AMENDMENT 04

FUNDING OPPORTUNITY ANNOUNCEMENT (FOA)
Number N00244-19-S-F002

"FY19 – FY20 Department of Defense HIV/AIDS Prevention Program: Military Specific HIV/AIDS Prevention, Care, and Treatment Program for PEPFAR (President's Emergency Plan for AIDS Relief) Funded Countries"

The purpose of this Amendment 04 is to incorporate the following:

DHAPP is accepting "Concept Papers" for the following countries through 7 May 2019:

El Salvador, Honduras and Guatemala: DHAPP—Central America Regional Partnership for Sustainable HIV Epidemic Control in the Guatemalan, Honduran and Salvadoran Militaries;

Dominican Republic: DHAPP--FFAARD Partnership for Sustainable HIV Epidemic Control in Border Region;

Malawi: DHAPP--MDF Partnership for Sustainable HIV Epidemic Control

NOTE: Each narrative is a standalone effort and should not be combined with another narrative and all the program elements (tasks) in each specific narrative must be addressed in that concept paper submission.

E-mail address for submission of Concept Papers: usn.nhrc.dhapp@mail.mil

The full solicitation is available at: http://www.grants.gov/

Eligible Applicants are requested to submit **Concept Papers** following the guidelines and format provided in the N00244-19-S-F002, Section II, D.

All respondents must demonstrate the 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.

El Salvador, Honduras and Guatemala: DHAPP—Central America Regional Partnership for Sustainable HIV Epidemic Control in the Guatemalan, Honduran and Salvadoran Militaries

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. DHAPP provides strategic information and supports defense forces in HIV prevention, care, and treatment for HIV-infected individuals and their families.

On October 1, 2013, DoD established the Defense Health Agency (DHA) as part of the U.S. Military Health System governance reform. DHA is a joint, integrated Combat Support Agency that enables the Army, Navy, and Air Force medical services to provide a medically ready force

and ready medical force to COCOMs in both peacetime and wartime. In July 2014, the Deputy Secretary of Defense approved the realignment of medical Executive Agent organizations to DHA, including DHAPP. The transition to DHA from the Secretary of the Navy was completed on August 20, 2017. DHAPP is now a division under the Research and Development (J-9) Directorate and continues to be cornerstone of the global health engagement portfolio delivering solutions to COCOMs. The DHAPP headquarters office remains at Naval Base Point Loma in San Diego, California.

In 2014, PEPFAR moved from an “emergency” response to a strategy focused on sustainable control of the HIV epidemic. In doing so, PEPFAR adopted the United Nations Programme on HIV/AIDS (UNAIDS) global 90-90-90 goals that state by 2020: 90% of people with HIV are diagnosed, 90% of them are on ART and 90% 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 is reported at the site level. This data allows 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 is analyzed at DHAPP headquarters and summary data is collected by the Office of the Global AIDS Coordinator so each USG country team can review military program results at the national level.

In fiscal year (FY) 2017, DHAPP supported 56 national 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 FY17 included 54 NGOs and universities working in 55 countries.

Budget

	Phase 1	**Phase 2**	**Phase 3**	**Phase 4**	**Total**
Care & Treatment	**$77,186**	**$77,186**	**$77,186**	**$77,186**	**308,744**
HVCT- HIV Testing Services HTXS- Adult Treatment	**HVCT- 34,306 HTXS- 42,880**	**HVCT- 34,306 HTXS- 42,880**	**HVCT- 34,306 HTXS- 42,880**	**HVCT- 34,306 HTXS- 42,880**	**HVCT- 137,224 HTXS- 171,520**
Health Systems Strengthening	**169,814**	**169,814**	**169,814**	**169,814**	**679,256**
OHSS- Health Systems Strengthening HVSI- Strategic Information	**OHSS- 99,847 HVSI-70,327**	**OHSS- 99,847 HVSI-70,327**	**OHSS- 99,847 HVSI-70,327**	**OHSS- 99,847 HVSI-70,327**	**OHSS- 399,388 HVSI-281,308**
	247,000	**247,000**	**247,000**	**247,000**	**988,000**

Approaches to Reaching Sustainable Epidemic Control

Proposals are requested to support the Guatemalan, Honduran and Salvadoran Armed Forces to reach sustainable control of the HIV/AIDS epidemic through the pillars of transparency, accountability, and impact.

The TBD partner'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 US Embassies in these countries, the DOD adult and pediatric treatment program manager based at the Military Health Department, other DHAPP supported implementing partners working in these countries, other bilateral and multilateral agencies with similar objectives and the DHAPP Headquarters Team. The Grantee is the Implementing Partner and will be referred to as IP in this document.

Targets

Progress towards epidemic control will be successfully measured, in part, through an effective strategic information framework that not only monitors program outputs, 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 Monitoring, Evaluation, and Reporting (MER) indicators continue to evolve in order to reflect the progression of U.S. government (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. These programs should continually monitor and assess any acute programmatic issues and collect additional data to inform program improvement.

The indicators listed below strives to drive program monitoring to 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.

Testing

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
HTS_INDEX			
HTS_TST	Number of individuals who were identified and tested using Index testing services and received their results	20	180
HTS_TST_POS	Number of individuals who received HIV Testing Services (HTS) and received their test results	20	180
	Number of individuals who received HIV Testing Services (HTS) and received their positive test results	6	54

Treatment

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
TX_CURR	Number of adults and children currently receiving antiretroviral therapy (ART)	20	112
TX_NEW	Number of adults and children newly enrolled on antiretroviral therapy (ART)	6	54

Technical Narrative

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

HIV Testing Services

Finding the remaining persons who are living with HIV infection is the first priority for reaching HIV epidemic control. Current data shows that the most effective strategy for case-finding is through testing of sexual partners of PLHIV as well as children of HIV+ mothers. The FAG HIV/AIDS program is strategically placed to initiate military index testing in Central America to reach these individuals through improving index testing services within the HIV testing centers and a focus on the centralized testing location at the Military Hospital in an effort to assist the MOH in achieving the "first 90": 90% of all priority populations living with HIV know their status.

IP activity will focus specifically on index testing, especially for priority populations, to provide high yield testing to those most at risk for infection.

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

The IP will be responsible for:

- Technical Assistance for Index testing at both military hospitals
  - Train patient navigators, nurses and physicians to implement stigma-free and confidential index testing effectively at the Hospital Militar Central and provide monitoring and mentoring to ensure continued efficacy of program.
  - Diagnose 60 new PLHIV through index testing 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 diagnosed or treated at the hospital.
  - Index-case testing for all children under 15 years of age with HIV- infected mothers.
- Directly link PLHIV from HTS to clinical care and treatment services, including documenting successful linkage both within and outside of the military hospital.
- Monthly reporting and review of index testing yield; modifying strategies that are not identifying and/or linking significant numbers of HIV positive persons to HIV care and treatment

HIV Treatment

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 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 grants, IPs should also seek opportunities to support effective joint program implementation.

Additionally, IPs 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.

Sustained viral suppression of all PLHIV is the key to HIV epidemic control. To this end, the IP will work closely with the XDF to scale-up viral load testing coverage and suppression in an effort to achieve 90-90-90 goals for military personnel. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 90: 90% viral suppression among PLHIV taking ART.

The IP 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 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 IP 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).

These activities will address the 2nd 90 in the WHO 2020 goals (90% of diagnosed PLWHIV on ART treatment). The IP will achieve this through supporting the FAG and FAES in the following activities:

- Adherence: IP will support the FAG and FAES in designing and implementing strategies to improve adherence to treatment. Strategies should include but are not limited to:
    - Improved patient tracking system including documentation tools
    - Development and execution of patient reintegration plan for all patients lost to follow up
    - Review of patient acceptability and impact on adherence of de-centralized follow up for multi-month scripting, program modification and follow-up training of patient navigators based on findings.
- Technical Assistance to support the FAG and FAES in quality assurance of treatment to include but not limited to the following activities:
    - IP to guide monthly rounds to review significant morbidity or mortality outcomes, including improvement plans
    - Identify areas for improvement through rounds and tracking tool
    - IP to collaborate with FAG and FAES to train providers in identified areas for improvement.
    - ART Monitoring and Evaluation and Reporting utilizing MOH and PEPFAR tools
- TA for commodities consumption forecasting and supply management including improving communication pathways with MOH and budget forecasting to ensure programs can adequately care for current patients and absorb new patients without strain to the healthcare system or detriment to quality of care.

Strategic Information

The IP will support the 3 militaries in improving the sustainability and efficacy of their programs through improving local capacity and standard practices for data use utilizing the following activities:

- HIV and STI Monitoring and Evaluation: Collection and analysis of military-wide data, adapting PEPFAR MER indicators to include data from non-PEPFAR sites for above-site analysis to inform strategic direction

    - IP will assist the militaries in assessing and modifying data collection tools to ensure all appropriate data points and disaggregates are collected.
    - IP will assist the militaries analyzing and visualizing collected data to inform policy and planning decisions.
    - Above-site assistance to militaries for the quarterly review of treatment cascade.

- M&E: Site-level monitoring and data analysis to ensure compliance with strategic plan and implement correction where needed.
    - IP will assist the military in frequent, in-depth site visits to review data collection implementation and sight-level adherence to guidelines and best practices.
    - IP will assist sites in determining success of sites in contributing to the 95-95-95 country goals through the monitoring of disaggregated testing yield, PLHIV starting and adhering to treatment, and patient health outcomes.

Health System Strengthening

The IP will support the FAES, FAH and FAG HIV Programs in each country at an above-site level to improve quality of care for all HIV services and removal of barriers to service uptake for all at-risk military as well as the communities served by the military health services.
The IP will achieve these goals through the following interventions:

- The IP will assist all 3 militaries with training and follow-up monitoring and evaluation for DTA for HIV Rapid Test (Proficiency Test):
    - IP will utilize MOH trainers to train MOD labs to perform QA/QI panels verifying the quality of HIV rapid tests as well as carry out one round of QA/QI. Expert trainers will be provided by MOH. IP will be responsible for all logistics and coordination of training and follow-up M&E.
    - IP will coordinate with all 3 militaries to integrate QA/QI into policies as standard practice.
    - IP will coordinate with all 3 militaries to provide improvement plans on a site-specific basis.

- S+D: IP will provide and execute comprehensive Stigma and Discrimination (S+D) reduction plan in collaboration with each country to focus specifically on training of military leaders and medical professionals in improving access and uptake of services through reducing Stigma and Discrimination. This plan should include a needs assessment, training development and execution, policy review and recommendations.

- Forecast ARV, Condoms and HIV Test needs: In Guatemala, IP will assist the military in aligning procurements with MOH procurements through planning and tracking commodity needs and provision, this will be done through training and mentoring, such that capacity is built for these activities within the MOD, and only minimal mentoring would be required after year 1.

Policy and Planning

The IP will assist all 3 militaries at an above-site level to improve policies as well as planning practices. The objective of these activities is to move the militaries towards sustainability of effective programs.
In each country the IP will organize at least one workshop with key stakeholders and decision-makers. The objectives to be met in each country are:

- Update of treatment policies to adhere to WHO and MOH guidelines, especially the inclusion of index testing, test and start, differentiated models of care such as multi-month scripting, transition to Dolutegravir and viral load testing.
- Detailed annual plan, including execution plan and indicators of success.
- Revision of 5-year plan.

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.

The IP will train military health leadership to utilize the SIMS tool to perform their own SIMS-like analysis of their programs outside of the two sites receiving site-level support. The objective of this activity is to increase military capacity for efficient analysis of program quality, and agility in program improvement.

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 implementing partners are responsible for taking corrective action for items within the IP 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 Grantee 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 IP 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.
- Support for 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 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.

Work Plans

The Grantee 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.

Reporting

- Quarterly Fiscal Reports: The grantee must submit quarterly programmatic and financial reports to DHAPP in order to monitor expenditures according to the program budget codes. The report template will be provided by DHAPP. Submit data within 30 calendar days following each reporting period (3/31, 6/30, 9/30, and 12/31).
- Interim Progress/Monitoring, Evaluation, and Reporting (MER) 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: 12/31, 3/31, 6/30 and 9/30. The Grantee shall provide reports in accordance with the template provided by DHAPP
- Reports will follow DHAPP Headquarters and Country Team Templates

Dominican Republic: DHAPP--FFAARD Partnership for Sustainable HIV Epidemic Control in Border Region

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.

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HTXS- Adult Treatment	75,000	75,000	75,000	75,000	300,000
Health Systems Strengthening	100,000	100,000	100,000	100,000	400,000
OHSS- Health Systems Strengthening	75,000	75,000	75,000	75,000	75,000
HVSI- Strategic Information	25,000	25,000	25,000	25,000	25,000
TOTAL	**175,000**	**175,000**	**175,000**	**175,000**	**700,000**

Approaches to Reaching Sustainable Epidemic Control

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

The TBD partner'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.

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The proposal will address approaches to reaching the following targets for military and civilian populations.

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	45	405
HTS_TST	Number of individuals who received HIV Testing Services (HTS) and received their test results	45	405
HTS_TST_POS	Number of individuals who received HIV Testing Services (HTS) and received their positive test results	12	113

Treatment

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
TX_CURR	Number of adults and children currently receiving antiretroviral therapy (ART)	86	74
TX_NEW	Number of adults and children newly enrolled on antiretroviral therapy (ART)	15	130

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	77	696

Technical Narrative

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

HIV Testing Services

Finding the remaining persons who are living with HIV infection is the first priority for reaching HIV epidemic control. Current data shows that the most effective strategy for case-finding is through testing of sexual partners of PLHIV as well as children of HIV+ mothers. The FFAARD HIV/AIDS program is strategically placed to reach these individuals through improving index testing services within the HIV treatment centers at 2 Military Hospitals in an effort to assist the MOH in achieving the "first 90": 90% of all priority populations 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.

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 FFAARD program. The IP will monitor HIV index 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 IP will be responsible for:

- Technical Assistance for Index testing at both military hospitals
    - Train testers to implement stigma-free and confidential index testing and provide monitoring and mentoring to ensure continued efficacy of program.
    - Diagnosing 125 PLHIV through index testing with all of those diagnosed linked to HIV care and treatment services and offered same day initiation on ART.
    - 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.
    - Appropriate confidential tools to accurately track new contacts

HIV Treatment

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 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 grants, IPs should also seek opportunities to support effective joint program implementation.
Additionally, IPs 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.
Sustained viral suppression of all PLHIV is the key to HIV epidemic control. To this end, the IP will work closely with the XDF to scale-up viral load testing coverage and suppression in an effort to achieve 90-90-90 goals for military personnel. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 90: 90% viral suppression among PLHIV taking ART.

The IP 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 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 IP 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).

- Adherence: IP will support the FFAARD in designing and implementing strategies to improve adherence to treatment and removing barriers to treatment, especially among the migrant population. Strategies should include but are not limited to:
    - Improved patient tracking system including documentation tools
    - Development and execution of patient reintegration plan for all patients lost to follow up
    - Implementation of multi-month scripting and patient mentors to reduce loss to follow-up
- Technical Assistance to support the FFAARD in Quality Assurance of treatment to include but not limited to the following activities:
    - IP to guide monthly rounds to review significant morbidity or mortality outcomes, including improvement plans
    - Identify areas for improvement through rounds and tracking tool
    - IP to collaborate with FFAARD MIHTP (Military International HIV Training Program) graduates to train providers in identified areas for improvement.
    - ART Monitoring and Evaluation and Reporting utilizing MOH and PEPFAR tools

TA for commodities consumption forecasting and supply management including improving communication pathways with MOH and budget forecasting to ensure programs can adequately care for current patients and absorb new patients without strain to the healthcare system or detriment to quality of care.

Viral Load Scale-up

Sustained viral suppression of all PLHIV is the key to HIV epidemic control. To this end, the IP will work closely with the XDF to scale-up viral load testing coverage and suppression in an effort to achieve 90-90-90 goals for military personnel. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 90: 90% viral suppression among PLHIV taking ART.

The IP 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 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 IP 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).

The IP will be responsible for supporting the FFAARD in the following activities:

- Ensure VL testing of all persons on ART at least annually and according to national policy
- Provide QA and training to ensure VL testing is accurate and dependable
- Ensure appropriate usage of VL testing to guide patient managments

Strategic Information

The IP will support the three militaries in improving the sustainability and efficacy of their programs through improving local capacity and standard practices for data use utilizing the following activities:

- HIV and STI Monitoring and Evaluation: Collection and analysis of military-wide data, adapting PEPFAR MER indicators to include data from non-PEPFAR sites for above-site analysis to inform strategic direction
    - IP will assist the militaries in assessing and modifying data collection tools to ensure all appropriate data points and disaggregates are collected.
    - IP will assist the militaries analyzing and visualizing collected data to inform policy and planning decisions.
    - Above-site assistance to militaries for the quarterly review of treatment cascade.

- M&E: Site-level monitoring and data analysis to ensure compliance with strategic plan and implement correction where needed.
    - IP will assist the military in frequent, in-depth site visits to review data collection implementation and sight-level adherence to guidelines and best practices.
    - IP will assist sites in determining success of sites in contributing to the 95-95-95 country goals through the monitoring of disaggregated testing yield, PLHIV starting and adhering to treatment, and patient health outcomes.

Health System Strengthening

The IP will support the FFAARD HIV Program at an above-site level to improve quality of HIV services and removal of barriers to service uptake for all at-risk military as well as the communities served by the military health services, including MSM, FSW, TW and migrants. The IP will achieve these goals through the following interventions:

- S+D: IP will provide and execute comprehensive Stigma and Discrimination (S+D) reduction plan in collaboration with FFAARD to include training of military leaders and medical professionals with specific focus on Key and Priority populations most vulnerable to HIV, including MSM, FSW, TW and migrants and HIV-related S+D. This plan should include a needs assessment, training development and execution, policy review and recommendations.

- Forecast ARV, condoms, laboratory commodities and HIV rapid test kits: IP will assist the military in aligning procurements with MOH procurements through planning and tracking commodity needs and provision, this will be done through training and mentoring, such that capacity is built for these activities within the FFAARD, and only minimal mentoring would be required after year one.
- Assist militaries with updating of HIV policies to adhere to WHO and MOH guidelines, especially the inclusion of test and start, same day initiation, index testing, , differentiated models of care such as multi-month scripting, transition to Dolutegravir-based ART and appropriate viral load testing.

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 implementing partners are responsible for taking corrective action for items within the IP 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 Grantee 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 IP 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.
- Support for 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 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.

Work Plans

The Grantee 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.

Reporting

- Quarterly Fiscal Reports: The grantee must submit quarterly programmatic and financial reports to DHAPP in order to monitor expenditures according to the program budget codes. The report template will be provided by DHAPP. Submit data within 30 calendar days following each reporting period (3/31, 6/30, 9/30, and 12/31).
- Interim Progress/Monitoring, Evaluation, and Reporting (MER) 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: 12/31, 3/31, 6/30 and 9/30. The Grantee shall provide reports in accordance with the template provided by DHAPP
- Reports will follow DHAPP Headquarters and Country Team Templates

Malawi: DHAPP--MDF Partnership for Sustainable HIV Epidemic Control

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. DHAPP provides strategic information and supports defense forces in HIV prevention, care, and treatment for HIV-infected individuals and their families.

On October 1, 2013, DoD established the Defense Health Agency (DHA) as part of the U.S. Military Health System governance reform. DHA is a joint, integrated Combat Support Agency that enables the Army, Navy, and Air Force medical services to provide a medically ready force and ready medical force to COCOMs in both peacetime and wartime. In July 2014, the Deputy Secretary of Defense approved the realignment of medical Executive Agent organizations to

DHA, including DHAPP. The transition to DHA from the Secretary of the Navy was completed on August 20, 2017. DHAPP is now a division under the Research and Development (J-9) Directorate and continues to be cornerstone of the global health engagement portfolio delivering solutions to COCOMs. The DHAPP headquarters office remains at Naval Base Point Loma in San Diego, California.

In 2014, PEPFAR moved from an “emergency” response to a strategy focused on sustainable control of the HIV epidemic. In doing so, PEPFAR adopted the United Nations Programme on HIV/AIDS (UNAIDS) global 90-90-90 goals that state by 2020: 90% of people with HIV are diagnosed, 90% of them are on ART and 90% 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 is reported at the site level. This data allows 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 is analyzed at DHAPP headquarters and summary data is collected by the Office of the Global AIDS Coordinator so each USG country team can review military program results at the national level.

In fiscal year (FY) 2017, DHAPP supported 56 national 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 FY17 included 54 NGOs and universities working in 55 countries.

Budget

Choose from the following budget codes:	**Phase 1***	**Phase 2**	**Phase 3**	**Phase 4**	**Total**
Care & Treatment	**$922,399**	**$1,229,865**	**$1,229,865**	**$1,229,865**	**$4,611,993**
HBHC- Adult Care and Support, HVCT- HIV Testing Services HVTB- TB/HIV PDCS- Pediatric Care and Support HTXD- ARV Drugs HTXS- Adult Treatment PDTX- Pediatric	**HBHC- $78,125 HVCT- $197232 HVTB- $30,000 HTXS- $587,042 PDTX- $30000**	**HBHC- $104,167 HVCT- $262,975HVTB- $40,000 HTXS- $782,723 PDTX- $40,000**	**HBHC- $104,167 HVCT- $262,975HVTB- $40,000 HTXS- $782,723 PDTX- $40,000**	**HBHC- $104,167 HVCT- $262,975HVTB- $40,000 HTXS- $782,723 PDTX- $40,000**	

Treatment					
Prevention	**$694,700**	**$763,380**	**$763,380**	**$763,380**	**$2,984,841**
MTCT- Prevention of Mother to Child Transmission HVAB/Y HVOP – Other Sexual Prevention CIRC- Voluntary Medical Male Circumcision	**HVAB/Y- $43,290 HVOP- $132,752 MTCT- $30,000 CIRC- $488,657**	**HVAB/Y- $57,720 HVOP- $150,000 MTCT- $45,000 CIRC- $488,657**	**HVAB/Y- $57,720 HVOP- $150,000 MTCT- $45,000 CIRC- $488,657**	**HVAB/Y- $57,720 HVOP- $150,000 MTCT- $45,000 CIRC- $488,657**	
Health Systems Strengthening	**$176,580**	**$176,580**	**$176,580**	**$176,580**	**$706,320**
OHSS- Health Systems Strengthening	**OHSS- $176,580**	**OHSS- $176,580**	**OHSS- $176,580**	**OHSS- $176,580**	
TOTAL	**$1,793,679**	**$2,169,826**	**$2,169,826**	**$2,169,826**	**8,303,155**

*****Please note that Phase 1 funding is intended to cover 9 months of work to accomplish the targets outlined below. All subsequent phases represent 12-month phases.

Approaches to Reaching Sustainable Epidemic Control

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

The TBD partner'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 US Embassies in these countries, the DOD adult and pediatric treatment program manager based at the Military Health Department, other DHAPP supported implementing partners working in these countries, other bilateral and multilateral agencies with similar objectives and the DHAPP Headquarters Team. The Grantee is the Implementing Partner and will be referred to as IP in this document.

Targets

Progress towards epidemic control will be successfully measured, in part, through an effective strategic information framework that not only monitors program outputs, 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 Monitoring, Evaluation, and Reporting (MER) indicators continue to evolve in order to reflect the progression of U.S. government (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. These programs should continually monitor and assess any acute programmatic issues and collect additional data to inform program improvement.

The indicators listed below strives to drive program monitoring to 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 and objectives for military and civilian populations. Please note that the targets for Phase 1 or "year 1" as it may be referred to, reflect 9 months of activities.

Prevention

Indicator	Label	Targets
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	3,115
TB_PREV (Numerator)	Number of ART patients who completed a course of TB preventive therapy during the reporting period (for continuous IPT programs, this includes the patients who have completed the first 6 months of isoniazid preventive therapy (IPT))	3,413

TB_PREV (Denominator)	Number of ART patients who are expected to complete a course of TB preventive therapy during the reporting period (for programs using continuous IPT, this includes only the patients who are scheduled to complete the first 6 months of therapy)	3,791
VMMC_CIRC	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program within the reporting period	6,101

HIV Prevention

The IP will support both the MDF and the national MOH HIV Prevention Program. The IP 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 communities served by the military health services. These priority populations (PP) include adolescent girls and young women, clients of sex workers and other at-risk men.

The following 2 populations will require tailored strategies that address the needs and barriers specific to the targeted group:

- Military populations: The IP will support the MDF in reaching 1,562 active duty military members through comprehensive preventative education as well as linkage to VMMC, HTS and C+T services.
- Adolescent Girls and Young Women: The IP will follow PEPFAR DREAMS guidelines to reach 1,178AGYW at DREAMS sites in Zomba and Blantyre to improve layering by ensuring that the full DREAMS core package is offered to DREAMS recipients who are engaging in transactional sex and/or sex work. Efforts should include more intensive monitoring and support the practice of active linkages, rather than passive referrals.

The IP will ensure that the required 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 including
• 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.

VMMC Program

The IP will ensure that the MDF 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
- Ensure HIV Testing to 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.
- VMMC education, safe sex practices and provision of condoms, ensuring that VMMC is incorporated into prevention education.
- HIV Testing to all clients and tracked referral to HIV treatment programs for those who test HIV positive for same-day initiation of ART. The IP will be responsible for VMMC modality of the HTS_TST MER indicator.

The IP 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 Funding Agency POC and the Malawi PEPFAR Coordinator within 24 hours of the AE occurring. The IP will collaborate with other PEPFAR VMMC implementing partners to ensure VMMC coverage in scale up districts and populations.

The IP 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:

2. Recruits: In an effort to offer 100% VMMC coverage in the MDF in an efficient manner, the IP will support the MDF in their routine offer of VMMC to MDF recruits within the recruit training period.
3. Active Duty Males: The IP will support the MDF in holding campaigns at

garrisons and camps for VMMC demand creation.

4. Civilians: The IP 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.
5. High risk men: The IP 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

Technical Area Targets, Year 1		
Indicator	**Label**	**Targets**
HTS_INDEX	Number of individuals who were identified and tested using Index testing services and received their results	488
HTS_SELF	Number of individual HIV self-test kits distributed	3,375
HTS_TST	Number of individuals who received HIV Testing Services (HTS) and received their test results	25,608
HTS_TST_POS	Number of individuals who received HIV Testing Services (HTS) and received their positive test results	2,060
PMTCT_EID	Number of infants born to HIV-positive women who received a first virologic HIV test (sample collected) by 12 months of age	541
PMTCT_STAT	Number of pregnant women with known HIV status at antenatal care	858
PMTCT_STAT_POS	Number of pregnant women with known positive HIV status at antenatal care	601
TB_STAT	Number of new and relapsed TB cases with documented HIV status, during the reporting period	21
TB_STAT_POS	Number of new and relapsed TB cases with documented HIV positive status, during the reporting period	15

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 us that most of those who do not yet know about their infection are men. The MDF HIV/AIDS program is strategically placed to reach men; therefore, the IP will work closely with the MDF 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 MDF 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.

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 MDF program. The IP should work to achieve 100% linkage of HIV+ individuals identified. The IP 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 IP will be responsible for:

- HTS to military bases and facilities
    - Diagnosing 1,820 PLHIV with 90% 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 at least 90% of those diagnosed are linked to HIV treatment services
- 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 MDF 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
- Link males to VMMC services

Treatment

Technical Area Targets, Year 1		
Indicator	**Label**	**Targets**
PMTCT_ART	Number of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission during pregnancy	600
TB_ART	Number of TB cases with documented HIV positive status who start or continue ART during the reporting period	15
TX_CURR	Number of adults and children currently receiving antiretroviral therapy (ART)	11,661
TX_NEW	Number of adults and children newly enrolled on antiretroviral therapy (ART)	1,927
TX_TB (Numerator)	Number of ART patients who were started on TB treatment during the semiannual reporting period.	3,796
TX_TB (Denominator)	Number of ART patients who were screened for TB at least once during the semiannual reporting period.	8,745

HIV Treatment

These activities will address the 2nd 90 in the UNAIDS 2020 goals (90% of diagnosed PLWHIV on ART treatment). The IP will achieve this through supporting the MDF in the following activities:

- Offering same-day ART initiation for newly-diagnosed PLWHIV
- Finding and initiating or re-starting previously diagnosed PLWHIV who are not on ART
- Utilizing innovative evidence-based strategies to improve adherence and reduce loss to follow up (LTFU) for individuals already on ART. This can include expert clients/ peer educators, support groups, education for PLWHIV and any other strategies that
- Assisting MDF in adhering to MOH, PEPFAR and WHO guidances, including Test and Start and transitioning to Dolutegravir as the preferred ART therapy.
- Offering active linkage to non-MDF sites and registration of completed linkages for individuals who refuse same-day ART initiation at the MDF site.
- Continued Training updates on comprehensive care and treatment for healthcare workers, including PHDP.

- Continued Monitoring and Evaluation of program performance.

- Support of Case Reviews to identify and discuss negative patient outcomes (including OIs, mortality, high VL etc), causes and how to prevent such outcomes.

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 updated from PEPFAR to further understand the high benefits in the face of a potential NTD signal.
Children (< 30kg) 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.

TB preventive therapy (TPT) must be scaled up for all PLHIVs as an integral part of the clinical care package. DHAPP-supported care and treatment programs need to catalyze the introduction and scale-up of TPT. 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. As a consequence, 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, IPs should also seek opportunities to support effective joint program implementation. Additionally, IPs 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. Infection prevention and control basics will also be important for ART adherence clubs and other community clinical work.

Viral Suppression

Technical Area Targets, Year 1		
Indicator	**Label**	**Targets**
TX_PVLS (Numerator)	Number of ART patients with suppressed VL results (<1,000 copies/ml) documented in the medical or laboratory records/LIS within the past 12 months	7,085
TX_PVLS (Denominator	Number of ART patients with a VL result documented in the medical or laboratory records/LIS within the past 12 months.	7,871

Viral Load Scale-up

The IP will work closely with the MDF to scale-up viral load testing coverage in an effort to achieve 90-90-90 goals for military personnel. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 90: 90% viral suppression among PLHIV taking ART.

The IP will be responsible for supporting the MDF in the following activities:

- Follow MOH guidelines for VL testing
- Ensure the capacity exists to test at least 90% of persons currently on ART annually
- Evaluate need for further DBS or plasma VL testing capabilities
- Provide Continuing Education training to ensure VL testing is accurate and dependable
- Ensure appropriate usage of VL testing outside of testing for patients

Viral load, a complex molecular test is primarily performed at centralized laboratories located at the national or regional levels of the tiered laboratory network. This requires robust laboratory systems including an efficient sample referral network for transportation of specimens from various clinics or treatment sites.

The IP should ensure the partner military has access to 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 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 IP 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 multi-month supplies of ART and fast-tracking as an incentive and given the message that undetectable equals untransmittable (U=U).

Health Systems

Technical Area Targets, Year 1		
Indicator	**Label**	**Targets**
EMR_SITE	Number of PEPFAR-supported facilities that have an electronic medical record (EMR) system within the following service delivery points: HIV Testing Services, Care & Treatment, Antenatal or Maternity Services, Early Infant Diagnosis or Under Five Clinic, or TB/HIV Services	6

The IP will expand the existing Military Health Information System to include full functionality at two additional sites as well as ensure support of continued functionality and use at existing sites and ensure the transition to utilization of the HIS as the primary data source for PEPFAR and MOH reporting at active sites, rather than duplicating efforts and utilizing paper sources.

Activities to achieve this goal should include:

- Installation of hardware and software at two new sites
- Maintenance and updating of existing software and hardware as necessary
- Training for all users, including follow-up training for all current users
- M&E, to identify and correct both software and user errors quickly and effectively.
- Help Desk support
- Update user guide reference materials

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 implementing partners are responsible for taking corrective action for items within the IP 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 Grantee 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 IP 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.
- Support for 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 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.

Work Plans

The Grantee 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. Please note that the first phase should be planned for 9 months.

Reporting

- Quarterly Fiscal Reports: The grantee must submit quarterly programmatic and financial reports to DHAPP in order to monitor expenditures according to the program budget codes. The report template will be provided by DHAPP. Submit data within 30 calendar days following each reporting period (3/31, 6/30, 9/30, and 12/31).
- Interim Progress/Monitoring, Evaluation, and Reporting (MER) 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: 12/31, 3/31, 6/30 and 9/30. The Grantee shall provide reports in accordance with the template provided by DHAPP
- Reports will follow DHAPP Headquarters and Country Team Templates