AMENDMENT 09

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 09 is to incorporate the following:

DHAPP is accepting "Concept Papers" for Eswatini: DHAPP—Umbutfo Eswatini Defence Force (UEDF) Partnership for Sustainable HIV Epidemic Control as described below through 4 December 2019.

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-F0002, Section II. D.

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.

Eswatini: DHAPP—Umbutfo Eswatini Defence Force (UEDF) 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

	Phase 1	Phase 2	Phase 3	Phase 4	Total
Care & Treatment	**$1,721,571**	**$1,721,571**	**$1,721,571**	**$1,721,571**	**$6,886,284**
HBHC- Adult Care and Support, HVCT- HIV Testing Services	$478,058 $242,624	$478,058 $242,624	$478,058 $242,624	$478,058 $242,624	$1,912,232 $970,496
HTXS- Adult Treatment	$1,000,889	$1,000,889	$1,000,889	$1,000,889	$4,003,556
Prevention	**$305,600**	**$305,600**	**$305,600**	**$305,600**	**$1,222,400**
HVOP – Other Sexual Prevention	$250,000	$250,000	$250,000	$250,000	$1,000,000
CIRC- Voluntary Medical Male Circumcision	$55,600	$55,600	$55,600	$55,600	$222,400
Health Systems Strengthening	**$131,531**	**$131,531**	**$131,531**	**$131,531**	**$526,124**
HLAB- Laboratory Infrastructure	$131,531	$131,531	$131,531	$131,531	$526,124
TOTAL	**$2,158,702**	**$2,158,702**	**$2,158,702**	**$2,158,702**	**$8,634,808**

Approaches to Reaching Sustainable Epidemic Control

Proposals are requested to support Eswatini 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.

Prevention

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
GEND_GBV	Number of people receiving post-gender-based violence clinical care based on the minimum package	5	15
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	6400	
PrEP_CURR	Number of individuals, inclusive of those newly enrolled, that received oral antiretroviral pre-exposure prophylaxis to prevent HIV during the reporting period	105	345
PrEP_NEW	Number of individuals who have been newly enrolled on oral antiretroviral pre-exposure prophylaxis to prevent HIV infection in the reporting period	35	115
TB_PREV	Proportion of ART patients who completed a standard course of TB preventive therapy within the semiannual reporting period	95%	95%
VMMC_CIRC	Number of males circumcised as part of the voluntary medical male circumcision for HIV prevention program within the reporting period	400	

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	62	225
HTS_RECENT	Number of newly diagnosed HIV-positive persons who received testing for recent infection with a documented result during the reporting period	71	414
HTS_SELF	Number of individual HIV self-test kits distributed	300	1200
HTS_TST	Number of individuals who received HIV Testing Services and received their test results	529	3585
TB_STAT	Percentage of new and relapse TB cases with documented HIV status	99%	99%

Treatment

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
TB_ART	Proportion of HIV-positive new and relapsed TB cases on ART during TB treatment	100%	100%
TX_CURR	Number of adults and children currently receiving antiretroviral therapy (ART)	457	2528
TX_ML	Number of ART patients with no clinical contact since their last expected contact	44	
TX_NEW	Number of adults and children newly enrolled on antiretroviral therapy (ART)	75	425
TX_TB	Proportion of ART patients screened for TB in the semiannual reporting period who start TB treatment	100%	100%

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%	95%

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 Prevention

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 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.
- 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 IP will ensure that the UEDF 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
- Effective monitoring and reporting of VMMC program data and adverse events as well as linked STI and HIV program data.

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 Eswatini 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:

1. Recruits: In an effort to offer 100% VMMC coverage in the UEDF in an efficient manner, the IP will support the UEDF in their routine offer of VMMC to UEDF recruits within the recruit training period.
2. Active Duty Males: The IP will support the UEDF in holding campaigns at garrisons and camps for VMMC demand creation.
3. Civilians: The IP will support the national VMMC program in conducting VMMC for civilians in DoD facilities, targeting high risk- males between the ages of 15-29 years old.
4. 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, c) partners of HIV positive persons, d) 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 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 IP should work with the partner military to identify priority groups, set targets, and plan for PrEP implementation and implementation.
- IPs 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 us that most of those who do

not yet know about their infection are men. The UEDF HIV/AIDS program is strategically placed to reach men; therefore, the IP will work closely with the UEDF 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 UEDF 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 UEDF 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 536 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 UEDF 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

HIV Treatment

Support for treatment of HIV is an essential component of this FOA. 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 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.

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 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 UEDF to scale-up viral load 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 IP 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 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).

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 IP 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.

- Establishing, developing, and maintaining a Quality Management System (QMS) based on the ISO 9001 standards.
- 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 UEDF 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 viral load for treatment monitoring.

DHAPP's priority is access to critical HIV treatment monitoring which is viral load. Viral load 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 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