AMENDMENT 08

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 08 is to incorporate the following:

DHAPP is accepting "Concept Papers" from Faith-Based Organizations (FBOs) as well as faith and community partners for Sustainable HIV Epidemic Control in Malawi as described below through 24 November 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.

Malawi: DHAPP–MDF Partnership with Faith Communities 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	**100,000**	**100,000**	**100,000**	**100,000**	**400,000**
HBHC- Adult Care and Support,	**100,000**	**100,000**	**100,000**	**100,000**	**400,000**
Prevention	**400,000**	**400,000**	**400,000**	**400,000**	**1,600,000**
HVAB/Y HVOP – Other Sexual Prevention	**100,000** **300,000**	**100,000** **300,000**	**100,000** **300,000**	**100,000** **300,000**	**400,000** **1,200,000**
TOTAL	**500,000**	**500,000**	**500,000**	**500,000**	**2,000,000**

Approaches to Reaching Sustainable Epidemic Control

Proposals are requested from faith-based communities and organizations, to support the MDF and communities surrounding their health facilities 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**
1. AGYW_PREV	Percentage of adolescent girls and young women (AGYW) that completed at least the DREAMS primary package of evidence-based services/interventions.	200	[need a %] 1500
2. 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		

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

Faith-based structures are an integral part of the community in all of the countries in which we work, and have durable relationships built on trust and ministry. Thus, enhanced engagement with faith communities, and with faith and traditional leaders, represents a pivotal opportunity to accelerate uptake of optimized HIV prevention activities to address key issues in HIV epidemic control. The IP will ensure that faith leaders in the military and in communities surrounding military bases are providing standardized, evidence-based messages and targeted 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, especially those who are not being linked to services through currently established activities. These priority populations (PP) should include youth aged 9-14, men and HIV discordant couples. .

Activities will focus on engaging communities of faith to understand the epidemic, raise community awareness, and increase uptake of critical treatment and prevention interventions for men and children through existing and additional FBO, faith and community partners. These activities will include:

- Adaptation, contextualization, and production (print and digital) of new messaging about HIV testing, linkage, and retention (e.g. Test & Start, U=U), for widespread dissemination in churches and mosques
- Building capacity among local faith leaders and workers; including pastors, pastors' wives, imams and their wives, children's religious and youth teachers (Sunday School, Madrasa), and mothers; and among FBO, to create demand for targeted use of HIV testing and self-testing as appropriate
- Engaging faith leaders (such as pastors, imams, men's/women's/youth leaders) and HIV-competent workers in congregations (community health workers, expert clients, peer educators) to increase targeted use of HIV testing or self-testing, linkage and retention, in and beyond faith communities

Assure congregants who are identified as at risk are properly linked to HTS and treatment service sites and partners.

Adherence support

To operationalize pathways to epidemic control, UNAIDS established, countries endorsed, and PEPFAR supports, global 90/90/90 targets for 2020 with 95/95/95 targets for 2030 through specific program actions to diagnose persons infected with HIV, provide life-saving ARV therapy for PLHIV, and support retention and adherence to ensure HIV viral suppression and improve management of advanced HIV disease to reduce AIDS-related deaths. Faith-based community groups are well positioned to support retention and adherence to ensure HIV viral suppression.

Strategies should be proposed that communicate the importance of retention in care and adherence to HIV medications for PLHIV as well as adherence to Pre-exposure prophylaxis (PrEP) for persons who are trying to prevent HIV infection. These activities could be part of a chronic disease approach that encourages health lifestyles and behaviors to prevent other common chronic diseases like hypertension, diabetes, cardiac disease and cancer. Differentiated care and innovative community support models should focus on populations that have difficulty with retention, such as children, adolescents (especially those in boarding schools), young adults, men, pregnant women, and key populations. Adherence programs should be focused on all persons who need to take regular medications but with special approaches to those with elevated HIV viral loads. Examples of differentiated models for pediatric and adolescents are listed in the PEPFAR Solutions Platform (https://www.pepfarsolutions.org/) and include Operation Triple Zero and Zvandiri.

Activities will focus on engaging communities of faith to understand the epidemic, raise community awareness, and increase uptake of critical treatment and prevention interventions for men and children through existing and additional FBO, faith and community partners. These activities will include:

– Engaging champions in faith communities to strengthen support for linkage and adherence
– Programming on HIV education and stigma reduction, including addressing ARV non-adherence related to faith healing in congregations
– Convening key stakeholders to facilitate sharing solutions

Approaches should reach at-risk populations, facilitate continued ART adherence, re-link those who disengage from clinical care, and retain newly diagnosed PLHIV. Proposals should include provision or referral of PLHIV in community-based programs such as home-based care, support groups for PLHIV, psychosocial support and mental health services, post-test-clubs, etc. Quality management will become an increasingly important function of the HIV program to monitor the epidemic and quality of outcomes of those living with HIV. Monitoring the epidemic and the quality of services will also facilitate a public health response that sustains epidemic control.

Adherence support should impose no additional burden on patients and monitoring of adherence to treatment should be conducted at the patient's convenience - either in the home by family or community workers, or by remote telephonic or video communication.

Justice for Children

Justice for Children is a priority of *PEPFAR's Faith and Community Initiative*, an essential component of the broader PEPFAR Strategy for Accelerating Epidemic Control through community engagement. According to several population-based HIV impact assessments (PHIAs) and Violence Against Children Surveys (VACS), it is apparent that vulnerability for HIV is linked to sexual violence and begins very young. VACs and program experience also show that children rarely disclose sexual violence when it does occur and that community norms may serve as a deterrent to formal reporting. Thus, preventing sexual violence among 9-14 year olds and responding to sexual violence among all children to ameliorate its negative consequences are fundamental approaches for preventing HIV.

PEPFAR has a strong history of combatting sexual violence among youth--including the provision of compelling data for policy and programmatic change through the VACS. Primary prevention of sexual violence is also prioritized in our most recent Country Operational Plan (COP) strategy and development processes. Therefore, the activities for this priority will build upon existing activities occurring through the broader PEPFAR portfolio, particularly in DREAMS and OVC. It will also take advantage of strong leaders (faith, traditional, community) within the countries we serve, and engage critical systems beyond health (law enforcement, child welfare, legal, justice).

Definitions

Sexual violence prevention – includes primary (keeping sexual violence from happening in the first place) and secondary (dealing with it once it has happened to ensure that perpetrators are held accountable, and survivors get necessary services).

Justice Sector Engagement – activities specifically focused on disclosure, reporting, and holding perpetrators accountable. Must include sectors beyond health – including criminal justice (law enforcement, prosecution, judicial), child welfare, and ensuring that communities support survivors to seek justice.

The activities under Justice for Children will have a large focus on the Justice Sector response, as well as broader sexual violence prevention for 9-14 year olds in support of ensuring justice for children. Activities should leverage complementary work taking place through the DREAMS and OVC platforms, including a particular focus in DREAMS SNUs to fill any gaps.

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