,000	$13,000	$13,000	$13,000	$52,000
Prevention	**$25,000**	**$25,000**	**$25,000**	**$25,000**	**$100,000**
Community Mobilization,	$25,000	$25,000	$25,000	$25,000	$100,000

Behavior, & Norms Change – SD					
TOTAL	**$203,000**	**$203,000**	**$203,000**	**$203,000**	**$812,000**

Approaches to Reaching Sustainable Epidemic Control

Proposals are requested to support the Armed Forces of Liberia (AFL) to reach sustainable control of the HIV/AIDS epidemic through the pillars of transparency, accountability, and impact.

The Recipient's program should emphasize capacity building across all activities and technical areas. All proposals should detail how the Recipient will engage the partner military leadership as well as personnel at all levels in this work; and, specifically how the partner will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Within the proposal, the Recipient will need to demonstrate transition of programmatic capabilities and capacity to the military over the life of the award.

The Recipient must work in complete coordination with the partner militaries' HIV prevention and health services, as well as the DHAPP/DoD Program Manager based at the U.S. Embassies in these countries, the DoD adult and pediatric treatment program manager based at the Military Health Department, other DHAPP supported Recipients working in these countries, other bilateral and multilateral agencies with similar objectives and the DHAPP Headquarters Team.

Targets

Prevention

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
1. PP_PREV	1. Number of priority populations (PP) reached with the standardized, evidence-based intervention(s) required that are designed to promote the adoption of HIV prevention behaviors and service uptake	555	-
2. FPINT_SITE	2. Number of HIV service delivery points (SDP) at a site supported by PEPFAR that are providing integrated voluntary family planning (FP) services	2	-

Testing

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**

1. HTS_INDEX	1. Number of individuals who were identified and tested using Index testing services and received their results	20	100
2. HTS_TST	2. Number of individuals who received HIV Testing Services (HTS) and received their test results (HTS_TST_POS in parentheses)	60 (8)	240(32)

Treatment

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
1. TX_CURR	1. Number of adults and children currently receiving antiretroviral therapy (ART)	25	100
2. TX_NEW	2. Number of adults and children newly enrolled on antiretroviral therapy (ART)	8	32

Viral Suppression

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
1. TX_PVLS	1. Percentage of ART patients with a viral load result documented in the medical record and/or laboratory information systems (LIS) within the past 12 months with a suppressed viral load (<1000 copies/ml)	95% (17/18)	95% (70/74)

Technical Narrative

The Recipient will address the technical approach to each area. The Recipient will be responsible for providing the following in close collaboration with other DHAPP-funded recipients and the host military.

HIV Prevention

The Recipient will ensure that the partner military is providing standardized, evidence-based interventions that are designed to promote the adoption of HIV prevention behaviors and service uptake for all military and other uniformed services as well as other priority populations served by the military health services. These priority populations (PP) should include men that have sex with men (MSM), sex workers and their clients, displaced persons, fishing communities, mobile populations, HIV serodiscordant couples, adolescent girls and young women and illicit drug users.

The Recipient will ensure that the following interventions for adults and youth include:

- Promotion of relevant adult- and youth-friendly prevention and clinical services and demand creation to increase awareness, acceptability, and uptake of these services.
- Information, education, and skills development to reduce HIV risk and vulnerability; correctly identify HIV prevention methods; adopt and sustain positive behavior change; and promote gender equity and supportive norms and stigma reduction.
- Referral to or provision of HIV testing; facilitated linkage to care and prevention services; and/or support services to promote use of, retention in, and adherence to care.
- Condom and lubricant (where feasible) promotion, skills building, and facilitated access to condoms and lubricant (where feasible) through direct provision or linkages to social marketing and/or other service outlets.
- Programs targeting adults to raise awareness of HIV risks for young people, promote positive parenting and mentoring practices, and effective adult-child communication about sexuality and sexual risk reduction.

HIV Testing Services

Finding the remaining persons who are living with HIV infection is the first priority for reaching HIV epidemic control. Current epidemiology shows that most of those who do not yet know about their infection are men. The AFL HIV/AIDS program is strategically placed to reach men; therefore, the Recipient will work closely with the AFL on HIV Testing Services (HTS), particularly index testing, in an effort to achieve the "first 95" for military personnel: 95% of all AFL personnel living with HIV know their status.

HTS will focus primarily on index testing to provide high yield testing to those most at risk for infection. The local epidemiology and situational analysis should guide the use of other testing methodologies to identify those who are living with HIV.

Where possible, a rapid test for recent infection (RTRI) should be conducted for all of those found to be newly positive. Those who test positive are classified as "probable recent HIV infections" until results of viral load are available. The index testing of these persons should receive high priority and robust efforts should be made to reach all contacts.

Provider-Initiated Testing and Counseling (PITC) will continue in the fixed sites for both the military and civilian cohorts. PITC should focus in clinical areas that have shown a high yield such as tuberculosis (TB) and sexually transmitted infection (STI) clinics.

Ensuring that any positives identified are linked to HIV care and treatment is essential to the success of the AFL program. The Recipient should work to achieve 100% linkage of HIV+ individuals identified. The Recipient will monitor HIV testing yield, modifying strategies or locations that are not identifying and/or linking significant numbers of HIV positive persons to HIV care and treatment.

The Recipient will be responsible for:

- HTS to military bases and facilities
    - Diagnosing 20 PLHIV with 95% of those diagnosed linked to HIV care and

treatment services
    - Index-case testing for all sexual partners of HIV-infected military personnel and civilians
    - Index-case testing for all children under 15 years of age with HIV-infected mothers.
    - Index clients should also be offered self-testing for partners if they do not volunteer for partner notification.
- HTS to military bases and facilities, ensuring that all of those diagnosed are linked to HIV treatment services and receive same-day initiation of ART.
- Quality improvement and quality assurance for all AFL HTS, including continuous training and mentoring and supervision visits, at least quarterly.
- Conducting proficiency testing for all HTS sites and individuals.
- Tracking PLHIV from HTS to clinical care and treatment services.

HIV Treatment

Support for treatment of HIV is an essential component of this PA. The following issues should be considered in supporting the treatment of PLHIV in AFL military populations.

Dolutegravir (DTG)-containing regimens are the preferred first-line antiretroviral therapies (ART) due to superior efficacy, tolerability and higher threshold for resistance compared to efavirenz (EFV)-containing regimens. The fixed dose combination (FDC) of tenofovir disoproxil fumarate/lamivudine/dolutegravir (TLD) is currently priced as the least expensive FDC, and it is expected that prices will go down as generic manufacturing scales up. For these reasons, DHAPP now recommends TLD as the preferred option for ART, and further recommends that DHAPP-supported programs switch over to TLD as soon as possible in a coordinated fashion as supply becomes available.

Programs should carefully assess the risks and benefits of TLD in child-bearing age women. See published updated from WHO and PEPFAR to further understand the high benefits in the face of a potential NTD signal.

Children (< 20kg) are not expected to be included in the initial roll-out of TLD. Development of pediatric DTG formulations and evaluation of appropriate DTG dosing in infants and children are underway.

A priority of HIV programs is to find, diagnose and treat people with TB disease and ensure that they become non-infectious. For all those who do not have active TB, prevention of TB is a priority using nationally approved TB preventive therapy (TPT).

TPT must be scaled up for all PLHIVs as an integral part of the clinical care package. Recipients are expected to increase the use of TB diagnostic testing within DHAPP-supported HIV care and treatment facilities and promote the use of TPT as a routine part of HIV care. In short, all newly diagnosed HIV persons should be offered TB treatment or preventive therapy, and all persons assessed for TB should be tested for HIV.

Programs should have clear policies and/or guidelines for the use of TPT, and should plan for programmatic and clinical trainings, procurement and supply management, adequate diagnostic capacity (including specimen transportation) and development of appropriate data collection systems. In Global Fund high-impact countries implementing joint TB/HIV awards, Recipients should also seek opportunities to support effective joint program implementation.

Additionally, the Recipient should implement TB infection prevention and control activities to minimize the risk of TB transmission and provide safe health seeking environment. This is critical in DHAPP-supported settings where clients at high risk for TB and HIV often co-mingle. It also puts the health care workers at the highest risk of contracting TB disease. Activities aimed at preventing transmission at facility-level include administrative and environmental controls, and the availability and use of personal protective equipment.

Cervical cancer screening for HIV+ women should be integrated into routine HIV treatment services in each country program. A "screen-and-treat" approach is recommended for the management of precancerous lesions to maximize opportunities for immediate cryotherapy or thermal ablation treatment for eligible women without the need for diagnostic pathology confirmation and to reduce loss to follow-up.

Viral Load (VL) Scale-up

Sustained viral suppression of all PLHIV is the key to HIV epidemic control. To this end, the Recipient will work closely with the AFL to scale-up VL testing coverage and suppression in an effort to achieve 95-95-95 goals for military personnel. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 95: 95% viral suppression among PLHIV taking ART.

The Recipient should ensure that the partner military has access to timely VL testing and that capacity exists to test at least 95% of persons currently on ART annually. To ensure this capacity the appropriate use of both plasma and dried blood spots (DBS) should be considered to increase access to routine viral load monitoring.

DBS are easy to collect and store under field conditions, no phlebotomist required, easy to transport to centralized laboratories, reduced cost associated with collection materials and transportation under ambient temperature. The DBS technology is applicable to both adult and pediatric populations and the small volume of blood required for preparing DBS makes it suitable for pediatric populations.

The Recipient will ensure that VL results are made available in a reasonable amount of time to both the health care provider and the client. These results should be used to ensure that those who are not virally suppressed are linked to adherence support and close follow-up leading to either suppression or ART modification as needed. Those who are suppressed should be encouraged to stay suppressed and should be offered differentiated models of care including multi-month supplies of ART and fast-tracking as an incentive, and given the message that undetectable equals untransmittable (U=U).

Health System Strengthening

DHAPP is working to enhance the ability of governments to manage their epidemics, respond to broader health needs impacting affected communities, and address new and emerging health concerns. Activities include the following:

Laboratory capacity building

The Recipient will be responsible for:

- Inventory control, forecasting, and ensuring the procurement of laboratory reagents to ensure that laboratory services are uninterrupted.
- Procurement of service maintenance contracts, calibration of equipment, and training of the laboratory staff on the use of the equipment.
- Ensuring quality improvement of laboratories using Site Improvement Monitoring System (SIMS), Strengthening Laboratory Management Toward Accreditation (SLMTA) and Stepwise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA) to reach full ISO 15189 accreditation of main laboratories and quality improvement of all satellite laboratories and HIV test sites.
- Monitoring laboratory quality and adherence to quality systems, method validation, provision of proficiency testing panels for rapid HIV testing, VL, CD4, TB, STI and other tests critical to HIV epidemic control.
- Conducting routine visits to laboratories to assess achievements, review/evaluate activities, and provide recommendations with the development of improvement plans to resolve any identified problems.
- Linking AFL laboratory services to other laboratory resources at the district, provincial, and national levels.
- Ensure that the laboratory has an updated SOP for accuracy and consistency
- Ensure laboratory staff have access to capacity building through regular training with local partners and others available in country.
- Work along with laboratory staff to enhance storage capacity and sample collection and transport for data integrity and compliance.

The procurement of supplies, support, and equipment should use government and other donor sources when possible (Ministry of Health, Ministry of Defense, Global Fund, etc).

DHAPP will continue to reduce its overall level of support for CD4 testing to prioritize access to VL testing. CD4 count is not needed to determine eligibility for ART (and continued CD4 testing may perpetuate the belief that CD4 count thresholds are criteria for initiating ART) and, as reflected in current WHO guidelines, CD4 is inferior to viral load for treatment monitoring.

DHAPP's priority is access to critical HIV treatment monitoring which is through the use of VL and VL should be conducted at least once annually for stable patients and more frequently for new, unstable and pediatric patients.

The purpose of SIMS is to provide a standardized approach and set of tools for monitoring program quality at DHAPP-supported sites and entities that guide and support service delivery. SIMS assessment results are used to strengthen alignment with global and national standards and

facilitate program improvement as a component of an overall quality management strategy. SIMS is also used to identify performance issues that may impact patient outcomes or the integrity of reporting for MER targets or disaggregates. Low final scores (reds and yellows) from these core essential elements (CEEs) highlight potential issues with service delivery, site performance or oversight, and/or documentation of patient results. Site-level triangulation of MER and SIMS data can be used to contextualize performance and could be useful to determine if performance challenges at a site are due to issues related to the underlying quality of service provision.

SIMS aims to: (1) facilitate improvement in the quality of DHAPP-supported services and technical assistance, (2) ensure accountability of USG investments, and (3) maximize impact on the HIV epidemic.

SIMS assessment results confirm compliance to minimum quality assurance standards and identify areas where improvements in DHAPP-supported programs can be made.

Programs should conduct SIMS assessments in accordance with DHAPP guidance, and Recipients are responsible for taking corrective action for items within the Recipient SOW and per discussion with DHAPP USG staff.

Client, Patient, and Program Data Monitoring

Successful collection, evaluation, and use of client/patient level data is critical to good patient care and to the success of the partner military HIV program's ability to monitor progress towards epidemic control. The Recipient will work with the partner military and Ministry of Health (MOH) or other organizations, as appropriate, to support the collection of patient-level data, the clinical and programmatic use of data, and the reporting of site-level data to DHAPP HQ and the partner military leadership.

The Recipient will be responsible for:

- Staffing, support, and mentoring of existing partner military staff for paper and electronic data entry.
- Timely, accurate reporting of all indicators required by the partner military and DHAPP.
- Ensuring confidentiality and security of data, in line with Ministry of Defense (MOD), MOH, and national guidelines from clinic to storage to dissemination.
- Securing all patient-level and site-level data from dissemination outside of the partner military and DHAPP without prior approval from the partner military.
- Supporting paper and electronic data entry, cleaning, reporting, and use.

Data Quality

Measuring the success of HIV/AIDS initiatives requires strong monitoring and evaluation (M&E) systems that produce high quality data. Efforts to ensure data quality, therefore, are not singular events occurring randomly. Rather, these processes need to become institutionalized as part routine data management processes. Once achieved, data quality helps to ensure that limited resources are used effectively, that progress toward established goals are accurately monitored, and that decisions are based on strong evidence. Attention to data quality ensures that target-setting and results reporting are informed by valid and sensitive information, and that all partners are thinking about and collecting and organizing this information in the same manner. In this way,

attention to data quality leads to improved program performance and to more efficient resource management.

Data quality has always been a focus of global HIV monitoring and reporting efforts. Specifically, all countries conducting programming supported by DHAPP are expected to have a data quality strategy in place. For example, data quality assessments (DQAs) should be conducted routinely and action should be taken as a result of these DQAs. If errors are identified in data, these should be remediated at the point of service delivery as well as in the DHAPP and host-country reporting systems as soon as possible. Standard operating procedures for routine data quality review should also be in place. Data should be routinely reviewed for errors before submission to ensure that the data passes the data quality checks outlined within the guidance, the DC2 validations, and the Data for Accountability, Transparency, and Impact Monitoring (DATIM) Data Review Tool.

Virtual Communities of Practice

The Recipient should support the development of virtual communities of practice (vCoP). These evidence-based, virtual, face-to-face health workforce development and collaborative problem-solving platforms, serve to create ongoing dialogue and collaboration among key staff in the military health care systems. They provide a consistent platform for conducting low-dose, high-frequency learning and collaboration sessions. The goal is to build a vCoP for each partner military where DHAPP works in collaboration with DHAPP HQ, field staff and other Recipients working in that country.

Key requirements are equipment and connectivity as well as personnel who can coordinate, manage and lead regular vCoP sessions. These roles may need to be held by the Recipient until they can be transitioned to the partner military.

Work Plans

The Recipient must submit annual, programmatic and financial, work plans to the DHAPP Program Manager and DHAPP HQ (budget breakdown per activity and for program management is required). Work plans should include an activities implementation timeline as well as monitoring and evaluation timeline.

Mozambique: DHAPP - Forcas Armadas de Defesa de Mocambique (FADM) Partnership for Sustainable HIV Epidemic Control

NOTE: Application submissions for this narrative are due by 5pm ET on February 5, 2021. Submission received after the deadline will not be considered for funding

Introduction

The HIV/AIDS epidemic has been devastating and negatively affected many militaries and other uniformed organizations worldwide by reducing military readiness, limiting deployments, causing physical and emotional decline in infected individuals and their families, posing risks to military personnel and their extended communities, and impeding peacekeeping activities. As HIV management improves, many of these impacts are disappearing, however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries in addition to other long-term chronic disease management issues.

The US Government has a long history of international collaboration and partnerships in the fight against HIV/AIDS, providing funding, technical assistance, and program support. These collaborations are all contributing to HIV epidemic control.

Over the years, the United States Department of Defense (DoD) HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries in an effort to control the HIV epidemic among their respective military services. DHAPP is the DoD implementing agency collaborating with the US Department of State, the Health Resources and Services Administration, Peace Corps, US Agency for International Development (USAID), and the Centers for Disease Control and Prevention (CDC), in the US President's Emergency Plan for AIDS Relief (PEPFAR). DHAPP receives funding for its programs from two sources: a congressional plus-up to the Defense Health Program (DHP) and funding transfers from the Department of State for PEPFAR. Working closely with DoD, U.S. Unified Combatant Commanders, Joint United Nations Programme on HIV/AIDS (UNAIDS), university collaborators, and other nongovernmental organizations (NGOs), DHAPP's mission is to build capable military partners through military-specific, culturally focused, HIV/AIDS cooperation and assistance.

In the Defense Security Cooperation Agency guidance, the US Secretary of Defense has identified HIV/AIDS in foreign militaries as a national security issue. Pursuing HIV/AIDS activities with foreign militaries is clearly tied to security interests, regional stability, humanitarian concerns, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing societies. DHAPP employs an integrated bilateral and regional strategy for HIV/AIDS cooperation and security assistance. DHAPP implements bilateral and regional strategies in coordination with respective Combatant Commands (COCOMs) and Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the US Under Secretary of Defense for Policy and by the Office of the Global AIDS Coordinator(OGAC). DHAPP provides strategic information and supports defense forces in HIV prevention, care, and treatment for HIV-infected individuals and their families.

PEPFAR adopted the United Nations Programme on HIV/AIDS (UNAIDS) global 95-95-95 (formerly 90-90-90) goals that state by 2030: 95% of people with HIV are diagnosed, 95% of them are on antiretroviral therapies (ART) and 95% of them are virally suppressed.

PEPFAR Monitoring, Evaluation, and Reporting (MER) indicators are collected and reported to efficiently use data to drive decision-making and focus HIV programming in the right geographic areas. DHAPP uses the same program indicators for Defense Health Program (DHP) and PEPFAR funded programs. DHAPP collects MER indicator results on a quarterly semi-annual, and annual basis, depending on indicator and data are reported at the site level to DHAPP. These data allow DHAPP to analyze and evaluate gaps in programming and achievement and identify needs for shifts to reach our shared goals. Due to security sensitivities regarding military site locations and troop movement, all site-level data are analyzed at DHAPP headquarters and summary data are reported to OGAC so that other USG country team agencies can review military program results aggregated at the national level.

Transition to Local Partners: Local partners are encouraged to apply to this announcement.

To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and community-based and community-led organizations – regardless of current antiretroviral (ARV) coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term, local partner engagement and impact.

All respondents must demonstrate the active support of the in-country military and the DoD representative in the corresponding U.S. Embassy in the planning and execution of their proposals.

In fiscal year (FY) 2019, DHAPP supported 52 active HIV programs, mainly through direct military-to-military cooperation in addition to support from contracting external organizations and academic institutions to assist with specific aspects of proposed programs. Partners in FY19 included 35 Non-Governmental Organizations (NGO)s and universities working in 46 countries.

Budget

PEPFAR activities and services and corresponding budgets and expenditures are uniformly organized into a classification structure referred to as PEPFAR Financial Classifications. In this structure, the PEPFAR funded activities and services are classified systematically as interventions, which is a combination of programs (and sub-programs) and beneficiaries (and sub beneficiaries). Budget and program expenditures are further arrayed according to the cost classification. The below link contains the PEPFAR Financial Classifications Reference Guide and summaries of these classification definitions.
https://datim.zendesk.com/hc/en-us/articles/360015671212-PEPFAR-Financial-Classifications-Reference-Guide. The estimate budget for this program announcement in the format of the PEPFAR Financial Classifications is as follows:

Estimated Budget to be used as Framework

Program Area	Year 1	Year 2	Year 3	Year 4	Total

Prevention	**$1,794,761**	**$1,794,761**	**$1,794,761**	**$1,794,761**	**$8,004,040**
PREV: PrEP-SD	$175,250	$175,250	$175,250	$175,250	$701,000
PREV: VMMC-SD	$1,619,511	$1,619,511	$1,619,511	$1,619,511	$6,478,044
Care & Treatment	**$4,212,577**	**$4,212,577**	**$4,212,577**	**$4,212,577**	**$16,850,308**
HTS: Community-based testing-SD	$40,671	$40,671	$40,671	$40,671	$162,684
HTS: Facility-based testing-SD	$175,000	$175,000	$175,000	$175,000	$700,000
C&T HIV Clinical Services-SD	$3,996,906	$3,996,906	$3,996,906	$3,996,906	$15,987,624
Health Systems Strengthening	**$119,925**	**$119,925**	**$119,925**	**$119,925**	**$479,700**
ASP: Lab systems strengthening-NSD	$119,925	$119,925	$119,925	$119,925	$479,700
Program Management	**$1,345,009**	**$1,345,009**	**$1,345,009**	**$1,345,009**	**$5,380,036**
TOTAL	**$7,472,272**	**$7,472,272**	**$7,472,272**	**$7,472,272**	**$29,889,088**

Approaches to Reaching Sustainable Epidemic Control

Proposals are requested to support the Mozambique Armed Forces (FADM) to reach sustainable control of the HIV/AIDS epidemic through the pillars of transparency, accountability, and impact.

The Recipient's program should emphasize capacity building across all activities and technical areas. All proposals should detail how the Recipient will engage the partner military leadership as well as personnel at all levels in this work; and, specifically how the partner will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Within the proposal, the Recipient will need to demonstrate transition of programmatic capabilities and capacity to the military over the life of the award.

The Recipient must work in complete coordination with the partner militaries' HIV prevention and health services, as well as the DHAPP/DoD Program Manager based at the U.S. Embassies in these countries, the DoD adult and pediatric treatment program manager based at the Military Health

Targets

Progress towards epidemic control will be successfully measured, in part, through an effective strategic information framework that monitors not only program outputs as compared to planned targets, but also key outcomes and programmatic impact.

Collection and use of disaggregated data that characterizes the populations served in the lowest geographic areas where HIV services are being provided is critical in understanding current program performance and planning for future performance. Consequently, the MER indicators continue to evolve in order to reflect the progression of USG support and global HIV response guidelines. Measuring the impact of support at national and regional above-site levels down to direct services at the site-level is paramount to DHAPP's program implementation and monitoring approach.

MER indicators are not an exhaustive list of all metrics that should be monitored by DHAPP-supported programs. DHAPP also collects a custom indicator. All programs should continually monitor and assess any acute programmatic issues and collect additional data to inform program

improvement.

The indicators listed below support a patient-centered program monitoring approach. Per the 2017 WHO Consolidated Guidelines on Person-Centered HIV Patient Monitoring and Case Surveillance, person-centered monitoring refers to a shift from monitoring measuring services (e.g., the number of individuals tested or people on treatment) to monitoring people at the center of their access to linked HIV and health services. In essence, this marks a shift to better support the clients accessing services by focusing more on their individual health outcomes.

The proposal will address approaches to reaching the following targets for military and civilian populations. Targets are listed using the associated PEPFAR Monitoring, Evaluation, and Reporting Indicator. Please see the most recent Monitoring, Evaluation, and Reporting Indicator Reference Guide for more detail at https://datim.zendesk.com/hc/en-us/articles/360000084446-MER-Indicator-Reference-Guides .

Prevention

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
1. PP_PREV	Number of priority populations reached with standardized HIV prevention intervention(s) that are evidence-based	9,996	13,251
2. VMMC_CIRC	Number of males who received a circumcision and reported a follow-up status	1,753	15,773
3. PrEP_CURR	Number of individuals, inclusive of those newly enrolled, that received PrEP	1,500	3,502
4. PrEP_NEW	Number of individuals who were newly enrolled on PrEP	1,500	3,502
5. FPINT_SITE	Number of HIV service delivery points (SDP) at a site supported by PEPFAR that are providing integrated voluntary family planning (FP) services	17	17
6. TB_PREV	Proportion of ART patients who started on a standard course of TB Preventive Treatment (TPT) in the previous reporting period who completed therapy	100% (1,047/1,047)	(100% (7,682/ 7,682)

Testing

Technical Area Targets, Year 1

Indicator	Label	Military Only	Civilian
7. HTS_INDEX	The total number of contacts who were tested for HIV and received their results	765	6,194
8. HTS_TST	Number of individuals who received HIV Testing Services (HTS) and received their test results (includes HTS_INDEX)	4,696	40,861
9. PMTCT_EID	Percentage of infants born to HIV-positive women who received a first virologic HIV test (sample collected) by 12 months of age	0% (0)	100% (439)
10. PMTCT_STAT	Percentage of pregnant women with known HIV positive status at first antenatal care visit (ANC1) (includes those who already knew their HIV positive status prior to ANC1)	100% (90)	100% (3,611)
11. TB_STAT	Percentage of new and relapsed TB cases with documented HIV status, during the reporting period	100% (102)	100% (1,397)
12. CXCA_SCRN	Number of HIV-positive women on ART screened for cervical cancer	127	2,000

Treatment

Technical Area Targets, Year 1

Indicator	Label	Military Only	Civilian
13. CXCA_TX	Percentage of cervical cancer screen-positive women who are HIV-positive and on ART eligible for cryotherapy, thermocoagulation or LEEP who received cryotherapy, thermocoagulation or LEEP	23	225
14. PMTCT_ART	Percentage of HIV-positive pregnant women who received ART to reduce the	100% (0)	100% (460)

	risk of mother-to-child-transmission (MTCT) during pregnancy		
15. TB_ART	Percentage of HIV-positive new and relapsed TB cases on ART during TB treatment	95% (71)	95% (637)
16. TX_CURR	Number of adults and children currently receiving antiretroviral therapy (ART)	2,405	21,643
17. TX_NEW	Number of adults and children newly enrolled on antiretroviral therapy (ART)	450	4,049
18. TX_TB	Percentage of ART patients screened for TB in the semiannual reporting period who start TB treatment.	100% (90)	100% (806)

Viral Suppression

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
19. TX_PVLS	Percentage of ART patients with a suppressed viral load (VL) result (<1000 copies/ml) documented in the medical or laboratory records/laboratory information systems (LIS) within the past 12 months	95% (2,118)	95% (19,063)

Technical Narrative

The Recipient will address the technical approach to each area. The Recipient will be responsible for providing the following in close collaboration with other DHAPP-funded recipients and the host military.

HIV Prevention

The Recipient will ensure that the partner military is providing standardized, evidence-based interventions that are designed to promote the adoption of HIV prevention behaviors and service uptake for all military and other uniformed services as well as other priority populations served by the military health services. These priority populations (PP) should include men that have sex with men (MSM), sex workers and their clients, displaced persons, fishing communities, mobile populations, HIV discordant couples, adolescent girls and young women and illicit drug users.

The Recipient will ensure that the following interventions for adults and youth include:

- Promotion of relevant adult- and youth-friendly prevention and clinical services and demand creation to increase awareness, acceptability, and uptake of these services;
- Information, education, and skills development to reduce HIV risk and vulnerability; correctly identify HIV prevention methods; adopt and sustain positive behavior change; and promote gender equity and supportive norms and stigma reduction;
- Referral to or provision of HIV testing; facilitated linkage to care and prevention services; and/or support services to promote use of, retention in, and adherence to care;
- Condom and lubricant (where feasible) promotion, skills building, and facilitated access to condoms and lubricant (where feasible) through direct provision or linkages to social marketing and/or other service outlets;
- Programs targeting adults to raise awareness of HIV risks for young people, promote positive parenting and mentoring practices, and effective adult-child communication about sexuality and sexual risk reduction.

Voluntary Male Medical Circumcision

The Recipient will ensure that the FADM is following PEPFAR guidance, WHO recommendations and the national guidelines for conducting VMMC. The full package of VMMC services will be offered including:

- Demand creation, VMMC education, safe sex practices and provision of condoms;
- HIV screening or testing* (see addendum below) for all clients and tracked referral to HIV treatment programs for those who test HIV positive for same-day initiation of ART;
- Examination and evaluation for active sexually transmitted infections (STI);
- STI-positive persons will be deferred from VMMC and referred for immediate treatment of STI as well as counseled to return for VMMC when STI is resolved;
- Post-VMMC wound care and safe sex education including promotion of 6-week abstinence period post-VMMC;
- Effective monitoring and reporting of VMMC program data and adverse events as well as linked STI and HIV program data;

The Recipient will follow all PEPFAR adverse event reporting protocols for any notifiable adverse events (NAE) occurring during the VMMC procedure or within 30 days following surgical circumcision. This includes notifying the PEPFAR Funding Agency point of contact (POC) and the Mozambique PEPFAR Coordinator within 24 hours of the NAE occurring. The Recipient will collaborate with other PEPFAR VMMC recipients to ensure VMMC coverage in scale up districts and populations.

The Recipient will offer surgical VMMCs, only to males 15 years of age and older, or Shang Ring to boys 10-14 years of age and older with immature penile anatomy..

VMMC activities will be implemented concurrently with other component activities such as HIV Testing Services, treatment for STIs, promotion of safer-sex practices and condom distribution.

VMMC Strategy:

5. Recruits: In an effort to offer 100% VMMC coverage in the FADM in an efficient manner, the Recipient will support the FADM in their routine offer of VMMC to FADM recruits within the recruit training period;
6. Active Duty Males: The Recipient will support the FADM in holding campaigns at garrisons and camps for VMMC demand creation;
7. Civilians: The Recipient will support the national VMMC program in conducting VMMC for civilians in DoD allocated PEPFAR VMMC scale-up districts, targeting high risk- males between the ages of 15-29 years old;
8. High risk men: The Recipient will build strong referral systems to reach and offer VMMC to: a) STI patients (post treatment), b) alcohol risk reduction clients, 3) partners of HIV positive persons, 4) other men who are identified as high risk for HIV.

*Testing in VMMC settings.
Testing in VMMC settings has historically produced very low HIV yields and may be replaced with screening using a validated tool. Validation should be conducted in at least one large VMMC site to determine if the tool is screening out the right people (HIV-negative) yet not also screening out the wrong people (HIV-positive who are not yet diagnosed). Evaluation of the screening tool should include:

- Test a number of men who seek VMMC services based on established sample size calculation using appropriate HIV prevalence estimates;
- The screening tool performance should be compared with universal national HIV testing algorithm results for all persons using a standard two by two table. Screening tool sensitivity, specificity as well as positive and negative predictive values will allow an informed decision to be made on tool performance and guide modifications;
- Test yields for universal and pre-screening should be compared;
- Technical assistance for this work is available from DHAPP.

HIV Testing Services

Finding the remaining persons who are living with HIV (PLHIV) infection is the first priority for reaching HIV epidemic control. Current epidemiology shows that most of those who do not yet know about their infection are men. The FADM HIV/AIDS program is strategically placed to reach men; therefore, the Recipient will work closely with the FADM on HIV Testing Services (HTS), particularly index testing, in an effort to achieve the “first 95” for military personnel: 95% of all FADM personnel living with HIV know their status.

HTS will focus primarily on index testing to provide high yield testing to those most at risk for infection. The local epidemiology and situational analysis should guide the use of other testing methodologies to identify those who are living with HIV.

Where possible, a rapid test for recent infection (RTRI) should be conducted for all of those found to be newly positive. Those who test positive are classified as “probable recent HIV infections” until results of viral load are available. The index testing of these persons should receive high priority and robust efforts should be made to reach all contacts.

Provider-Initiated Testing and Counseling (PITC) will continue in the fixed sites for both the military and civilian cohorts. PITC should focus in clinical areas that have shown a high yield such as tuberculosis (TB) and STI clinics.

Ensuring that any clients with positive results are linked to HIV care and treatment is essential to the success of the FADM program. The Recipient should work to achieve 100% linkage of HIV-positive individuals identified. The Recipient will monitor HIV testing yield, modifying strategies or locations that are not identifying and/or linking significant numbers of HIV positive persons to HIV care and treatment.

The Recipient will be responsible for:

- HTS to military bases and facilities:
    - Diagnosing FADM PLHIV with 95% of those diagnosed linked to HIV care and treatment services;
    - Index-case testing for all sexual partners of HIV-infected military personnel and civilians;
    - Index-case testing for all children under 15 years of age with HIV-infected mothers;
    - Index clients should also be offered self-testing for partners if they do not volunteer for partner notification;
- HTS to military bases and facilities, ensuring that all of those diagnosed are linked to HIV treatment services and receive same day initiation of ART;
- Self-testing should be made available for military personnel, AGYW and their partners, male partners of ANC clients, sex workers, MSM and other key and priority populations (young men and at-risk males) that face high levels of stigma and discrimination. Following self-testing, facility referral and the regular diagnostic algorithm can be used according to national standards. It is vital to engage community groups to advocate for, design, implement, and analyze the success of HIVST;
- Quality improvement and quality assurance for all FADM HTS including continuous training and mentoring and supervision visits, at least quarterly;
- Conducting proficiency testing for all HTS sites and individuals;
- Tracking PLHIV from HTS to clinical care and treatment services;
- Linking males to VMMC services.

HIV Treatment

Support for treatment of HIV is an essential component of this PA. The following issues should be considered in supporting the treatment of PLHIV in military populations.

Dolutegravir (DTG)-containing regimens are the preferred first-line antiretroviral therapies (ART) due to superior efficacy, tolerability and higher threshold for resistance compared to efavirenz (EFV)-containing regimens. The fixed dose combination (FDC) of tenofovir disoproxil fumarate/lamivudine/dolutegravir (TLD) is currently priced as the least expensive FDC, and it is expected that prices will go down as generic manufacturing scales up. For these reasons, DHAPP now recommends TLD as the preferred option for ART, and further recommends that DHAPP-supported programs switch over to TLD as soon as possible in a coordinated fashion as supply

becomes available.

Programs should carefully assess the risks and benefits of TLD in child-bearing age women. See published updated from WHO and PEPFAR to further understand the high benefits in the face of a potential NTD signal.

Children (< 20kg) are not expected to be included in the initial roll-out of TLD. Development of pediatric DTG formulations and evaluation of appropriate DTG dosing in infants and children are underway.

A priority of HIV programs is to find, diagnose and treat people with TB disease and ensure that they become non-infectious. For all those who do not have active tuberculosis, prevention of TB is a priority using nationally approved TB preventive therapy (TPT).

TPT must be scaled up for all PLHIVs as an integral part of the clinical care package. Recipients are expected to increase the use of TB diagnostic testing within DHAPP-supported HIV care and treatment facilities and promote the use of TPT as a routine part of HIV care. In short, all newly-diagnosed HIV persons should be offered TB treatment or preventive therapy, and all persons assessed for TB should be tested for HIV.

Programs should have clear policies and/or guidelines for the use of TPT, and should plan for programmatic and clinical trainings, procurement and supply management, adequate diagnostic capacity (including specimen transportation) and development of appropriate data collection systems. In Global Fund high-impact countries implementing joint TB/HIV awards, Recipients should also seek opportunities to support effective joint program implementation.

Additionally, Recipients should implement TB infection prevention and control activities to minimize the risk of TB transmission and provide safe health seeking environment. This is critical in DHAPP-supported settings where clients at high risk for TB and HIV often co-mingle. It also puts the health care workers at the highest risk of contracting TB disease. Activities aimed at preventing transmission at facility-level include administrative and environmental controls, and the availability and use of personal protective equipment.

Cervical cancer screening for HIV+ women should be integrated into routine HIV treatment services in each country program. A “screen-and-treat” approach is recommended for the management of precancerous lesions to maximize opportunities for immediate cryotherapy or thermal ablation treatment for eligible women without the need for diagnostic pathology confirmation and to reduced loss to follow-up.

Viral Load (VL) Scale-up

Sustained viral suppression of all PLHIV is the key to HIV epidemic control. To this end, the Recipient will work closely with the FADM to scale-up VL testing coverage and suppression in an effort to achieve 95-95-95 goals for military personnel. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 95: 95% viral suppression among PLHIV taking ART.

The Recipient should ensure the partner military has access to timely VL testing and that capacity exists to test at least 95% of persons currently on ART annually. To ensure this capacity the appropriate use of both plasma and dried blood spots (DBS) should be considered to increase access to routine VL monitoring.

DBS are easy to collect and store under field conditions, no phlebotomist required, easy to transport to centralized laboratories, reduced cost associated with collection materials and transportation under ambient temperature. The DBS technology is applicable to both adult and pediatric populations and the small volume of blood required for preparing DBS makes it suitable for pediatric populations.

The Recipient will ensure that VL results are made available in a reasonable amount of time to both the health care provider and the client. These results should be used to ensure that those who are not virally suppressed are linked to adherence support and close follow-up leading to either suppression or ART modification as needed. Those who are suppressed should be encouraged to stay suppressed and should be offered differentiated models of care, including multi-month supplies of ART and fast-tracking, as an incentive, and given the message that undetectable equals untransmittable (U=U).

Health System Strengthening

DHAPP is working to enhance the ability of governments to manage their epidemics, respond to broader health needs impacting affected communities, and address new and emerging health concerns. Activities include the following:

6. Laboratory capacity building

   The Recipient will be responsible for:

   - Inventory control, forecasting, and ensuring the procurement of laboratory reagents to ensure that laboratory services are uninterrupted;
   - Procurement of service maintenance contracts, calibration of equipment, and training of the laboratory staff on the use of the equipment;
   - Ensuring quality improvement of laboratories using Site Improvement Monitoring System (SIMS), Strengthening Laboratory Management Toward Accreditation (SLMTA) and Stepwise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA) to reach full ISO 15189 accreditation of main laboratories; and quality improvement of all satellite laboratories and HIV test sites.
   - Monitoring laboratory quality and adherence to quality systems, method validation, provision of proficiency testing panels for rapid HIV testing, viral load, CD4, TB, STI and other tests critical to HIV epidemic control;
   - Conducting routine visits to laboratories to assess achievements, review/evaluate activities, and provide recommendations with the development of improvement plans to resolve any identified problems;
   - Linking FADM laboratory services to other laboratory resources at the district, provincial, and national levels.

The procurement of supplies, support, and equipment should use government and other donor sources when possible (Ministry of Health, Ministry of Defense, Global Fund, etc).

DHAPP will continue to reduce its overall level of support for CD4 testing to prioritize access to VL testing. CD4 count is not needed to determine eligibility for ART (and continued CD4 testing may perpetuate the belief that CD4 count thresholds are criteria for initiating ART) and, as reflected in current WHO guidelines, CD4 is inferior to VL for treatment monitoring.

DHAPP's priority is access to critical HIV treatment monitoring, which is through use of VL, and which should be conducted at least once annually for stable patients and more frequently for new, unstable and pediatric patients.

Site Improvement through Monitoring System (SIMS)

The purpose of SIMS is to provide a standardized approach and set of tools for monitoring program quality at DHAPP-supported sites and entities that guide and support service delivery. SIMS assessment results are used to strengthen alignment with global and national standards and facilitate program improvement as a component of an overall quality management strategy. SIMS is also used to identify performance issues that may impact patient outcomes or the integrity of reporting for MER targets or disaggregates. Low final scores (reds and yellows) from these core essential elements (CEEs) highlight potential issues with service delivery, site performance or oversight, and/or documentation of patient results. Site-level triangulation of MER and SIMS data can be used to contextualize performance and could be useful to determine if performance challenges at a site are due to issues related to the underlying quality of service provision.

Site Improvement through Monitoring System (SIMS) aims to: (1) facilitate improvement in the quality of DHAPP-supported services and technical assistance, (2) ensure accountability of U.S. government investments, and (3) maximize impact on the HIV epidemic.

SIMS assessment results confirm compliance to minimum quality assurance standards and identify areas where improvements in DHAPP-supported programs can be made.

Programs should conduct SIMS assessments in accordance with DHAPP guidance and Recipients are responsible for taking corrective action for items within the Recipient SOW and per discussion with DHAPP USG staff.

Client, Patient, and Program Data Monitoring

Successful collection, evaluation, and use of client/patient level data is critical to good patient care and to the success of the partner military HIV program's ability to monitor progress towards epidemic control. The Recipient will work with the partner military and Ministry of Health (MOH) or other organizations, as appropriate, to support the collection of patient-level data, the clinical and programmatic use of data, and the reporting of site-level data to DHAPP HQ and the partner military leadership.

The Recipient will be responsible for:

- Staffing, support, and mentoring of existing partner military staff for paper and electronic data entry
- Timely, accurate reporting of all indicators required by the partner military and DHAPP
- Ensuring confidentiality and security of data, in line with Ministry of Defense (MOD), Ministry of Health (MOH), and national guidelines from clinic to storage to dissemination.
- Securing all patient-level and site-level data from dissemination outside of the partner military and DHAPP without prior approval from the partner military
- Support for paper and electronic data entry, cleaning, reporting, and use

Data Quality

Measuring the success of HIV/AIDS initiatives requires strong monitoring and evaluation (M&E) systems that produce high quality data. Efforts to ensure data quality, therefore, are not singular events occurring randomly. Rather, these processes need to become institutionalized as part routine data management processes. Once achieved, data quality helps to ensure that limited resources are used effectively, progress toward established goals are accurately monitored, and that decisions are based on strong evidence. Attention to data quality ensures that target-setting and results reporting are informed by valid and sensitive information, and that all partners are thinking about and collecting and organizing this information in the same manner. In this way, attention to data quality leads to improved program performance and to more efficient resource management.

Data quality has always been a focus of global HIV monitoring and reporting efforts. Specifically, all countries conducting programming supported by DHAPP are expected to have a data quality strategy in place. For example, data quality assessments (DQAs) should be conducted routinely and action should be taken as a result of these DQAs. If errors are identified in data, these should be remediated at the point of service delivery as well as in the DHAPP and host-country reporting systems as soon as possible. Standard operating procedures for routine data quality review should also be in place. Data should be routinely reviewed for errors before submission to ensure that the data passes the data quality checks outlined within the guidance, the DC2 validations, and the Data for Accountability, Transparency, and Impact Monitoring (DATIM) Data Review Tool.

Virtual Communities of Practice

The Recipient should support the development of virtual communities of practice (vCoP). These evidence-based, virtual, face-to-face health workforce development and collaborative problem-solving platforms, serve to create ongoing dialogue and collaboration among key staff in the military health care systems. They provide a consistent platform for conducting low-dose, high-frequency learning and collaboration sessions. The goal is to build a vCoP for each partner military where DHAPP works in collaboration with DHAPP HQ, field staff and other Recipients working in that country.

Key requirements are equipment and connectivity as well as personnel who can coordinate, manage and lead regular vCoP sessions. These roles may need to be held by the Recipient until they can be transitioned to the partner military.

Work Plans

The Recipient must submit annual, programmatic and financial, work plans to the DHAPP Program Manager and DHAPP HQ (budget breakdown per activity and for program management is required). Work plans should include an activities implementation timeline as well as monitoring and evaluation timeline.

Togo: DHAPP—Armed Forces of Togo (FAT) Partnership for Sustainable HIV Epidemic Control

NOTE: Application submissions for this narrative are due by 5pm ET on February 5, 2021. Submission received after the deadline will not be considered for funding

Introduction

The HIV/AIDS epidemic has been devastating and negatively affected many militaries and other uniformed organizations worldwide by reducing military readiness, limiting deployments, causing physical and emotional decline in infected individuals and their families, posing risks to military personnel and their extended communities, and impeding peacekeeping activities. As HIV management improves, many of these impacts are disappearing; however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries in addition to other long-term chronic disease management issues.

The U.S. Government (USG) has a long history of international collaboration and partnerships in the fight against HIV/AIDS, providing funding, technical assistance, and program support. These collaborations are all contributing to HIV epidemic control.

Over the years, the United States Department of Defense (DoD) HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries in an effort to control the HIV epidemic among their respective military services. DHAPP is the DoD implementing agency collaborating with the U.S. Department of State, the Health Resources and Services Administration, Peace Corps, U.S. Agency for International Development (USAID), and the Centers for Disease Control and Prevention (CDC), in the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). DHAPP receives funding for its programs from two sources: a congressional plus-up to the Defense Health Program (DHP) and funding transfers from the Department of State for PEPFAR. Working closely with DoD, U.S. Unified Combatant Commanders, Joint United Nations Programme on HIV/AIDS (UNAIDS), university collaborators, and other nongovernmental organizations (NGOs), DHAPP's mission is to build capable military partners through military-specific, culturally focused, HIV/AIDS cooperation and assistance.

In the Defense Security Cooperation Agency guidance, the U.S. Secretary of Defense has identified HIV/AIDS in foreign militaries as a national security issue. Pursuing HIV/AIDS activities with foreign militaries is clearly tied to security interests, regional stability, humanitarian concerns, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing societies. DHAPP employs an integrated bilateral and regional strategy for HIV/AIDS cooperation and security assistance. DHAPP implements bilateral and regional strategies in coordination with respective Combatant Commands (COCOMs) and Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the US Under Secretary of Defense for Policy and by the Office of the Global AIDS Coordinator (OGAC). DHAPP provides strategic information and supports defense forces in HIV prevention, care, and treatment for HIV-infected individuals and their families.

PEPFAR adopted the UNAIDS global 95-95-95 (formerly 90-90-90) goals that state by 2030: 95% of people with HIV are diagnosed, 95% of them are on antiretroviral therapies (ART) and 95% of them are virally suppressed.

PEPFAR Monitoring, Evaluation, and Reporting (MER) indicators are collected and reported to efficiently use data to drive decision-making and focus HIV programming in the right geographic areas. DHAPP uses the same program indicators for DHP and PEPFAR-funded programs. DHAPP collects MER indicator results on a quarterly, semi-annual, and annual basis, depending on indicator and data are reported at the site level to DHAPP. These data allow DHAPP to analyze and evaluate gaps in programming and achievement and identify needs for shifts to reach our shared goals. Due to security sensitivities regarding military site locations and troop movement, all site-level data are analyzed at DHAPP headquarters and summary data are reported to OGAC so that other USG country team agencies can review military program results aggregated at the national level.

Transition to Local Partners: Local partners are encouraged to apply to this announcement. To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and community-based and community-led organizations – regardless of current antiretroviral (ARV) coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term, local partner engagement and impact.

All respondents must demonstrate the active support of the in-country military and the DoD representative in the corresponding U.S. Embassy in the planning and execution of their proposals.

In fiscal year (FY) 2019, DHAPP supported 52 active HIV programs, mainly through direct military-to-military cooperation in addition to support from contracting external organizations and academic institutions to assist with specific aspects of proposed programs. Partners in FY19 included 35 NGOs and universities working in 46 countries.

Estimated Budget to be used as Framework

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Total**
Program Management	**$62,000**	**$62,000**	**$62,000**	**$62,000**	**$248,000**
Care & Treatment	**$57,600**	**$57,600**	**$57,600**	**$57,600**	**$230,400**
HIV clinical services - NSD	$57,600	$57,600	$57,600	$57,600	$230,400
Socio-Economic	**$30,200**	**$30,200**	**$30,200**	**$30,200**	**$120,800**
Case Management - SD	$30,200	$30,200	$30,200	$30,200	$120,800
HIV Testing Services	**$57,000**	**$57,000**	**$57,000**	**$57,000**	**$228,000**
Testing: Not disaggregated - NSD	$57,000	$57,000	$57,000	$57,000	$228,000
Prevention	**$64,600**	**$64,600**	**$64,600**	**$64,600**	**$258,400**
Prevention: Not disaggregated - NSD	$64,600	$64,600	$64,600	$64,600	$258,400

Above Site Programming	**$41,600**	**$41,600**	**$41,600**	**$41,600**	**$166,400**
Laboratory systems strengthening	$41,600	$41,600	$41,600	$41,600	$166,400
TOTAL	**$313,000**	**$313,000**	**$313,000**	**$313,000**	**$1,252,000**

Approaches to Reaching Sustainable Epidemic Control

Proposals are requested to support the Armed Forces of Togo (FAT) to reach sustainable control of the HIV/AIDS epidemic through the pillars of transparency, accountability, and impact.

The Recipient's program should emphasize capacity building across all activities and technical areas. All proposals should detail how the Recipient will engage the partner military leadership as well as personnel at all levels in this work; and, specifically how the Recipient will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Within the proposal, the Recipient will need to demonstrate transition of programmatic capabilities and capacity to the military over the life of the award.

The Recipient must work in complete coordination with the partner militaries' HIV prevention and health services, as well as the DHAPP/DoD Program Manager based at the U.S. Embassies in these countries, the DoD adult and pediatric treatment program manager based at the Military Health Department, other DHAPP supported Recipients working in these countries, other bilateral and multilateral agencies with similar objectives and the DHAPP Headquarters Team.

Targets

Progress towards epidemic control will be successfully measured, in part, through an effective strategic information framework that monitors not only program outputs as compared to planned targets, but also key outcomes and programmatic impact.

Collection and use of disaggregated data that characterize the populations served in the lowest geographic areas where HIV services are being provided are critical in understanding current program performance and planning for future performance. Consequently, the MER indicators continue to evolve in order to reflect the progression of USG support and global HIV response guidelines. Measuring the impact of support at national and regional above-site levels down to direct services at the site-level is paramount to DHAPP's program implementation and monitoring approach.

MER indicators are not an exhaustive list of all metrics that should be monitored by DHAPP-supported programs. DHAPP also collects a custom indicator. All programs should continually monitor and assess any acute programmatic issues and collect additional data to inform program improvement.

The indicators listed below support a patient-centered program monitoring approach. Per the 2017

WHO Consolidated Guidelines on Person-Centered HIV Patient Monitoring and Case Surveillance, person-centered monitoring refers to a shift from monitoring measuring services (e.g., the number of individuals tested or people on treatment) to monitoring people at the center of their access to linked HIV and health services. In essence, this marks a shift to better support the clients accessing services by focusing more on their individual health outcomes.

The proposal will address approaches to reaching the following targets for military and civilian populations. Targets are listed using the associated PEPFAR MER Indicator. Please see the most recent MER Indicator Reference Guide for more detail at https://datim.zendesk.com/hc/en-us/articles/360000084446-MER-Indicator-Reference-Guides.

Prevention

Technical Area Targets, Year 1		
Indicator	**Label**	**Military**
FPINT_SITE	Number of HIV service delivery points (SDP) at a site supported by PEPFAR that are providing integrated voluntary family planning (FP) services	17
PP_PREV	Number of priority populations (PP) reached with the standardized, evidence-based intervention(s) required that are designed to promote the adoption of HIV prevention behaviors and service uptake	4,200

Testing

Technical Area Targets, Year 1			
Indicator	**Label**	**Military**	**Civilian**
HTS_INDEX	Number of individuals who were identified and tested using Index testing services and received their results	100	480
HTS_TST	Number of individuals who received HIV Testing Services (HTS) and received their test results	263	1,289
PMTCT_EID	Percentage of infants born to HIV-positive women who received a first virologic HIV test (sample collected) by 12 months of age	95%	95%

PMTCT_STAT	Percentage of pregnant women with known HIV status at antenatal care (includes those who already knew their HIV status prior to ANC)	100%	100%

Treatment

Technical Area Targets, Year 1			
Indicator	**Label**	**Military**	**Civilian**
PMTCT_ART	Percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy	100%	100%
TX_CURR	Number of adults and children currently receiving antiretroviral therapy (ART)	310	1,351
TX_NEW	Number of adults and children newly enrolled on antiretroviral therapy (ART)	27	129

Viral Suppression

Technical Area Targets, Year 1			
Indicator	**Label**	**Military**	**Civilian**
TX_PVLS	Percentage of ART patients with a suppressed viral load (VL) result (<1000 copies/ml) documented in the medical or laboratory records/laboratory information systems (LIS) within the past 12 months	95%	95%

Technical Narrative

The Recipient will address the technical approach to each area. The Recipient will be responsible for providing the following in close collaboration with other DHAPP-funded Recipients and the host military.

HIV Prevention

The Recipient will ensure that the partner military is providing standardized, evidence-based interventions that are designed to promote the adoption of HIV prevention behaviors and service uptake for all military and other uniformed services as well as other priority populations served by the military health services. These priority populations (PP) should include men that have sex with men (MSM), sex workers and their clients, displaced persons, fishing communities, mobile populations, HIV serodiscordant couples, adolescent girls and young women and illicit drug users.

The Recipient will ensure that the following interventions for adults and youth include:

- Promotion of relevant adult- and youth-friendly prevention and clinical services and demand creation to increase awareness, acceptability, and uptake of these services.
- Information, education, and skills development to reduce HIV risk and vulnerability; correctly identify HIV prevention methods; adopt and sustain positive behavior change based on SABERS findings; and promote gender equity and supportive norms and stigma reduction.
- Referral to or provision of HIV testing; facilitated linkage to care and prevention services; and/or support services to promote use of, retention in, and adherence to care.
- Condom and lubricant (where feasible) promotion, skills building, and facilitated access to condoms and lubricant (where feasible) through direct provision or linkages to social marketing and/or other service outlets.
- Programs targeting adults to raise awareness of HIV risks for young people, promote positive parenting and mentoring practices, and effective adult-child communication about sexuality and sexual risk reduction.

HIV Testing Services

Finding the remaining persons who are living with HIV infection is the first priority for reaching HIV epidemic control. Current epidemiology shows that most of those who do not yet know about their infection are men. The FAT HIV/AIDS program is strategically placed to reach men; therefore, the Recipient will work closely with the FAT on HIV Testing Services (HTS), particularly index testing, in an effort to achieve the “first 95” for military personnel: 95% of all FAT personnel living with HIV know their status.

HTS will focus primarily on index testing to provide high yield testing to those most at risk for infection. The local epidemiology and situational analysis should guide the use of other testing methodologies to identify those who are living with HIV.

Where possible, a rapid test for recent infection (RTRI) should be conducted for all of those found to be newly positive. Those who test positive are classified as “probable recent HIV infections” until results of viral load are available. The index testing of these persons should receive high priority and robust efforts should be made to reach all contacts.

Provider-Initiated Testing and Counseling (PITC) will continue in the fixed sites for both the military and civilian cohorts. PITC should focus in clinical areas that have shown a high yield such as tuberculosis (TB) and sexually transmitted infections (STI) clinics.

Ensuring that any clients with positive test results identified are linked to HIV care and treatment is essential to the success of the FAT program. The Recipient should work to achieve 100% linkage of HIV-positive individuals identified. The Recipient will monitor HIV testing yield; modifying strategies or locations that are not identifying and/or linking significant numbers of HIV positive persons to HIV care and treatment.

The Recipient will be responsible for:

- HTS to military bases and facilities
    - Diagnosing 140 PLHIV with 95% of those diagnosed linked to HIV care and treatment services
    - Index-case testing for all sexual partners of HIV-infected military personnel and civilians
    - Index-case testing for all children under 15 years of age with HIV-infected mothers.
    - Index clients should also be offered self-testing for partners if they do not volunteer for partner notification.
- HTS to military bases and facilities, ensuring that all of those diagnosed are linked to HIV treatment services and receive same day initiation of ART.
- Quality improvement and quality assurance for all FAT HTS including continuous training and mentoring and supervision visits, at least quarterly
- Conducting proficiency testing for all HTS sites and individuals
- Tracking PLHIV from HTS to clinical care and treatment services.

HIV Treatment

Support for treatment of HIV is an essential component of this PA. The following issues should be considered in supporting the treatment of people living with HIV (PLHIV) in military populations.

Dolutegravir (DTG)-containing regimens are the preferred first-line antiretroviral therapies (ART) due to superior efficacy, tolerability and higher threshold for resistance compared to efavirenz (EFV)-containing regimens. The fixed dose combination (FDC) of tenofovir disoproxil fumarate/lamivudine/dolutegravir (TLD) is currently priced as the least expensive FDC, and it is expected that prices will go down as generic manufacturing scales up. For these reasons, DHAPP now recommends TLD as the preferred option for ART, and further recommends that DHAPP-supported programs switch over to TLD as soon as possible in a coordinated fashion as supply becomes available.

Programs should carefully assess the risks and benefits of TLD in child-bearing age women. See published updated from WHO and PEPFAR to further understand the high benefits in the face of a potential NTD signal.

Children (< 20kg) are not expected to be included in the initial roll-out of TLD. Development of pediatric DTG formulations and evaluation of appropriate DTG dosing in infants and children are underway.

A priority of HIV programs is to find, diagnose and treat people with TB disease and ensure that they become non-infectious. For all those who do not have active TB, prevention of TB is a

priority using nationally approved TB preventive therapy (TPT).

TPT must be scaled up for all PLHIVs as an integral part of the clinical care package. Recipients are expected to increase the use of TB diagnostic testing within DHAPP-supported HIV care and treatment facilities and promote the use of TPT as a routine part of HIV care. In short, all newly diagnosed HIV persons should be offered TB treatment or preventive therapy and all persons assessed for TB should be tested for HIV.

Programs should have clear policies and/or guidelines for the use of TPT, and should plan for programmatic and clinical trainings, procurement and supply management, adequate diagnostic capacity (including specimen transportation) and development of appropriate data collection systems. In Global Fund high-impact countries implementing joint TB/HIV grants, Recipients should also seek opportunities to support effective joint program implementation.

Additionally, Recipients should implement TB infection prevention and control activities to minimize the risk of TB transmission and provide safe health seeking environment. This is critical in DHAPP-supported settings where clients at high risk for TB and HIV often co-mingle. It also puts the health care workers at the highest risk of contracting TB disease. Activities aimed at preventing transmission at facility-level include administrative and environmental controls, and the availability and use of personal protective equipment.

A priority of HIV programs is to find, diagnose and treat HIV-positive pregnant women to ensure that they do not transmit HIV to their children. Additionally, cervical cancer screening for HIV+ women should be integrated into routine HIV treatment services in each country program. A “screen-and-treat” approach is recommended for the management of precancerous lesions to maximize opportunities for immediate cryotherapy or thermal ablation treatment for eligible women without the need for diagnostic pathology confirmation and to reduce loss to follow-up.

Viral Load (VL) Scale-up

Sustained viral suppression of all PLHIV is the key to HIV epidemic control. To this end, the Recipient will work closely with the FAT to scale-up VL testing coverage and suppression in an effort to achieve 95-95-95 goals for military personnel. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 95: 95% viral suppression among PLHIV taking ART.

The Recipient should ensure the partner military has access to timely VL testing and that capacity exists to test at least 95% of persons currently on ART annually. To ensure this capacity the appropriate use of both plasma and dried blood spots (DBS) should be considered to increase access to routine viral load monitoring.

DBS are easy to collect and store under field conditions, no phlebotomist required, easy to transport to centralized laboratories, reduced cost associated with collection materials and transportation under ambient temperature. The DBS technology is applicable to both adult and pediatric populations and the small volume of blood required for preparing DBS makes it suitable for pediatric populations.

The Recipient will ensure that VL results are made available in a reasonable amount of time to both

the health care provider and the client. These results should be used to ensure that those who are not virally suppressed are linked to adherence support and close follow-up leading to either suppression or ART modification as needed. Those who are suppressed should be encouraged to stay suppressed and should be offered differentiated models of care, including multi-month supplies of ART and fast-tracking as an incentive, and given the message that undetectable equals untransmittable (U=U).

Health System Strengthening

DHAPP is working to enhance the ability of governments to manage their epidemics, respond to broader health needs impacting affected communities, and address new and emerging health concerns. Activities include the following:

7. Laboratory capacity building

   The Recipient will be responsible for:

   - Inventory control, forecasting, and ensuring the procurement of laboratory reagents to ensure that laboratory services are uninterrupted.
   - Procurement of service maintenance contracts, calibration of equipment, and training of the laboratory staff on the use of the equipment.
   - Ensuring quality improvement of laboratories using Site Improvement Monitoring System (SIMS), Strengthening Laboratory Management Toward Accreditation (SLMTA) and Stepwise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA) to reach full ISO 15189 accreditation of main laboratories and quality improvement of all satellite laboratories and HIV test sites.
   - Monitoring laboratory quality and adherence to quality systems, method validation, provision of proficiency testing panels for rapid HIV testing, VL, CD4, TB, STI and other tests critical to HIV epidemic control.
   - Conducting routine visits to laboratories to assess achievements, review/evaluate activities, and provide recommendations with the development of improvement plans to resolve any identified problems.
   - Linking FAT laboratory services to other laboratory resources at the district, provincial, and national levels.

The procurement of supplies, support, and equipment should use government and other donor sources when possible (Ministry of Health, Ministry of Defense, Global Fund, etc.).

DHAPP will continue to reduce its overall level of support for CD4 testing to prioritize access to VL testing. CD4 count is not needed to determine eligibility for ART (and continued CD4 testing may perpetuate the belief that CD4 count thresholds are criteria for initiating ART) and, as reflected in current WHO guidelines, CD4 is inferior to viral load for treatment monitoring.

DHAPP's priority is access to critical HIV treatment monitoring which is through use of VL and should be conducted at least once annually for stable patients and more frequently for new, unstable and pediatric patients.

Site Improvement through Monitoring System (SIMS)

The purpose of SIMS is to provide a standardized approach and set of tools for monitoring program

quality at DHAPP-supported sites and entities that guide and support service delivery. SIMS assessment results are used to strengthen alignment with global and national standards and facilitate program improvement as a component of an overall quality management strategy. SIMS is also used to identify performance issues that may impact patient outcomes or the integrity of reporting for MER targets or disaggregates. Low final scores (reds and yellows) from these core essential elements (CEEs) highlight potential issues with service delivery, site performance or oversight, and/or documentation of patient results. Site-level triangulation of MER and SIMS data can be used to contextualize performance and could be useful to determine if performance challenges at a site are due to issues related to the underlying quality of service provision.

SIMS aims to: (1) facilitate improvement in the quality of DHAPP-supported services and technical assistance, (2) ensure accountability of USG investments, and (3) maximize impact on the HIV epidemic.

SIMS assessment results confirm compliance to minimum quality assurance standards and identify areas where improvements in DHAPP-supported programs can be made.

Programs should conduct SIMS assessments in accordance with DHAPP guidance, and Recipients are responsible for taking corrective action for items within the Recipient SOW and per discussion with DHAPP USG staff.

Client, Patient, and Program Data Monitoring

Successful collection, evaluation, and use of client/patient level data are critical to good patient care and to the success of the partner military HIV program's ability to monitor progress towards epidemic control. The Recipient will work with the partner military and Ministry of Health (MOH) or other organizations, as appropriate, to support the collection of patient-level data, the clinical and programmatic use of data, and the reporting of site-level data to DHAPP HQ and the partner military leadership.

The Recipient will be responsible for:

- Staffing, support, and mentoring of existing partner military staff for paper and electronic data entry.
- Timely, accurate reporting of all indicators required by the partner military and DHAPP.
- Ensuring confidentiality and security of data, in line with Ministry of Defense (MOD), MOH, and national guidelines from clinic to storage to dissemination.
- Securing all patient-level and site-level data from dissemination outside of the partner military and DHAPP without prior approval from the partner military.
- Support for paper and electronic data entry, cleaning, reporting, and use.

Data Quality

Measuring the success of HIV/AIDS initiatives requires strong monitoring and evaluation (M&E) systems that produce high quality data. Efforts to ensure data quality, therefore, are not singular events occurring randomly. Rather, these processes need to become institutionalized as part routine data management processes. Once achieved, data quality helps to ensure that limited resources are used effectively, progress toward established goals are accurately monitored, and that decisions are based on strong evidence. Attention to data quality ensures that target-setting

and results reporting are informed by valid and sensitive information, and that all partners are thinking about and collecting and organizing this information in the same manner. In this way, attention to data quality leads to improved program performance and to more efficient resource management.

Data quality has always been a focus of global HIV monitoring and reporting efforts. Specifically, all countries conducting programming supported by DHAPP are expected to have a data quality strategy in place. For example, data quality assessments (DQAs) should be conducted routinely and action should be taken as a result of these DQAs. If errors are identified in data, these should be remediated at the point of service delivery as well as in the DHAPP and host-country reporting systems as soon as possible. Standard operating procedures for routine data quality review should also be in place. Data should be routinely reviewed for errors before submission to ensure that the data passes the data quality checks outlined within the guidance, the DC2 validations, and the Data for Accountability, Transparency, and Impact Monitoring (DATIM) Data Review Tool.

Virtual Communities of Practice

The Recipient should support the development of virtual communities of practice (vCoP). These evidence-based, virtual, face-to-face health workforce development and collaborative problem-solving platforms, serve to create ongoing dialogue and collaboration among key staff in the military health care systems. They provide a consistent platform for conducting low-dose, high-frequency learning and collaboration sessions. The goal is to build a vCoP for each partner military where DHAPP works in collaboration with DHAPP HQ, field staff and other Recipients working in that country.

Key requirements are equipment and connectivity as well as personnel who can coordinate, manage and lead regular vCoP sessions. These roles may need to be held by the Recipient until they can be transitioned to the partner military.

Work Plans

The Recipient must submit annual, programmatic and financial, work plans to the DHAPP Program Manager and DHAPP HQ (budget breakdown per activity and for program management is required). Work plans should include an activities implementation timeline as well as monitoring and evaluation timeline.

Uganda: DHAPP—Uganda People's Defense Force (UPDF) Partnership for Sustainable HIV Epidemic Control

NOTE: Application submissions for this narrative are due by 5pm ET on February 5, 2021. Submission received after the deadline will not be considered for funding

Introduction

The HIV/AIDS epidemic has been devastating and negatively affected many militaries and other uniformed organizations worldwide by reducing military readiness, limiting deployments, causing physical and emotional decline in infected individuals and their families, posing risks to military personnel and their extended communities, and impeding peacekeeping activities. As HIV management improves, many of these impacts are disappearing, however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries in addition to other long-term chronic disease management issues.

The U.S. Government (USG) has a long history of international collaboration and partnerships in the fight against HIV/AIDS, providing funding, technical assistance, and program support. These collaborations are all contributing to HIV epidemic control.

Over the years, the United States Department of Defense (DoD) HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries in an effort to control the HIV epidemic among their respective military services. DHAPP is the DoD implementing agency collaborating with the U.S. Department of State, the Health Resources and Services Administration, Peace Corps, U.S. Agency for International Development (USAID), and the Centers for Disease Control and Prevention (CDC), in the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). DHAPP receives funding for its programs from two sources: a congressional plus-up to the Defense Health Program (DHP) and funding transfers from the Department of State for PEPFAR. Working closely with DoD, U.S. Unified Combatant Commanders, Joint United Nations Programme on HIV/AIDS (UNAIDS), university collaborators, and other nongovernmental organizations (NGOs), DHAPP's mission is to build capable military partners through military-specific, culturally focused, HIV/AIDS cooperation and assistance.

In the Defense Security Cooperation Agency guidance, the U.S. Secretary of Defense has identified HIV/AIDS in foreign militaries as a national security issue. Pursuing HIV/AIDS activities with foreign militaries is clearly tied to security interests, regional stability, humanitarian concerns, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing societies. DHAPP employs an integrated bilateral and regional strategy for HIV/AIDS cooperation and security assistance. DHAPP implements bilateral and regional strategies in coordination with respective Combatant Commands (COCOMs) and Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the U.S. Under Secretary of Defense for Policy and by the Office of the Global AIDS Coordinator (OGAC). DHAPP provides strategic information and supports defense forces in HIV prevention, care, and treatment for HIV-infected individuals and their families.

PEPFAR adopted the UNAIDS global 95-95-95 (formerly 90-90-90) goals that state by 2030: 95% of people with HIV are diagnosed, 95% of them are on antiretroviral therapies (ART) and 95% of them are virally suppressed.

PEPFAR Monitoring, Evaluation, and Reporting (MER) indicators are collected and reported to efficiently use data to drive decision-making and focus HIV programming in the right geographic areas. DHAPP uses the same program indicators for DHP and PEPFAR funded programs. DHAPP collects MER indicator results on a quarterly, semi-annual, and annual basis, depending on indicator and data are reported at the site level to DHAPP. These data allow DHAPP to analyze and evaluate gaps in programming and achievement and identify needs for shifts to reach our shared goals. Due to security sensitivities regarding military site locations and troop movement, all site-level data are analyzed at DHAPP headquarters and summary data are reported to OGAC so that other USG country team agencies can review military program results aggregated at the national level.

Transition to Local Partners: Local partners are encouraged to apply to this announcement. To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and community-based and community-led organizations – regardless of current antiretroviral (ARV) coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term, local partner engagement and impact.

All respondents must demonstrate the active support of the in-country military and the DoD representative in the corresponding U.S. Embassy in the planning and execution of their proposals.

In fiscal year (FY) 2019, DHAPP supported 52 active HIV programs, mainly through direct military-to-military cooperation in addition to support from contracting external organizations and academic institutions to assist with specific aspects of proposed programs. Partners in FY19 included 35 Non-Governmental Organizations (NGO)s and universities working in 46 countries.

Budget

PEPFAR activities and services and corresponding budgets and expenditures are uniformly organized into a classification structure referred to as PEPFAR Financial Classifications. In this structure, the PEPFAR funded activities and services are classified systematically as interventions, which is a combination of programs (and sub-programs) and beneficiaries (and sub beneficiaries). Budget and program expenditures are further arrayed according to the cost classification. The below link contains the PEPFAR Financial Classifications Reference Guide and summaries of these classification definitions.
https://datim.zendesk.com/hc/en-us/articles/360015671212-PEPFAR-Financial-Classifications-Reference-Guide. The estimate budget for this program announcement in the format of the PEPFAR Financial Classifications is as follows:

Estimated Budget to be used as a Framework

	Year 1	Year 2	Year 3	Year 4	Total
Program Management	**$905,077**	**$905,077**	**$905,077**	**$905,077**	**$3,620,308**
IM Program Management-NSD (Non-targeted population: Not disaggregated)	**$877,011**	**$877,011**	**$877,011**	**$877,011**	**$3,508,044**
IM Program Management-NSD (Key Populations: Not disaggregated)	**$28,066**	**$28,066**	**$28,066**	**$28,066**	**$112,264**
Care & Treatment	**$1,539,215**	**$1,539,215**	**$1,539,215**	**$1,539,215**	**$6,156,860**
HIV Clinical Services-SD (Non-targeted pop: Young people and adolescents)	**$297,213**	**$297,213**	**$297,213**	**$297,213**	**$1,188,852**
HIV Laboratory Services (Military & other uniformed services)	**$60,800**	**$60,800**	**$60,800**	**$60,800**	**$243,200**
HIV Clinical Services-NSD (Adult women)	**$31,707**	**$31,707**	**$31,707**	**$31,707**	**$126,828**
HIV Clinical Services-NSD (Non-Disaggregated)	**$986,537**	**$986,537**	**$986,537**	**$986,537**	**$3,946,148**
Non-Disaggregated - NSD (Non-Disaggregated)	**$86,958**	**$86,958**	**$86,958**	**$86,958**	**$347,832**
Non-Disaggregated-NSD (Military & other uniformed services)	**$76,000**	**$76,000**	**$76,000**	**$76,000**	**$304,000**
Prevention	**$984,228**	**$984,228**	**$984,228**	**$984,228**	**$3,936,912**
VMMC-SD (Military & other	**$684,578**	**$684,578**	**$684,578**	**$684,578**	**$2,738,312**

uniformed services) Community mobilization, behavior & norms change-SD (Young women & Adolescent females) Primary prevention of HIV and sexual violence-NSD (Pregnant & breastfeeding women) Community mobilization, behavior & norms change-SD (Key pops)	**$190,000** **$75,686** **$33,964**	**$190,000** **$75,686** **$33,964**	**$190,000** **$75,686** **$33,964**	**$190,000** **$75,686** **$33,964**	**$760,000** **$302,744** **$135,856**
Above Site Programming	**$91,200**	**$91,200**	**$91,200**	**$91,200**	**$364,800**
Policy planning, coordination & management of disease control programs-NSD (Military & other uniformed services)	**$91,200**	**$91,200**	**$91,200**	**$91,200**	**$364,800**
HIV Testing Services	**$69,805**	**$69,805**	**$69,805**	**$69,805**	**$279,220**
Community-based testing-SD (Military & other uniformed services) Community-based testing-SD (Key population)	**$14,896** **$54,909**	**$14,896** **$54,909**	**$14,896** **$54,909**	**$14,896** **$54,909**	**$59,584** **$219,636**
Socioeconomic	**$131,628**	**$131,628**	**$131,628**	**$131,628**	**$131,628**
Case Management-SD (Orphans & vulnerable children: Not disaggregated)	**$116,428** **$15,200**	**$116,428** **$15,200**	**$116,428** **$15,200**	**$116,428** **$15,200**	**$465,712** **$60,800**

Legal, human rights & protection-SD (Orphans & vulnerable children)					
TOTAL	**$3,771,153**	**$3,771,153**	**$3,771,153**	**$3,771,153**	**$14,884,612**

Approaches to Reaching Sustainable Epidemic Control

Proposals are requested to support the Uganda People's Defense Force (UPDF) to reach sustainable control of the HIV/AIDS epidemic through the pillars of transparency, accountability, and impact.

The Recipient's program should emphasize capacity building across all activities and technical areas. All proposals should detail how the Recipient will engage the partner military leadership as well as personnel at all levels in this work; and, specifically how the partner will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Within the proposal, the Recipient will need to demonstrate transition of programmatic capabilities and capacity to the military over the life of the award.

The Recipient must work in complete coordination with the partner militaries' HIV prevention and health services, as well as the DHAPP/DoD Program Manager based at the U.S. Embassies in these countries, the DoD adult and pediatric treatment program manager based at the Military Health Department, other DHAPP supported Recipients working in these countries, other bilateral and multilateral agencies with similar objectives and the DHAPP Headquarters Team.

Targets

Progress towards epidemic control will be successfully measured, in part, through an effective strategic information framework that monitors not only program outputs as compared to planned targets, but also key outcomes and programmatic impact.

Collection and use of disaggregated data that characterizes the populations served in the lowest geographic areas where HIV services are being provided is critical in understanding current program performance and planning for future performance. Consequently, the MER indicators continue to evolve in order to reflect the progression of USG support and global HIV response guidelines. Measuring the impact of support at national and regional above-site levels down to direct services at the site-level is paramount to DHAPP's program implementation and monitoring approach.

MER indicators are not an exhaustive list of all metrics that should be monitored by DHAPP-supported programs. DHAPP also collects a custom indicator. All programs should continually monitor and assess any acute programmatic issues and collect additional data to inform program improvement.

The indicators listed below support a patient-centered program monitoring approach. Per the 2017 WHO Consolidated Guidelines on Person-Centered HIV Patient Monitoring and Case Surveillance, person-centered monitoring refers to a shift from monitoring measuring services (e.g., the number

of individuals tested or people on treatment) to monitoring people at the center of their access to linked HIV and health services. In essence, this marks a shift to better support the clients accessing services by focusing more on their individual health outcomes.

The proposal will address approaches to reaching the following targets for military and civilian populations. Targets are listed using the associated PEPFAR MER Indicator. Please see the most recent MER Indicator Reference Guide for more detail at https://datim.zendesk.com/hc/en-us/articles/360000084446-MER-Indicator-Reference-Guides .

Prevention

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
AGYW_PREV	Percentage of adolescent girls and young women (AGYW) that completed at least the DREAMS primary package of evidence-based services/interventions.	0	1976 (no denominator available)
OVC_SERV	Number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV	0	5532
PP_PREV	Number of priority populations (PP) reached with the standardized, evidence-based intervention(s) required that are designed to promote the adoption of HIV prevention behaviors and service uptake	5752	1015
TB_PREV	Among those who started a course of TPT in the previous reporting period, the number that completed a full course of therapy.	1266	5066
VMMC_CIRC	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program within the reporting period.	3640	24,360

Testing

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
CXCA_SCRN	Percentage of HIV-positive women on ART screened for cervical cancer.	0	44% (3796/8483)
HTS_INDEX	Number of individuals who were identified and tested using Index testing services and received their results	285	530

HTS_RECENT	Number of newly diagnosed HIV-positive persons who received testing for recent infection with a documented result during the reporting period	157	135
HTS_TST	Number of individuals who received HIV Testing Services (HTS) and received their test results.	2154	9183
PMTCT_EID	Percentage of infants born to HIV-positive women who received a first virologic HIV test (sample collected) by 12 months of age.	0	100% (2332/ 2332)
PMTCT_STAT	Percentage of pregnant women with known HIV status at antenatal care (includes those who already knew their HIV status prior to ANC)	0	100% (8847/ 8847)
TB_STAT	Percentage of new and relapse TB cases with documented HIV status	100% (394/394)	100% (394/394)

Treatment

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
PMTCT_ART	Percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy.	0	98% (2454/2504)
TB_ART	Number of TB cases with documented HIV-positive status who start or continue ART during the reporting period.	166	159
TX_CURR	Number of adults and children currently receiving antiretroviral therapy (ART)	8992	15,310
TX_NEW	Number of adults and children newly enrolled on antiretroviral therapy (ART)	44	441
TX_TB	Number of ART patients who were screened for TB at least once during the semiannual reporting period.	4858	19431

Viral Suppression

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**

18. TX_PVLS	18. Percentage of ART patients with a suppressed viral load (VL) result (<1000 copies/ml) documented in the medical or laboratory records/laboratory information systems (LIS) within the past 12 months	95% (10,626/ 11,185)	95% (10,209 /10,747)

Health Systems

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
19. EMR_SITE	Number of PEPFAR-supported facilities that have an electronic medical record (EMR) system within the following service delivery areas: HIV Testing Services, Care & Treatment, Antenatal or Maternity Services, Early Infant Diagnosis or Under Five Clinic, or TB/HIV Services	28	0

Technical Narrative

The Recipient will address the technical approach to each area. The Recipient will be responsible for providing the following in close collaboration with other DHAPP-funded Recipients and the host military.

HIV Prevention

The Recipient will ensure that the partner military is providing standardized, evidence-based interventions that are designed to promote the adoption of HIV prevention behaviors and service uptake for all military and other uniformed services as well as other priority populations served by the military health services. These priority populations (PP) should include men that have sex with men (MSM), sex workers and their clients, displaced persons, fishing communities, mobile populations, HIV serodiscordant couples, adolescent girls and young women and illicit drug users.

The Recipient will ensure that the following interventions for adults and youth include:

- Promotion of relevant adult- and youth-friendly prevention and clinical services and demand creation to increase awareness, acceptability, and uptake of these services.
- Information, education, and skills development to reduce HIV risk and vulnerability; correctly identify HIV prevention methods; adopt and sustain positive behavior change; and promote gender equity and supportive norms and stigma reduction.
- Referral to or provision of HIV testing; facilitated linkage to care and prevention services; and/or support services to promote use of, retention in, and adherence to care.
- Condom and lubricant (where feasible) promotion, skills building, and facilitated access to condoms and lubricant (where feasible) through direct provision or linkages to social marketing and/or other service outlets.

- Programs targeting adults to raise awareness of HIV risks for young people, promote positive parenting and mentoring practices, and effective adult-child communication about sexuality and sexual risk reduction.

Voluntary Male Medical Circumcision (VMMC)
The Recipient will ensure that the UPDF is following PEPFAR guidance, WHO recommendations and the national guidelines for conducting VMMC. The full package of VMMC services will be offered, including:

- Demand creation, VMMC education, safe sex practices and provision of condoms
- HIV screening or testing* (see addendum below) for all clients and tracked referral to HIV treatment programs for those who test positive for same-day initiation of ART.
- Examination and evaluation for active sexually transmitted infections (STI).
- STI-positive persons will be deferred from VMMC and referred for immediate treatment of STI, as well as counseled to return and actively invited for VMMC when STI is resolved.
- Post-VMMC wound care (WHO Clean Care) and safe sex education including promotion of 6-week abstinence period post-VMMC.
- Effective monitoring and reporting of VMMC program data and adverse events as well as linked STI and HIV program data.

The Recipient will follow all PEPFAR adverse event reporting protocols for any notifiable adverse events (NAE) occurring during the VMMC procedure or within 30 days following surgical circumcision. This includes notifying the PEPFAR Funding Agency point of contact (POC) and the Uganda PEPFAR Coordinator within 24 hours of the NAE occurring. The Recipient will collaborate with other PEPFAR VMMC Recipients to ensure VMMC coverage in scale up districts and populations.

The Recipient will offer surgical VMMCs to males over 15 years of age ensuring that no boys 15 years or younger, or those with immature penile anatomy are included unless Shang Ring is used (10-14 years of age).

VMMC activities will be implemented concurrently with other component activities such as HIV Testing Services, treatment for STIs, promotion of safer-sex practices and condom distribution.

VMMC Strategy:

9. Recruits: In an effort to offer 100% VMMC coverage in the UPDF in an efficient manner, the Recipient will support the UPDF in their routine offer of VMMC to UPDF recruits within the recruit training period.
10. Active-Duty Males: The Recipient will support the UPDF in holding campaigns at garrisons and camps for VMMC demand creation.
11. Civilians: The Recipient will support the national VMMC program in conducting VMMC for civilians in DoD allocated PEPFAR VMMC scale-up districts, targeting high risk- males between the ages of 15-29 years old.

12. High risk men: The Recipient will build strong referral systems to reach and offer VMMC to: a) STI patients (post-treatment), b) alcohol risk reduction clients, 3) partners of HIV positive persons, 4) other men who are identified as high risk for HIV.

*Testing in VMMC settings

Testing in VMMC settings has historically produced very low HIV yields and may be replaced with screening using a validated tool. Validation should be conducted in at least one large VMMC site to determine if the tool is screening out the right people (HIV-negative) yet not also screening out the wrong people (HIV-positive who are not yet diagnosed). Evaluation of the screening tool should include:

- Test a number of men who seek VMMC services based on established sample size calculation using appropriate HIV prevalence estimates.
- The screening tool performance should be compared with universal national HIV testing algorithm results for all persons using a standard two by two table. Screening tool sensitivity, specificity as well as positive and negative predictive values will allow an informed decision to be made on tool performance and guide modifications.
- Test yields for universal and pre-screening should be compared.
- Technical assistance for this work is available from DHAPP.

Pre-exposure Prophylaxis (PrEP)

Oral pre-exposure prophylaxis with oral tenofovir or tenofovir-containing regimens has been shown to reduce the risk of HIV acquisition among numerous populations. WHO guidelines recommend offering oral PrEP to those at substantial risk of HIV infection, defined as an incidence rate of or exceeding 3 per 100 persons per year. This level of risk has been seen among sero-discordant couples with inconsistent condom use when the partner living with HIV is not virally suppressed, MSM, transgender women, sex workers (SW) of all genders, people who inject drugs (PWID), and older adolescent girls and young women (AGYW) in many parts of sub-Saharan Africa. DHAPP supports WHO guidelines on the use of PrEP as part of a package of comprehensive prevention services that includes risk reduction education and counselling, condom promotion, VMMC, and structural interventions to reduce vulnerability to HIV infection.

- The Recipient should work with the partner military to identify priority groups, set targets, and plan for PrEP implementation and implementation.
- The Recipient should engage with partner militaries to advance “above-site” PrEP readiness and implementation. These activities may include developing national policies; implementation and operational guidelines; product registration; supporting awareness-building and demand-creation efforts; testing integrated PrEP service delivery models; and exploring private sector engagement. Communication efforts will be needed to educate potential PrEP clients and to train health care providers on PrEP benefits, risks, and procedures. Civil society groups already working with the key and other vulnerable populations should be engaged to assist in outreach.
- High-quality PrEP materials can be found at the following links:

- Implementation tools: http://www.who.int/hiv/pub/prep/prep-implementation-tool/en/
- Readiness materials, training materials, monitoring and evaluation (M&E) materials, advocacy materials, and demand creation materials including communications tools: www.prepwatch.org
- Training materials and M&E tools in several languages (English, French, Spanish, and Portuguese): http://icap.columbia.edu/resources/PrEP-kit

HIV Testing Services

Finding the remaining persons who are living with HIV infection is the first priority for reaching HIV epidemic control. Current epidemiology shows that most of those who do not yet know about their infection are men. The UPDF HIV/AIDS program is strategically placed to reach men; therefore, the Recipient will work closely with the UPDF on HIV Testing Services (HTS), particularly index testing and self-testing, in an effort to achieve the "first 95" for military personnel: 95% of all UPDF personnel living with HIV know their status.

HTS will focus primarily on index testing to provide high-yield testing to those most at risk for infection. The local epidemiology and situational analysis should guide the use of other testing methodologies to identify those who are living with HIV.

Where possible, a rapid test for recent infection (RTRI) should be conducted for all of those found to be newly positive. Those who test positive are classified as "probable recent HIV infections" until results of viral load are available. The index testing of these persons should receive high priority and robust efforts should be made to reach all contacts.

Provider-Initiated Testing and Counseling (PITC) will continue in the fixed sites for both the military and civilian cohorts. PITC should focus in clinical areas that have shown a high yield such as tuberculosis (TB) and STI clinics.

Ensuring that any clients with positive results are linked to HIV care and treatment is essential to the success of the UPDF program. The Recipient should work to achieve 100% linkage of HIV-positive individuals identified. The Recipient will monitor HIV testing yield, modifying strategies or locations that are not identifying and/or linking significant numbers of HIV-positive persons to HIV care and treatment.

The Recipient will be responsible for:

- HTS to military bases and facilities
  - Diagnosing 508 people living with HIV (PLHIV) with 95% of those diagnosed linked to HIV care and treatment services.
  - Index-case testing for all sexual partners of HIV-infected military personnel and civilians.
  - Index-case testing for all children under 15 years of age with HIV-infected mothers.
  - Index clients should also be offered self-testing for partners if they do not volunteer for partner notification.

- HTS to military bases and facilities, ensuring that all of those diagnosed are linked to HIV treatment services and receive same day initiation of ART.
- Self-testing should be made available for military personnel, adolescent girls and young women (AGYW) and their partners, male partners of ANC clients, sex workers, MSM and other key and priority populations (young men and at risk males) that face high levels of stigma and discrimination. Following self-testing, facility referral and the regular diagnostic algorithm can be used according to national standards. It is vital to engage community groups to advocate for, design, implement, and analyze the success of HIVST.
- Quality improvement and quality assurance for all UPDF HTS, including continuous training and mentoring and supervision visits, at least quarterly.
- Conducting proficiency testing for all HTS sites and individuals.
- Tracking PLHIV from HTS to clinical care and treatment services.
- Linking males to VMMC services.

HIV Treatment

Support for treatment of HIV is an essential component of this PA. The following issues should be considered in supporting the treatment of PLHIV in military populations.

Dolutegravir (DTG)-containing regimens are the preferred first-line antiretroviral therapies (ART) due to superior efficacy, tolerability and higher threshold for resistance compared to efavirenz (EFV)-containing regimens. The fixed dose combination (FDC) of tenofovir disoproxil fumarate/lamivudine/dolutegravir (TLD) is currently priced as the least expensive FDC, and it is expected that prices will go down as generic manufacturing scales up. For these reasons, DHAPP now recommends TLD as the preferred option for ART, and further recommends that DHAPP-supported programs switch over to TLD as soon as possible in a coordinated fashion as supply becomes available.

Programs should carefully assess the risks and benefits of TLD in child-bearing age women. See published updated from WHO and PEPFAR to further understand the high benefits in the face of a potential NTD signal.

Children (< 20kg) are not expected to be included in the initial roll-out of TLD. Development of pediatric DTG formulations and evaluation of appropriate DTG dosing in infants and children are underway.

A priority of HIV programs is to find, diagnose and treat people with TB disease and ensure that they become non-infectious. For all those who do not have active tuberculosis, prevention of TB is a priority using nationally approved TB preventive therapy.

TB preventive therapy (TPT) must be scaled up for all PLHIVs as an integral part of the clinical care package. IPs are expected to increase the use of TB diagnostic testing within DHAPP-supported HIV care and treatment facilities and promote the use of TPT as a routine part of HIV care. In short, all newly diagnosed HIV persons should be offered TB treatment or preventive therapy and all persons assessed for TB should be tested for HIV.

Programs should have clear policies and/or guidelines for the use of TPT, and should plan for

programmatic and clinical trainings, procurement and supply management, adequate diagnostic capacity (including specimen transportation) and development of appropriate data collection systems. In Global Fund high-impact countries implementing joint TB/HIV awards, Recipients should also seek opportunities to support effective joint program implementation.

Additionally, the Recipient should implement TB infection prevention and control activities to minimize the risk of TB transmission and provide safe health seeking environment. This is critical in DHAPP-supported settings where clients at high risk for TB and HIV often co-mingle. It also puts the health care workers at the highest risk of contracting TB disease. Activities aimed at preventing transmission at facility-level include administrative and environmental controls, and the availability and use of personal protective equipment.

Cervical cancer screening for HIV+ women should be integrated into routine HIV treatment services in each country program. A "screen-and-treat" approach is recommended for the management of precancerous lesions to maximize opportunities for immediate cryotherapy or thermal ablation treatment for eligible women without the need for diagnostic pathology confirmation and to reduced loss to follow-up

Viral Load (VL) Scale-up

Sustained viral suppression of all PLHIV is the key to HIV epidemic control. To this end, the Recipient will work closely with the UPDF to scale-up VL testing coverage and suppression in an effort to achieve 95-95-95 goals for military personnel. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 95: 95% viral suppression among PLHIV taking ART.

The Recipient should ensure the partner military has access to timely VL testing and that capacity exists to test at least 95% of persons currently on ART annually. To ensure this capacity the appropriate use of both plasma and dried blood spots (DBS) should be considered to increase access to routine viral load monitoring.

DBS are easy to collect and store under field conditions, no phlebotomist required, easy to transport to centralized laboratories, reduced cost associated with collection materials and transportation under ambient temperature. The DBS technology is applicable to both adult and pediatric populations and the small volume of blood required for preparing DBS makes it suitable for pediatric populations.

The Recipient will ensure that VL results are made available in a reasonable amount of time to both the health care provider and the client. These results should be used to ensure that those who are not virally suppressed are linked to adherence support and close follow-up leading to either suppression or ART modification as needed. Those who are suppressed should be encouraged to stay suppressed and should be offered differentiated models of care, including multi-month supplies of ART and fast-tracking as an incentive, and given the message that undetectable equals untransmittable (U=U).

Health System Strengthening

DHAPP is working to enhance the ability of governments to manage their epidemics, respond to broader health needs impacting affected communities, and address new and emerging health concerns. Activities include the following:

Laboratory capacity building

The Recipient will be responsible for:

- Inventory control, forecasting, and ensuring the procurement of laboratory reagents to ensure that laboratory services are uninterrupted.
- Procurement of service maintenance contracts, calibration of equipment, and training of the laboratory staff on the use of the equipment.
- Ensuring quality improvement of laboratories using Site Improvement Monitoring System (SIMS), Strengthening Laboratory Management Toward Accreditation (SLMTA) and Stepwise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA) to reach full ISO 15189 accreditation of main laboratories and quality improvement of all satellite laboratories and HIV test sites.
- Monitoring laboratory quality and adherence to quality systems, method validation, provision of proficiency testing panels for rapid HIV testing, VL, CD4, TB, STI and other tests critical to HIV epidemic control.
- Conducting routine visits to laboratories to assess achievements, review/evaluate activities, and provide recommendations with the development of improvement plans to resolve any identified problems.
- Linking UPDF laboratory services to other laboratory resources at the district, provincial, and national levels.

The procurement of supplies, support, and equipment should use government and other donor sources when possible (Ministry of Health, Ministry of Defense, Global Fund, etc).

DHAPP will continue to reduce its overall level of support for CD4 testing to prioritize access to viral load testing. CD4 count is not needed to determine eligibility for ART (and continued CD4 testing may perpetuate the belief that CD4 count thresholds are criteria for initiating ART) and, as reflected in current WHO guidelines, CD4 is inferior to VL for treatment monitoring.

DHAPP's priority is access to critical HIV treatment monitoring, which is via VL testing. VL should be conducted at least once annually for stable patients and more frequently for new, unstable and pediatric patients.

Site Improvement through Monitoring System (SIMS)

The purpose of SIMS is to provide a standardized approach and set of tools for monitoring program quality at DHAPP-supported sites and entities that guide and support service delivery. SIMS assessment results are used to strengthen alignment with global and national standards and facilitate program improvement as a component of an overall quality management strategy. SIMS is also used to identify performance issues that may impact patient outcomes or the integrity of reporting for MER targets or disaggregates. Low final scores (reds and yellows) from these core

essential elements (CEEs) highlight potential issues with service delivery, site performance or oversight, and/or documentation of patient results. Site-level triangulation of MER and SIMS data can be used to contextualize performance and could be useful to determine if performance challenges at a site are due to issues related to the underlying quality of service provision.

Site Improvement through Monitoring System (SIMS) aims to: (1) facilitate improvement in the quality of DHAPP-supported services and technical assistance, (2) ensure accountability of U.S. government investments, and (3) maximize impact on the HIV epidemic.

SIMS assessment results confirm compliance to minimum quality assurance standards and identify areas where improvements in DHAPP-supported programs can be made.

Programs should conduct SIMS assessments in accordance with DHAPP guidance and Recipients are responsible for taking corrective action for items within the Recipient SOW and per discussion with DHAPP USG staff.

Client, Patient, and Program Data Monitoring

Successful collection, evaluation, and use of client/patient level data is critical to good patient care and to the success of the partner military HIV program's ability to monitor progress towards epidemic control. The Recipient will work with the partner military and Ministry of Health (MOH) or other organizations, as appropriate, to support the collection of patient-level data, the clinical and programmatic use of data, and the reporting of site-level data to DHAPP HQ and the partner military leadership.

The Recipient will be responsible for:

- Staffing, support, and mentoring of existing partner military staff for paper and electronic data entry
- Timely, accurate reporting of all indicators required by the partner military and DHAPP
- Ensuring confidentiality and security of data, in line with Ministry of Defense (MOD), MOH, and national guidelines from clinic to storage to dissemination.
- Securing all patient-level and site-level data from dissemination outside of the partner military and DHAPP without prior approval from the partner military
- Supporting paper and electronic data entry, cleaning, reporting, and use

Data Quality

Measuring the success of HIV/AIDS initiatives requires strong monitoring and evaluation (M&E) systems that produce high quality data. Efforts to ensure data quality, therefore, are not singular events occurring randomly. Rather, these processes need to become institutionalized as part routine data management processes. Once achieved, data quality helps to ensure that limited resources are used effectively, progress toward established goals are accurately monitored, and that decisions are based on strong evidence. Attention to data quality ensures that target-setting and results reporting are informed by valid and sensitive information, and that all partners are thinking about and collecting and organizing this information in the same manner. In this way, attention to data quality leads to improved program performance and to more efficient resource management.

Data quality has always been a focus of global HIV monitoring and reporting efforts. Specifically, all countries conducting programming supported by DHAPP are expected to have a data quality strategy in place. For example, data quality assessments (DQAs) should be conducted routinely and action should be taken as a result of these DQAs. If errors are identified in data, these should be remediated at the point of service delivery as well as in the DHAPP and host-country reporting systems as soon as possible. Standard operating procedures for routine data quality review should also be in place. Data should be routinely reviewed for errors before submission to ensure that the data passes the data quality checks outlined within the guidance, the DC2 validations, and the Data for Accountability, Transparency, and Impact Monitoring (DATIM) Data Review Tool.

Virtual Communities of Practice

The Recipient should support the development of virtual communities of practice (vCoP). These evidence-based, virtual, face-to-face health workforce development and collaborative problem-solving platforms, serve to create ongoing dialogue and collaboration among key staff in the military health care systems. They provide a consistent platform for conducting low-dose, high-frequency learning and collaboration sessions. The goal is to build a vCoP for each partner military where DHAPP works in collaboration with DHAPP HQ, field staff and other Recipients working in that country.

Key requirements are equipment and connectivity as well as personnel who can coordinate, manage and lead regular vCoP sessions. These roles may need to be held by the Recipient until they can be transitioned to the partner military.

Work Plans

The Recipient must submit annual, programmatic and financial, work plans to the DHAPP Program Manager and DHAPP HQ (budget breakdown per activity and for program management is required). Work plans should include an activities implementation timeline as well as monitoring and evaluation timeline.

Vietnam: DHAPP—Vietnam Military Medical Department (MMD) Partnership for Sustainable HIV Epidemic Control

NOTE: Application submissions for this narrative are due by 5pm ET on February 5, 2021. Submission received after the deadline will not be considered for funding

Introduction

The HIV/AIDS epidemic has been devastating and negatively affected many militaries and other uniformed organizations worldwide by reducing military readiness, limiting deployments, causing physical and emotional decline in infected individuals and their families, posing risks to military personnel and their extended communities, and impeding peacekeeping activities. As HIV management improves, many of these impacts are disappearing; however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries in addition to other long-term chronic disease management issues.

The U.S. Government (USG) has a long history of international collaboration and partnerships in the fight against HIV/AIDS, providing funding, technical assistance, and program support. These collaborations are all contributing to HIV epidemic control.

Over the years, the United States Department of Defense (DoD) HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries in an effort to control the HIV epidemic among their respective military services. DHAPP is the DoD implementing agency collaborating with the U.S. Department of State, the Health Resources and Services Administration, Peace Corps, U.S. Agency for International Development (USAID), and the Centers for Disease Control and Prevention (CDC), in the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). DHAPP receives funding for its programs from two sources: a congressional plus-up to the Defense Health Program (DHP) and funding transfers from the Department of State for PEPFAR. Working closely with DoD, U.S. Unified Combatant Commanders, Joint United Nations Programme on HIV/AIDS (UNAIDS), university collaborators, and other nongovernmental organizations (NGOs), DHAPP's mission is to build capable military partners through military-specific, culturally focused, HIV/AIDS cooperation and assistance.

In the Defense Security Cooperation Agency guidance, the U.S. Secretary of Defense has identified HIV/AIDS in foreign militaries as a national security issue. Pursuing HIV/AIDS activities with foreign militaries is clearly tied to security interests, regional stability, humanitarian concerns, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing societies. DHAPP employs an integrated bilateral and regional strategy for HIV/AIDS cooperation and security assistance. DHAPP implements bilateral and regional strategies in coordination with respective Combatant Commands (COCOMs) and Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the U.S. Under Secretary of Defense for Policy and by the Office of the Global AIDS Coordinator (OGAC). DHAPP provides strategic information and supports defense forces in HIV prevention, care, and treatment for HIV-infected individuals and their families.
PEPFAR adopted UNAIDS' global 95-95-95 (formerly 90-90-90) goals that state by 2030: 95% of people with HIV are diagnosed, 95% of them are on ART and 95% of them are virally suppressed.

DHAPP shifted with PEPFAR in how Monitoring, Evaluation, and Reporting (MER) indicators are

collected and reported to efficiently use data to drive decision-making and focus HIV programming in the right geographic areas. DHAPP collects MER indicator results on a quarterly and semi-annual basis, and data are reported at the site level. These data allow DHAPP to understand the gaps in programming and needs for shifts to reach our shared goals. Due to security sensitivities regarding military site locations and troop movement, all site-level data are analyzed at DHAPP headquarters and summary data is collected by OGAC so each USG country team can review military program results at the national level.

Transition to Local Partners: Local partners are encouraged to apply to this announcement. To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and community-based and community-led organizations – regardless of current antiretroviral (ARV) coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term, local partner engagement and impact.

All respondents must demonstrate the active support of the in-country military and the DoD representative in the corresponding U.S. Embassy in the planning and execution of their proposals. The selected Grantee is the Implementing Partner and will be referred to as IP in this document.

In fiscal year (FY) 2019, DHAPP supported 52 active HIV programs, mainly through direct military-to-military cooperation in addition to support from contracting external organizations and academic institutions to assist with specific aspects of proposed programs. Partners in FY19 included 35 Non-Governmental Organizations (NGO)s and universities working in 46 countries.

Budget

PEPFAR activities and services and corresponding budgets and expenditures are uniformly organized into a classification structure referred to as PEPFAR Financial Classifications. In this structure, the PEPFAR funded activities and services are classified systematically as interventions, which is a combination of programs (and sub-programs) and beneficiaries (and sub beneficiaries). Budget and program expenditures are further arrayed according to the cost classification. The below link contains the PEPFAR Financial Classifications Reference Guide and summaries of these classification definitions.
https://datim.zendesk.com/hc/en-us/articles/360015671212-PEPFAR-Financial-Classifications-Reference-Guide. The estimate budget for this program announcement in the format of the PEPFAR Financial Classifications is as follows:

Estimated Budget to be used as a Framework

	Year 1	**Year 2**	**Year 3**	**Year 4**	**TOTAL**
Program Management	**$139,231**	**$139,231**	**$139,231**	**$139,231**	**$556,924**
Above Site Programming	**$545,555**	**$545,555**	**$545,555**	**$545,555**	**$2,182,220**
HMIS, Surveillance, & Research – NSD	$20,400	$20,400	$20,400	$20,400	$81,600

Human Resources for Health – NSD	$251,355	$251,355	$251,355	$251,355	$1,005,420
Laboratory Systems Strengthening – NSD	$137,700	$137,700	$137,700	$137,700	$550,800
Policy, planning, coordination & management – NSD	$136,100	$136,100	$136,100	$136,100	$544,400
Care & Treatment	**$17,000**	**$17,000**	**$17,000**	**$17,000**	**$68,000**
HIV Clinical Services – SD	$17,000	$17,000	$17,000	$17,000	$68,000
HIV Testing Services	**$85,000**	**$85,000**	**$85,000**	**$85,000**	**$340,000**
Facility-based testing – NSD	$85,000	$85,000	$85,000	$85,000	$340,000
Prevention	**$161,420**	**$161,420**	**$161,420**	**$161,420**	**$645,680**
Community Mobilization, Behavior & Norms Change – SD	$161,420	$161,420	$161,420	$161,420	$645,680
TOTAL	**$948,206**	**$948,206**	**$948,206**	**$948,206**	**$3,792,824**

APPROACHES TO REACHING SUSTAINABLE EPIDEMIC CONTROL

Proposals are requested to support the Vietnam MMD to reach sustainable control of the HIV/AIDS epidemic through the pillars of transparency, accountability, and impact. The Recipient will work directly with the Ministry of Defense (MoD)/MMD to implement select components of the military HIV program in order to contribute to Vietnam's achieving the 95-95-95 goals for ending AIDS epidemic by 2030.
The Recipient's program should emphasize capacity building across all activities and technical areas. All proposals should detail how the partner will engage the partner military leadership as well as personnel at all levels in this work; and, specifically how the partner will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Within the proposal the Recipient will need to demonstrate transition of programmatic capabilities and capacity to the military over the life of the award.

The Recipient must work in coordination with the MoD/MMD's leadership and staff at the Preventive Medicine Section, who are assigned by MoD to oversee all HIV/AIDS prevention and control activities in the military, as well as with DoD Program Management staff based at the U.S. Embassy in Hanoi, other bilateral and multilateral agencies with similar objectives, and the DHAPP Headquarters Team.

TARGETS

Progress towards epidemic control will be successfully measured, in part, through an effective strategic information framework that not only monitors program outputs as compared to planned targets, but also key outcomes and programmatic impact.

Collection and use of disaggregated data that characterize the populations served in the lowest geographic areas where HIV services are being provided is critical to understanding current program performance and planning for future performance. Consequently, the MER indicators continue to evolve in order to reflect the progression of USG support and global HIV response guidelines. Measuring the impact of support at national and regional above-site levels down to direct services at the site-level is paramount to DHAPP's program implementation and monitoring approach.

MER indicators are not an exhaustive list of all metrics that should be monitored by DHAPP-supported programs. DHAPP also collects custom indicators. All programs should continually monitor and assess any acute programmatic issues and collect additional data to inform program improvement.

The indicators listed below strive to drive program monitoring toward a more patient-centered approach. Per the 2017 WHO Consolidated Guidelines on Person-Centred HIV Patient Monitoring and Case Surveillance, person-centered monitoring refers to a shift from monitoring measuring services (e.g., the number of individuals tested or people on treatment) to monitoring people at the center of their access to linked HIV and health services. In essence, this marks a shift to better support the clients accessing services by focusing more on their individual health outcomes.

The proposal will address approaches to reaching the following targets for military and civilian populations.

Prevention

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
PP_PREV	Number of priority populations reached with the standardized, evidence-based intervention(s) required that are designed to promote the adoption of HIV prevention behaviors and service uptake	50,000	-
TB_PREV	Among those who started a course of TPT in the previous reporting period, the number that completed a full course of therapy.	14/14	74/80

Testing

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
HTS_TST	Number of individuals who received HIV Testing Services and received their test results	6,000	23,535

HTS_TST_POS	Number of individuals who received HIV Testing Services and received their positive test results	7	59
HTS_INDEX	Number of individuals who were identified and tested using Index testing services and received their results	-	35

Treatment

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
TX_CURR	Number of adults and children currently receiving antiretroviral therapy (ART)	50	314
TX_NEW	Number of adults and children newly enrolled on antiretroviral therapy (ART)	6	49
TX_TB	Number of ART patients who were screened for TB at least once during the semiannual reporting period.	42	378

Viral Suppression

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
TX_PVLS	Percentage of ART patients with a suppressed viral load (VL) result (<1000 copies/ml) documented in the medical or laboratory records/laboratory information systems (LIS) within the past 12 months	95% (59/62)	95% (323/340)

Clinical laboratory support

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
LAB_PTCQI	Number of PEPFAR-supported laboratory-based testing and/or Point-of-Care Testing (POCT) sites engaged in continuous quality Improvement (CQI) and proficiency testing (PT) activities	16	-

TECHNICAL NARRATIVE

The Recipient will address the technical approach to each area. The Recipient will be responsible

for providing the following in close collaboration with other DHAPP-funded implementing partners and the host military.

HIV Prevention

The Recipient will ensure that the partner military is providing standardized, evidence-based interventions that are designed to promote the adoption of HIV prevention behaviors and service uptake for all military and other uniformed services as well as for other priority populations served by the military health services. These priority populations (PP) should include men that have sex with men (MSM), sex workers and their clients, displaced persons, fishing communities, mobile populations, HIV discordant couples, adolescent girls and young women and illicit drug users.

The IP will ensure that the following interventions for adults and youth include:

- Promotion of relevant adult- and youth-friendly prevention and clinical services and demand creation to increase awareness, acceptability, and uptake of these services;
- Information, education, and skills development to reduce HIV risk and vulnerability; correctly identify HIV prevention methods; adopt and sustain positive behavior change; and promote gender equity and supportive norms and stigma reduction;
- Referral to or provision of HIV testing; facilitated linkage to care and prevention services; and/or support services to promote use of, retention in, and adherence to care;
- Condom and lubricant (where feasible) promotion, skills building, and facilitated access to condoms and lubricant (where feasible) through direct provision or linkages to social marketing and/or other service outlets; and
- Programs targeting adults to raise awareness of HIV risks for young people, promotion of positive parenting and mentoring practices, and effective adult-child communication about sexuality and sexual risk reduction.

Specifically, for the Vietnam program, please consider the following contextual elements:

In its National Strategy to End AIDS by 2030, the Government of Vietnam (GVN) tasked the MoD/MMD with creating a critical HIV counselor education program, the “HIV Counselor Education Program,” designed to reach approximately 50,000 new military inductees per year. The Recipient will ensure that the partner military is providing standardized, evidence-based interventions through this counseling program that promote the adoption of HIV prevention behaviors and service uptake for military populations prioritized by the military government strategy. Specifically, the Recipient must collaborate closely with and support the MMD in updating and implementing actions to provide key messages on HIV and other sexually transmitted infections (STIs), including innovative approaches to HIV prevention (e.g., index testing, partner notification) and treatment (e.g., same day ARV treatment).

Besides enabling the requested interventions above, the Recipient will ensure that the HIV Counselor Education Program content and design align with the following technical/programmatic recommendations (NB: These recommendations are not exhaustive.):

- Promote prevention and clinical services, and create demand to increase uptake of these services;

- Reduce HIV risk and vulnerability; correctly identify HIV prevention methods; adopt and sustain positive behavior change; and promote gender equity and supportive norms and stigma reduction;
- Refer to or provide HIV testing; facilitate linkage to care and prevention services; and/or support services to promote use of, retention in, and adherence to care;
- Promote condom and lubricant (where feasible) use, skills building;
- Expand the program to military school students and general military active-duty forces; and
- Support the military government in promoting the role of inductees as community HIV advocates after they complete military service and return to their communities (the "change agents" concept).

HIV Testing Services (HTS)

Finding the remaining persons who are living with HIV infection is the first priority for reaching HIV epidemic control. Current epidemiology shows that most of those who do not yet know about their infection are men. The Vietnam MMD HIV/AIDS program is strategically placed to reach men; therefore, the Recipient will work closely with the MMD on HTS, particularly index testing and self-testing, in an effort to achieve the "first 95" for those seen at military clinics: 95% of all people living with HIV (PLHIV) seen at MMD clinics know their HIV status.

HTS will focus primarily on index testing to provide high-yield testing to those most at risk for infection. The local epidemiology and situational analysis should guide the use of other testing methodologies to identify those who are living with HIV.

Where possible, a rapid test for recent infection (RTRI) should be conducted for all of those found to be newly positive. Those who test positive are classified as "probable recent HIV infections" until results of viral load are available. The index testing of these persons should receive high priority and robust efforts should be made to reach all contacts.

Provider-Initiated Testing and Counseling (PITC) will continue in the fixed sites for both the military and civilian cohorts. PITC should focus in clinical areas that have shown a high yield such as tuberculosis (TB) and STI clinics.

Ensuring that any clients with positive results are linked to HIV care and treatment is essential to the success of the MMD program. The Recipient should work to achieve 100% linkage of HIV-positive individuals identified. The Recipient will monitor HIV testing yield, modifying strategies or locations that are not identifying and/or linking significant numbers of HIV positive persons to HIV care and treatment.

The Recipient will be responsible for:

- HTS to military bases and facilities
    - Diagnosing 66 PLHIV with 100% of those diagnosed linked to HIV care and treatment services;
    - Index-case testing for all sexual partners of HIV-infected military

personnel and civilians;
    - Index-case testing for all children under 15 years of age with HIV-infected mothers;
    - Index clients should also be offered self-testing for partners if they do not volunteer for partner notification.
- HTS to military bases and facilities, ensuring that all of those diagnosed are linked to HIV treatment services and receive same-day initiation of ART.
- Self-testing for military personnel, adolescent girls and young women (AGYW) and their partners, male partners of ANC clients, sex workers, MSM and other key and priority populations (young men and at-risk males) who face high levels of stigma and discrimination. Following self-testing, facility referral and the regular diagnostic algorithm can be used according to national standards. It is vital to engage community groups to advocate for, design, implement, and analyze the success of HIVST.
- Quality improvement and quality assurance for all MMD HTS, including continuous training and mentoring and supervision visits, at least quarterly.
- Conducting proficiency testing for all HTS sites and individuals.
- Tracking PLHIV from HTS to clinical care and treatment services.
- Ensuring high-quality recency testing for all newly diagnosed HIV-positive persons by well-trained, certified testers using TRACE format of 3 QCs and 10 TPs (COP Section 6.3.1.6), and support reporting of MER indicator HTS_Recent and narratives.

Specifically, for the Vietnam program, please consider the following contextual elements:

The Recipient will strengthen HTS services in the military health care system through i) strengthening the capacity of military health care facilities mainly in Northern Economic Zone (NEZ) and Ho Chi Minh City Zone (HMZ) to provide quality HIV counseling and testing services (serving both military and civilian populations, modalities including client-initiated, provider-initiated, or index testing through PNS); ii) incorporating critical HTS messages into the military's community medical missions; and iii) enhancing referrals from HTS to other support services. The Recipient is to ensure that service delivery in the military system is per the updated policies and guidance by the national government (Ministry of Health) and PEPFAR where appropriate.

Besides the requested targets and the above requirements, the Recipient will ensure that the program content and design conform to the following technical/programmatic recommendations (NB: This list is not exhaustive.):

- Quality improvement and quality assurance for all supported HTS services including continuous training and mentoring and supervision visits, at least quarterly;
- Proficiency testing for all HTS sites and individuals;
- Tracking PLHIV from HTS to clinical care and treatment services;
- Monitoring HIV testing yield; modifying strategies or locations that are not identifying and/or linking significant numbers of HIV positive persons to HIV care and treatment; and
- Monitoring and provide technical assistance (TA) on standard precaution practices to ensure safe working environment for health care staff and safe

provision of services to clients and patients.

HIV Treatment

Support for treatment of HIV is an essential component of this PA. The following issues should be considered in supporting the treatment of PLHIV in military clinics or military outpatient clinics (OPCs).

Dolutegravir (DTG)-containing regimens are the preferred first-line antiretroviral therapies (ART) due to superior efficacy, tolerability and higher threshold for resistance compared to efavirenz (EFV)-containing regimens. The fixed dose combination (FDC) of tenofovir disoproxil fumarate/lamivudine/dolutegravir (TLD) is currently priced as the least expensive FDC, and it is expected that prices will go down as generic manufacturing scales up. For these reasons, DHAPP now recommends TLD as the preferred option for ART, and further recommends that DHAPP-supported programs switch over to TLD as soon as possible in a coordinated fashion as supply becomes available.

Programs should carefully assess the risks and benefits of TLD in child-bearing age women. See published updates from WHO and PEPFAR (COP Section 6.5.1.2) to further understand the high benefits in the face of a potential Neural Tube Defect (NTD) signal.

Children (< 20kg) are not expected to be included in the initial roll-out of TLD. Development of pediatric DTG formulations and evaluation of appropriate DTG dosing in infants and children are underway.

A priority of HIV programs is to find, diagnose and treat people with tuberculosis (TB) disease and ensure that they become non-infectious. TB screening algorithms should incorporate COVID-19 evaluation pathways. PLHIV screened for COVID-19 should be screened for TB. PLHIV screened for TB should be screened for COVID-19. For all those who do not have active TB, prevention is a priority using nationally approved TB preventive therapy (TPT).

TPT must be scaled up for all PLHIVs as an integral part of the clinical care package. Recipients are expected to increase the use of TB diagnostic testing within DHAPP-supported HIV care and treatment facilities and promote the use of TPT as a routine part of HIV care. In short, all newly=diagnosed HIV persons should be offered TB treatment or preventive therapy, and all persons assessed for TB should be tested for HIV.

Programs should have clear policies and/or guidelines for the use of TPT, and should plan for programmatic and clinical trainings, procurement and supply management, adequate diagnostic capacity (including specimen transportation) and development of appropriate data collection systems. In Global Fund high-impact countries implementing joint TB/HIV grants, Recipients should also seek opportunities to support effective joint program implementation.

Recipients should work with counterparts to ensure that all PLHIV have access to six months multi-month dispensing, ideally through community-based distribution points, to maintain adequate supply of ARVs at home, as well as of TB medicines, TPT and other required medications.

Additionally, Recipients should implement TB infection prevention and control activities to

minimize the risk of TB transmission and provide safe health seeking environment. This is critical in DHAPP-supported settings where clients at high risk for TB and HIV often co-mingle. It also puts the health care workers at the highest risk of contracting TB disease. Activities aimed at preventing transmission at facility-level include administrative and environmental controls, and the availability and use of personal protective equipment.

Specifically, for the Vietnam program, please consider the following contextual elements:

The Recipient will support the military in reaching the second 95 goal, focusing on NEZ and HMZ provinces. The Recipient will provide on-going technical assistance to support the military health system to strengthen select service and management areas related to quality and continuum of treatment, including the on-going process of transitioning DHAPP-supported HIV patients from military OPCs to GVN facilities. The following activities should be considered:

2. Provide essential support to ensure effective HIV treatment and proper patient management (including patient transitioning) at PEPFAR-supported military OPCs, prioritizing sites within NEZ and HMZ provinces. Depending on current and prospective programming, the support can be direct service delivery plus TA, or just responsive TA.
3. Provide relevant military healthcare staff with refresher trainings and TA on the rolling out of/adherence to updated clinical guidance and policies on and around HIV treatment (including but not limited to same day treatment initiation, TLD transition, multi-month dispensing, optimization of treatment retention, social health insurance enrollment/ reimbursement of HIV/AIDS services; TB prevention, TB and HBV/HCV co-infection with HIV, STIs, Index testing and partner notification services, and "U=U" HIV stigma and discrimination reduction).
4. Strengthen referral systems among military sites (HTS sites to OPCs, TB sites to and from OPCs) and between military and civilian sites.
5. Monitor and provide TA on standard precaution practices to ensure safe working environments for health care staff and safe provision of services to patients.

Viral Load (VL) Scale-up

Sustained viral suppression of all PLHIV is the key to HIV epidemic control. To this end, the Recipient will work closely with the MMD to scale-up VL testing coverage and suppression in an effort to achieve 95-95-95 goals for PLHIV in military clinics. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 95: 95% viral suppression among PLHIV taking ART.

The Recipient should ensure the partner military has access to timely VL testing and that capacity exists to test at least 95% of persons currently on ART annually. To ensure this capacity the appropriate use of both plasma and dried blood spots (DBS) should be considered to increase access to routine viral load monitoring.

DBS are easy to collect and store under field conditions, no phlebotomist required, easy to transport to centralized laboratories, reduced cost associated with collection materials and transportation under ambient temperature. The DBS technology is applicable to both adult and pediatric populations and the small volume of blood required for preparing DBS makes it suitable

for pediatric populations.

The Recipient will ensure that VL results are made available in a reasonable amount of time to both the health care provider and the client. These results should be used to ensure that those who are not virally suppressed are linked to adherence support and close follow-up leading to either suppression or ART modification as needed. Those who are suppressed should be encouraged to stay suppressed and should be offered differentiated models of care, including multi-month supplies of ART and fast-tracking, as an incentive, and given the message that "undetectable equals untransmittable (U=U). "

HEALTH SYSTEM STRENGTHENING

DHAPP is working to enhance the ability of governments to manage their epidemics, respond to broader health needs impacting affected communities, and address new and emerging health concerns. Activities include the following:

Laboratory capacity building

The Recipient will be responsible for providing technical assistance to the military in their efforts to:

- Conduct inventory control, forecasting, and procurement of laboratory reagents to ensure that laboratory services are uninterrupted;
- Procure service maintenance contracts, calibrate equipment, and train laboratory staff on the use of the equipment;
- Ensure quality improvement of laboratories using Site Improvement Monitoring System (SIMS), Strengthening Laboratory Management Toward Accreditation (SLMTA) and Stepwise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA) to reach full ISO 15189 accreditation of main laboratories and quality improvement of all satellite laboratories and HIV test sites;
- Monitor laboratory quality and adherence to quality systems, method validation, provision of proficiency testing panels for rapid HIV testing, VL, CD4, TB, STI and other tests critical to HIV epidemic control;
- Conduct routine visits to laboratories to assess achievements, review/evaluate activities, and provide recommendations with the development of improvement plans to resolve any identified problems; and
- Link the MMD laboratory services to other laboratory resources at the district, provincial, and national levels.

The procurement of supplies, support, and equipment should use government and other donor sources when possible (Ministry of Health, Ministry of Defense, Global Fund, etc).

DHAPP will continue to reduce its overall level of support for CD4 testing to prioritize access to VL testing. CD4 count is not needed to determine eligibility for ART (and continued CD4 testing may perpetuate the belief that CD4 count thresholds are criteria for initiating ART) and, as reflected in current WHO guidelines, CD4 is inferior to VL for treatment monitoring.

DHAPP's priority is access to critical HIV treatment monitoring, which is through use of VL, and which should be conducted at least once annually for stable patients and more frequently for new, unstable and pediatric patients.

Laboratory Quality Management System Capacity

Clinical laboratories for HIV diagnosis, care and treatment are present in all Vietnam military hospitals at central and regional levels. However, the capacity of the laboratories, especially on quality management systems (QMS,) needs to be strengthened to meeting national and international standards.

The Recipient will be required to support the military medical system to:

- Strengthen QMS capacity for laboratories at military facilities, particularly in NEZ and HMZ, through activities such as: training and onsite mentoring/TA; strategizing aggressive support for select labs to obtain international accreditations (ISO 15189 or equivalent) or the national equivalent;
- Strengthen the capacity of military medical universities/colleges to teach basic quality management components as a sustainability effort through activities such as training and coaching for teaching staff, and support for development/integration of training components into official academic programs.

All efforts are based on quality management guidelines/requirements of the MoH or recognized international institutions.

Nursing Capacity Building

The Recipient will work with the MMD to increase the quality of HIV/AIDS prevention and treatment services, and to strengthen the nursing role in the military medical facilities of NEZ and HMZ. The Recipient will support institutionalizing best practices and technical guidance into the pre-service training curriculum and materials at the military medical and nursing schools. Main activities include:

- Support development, adaptation and dissemination of policies and technical guidance to the military medical system;
- Build capacity for the nursing workforce in the areas of HIV and other infectious diseases nursing care and support (clinical, psychological, social and prevention services), integrate the quality of HIV/AIDS services into hospital quality management system, trainings on Clinical Trainer Teaching (CTT) for Nurses, stigma and discrimination (S&D), focusing on military personnel in the NEZ and HMZ through workshops/trainings and onsite technical assistance;
- Develop/revise/adapt nursing best practices, technical guidance on above areas into the pre-service training curriculum and training materials at the military medical and nursing schools;
- Promote and integrate standard precautions into the training curriculum and TA to ensure safe working environments for health care staff and safe services for patients; and
- Strengthen the military-civilian collaborative and supportive relationship to empower military nurses in HIV care and other related areas.

Monitoring, Evaluation and Reporting (MER)

The Recipient will work to strengthen the MER capacity of military healthcare staff for the ultimate goals of strengthening the military's program planning, strategizing, management, implementation and ownership. Part of these goals also include enhancing alignment of military system's reporting with national requirements and standards; and sharing of military HIV program data with the national systems/platforms for an enhanced national Case-Based Surveillance (CBS) system and public health responses (PHR).

The following are suggested interventions for the Recipient toward achieving the above goals:

- Training and TA to relevant military staff on updated national and PEPFAR MER requirements including, but not limited to, data collection for reporting to MER indicators, monitoring data quality, analyzing data sites to support program planning, decision making and quality improvement;
- TA support to the military on implementation of a management information system, strengthening collaboration and sharing HIV/AIDS program data in the military with the Ministry of Health.

Special attention shall be paid towards the followings regarding MER support during the entire life of the grant:

Data Monitoring: The Recipient will work with the military to improve the collection of patient-level data, the clinical and programmatic use of data, and the reporting of site-level data to DHAPP HQ and the partner military leadership. The Recipient will work with the military to ensure:

- Confidentiality and security of data, in line with MOD, MOH, and national guidelines;
- Timely, accurate reporting of all indicators required by the MOH, partner military and DHAPP; and
- Accurate data entry, cleaning, reporting, and use.

*Data Quality***:** The Recipient will work with the military to ensure all data be routinely reviewed for errors before submission and to ensure that the data pass quality checks outlined in the guidance and the Data Review Tool available in DATIM.

Site Improvement through Monitoring System (SIMS)

The purpose of SIMS is to provide a standardized approach and set of tools for monitoring program quality at DHAPP-supported sites and entities that guide and support service delivery. SIMS assessment results are used to strengthen alignment with global and national standards and facilitate program improvement as a component of an overall quality management strategy. SIMS is also used to identify performance issues that may impact patient outcomes or the integrity of reporting for MER targets or disaggregates. Low final scores (reds and yellows) from these core essential elements (CEEs) highlight potential issues with service delivery, site performance or oversight, and/or documentation of patient results. Site-level triangulation of MER and SIMS data can be used to contextualize performance and could be useful to determine if performance challenges at a site are due to issues related to the underlying quality of service provision.

Site Improvement through Monitoring System (SIMS) aims to: (1) facilitate improvement in the quality of DHAPP-supported services and technical assistance, (2) ensure accountability of U.S. government investments, and (3) maximize impact on the HIV epidemic.

SIMS assessment results confirm compliance to minimum quality assurance standards and identify areas where improvements in DHAPP-supported programs can be made.

Programs should conduct SIMS assessments in accordance with DHAPP guidance and Recipients are responsible for taking corrective action for items within the Recipient SOW and per discussion with DHAPP USG staff.

Client, Patient, and Program Data Monitoring

Successful collection, evaluation, and use of client/patient level data is critical to good patient care and to the success of the partner military HIV program's ability to monitor progress towards epidemic control. The Recipient will work with the partner military and Ministry of Health (MOH) or other organizations, as appropriate, to support the collection of patient-level data, the clinical and programmatic use of data, and the reporting of site-level data to DHAPP HQ and the partner military leadership.

The Recipient will be responsible for:

- Staffing, support, and mentoring of existing partner military staff for paper and electronic data entry
- Timely, accurate reporting of all indicators required by the partner military and DHAPP
- Ensuring confidentiality and security of data, in line with Ministry of Defense (MOD), Ministry of Health (MOH), and national guidelines from clinic to storage to dissemination.
- Securing all patient-level and site-level data from dissemination outside of the partner military and DHAPP without prior approval from the partner military
- Support for paper and electronic data entry, cleaning, reporting, and use

Data Quality

Measuring the success of HIV/AIDS initiatives requires strong monitoring and evaluation (M&E) systems that produce high quality data. Efforts to ensure data quality, therefore, are not singular events occurring randomly. Rather, these processes need to become institutionalized as part routine data management processes. Once achieved, data quality helps to ensure that limited resources are used effectively, progress toward established goals are accurately monitored, and that decisions are based on strong evidence. Attention to data quality ensures that target-setting and results reporting are informed by valid and sensitive information, and that all partners are thinking about and collecting and organizing this information in the same manner. In this way, attention to data quality leads to improved program performance and to more efficient resource management.

Data quality has always been a focus of global HIV monitoring and reporting efforts. Specifically, all countries conducting programming supported by DHAPP are expected to have a data quality strategy in place. For example, data quality assessments (DQAs) should be conducted routinely and action should be taken as a result of these DQAs. If errors are identified in data, these should be remediated at the point of service delivery as well as in the DHAPP and host-country reporting systems as soon as possible. Standard operating procedures for routine data quality review should also be in place. Data should be routinely reviewed for errors before submission to ensure that the

data passes the data quality checks outlined within the guidance, the DC2 validations, and the Data for Accountability, Transparency, and Impact Monitoring (DATIM) Data Review Tool.

Virtual Communities of Practice

The Recipient should support the development of virtual communities of practice (vCoP). These evidence-based, virtual, face-to-face health workforce development and collaborative problem-solving platforms, serve to create ongoing dialogue and collaboration among key staff in the military health care systems. They provide a consistent platform for conducting low-dose, high-frequency learning and collaboration sessions. The goal is to build a vCoP for each partner military where DHAPP works in collaboration with DHAPP HQ, field staff and other Recipients working in that country.

Key requirements are equipment and connectivity as well as personnel who can coordinate, manage and lead regular vCoP sessions. These roles may need to be held by the Recipient until they can be transitioned to the partner military.

Work Plans

The Recipient must submit annual, programmatic and financial, work plans to the DHAPP Program Manager and DHAPP HQ (budget breakdown per activity and for program management is required). Work plans should include an activities implementation timeline as well as monitoring and evaluation timeline.

Zambia: DHAPP – ZDF Partnership for Sustainable HIV Epidemic Control

NOTE: Application submissions for this narrative are due by 5pm ET on February 5, 2021. Submission received after the deadline will not be considered for funding

Introduction

The HIV/AIDS epidemic has been devastating and negatively affected many militaries and other uniformed organizations worldwide by reducing military readiness, limiting deployments, causing physical and emotional decline in infected individuals and their families, posing risks to military personnel and their extended communities, and impeding peacekeeping activities. As HIV management improves, many of these impacts are disappearing, however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries in addition to other long-term chronic disease management issues.

The US Government has a long history of international collaboration and partnerships in the fight against HIV/AIDS, providing funding, technical assistance, and program support. These collaborations are all contributing to HIV epidemic control.

Over the years, the United States Department of Defense (DoD) HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries in an effort to control the HIV epidemic among their respective military services. DHAPP is the DoD implementing agency collaborating with the US Department of State, the Health Resources and Services Administration, Peace Corps, US Agency for International Development (USAID), and the Centers for Disease Control and Prevention (CDC), in the US President's Emergency Plan for AIDS Relief (PEPFAR). DHAPP receives funding for its programs from two sources: a congressional plus-up to the Defense Health Program (DHP) and funding transfers from the Department of State for PEPFAR. Working closely with DoD, U.S. Unified Combatant Commanders, Joint United Nations Programme on HIV/AIDS (UNAIDS), university collaborators, and other nongovernmental organizations (NGOs), DHAPP's mission is to build capable military partners through military-specific, culturally focused, HIV/AIDS cooperation and assistance.

In the Defense Security Cooperation Agency guidance, the US Secretary of Defense has identified HIV/AIDS in foreign militaries as a national security issue. Pursuing HIV/AIDS activities with foreign militaries is clearly tied to security interests, regional stability, humanitarian concerns, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing societies. DHAPP employs an integrated bilateral and regional strategy for HIV/AIDS cooperation and security assistance. DHAPP implements bilateral and regional strategies in coordination with respective Combatant Commands (COCOMs) and Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the US Under Secretary of Defense for Policy and by the Office of the Global AIDS Coordinator(OGAC). DHAPP provides strategic information and supports defense forces in HIV prevention, care, and treatment for HIV-infected individuals and their families.

PEPFAR adopted the United Nations Programme on HIV/AIDS (UNAIDS) global 95-95-95 (formerly 90-90-90) goals that state by 2030: 95% of people with HIV are diagnosed, 95% of them are on antiretroviral therapies (ART) and 95% of them are virally suppressed.

PEPFAR Monitoring, Evaluation, and Reporting (MER) indicators are collected and reported to efficiently use data to drive decision-making and focus HIV programming in the right geographic areas. DHAPP uses the same program indicators for Defense Health Program (DHP) and PEPFAR funded programs. DHAPP collects MER indicator results on a quarterly semi-annual, and annual basis, depending on indicator and data are reported at the site level to DHAPP. These data allow DHAPP to analyze and evaluate gaps in programming and achievement and identify needs for shifts to reach our shared goals. Due to security sensitivities regarding military site locations and troop movement, all site-level data are analyzed at DHAPP headquarters and summary data are reported to OGAC so that other USG country team agencies can review military program results aggregated at the national level.

Transition to Local Partners: Local partners are encouraged to apply to this announcement.

To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and community-based and community-led organizations – regardless of current antiretroviral (ARV) coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term, local partner engagement and impact.

All respondents must demonstrate the active support of the in-country military and the DoD representative in the corresponding U.S. Embassy in the planning and execution of their proposals.

In fiscal year (FY) 2019, DHAPP supported 52 active HIV programs, mainly through direct military-to-military cooperation in addition to support from contracting external organizations and academic institutions to assist with specific aspects of proposed programs. Partners in FY19 included 35 Non-Governmental Organizations (NGO)s and universities working in 46 countries.

Estimated Budget to be used as a Framework

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Total**
Program Management	**$996,746**	**$996,746**	**$996,746**	**$996,746**	**$3,986,984**
Above Site Programming	**$401,317**	**$401,317**	**$401,317**	**$401,317**	**$1,605,268**
HMIS, Surveillance, and Research – NSD	$73,000	$73,000	$73,000	$73,000	$292,000
Human Resources for Health – NSD	$328,317	$328,317	$328,317	$328,317	$1,313,268
Care & Treatment	**$373,015**	**$373,015**	**$373,015**	**$373,015**	**$1,492,060**
HIV Clinical Services – SD	$227,015	$227,015	$227,015	$227,015	$1,800,000

Non Disag – SD	$146,000	$146,000	$146,000	$146,000	$3,479,300
HIV Testing Services	**$634,972**	**$634,972**	**$634,972**	**$634,972**	**$2,539,888**
Community-based Testing – NSD	$91,576	$91,576	$91,576	$91,576	$366,304
Community-based Testing – SD	$543,396	$543,396	$543,396	$543,396	$2,173,584
Prevention	**$227,103**	**$227,103**	**$227,103**	**$227,103**	**$908,412**
Community Mobilization, Behavior, and Norms Change – NSD	$71,000	$71,000	$71,000	$71,000	$284,000
Community Mobilization, Behavior, and Norms Change – SD	$156,103	$156,103	$156,103	$156,103	$624,412
Socioeconomic	**$1,058,500**	**$1,058,500**	**$1,058,500**	**$1,058,500**	**$4,234,000**
Case Management – NSD	$31,950	$31,950	$31,950	$31,950	$127,800
Case Management – SD	$464,570	$464,570	$464,570	$464,570	$1,858,280
Economic Strengthening – NSD	$67,450	$67,450	$67,450	$67,450	$269,800
Psychosocial Support – NSD	$158,930	$158,930	$158,930	$158,930	$635,720
Psychosocial Support – SD	$7,100	$7,100	$7,100	$7,100	$28,400
Case Management – SD	$328,500	$328,500	$328,500	$328,500	$1,314,000
TOTAL	**$3,691,653**	**$3,691,653**	**$3,691,653**	**$3,691,653**	**$14,766,612**

Approaches to Reaching Sustainable Epidemic Control

Proposals are requested to support the Zambia Defense Force (ZDF) to reach sustainable control of the HIV/AIDS epidemic through the pillars of transparency, accountability, and impact.

The Recipient's program should emphasize capacity building across all activities and technical areas. All proposals should detail how the Recipient will engage the partner military leadership as well as personnel at all levels in this work; and, specifically how the partner will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Within the proposal, the Recipient will need to demonstrate transition of programmatic capabilities and capacity to the military over the life of the award.

The Recipient must work in complete coordination with the partner militaries' HIV prevention and health services, as well as the DHAPP/DoD Program Manager based at the U.S. Embassies in these countries, the DoD adult and pediatric treatment program manager based at the Military Health Department, other DHAPP supported Recipients working in these countries, other bilateral and multilateral agencies with similar objectives and the DHAPP Headquarters Team.

Targets

Progress towards epidemic control will be successfully measured, in part, through an effective strategic information framework that monitors not only program outputs as compared to planned targets, but also key outcomes and programmatic impact.

Collection and use of disaggregated data that characterizes the populations served in the lowest geographic areas where HIV services are being provided is critical in understanding current program performance and planning for future performance. Consequently, the MER indicators continue to evolve in order to reflect the progression of USG support and global HIV response guidelines. Measuring the impact of support at national and regional above-site levels down to direct services at the site-level is paramount to DHAPP's program implementation and monitoring approach.

MER indicators are not an exhaustive list of all metrics that should be monitored by DHAPP-supported programs. DHAPP also collects a custom indicator. All programs should continually monitor and assess any acute programmatic issues and collect additional data to inform program improvement.

The indicators listed below support a patient-centered program monitoring approach. Per the 2017 WHO Consolidated Guidelines on Person-Centered HIV Patient Monitoring and Case Surveillance, person-centered monitoring refers to a shift from monitoring measuring services (e.g., the number of individuals tested or people on treatment) to monitoring people at the center of their access to linked HIV and health services. In essence, this marks a shift to better support the clients accessing services by focusing more on their individual health outcomes.

The proposal will address approaches to reaching the following targets for military and civilian populations. Targets are listed using the associated PEPFAR Monitoring, Evaluation, and Reporting Indicator. Please see the most recent Monitoring, Evaluation, and Reporting Indicator Reference Guide for more detail at https://datim.zendesk.com/hc/en-us/articles/360000084446-MER-Indicator-Reference-Guides .

Prevention

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
FPINT_SITE	Number of HIV service delivery points (SDP) at a site supported by PEPFAR that are providing integrated voluntary family planning (FP) services	57	-
PrEP_CURR	Number of individuals, inclusive of those newly enrolled, that received oral antiretroviral pre-exposure prophylaxis (PrEP) to prevent HIV during the reporting period	200	800
PrEP_NEW	Number of individuals who were newly enrolled on oral antiretroviral pre-exposure prophylaxis (PrEP) to prevent HIV infection in the reporting period	140	560
PP_PREV	Number of priority populations reached with standardized HIV prevention intervention(s) that are evidence-based	600	2,400
OVC_SERV	Number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV (SET TARGETS FOR CIVILIANS ONLY)		13,000

Testing

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
HTS_INDEX	Number of individuals who were identified and tested using Index testing services and received their results	1,000	4,000
HTS_RECENT	Number of newly diagnosed HIV-positive persons who received testing for recent infection with a documented result during the reporting period	300	1,200

HTS_SELF	Number of individual HIV self-test kits distributed	300	1,200
HTS_TST	Number of individuals who received HIV Testing Services (HTS) and received their test results	1,300	5,200
HTS_TST_POS	Number of individuals who received HIV Testing Services (HTS) and received a positive test result	305	1,215
OVC_HIVSTAT	Percentage of orphans and vulnerable children (<18 years old) with HIV status reported to implementing partner. (SET TARGETS FOR CIVILIANS ONLY)		100% (12,800)

Technical Narrative

The Recipient will address the technical approach to each area. The Recipient will be responsible for providing the following in close collaboration with other DHAPP-funded Recipients and the host military.

HIV Prevention

The recipient will ensure that the partner military is providing standardized, evidence-based interventions that are designed to promote the adoption of HIV prevention behaviors and service uptake for all military and other uniformed services as well as other priority populations served by the military health services. These priority populations (PP) should include men that have sex with men (MSM), sex workers and their clients, displaced persons, fishing communities, mobile populations, HIV discordant couples, adolescent girls and young women and illicit drug users. The Recipient will ensure that the following interventions for adults and youth include:

- Promotion of relevant adult and youth friendly prevention and clinical services and demand creation to increase awareness, acceptability, and uptake of these services.
- Information, education, and skills development to: reduce HIV risk and vulnerability; correctly identify HIV prevention methods; adopt and sustain positive behavior change; and promote gender equity and supportive norms and stigma reduction.
- Referral to or provision of HIV testing; facilitated linkage to care and prevention services; and/or support services to promote use of, retention in, and adherence to care.
- Condom and lubricant (where feasible) promotion, skills building, and facilitated access to condoms and lubricant (where feasible) through direct provision or linkages to social marketing and/or other service outlets.
- Programs targeting adults to raise awareness of HIV risks for young people, promote positive parenting and mentoring practices, and effective adult-child communication about sexuality and sexual risk reduction.

Pre-exposure Prophylaxis (PrEP)

Oral pre-exposure prophylaxis with oral tenofovir or tenofovir-containing regimens has been shown to reduce the risk of HIV acquisition among numerous populations. WHO guidelines recommend offering oral PrEP to those at substantial risk of HIV infection, defined as an incidence rate of or exceeding 3 per 100 persons per year. This level of risk has been seen among sero-discordant couples with inconsistent condom use when the partner living with HIV is not virally suppressed, MSM, transgender women, sex workers (SW) of all genders, people who inject drugs (PWID), and older adolescent girls and young women (AGYW) in many parts of sub-Saharan Africa. DHAPP supports WHO guidelines on the use of PrEP as part of a package of comprehensive prevention services that includes risk reduction education and counselling, condom promotion, VMMC, and structural interventions to reduce vulnerability to HIV infection.

- The Recipient should work with the partner military to identify priority groups, set targets, and plan for PrEP implementation and implementation.
- Recipients should engage with partner militaries to advance "above-site" PrEP readiness and implementation. These activities may include: developing national policies; implementation and operational guidelines; product registration; supporting awareness-building and demand-creation efforts; testing integrated PrEP service delivery models; and exploring private sector engagement. Communication efforts will be needed to educate potential PrEP clients and to train health care providers on PrEP benefits, risks, and procedures. Civil society groups already working with the key and other vulnerable populations should be engaged to assist in outreach. High-quality PrEP materials can be found at the following links:
    - Implementation tools: http://www.who.int/hiv/pub/prep/prep-implementation-tool/en/
    - Readiness materials, training materials, monitoring and evaluation (M&E) materials, advocacy materials, and demand creation materials including communications tools: www.prepwatch.org
    - Training materials and M&E tools in several languages (English, French, Spanish, and Portuguese): http://icap.columbia.edu/resources/PrEP-kit

HIV Testing Services

Finding the remaining persons who are living with HIV infection is the first priority for reaching HIV epidemic control. Current epidemiology shows that most of those who do not yet know about their infection are men. The ZDF HIV/AIDS program is strategically placed to reach men; therefore, the Recipient will work closely with the ZDF on HIV Testing Services (HTS), particularly index testing and self-testing, in an effort to achieve the "first 90" for military personnel: 90% of all ZDF personnel living with HIV know their status.

HTS will focus primarily on index testing to provide high yield testing to those most at risk for infection. The local epidemiology and situational analysis should guide the use of other testing methodologies to identify those who are living with HIV.

Where possible, a rapid test for recent infection (RTRI) should be conducted for all of those found to be newly positive. Those who test positive are classified as "probable recent HIV infections" until results of viral load are available. The index testing of these persons should

receive high priority and robust efforts should be made to reach all contacts.

Provider-Initiated Testing and Counseling (PITC) will continue in the fixed sites for both the military and civilian cohorts. PITC should focus in clinical areas that have shown a high yield such as TB and sexually transmitted infection (STI) clinics.

Ensuring that any positives identified are linked to HIV care and treatment is essential to the success of the ZDF program. The Recipient should work to achieve 100% linkage of HIV+ individuals identified. The Recipient will monitor HIV testing yield; modifying strategies or locations that are not identifying and/or linking significant numbers of HIV positive persons to HIV care and treatment.

The Recipient will be responsible for:

- HTS to military bases and facilities
    - Diagnosing 1,520 PLHIV with 95% of those diagnosed linked to HIV care and treatment services
    - Index-case testing for all sexual partners of HIV-infected military personnel and civilians
    - Index-case testing for all children under 15 years of age with HIV-infected mothers.
    - Index clients should also be offered self-testing for partners if they do not volunteer for partner notification.
- HTS to military bases and facilities, ensuring that all of those diagnosed are linked to HIV treatment services and receive same day initiation of ART.
- Self-testing should be made available for military personnel, AGYW and their partners, male partners of ANC clients, sex workers, MSM and other key and priority populations (young men and at risk males) that face high levels of stigma and discrimination. Following self-testing, facility referral and the regular diagnostic algorithm can be used according to national standards. It is vital to engage community groups to advocate for, design, implement, and analyze the success of HIVST.
- Quality improvement and quality assurance for all XDF HTS including continuous training and mentoring and supervision visits, at least quarterly
- Conducting proficiency testing for all HTS sites and individuals
- Tracking PLHIV from HTS to clinical care and treatment services.
- Monitoring HIV testing yield; modifying strategies or locations that are not identifying and/or linking significant numbers of HIV positive persons to HIV care and treatment
- Linking males to VMMC services.

Health System Strengthening

DHAPP is working to enhance the ability of governments to manage their epidemics, respond to broader health needs impacting affected communities, and address new and emerging health concerns. Activities include the following:

Laboratory capacity building

The Recipient will be responsible for:

- Inventory control, forecasting, and ensuring the procurement of laboratory reagents to ensure that laboratory services are uninterrupted
- Procurement of service maintenance contracts, calibration of equipment, and training of the laboratory staff on the use of the equipment
- Ensuring quality improvement of laboratories using Site Improvement Monitoring System (SIMS), Strengthening Laboratory Management Toward Accreditation (SLMTA) and Stepwise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA) to reach full ISO 15189 accreditation of main laboratories and quality improvement of all satellite laboratories and HIV test sites.
- Monitoring laboratory quality and adherence to quality systems, method validation, provision of proficiency testing panels for rapid HIV testing, viral load, CD4, TB, STI and other tests critical to HIV epidemic control.
- Conducting routine visits to laboratories to assess achievements, review/evaluate activities, and provide recommendations with the development of improvement plans to resolve any identified problems.
- Linking ZDF laboratory services to other MOH laboratory resources at the district, provincial, and national levels.

The procurement of supplies, support, and equipment should use government and other donor sources when possible (Ministry of Health, Ministry of Defense, Global Fund, etc).

DHAPP will continue to reduce its overall level of support for CD4 testing to prioritize access to viral load testing. CD4 count is not needed to determine eligibility for ART (and continued CD4 testing may perpetuate the belief that CD4 count thresholds are criteria for initiating ART) and, as reflected in current WHO guidelines, CD4 is inferior to viral load for treatment monitoring.

DHAPP's priority is access to critical HIV treatment monitoring which is through use of viral load (VL) and should be conducted at least once annually for stable patients and more frequently for new, unstable and pediatric patients.

Supply Chain

The Recipient will be responsible for:

- • Conducting trainings and refresher trainings for ZDF staff in supply chain management system (site-based)Maintaining and upgrading the logistics management information system (LMIS)

• Supporting the Defence Force School of Health Sciences (DSHS) as Trainer of Trainers (TOT) in supply chain management including ARV, laboratory and HIV test kits inventory management, distribution planning, forecasting and, quantification in partnership with the GHSC/PSM USAID Project to facilitate the rolling out of pre-service in logistics management at DSHS

• Reviewing and updating ZDF laboratory logistics management policy to ensure it is effective and efficient in establishing protocols and processes for inventory planning and timely replenishment of equipment, materials and lab commodities to enable the maintenance of optimal inventory levels in all sites. This includes rolling out of the policy

• Reproducing existing inventory management SOPs, ordering and reordering forms, and logistics management workbooks and distribute them to 52 ZDF sites

• Developing and implementing action plans to address needs of laboratories identified with procurement needs within the means of ZDF's own budget

• Providing ZDF with linkages to other funding sources, including public private partnerships (PPP) to meet lab procurement needs

• Transitioning ZDF sites from a paper-based ARV, HIV test kits, and laboratory commodities logistics management system to the electronic Logistics Management Information System (eLMIS) to enable efficient management of HIV related logistics

• Supporting Regional Quality Managers to conduct quarterly post- training quarterly technical support and mentoring visits in 32 ZDF sites to support the implementation of eLMIS

• Supporting the HIV/AIDS Secretariat to conduct quarterly meeting with Directors of Medical Services (DMSs), Deputy Directors Nursing (DDNs) and headquarter pharmacy and laboratory managers to analyze inventory data and use data to inform high level logistics management decision making and on-site mentorship trainings to be conducted by the ZDF Regional Quality Managers

• Procuring all-in-one business desktop computers, laptops, printers, back-up media flash disks, wireless router/WIFI access points, network switches, internet router/dongles, local area network (LAN) sundries, Solar sundries and uninterrupted power supply (UPS) units for 12 ZDF eLMIS sites

• Training ZDF data clerks in 52 ZDF sites in eLMIS: data entry and basic troubleshooting and debugging skills

Site Improvement through Monitoring System (SIMS)

The purpose of SIMS is to provide a standardized approach and set of tools for monitoring program quality at DHAPP-supported sites and entities that guide and support service delivery. SIMS assessment results are used to strengthen alignment with global and national standards and facilitate program improvement as a component of an overall quality management strategy. SIMS is also used to identify performance issues that may impact patient outcomes or the integrity of reporting for MER targets or disaggregates. Low final scores (reds and yellows) from these core essential elements (CEEs) highlight potential issues with service delivery, site performance or oversight, and/or documentation of patient results. Site-level triangulation of MER and SIMS data can be used to contextualize performance and could be useful to determine if performance challenges at a site are due to issues related to the underlying quality of service provision.

Site Improvement through Monitoring System (SIMS) aims to: (1) facilitate improvement in the quality of DHAPP-supported services and technical assistance, (2) ensure accountability of U.S. government investments, and (3) maximize impact on the HIV epidemic.

SIMS assessment results confirm compliance to minimum quality assurance standards and identify areas where improvements in DHAPP-supported programs can be made.

Programs should conduct SIMS assessments in accordance with DHAPP guidance and Recipients are responsible for taking corrective action for items within the Recipient SOW and per discussion with DHAPP USG staff.

Client, Patient, and Program Data Monitoring

Successful collection, evaluation, and use of client/patient level data is critical to good patient care and to the success of the partner military HIV program's ability to monitor progress towards epidemic control. The Recipient will work with the partner military and Ministry of Health (MOH) or other organizations, as appropriate, to support the collection of patient-level data, the clinical and programmatic use of data, and the reporting of site-level data to DHAPP HQ and the partner military leadership.

The Recipient will be responsible for:

- Staffing, support, and mentoring of existing partner military staff for paper and electronic data entry
- Timely, accurate reporting of all indicators required by the partner military and DHAPP
- Ensuring confidentiality and security of data, in line with Ministry of Defense (MOD), Ministry of Health (MOH), and national guidelines from clinic to storage to dissemination.
- Securing all patient-level and site-level data from dissemination outside of the partner military and DHAPP without prior approval from the partner military
- Support for paper and electronic data entry, cleaning, reporting, and use

Data Quality

Measuring the success of HIV/AIDS initiatives requires strong monitoring and evaluation (M&E) systems that produce high quality data. Efforts to ensure data quality, therefore, are not singular events occurring randomly. Rather, these processes need to become institutionalized as part routine data management processes. Once achieved, data quality helps to ensure that limited resources are used effectively, progress toward established goals are accurately monitored, and that decisions are based on strong evidence. Attention to data quality ensures that target-setting and results reporting are informed by valid and sensitive information, and that all partners are thinking about and collecting and organizing this information in the same manner. In this way, attention to data quality leads to improved program performance and to more efficient resource management.

Data quality has always been a focus of global HIV monitoring and reporting efforts. Specifically, all countries conducting programming supported by DHAPP are expected to have a data quality strategy in place. For example, data quality assessments (DQAs) should be conducted routinely and action should be taken as a result of these DQAs. If errors are identified in data, these should be remediated at the point of service delivery as well as in the DHAPP and host-country reporting systems as soon as possible. Standard operating procedures for routine data quality review should also be in place. Data should be routinely reviewed for errors before submission to ensure that the data passes the data quality checks outlined within the guidance, the DC2 validations, and the Data for Accountability, Transparency, and Impact Monitoring (DATIM) Data Review Tool.

Virtual Communities of Practice

The Recipient should support the development of virtual communities of practice (vCoP). These evidence-based, virtual, face-to-face health workforce development and collaborative problem-solving platforms, serve to create ongoing dialogue and collaboration among key staff in the

military health care systems. They provide a consistent platform for conducting low-dose, high-frequency learning and collaboration sessions. The goal is to build a vCoP for each partner military where DHAPP works in collaboration with DHAPP HQ, field staff and other Recipients working in that country.

Key requirements are equipment and connectivity as well as personnel who can coordinate, manage and lead regular vCoP sessions. These roles may need to be held by the Recipient until they can be transitioned to the partner military.

Work Plans

The Recipient must submit annual, programmatic and financial, work plans to the DHAPP Program Manager and DHAPP HQ (budget breakdown per activity and for program management is required). Work plans should include an activities implementation timeline as well as monitoring and evaluation timeline.

activities implementation timeline as well as monitoring and evaluation timeline.