AMENDMENT 0014

BROAD AGENCY ANNOUNCEMENT (BAA)
Number DHAPP-BAA-15-002

"FY15 – FY16 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 0014 is to revise page 10 of the DHAPP-BAA-15-002, paragraph III. Eligibility Information and incorporate the Request for Concept Papers for South Africa, Malawi and Uganda through 23 April 2016 as described below:

1. Page 10 of BAA, **Paragraph III. Eligibility Information** is revised as follows:

III. ELIGIBILITY INFORMATION

All responsible sources from academia, industry, and non-governmental organizations may submit proposals under this BAA. No grants or cooperative agreements may be awarded directly to foreign military establishments**. All respondents must demonstrate the active support of the in-country military and the DoD representative in the corresponding U.S. Embassy in the planning and execution of their proposals.**

The Federal Funding Accountability and Transparency Act of 2006 (Public Law 109-282), as amended by Section 6202 of Public Law 110-252, requires that all agencies establish requirements for recipient reporting information on sub-awards and executive total compensation as codified in 2 CFR 33.110. **Any company, profit agency, or university that applies for financial assistance (either grants or cooperative agreements) as either a prime or sub-recipient under this BAA must provide information in its proposal that describes the necessary processes and systems in place to comply with the reporting requirements identified in 2 CFR 33.220.**

An entity is **exempt** from this requirement **UNLESS** in the preceding fiscal year it received: a) 80 percent or more of its annual gross revenue in Federal contracts (and subcontracts), loans, grants (and sub-grants), and cooperative agreements; b) $25 million or more in annual gross revenue from Federal contracts (and subcontracts), loans, grants (and sub-grants), and cooperative agreements; and c) the public does not have access to information about the compensation of the senior executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 or section 6104 of the Internal Revenue Code of 1986.

2. **NHRC/DHAPP is accepting "Concept papers" for South Africa, Malawi, and Uganda as described below through 23 April 2016.**

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 DHAPP BAA-15-002, Section IV.

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.

South Africa: VMMC in Military Settings

	Phase 1	Phase 2	Phase 3
CIRC	$3,300,000	$300,000	$300,000
TOTAL	**$3,300,000**	**$300,000**	**$300,000**

Proposals are requested to support South Africa achieve HIV epidemic control through efficient direct service delivery support implementation of a minimum package of health services as part of the VMMC for HIV prevention program among members of the South African National Defense Force (SANDF), their families, and the civilian communities served by the South African National Defense Force (SANDF). The partner should understand the South African National Defense Force (SANDF) structures to inform VMMC service delivery and demand generation and should be willing to work directly with the South African National

Defense Force (SANDF) to aggressively scale-up the military VMMC program to achieve HIV epidemic control within the military and surrounding communities over the life of this project.

Department of Defense HIV/AIDS Prevention Program (DHAPP) programming to support the South African National Defense Force (SANDF) VMMC program will focus on the following technical areas: 1) offer (and make available) HIV testing and counseling for all male clients and, where possible, their partners; 2) active referral of clients determined to be HIV-positive to HIV care and treatment programs, including determination of successful linkage; 3) age-appropriate sexual risk reduction counseling and counseling, including recommendations for abstinence during wound healing; pre-procedure clinical screening (focused physical exam and medical history) to detect sexually transmitted infections (STI) and contraindications to circumcision; 4) treatment of STIs that are detected; 5) circumcision by a medical method recognized by WHO (surgery or device); 6) post-procedure follow-up, including systematic assessment of adverse events; and, 7) provision and promotion of correct and consistent use of condoms, preferably both male and female condoms.

The partner's program should emphasize capacity building across all activities and technical areas. All proposals should detail how the partner will engage the South African National Defense Force (SANDF) leadership as well as South African 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 South African 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.

Phase one will therefore focus on scale up and expansion of HIV VMMC in the civilian populations surrounding military bases particularly in Enhlanzeni district with concurrent recruitment and strengthening of the VMMC services for SANDF personnel and their dependents.

The partner must work in complete coordination with the South African National Defense Force (SANDF)'s HIV prevention and health services, as well as the DHAPP/DoD Program Manager based at the US Embassy in South Africa, the DOD adult and pediatric treatment program manager based at the Military Health Department, other in country agencies and the DHAPP Headquarters Team. The Grantee is the Implementing Partner and will be referred to as IP in this document.

Any reimbursement to clients for travel and any rewards to teams of mobilizers to increase uptake of VMMC should be carefully evaluated to assure there is no one-for-one remuneration for VMMCs performed, and no actual or perceived coercion of clients.

Voluntary Medical male Circumcision

Indicator	Label	Military Only	Civilian
VMMC_CIRC_DSD	# of males circumcised as part of the voluntary medical male circumcision for HIV prevention program	TBD	TBD
VMMC_AE_DSD	# of VMMC clients that experienced one or more surgical intra-operative, surgical post-operative, and/or medical device-related moderate or severe AE(s) during the reporting period, according to the date of surgery or device placement.	TBD	TBD

The South African National Defense Force (SANDF) currently provides VMMC services from three military sites in Tshwane, Capricorn and Amajuba districts. At present, these three clinical sites provide care and treatment services for a very limited number of Active Duty SANDF personnel. In order to expand VMMC coverage to outlying military bases where soldiers cannot reasonably reach one of the existing military VMMC facilities, the SANDF will begin providing mobile VMMC services using 4 new multi-room mobile clinics. The IP will work directly with the SANDF in Tshwane, Capricorn and Amajuba districts district at already existing fixed sites in addition to supporting the expansion and implementation of mobile MMC services to achieve the military HIV VMMC targets in Mpumalanga, Ehlanzeni district. Phase one will therefore focus on scale up and expansion of HIV VMMC in the civilian populations surrounding military bases particularly in Ehlanzeni district with concurrent recruitment and strengthening of the VMMC services for SANDF personnel and their dependents.

The IP will be responsible for:

Strategic Pivot to Maximize Epidemic Control and Rationalize Resources
PEPFAR is prioritizing VMMC investments to maximize epidemic impact through:
1) targeting VMMC services to geographic areas with highest HIV burden and low male circumcision prevalence; 2) focusing VMMC demand creation and service design to reach age groups most immediately at risk of acquiring HIV heterosexually; and,
3) reaching highest risk sub-populations of the VMMC eligible population as dictated by country epidemics (e.g., males in serodiscordant relationships with HIV-positive female partners, clients of commercial sex workers, males attending STI clinics, military populations, migrant workers in transport sectors).

Comply with PEPFAR Policy Guidance Directives for All VMMC Activities
All implementing mechanisms funded to support DSD VMMC services must fully comply with the PEPFAR policy guidance directives.

Providing the WHO Minimum Package of Services
In response to the 2007 WHO normative guidance, PEPFAR continues to support implementation of a minimum package of health services as part of the VMMC for HIV prevention program.

Ensure External Quality Assurance (EQA) and Continuous Quality Improvement (CQI) Activities are conducted
Activities for in depth assessments of quality and safety of services must be in place. External quality assurance (EQA) assessments may be conducted to objectively gauge the safety, quality, and compliance of programs with clinical standards of care, international best practices, and PEPFAR Policy Guidance.

Counseling and Referral of HIV-positive Clients to Care and Treatment Services
For HIV-positive men, it is important to ensure that comprehensive post-test counseling includes information that circumcision is not recommended for them for HIV prevention purposes, as VMMC does not protect them against acquiring HIV and does not lower their risk of transmitting HIV to others. If an HIV-positive client elects to undergo VMMC for reasons other than HIV prevention, however, he should be allowed to do so, provided he is healthy enough for the procedure.

Implement Systems for Monitoring and Reporting
Programs supporting VMMC must include systems for monitoring and reporting of VMMC indicators and required disaggregation so that progress towards established targets and frequency of adverse events can be tracked. The priority age group for the South African PEPFAR VMMC program VMMC is males 15-34 years of age.

HIV/AIDS Testing Services

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
HTC_TST	# of individuals who received HTS services for HIV and received their test results	TBD	TBD

The IP will work closely with the South African National Defense Force (SANDF) to aggressively scale-up HIV Testing Services in an effort to achieve the 1st 90 for military personnel: 90% of all South Africa Military PLHIV know their status. VMMC represents a rare and valuable opportunity to provide HIV testing services (HTS) to men and, if necessary, to link them to care. In an effort to reach these men before they become symptomatic, HTS will

focus primarily on outreach testing to larger, high HIV-burden military locations. Outreach testing should be closely linked to the mobile ART clinic schedule, ideally with both services provided concurrently to maximize linkage. When men seek VMMC services, it provides an ideal opportunity to address some aspects of sexual and reproductive health.

HTC in the facility and in the community can contribute to demand creation for VMMC services. It is important to capitalize on this opportunity by ensuring that HTC facilities are referring eligible clients to VMMC services.

Provider-Initiated Testing and Counseling (PITC) will continue in the fixed sites for both the military and civilian cohorts as part of VMMC program. Ensuring that any positives identified are linked to HIV care and treatment is essential to the success of the SANDF program. The IP should work to achieve 90% linkage of HIV+ individuals identified through PITC and 85% of HIV+ individuals identified through outreach testing to HIV clinical care and treatment. This may require that sites develop and implement novel mechanisms to facilitate and confirm successful linkage to care (e.g., escorting clients from the VMMC center to the ART center, or enabling staff to register clients for ART at the VMMC center).

The limits of the protective benefits of VMMC should be explained to HIV-positive men and their partners, and if a client requests VMMC anyway (for reasons other than HIV prevention) and is healthy enough and is clinically fit (i.e., his CD4 count is above the treatment initiation threshold), VMMC should be made available to him. If men test HIV-negative as part of the VMMC program services, they can be counseled and given specific information about how to protect themselves from HIV infection. Services for these men should include the provision of condoms and risk-reduction counseling.

VMMC should be recommended to all HIV-negative males who receive HTC services in any setting, especially those men who are at high risk of HIV acquisition from heterosexual sex (e.g., STI clinic clients and those in discordant partnerships). It is especially important for program staff to follow up actively with males whose circumcision procedure has been deferred because of an STI. It is crucial that VMMC programs develop routine systems to follow up with these males, who show evidence of having had unprotected sex, to ensure that they return to the VMMC facility for circumcision immediately following their STI treatment. VMMC programs should also give particular priority to HIV-negative males in HIV-discordant partnerships.

Training

Programs should ensure appropriate and adequate training for health care workers and non-clinical staff providing VMMC services and include mechanisms for assuring initial and continued competency post-training. Health care providers designated to provide a higher volume of services or services at a fixed site frequency should be prioritized for training.

The IP will be responsible for:

- Monitoring how many VMMCs each provider trained with PEPFAR funds actually conduct following his/her training.
- Ensuring that those performing a “low” number in specific periods and/or cumulatively, as determined in conjunction with the training programs, may be prioritized for supportive supervision, competency assessment, or retraining.

Balancing Supply and Demand

VMMC programs need to continually assess and recalibrate the balance of VMMC supply (capacity of the system to deliver VMMC services) and demand (number of males seeking services). Programs should plan for timely procurement and distribution of VMMC commodities and equipment including: pharmaceuticals, surgical instruments, devices, consumables and medical and waste management supplies. Programs can use PEPFAR funds to procure WHO pre-qualified devices and use them in routine service delivery, following WHO guidance. PrePex is pre-qualified for ages ≥18 years and could extend to eligible adolescents aged 13-18 years under active surveillance. Additionally, pre-qualified sizes must be used.

Other Prevention

The IP will work closely with the SANDF to ensure that all patients with presumptive TB or TB disease receive HIV testing and provide immediate access to ART for patients, with the goal of providing universal ART coverage among HIV-infected TB patients and universal TB screening for all HIV-infected individuals.

- In the first year of this effort, the IP will work with the Military and other partners to select a few target or “hotspot” locations/sites in geographically prioritized regions (Mpumalanga, Ehlanzeni) based on available HIV prevalence data. Sites defined as hotspots include but are not limited to; presence of a military camp with a large number of soldiers, high HIV/STI prevalence, observed high frequency of multiple sex partners, emergence of small towns with venues where soldiers and FSW fraternize, high priority locations for Military, places with poor access to prevention services for new recruits, and sites with a combination of families and FSW. Proposed activities to reduce HIV risk at the selected locations will include STI screening and care, referrals to MC services, provision of HIV risk reduction education, alcohol harm reduction, and condoms. In addition, activities will include mobile HIV testing/counseling and linkage/referral to civilian and military care centers of 100% of positive HIV results.

- Developing a program to increase access and use of a minimum package of HIV prevention services to active duty members and target group members (FSWs, Civilian employees within the Military, family of the military and other

civilian community in and around the military camps). Minimum HIV prevention packages for Uniformed Services include, Health Education, Peer Education, STI prevention, diagnosis and treatment, SBC materials, HCT with linkage to prevention of mother-to-child transmission (PMTCT), and anti-retroviral therapy (ART), condom promotion and provision, workplace policy, post-exposure prophylaxis (PEP). Minimum HIV Prevention Packages for Sex Workers include: Life skills, peer education, condom promotion and distribution, STI diagnosis and treatment, HCT, outreach programs, sex worker-friendly services, sex worker support groups, referral linkages between services, participation of sex workers in HIV prevention programs.

WORK PLANS

Grantee must submit annual, programmatic and financial, work plans to DHAPP Program Manager and DHAPP HQ (Budget breakdown per activity and for program management is required). Work plans include activities implementation timeline, including the M&E ones.

REPORTING

- Quarterly Fiscal Reports: Grantee must submit quarterly programmatic and financial reports to DHAPP in order to monitor expenditures according to the program area(s) [HVAB; HVOP; etc]. The report template will be provided by DHAPP. Submit 30 calendar days after each reporting period (3/31, 6/30, 9/30, and 12/31).
- Interim Progress: Indicator Report: This report shall summarize progress in relation to the approved Work Plan as well as monitor grant deliverables. The Grantee shall submit quarterly indicator reports in accordance with the format provided by the Program Office within 45 calendar days following the end of the reporting period: 12/31, 3/31, 6/30 and 9/30. The Recipient shall provide reports in accordance with the template provided by NHRC
- Reports will follow DHAPP Headquarters and Country Team Templates

Malawi: Cross Cutting in Military Settings

	Phase 1	Phase 2	Phase 3
PDTX	$25,000	$50,000	$50,000
OHSS	$50,000	$100,000	$100,000
MTCT	$100,000	$200,000	$200,000
HVTB	$25,000	$50,000	$50,000
HVSI	$25,000	$50,000	$50,000
HVOP	$75,000	$150,000	$150,000
HVCT	$125,000	$250,000	$250,000
HTXS	$210,000	$420,000	$420,000
HBHC	$75,000	$150,000	$150,000
CIRC	$50,000	$100,000	$100,000
TOTAL	**$760,000**	**$1,520,000**	**$1,520,000**

Proposals are requested to support Malawi to reduce the number of new HIV infections and other sexually transmitted diseases among members of the Malawi Military, their families, and the civilian communities served by the Malawi Defense Force Military. The TBD partner will work directly with the MDF to aggressively scale-up the military ART program to achieve 90-90-90 goals for HIV epidemic control within the military over the life of this project. Department of Defense HIV/AIDS Prevention Program (DHAPP) programming to support the MDF will focus on the following technical areas: 1) HIV/AIDS Care and Treatment; 2) HIV Testing Services; 3) Tuberculosis Diagnostics and Treatment amongst HIV co-infected individuals; 4) Prevention of Mother-to-Child Transmission; 4) Clinical Laboratory Support; and, 5) HIV Clinical Monitoring Systems.

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 MDF leadership as well as MDF 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 MDF 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 MDF HIV prevention and health services, as well as the DHAPP/DoD Program Manager based at the US Embassy in Malawi, the MDF HIV Program Coordinator and the DHAPP Headquarters Team. The Grantee is the Implementing Partner and will be referred to as IP in this document.

HIV/AIDS Care and Treatment (Phase One $235,000) (Phase Two $470,000) (Phase Three $470,000)

Technical Area Targets							
Indicator	**Label**	**Mil Only Year 1**	**CIV Only Year 1**	**Mil Only Year 2**	**CIV Only Year 2**	**MIL Only Year 3**	**CIV Only Year 3**
TX_NEW	# of adults and children newly enrolled on ART	50	368	185	1339	204	1473
TX_CURR	# of adults and children currently receiving ART	332	2433	721	6619	906	7950
TX_RET	% of adults and children known to be alive and on treatment 12 months after initiation of ART	85%	85%	85%	85%	85%	85%
CARE_NEW	# of HIV+ adults and children newly enrolled in clinical care during the reporting period who received at least one of the following at enrollment: (clinical assessment (WHO staging) OR CD4 count OR viral load	54	392	195	1409	218	1578
CARE_CURR	# of HIV+ adults and children who received at least one of the following during	482	3532	759	6967	850	

	the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load						7803
CARE_SITE	Percentage of PEPFAR-supported clinical care sites at which at least 80% of PLHIV received all of the following during the reporting period: 1) clinical assessment (WHO staging) OR CD4 count OR viral load, AND 2) TB screening at last visit, AND 3) if eligible, cotrimoxazole	100%	100%	100%	100%	100%	100%

Phase One:
The IP will work closely with the MDF to aggressively scale-up ART coverage in an effort to achieve 90-90-90 goals for military personnel. The WHO guidelines should be implemented in the military settings now regarding test and start. All active duty members should be placed on ARVs. The IP should track and monitor the progress of test and start to ensure all our members are on ARVs over the next few months at the start of the grant. In addition, the IP must track and monitor the program's success in keeping both military and civilians on treatment and virally suppressed by tracking viral load at least yearly. As the country moves to test and start, then the military programs should place all the civilians on ARVs as soon as possible.

Phase Two:
The IP will work closely with the MDF to aggressively scale-up ART coverage in an effort to achieve 90-90-90 goals for military personnel. The WHO guidelines should be implemented in the military settings now regarding test and start. All active duty members should be placed on ARVs. The IP should track and monitor the progress of test and start to ensure all our members are on ARVs over the next few months at the start of the grant. In addition, the IP must track and monitor the program's success in keeping both military and civilians on treatment and virally suppressed by tracking viral load at least yearly. As the country moves

to test and start, then the military programs should place all the civilians on ARVs as soon as possible.

Phase Three:
The IP will work closely with the MDF to aggressively scale-up ART coverage in an effort to achieve 90-90-90 goals for military personnel. The WHO guidelines should be implemented in the military settings now regarding test and start. All active duty members should be placed on ARVs. The IP should track and monitor the progress of test and start to ensure all our members are on ARVs over the next few months at the start of the grant. In addition, the IP must track and monitor the program's success in keeping both military and civilians on treatment and virally suppressed by tracking viral load at least yearly. As the country moves to test and start, then the military programs should place all the civilians on ARVs as soon as possible.

The MDF currently provides HIV/AIDS care and treatment services in eleven of thirteen total military facilities, including Chilumba Barracks, Moyale Barracks, Kasungu Engineers Battalion, MAFCO, Parachute Battilion, Mvera Support Battalion, Kamuzu Barracks, Lilongwe Airbase, Marine Unit, Cobbe Barracks and Changalume Barracks. At present, these eleven clinical sites provide care and treatment services for a very limited number of MDF personnel. 80% of clients seen in these facilities are civilian patients living in the surrounding communities. The IP will work directly with the MDF at the eleven fixed sites to achieve the military HIV care and treatment targets.

The IP will be responsible for:

- Enrollment into HIV clinical care and treatment
  - Identification and aggressive enrollment of HIV-infected military personnel into clinical care and treatment at either the current fixed sites or through mobile ART outreach
  - Passive enrollment of HIV-infected civilians and dependents into clinical care and treatment at the eleven military ART sites including Chilumba Barracks, Moyale Barracks, Kasungu Engineers Battalion, MAFCO, Parachute Battilion, Mvera Support Battalion, Kamuzu Barracks, Lilongwe Airbase, Marine Unit, Cobbe Barracks and Changalume Barracks.
- Ongoing clinical support for all Pre-ART and ART patients.
  - Clinical monitoring of all HIV+ positive patients including CD4 in line with the current national guidelines, hemoglobin, creatinine, tuberculosis screening, screening for other opportunistic infections including cryptococcosis, etc.
  - Positive Health, Dignity, and Prevention (PHDP) services including STI screening and treatment, prevention of unintended pregnancies among women living with HIV, Nutritional assessment Counseling Support (NACS) of HIV+ patients, cervical cancer screening, etc.
  - Cotrimoxazole prophylaxis for HIV positive patients, fluconazole prophylaxis for asymptomatic cryptococcal antigenemia with CD4<100 cells/uL, Isonizaid Preventive Therapy, etc.

- Universal TB screening using standard TB questionnaire at least every 6 months for 100% of HIV-infected individuals in care.
- Close coordination with MDF to track down and follow enrolled patients that are deployed, to ensure they have their meds and continue to receive regular CD4 and other required lab checks.
- Retention support including treatment literacy, active tracing and peer support for HIV+ patients, and other evidence-based retention interventions for adults, children, and pregnant women on ART.
- IP to ensure 100% TB patients tested for HIV and 100% HIV patients tested for TB annually.

- Coordination of HIV clinical care and treatment services
  - Planning, logistics, and use of mobile ART clinics to reach military ART targets
  - Ensuring best use of the vehicles to be purchased to support the ART mobile activity
  - Linking MDF personnel, including clinical staff, to other local HIV clinical care and treatment resources provided by the MOH, PEPFAR IPs, or other relevant entities.
  - Promoting ongoing communication and collaboration between MDF clinical services and other district/provincial/national level care and treatment programs and/or government entities
  - Ensuring the availability of essential HIV clinical commodities through support for forecasting, responsible use, stock management, and other activities critical to ensuring a secure supply
  - Ensuring HIV+ patients exhibiting immunologic failure on first-line ART are screened for adherence and switched to appropriate second-line therapy (based on available population-level genotypic resistance data) when indicated
  - Referral for hospital admission when clinically indicated
- Support of the MDF scaling up viral load testing as per current WHO and national guidelines, with reporting on:
  - TX_VIRAL: Percentage of ART patients with a viral load result documented in the medical record within the past 12 months
  - TX_UNDETECT: Proportion of viral load tests with an undetectable viral load (<1000 copies/ml)
- Clinical laboratories for HIV care and treatment are present in all three MDF ART facilities. However, the capacity of the laboratories, including equipment, physical infrastructure, and personnel, vary greatly between the three sites. The IP will work with MDF clinical and laboratory staff in support of all HIV laboratory services.

The IP will be responsible for:

- Procurement of necessary laboratory equipment, aligned with the national and international laboratory standards and guidelines as well as consumable point-of-care test devices such as serum cryptococcal semi-quantitative lateral flow assays

- Inventory control, forecasting, and procurement of laboratory reagents to ensure that laboratory services are uninterrupted
- Installation of equipment, procurement of service maintenance contracts (when applicable), and training of the laboratory staff on the use of the equipment
- Monitoring laboratory quality and adherence to quality systems guidelines through routine visits to each of the labs to assess achievements, review/evaluate activities, and provide recommendations with the development of improvement plans to resolve any identified problems.
- Linking MDF laboratory services to other laboratory resources at the district, provincial, and national levels.

- **PDTX**
- The IP will work closely with the MDF to aggressively scale-up ART coverage in an effort to achieve 90-90-90 goals for pediatric patients in order to reduce HIV-related morbidity and mortality for infants, children, and adolescents living with HIV.
  To achieve this objective the IP will work with the MDF to:
- Increase pediatric HIV case-finding through increases in routine, systematic HIV testing of all children and adolescents in high-priority clinical settings, expansion of coverage of HIV DNA PCR testing, and determination of final HIV status for all HIV-exposed infants with effective linkage and initiation of ART.
- Build an MDF healthcare workforce trained to provide pediatric HIV care and treatment services.
- Provide pediatric ART regimens as per current national pediatric ART guidelines.
- Achieve long-term retention and viral suppression in HIV care and treatment for children using family-and adolescent-friendly service delivery models at all levels of the health care system and improve linkages with community systems of support.
- Create an enabling environment for HIV/AIDS testing, care and treatment services for infants, children and adolescents by updating policies and mobilizing and educating communities.

HIV/AIDS Testing Services (Phase One $125,000) (Phase Two $250,000) (Phase Three $250,000)

Technical Area Targets, Year 1							
Indicator	**Label**	**Military Only Year 1**	**Civilian Only Year 1**	**Military Only Year 2**	**Civilian Only Year 2**	**Military Year 3**	**Civilian Year 3**

HTC_TST	# of individuals who received HTS services for HIV and received their test results	2254	7993	1961	15,158	2063	18,493

The IP will work closely with the MDF to aggressively scale-up HIV Testing Services in an effort to achieve the 1st 90 for military personnel: 90% of all MDF PLHIV know their status. Commonly, military PLHIV only access treatment at one of the three military ART facilities when they are symptomatic. In an effort to reach these men and women before they become symptomatic, HTS will focus primarily on outreach testing to larger, high HIV-burden military locations. Outreach testing should be closely linked to the mobile ART clinic schedule, ideally with both services provided concurrently to maximize linkage. Provider-Initiated Testing and Counseling (PITC) will continue in the fixed sites for both the military and civilian cohorts. 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 90% linkage of HIV+ individuals identified through PITC and 85% of HIV+ individuals identified through outreach testing to HIV clinical care and treatment. 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:

- Outreach HTS to military bases and facilities
  - Diagnosing 10,247 military PLHIV with greater than 90% of those diagnosed linked to HIV care and treatment services (we should directly walk patients over to our clinical care sites for HIV retesting and starting on ARVs)
  - Index-case testing for family members and dependents of HIV-infected military personnel. We should be identifying all HIV positive family members and offering HIV testing and this should be documented and tracked that all family members were tested (spouse and all children if the female spouse is positive).
  - Index-case testing for HIV-infected spouses and dependents of military personnel
  - Coordination of outreach HTS with mobile ART clinic activities to ensure greater than 95% linkage to care.
- Provider-Initiated testing and counseling within military health services for both military personnel and civilians with 90% of positives diagnosed through PITC linked to HIV care and treatment services
- Quality Improvement / Quality Assurance for all MDF HTS including continuous training and mentoring
- Tracking PLHIV from HTS to clinical care and treatment services and monitoring the follow up of patients to ensure a minimal loss to follow up.

Prevention of Mother-to-Child Transmission (Phase One $100,000) (Phase Two $200,000) (Phase Three $200,000)

Technical Area Targets		
Indicator	**Label**	**Target**
PMTCT_STAT	% of pregnant women with known status (includes women who were tested for HIV and received their results)	95%
PMTCT_ART	% of HIV+ pregnant women who received ART to reduce risk for mother-to-child-transmission during pregnancy	95%
PMTCT_EID	% of infants born to HIV-positive women who had a virologic HIV test done within 12 months of birth	100%

The IP will support the three MDF ART sites to ensure that 1) all pregnant women are aware of their HIV status; and 2) all HIV+ pregnant women are initiated and retained on ART to reduce risk for mother-to-child transmission during pregnancy.

The IP will be responsible for:

- Supporting MDF clinical services to screen all pregnant women attending military health services for HIV
- Initiating all HIV+ pregnant women on ART; with a focus on adherence and retention during pregnancy and post-partum
- Quality Assurance / Quality Improvement of MDF PMTCT services
- Ensuring post-partum neonatal ART prophylaxis per existing Option B/B+ guidelines
- Routine Early Infant Diagnosis of exposed infants based on current WHO and National guidelines to include EID virological testing.
- Support PMTCT counseling and ancillary support to include breastfeeding
- Partner HIV testing for pregnant women to identify HIV serodiscordant couples

HIV Strategic Information (Phase One $25,000) (Phase Two $50,000) (Phase Three $50,000)

IP will support HIV/AIDS behavioral, epidemiological and biological surveillance, on a quarterly basis will support monitoring and reporting site level results (SEAS) through data verification exercises, quarterly data analysis and review for program adjustments and data dissemination activities, Site Improvement through Monitoring Systems (SIMS), and assisting the MDF to strengthen such systems. Successful tracking of patient level data is critical to the success of the MDF clinical care and treatment program's ability to monitor progress towards epidemic control. The military is a highly mobile population. Clinical HIV monitoring systems, including patient level data, will be required to ensure that MDF clinical staff and program managers at national and subnational levels have access to the right information at the right time in any location the patient may be seen. The IP will work with the MDF to support the electronic collection of patient-level data, the clinical and programmatic use of electronic

data, and the reporting of site-level data to DHAPP HQ and the MDF leadership. All electronic medical record (EMR) work should be coordinated and aligned with PEPFAR, MOH/MOD, clinical staff requirements, and national/international standards where they exist and IP implementing EMR system. The IP should state what system they intend to use for HIV clinical care and treatment; how the data collected within this system will be accessed by the MDF clinical staff and leadership; and, how the IP will responsibly protect military data from dissemination outside of MDF and DHAPP.

The IP will be responsible for:

- Staffing support and mentoring of existing MDF staff for data entry, information technology assistance, data managers, etc. to fill any gaps where the MDF is unable to provide sufficient staff
- Procurement of necessary hardware and software, aligned with the national and international laboratory standards and guidelines
- Training and on-the-job mentorship of MDF clinical staff on the use of any clinical monitoring system at site and national/program levels
- Ensuring confidentiality and security of data, in line with MOD, MOH, and national guidelines
- Quality Assurance / Quality Improvement for all data collection, reporting, and use.
- Timely, accurate reporting of all indicators required by the MDF, DHAPP, and PEPFAR
- Securing all patient-level and site-level data from dissemination outside of MDF and DHAPP without prior approval from MDF
- Support for data entry, cleaning, reporting, and use
- Implementation of clinical monitoring system, including maintenance of network infrastructure (if necessary)

Other Prevention (Phase One $75,000) (Phase Two $150,000) (Phase Three $150,000)

	Technical Area Targets						
Indicator	**Label**	**Military Only Year 1**	**Civilian Only Year 1**	**Military Only Year 2**	**Civilian Only Year 2**	**Military Only Year 3**	**Civilian Only Year 3**
PP_PREV	Number of individuals from priority populations who completed a standardized HIV prevention intervention, including the specified minimum components, during the reporting period	2145	7605	7018	24,880	8421	29,856

HTC-TST	Number of individuals who received HIV Testing and Counseling (HTC) services for HIV and received their test results						

The IP will work closely with the MDF to ensure that all patients with presumptive TB or TB disease receive HIV testing and provide immediate access to ART for patients, with the goal of providing universal ART coverage among HIV-infected TB patients and universal TB screening for all HIV-infected individuals.

- Activities will include mobile HIV testing/counseling and linkage/referral to civilian and military care centers of 100% of positive HIV results.

- Developing a program to increase access and use of a minimum package of HIV prevention services to uniformed services, Civilian employees within the military, family of the military and other civilian community in and around the military camps. Minimum HIV prevention packages for Uniformed Services include, Health Education, Peer Education, STI prevention, diagnosis and treatment, SBC materials, HCT with linkage to prevention of mother-to-child transmission (PMTCT), and anti-retroviral therapy (ART), condom promotion and provision, workplace policy, post-exposure prophylaxis (PEP). Minimum HIV Prevention Packages for Sex Workers include: Life skills, peer education, condom promotion and distribution, STI diagnosis and treatment, HCT, outreach programs, sex worker-friendly services, sex worker support groups, referral linkages between services, participation of sex workers in HIV prevention programs.

WORK PLANS

Grantee must submit annual, programmatic and financial, work plans to DHAPP Program Manager and DHAPP HQ (Budget breakdown per activity and for program management is required). Work plans include activities implementation timeline, including the M&E ones.

REPORTING

- **Quarterly Fiscal Reports: Grantee must submit quarterly programmatic and financial reports to DHAPP in order to monitor expenditures according to the program area(s) [HVCT, HVOP; etc.]. The report template will be provided by**

DHAPP. Submit 30 calendar days after each reporting period (3/31, 6/30, 9/30, and 12/31).

- **Interim Progress: Indicator Report: This report shall summarize progress in relation to the approved Work Plan as well as monitor grant deliverables. The Grantee shall submit quarterly indicator reports in accordance with the format provided by the Program Office within 45 calendar days following the end of the reporting period: 12/31, 3/31, 6/30 and 9/30. The Recipient shall provide reports in accordance with the template provided by NHRC**
- **Reports will follow DHAPP Headquarters and Country Team Templates**

Uganda: Ugandan People's Defence Force (UPDF): Dreams, HVOP

	Phase 1	Phase 2	Phase 3	Phase 4
Dreams	$300,000	$250,000	--	--
HVOP	$320,000	$320,000	$320,000	$320,000
TOTAL	**$620,000**	**$570,000**	**$320,000**	**$320,000**

The DoD PEPFAR Program in Uganda works with the Ugandan People's Defense Force (UPDF) to provide prevention, care, treatment, and monitoring for military members and their beneficiaries. The program will be expanded to participate in the PEPFAR DREAMS (Determined Resilient Empowered AIDS-Free Mentored State) that aims at reducing HIV infection among adolescent girls and young women (AGYW) 15 to 24 years of age. The goal of DREAMS is to achieve a 25% reduction in HIV incidence by the end of 2016 and a 40% reduction in HIV incidence by the end of 2017. The UPDF DREAMS initiative will be implemented in two districts within Uganda and will target uniformed personnel, their family members, and the civilian population surrounding the bases. This proposal will also aim to support HIV/AIDS Prevention within the UPDF with the same target populations, however country-wide. Activities aim to reduce the number of new HIV infections and other sexually transmitted infections (STIs) among members of the UPDF, their families, and the civilian communities surrounding the bases. The TBD partner will work closely with DHAPP staff and partners to implement the following activities:

DREAMS

For the Adolescent Girls and Young Women (AGYW):

- **Condom Promotion and Provision:** Identify condom outlets at the community and ensure they are consistently supplied with condoms. Hold skill building sessions to familiarize AGYW with the female condom.
- **HIV Testing and Counseling:** Undertake HTC in hotspots with the aim of identifying HIV-positive AGYW and linking them to care and treatment. Overall, strengthen linkages between HTC clients and clinical services.
- **Community mobilization:** Develop a comprehensive mobilization plan using different channels to mobilize AGYW for services. This will include engaging with community leaders, including use of traditional and religious structures and assessing communities to identify possible structures. Collaborate with existing OVC mechanisms in the community to reach households and out of school AGYW to offer them a complete package of household economic strengthening interventions, parenting programs, HIV/AIDS and GBV prevention, and linkages to post violence care and social protection.
- **Social Protection, Parenting/Care Giver Program**: Create AGYW family support groups, with aim of ensuring psychosocial support and treatment adherence.
- **School Based HIV and GBV Prevention:** Provide mechanisms to implement evidence-based, medically accurate and age-appropriate school-based HIV/AIDS and sex education, and GBV prevention in military based schools, using the HIV Education module and Doorways training programs.

- **Sexually Transmitted Infection Screening and Linkage:** Provide routine STI screening and linkages to treatment using outreaches. Link individuals screening positive for STIs to other appropriate high impact interventions.
- **Peer to peer psychosocial support**: Use existing peer groups to reach out to other peers for condom distribution and uptake of services like HCT, FP, and STI screening.
- **Post violence care**: Train social workers and other community social workers with basic knowledge and skills to prevent and respond to young people who have experienced gender related violence using the community component. Train health workers to manage and provide services to young people who have experienced gender related violence.

For Males 15+ Years

- **Linkage to VMMC of Uncircumcised Males:** Identify and target uncircumcised men aged 15+ years for linkage to VMMC services.
- **Linkage to ART in men with diagnosed HIV and not on treatment:** Conduct a sexual mapping exercise to determine the target men who are in the sexual networks of the selected AGYW. Undertake targeted HTC aimed at identifying the eligible men 15+ and link them to care and treatment. Through community workers, identify men 15+ who are HIV positive and not yet on ART and link them to care and treatment. Use peer educators including men on ART to share their stories and encourage those eligible to get enrolled on treatment.

HVOP

The Ugandan People's Defense Force (UPDF) military personnel are a priority population in Uganda with an increased risk for HIV infection. The Grantee will perform formative research to determine these risk factors as well as knowledge, attitudes and behaviors about HIV and related topics (alcohol, GBV, condom use, etc.) within the UPDF context. Grantee will use results from this
baseline data to develop a male condom social marketing campaign. The campaign should include 3 components: condom branding, development of a commodity logistics system, a sustained marketing campaign to promote the condoms. A minimum procurement and distribution of four million condoms is expected within the first year. Social marketing campaign around condoms will include printed and instructional materials for promotion and education. A monitoring and evaluation system should be created to track condom distribution, ensure no condom stock-outs and track changes in knowledge, attitudes and behaviors as a result of the campaign.

The formative research, condom branding, and distribution will be part of a minimum prevention packages for the various priority and key populations served by the military - which will entail: BCC/IEC to increase uptake of HIV prevention interventions (at individual and community-level using peer model and community engagement), risk reduction counseling - including consistent correct condom use (female/male), routine STI screening and treatment, targeted HIV testing with ART initiation, adherence support, link to family planning and spacing pregnancies, link to reproductive health, SGBV screening and Post Care-PEP.

HVOP –HIV Other Prevention - $320,000

Technical Area Targets, Year 1				
Indicator	**Label**	**Military**	**Military dependents**	**Total**
PP_PREV	Number of individuals from priority populations who completed a standardized HIV prevention intervention, including the specified minimum components, during the reporting period	15,000	35,000	50,000

WORK PLANS:

- 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 include activities implementation timeline, including the M&E ones.

REPORTING:

- Quarterly Fiscal Reports: Grantee must submit quarterly programmatic and financial reports to DHAPP in order to monitor expenditures according to the program area(s) [DREAMS; HVOP]. The report template will be provided by DHAPP. Submit 30 calendar days after each reporting period (3/31, 6/30, 9/30, and 12/31).
- Grantee will complete the DoD site-level Excel Accomplishments Spreadsheet (SEAS) for quarterly site level indicator reporting (results and narratives) by Implementing Mechanism, due no later than 30 days after quarter end. DHAPP Uganda program manager will review the data prior to sending it to DHAPP or inputting aggregate results into DATIM.
- Grantee with cooperate with and participate in quarterly or annual (depending on PEPFAR mechanism-specific guidance) Site Improvement for Monitoring Systems that will be conducted by DHAPP personnel.
- Reports will follow DHAPP Headquarters and Uganda PEPFAR Team Templates as directed by DHAPP Strategic Information team