Issue Date:	November 30, 2017
Deadline for Questions/Clarifications:	December 11, 2017 (8:00 a.m. Guatemala time)
Closing Date:	January 16, 2018 (8:00 a.m. Guatemala time)

Subject: Notice of Funding Opportunity Number: 72052018RFA00002

Program Title: Strengthening Care and Treatment Cascade Project

Ladies/Gentlemen:

The United States Agency for International Development (USAID) is seeking applications for a cooperative agreement from qualified U.S. and non-U.S. organizations to fund a program entitled "Strengthening Care and Treatment Cascade." Eligibility for this award is not restricted. See Section C of this Notice of Funding Opportunity (NOFO) for eligibility requirements.

Subject to the availability of funds an award will be made to the responsible applicant whose application best meets the objectives of this funding opportunity and the selection criteria contained herein. While one award is anticipated as a result of this NOFO, USAID reserves the right to fund any or none of the applications submitted.

For the purposes of this NOFO the term "Grant" is synonymous with "Cooperative Agreement"; "Grantee" is synonymous with "Recipient"; and "Grant Officer" is synonymous with "Agreement Officer." Eligible organizations interested in submitting an application should read this funding opportunity thoroughly to understand the type of program sought, application submission requirements, and evaluation process.

To be eligible for award, the applicant must provide all information as required in this NOFO and meet eligibility standards in Section C of this NOFO. This funding opportunity is posted on www.grants.gov, and may be amended. Potential applicants should regularly check the website to ensure they have the latest information pertaining to this NOFO. Applicants will need to have available or download the Adobe program to their computers in order to view and save the Adobe forms properly. It is the responsibility of the applicant to ensure that the entire NOFO has been received from the internet. USAID bears no responsibility for data errors resulting from transmission or conversion process. If you have difficulty registering on www.grants.gov or accessing the NOFO, please contact the Grants.gov Helpdesk at 1-800-518-4726 or via email at support@grants.gov for technical assistance.

The successful Applicant will be responsible for ensuring the achievement of the program objectives. Please read each section of the NOFO.

Please submit questions regarding this NOFO by e-mail to guatemalaproposals@usaid.gov by the date and time listed at the top of this letter. Responses to questions received prior to the deadline will be furnished to all potential applicants through an amendment to this notice posted to www.grants.gov. If you decide to submit an application, it should be submitted via email to guatemalaproposals@usaid.gov and received by the closing date and time indicated at the top of this cover letter.

Issuance of this notice of funding opportunity does not constitute an award commitment on the part of the Government nor does it commit the Government to pay for any costs incurred in preparation or submission of comments/suggestions or an application. Applications are submitted at the risk of the applicant. All preparation and submission costs are at the applicant's expense.

Thank you for your interest in USAID programs.

Sincerely,

Natalie J. Thunberg
Agreement Officer

TABLE OF CONTENTS

Abbreviations and Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-retroviral treatment
BSS	Behavioral surveillance survey
CA	Cooperative Agreement
C.A.	Central America
CCM	Country Coordinating Mechanism
CCR	Coordinated Community Response
CDC	Centers for Disease Control and Prevention
COMISCA	Council of Central American Ministers of Health (Spanish Acronym)
CQI	Continuous Quality Improvement
DATIM	Data for Accountability Transparency and Impact
DOD	Department of Defense
EA	Expenditure Analysis
ECR	Environmental Compliance Report
EMMP	Environmental Mitigation and Monitoring Plan
ERF	Environmental Review Form
FOIT	Focused Outcome and Impact Table
FSW	Female sex workers
GARPR	Global AIDS Response Progress Reporting
GBV	Gender-Based Violence
GFATM-GF	Global Fund to Fight AIDS, TB and Malaria
HIV	Human Immunodeficiency Virus
HR	Human resources
HSS	Health System Strengthening
HTC	HIV testing and counseling
HTS	HIV Testing Services
IE&C	Information, education and communication for behavioral change
IPT	Prophylactic Isoniazid
KP	Key populations
LIS	Laboratory Information System
MDR	Multi Drug Resistant
MEO	Mission Environmental officer
MER	Monitoring, Evaluation and Reporting
MOH	Ministry of Health
MSM	Men who have sex with men
NAP	National AIDS Program
NASA	National AIDS Spending Assessment
NCDs	Non-communicable diseases
OGAC	Office of Global AIDS Coordinator
OPQ	Optimizing performance and quality
PAHO	Pan American Health Organization
PASCA	Program for Strengthening the Central American Response to HIV
PEPFAR	President’s Emergency Plan for AIDS Relief
PLHIV	People Living with HIV

PP	Priority populations
PR	Principal Recipient
RCM	Regional Coordinating Mechanism
RDCS	Regional Development Cooperation Strategy
REA	Regional Environmental Advisor
ROP	PEPFAR Regional Operational Plan
RR	Rifampicin Resistance
SDG	Sustainable Development Goal
SDS	Strategic Direction Summary
SI	Strategic Information
SID	Sustainability Index and Dashboard
SIMS	Site Improvement through Monitoring System
SNU	Sub-national unit
STI	Sexually transmitted infection
SUMEVE	Unique System for HIV/AIDS Monitoring Evaluation and Epidemiological Surveillance (Spanish acronym)
TB	Tuberculosis
TGW	Transgender women
T&S	Test and Start
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	United States Agency for International Development
USG	United States government
WHO	World Health Organization

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SECTION A: PROGRAM DESCRIPTION

1. Summary and Background

The U.S. Agency for International Development (USAID) Mission in Guatemala intends to fund a five-year activity in Central America. Activities will focus on supporting countries to adopt and implement Test and Start (T&S), as a means[1] to reach the second and third UNAIDS 90-90-90 goals, such that 90% of people who know their HIV-positive status will access treatment, and 90% of people on treatment will have suppressed viral loads[2]. The emphasis of the activity is on strengthening HIV care and treatment services for key populations (KP) and priority populations (PP) with an emphasis on increasing treatment adherence and improving quality of life. All strategies and interventions should be evidence-based and cost effective.

The proposed activity will contribute to the development objectives for USAID in the region as described in USAID's Central America and Mexico Regional Development Cooperation Strategy (RDCS)[3] 2015-2019 and specifically towards achievement of Development Objective 4: *HIV prevalence in Central America contained, Intermediate Result 4.1 Effectiveness of comprehensive prevention, care and treatment services increased and 4.2 Health systems strengthened and sustained.* The activity will support the President's Emergency Plan for AIDS Relief (PEPFAR) *3.0 Strategy* with a focus on sustainable control of the epidemic and ensuring that effective treatment is available and accessible to those who need it most. [4]

The RDCS also lays out other non-HIV related regional priorities for USAID and emphasizes the commitment to coordination of the USAID Missions in the region.

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[1] *WHO (2016) Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Recommendations for a public health approach - Second edition (http://www.who.int/hiv/pub/arv/arv-2016/en/)*

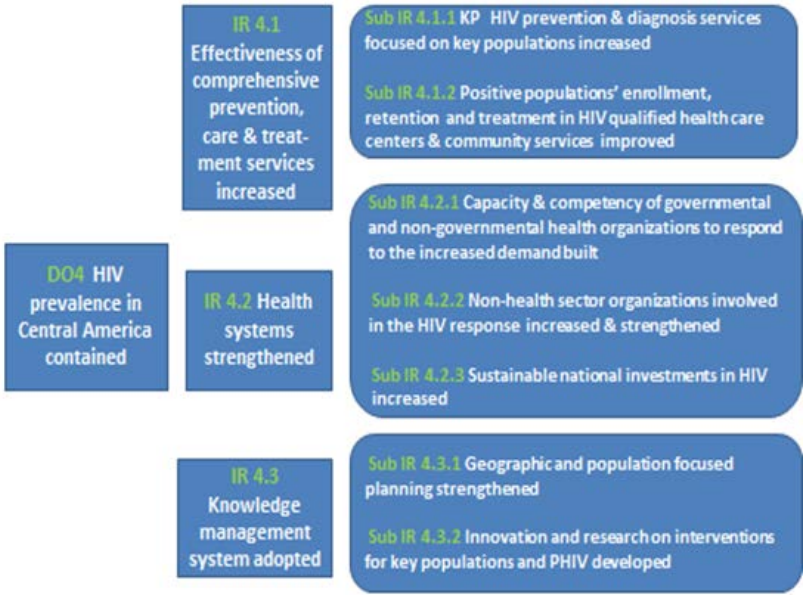
[2] UNAIDS (2014). *90-90-90 – An Ambitious Treatment Target to Help End the AIDS Epidemic*. Geneva. (http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf)

[3] *https://www.usaid.gov/sites/default/files/documents/.../FINAL_CAM_RDCS_public.pd*

[4] The Office of the Global AIDS Coordinator (2014). *PEPFAR 3.0 – Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation*. Washington, D.C. (http://www.pepfar.gov/documents/organization/234744.pdf)

Graph 1

Regional HIV/AIDS Project Results Framework



Activity Goal: *Strengthen the ability of El Salvador, Guatemala, Honduras, Nicaragua, and Panama to provide effective and sustainable high-quality, patient-centered, and free of stigma and discrimination services that successfully enroll and retain patients on HIV care and treatment.*

The activity goal will be achieved through the following objectives:

Objective 1: Strengthen host country capacity to provide sustainable high quality care and treatment services free of stigma and discrimination, including addressing service delivery related barriers to anti-retroviral treatment (ART) initiation for KP.

Objective 2: Strengthen People living with HIV (PLHIV) enrollment and retention across the continuum of care through HIV differentiated service delivery models tailored to KP.

Objective 3: Improve health care providers' response capacity to prevent, detect, and manage HIV/Tuberculosis (TB) coinfections at the facility and community levels.

Objective 4: Improve the generation, analysis, and use of strategic information related to the continuum of care for KP by national and subnational governments.

The activity will be implemented in the five countries in Central America comprising the Regional HIV/AIDS Program: El Salvador, Guatemala, Honduras, Nicaragua, and Panama. Within the countries, the activity will focus at the national level and priority municipalities with the greatest disease burden and unmet need for KP and PP HIV and AIDS related services.

Based on the above criteria, priority municipalities or sub-national units (SNUs)[5] will be identified, but they are subject to change in future years. The activity will adapt strategies according to each specific country context taking into account strengths and weaknesses.

I. Background

Guiding Frameworks

UNAIDS 90-90-90 Goals

All countries in Central America are publically in support of the UNAIDS 90-90-90 targets, which state that by 2020, 90% of people living with HIV will know their status, 90% of people who know their HIV-positive status will access treatment, and 90% of people on treatment will have suppressed viral loads[6]. The Regional HIV/AIDS Program is committed to supporting partner governments to achieve these ambitious goals and USAID's activities are now oriented to the 90-90-90 targets with the important recognition that these goals can only be met by national programs through a shift of focus towards sustainable epidemic control among key and priority populations most affected by HIV in the region. This activity will focus on supporting the second and third 90-90-90 goals to ensure that all those diagnosed with HIV receive the life-saving benefits of antiretroviral treatment (ART), which also prevents HIV-related illness and prevents new HIV infections.

WHO Guidelines

In 2016, the World Health Organization (WHO) issued updated guidelines[7] reiterating the 2015 recommendation[8] for the initiation of ART for all HIV positive individuals upon diagnosis, also known as test and start. This updated guidance also advocates for the differentiation of service delivery models in varied settings and with different populations to improve access and increase the financial and programmatic feasibility of implementing the test and start approach. The USAID Central America Regional HIV/AIDS program is working to support host-country governments as they adopt and roll out global best practices related to HIV/AIDS from the development of new national policies, guidelines and processes to the implementation at the site level with training, monitoring and evaluation. The USG is supporting countries to make test and start the official policy and explore different service delivery models such as task shifting and offering care and treatment at primary and secondary health care facilities to improve linkages among testing and treatment.

[5] Sub-national units (SNUs) is the PEPFAR term for the defined geographic areas within countries to enable in-depth analysis of PEPFAR programming and impact. In Central America an SNU is equal to a municipality.
[6] UNAIDS (2014). *90-90-90 – An Ambitious Treatment Target to Help End the AIDS Epidemic*. Geneva. (http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf)
[7] WHO (2016). Consolidated guidelines on the use of antiretroviral drugs for treating and preventing. HIV infection: Recommendations for a public health approach – Second edition (http://www.who.int/hiv/pub/arv/arv-2016/en/)
[8] WHO (2015). Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva. (http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en/)

In 2016, WHO also published updated guidelines specifically on HIV prevention, diagnosis, treatment and care for KP most affected by the epidemic[9]. The guidelines emphasize the importance of an evidence-based comprehensive package of HIV services that take into account the special needs and issues, relevant for KP. The updated guidelines include the importance of initiating test and start for KP and addressing the financial, social and legal issues that serve as barriers to accessing services.

Service delivery areas for treatment:

WHO has outlined the six essential operational and service delivery areas for ART:[10]

- Adherence to ART
- Retention across the continuum of care
- Service delivery, comprising service integration and linkage and decentralization of HIV care and treatment
- Human resources, including task shifting
- Laboratory and diagnostic services
- Procurement and supply management systems, including supply chain for diagnostics.

While this activity will not focus on all aspects of these areas, it will be important to take them into account when planning activities.

PEPFAR 3.0

The President's Emergency Plan for HIV/AIDS Relief (PEPFAR) has evolved from an emergency response during the first phase from 2003-2007 to move towards sustainability during the second phase from 2008-2012. Starting in 2013, PEPFAR has entered phase three with a strong focus on sustainable epidemic control to achieve the 90-90-90 goals. PEPFAR represents a USG inter-agency effort, and as a part of PEPFAR, the USAID Central America Regional HIV/AIDS program aligns its technical assistance efforts with broader PEPFAR strategies and in response to the needs of the Central American context. For the second phase of PEPFAR, the Regional HIV/AIDS Program operated under the framework of the Central America Regional Partnership Framework, a five-year strategy between the USG and the seven countries of Central America represented by the Council of Central American Ministers of Health (COMISCA – Spanish acronym).[11] The current work of the Regional HIV/AIDS Program builds on the solid foundation provided by the Partnership Framework for coordination and cooperation between the USG and partner governments around shared technical priorities such as strengthening health systems to provide quality care and treatment services and a focus on the sustainability. PEPFAR 3.0 has represented a pivot in terms of priorities and areas of work as the Central

[9]WHO(2016). Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations: 2016 update (http://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/).

[10]WHO. Consolidated guidelines on general HIV care and the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach. 2013. (http://www.who.int/iris/bitstream/10665/85321/1/9789241505727_eng.pdf, accessed 25 February 2014).

[11] COMISCA also includes the Dominican Republic, which is not included in the PEPFAR Central America program.

America Regional HIV/AIDS program operates within the framework of the PEPFAR 3.0 strategy, in particular the five PEPFAR action agendas: Impact, Efficiency, Sustainability, Partnership, and Human Rights.[12]

The Impact Action Agenda prioritizes the importance of doing the right things, in the right places, at the right time, which includes targeting KP and improving their access to prevention, care and treatment services. Removing barriers that prevent KP from receiving services is an essential part of this agenda. In Central America, this has led to analysis of the epidemic at a more granular, municipal level and a resulting focus on a smaller number of high burden municipalities. This geographic prioritization is nested within an on-going process of monitoring and evaluating all program activities to ensure impact and a focus on the key and priority populations driving the region's epidemic. This pivot also corresponds to the Efficiency Action Agenda, which emphasizes that resources are used transparently for the greatest possible impact. In Central America, this also means that the USG works with host country governments to analyze expenditures and look together for ways to increase the cost-effectiveness of HIV service delivery and to ensure the continuum of care.

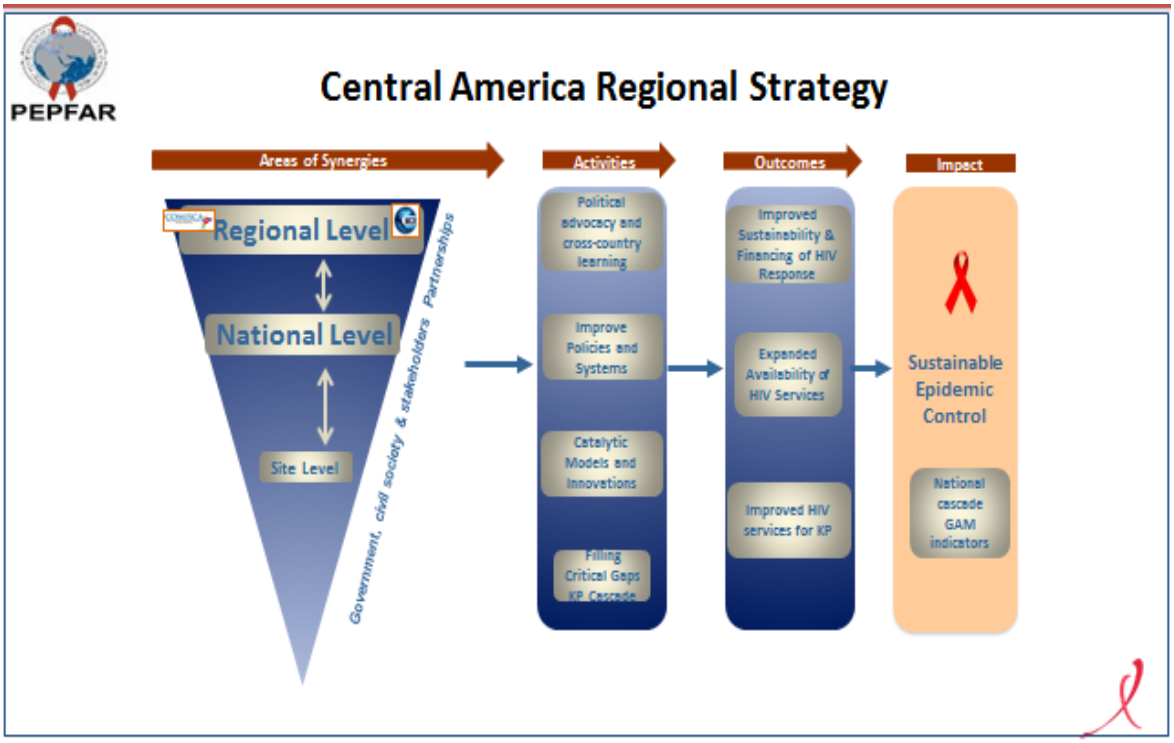
The Central America Regional HIV/AIDS Program continues to work together with all stakeholders towards ensuring a sustainable response which includes not only financial sustainability, but also includes building local capacity, especially of civil society, and institutionalizing processes and policies to guarantee quality services free of discrimination for key and priority populations. With the Partnership Action Agenda, PEPFAR recognizes that working together with all key stakeholders is essential for sustainable epidemic control calling for ever stronger coordination with multilateral partners such as the Joint United Nations Program on HIV/AIDS (UNAIDS) and the Global Fund to Fight AIDS, TB and Malaria. In Central America, the USG sees partnership with all key stakeholders as central to its work, from multi-lateral partners and Ministries of Health to civil society and other non-health sector entities such as Ministries of Finance, human rights institutions, and private sector, among others. Stigma and discrimination continue to be among the most significant barriers impacting KP' access to HIV prevention, care and treatment, a programmatic priority highlighted within PEPFAR's Human Rights Action Agenda.

PEPFAR is committed to addressing all of the social, cultural, economic, and legal barriers that inhibit equal access to health services. In Central America, the Regional HIV/AIDS Program is focused on reducing stigma and discrimination at all levels as an important pillar in its work to improve identification of HIV-infected key and priority populations and their subsequent uptake of HIV treatment.

[12] The Office of the Global AIDS Coordinator (2014). *PEPFAR 3.0 – Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation*. Washington, D.C.

Graph 2

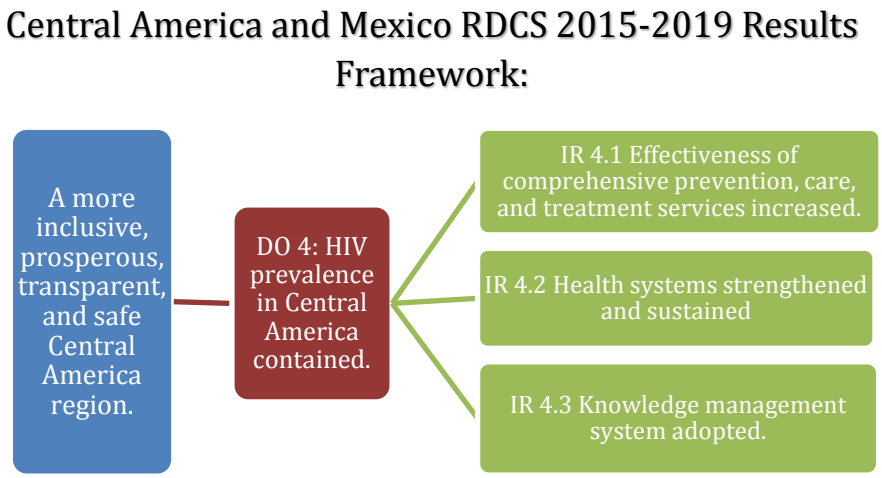
PEPFAR Central America Regional Strategic Approach



USAID's Regional HIV/AIDS Program follows the Interagency PEPFAR Central America strategic approach as outlined in the FY2017 Regional Operational Plan[13] working at the regional, national and site levels to support the regional HIV response and help countries achieve the 90-90-90 goals. At the highest level, USAID engages with the regional platforms represented by COMISCA and their technical advisory group for HIV/AIDS, the Regional Coordinating Mechanism (RCM) for political advocacy and regional strategic planning and coordination. At the national level, USAID works with national stakeholders including government, non-governmental entities, civil society, and multi-lateral organizations to improve policies and systems. At the site level, USAID provides technical assistance at health care facilities to improve adherence rates and quality of care and treatment services, which is the focus of this activity. In addition, USAID works to improve access to HIV prevention and testing for KP at the community level, and to increase demand for HIV services among the same KP.

[13] FY2017 Regional Operational Plan – Central America Region Strategic Direction Summary (http://www.pepfar.gov/documents/organization/266402.pdf).

Graph 3



USAID Missions and Other USG Agencies

The USAID Central America Regional HIV/AIDS program is based at USAID/Guatemala and coordinates with USAID Missions in the region, which include Guatemala, El Salvador, Honduras and Nicaragua, as well with the US Embassy in Panama, and also coordinates with USAID bilateral health programs in Guatemala, and other related USAID portfolios such as Democracy and Governance, which includes human rights-related issues.

The USAID Central America Regional HIV/AIDS Program operates within the interagency context of PEPFAR, which is led by the Office of the Global AIDS Coordinator (OGAC), at the Department of State based in Washington, and the Central America Regional PEPFAR Coordinator in Guatemala. USAID works closely with the other USG PEPFAR implementing agencies in the region, including the Centers for Disease Control and Prevention (CDC) and the Department of Defense (DOD).

Regional & National Strategic Plans

All USAID activities are aligned with regional and national strategic HIV/AIDS plans.[14] [15] [16] [17] [18] [19] USAID supports national programs providing care and treatment services

[14] Regional Coordinating Mechanism (March 2010). *Plan Estratégico Regional de VIH y sida de Centroamérica y República Dominicana 2010-2015.*
[15] *Ministerio de Salud de El Salvador* (March 2011) *Plan Estratégico Nacional Multisectorial de la Respuesta de VIH-Sida e ITS 2011-2015.*
[16] *Ministerio de Salud Pública y Asistencia Social de Guatemala* (June 2011) *Plan Estratégico Nacional para la Prevención, Atención y Control de ITS, VIH y Sida: Guatemala 2011-2015.*
[17] *Secretaría de Salud de Honduras* (December 2007) *III Plan Estratégico Nacional de Respuesta al VIH y Sida en Honduras.*
[18] CONISIDA (November 2012). *Plan Estratégico Nacional de ITS, VIH y sida 2011-2015*
[19] *Ministerio de Salud de Panamá* (February 2014) *Plan Estratégico Nacional Multisectorial de VIH/Sida 2014-2019.*

through strategic technical assistance. USAID works in close coordination with all stakeholders implementing the national strategic plan in each country.

Regional Sustainability Strategy

In 2012, COMISCA tasked the RCM with the development of a Regional Sustainability Plan to assure the long-term sustainability of universal access to HIV prevention, care and treatment services in the Central American region. With USG support, the RCM presented the plan in 2013 and it was subsequently adopted and ratified by COMISCA with the overall purpose of accelerating the progress towards achieving the goals of Universal Access and Millennium Development Goals (now the Sustainable Development Goals, or SDGs) in HIV prevention, care, treatment and support by focusing efforts and dedicating additional resources to the most effective interventions in the countries of Central America and the Dominican Republic. The plan's objectives include: a) Increase the effectiveness of prevention activities; b) Improve access to and quality and equity of care and treatment for people living with HIV in a sustainable manner; c) Strengthen the management and optimum use of resources for the national HIV response; and d) Reduce dependence on external resources for financing activities to reduce the number of new HIV infections through greater national ownership of the response[20]. The Regional HIV/AIDS program is guided by the Regional Sustainability Strategy and provides technical assistance to assist countries in implementing sustainable strategies to improve the quality of HIV care and treatment services.

Sustainability Index and Dashboard (SID)

In addition, PEPFAR Central America also uses the USG-developed Sustainability Index and Dashboard (SID) tool to measure progress towards sustainability across all four domains: 1) Governance, Leadership and Accountability; 2) National Health System & Service Delivery; 3) Strategic Investments, Efficiency & Sustainable Financing; and 4) Strategic Information. In 2016, PEPFAR organized SID meetings in all five Central American countries with a diverse mix of stakeholders. While each country had different results, the following elements emerged as sustainability strengths from a regional perspective: Planning and Coordination, Public Access to Information, Technical and Allocative Efficiencies, and Performance Data. The main sustainability vulnerabilities at a regional level were Private Sector Engagement, Service Delivery, Commodity Security and Supply Chain, and Domestic Resource Mobilization as can be seen in table 1, below.

[20] Regional Coordinating Mechanism (April 2013). *Estrategia de sostenibilidad de la Repuesta al VIH en Centroamérica y República Dominicana.* (http://mcrcomisca.org/sites/all/modules/ckeditor/ckfinder/userfiles/files/3_%20Estrategia%20de%20Sostenibilidad%20Regional.pdf)

Table 1: 2016 SID Central America Summary

Domains & Elements	El Salvador	Guatemala	Honduras	Nicaragua	Panama
Governance, Leadership and Accountability					
1. Planning & Coordination	9.70	6.53	10.00	10.00	9.50
2. Policies & Governance	6.67	6.53	6.37	7.50	6.92
3. Civil Society Engagement	7.00	6.12	5.76	5.93	7.50
4. Private Sector Engagement	2.01	2.50	2.36	2.57	3.26
5. Public Access to Information	9.00	7.00	5.00	8.00	8.00
National Health System and Service Delivery					
6. Service Delivery	6.71	4.31	5.60	5.56	7.31
7. Human Resources for Health	5.92	6.33	4.58	8.08	7.31
8. Commodity Security & Supply Chain	6.72	5.17	6.14	7.23	6.75
9. Quality Management	5.24	3.57	6.14	1.95	7.14
10. Laboratory	7.92	4.17	3.75	6.11	7.73
Strategic Investments, Efficiency, and Sustainable Financing					
11. Domestic Resource Mobilization	4.72	5.28	7.22	5.83	5.56
12. Technical & Allocative Efficiencies	7.94	6.23	8.65	8.45	8.13
Strategic Information					
13. Epidemiological & Health Data	5.95	4.52	6.13	6.67	7.22
14. Financial/Expenditure Data	8.75	7.08	4.58	5.83	5.83
15. Performance Data	6.76	5.38	7.43	7.66	8.13

Joint Approach

Within the context of the aforementioned guiding frameworks, the Global Fund, the Pan American Health Organization (PAHO), UNAIDS, PEPFAR, the CDC, and USAID came together in 2014 in coordination with the RCM to formally document a Joint Approach for HIV/AIDS activities in Central America and the Dominican Republic.[21] The purpose of the Joint Approach is to optimize resources for the HIV response and move towards financial and programmatic sustainability as defined by the requirements and qualifying factors for Global Fund grant recipients in the region. While the Joint Approach document will be updated to reflect the 2015 WHO guidelines, the guiding principles remain the same and include sustainable epidemic control as the overall development goal with a focus on KP and prioritizing geographic areas with the highest prevalence, universal access to care and treatment, the provision of a minimum prevention package, and other key activities such as human rights related activities and strengthening civil society and community groups. The Joint Approach ensures a coordinated,

[21] Enfoque Conjunto Para Aplicaciones De VIH/Sida En La Región De Centroamérica y la República Dominica Antes El Fondo Mundial De Lucha Contra El Sida, la Tuberculosis y la Malaria 2014-2020 (Abril 2014). (http://countryoffice.unfpa.org/dominicanrepublic/drive/EnfoqueconjuntoparaVIH.pdf).

consistent and coherent approach in all countries of the region from all multi-lateral and bilateral stakeholders in support of common goals.

Multi-sectorial Consultation Results[22]

The Regional HIV/AIDS Program works closely with all key stakeholders who are part of the regional and national HIV/AIDS response and considers their perspectives when planning future activities. In June 2016, over 120 key stakeholders from all five countries across relevant sectors (government, civil society, international donors, private sector and academia) participated in an on-line survey that included questions about the primary barriers for individuals to access HIV related services and their responses were used to guide the components of this and other future USAID activities. Stigma and discrimination were cited as major barriers to all types of services for KP most affected by the epidemic. High staff turnover in host-country government institutions was also cited as one reason contributing to stigma and discrimination. Respondents also reported lack of resources and lack of patient understanding about the importance of adherence as being the principal barriers to adherence in the region. Lack of processes and inadequate information systems were rated as the primary obstacle to proper follow-up for patients who are on ART, especially if they are not adherent.

HIV Context in Central America

Epidemiology

The HIV epidemic in Central America continues to be concentrated among certain KPs and low among the general population as reflected in Table 2 below. The KPs with the highest prevalence rates include transgender women (TGW), men who have sex with men (MSM), and female sex workers (FSW).

Table 2 Central America Demographic and Epidemiological Data

Indicator	ELS	GUA	HON	NIC	PAN	Total
Total Population (2018)	6,643,359	17,302,084	8,075,060	6,386,596	3,929,141	42,336,240
# Estimated People living with HIV (PLHIV) (year?)	20,874	47,800	23,000	11,130	15,423	118,227
HIV prevalence (%)	0.5	0.6	0.4	0.3	0.7	----
HIV incidence among adults (15-49)	0.02	0.04	0.01	0.02	0.05	-----
Estimated Population Size of MSM	54,140	122,000	43,439	57,742	15,842	293,163
MSM HIV Prevalence (%)	6-13.8	6.6-14.6	6.9-11.7	9.76	7.7	-----
Estimated Population Size of FSW	44,972	25,800	22,573	17,047	5,217	115,609
FSW HIV Prevalence	3.9-12.0	1.0-2.5	3.5-15.6	2.0-3.0	1.0	----

[22] [22] http://www.pasca.org/anuncios/reporte_sobre_consulta_multi_sectorial_espanol.pdf

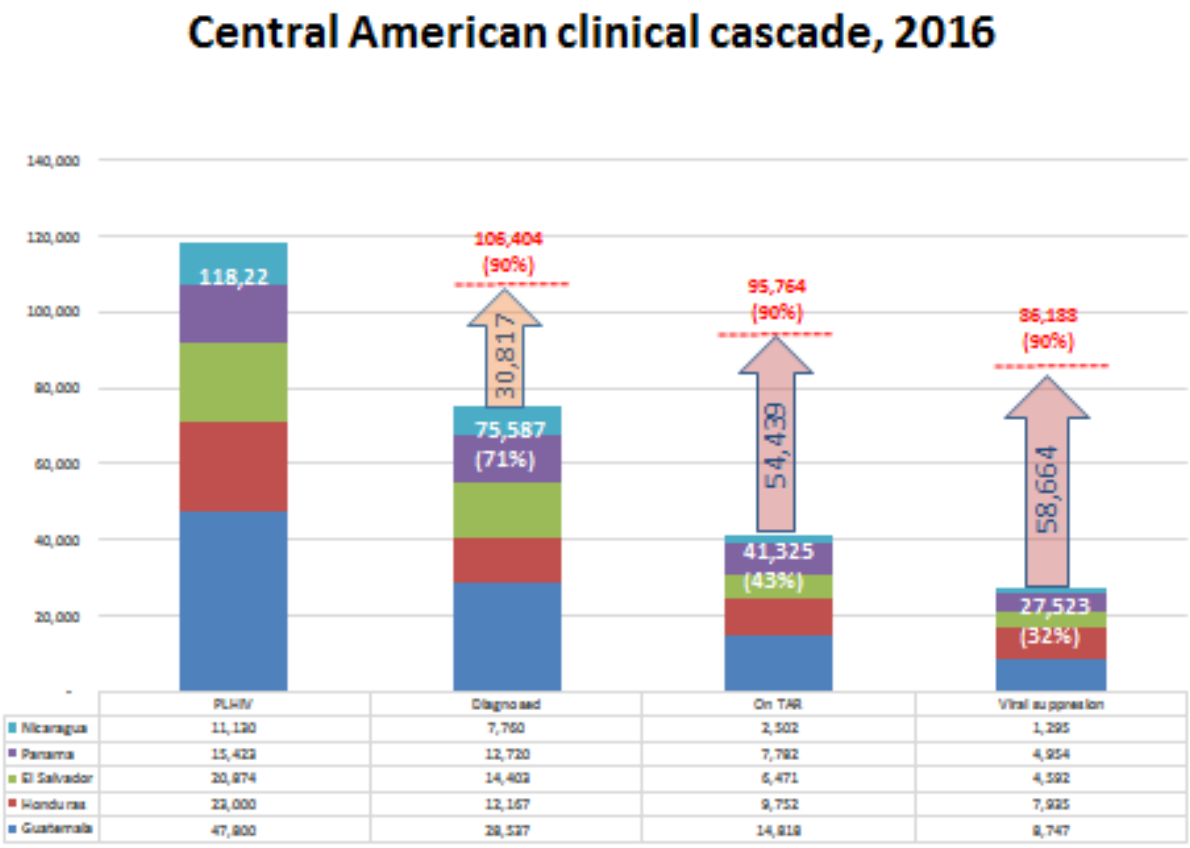
Estimated Population Size of TG	2,011	4,167	2,975	5,489	---	13,989
Transgender (TG) HIV Prevalence	23.8	13.8-30.9	31.9	18.6	15.0	----
Number of people diagnosed HIV- positive	14,403	28,537	12,167	7,760	12,720	75,587
Number of people receiving ART	6,471	14,818	9,752	2,502	7,782	41,325
Number of people in viral suppression	4,592	8,747	7,935	1,295	4,954	27,523
Number of TB cases that are HIV infected	240	840	340	140	180	-----
Source: National AIDS Programs/ National Statistical Institute/ Population Size Surveys						

The prevalence among FSWs has been in decline and due to lower prevalence in Guatemala, Nicaragua, and Panama the USG has prioritized working with FSW only in El Salvador and Honduras. The Regional HIV/AIDS Program focuses on MSM and TGW in all five countries due to their high prevalence rates. In addition, PEPFAR Central America considers the Garifuna ethnic group in Honduras as a Priority Population (PP) given their high HIV prevalence rates, most recently evidenced by the 2012 Behavioral Surveillance Survey (BSS) with rates of 4.2% in the urban Garifuna population, and 2.5 in the rural Garifuna population.

Clinical Cascades

Clinical Cascade (also referred to as the continuum of care), is a model that outlines the sequential milestones of comprehensive HIV clinical services from initial diagnosis to achieving the goal of viral suppression. The proportion of individuals living with HIV who are engaged successfully at each stage of the clinical cascade varies in each country, but as a region there are critical gaps across the cascade: 1) HIV case finding with only 64% of PLHIV diagnosed; 2) poor linkage of HIV positive individuals to treatment with only 37% of PLHIV on ART, and 3) suboptimal adherence with only 23% of PLHIV achieving viral suppression. This activity will focus primarily on gaps two and three above. Graph 4 shows the statistics on the clinical cascade for the relevant countries.

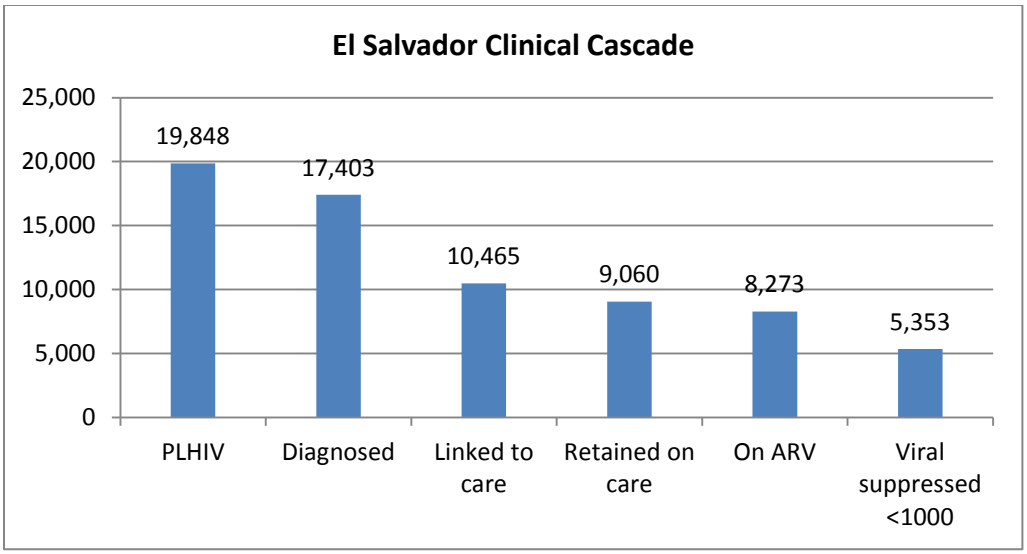
Graph 4



The following series of graphs shows the clinical cascades in each of the five countries and presents a brief analysis of each one. As the numbers reflected in graph 4 are provided by UNAIDS and the numbers provided in the countries' graphs are the official numbers provided by the Ministries of Health, they may be different. The number in column 1 of each of the cascades is an estimate.

In El Salvador, while 89% of PLHIV have been diagnosed, only 42% of PLHIV are on ART and only 27% have achieved viral suppression (Graph 5).

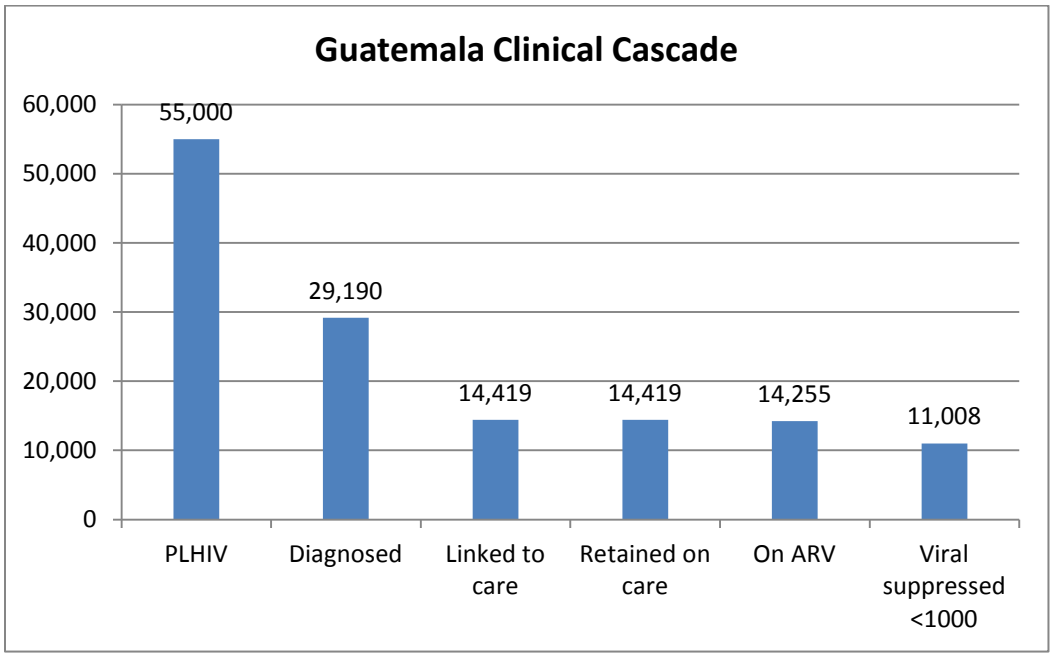
Graph 5



(Source: MoH SUMEVE Reports in 2015)

Guatemala has second lowest percentage of PLHIV having reached viral suppression at only 20% and only around half of those diagnosed are on ART 26.2% out of 53.8%. (Graph 6)

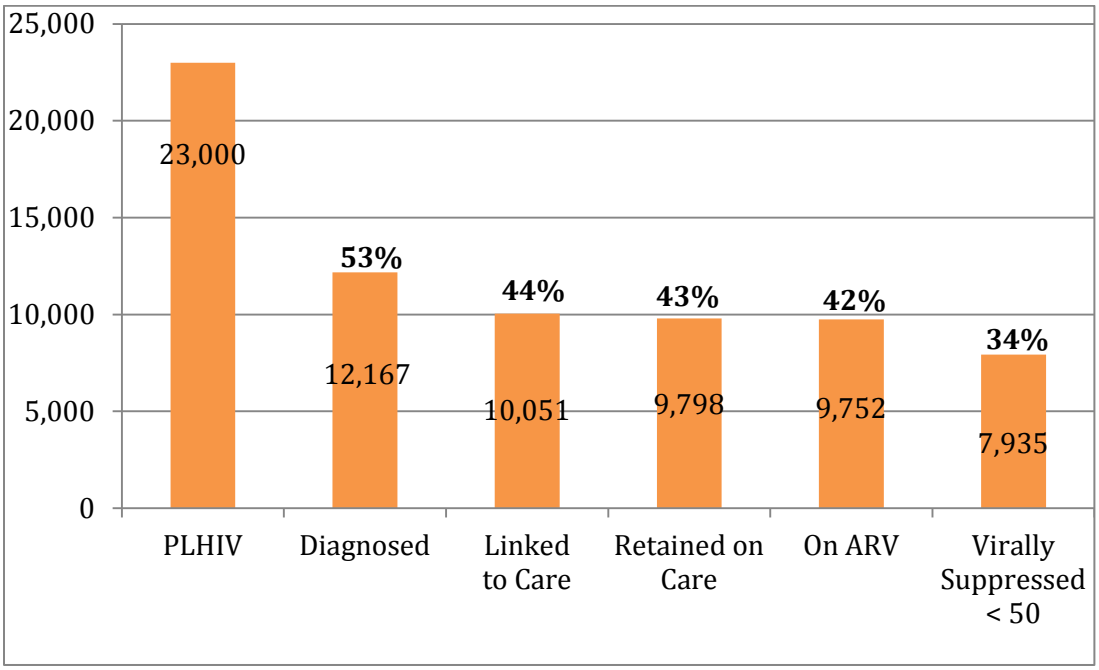
Graph 6



(Source: MoH Reports in 2015)

Honduras has the highest percent of those virally suppressed in the region (34%) and 42% of PLHIV on ART but there is still much need for improvement (Graph 7).

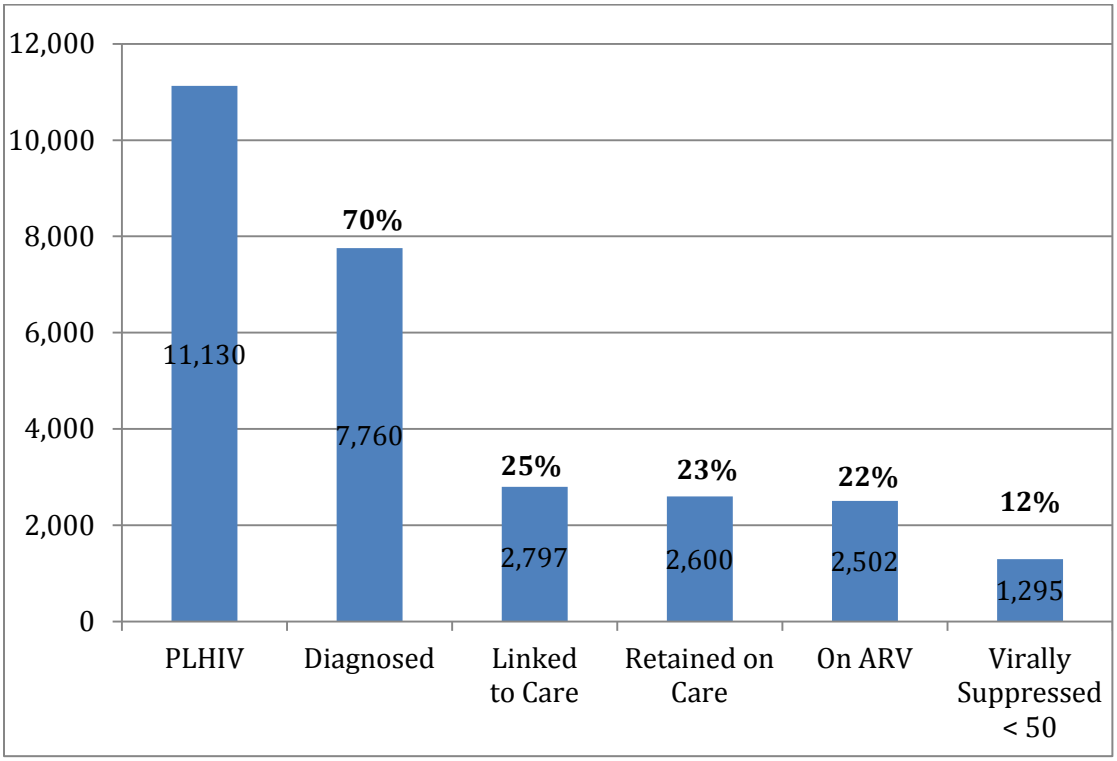
Graph 7
Honduras Clinical Cascade



(Source: MoH Reports in 2014)

While the percentage of individuals diagnosed represents the highest in the region, Nicaragua has the lowest percentage in the region of both individuals on ARV and virally suppressed at 22% and 12%, respectively (Graph 8).

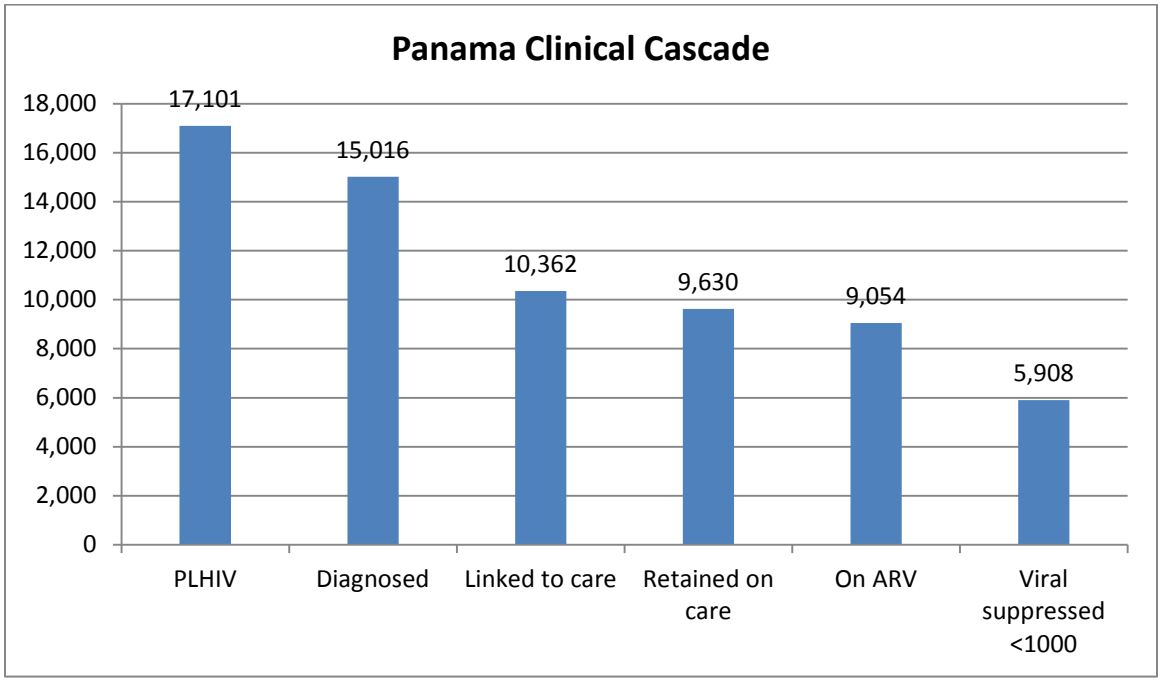
Graph 8
Nicaragua Clinical Cascade



(Source: MoH Reports in 2014)

Panama has the highest percentage of PLHIV on ART at 53%, but although the percentage of PLHIV who have achieved viral suppression is the second highest in the region, at only 34% much work still remains (Graph 9).

Graph 9
Panama Clinical Cascade



(Source: MoH Reports in 2015)

The above information presented by the graphs shows that there is still work to do in the area of the clinical cascade. The gap between the diagnosed individuals and the patients with viral suppression is still high, so part of this activity is aimed at reducing this gap.

Status of Test and Start in Central America

In October 2015 WHO issues the guidance called "test and start," recommending ART for everyone living with HIV at any CD4 cell count. The guidance recommends to start ART immediately for all HIV positive diagnoses, based on studies that show that the earlier the patients initiate ARV, the better the global health outcome is for the patients.

While many countries in the region are moving towards adoption of test and start, it is not yet an official policy, as seen in the following table. It should be noted that both Panama and Honduras are ahead in the implementation of the strategy. Honduras is in the process of approving the test and start strategy, while Panama has already approved it and is in the process of implementation. The other countries use test and start if selected by the health providers and not as a standard protocol.

Table 3: Guidelines & current practice for initiating ART for people living with HIV in Central America Countries - February 2,017					
	ELS	**GUA**	**HON**	**NIC**	**PAN**
National ART guidelines incorporate test	No	No	In process	No	Yes
Current protocol sets CD4 <=500 ml to start ART	Yes	Yes	Yes	Yes	No
T&S for KP	In process	No	No	No	Yes
T&S for KP for Pregnant women	Yes	Yes	Yes	Yes	Yes
T&S for TB patients	Yes	Yes	Yes	Yes	Yes
Current guidelines publication year	2,014	2,013	2,013	2,016	2,017
NAP reports clinical practice applying "Test and start"	Yes	Yes	No	No	Yes

The eventual rollout of test and start may be different in each country and within each municipality. The adoption of test and start will require updated implementation processes, norms, guidelines and the consideration of differentiated models of service delivery. Countries will require technical assistance at all levels to facilitate the adoption of test and start.

HIV/TB coinfection in Central America[23]

Based on the WHO report in 2016, the HIV, TB and HIV/TB coinfection response in Central America improved considerably between 1990 and 2014. However, some of the Central American countries are still lagging behind when compared to the average rate in the Americas region, which is 28 per 100,000 persons.

In 2015, the World Health Organization (WHO), PEPFAR, UNAIDS and the Global Fund issued updated guidelines[24] reiterating the need to scale-up HIV/TB collaborative activities (defined since 2004), considering that "people with HIV are 29 times more likely to develop TB disease than people without HIV. TB is a leading cause of death among people with HIV, accounting for one in five HIV-related deaths globally. Furthermore, one in four TB deaths globally was associated with HIV in 2013."

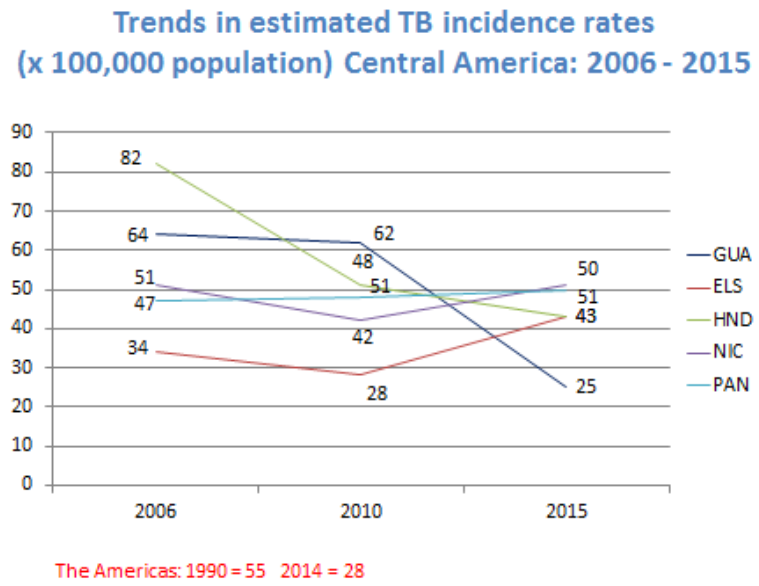
The Central American Region reduced its estimated TB incidence rate from 55 per 100,000 persons in 2006 to 28 per 100,000 in 2015. Guatemala and Honduras, which were the countries with highest incidence rates in 2006, show evident reduction trends, while Panama remains flat

[23] WHO (2016). *Global Tuberculosis Report.* Geneva, Switzerland. http://apps.who.int/iris/bitstream/10665/250441/1/9789241565394-eng.pdf?ua=1

[24] WHO (2015). *A guide to monitoring and evaluation for collaborative HIV/TB activities – 2015 revision.*

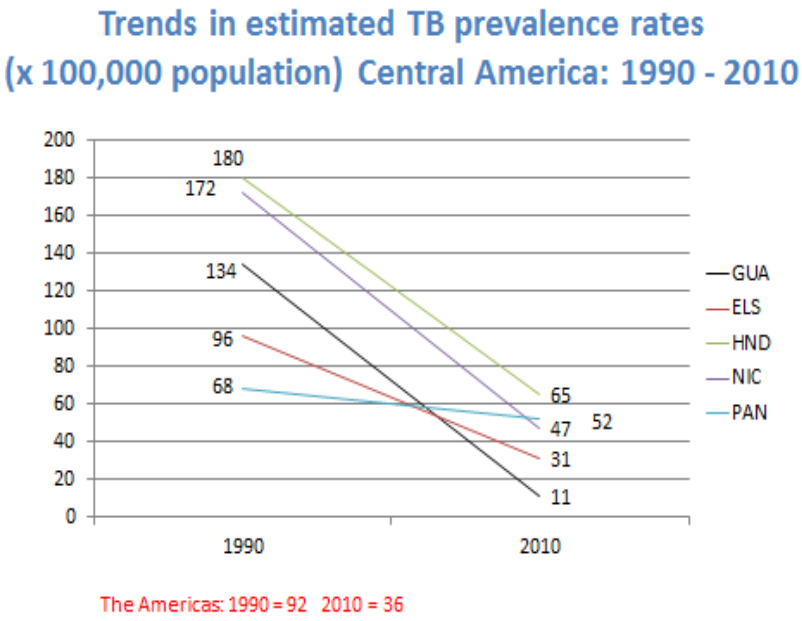
(unchanged) and El Salvador and Nicaragua present reduced incidence rates between 2006 and 2010 and an upward trend since then (Graph 10).

Graph 10



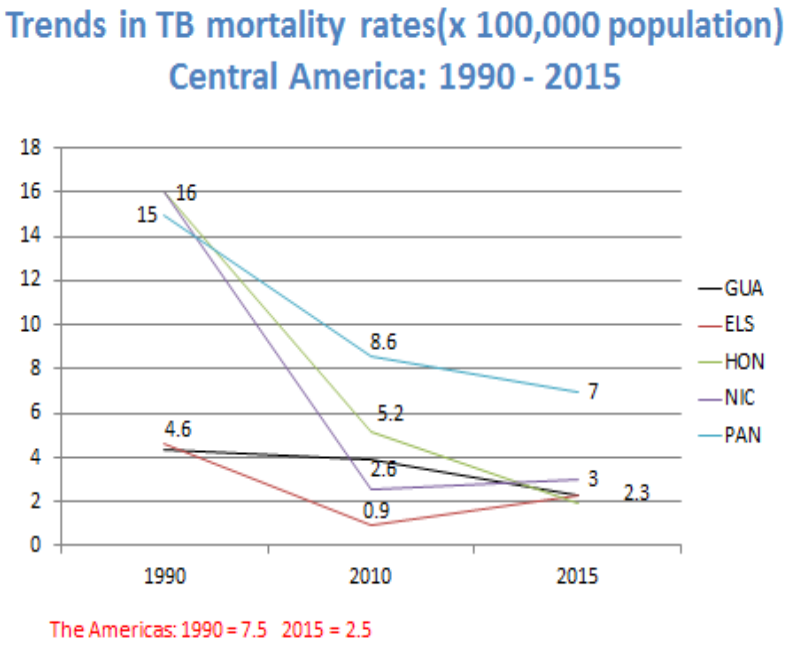
Estimated TB prevalence rates per 100,000 in Central American countries ranged between 65 (Honduras) and 11 (Guatemala) in 2010. All countries showed downward trends. Guatemala is the country with the lowest TB prevalence and Honduras with the highest as shown in Graph11.

Graph 11

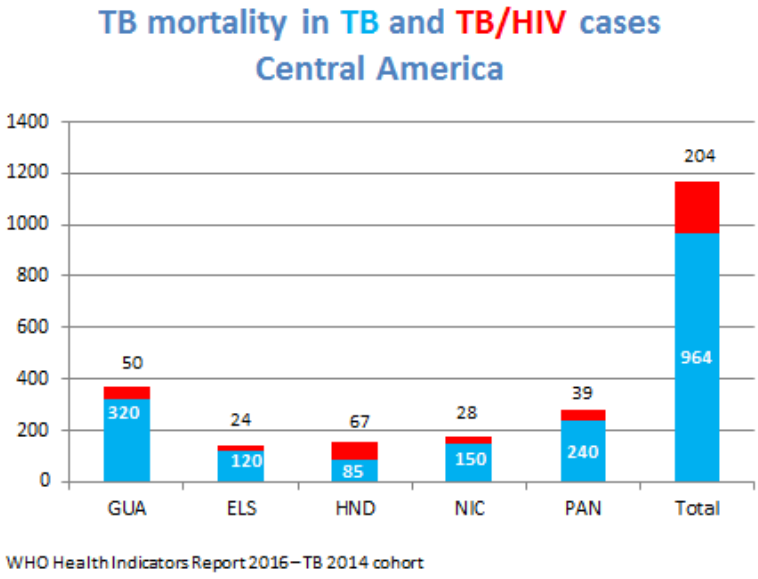


The Central American countries have reduced their average estimated TB mortality rate in the last 25 years, except for El Salvador and Nicaragua. In 2015 the death toll of TB in the region was 1,168 of which 204 (18%) corresponded to HIV/TB coinfection as shown in Graphs 12 and 13.

Graph 12

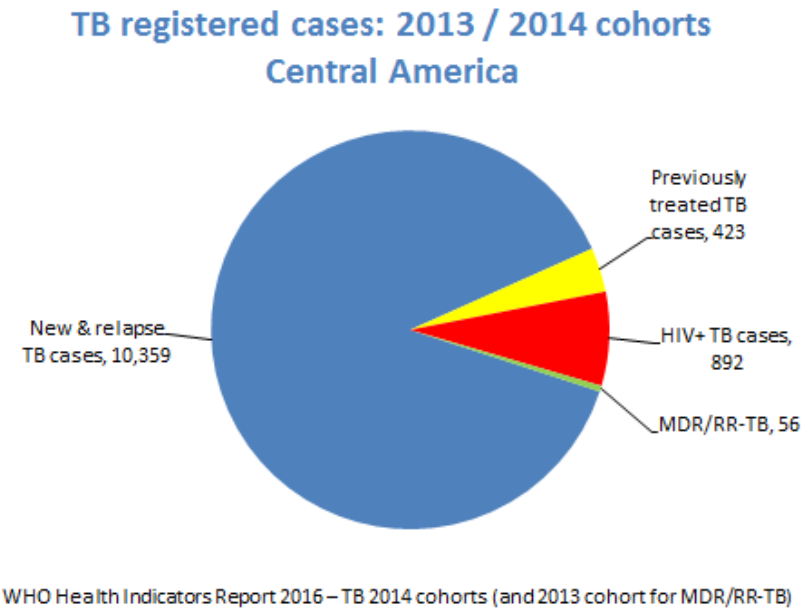


Graph 13



In the WHO health indicators report 2016-TB, the 2013-2014 cohorts reveal a total of 11,730 TB registered cases, in Central America. The distribution of these patients reveals that new and relapse cases represent 88% of the total, HIV+TB cases represent to 8%, previously treated patients 3% and multi-drug resistant 1% (Graph 14).

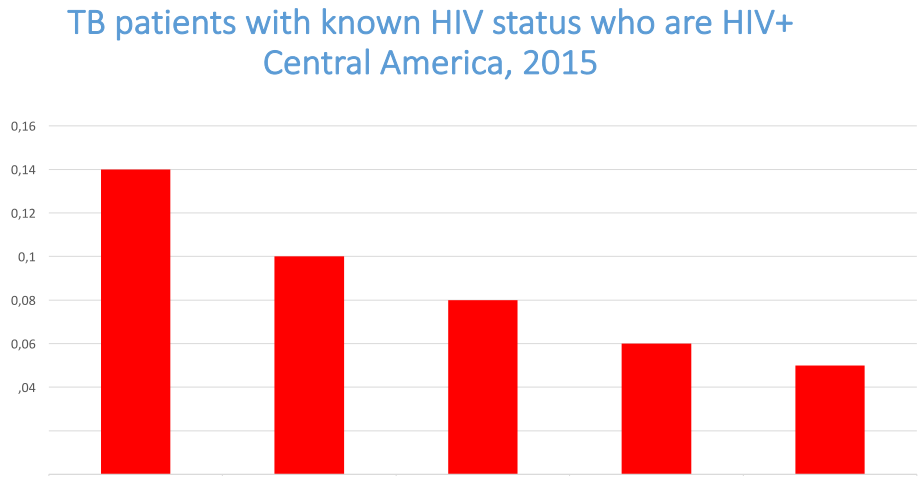
Graph 14



WHO Health Indicators Report 2016 – TB 2014 cohorts (and 2013 cohort for MDR/RR-TB)

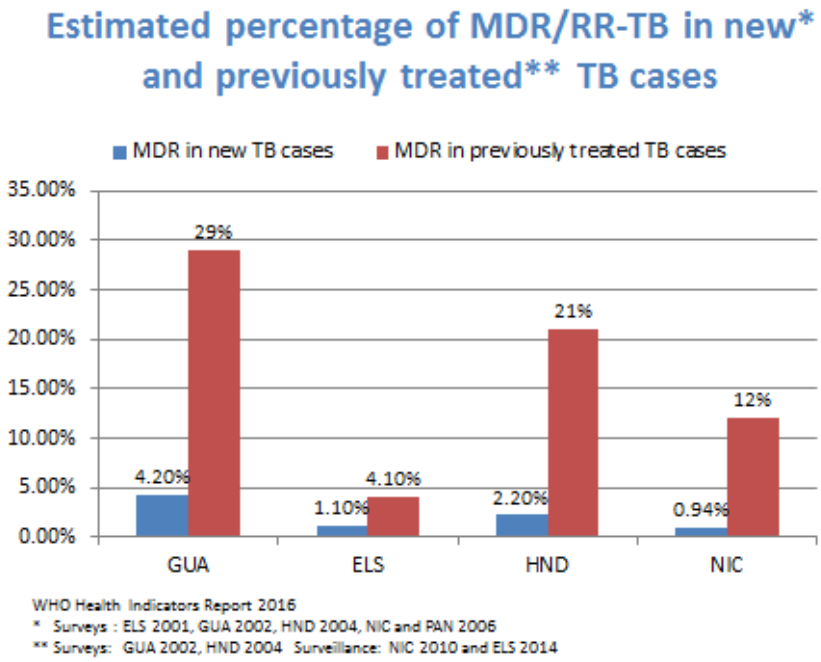
Panama has the highest percentage of TB patients with known HIV status who are living with HIV (14%), followed by Honduras (10%). El Salvador represents 8%, Guatemala 6% and Nicaragua 5%, as shown in Graph 15.

Graph 15



The graph below (Graph 16) shows the estimated percentage of Multidrug resistant and Rifampicin resistance MDR/RR-TB in new and previously treated TB cases, which is higher among previously treated TB patients. The most affected countries are Guatemala, Honduras and Nicaragua, with 29%, 21% and 12% correspondingly.

Graph 16



As the evidence shows, HIV/TB coinfection still represents a threat to peoples' lives and quality of life, particularly among KP. In 2015, 1,123 people died of TB in Central America; almost one-in-five (18%) suffered HIV/TB coinfection.

Gaps in collaborative HIV/TB activities

A rapid assessment of collaborative HIV/TB activities at the implementation level was carried out with key informants from the National TB Programs and donors in Central America. Results are presented in the following table (table 4), using traffic light color codes. This consultation revealed that collaborative activities have been incorporated in the planning cycles mainly from the National TB Programs' scope of work, with diverse implementation levels. However, incorporation of collaborative activities in planning cycles at the National AIDS Programs and HIV health care facilities (including ART clinics) remains incipient. This situation represents a valuable window of opportunity for improvement. It is important to notice that at a regional level the investigation of HIV prevalence among TB patients is consistent and adequate, but the determination of TB among PLHIV is deficient.

There is also not adequate integration of HIV/TB National strategic plans, which includes joint HIV/TB delivery services, use of prophylactic Isoniazid (IPT) among PLHIV, use of prophylactic Cotrimoxazole among coinfected HIV/TB patients and tracking of coinfection indicators.

In the table below, red indicates that the milestone has not been achieved; green indicates that the country is following protocols and following through on implementing as planned; and yellow indicates that implementation is in progress.

Table 4: Rapid assessment of collaborative HIV/TB activities implementation level in four Central American countries, 2015

Variables	Countries			
	Guatemala	**El Salvador**	**Honduras**	**Panama**
A. Establish and Strengthen the mechanisms for delivery integrated HIV/TB services				
A1. Set up and strengthen a coordinating body for collaborative HIV/TB activities				
Coordinating body is functional at all levels				
A2. Determine HIV prevalence among TB patients				
Determine TB prevalence among PLHIV				
A3. Carry out joint HIV/TB planning to integrate the delivery of HIV and TB services				
HIV/TB integrated National Strategic Plan				
HIV/ TB integrated GFATM grant				
Co-infection component included in HIV National Strategic Plan				
Co-infection component included in TB National Strategic Plan				
A4. Monitoring and evaluation collaborative HIV/TB activities				
Co-infection indicators incorporated in national information system				
Co-infection indicators periodically tracked and reported				
B. Reduce the burden of TB in PLHIV and initiate early ART				
B1. Intensify TB case finding in PLHIV				
Ensure high quality anti TB treatment				
B2. Initiate TB prevention with IPT				

Initiate early ARV				
B3. Ensure control of TB infection in health care facilities				
Ensure control of TB in congregate settings				
C. Reduce the burden of HIV in patients with presumptive and diagnosed TB				
C1. Provide HIV testing and counseling to patients with presumptive and diagnosed TB				
C2. Provide HIV prevention interventions for patients with presumptive and diagnosed TB				
C3. Provide CTX preventive treatment for TB patients living with HIV				
C4. Ensure HIV prevention interventions, treatment and care for TB patients living with HIV				
C5. Provide ART for TB patients living with HIV				

Source: WHO, PEPFAR, UNAIDS, The Global Fund: 2015 a Guide to M&E.

Based on the presented findings, and in order to address the identified gaps, the main components of the objective related with coinfection are: strengthen health services´ response capacity to prevent, diagnose and treat HIV and TB coinfection, through the design and successful implementation of HIV and TB collaborative activities, and create awareness on the importance of including in HIV services activities to reduce lost opportunities for effective prevention, detection and management of HIV and main coinfections/comorbidities.

The components focus on supporting Central American countries in their efforts to strengthen their HIV and TB national response by scaling up collaborative HIV/TB activities, mainstreaming health services to respond in a comprehensive, integrated approach to reduce the burden of disease among people who demand this services. Furthermore, there are lost opportunities for prevention, diagnosis and treatment of HIV, TB and other co-infections such as sexually transmitted infections (STIs) including Viral Hepatitis and comorbidities such as Diabetes and Mental disorders (particularly stress and depression which have been associated with poor adherence and negative health outcomes).

Stigma & Discrimination

Stigma and discrimination towards both PLHIV and KPs are widespread in the region according to studies such as the Stigma & Discrimination Index[25], which assesses most countries of the region. In all of the index studies, sexual minorities living with HIV reported much higher rates of stigma and discrimination than other PLHIV, indicating that they suffer from a double stigma.

[25] stigmaindex.org

In Nicaragua, TGW report higher rates of almost every type of exclusion mentioned in the survey from gossip to physical violence.[26] While there have been improvements over the years, stigmatizing attitudes are still found at the societal level as 4 out of every 10 respondents in a public opinion survey in the region reported discriminatory attitudes towards PLHIV or KPs.[27] A 2014 study showed that 32% of MSM and TGW in San Salvador postponed healthcare due to stigma and discrimination.[28] In surveys of TGW in Panama and El Salvador, TGW reported a litany of poor and abusive treatment at health care centers, including being turned away from medical treatment, public humiliation, prolonged waiting times as compared to other patients, and attempted sexual abuse from service delivery providers[29, 30]. In the multi-sectoral consultation, key stakeholders cited stigma and discrimination as the biggest barrier for KP to access services. Less is known about the specific barriers faced by Garifuna in Honduras in terms of access to HIV related services and further analysis is needed to ensure proper access to care and treatment services for this priority population. Belonging to sexual minorities, especially MSM and transgender, involves a discrimination and violence from society in general and medical staff. Every year people are murdered just for belonging to sexual minority groups.

Gender Analysis

In 2016, the PEPFAR team undertook a participatory gender analysis with key stakeholders in each country. The findings were very similar across countries with widespread stigma and discrimination towards sexual minorities. Key populations experience multiple, overlapping forms of stigma related to their sexual and gender identities and practices as well as their socio-economic position, involvement in sex work, and HIV status. Men do not access HIV services and in Honduras it was noted that Garifuna men did not access HIV testing services. Gender based violence (GBV), was mentioned in the majority of the countries as a pressing issue, which included sexual abuse to KP and lack of appropriate health services for GBV survivors, including HIV preventive services and while USAID has updated post-exposure prophylaxis protocols to include KPs, there are still barriers for KP to access GBV related services. In Nicaragua and Panama, it was noted that the transgender community experiences the highest levels of stigma and discrimination. Many laws and policies around HIV do not address KP specifically, and are without any specific characterization of KP, their particular needs or situation. In Nicaragua the need for a gender identity law for transgender people was highlighted and they do not have access to a legal identification with the gender identity that they want.

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[26] *Estudio Índice de Estigma y Discriminación en Personas con VIH-Nicaragua 2013* (http://www.stigmaindex.org/sites/default/files/reports/NicaraguaEstudio%20Final_ED_.pdf)

[27] USAID/PASCA *Estigma y Discriminación asociados al VIH: Encuesta de opinión pública. Informe regional. Centroamérica 2013.* (http://www.pasca.org/userfiles/INFORME%20EYD%202013%20REGION%20VFINAL%20FEBRERO%202014.pdf)

[28] Andrinopoulos, K, Hembling, J (2014), Unlocking health services for MSM and Transgender Women in San Salvador, Chapel Hill, NC. MEASURE Evaluation.

[29] Tallada, Joan, Aysa Saleh-Ramírez, Heather Bergmann, Jose Toro, y John Hembling. 2013. *Diagnóstico de Necesidades de Salud y Servicios Disponibles para La Población Trans de Panamá*. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

[30] Tallada, Joan, Aysa Saleh Ramírez, Heather Bergmann, Jose Toro. 2013. *Diagnóstico de Necesidades de Salud y Servicios Disponibles para Mujeres Trans de El Salvador*. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

Key Stakeholders

Government: Ministry of Health & Social Security - In all countries, the Ministry of Health plays the lead role in providing HIV prevention, care and treatment services and USAID works in close coordination with the governments in all areas[31]. As the vast majority of care and treatment services are provided by the Ministry of Health, the USG works closely with government partners to support the health system strengthening, above site activities, pilot projects to identify appropriate differentiated models of care for catalytic change and gap filling, providing technical assistance to address identified gaps and to improve quality and access to services. In most countries, Social Security Institutes also provide public HIV care and treatment services, and USAID also provides strategic assistance to Social Security sites.

Civil Society/KP & PLHIV Community Groups – Civil society plays many different roles in the HIV response and KP and PLHIV community groups are especially important partners and should be engaged at all levels of activity implementation. Civil society groups play an essential role in identifying and addressing the barriers to treatment and adherence. USAID establishes and maintains working relationships with the relevant civil society and community groups in each country. In some cases these organizations serve as USAID implementing partners through sub-grants to support activities across the cascade. In addition, regional civil society networks play an important role in the Central American response and include regional networks for key population organizations.

Global Fund – As the largest external donor in the region, followed by PEPFAR, the Global Fund provides resources for the purchase of ARVs in some countries and in support of other care and treatment services. Close coordination with Global Fund Principal Recipients (PR) is essential to ensure all resources are used for maximum impact, and often the USG provides key technical assistance to support successful implementation of Global Fund funded activities.

The Global Fund currently has grants in all five countries with different areas of focus. In Guatemala, the current grant centers on prevention, civil society strengthening, and treatment, care and support. In El Salvador, the Global Fund supports the strengthening of community-based services, stigma reduction and prevention activities. Global Fund financing in Honduras works to reduce HIV prevalence, in particular among vulnerable populations, improve survival among PLVIH on ART, prevent mother-to-child transmission and improve quality of life. In Nicaragua, the Global Fund supports the national program for prevention and care through government and civil society partnerships, including the development of new policies aimed at providing combination prevention services to KP and fostering increased access to HIV treatment and counseling and early enrollment in treatment. In Panama, the HIV portion of the current HIV and TB grant will focus on HIV prevention and includes packages for prevention services and HIV diagnosis among KP.

USAID and PEPFAR Implementing Partners – Collaboration between USAID and PEPFAR implementing partners is essential to maximize efficiency and impact, and is key for facilitating linkages between different pillars of the clinical cascade. While this activity will focus on site level work with facilities providing care and treatment services, it will also include a community

[31] USAID work with Ministry of Health facilities varies by country.

component to ensure link among facilities and communities. Close coordination with other USAID partners working in communities and facilities with a focus on HIV case finding and linkage to treatment after diagnosis will be crucial. This activity will also collaborate with USAID's supply chain partner who works to ensure commodity availability and support the updating of national norms for regimen selection and dosing as well as frequency of dispensing ART as countries adopt differentiated service delivery models to support the implementation of test and start. Meanwhile, other USG partners will work to improve laboratory services, including strengthening capacity for viral load testing. Other partners will operate at the above-site level to address issues such as sustainability and structural barriers at national and regional levels. This activity will focus on site level activities but will coordinate closely with the above-site activity (Central American Activity for a Sustainable Response to HIV), to inform the creation and updating of national level guidelines and norms related to treatment and adherence.

Building on Previous Work

For over two decades, the Regional HIV/AIDS Program and USAID bilateral HIV programs have worked to improve the quality of care and treatment services. This work has included establishing quality improvement processes at health facilities throughout the region and creating linkages between communities and facilities. USAID has also worked to build the capacity of human resources for health through both pre-service and in-service activities. The Recipient will be expected to build on this past experience and adopt any relevant best practices already in place.

Across the region, the USAID/Central America Capacity activity has worked to strengthen human resources for health to ensure effective and efficient delivery of comprehensive HIV care and treatment services through the institutionalization of quality improvement methodologies and providing technical assistance to address identified gaps in performance at each service delivery site supported. The activity uses the Optimizing Performance and Quality (OPQ) methodology to support a continuous quality improvement of care model and to optimize the performance of health workers, organizations, and systems. OPQ systematically and continuously applies operational standards based on good practices, evidence-based medicine, national STI/HIV/AIDS norms and protocols, and perceptions of user satisfaction. As described above, key populations report consistent discrimination in health care settings: a regional average of 93% (380/410) of people living with HIV stated they received a stigma- and discrimination-free service in facilities applying OPQ, ranging from 88% in Guatemala to 96% in Panama and El Salvador. All of the health facilities supported by the activity have quality committees conducting continuous improvement actions.

USAID/Capacity has also worked to create and institutionalize a Coordinated Community Response (CCR) methodology. The goal of CCR is to provide respectful, effective, equitable, and high-quality services for people at risk for, living with, or affected by HIV in the context of the need for long-term care and treatment. CCR-initiated HIV networks include representatives from public health facilities, civil society organizations, and community groups that provide services in the facilities' catchment areas. Services offered through the networks range from educational outreach to peer counseling and legal support. These networks provide referral and counter-referral and other support for adherence and also serve as mechanisms to monitor user

satisfaction with health services. The CCR approach is improving adherence to ART and facilitating bidirectional referrals among outreach workers, health workers, and other community workers and volunteers. In addition, the CCRs have led to the increased participation of KP including PLHIV, who are helping create support groups and service linkages. The networks' inclusion of MSM and TGW has raised awareness about sexual diversity. Under the guidance of the activity, the majority of facilities have built strategic alliances with municipalities, NGOs, civil society, and universities for performance gap closing.

In Nicaragua, the USAID/PREVENSIDA bilateral activity (2010-2017) aims to reduce HIV/AIDS transmission among the KP by improving healthy behaviors such as: increasing the use of condoms and access to HIV testing, and reducing the number of sexual partners. The activity has four components: institutional strengthening to key population NGOs, provision of a combination of prevention HIV services, reduction of stigma and discrimination, and increased participation in the national HIV response. The activity develops a unique identifier code for prevention, testing and care services that is also used by the Global Fund. In the last two years, it started supporting the continuum of care by working through civil society organizations to link individuals from KPs to testing, care and treatment services. The activity works to identify those PLHIV lost to follow-up and implements strategies to re-connect these individuals to care and treatment and support their adherence to ART.

In Honduras, bilateral USAID partners have provided important technical assistance to comprehensive care centers to improve and maintain quality in the context of health reform and decentralization of services. This support has included supporting the implementation of a national strategy for STIs & HIV/AIDS and increasing access to quality services.

Table 5: Building on Previous USAID Work to Improve Services for KPs : Illustrative Examples

Best Practices
• Quality improvement methodology centered on user-satisfaction like OPQ can lead to reduction in stigma and discrimination • Use of a unique identifier code for prevention and testing services and ideally for referrals and linking to care and treatment. • Use of peer interpersonal contact is more effective to reach KP at the community level and increase demand for services among healthy KP. • In cases of PLHIV who have abandoned treatment, the use of established multidisciplinary teams at health units that include peer educators enables the return of PLHIV to ART.
Lessons Learned
• Important to use participatory methods to create linkages between facilities and communities to foster partnerships and contribute to local empowerment and sustainability. • Interventions must be tailored to each key and priority population. • It regularly takes up to five separate interpersonal contacts with a trained peer educator to convince a PLHIV who abandoned treatment to return to treatment. • Despite regional similarities, activities must take into account country and subnational contexts

and differences – what works in one geographic area may not produce the same results in another.
- Regular communication and coordination with all key stakeholders implementing similar programs, especially Global Fund PRs and Ministries of Health, is essential to prevent duplication.

Activity Rationale

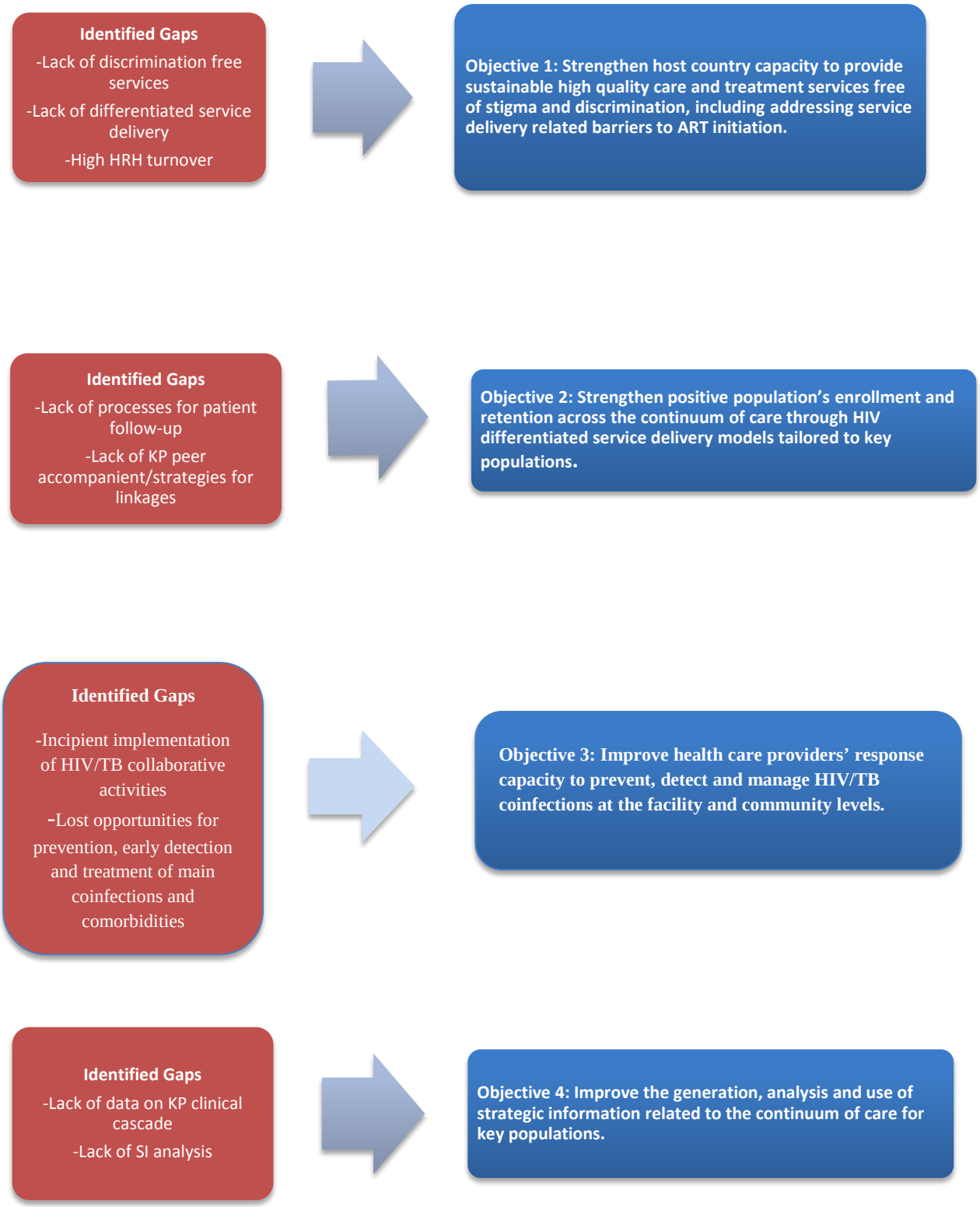
As seen above in the clinical cascades, all five countries have significant gaps in initiating PLHIV on ART and maintaining adherence to achieve viral suppression. This activity aims to assist the region in applying evidence-based strategies and approaches tailored to KP to address these gaps.

The factors that are preventing the countries from reaching the second and third 90 goals include:

- Persistent stigma and discrimination against KPs in health service delivery settings.
- Lack of sufficient KP-friendly service delivery models.
- Treatment adherence programs in facility and community settings are not institutionalized.
- Lack of processes and structures for ART patient follow-up
- High turnover in human resources for health.
- Lack of data on the clinical cascade for KPs.
- Insufficient use of strategic information to improve services.
- Insufficient domestic resource mobilization for HIV services.
- Lack of political will to support KP.

Consideration of these gaps and challenges has led to the development of the four activity objectives.

Graph 17: Activity Objectives



2. Scope

The purpose of this activity is to support countries to ensure that all eligible PLHIV are on treatment and achieve viral suppression through high quality and discrimination free care and treatment services.

This activity will focus on developing and implementing facility and community level strategies to promote adherence to HIV and TB treatment (if there is HIV-TB co-infection) and patient follow-up, including ensuring that 90's and cascade data are reported properly and in a timely manner to the HIV Information Systems for analysis and monitoring. Emphasis will be placed on the continued institutionalization of site level quality improvement processes to guarantee that countries have capacity to maintain high quality services for treatment and adherence support, especially as they transition to test and start and differentiated service delivery models. Strategies and approaches will need to be adapted for each specific country context. The activity will consider as an adult all the persons above 15 years of age in all the countries covered by the activity.

USAID defines the level of effort and budget for each country in its Regional Operational Plan, in its Strategic Direction Summary (SDS), and the Focused Outcome and Impact Table (FOIT), available at https://www.pepfar.gov/.

3. Objectives

Objective 1: Strengthen host country capacity to provide sustainable, high-quality care and treatment services free of stigma and discrimination, including addressing service delivery-related barriers to ART initiation.

As countries move to implement updated norms and guidelines around test and start and service delivery differentiation, they will need support at the site level as they adapt existing processes. Countries will need support to test these new models of differentiated care and to adjust them accordingly for countrywide implementation.

The goal of this activity is to help countries reach and also maintain patients on ART and with viral suppression over the long term. The Recipient should identify how to build on previous work to continue and institutionalize quality improvement processes that include strategies to maintain adherence and adapt and update them in accordance with the new differentiated service delivery models. Those quality improvement processes should include continued access to high quality care and treatment for KPs that is free from stigma and discrimination.

Differentiation of services alone will not increase the number of PLHIV on treatment if stigma and discrimination are still present in care and treatment services. Reducing stigma and discrimination towards KP and all PLHIV should be a priority at all sites receiving technical assistance. In addition, all other gaps in quality services, such as human resource capacity deficiencies, should be identified and addressed.

High public sector health staff turnover and lack of human resources represent challenges that the Recipient may not be able to address directly but will be expected to develop innovative strategies to mitigate those challenges to ensure that the quality of services is maintained.

Gender-based violence is often neglected or ignored among key populations. The Recipient should support health service delivery areas in the appropriate implementation of policies, norms and protocols to address gender-based violence, especially towards key populations, including clinical management and appropriate referral for follow-up treatment. The Recipient should coordinate policy-related activities with the USAID partners working in advocacy, awareness and policy development in the region.

The Recipient should support the service delivery areas in the implementation and use of an electronic medical record system (also known as electronic patient tracking systems), to assist clinical service provision for patients or program monitoring and reporting. This technical support should include training, software, data equipment and quality control on the medical record of patients, including appropriate filing of medical history and lab results.

The Recipient should support the active engagement in an international, national, or regionally recognized process for continuous quality improvement (CQI) and demonstrate measured improvement towards accreditation of laboratory or blood center/banks performing an HIV-related test.

The Recipient should document the TB screening of ART patients as well as the proportion that were diagnosed and started on TB therapy.

The following intermediate results will contribute to Result 1:

1.1 Technical assistance for implementation of differentiated service delivery models for increased efficiency provided.

1.2 Quality of patient centered treatment services improved and/or maintained.

1.3 Negative impact of human resources challenges mitigated.

Objective 1 Indicators:

- Number of sites implementing differentiated models of service delivery.*
- Number of countries with updated quality improvement processes that include Test and start and differentiation of service delivery.*
- Demonstrated and sustained increase in client satisfaction at supported care and treatment sites.
- Number of people receiving gender-based violence clinical care based on minimum package (PEPFAR MER2.0 Indicator GEND_GB).*
- Number of PEPFAR supported facility-based service delivery points supported by activity that have an electronic medical record system (PEPFAR MER2.0 Indicator EMR_Site).

- Percentage of people living with HIV on ART with a suppressed viral load (PEPFAR MER2.0 Indicator VL_SUPPRESSION_NAT)
- Number of health worker full time equivalents who are working on any HIV-related activities, i.e., prevention, treatment and other HIV support and are receiving any type of support from PEPFAR at facility and sites (PEPFAR MER2.0 Indicator HRH_CURR).
- Number of people living with HIV that report stigma and discrimination from health providers.*

  *mandatory indicators

Illustrative Benchmarks

1. Investment cases developed and disseminated that demonstrate savings from reduced clinical visits for stable patients and reduced ARV pick-up times for stable patients in two countries*
2. Non-stigma and discrimination policy in service providers developed and implemented. *

   *mandatory Benchmarks

Objective 2: Strengthen positive population's enrollment and retention across the continuum of care through HIV differentiated service delivery models tailored to key populations.

The Recipient must support countries to apply evidence-based interventions to improve adherence especially among KPs and to achieve viral suppression to reach the third 90 of the 90's goals. The Recipient must take into consideration the different factors that negatively impact adherence such as lack of adequate support from family and community, economic conditions, use of drugs/alcohol and stigma and discrimination at health services that discourage patients from returning. Once patients drop out of treatment, the countries in the region lack formal standardized processes for finding patients lost to follow-up and this activity should help address this issue at supported sites.

The Recipient should strengthen the health service activities with diverse types of modalities to increase the coverage of people tested, supporting the increase of availability of service delivery points offering test and referral and expand the activities to include non-traditional places where key populations can be reached and tested.

Engagement with KP and PLHIV community groups is essential to support efforts to keep patients adherent and reconnect patients lost to follow-up. While the type of engagement may vary by country, the Recipient will be expected to involve civil society such as local Governments, Faith-Based Organizations, NGOs, private sector and families to participate in the development of strategies to address adherence and patient follow-up.

Differentiated care for HIV requires delivery of different care packages for people based on their needs. As more people start treatment immediately after being diagnosed it is important to

maximize the quality of care and ensure efficient health services. In the case of this activity, the differentiated care describes the continuum of adaptations that should be made to HIV services (including ART delivery) to streamline care in the context of limited human resources and infrastructure, while addressing the needs of defined groups of patients, linkage to care with rapid initiation of ART, adherence, retention, "people-centered" integration with other services including STIs and other Communicable and Non Communicable Diseases (NCDs).

Differentiated models of care

This activity includes supporting countries primarily through technical assistance to implement differentiated models of care to enable limited resources to be used more effectively and efficiently to increase the number of individuals on treatment and keep them on treatment with limited cost increases. Countries should define stable patients based on simple clinical criteria or undetectable viral load with the goal of reducing their frequency of clinic visits to every 6-12 months.

Differentiated models of care include providing services according to the patient, context and needs and tailoring services and activities to the following[32]:

- Who - Target populations
- What – Services provided
- When – Frequency of service
- Where – Location where service is rendered
- How – Provider rendering service

The following will contribute to Objective 2:

2.1: Strengthen linkages to improve availability and accessibility to ART with emphasis on KPs.

2.2: Implementation of evidence-based adherence interventions supported including protocols and norms for patient follow-up.

2.3: Community and facility engagement to improve linkages and strengthen patient follow-up.

Objective 2 Indicators

- Number of adults newly enrolled on ART (PEPFAR MER2.0 Indicator TX_NEW)*
- Number of adults currently receiving ART (PEPFAR MER2.0 Indicator TX_CURR)*
- Percentage of adults known to be on treatment 12 months after initiation of ART (PEPFAR MER2.0 Indicator TX_RET)*
- Percentage of ART patients with a viral load result documented in the medical record and

[32] Office of the Global AIDS Coordinator. PEPFAR Technical Considerations for COP/ROP 2016. (http://www.pepfar.gov/documents/organization/252263.pdf)

/or laboratory information systems (LIS) within the past 12 months with a suppressed viral load (<1000 copies/m/ (PEPFAR MER2.0 Indicator TX_PVLS)*

- Number of individuals who received HIV Testing Services (HTS) and received their test results (PEPFAR MER2.0 Indicator HTS_TST)

*mandatory indicators

Illustrative Benchmarks

1. PEPFAR-supported sites implementing an in-service patient follow-up at care and treatment algorithm for non-adherent patients to increase retention.
2. Strategy for community-based follow-up including standardization of processes implemented.*
3. MoH Human resources in PEPFAR-supported sites trained on norms, protocols and/or policies related to the implementation of test and start and New Care models in four countries.*

*mandatory Benchmarks

Objective 3: Improve health care providers´ response capacity to prevent, detect and manage HIV/TB coinfections at the facility and community levels.

Central American countries have made significant progress in reducing the burden of disease due to HIV and Tuberculosis during the last decade. Yet, achieving Sustainable Development Goals which target their elimination still represents a challenge, specifically related to prevention, detection and effective management of HIV/TB coinfection. The Recipient should focus on reducing lost opportunities related to HIV/TB coinfections, and other main coinfections and comorbidities, through an integrated, patient-centered approach, mainstreaming HIV in local health services, communities and strengthening collaborative activities.

The early detection of signs and symptoms of TB, followed by the diagnosis and immediate initiation of treatment of PLHIV, increases the survival rate, improves the quality of life, and reduces the TB transmission to other members of the family and community. The initiation of preventive Isoniazid for those with latent infection with Mycobacterium Tuberculosis is crucial to prevent an active disease in carriers of the Mycobacterium. Supporting the implementation of policies in the administration of Cotrimoxazole as part of the management of co-infection is another aspect of the technical support that needs to be taken in consideration.

The Recipient should support the implementation of an integrated response of prevention, diagnosis, treatment and continuum of care related with TB co-infection and other infections such Hepatitis B and Hepatitis C.

The following Intermediate Results will contribute to Objective 3:

3.1 Strengthen response capacity at health care facility level to prevent, diagnose and treat HIV/TB coinfection, through successful implementation of collaborative activities at the facility and community level by searching for TB in people living with HIV.

3.2 Promote mainstreaming and integration of HIV services, including detection and effective management of HIV/TB coinfection and other key coinfections (e.g. STIs) / comorbidities (e.g. diabetes and other communicable and non-communicable diseases).

3.3 Improve civil society´s capacity and active involvement at the community level, in the prevention and management of HIV/TB coinfection and other coinfections and comorbidities, including contact tracking, screening and strengthening support networks.

Objective 3 Indicators:

- Number of adults living with HIV that have been diagnosed with TB.*
- Percentage of prioritized HIV/TB interventions implemented.
- Number of pilot models developed with integrated approaches to HIV, TB, HIV/TB and other coinfections and co-morbidities, disaggregated by facility and community level.
- Percentage of contacts of HIV/TB patients screened per type of screening.
- The proportion of ART patients who were screened who are receiving TB treatment (PEPFAR MER2.0 Indicator TX_TB).*
- Proportion of ART patients who completed a standard course of TB preventive therapy within the reporting period (PEPFAR MER2.0 Indicator TB_PREV)

  *mandatory indicators

Illustrative Benchmarks (in PEPFAR supported sites)

1. Health care providers working in PEPFAR supported sites trained in HIV/TB coinfection detection, care and support, in three countries.*
2. Baseline developed and conducted on number of TB patients detected among HIV positive cases.*
3. 90% of HIV diagnosed patients are screened for TB co-infection.*
4. At least 70% of all HIV patients who are TB negative receive a complete standard course of TB prevention therapy.*

   *mandatory Benchmarks

Objective 4: Improve the generation, analysis and use of strategic information related to the continuum of care for key populations.

To ensure countries are meeting the 90-90-90 goals, accurate and up-to-date data on the clinical cascade is essential. Currently many countries need special studies to determine their progress towards the 90-90-90 goals and/or to disaggregate that information by KP group. With the

SUMEVE[33] system, El Salvador has a functioning information system for surveillance and monitoring and evaluation that is able to produce the latest disaggregated data on the cascade per population. Similar Information Systems exist in all countries but not all are updated, so the Recipient should focus in developing the health providers' skills to gather and analyze the information in order to make decisions related with the continuum of care of patients.

The Recipient should emphasize the importance of using data for decision making with a focus on patient monitoring. The Recipient may need to work in the facilities to ensure that all patients' information clinical evolution is entered into the HIV Information System, as well as identify and monitor patients lost to follow-up.

When data is available from the current Capacity Plus Activity or other programs, that data will be used as baseline information. For those indicators without baselines, it is expected that the Recipient will establish a baseline at the start of the activity. Specific benchmarks have been defined in the ROP17-18 and its FOIT, which need to be addressed by the Recipient.

The following will contribute to Objective 4:

4.1 The use and analysis of strategic information at site level to improve linkages to treatment and adherence strengthened.

Objective 4 Indicators:

- Percentage of health service delivery points supported by PEPFAR that keep updated information with functioning patient tracking system which includes monitoring of those lost to follow-up.*

  *mandatory indicators

Illustrative Benchmarks

1. HIV information system working in real time, and being used to support the continuum of care and monitor lost to follow-up patients. *

   *mandatory Benchmarks

4. Activity Strategies and Technical Elements

Crosscutting Components

Sustainability & Capacity Building of Community Groups

[33] SUMEVE is the Spanish acronym for the unique system for HIV/AIDS monitoring evaluation and epidemiological surveillance and is administered by the Ministry of Health of El Salvador.

The activity should continue to support the capacity building of KP community groups and build on previous work in this area. The work with community groups may differ by country.

Stigma and Discrimination

Stigma and discrimination represents a major barrier that prevents KPs from accessing care and treatment and from adhering to treatment (the other factor is lack of financial resources). The Recipient should ensure that all care and treatment services provided are stigma-free and should develop strategies to address stigma and discrimination in the context of the adoption of test and start and differentiation of service delivery. [34]

Gender and GBV

Gender considerations in the context of KPs in Central America include all the expectations around gender for men and women and the negative societal response to individuals who do not meet the expectations in terms of behavior or gender identity, and this especially affects MSM and TGW. These negative gender norms can contribute to homophobia and transphobia, which puts these individuals at greater risk for GBV and HIV. The Recipient should take into account these norms, relationships and inequalities that will inevitably impact implementation and employ a strategy that responds to the unique needs of different groups. [35]

Gender considerations are central to all USAID activities and programs and should be reflected in all relevant activities. The gender focus for this activity is not on women and girls, but rather is related to how gender concerns affect certain KPs, especially TGW and to some extent MSM. These attitudes around gender can also play a role in civil society's participation or lack of participation in the response and also may influence funding for programs focused on KPs. For specific recommended activities on how to help close the gender gap, the Recipient should develop standalone or integrated activities to be included in a gender action plan to ensure that the project is reducing the gender gaps that were identified in the gender analysis that was carried out in the context of project design. Also, the Recipient must track the differential impacts on KP participants in all activities. (See information regarding Gender issues in Attachment 1 on Gender Policies and guidelines in Central America).

The Recipient will assure gender equity through the following strategies and methods:

- Incorporating multiple concepts of gender and male and female sex roles in all programming areas;
- Tracking the gender composition of the strategic alliances, training activities and consultant network activities;
- Establishing strategies to respond to the vulnerability that the different groups (men, women, and MSM) face, derived from their gender roles with emphasis in health provision settings;
- Providing opportunities for vulnerable women and men to participate in policy and programming decisions related to HIV/AIDS prevention;

[34] http://www.pasca.org/content/reporte-sobre-consulta-multisectorial-de-usaid
[35] http://www.pasca.org/content/analisis-de-genero-2016

- Providing community fora to increase the participation of vulnerable men and women in decision-making;
- Disseminating results of studies of differential gender roles through a proactive information system.

Relevant actions will include:

- Equitable participation of women and men will be promoted at activity staffing, training activities, advocacy strategic alliances membership, the PLHIV regional network and any other groups and convened meetings;
- Female decision makers will be encouraged to attend and be engaged in activities;
- Continued support for advocacy to reach policy and decision makers and program managers to make them aware of the current HIV/AIDS situation and the need to identify and respond to both male and female needs on HIV/AIDS prevention and care;
- Media professionals will be sensitized on the importance of gender and sexual equality and how inequalities fuel the HIV/AIDS epidemic;
- The Recipient will also take into account any specific gender and other cultural sensitivities as they relate to the Garifuna population;
- A Gender analysis for the activity as well as a Gender integration plan.

Cultural Sensitivities

The activity will take into account cultural considerations for all interventions where appropriate, especially in the context of the Garifuna community but may be applicable for other contexts as well, such as KP from indigenous communities.

Indigenous issues

Previous studies and secondary analysis related with indigenous communities and risk factors for HIV infection have shown that being an indigenous person serves as a protective factor for HIV, so the Recipient should include indigenous persons when they belong to key populations. Nevertheless, the Recipient should pay special attention to ensure that cultural sensitivity and appropriate integrated care in HIV and AIDS for indigenous populations should be included in their technical approach.

On the other hand, even though the geographical corridor with the highest prevalence is not located in indigenous communities, the migratory patterns of these communities should be taken in consideration as a risk factor for these communities, especially related with Garifuna population.

5. Place of Performance

The Recipient will develop activities in the following five countries for national activities: Guatemala, El Salvador, Honduras, Nicaragua, and Panama. Regional activities will include

Costa Rica and Belize in addition to the previous countries.

6. Period of Performance

Five-year period.

[END OF SECTION A]

SECTION B: FEDERAL AWARD INFORMATION

1. Estimate of Funds Available and Number of Awards Contemplated

Subject to funding availability, USAID intends to provide up to $15,000,000 in total USAID funding over a five (5) year period. The ceiling for this program is $15,000,000. Actual funding amounts are subject to availability of funds.

USAID intends to award one Cooperative Agreement pursuant to this NOFO.

USAID reserves the right to fund any one or none of the applications submitted.

2. Start Date and Period of Performance for Federal Awards

The period of performance anticipated herein is five (5) years. The estimated start date will be upon the signature of the award.

3. Substantial Involvement

Funding for PEPFAR activities, including Strengthening Care and Treatment, is approved annually through the PEPFAR Regional Operational Plan (ROP) process. The AOR will communicate any changes in technical guidance and funding levels that may impact Strengthening Care and Treatment implementation.

USAID will be substantially involved in the following areas:

1. AOR Approval of the Recipient's Work Plans. Significant changes to the approved plan shall be presented and will require additional approval. The work plan must be prepared in coordination and consultation with USAID/Guatemala.
1. AOR Approval of the Activity Monitoring, Evaluation, and Learning Plan. Significant changes made to the approved plan will require additional approval. USAID will monitor Recipient's progress toward achievement of program results during the course of the cooperative agreement.
2. AOR Approval of specified key personnel
3. AOR Approval of all training, promotional, education, communication, media releases materials, otherwise known as information, education and communication for behavioral change (IE& C) materials and IE& C campaigns that the Recipient develops prior to printing, reproducing, disseminating or airing.
4. Recipient will coordinate all activities directly with the AOR (with assistance as designated with activity managers (AM) or other USAID HIV Technical Officers in the region). Communication between the Recipient's Country representatives (AMs) in each country and the bilateral missions will be in close coordination with the AOR based in USAID/Guatemala. USAID/Guatemala will share the quarterly progress reports with the

other Missions. In countries with no USAID presence, the coordination with US Embassy or other high level of designed Officer will be through the AOR, based in Guatemala.

5. The COP or Country Representatives from the Recipient must participate in the partners meeting with the HIV/AIDS officers, other implementing partners and other staff of the bilateral missions.

4. Title to Property

Property title under the resultant agreement shall vest with the recipient in accordance with the Requirements of 2 CFR 200.

5. Authorized Geographic Code

The geographic code for this program is 935**.**

6. Purpose of the Award

The principal purpose of the relationship with the Recipient and under the subject program is to transfer funds to accomplish a public purpose of support or stimulation of the Strengthening Care and Treatment Cascade which is authorized by Federal statute.

The successful Recipient will be responsible for ensuring the achievement of the program objectives and the efficient and effective administration of the award through the application of sound management practices. The Recipient will assume responsibility for administering Federal funds in a manner consistent with underlying agreements, program objectives, and the terms and conditions of the Federal award. The Recipient using its own unique combination of staff, facilities, and experience, has the primary responsibility for employing whatever form of sound organization and management techniques may be necessary in order to assure proper and efficient administration of the resulting award.

[END OF SECTION B]

SECTION C: ELIGIBILITY INFORMATION

1. Eligible Applicants

U.S. and non-US organizations may participate under this NOFO.

Applicants must have established financial management, monitoring and evaluation processes, internal control systems, and policies and procedures that comply with established U.S. Government standards, laws, and regulations. The successful applicant will be subject to a responsibility determination assessment (Pre-award Survey) by the Agreement Officer (AO).

The Recipient must be a responsible entity. The AO may determine that a pre-award survey is required to conduct an examination that will determine whether the prospective recipient has the necessary organization, experience, accounting and operational controls, and technical skills – or ability to obtain them – in order to achieve the objectives of the program and comply with the terms and conditions of the award.

2. Cost Sharing or Matching

USAID has established a required cost share of 20 percent of the USAID contribution to the Strengthening Care and Treatment Project. This amount is required for the applicant to be eligible for award. Such funds may be mobilized from the recipient; other multilateral, bilateral, and foundation donors; host governments; and local organizations, communities and private businesses that contribute financially and in-kind to implementation of activities at the country level. For guidance on cost sharing in grants and cooperative agreements see 2 CFR 200.306 and 2 CFR 700.10.

[END OF SECTION C]

SECTION D: APPLICATION AND SUBMISSION INFORMATION

1. Agency Point of Contact

USAID/Guatemala
Ms. Deborah Perlman
Acquisition and Assistance Specialist
guatemalaproposals@usaid.gov

Questions regarding this NOFO should be submitted electronically to the email address above no later than the date and time indicated on the cover letter. Any information given to a prospective Applicant concerning this NOFO will be furnished promptly to all other prospective Applicants as an amendment to this NOFO, if that information is necessary in submitting applications or if the lack of it would be prejudicial to any other prospective Applicant.

2. Content and Form of Application Submission

Each Applicant shall furnish the information required by this NOFO. Applications shall be submitted in two separate parts: (a) Technical Application, and (b) Cost/Business Application. Applicants are expected to review, understand, and comply with all aspects of the NOFO.

Any erasures or other changes to the application must be initiated by the person signing the application. Applications signed by an agent on behalf of the Applicant shall be accompanied by evidence of that agent's authority, unless that evidence has been previously furnished to the issuing office.

Applicants who include data that they do not want disclosed to the public for any purpose or used by the U.S. Government except for evaluation purpose, should mark the title page with the following legend:

"This application includes data that shall not be disclosed outside the U.S. Government and shall not be duplicated, used, or disclosed – in whole or in part – for any purpose other than to evaluate this application. If, however, a grant is awarded to this Applicant as a result of – or in connection with – the submission of this data, the U.S. Government shall have the right to duplicate, use, or disclose the data to the extent provided in the resulting grant. This restriction does not limit the U.S. Government's right to use information contained in this data if it is obtained from another source without restriction. The data subject to this restriction are contained in sheets {insert sheet numbers} and, mark each sheet of data it wished to restrict with the following legend:

"Use or disclosure of data contained on this sheet is subject to the restriction on the title page of this application."

Applicants should retain for their records one (1) copy of the application and all enclosures which accompany it.

3. Application Submission Procedures

It is the Applicant's responsibility to ensure that all necessary documentation is complete and received on time.

Applications must be submitted electronically to guatemalaproposals@usaid.gov.

For an application sent by multiple emails, please indicate in the subject line of the email whether the email relates to the technical or cost application, and the desired sequence of multiple emails (if more than one is sent) and of attachments (e.g. "No. 1 of 4," etc.). For example, if your cost application is being sent in two emails, the first email should have a subject line which says: "RFA-520-17-000001, [organization name], Cost Application, Part 1 of 2." Each email must not exceed **20 MB**, and attachments must not be zipped files. In the case of the Cost Application, in addition to the MS Word and PDF files, the electronic submission must also include a budget in a non-protected MS Excel file. Technical and Cost Applications must be kept separate from each other. Technical Applications must not make reference to cost data in order that the technical evaluation may be made strictly on the basis of technical merit.

USAID's preference is that the technical application and the cost application be submitted as single email attachments, e.g. that you consolidate the various parts of a technical application into a single document before sending them. If this is not possible, please provide instructions on how to collate the attachments. USAID will not be responsible for errors in compiling electronic applications if no instructions are provided or are unclear. All applications received by the submission deadline will be reviewed for responsiveness to the NOFO and the application format. No addition or modifications will be accepted after the submission date.

After you have sent your applications electronically, immediately check your own email to confirm that the attachments you intended to send were indeed sent. If you discover an error in your transmission, please send the material again and note in the subject line of the email or indicate in the file name if submitted via grants.gov that it is a "corrected" submission. Do not send the same email more than once unless there has been a change, and if so, please note that it is a "corrected" email.

4. Technical Application Format

Applicants shall submit an application in response to this solicitation that is specific, clear, and complete, and that responds to the instructions set forth in this section.

a) Cover Page

The Cover Page should include the following:

i. Project title;
ii. Notice of Funding Opportunity reference number;
iii. Name of organization(s) applying for the agreement;
iv. Any partnerships; and
v. Contact person, telephone number, fax number, address, and types name(s) and title(s) of person(s) that is authorized to respond to the application, and corresponding signatures.

b) The Application shall be written in English and typed on standard 8 1/2" x 11" paper, single spaced, Times New Roman font size 12, with each page numbered consecutively.
c) The technical application should not exceed 40 pages in length. Any additional pages will not be evaluated. The Technical Approach shall not merely repeat the contents of the Program Description; rather, it shall offer original, critical thinking and analysis related to each result.
d) The application must be organized according to the Technical Evaluation Criteria.
e) A page in the technical proposal that contains a table, graph, etc., not otherwise excluded below, is subject to the 40-page limitation.
f) Not included in this page limitation are the following:

i. Table of Contents;
ii. Dividers;
iii. Appendix attachments with biographical information (i.e. resumes and other supporting documentation provided by the Applicant) for proposed candidates;
iv. Past Performance Information/Summary Table;
v. Acronym list;
vi. Charts, such as Organizational Chart;
vii. Performing Monitoring, Evaluation and Learning Plan.

The technical application should include the following sections:

I. Executive Summary
II. Technical Approach
III. Management and Staffing Plan
IV. Institutional Capacity and Past Performance
V. Appendix

The application should include the following sections and information:

I. Executive Summary

The Executive Summary will summarize the technical approach, the qualifications and experience of key personnel, the management approach, and relevant past performance. This summary is part of the 40 page limit.

II. Technical Approach

The technical narrative shall describe the Applicant's capability and approach to achieving the activity's objective: to strengthen the ability of El Salvador, Guatemala, Honduras, Nicaragua and Panama to provide effective and sustainable high quality patient centered services that successfully retain patients on HIV care and treatment. The applicant must include the following elements:

A. A description of challenges, needs, and opportunities in each country related to the Program Description;
B. A Logical Framework that outlines results, objectives, and verifiable indicators;
C. A description of the context in which the project will be implemented, including geographic areas and main counterparts;
D. A detailed description of how expected results for each project objective are going to be achieved, how the core implementation and cross-cutting principles will be integrated, and how the project will ensure sustainability and institutionalization of activities initiated by the project. Applicants must clearly indicate and show how gender issues will be identified and addressed; how expected results will be attained taking gender into account; and what resources will be provided.
E. A description of how the Applicant will apply evidence-based interventions to improve adherence, especially among KP, to achieve viral suppression.
F. The Applicant will present a comprehensive strategy, methodology, and solid and reasonable timeline to improve health care providers' response capacity to prevent, detect and manage HIV/TB co-infection at the facility level.
G. A description of how the Applicant will provide high quality technical support to the MoH in regards to care and treatment services free of stigma and discrimination and reduce barriers to initiate antiretroviral treatment and adherence to ART.

III. Management and Staffing Plan

The Management and Staffing Plan should address the following points:

- The USAID Central America Regional Program expects that the Applicant will maintain open, timely and effective communications with USAID Central America Regional Program, resulting in an implementation partnership that proactively addresses potential problems with flexible, workable solutions.
- If the Applicant intends to develop broad institutional partnerships, alliances, sub-contracts, or sub agreements as part of implementing the Agreement Program Description, the Applicant shall clearly identify and describe the roles and responsibilities of each entity. The Applicant must discuss the nature of organizational linkages between the prime awardee and any sub-contractor, Partner, and joint venture entity. This will include a discussion of roles and responsibilities, relationships, lines of authority and

accountability and mechanisms for utilizing and sharing resources to achieve results. The Applicants must present a chart that clearly describes lines of reporting and decision-making between the prime, sub-partner, headquarter, and offices in each country, in addition to proposed key and non-key positions.

- Applicants must submit a key personnel annex. The annex must include CVs not to exceed three pages of staff candidates, a list of references (at least one subordinate, one peer, and one manager) not associated with the applicant organization. The Applicant shall provide a staffing plan, identifying proposed individuals to fill key personnel positions, their qualifications, the stages of the activity at which they will be expected to be working, and what they are expected to contribute.
- The applicant must include the following elements:

  A. An organigram
  B. List of key personnel

Key Personnel: The Applicant shall identify key personnel with work experience related to the RFA components and experience in the national or international arenas. Specific criteria for key staff:

Chief of Party (Qty 1)

The Chief of Party must have at least 10 years of experience in managerial positions in Guatemala or in Latin America with eight years of experience in the health sector. Especially pertinent experience includes work in HIV/AIDS. S/he must have a Master Degree in Business Administration, Medicine, or a related field. The Chief of Party must demonstrate skills in problem solving, collaboration, leading team work, creativity and willingness to innovate, regional strategies to improve quality of life for key populations, management skills, and a history of productive engagement with a wide range and levels of organizations (government, private sector, NGOs, research institutions). S/he must be fluent in Spanish and English.

Country Representatives (Qty 5)

There will be one Country Representative in each country (Guatemala, El Salvador, Honduras, Nicaragua and Panama). They must have no less than six years of experience in managerial positions in Latin America, five years of experience in the health sector with an emphasis on HIV/AIDS. She/he must have a B.A. in business administration, social sciences, or a medical field. She/he shall have demonstrated experience as a manager of health activities, performing monitoring and evaluation and leading technical groups, and must be fluent in Spanish and English.

HIV/AIDS Senior Advisor (Qty 1)

The HIV/AIDS Senior Advisor will provide technical guidance to the team in all five countries. This Senior Advisor must have no less than eight years of experience in the HIV/AIDS health sector. A B.A. in the medical area or related field is required. S/he shall have demonstrated technical expertise and have relevant technical background in regional public health and

HIV/AIDS and development of sustainability process for health programs. S/he must be fluent in English and Spanish.

IV. Institutional Capacity and Past Performance

Past Performance will be used as an evaluation factor for this NOFO.

Applicants must submit at least three and no more than five past performance information data sheets from recent and relevant projects to USAID.

Applicants should also describe their institutional experience and capacity in the following areas:

- Implementation of HIV/AIDS prevention programs and programs of similar technical content and scope as described in the Program Description
- Conforming with assistance requirements and to achieving expected results, timeliness of performance, including adherence to implementation plan schedules, delivery of quality reports, and effectiveness of home and field management to make prompt decisions and ensure efficient operation of tasks.
- Strengthening HIV positive population's enrollment and retention across the continuum of care through HIV differentiated service delivery models tailored to KPs.

5. Cost Application Format

The Cost/Business application is to be submitted under a separate cover from the Technical Application. The Applicant is requested to submit a budget broken down by program years with an accompanying detailed budget narrative which provides in detail the total costs for implementation of the program as further detailed below.

The Cost/Business application must contain the following sections:

a) Cover page
b) Signed SF 424 Forms
c) Budget
d) Budget Narrative
e) A copy of the latest Negotiated Indirect Cost Rate Agreement if your organization or any sub-partner that has such an agreement with the U.S. Government
f) Commitment letters from all proposed sub-awardees
g) Dun and Bradstreet and SAM.gov Registration (active)
h) Certifications, Assurances and Other Statements of the Applicant

The following sections describe the documentation that Applicants for Assistance award must submit to USAID prior to award. While there is no page limit for this portion, Applicants are encouraged to be as concise as possible, but still provide the necessary detail to address the following:

a. Cover Page

The Cost/Business Application cover page must contain the same information as the technical application cover page.

b. SF 424 Forms

The Applicant shall submit the application using the SF-424 series:

• SF-424 Application for Federal Assistance
http://apply07.grants.gov/apply/forms/sample/SF424_2_1-V2.1.pdf
Instructions: http://www.grants.gov/web/grants/form-instructions/sf-424-instructions.html

• SF-424A Budget Information – Non-construction Programs
http://apply07.grants.gov/apply/forms/sample/SF424A-V1.0.pdf
Instructions: http://www.grants.gov/web/grants/form-instructions/sf-424a-instructions.html

• SF-424B Assurances – Non-construction Programs
http://apply07.grants.gov/apply/forms/sample/SF424B-V1.1.pdf
Instructions: http://www.grants.gov/web/grants/form-instructions/sf-424b-instructions.html

c. Budget

The electronic copy of the Budget must be submitted as an unprotected Excel file (MS Office 2000 or later versions) with visible formulas and references and shall be broken out by activity year.

The budget must include a breakdown of all costs associated with the program according to the costs of, if applicable, headquarters, regional and/or country offices.

Individual subcontractors/sub-awardees must include the same cost element breakdowns in their budgets as applicable.

Pursuant to 2 CFR 200 Contract means a legal instrument by which the Applicant purchases property or services needed to carry out the activity or program under a resulting award. The term does not include a legal instrument when the substance of the transaction meets the definition of a Federal award or sub-award (see § 200.92 Sub-award), even if the Applicant considers it a contract. The Applicant must describe the work to be performed, the risk borne by the contractor, the contractor's investment, the amount of subcontracting proposed by the contractor, and the quality of its record of past performance for similar work. For-profit contract organizations that work under the award and do not meet the above definition of a sub-awardee are eligible for profit/fee.

The budget should include costs to ensure an appropriate coordination, collaboration and information sharing with other USAID, U.S. Government Agencies, other international donors, the GOG, including municipal governments and private sector stakeholders and civil society organizations.

Applicants must submit a summary and a detailed budget as follows:

Summary Budget						
Cost Elements	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
1. Salaries and Wages						
2. Fringe Benefits						
3. Allowances						
4. Consultants						
5. Travel, Transportation, and Per Diem						
6. Equipment and Supplies						
7. Contractual						
8. Sub-grants						
9. Other Direct Costs						
10. Indirect Costs						
Estimated Cost (sum 1 to 10)						
11. Cost Share						
TOTAL AWARD BUDGET						

Note: Individual sub-awards proposed as part of application must include the same cost element break-downs in their budget as applicable.

Illustrative description of the cost elements are provided below:

1. Salary and Wages – must be proposed in accordance with the Applicant's personnel policies and must include as much as possible information about the personnel's name, position, salary rate, level of effort and salary escalation factors. Explain assumptions in the Budget Narrative.

2. Fringe Benefits – If the Applicant has a fringe benefit rate approved by an agency of the U.S. Government, the Applicant must use such rate and provide evidence of its approval. If an Applicant does not have a fringe benefit rate approved, the application must propose a rate and explain how the Applicant determined the rate; in this case, the narrative must include a detailed breakdown comprised of all items of fringe benefits (e.g., unemployment insurance, workers compensation, health and life insurance, retirement, FICA, etc.) and the costs of each, expressed in U.S. dollars and as a percentage of salaries.

3. Allowances: Allowances should be broken down by specific type and by person, and should be in accordance with applicant's policies and generally aligned with the Department of State Standard Regulations (DSSR).

4. Consultants – Short-term expert services rendered by persons who are members of a particular profession or possess a special skill and who are not officers or employees of the Awardee/Recipient. Costs of consultants must be broken down by person months or days.

5. Travel, Transportation and Per Diem – Cost principles in 2 CFR 200, Subpart E provide for costs for transportation, lodging, meals and incidental expenses. Costs should be broken down by the number of trips, domestic and international, cost per trip, per diem and other related travel costs.

6. Equipment and Supplies – Supplies includes all property except land or interest in land. Costs should be broken down by types and units.

7. Contractual – Any goods and services being procured through a contract mechanism.

8. Sub-grants – The Applicant should identify the activities to be implemented through sub-grants. The Applicant shall describe its approach to, and how it will manage, the competition and award of sub-awards in line with USAID best practices and the Guatemalan context.

9. Other Direct Costs – Applicants must detail any other direct costs, including the costs of communications, report preparation, passport issuance, visas, medical exams and inoculations, insurance (other than insurance included in the Applicant's fringe benefits), equipment, office rent, communication component, etc.

10. Indirect Costs – The Applicant must support the proposed indirect cost rate with a letter from a cognizant, U.S. Government audit agency, a Negotiated Indirect Cost Agreement (NICRA). The active should clearly explain the base and the calculation for the indirect costs.

If it does not have a NICRA, the Applicant should submit the following:

Reviewed Financial Statements Report: a report issued by a Certified Public Account (CPA) documenting the review of the financial statements was performed in accordance with Statements on Standards for Accounting and Review Services; that management is responsible for the preparation and fair presentation of the financial statements in accordance with the applicable financial reporting framework and for designing, implementing and maintaining internal control relevant to the preparation. The account must also state the he or she is not aware of any material modifications that should be made to the financial statements; or

Audited Financial Statements Report: An auditor issues a report documenting the audit was conducted in accordance with Generally Accepted Auditing Standards (GAAS), the financial statements are the responsibility of management, provides an opinion that the financial statements present fairly in all material respects the financial position of the company and the results of operations are in conformity with the applicable financial reporting framework (or issue a qualified opinion if the financial statements are not in conformity with the applicable financial reporting framework.

If the apparently successful Applicant has never received a negotiated indirect cost rate, the apparently successful Applicant may choose to charge the administrative/management costs as direct costs or to charge a de Minimis rate of 10% of modified total direct costs (see 2 CFR 200.414(f)). If the prospective Applicant chooses the de Minimis rate, the AO must incorporate the 10% indirect cost rate in the award budget and the Recipient must follow the requirements in 2 CFR 200.414(f).

11. Cost Share – USAID has established a required cost share of 20% of the Award's activities value for the recipient of the award. Cost sharing must be verifiable from the recipient's records, is subject to the requirements of Standard Provision entitled "Cost Share" and can be audited. The Applicants should estimate the amount of cost-sharing resources to be mobilized over the life of the agreement and specify the sources of such resources, and the basis of calculation in the budget narrative. Applicants should also provide a breakdown of the cost share (financial and in-kind contributions) of all organizations involved in implementing the resulting Cooperative Agreement.

d. Budget Narrative

The budget must have an accompanying detailed budget narrative that provides details for implementing the program. The budget narrative must be submitted in Word, text accessible. The budget narrative should provide information regarding the basis of estimate for each line item including reference to sources used to substantiate the cost estimate (e.g. organization's policy, payroll document, and vendor quotes, etc.).

The budget narrative should be organized using the same structure of the budget.

e. Dun and Bradstreet and SAM.gov Registration

USAID may not award to an Applicant until the Applicant has complied with all applicable unique entity identifier and SAM requirements. Each Applicant is required to:

1. Be registered in SAM before submitting its Application. SAM is streamlining processes, eliminating the need to enter the same data multiple times, and consolidating hosting to make the process of doing business with the government more efficient;

2. Provide a valid unique entity identifier in its application; and

3. Continue to maintain an active SAM registration with current information at all times during which it has an active Federal award or an application or plan under consideration by a Federal awarding agency.

f. Funding Restrictions

USAID policy is not to award profit under assistance instruments. However, all reasonable, allocable and allowable expenses, both direct and indirect, which are related to the agreement

program and are in accordance with applicable cost principle under 2 CFR 200 Subpart E. of the Uniform Administrative Requirements may be paid under the anticipated award.

Construction is not allowed under this project.

g. Certifications, Assurances and Other Statements of the Applicant

The business section of the cost/business application shall include the following:

1. Applicants must complete and sign the Certifications, Assurances, and Representations included in the following link: https://www.usaid.gov/sites/default/files/documents/1868/303mav.pdf.

2. Proposed key personnel must sign the Individual Key Certification per ADS 206 available at the following link: https://www.usaid.gov/ads/policy/200/20657m1.

3. The cost/business application should also include evidence of responsibility that the Agreement Officer can use to determine that the Applicant:

    a. Has adequate financial resources or the ability to obtain such resources as require during the performance of the award;
    b. Has the ability to comply with the award conditions, taking into account all existing and currently prospective commitments of the Applicant;
    c. Has a satisfactory record of performance. Past relevant unsatisfactory performance is ordinarily sufficient to justify a finding of non-responsibility, unless there is clear evidence of subsequent satisfactory performance;
    d. Has a satisfactory record of integrity and business ethics; and
    e. Is otherwise qualified and eligible to receive a Cooperative Agreement under applicable laws and regulations (e.g., EEO, Prohibition on Assistance to Drug Traffickers for Covered Countries and Individuals (ADS 206)).

4. Potential Request for Additional Documentation: Upon consideration of award or during the negotiations leading to an award, Applicants may be required to submit additional documentation deemed necessary for the Agreement Officer to make an affirmative determination of responsibility. USAID/Guatemala's Agreement Officer will request the following information from only the Apparently Successful Applicant:

    - Branding Strategy and Marking Plan. A Branding Strategy and Marking Plan shall be in accordance with the USAID Branding and Marking plan as required per ADS 320. Refer to ADS 320, (http://www.usaid.gov/policy/ads/300/320) specifically 320.3.3 for more information.
    - Certificate of Compliance: A copy of your Certificate of Compliance if your organization's systems have been certified by USAID/Washington's Office of Acquisition and Assistance (M/OAA).

h. Additional Requirements

If the Applicant has established a consortium or another legal relationship among its partners, the Cost/Business application must include a copy of the legal relationship between the parties. The agreement should include a full discussion of the relationship between the Applicant and Sub-Applicant(s) including identification of the Applicant with whom USAID will work with for purposes of Agreement administration, identity of the Applicant which will have accounting responsibility, how Agreement effort will be allocated and the express agreement of the principals thereto to be held jointly and severely liable for the acts or omissions of the other.

Additionally, if the Applicant is selected for award, it is a requirement that the organization is legally registered in the country of Guatemala. If the Applicant is a U.S. Organization and it is not registered in the country at the time of the award, the registration process should be completed during the first year of activity implementation or sooner. Costs associated with this registration process should be included as part of the Applicant's overhead costs since these are considered cost of doing business.

[END OF SECTION D]

SECTION E: APPLICATION REVIEW INFORMATION

1. Overview

Award will be made based on the ranking of applications according to the merit review criteria. Technical Applications and their associated Cost Application will be reviewed separately. Technical Applications will be reviewed using points against each merit review criteria and sub-criteria. Where sub-criteria exist, these will be used as elements to be considered when establishing the overall rating for the major criterion. Cost will not been assigned a numerical rating; however, cost estimates will be analyzed as part of the application review process for realism, allocability, reasonableness and allowability. The criteria presented below have been tailored to the requirements of this particular NFO. Applicants should note that these criteria serve to: (a) identify the significant matters that applicants should address in their applications, (b) set the standard against which all applications will be reviewed, and (c) inform an award decision. To facilitate the review of applications, applicants must organize the narrative sections of their applications with the same headings and in the same order as the merit review criteria. The technical narrative must follow the structure of the program description included in this NOFO.

2. Merit Review Criteria

The following evaluation factors and sub criteria are listed in order of importance starting with the most important factors listed first.

USAID will evaluate the extent to which the Applicant's Technical Approach is comprehensive and will meet the objectives and expected results as described in the program description.

I. Technical Approach (60 points)

The Applicant's technical approach shall be evaluated based on the extent to which the application:

- Adequately describes the challenges, needs, and opportunities in each country related to the Program Description; including the geographical areas and main counterparts;
- Provides a Logical Framework that outlines results, objectives, and verifiable indicators;
- Provides a detailed description of how expected results for each project objective are going to be achieved, how the core implementation and cross-cutting principles will be integrated, how the project will apply evidence-based interventions to improve adherence especially among KP and to achieve viral suppression.

- Indicate and shows how gender issues will be identified and addressed, how expected results will be attained taking gender into account, and how the project will ensure sustainability and institutionalization of activities initiated by the project.

- Presents a comprehensive strategy, methodology, and solid and reasonable timeline to improve health care providers' response capacity to prevent, detect and manage HIV/TB co-infection at the facility level.

- Demonstrates how it will provide high quality technical support to the MoH in regards to care and treatment services free of stigma and discrimination and reduce barriers to initiate antiretroviral treatment and adherence to ART.

II. Management and Staffing Plan (25 points)

The Applicant's Management and Staffing Plan shall be evaluated based on the extent to which the application:

- Demonstrates that the proposed organizational and operational structure and staffing incorporates the mix of requisite skills and relevant experience to achieve activity results.
- Provides an adequate staffing plan, describing key personnel and staff strengths (i.e., skills, education, and experience) vis-à-vis their roles and responsibilities in the proposal. Key personnel must demonstrate the ability to successfully and effectively implement the proposed program and describe how the proposed personnel will contribute holistically to both the technical and administrative needs of the activity, size and proposed results.
- Includes proposed personnel whose composition endeavors gender equity and inclusion of indigenous participation in the staffing plan.

III. Institutional Capacity and Past Performance (15 points)

The Applicant's Institutional Capacity and Past Performance shall be evaluated based on the extent to which the application:

- Demonstrates recent and relevant success in the implementation of HIV/AIDS prevention programs and technical experience in programs of similar technical content and scope as described in the Program Description;
- Demonstrates a record of conforming to assistance requirements and to achieving expected results, timeliness of performance, including adherence to implementation plan schedules, delivery of quality reports, and effectiveness of home and field management to make prompt decisions and ensure efficient operation of tasks.
- Demonstrates its capability to strengthen the HIV positive population's enrollment and retention across the continuum of care through HIV differentiated service delivery models tailored to KPs.

3. Cost Evaluation Criteria

Only the cost application(s) of the apparently successful applicant(s) will be evaluated for cost effectiveness. Proposed costs shall be evaluated for cost realism, completeness, reasonableness, allowability, and allocability. This analysis is intended to determine the degree to which the costs included in the cost application are fair and reasonable. Other considerations are the completeness of the application, adequacy of budget detail and consistency with elements of the technical application. In addition, the organization must demonstrate adequate financial management capability, to be measures for a responsibility determination.

Cost estimates will be analyzed as part of the application evaluation process. Proposed costs may be adjusted, for purposes of evaluation, based on results of the cost analysis and its assessment of reasonableness, completeness, and credibility.

USAID has established a required cost share of 20 percent of the Award's projected value for the recipient of the award. USAID shall make the final determination and assess whether or not the Applicants cost share contributions (e.g. categories or items) meet the standards set in 2 CFR 200.

4. Review and Selection Process

Technical applications will be reviewed in accordance with the merit review criteria set forth above by a Selection Committee (SC) composed of USAID employees and technical experts. The Cost application for the apparently successful applicant will be evaluated by the Agreement Officer on cost effectiveness, reasonableness, and fairness. A Member of the Selection Committee will evaluate the cost application for cost realism. An award will be made to the responsible applicant whose application best responds to the criteria specified above and proposes fair and reasonable costs. The final award decision is made, while considering the recommendations of the SC, by the Agreement Officer.

Authority to obligate the Government: the Agreement Officer is the only individual who may legally commit the U.S. Government to the expenditure of public funds. No costs chargeable to the proposed Agreement may be incurred before receipt of either an Agreement signed by the Agreement Officer or a specific, written authorization from the Agreement Officer.

5. Anticipated Announcement and Federal Award Dates

An award is anticipated on or about April or May 2018.

[END OF SECTION E]

SECTION F: FEDERAL AWARD ADMINISTRATION INFORMATION

1. Federal Award Notices

Award of the agreement contemplated by this NOFO cannot be made until funds have been appropriated, allocated and committed through internal USAID procedures. While USAID anticipates that these procedures will be successfully completed, potential applicants are hereby notified of these requirements and conditions for the award. The Agreement Officer is the only individual who may legally commit the Government to the expenditure of public funds. No costs chargeable to the proposed Agreement may be incurred before receipt of either a fully executed Agreement or a specific, written authorization from the Agreement Officer.

The Notice of Award signed by an Agreement Officer is the authorizing document, which shall be transmitted to the individual with the authority to enter agreements on behalf of the Recipient for countersignature to the authorized agent of the successful organization electronically, to be followed by original copies for execution. USAID will submit letters electronically to unsuccessful applicants after reviewing applications; unsuccessful applicants may request additional feedback on their applications by sending an e-mail message to guatemalaproposals@usaid.gov.

2. Administrative & National Policy Requirements

For U.S. organizations, 2 CFR 700, 2 CFR 200, and ADS 303maa, Standard Provisions for U.S. Non-governmental Organizations are applicable.

For non-U.S. organizations, ADS 303mab, Standard Provisions for Non-U.S. Non-governmental Organizations will apply.

3. Participant Training

For all training activities financed under this cooperative agreement the Recipient must comply with Automated Directives system (ADS) Chapter 253 and other USAID/Guatemala specific policies and procedures (i.e., Mission Order 253) governing the effective, efficient planning, design, and implementation of such training programs. The Recipient will also be responsible for entering training information into the TraiNet database on a quarterly basis. Each quarterly report will include a confirmation that this requirement has been met. For all project-funded trips to the United States, the recipient shall follow the guidelines included in ADS 252.

4. Value Added Tax

Use of EXENIVA form is authorized only for official project related procurement. USAID will support the customs clearance of official project vehicles. These vehicles will be cleared free of duty and IVA and will be titled to USAID/Guatemala with MI license plates. Upon award of the Cooperative Agreement, the Recipient must appoint two individuals to be trained and provided access to EXENIVA. The names of the appointed persons must be provided to the AOR.

5. Legal Registration in the Cooperating Country

The Recipient is responsible for complying with all applicable local laws regarding fringe benefits for its local employees, local business operations, including but not limited to the registration of its offices in the local country.

6. Climate Risk Management

All USAID projects and activities approved after October 1, 2016 are required to be assessed for climate risks, and the results of that analysis will be documented in the Activity's Initial Environmental Examination (IEE) (see Climate Risk Management for USAID Projects and Activities, a Mandatory Reference for ADS Chapter 201). This process of assessing, addressing, and adaptively managing climate risks is known as climate risk management (CRM). For USAID's purposes, climate risks are potential negative consequences on projects or activities due to changing climatic conditions. The goal of CRM is to both render USAID's work more climate resilient (i.e., better able to anticipate, prepare for and adapt to changing climate conditions and withstand, respond to and recover rapidly from disruptions) and to avoid maladaptation (i.e., development efforts that inadvertently increase climate risks). By using climate risk assessments to inform decision-making at the strategy, project and activity levels, USAID is better able to manage climate risks and more effectively pursue its mission to end extreme poverty and to promote resilient, democratic societies while advancing our security and prosperity.

The goal of climate risk assessment at the activity level is to identify ways in which to integrate measures to address climate risks into activity design and/or to provide instructions to implementers to ensure that they adequately assess and address climate risks throughout implementation. To comply with this requirement, the IEE must include a summary of the approach to activity-level CRM and major results, as well as a completed Climate Risk Management Summary Table. For the Strengthening Care and Treatment Cascade project, USAID/Guatemala will conduct the climate risk assessment and present results to the Recipient during the Post Award Orientation Meeting. If the assessment indicates moderate or high climate risks, each risk must be addressed by integrating risk management measures into activity implementation. This will be done through an environmental mitigation and monitoring plan (EMMP), where the Recipient will describe specifically how it will implement all IEE conditions and mitigation measures that result from the CRM that apply to proposed activities within the scope of the award, including identified climate risks.

7. Electronic Payment System

Definitions:

"Cash Payment System" means a payment system that generates any transfer of funds through a transaction originated by cash, check, or similar paper instrument. This includes electronic payments to a financial institution or clearing house that subsequently issues cash, check, or similar paper instrument to the designated payee.

"Electronic Payment System" means a payment system that generates any transfer of funds, other than a transaction originated by cash, check, or similar paper instrument that is initiated through an electronic terminal, telephone, mobile phone, computer, or magnetic tape, for the purpose of ordering, instructing or authorizing a financial institution to debit or credit an account. The term includes debit cards, wire transfers, transfers made at automatic teller machines, and point-of-sale terminals.

The recipient agrees to use an electronic payment system for any payments under this award to beneficiaries, sub recipients, or contractors.

Exceptions. Recipients are allowed the following exceptions, provided the recipient documents its files with the appropriate justification:

- Cash payments made while establishing electronic payment systems, provided that this exception is not used for more than six months from the effective date of this award.
- Cash payments made to payees where the recipient does not expect to make payments to the same payee on a regular, recurring basis, and payment through an electronic payment system is not reasonably available.
- Cash payments to vendors below $3,000, when payment through an electronic payment system is not reasonably available.
- The Recipient has received a written exception from the Agreement Officer that a specific payment or all cash payments are authorized based on the Recipient's written justification, which provides a basis and cost analysis for the requested exception.

More information about how to establish, implement, and manage electronic payment methods is available to recipients at http://solutionscenter.nethope.org/programs/c2e-toolkit
For all project-funded trips to the United States, the Recipient must follow the guidelines included in ADS 252

8. Reporting Requirements

A. Annual Work Plan

Within 45 days of award of the Cooperative Agreement, the Recipient will submit for USAID

AOR approval its initial strategic work plan covering the period from award date through September 30, 2018. The Plan shall include a description of activities, timelines and budgets, and will identify any start up activities required, as well as critical paths and milestones for the subsequent years of the agreement. The recipient must submit subsequent annual work plans by August 30 of each year.

The Annual Work Plans must include:

- Proposed accomplishments for the fiscal year, and expected progress toward achieving CA results that are linked to the Activity Monitoring, Evaluation, and Learning Plan;
- Timeline for implementation of the year's proposed activities, including target completion dates;
- Information on how activities will be implemented;
- Analysis of possible obstacles hindering achievement of objectives;
- Target Setting: The recipient will work collaboratively with the AOR to set annual activity targets that will contribute to reaching strategic plans. Annual targets will also contribute to global PEPFAR targets as set out by the PEPFAR Blueprint: Creating an AIDS-free Generation or current guidance established by the Office of the Global AIDS Coordinator and country PEPFAR Coordination Office as well as the Monitoring, Evaluation and Reporting (MER 2.0), Indicators Reference Guide Oct.2016 from OGAC. Initial activity target setting will be informed by existing and activity baseline data that should be available within 180 days of activity start-up. Annual targets must also be established for each indicator and presented to the USAID/Guatemala AOR during the development of the annual USAID Operational Plan and USG Regional Operational Plan.
- Detailed budget by principal activities and also by line item and countries. Beginning on year 2, the Annual Work Plan must show planned expenditures by quarterly and actual expenditures to date;
- Activity Fact Sheet or Activity Profile, in Spanish and English, that summarizes pertinent information regarding the activities developed in C.A. that can be used for preparing media kits and for disseminating to interested stakeholders;
- A description of any information, communication, education, and training materials planned.
- Proposed activities, including planned local and international training events, expected results.
- A description on use of other sources of funds (when applicable) that shall be submitted in a separate section of the Annual Work Plan (and reports) in order to facilitate tracking;

B. Performance Reports

Thirty (30) days after the end of each quarter, on January 30, April 30, and July 30, the Recipient will be required to provide quarterly performance reports to describe activities undertaken during the quarter, report on progress made toward achieving results, and explain any necessary adjustments for activities, timelines, etc. that will be undertaken in the next quarter. Any

implementation problems should be discussed in the reports as well as the corrective actions taken and the costs associated with the delay. As part of each quarterly report, the Recipient shall submit a list of all in country training events that the project supported during the reporting period. This report shall include at a minimum: name of the training program, field of study, relationship to the objectives of this instrument, start and end dates, estimated cost (USAID's cost and partner's cost disaggregated by instruction, trainee, and travel) and number of male and female participants. The Recipient is required to provide quarterly data for the required Performance Indicators, using the PMP matrix. A matrix with the indicator report must be submitted as an annex to the quarterly reports.

The fourth quarterly report shall also serve as the Annual Performance Report and shall be submitted on October 30. The annual report should also consolidate data from the previous quarterly reports in order to present annual totals for the numerical targets. The Annual reports shall include success stories for publication. The annual report should address accomplishments, progress toward achievement of results, and any problems encountered during the performance period. The report should include information on performance measures, indicators and benchmarks, tied to the Annual Work Plan and the Performance Monitoring Plan targets, for the quarter and the entire previous fiscal year.

Twice yearly, PEPFAR requires performance reports reflecting more detailed data on achievements and targets. The Recipient will submit to USAID /Guatemala a narrative report describing the achievement of targets, and for selected indicators the Recipient will enter the data into DATIM (Data for Accountability, Transparency and Impact). The Recipient will incorporate this information into the quarterly/annual reports due on April 30 and October 31. Based on the Monitoring Plan to be developed by the Recipient in collaboration with USAID, the supplemental information in the report should include the following: a) explanation of quantifiable output of the programs or projects supported; b) reasons why established goals and objectives were not met, if appropriate; c) analysis and explanation of cost overruns or high unit costs; and d) information on all awards made to sub-partners. The Recipient must immediately notify USAID of developments that have a significant impact on award-supported activities. Further, notification must include a statement of the action taken or contemplated, and any assistance needed to resolve the situation.

The Recipient will maintain a consolidated database that tracks sub-partner performance. Performance data shall be in accordance with the standard set for HIV and AIDS indicators that USAID is required to report on, including PEPFAR requirements (such Expenditure Analysis). In addition, performance data should meet reasonable standards of validity, reliability, timeliness, precision, and integrity.

C. Activity Monitoring, Evaluation, and Learning Plan

This plan will include:

- A monitoring plan (MP) to measure and assess activity results with appropriate indicators for each level of the results framework.
- A strategic evaluation and learning agenda, i.e., a set of questions which the

program intends to answer via systematic research methods. Because USAID intends to separately procure an independent impact evaluation of this award, recipients should focus their evaluation agenda on more formative and process evaluation questions and situational or needs assessments. Such internal evaluations (conducted by the awardee) are subject to review and approval by USAID.

Within 90 days of award, the recipient shall submit in writing to USAID/Guatemala a final Monitoring Plan (MP) for the full time frame of the activity.

(a) Monitoring Plan

Upon award, the recipient shall work with the USAID/Guatemala Agreement Officer's Representative (AOR) and HIV/AIDS Multisector Team Strategic Information staff to ensure that indicators are aligned with the Mission's development objectives and results framework, as well as with required PEPFAR and health strategic objectives. The recipient will also consult with other relevant implementing partners and Technical Working Groups in developing the final MP. MP indicators will feed into USAID and PEPFAR reporting, as well as reporting for other Presidential initiatives. Please refer to www.pepfar.gov for updated PEPFAR Monitoring, Evaluation, and Reporting (MER) indicators. PEPFAR MER indicators should form an important part of the monitoring plan, but the plan should go beyond them via the inclusion of custom indicators to get more finely grained activity monitoring.

USAID requires that all performance measures be part of a coherent system that will objectively assess the overall progress of activities with the ultimate goal of achieving the expected results outlined in the Program Description. Where relevant, the MP should enable tracking of higher-level outcomes.

The MP should include indicators, baselines and targets pertinent to activity-level management and monitoring, which clearly support achievement of USAID/Guatemala's Health and HIV and AIDS goals and targets. The recipient shall develop a robust data collection system, which includes adequate data quality controls and complies with all USAID data quality requirements, ADS 203.3.11. Each indicator in the final MP will have a performance indicator reference sheet that provides detailed descriptions of the indicator, numerator and denominator where percent measures are used, and a data collection plan. Where appropriate, MP baselines should draw on regional results as well as other studies and surveys.

The MP shall specify approximate dates for data collection, the method, type, and source of information to be collected, and shall report on these indicators in line with existing and future USG guidance.

The MP should also present measures and approaches through which outcomes of capacity building and coordination activities can be measured and verified. USAID expects the recipient to be innovative and creative in capturing, documenting, and reporting on its monitoring indicators.

A baseline has to be defined either from the previous policy activity or measured in the first year of the activity, as well as Recipient's goals proposed to each year and the end of this agreement. Once approved, this plan will provide the basis for the implementing organization's progress reporting throughout the life of this agreement.

Intervals must be no less frequent than annually nor more frequent than quarterly except in unusual circumstances, for example where more frequent reporting is necessary for the effective monitoring of the Federal award or could significantly affect program outcomes. Annual reports must be due 90 calendar days after the reporting period; quarterly or semiannual reports must be due 30 calendar days after the reporting period.

The non-Federal entity must inform the Federal awarding agency or pass-through entity as soon as the following types of conditions become known:

(1) Problems, delays, or adverse conditions which will materially impair the ability to meet the objective of the Federal award. This disclosure must include a statement of the action taken, or contemplated, and any assistance needed to resolve the situation.

(2) Favorable developments which enable meeting time schedules and objectives sooner or at less cost than anticipated or producing more or different beneficial results than originally planned.

(b) Evaluation and Learning Agenda

The recipient is encouraged to create a list of evaluation questions that should be answered to ensure successful implementation – e.g., questions about community needs, perceptions of the activity, barriers to achieving targeted outcomes, piloting of tools, etc. In consultation with USAID, data generated by the plan will be used to design and modify programmatic approaches to improve impact. The recipient should carry out formative research on priority groups of interest, including potentially generating biologic and behavioral data on these populations, to feed into intervention design. Indicators that are reported in individual country OP must be reported and broken out by country and included in quarterly reports. Recipient may be requested to report outside quarterly report timeframes to meet ROP deadlines for ROP-specific indicators. This additional reporting may be necessary in order to set targets and explain performance outside target ranges. Moreover, over the life of the activity, Recipient may be requested to report on additional indicators or changes.

D. Security Plan

The Recipient must submit a detailed Security Plan that describes the Recipient's plan to safeguard all project operations. The plan is to be implemented and maintained by all subawardees as well. The Recipient must share the security plan with the Agreement Officer and AOR, but it will not be approved by USAID personnel. The plan must include the following:

a. Procedures for reporting and addressing security threats;
b. Procedures for reporting any deaths related to the project;

c. Procedures for reporting and addressing any persons missing or kidnapping incidents;
d. Name and contact information of security contact person for the head office and regional office(s);
e. An internal cascade list for communicating with staff to be updated and maintained by the Recipient.

The Recipient must provide the name, address, and telephone numbers of the Chief of Party and his/her designee to USAID as principal contacts in case of security situations/emergencies. Recipients are responsible for sharing information with their staff.

The Security Plan should be revised every fiscal year to ensure it responds to the needed security measures giving the ever-changing conditions, and should be submitted in conjunction with the Annual Work Plan.

E. Closeout/Demobilization Plan

Six months prior to the completion date of the Cooperative Agreement, a close-out/ demobilization plan including the proposed disposition of equipment, including vehicles, will be submitted to the USAID Agreement Officer for approval with copy to the AOR. The close-out plan shall include a list of actions for close-out activities; an analysis of progress to date and, if necessary, expedite timelines to ensure completion; and a pipeline analysis to ensure that there are sufficient funds available to finalize activities and complete all requirements. The report should include a final inventory of all residual non-expendable property that was acquired or furnished by the Government under the Cooperative Agreement and request disposition approval for any property acquired or furnished by the Government under the program. Particular care should be taken regarding vehicles, since their legal transfer may require a special procedure that would need to be completed before the completion date of the award. For U.S. organizations, demobilization plans need to include: closing of offices, disposition of all equipment (including vehicles), disposition of residual supplies, repatriation of expatriate staff, household and POV shipments, etc.

F. Final Performance Report

A draft Final Performance Report is required within 30 days of the expiration of this Agreement for USAID's comments. The Final Report will be due 60 days after expiration of the agreement. The final report will highlight major successes achieved during the entire period of performance with reference to established targets, and should also discuss any shortcomings and/or difficulties encountered. An additional function of this report is to outline lessons learned and make recommendations for any future activity. The Recipient shall submit an electronic copy of this report to the USAID/Guatemala Activity Manager in English and an additional copy to the Development Experience Clearinghouse to the following e-mail address: docsubmit@dec.cdie.org.

G. Financial Reporting

In accordance with 2 CFR 200.327, the SF 425 must be submitted on a quarterly basis. The recipient shall submit these forms in the following manner:

(2) If the Recipient has a Letter of Credit with the US government then, on a quarterly basis, report expenditures/liquidations to DHHS electronically on the Federal Financial Report (FFR/SF-425), lines 10a – 10c and the FFR Attachment (SF-425A) using the DHHS Payment Management System.

(3) The SF 425 (and SF 425a if necessary) must be submitted via electronic format to the Agreement Officer's Representative (AOR), the Agreement Officer (AO), and the USAID/Guatemala Financial Management Office. The Federal Financial Report (FFR/SF-425) is available in PDF or Excel format at the OMB website: http://www.whitehouse.gov/omb/grants_forms/.

(4) The financial reports are due 30 days after the end of each fiscal year quarter on October 30, January 30, April 30, and July 31.

(5) If the Recipient has a Letter of Credit with the US government then, a copy of the "Final" Federal Financial Report (FFR/SF-425) report for this award is to be submitted to the USAID LOC Team at locfinalreport@usaid.gov.7.

Reporting Requirements Summary		
Report	**Due Date**	**Format**
Annual Work Plans	The first plan is due 45 days after award. Subsequent year Annual Work Plans are due on August 30 of each year.	Electronic. Recipient may be requested to present this orally as well. English and Spanish.
Monitoring, Evaluation, and Learning Plan	90 days after award date.	Electronic. English.
Quarterly Performance Reports	30 days after the end of each quarter. Due dates shall be: Qtr 1 = January 30; Qtr 2= April 30; Qtr 3= July 30.	Electronic. English and Spanish.
Quarterly Financial Reports	30 days after each quarter. Due dates shall be: Qtr 1 = January 30; Qtr 2= April 30; Qtr 3= July 30; Qtr 4 = October 30.	Electronic. English.
Annual Performance Reports	Annual performance reports are due on October 30 of each calendar year.	Electronic. Recipient may be requested to present orally as well. English and Spanish.
Final Report	Draft final report is due no later than 90 days prior to end of the award and final report due no later than 30 days after the award end date.	Electronic. English and Spanish.
Security Plan	90 days after award date.	Electronic. English.

Closeout/Demobilization Plan	90 days before the end of the agreement	Electronic. English.

9. Program Income

Applicants are requested to mention in the application whether program income is anticipated under the resulting award. If an activity under the award generates a profit, in accordance with Required as Applicable Standard Provision entitled "Program Income", income earned during the project period must be added to the total program amount and used to further eligible project or program objectives, unless this award Schedule specifies otherwise.

10. Branding & Marking

Only the apparently successful Applicant will be required to submit a Branding Strategy and Marking Plan to be evaluated and approved by the Agreement Officer prior to award of the Cooperative Agreement. These plans shall be prepared in accordance with the guidance in ADS 320 "Branding and Marking" and the Graphic Standard Manual. The apparently successful Applicant should use the template included in Attachment 2 of this RFA.

11. Environmental Compliance

The Foreign Assistance Act of 1961, as amended, Section 117 requires that the impact of USAID's activities on the environment be considered and that USAID include environmental sustainability as a central consideration in designing and carrying out its development programs. This mandate is codified in Federal Regulations (22 CFR 216) and in USAID's Automated Directives System (ADS) Parts 201.5.10g and 204 (http://www.usaid.gov/who-we¬are/agency-policy/series-200), which, in part, require that the potential environmental impacts of USAID¬ financed activities are identified prior to a final decision to proceed and that appropriate environmental safeguards are adopted for all activities. The Recipient's environmental compliance obligations under these regulations and procedures are specified in the following paragraphs of this Cooperative Agreement.

In addition, the Recipient must comply with host country environmental regulations unless otherwise directed in writing by USAID.

No action funded under the resulting CA will be implemented unless an environmental threshold determination, as defined by 22 CFR 216, has been reached for that activity, as documented in a Request for Categorical Exclusion (RCE), Initial Environmental Examination (IEE) duly signed by the Bureau Environmental Officer (BEO).

An Initial Environmental Examination (IEE) LAC-IEE-16-46 has been approved for Development Objective 4: HIV Prevalence in Central America Contained, funding this cooperative agreement (CA). The IEE covers activities expected to be implemented under this CA. USAID has determined that a Negative Determination with Conditions applies to one or

more of the proposed actions. This indicates that if these actions are implemented subject to the specified conditions, they are expected to have no significant adverse effect on the environment. The recipient shall be responsible for implementing all IEE conditions pertaining to actions to be funded under this CA.

As part of its initial Work Plan, and all Annual Work Plans thereafter, the recipient, in collaboration with the USAID AOR, and MEO, REA, or BEO, as appropriate, shall review all ongoing and planned actions under this CA to determine if they are within the scope of the approved IEE.

If the Recipient plans any new actions outside the scope of the approved IEE, the Recipient shall inform USAID in writing of these changes. No such new actions shall be undertaken prior to receiving written USAID approval.

When the approved IEE contains one or more Negative Determinations with Conditions, the Recipient shall:

- Prepare an environmental mitigation and monitoring plan (EMMP) for each proposed action under the Negative Determination with Conditions in the IEE, describing how the Recipient will, in specific terms; implement all IEE conditions that apply within the scope of the award. The EMMP format is attached. The EMMP shall include monitoring the implementation of the conditions and their effectiveness.
- Integrate a completed EMMP into the initial work plan.
- Prepare an Environmental Compliance Report (ECR) at the end of the year or as per reporting requirements of the contract. The ECR shall be based on the monitoring of mitigation measures using Table 3 of the EMMP.
- A revised EMMP must be completed and approved in subsequent Annual Work Plans, making any necessary adjustments to implementation in order to minimize adverse impacts to the environment.

A provision for sub-awards is included under this award. Therefore, the Recipient will prepare an EMMP for each proposed sub-award, except those that qualify for a categorical exclusion. In the case of a categorical exclusion, the Recipient shall complete and submit for USAID approval table 1 of the EMMP (Environmental Review Form- ERF). In order to ensure the funded proposals will result in no adverse environmental impacts. Implementation of sub-awards shall not begin prior to USAID written approval of the corresponding EMMP. The Recipient is responsible for ensuring that mitigation measures specified in the EMMP are implemented."

[END OF SECTION F]

SECTION G: FEDERAL AWARDING AGENCY CONTACT(S)

The Agreement Officer for this Award is:

USAID/Guatemala
Ms. Natalie J. Thunberg
Agreement Officer

The A&A Specialist for this Award is:

USAID/Guatemala
Ms. Deborah Perlman
Acquisition and Assistance Specialist
Email: guatemalaproposals@usaid.gov

[END OF SECTION G]

SECTION H: OTHER INFORMATION

USAID reserves the right to fund any or none of the applications submitted.

Attachments to the RFA:

Attachment 1: Past Performance Information Data Sheets

Attachment 2: Branding and Marking Template

[END OF SECTION H]

Attachment 1 – Past Performance Information Data Sheets

Attachment 1

Past Performance Information (PPI)

(To be completed by the applicant)

1.	**Award Number:**
2.	**Contractor/Recipient (Name and Address):**
3.	**Type of Award:**
4.	**Complexity of Work: Difficult _____Routine _____**
5.	**Description, location, and relevancy of work:**
6.	**Dollar Value of Work : _____ Status: Active ____Completed _____**
7.	**Date of Award: _____** **Award Completion Date (including extensions): _____**
8.	**Type and Extent of Subawards:**
9.	**Name, Address, Telephone Number, and E-mail Address of the Awarding Contracting/Agreement Officer and/or the Contracting/Agreement Officer 's Representative (and other references as applicable):**

Attachment 2

ASSISTANCE BRANDING AND MARKING TEMPLATE

- **Blue filled out by the Apparently Successful Applicant**

Branding Strategy for the [Name] Project

With reference to ADS 320.3.3 and 2 CFR 700, below is the Branding Strategy**:**

1. **Program Name: [Name]** (Follow guidelines in March 16, 2016 USAID Graphic Standards Manual and Partner Co-branding Guide, Section 4 entitled Grants, Cooperative Agreements & Assistance.

1.1 Identify project name in English and host-country language(s).

2. **How the program will be positioned:** This section discusses how to publicize the program, visibility considerations, and includes a description of the communications tools to be used.

   The Recipient may use co-branding and co-marking in accordance with ADS 320.3.3.1 for visual, textual and verbal materials and communications, which may be translated into host-country languages as appropriate. Presumptive exceptions will be outlined in the Marking Plan and if/when a situation arises that is not considered in the Marking Plan, it will be evaluated on a case-by-case basis by the Agreement Officer's Representative (AOR) and Agreement Officer (AO).

3. **Desired level of visibility**: Select high, medium or low visibility determined by considerations for each project and its communication strategy.

4. **Other organizations to be acknowledged:** The Apparently Successful Applicant may propose to acknowledge other organizations during project activities such as the Host Country Government Counterparts by including this Section into its Branding Strategy. The

proposed Marking Plan may also outline these situations as well. Situations that arise that are not considered in the Marking Plan, will be evaluated on a case-by-case basis by the Agreement Officer's Representative (AOR) and Agreement Officer (AO).

6. AUDIENCES

Subject to approval by USAID, _____ has the following target audiences with whom it will promote and publicize USAID sponsorship:

5.1 Primary audience(s):

5.2 Secondary audiences:

7. MESSAGES

All communication materials and activities will use USAID visual, textual and/or verbal branding. As such, all materials and activities will acknowledge that they were produced with support "from the American people."

Guidelines for visual branding and marking are contained in the USAID Graphic Standards Manual and Partner Co-Branding Guide (March 2016) and the Recipient will use the following verbal and textual branding:

Examples:

The USAID [Name] Project.

XYZ, Director of the USAID [Name] Project.

In cases where a host-country language predominates over English, the appropriate translation into the host-country language will be used in branding and marking the program.

The [Name] Project will follow specific procedures for including the Branding Strategy requirements as stated in the mandatory internal reference Branding and Marking in USAID Direct Contracting in the Automated Directives System, Chapter 320 and 2 CFR 700

8. COMMUNICATION TOOLS

The following communication tools will be used (see ADS 320and ADS 558 on Social Media). The Recipient may add to this list.

Each item listed below will be considered in the Table 1. Marking Plan and, as relevant, in Table 2.

Exceptions to Marking.

Item

9. KEY MILESTONES AND OPPORTUNITIES

The following key milestones are anticipated to generate awareness that the program is from the American people. These milestones may be linked to specific points in time, such as at the beginning or end of a program, or to an opportunity to showcase reports or other materials (consult ADS ADS 320 and 2 CFR 700). These include, but are not limited to:

- training events,
- publishing reports,
- highlighting success stories,
- promoting final or interim reports, and
- communicating program impact/overall results
- speaking engagements, including in communities.

10 ACKNOWLEDGEMENTS

10.1 ACKNOWLEDGING USAID AND THE USAID [Name] PROJECT

The following acknowledgment will be included on internal publications, such as quarterly reports, as appropriate:

This document was produced for review by the United States Agency for International Development. It was prepared by _____ *for the* ***[Name] Project,*** *[award number].*

10.2 ACKNOWLEDGING HOST-COUNTRY GOVERNMENTS

All [Name] Project communication material and activities will follow USAID Branding Guidelines. Decisions to co-brand with a host-country government entity may be made and will be considered in the Marking Plan. Co-branding with host-country partners may be desirable to communicate ownership and engagement.

10.3 ACKNOWLEDGING OTHER HOST-COUNTRY PARTNERS

Co-branding with other host-country partners will occur when these organizations have contributed funds and/or significant in-kind items or assistance to the activity. Co-branding with in-country partners may be desirable to communicate ownership and engagement.

10.4 CO-BRANDING WITH OTHER INTERNATIONAL ORGANIZATIONS AND OTHER USG AGENCIES

The ADS 320 and USAID Graphic Standards Manual and Partner Co-Branding Guide (March 2016) guidelines for co-branding with other international organizations will be followed.

Marking Plan for the [Name] Project

With reference to ADS 320.3.3 and 2 CFR 700, below is the required Marking Plan**:**

1.0 MARKING

1.1 MARKING PLAN

Table 1 outlines the types of materials and activities that may be produced under the USAID [Name] Project. Any materials and activities that are not anticipated below, but are produced under the initiative, will also be subject to branding guidelines and AO approval, as appropriate. The goal is to mark programs and projects, and not implementing partners.

All materials, activities and deliverables marked with the USAID logo for the [Name] Project will follow design guidance for color, type, and layout in the USAID Graphic Standards Manual and Partner Co-Branding Guide (March 2016) as related to equipment, reports, studies, events, and public communication (including printed products, audio, visual, and electronic materials), etc. The USAID logo will be used for programmatic correspondence. Recipient's letterhead will be used for administrative correspondence and will not have the USAID logo. Business cards will not show the USAID logo but may use text: USAID Recipient.

Please provide graphic examples of visual marking of materials, activities and deliverables using the USAID logo and project name in situations of co-branding and no-branding, in both English and Spanish.

There are two criteria used to determine when the disclaimer provision must be used:

a) As per 2 FR 700.16(c) (1) Studies, reports, publications, Web sites, and all informational and promotional products not authored, reviewed, or edited by USAID; and
b) As per the discretion of the AOR and Recipient's consideration of a specific situation.

The provision is as follows in English and Spanish:

This study/report/Web site (specify) is made possible by the support of the American People through the United States Agency for International Development (USAID). The contents of this (specify) are the sole responsibility of (name of organization) and do not necessarily reflect the views of USAID or the United States Government.

Est(e/a) [especificar: publicación, video, sitio Web u otro producto de información] es posible gracias al apoyo del Pueblo de los Estados Unidos a través de la Agencia de los Estados Unidos para el Desarrollo Internacional (USAID). El contenido de este (especificar) es responsabilidad exclusiva de (nombre de la organización y autor) y el mismo no necesariamente refleja la perspectiva de USAID ni del Gobierno de los Estados Unidos de América.

Marking Requirements for the [Name of the Project]

TABLE 1. MARKING PLAN FOR MATERIALS AND ACTIVITIES (illustrative examples only)

Follow the guidelines contained in the USAID Graphic Standards Manual and Partner Co-Branding Guide (March 2016).

Category/Material	**Type of Marking**	**Visual, Verbal, Textual** **—** **Disclaimer**
Administrative		
Program related stationery products	The USAID logo will be used.	Visual Textual
Contract Deliverables: documents, publications, studies, reports, papers, technical assistance consultant reports	Follow guidelines for exclusive marking. Use specific language for deliverables when submitted to USAID for review.	Visual Textual
Program Communication		
Technical reports, publications, documents, studies	The USAID logo will appear on the cover; design follows guidelines for exclusive branding unless co-branding is acceptable or an exemption is provided for no branding.	Visual Textual — Consider Disclaimer

Training materials, manuals and sessions	The USAID logo will appear on the cover of documents and verbal branding will be used at training sessions; design follows guidelines for exclusive branding unless co-branding or an exception for no marking is indicated.	Visual, Textual, Verbal — Consider Disclaimer for Visual & Textual
Audiovisual: Video, CDs-ROM, Animated Infographics	The USAID logo will be printed on CD labels, splash screen/menus, and packaging; design follows guidelines for exclusive branding unless co-branding or an exemption is indicated for no marking.	Visual
PowerPoint presentations	The USAID logo is required as per USAID presentation template; design follows guidelines for the exclusive branding unless co-branding is acceptable or an exemption for no branding is indicated. Templates available at www.usaid.gov/branding/resources	Visual
Posters, banners, exhibition booth signs, event signage	The USAID logo will appear on the material; design follows guidelines for exclusive branding unless co-branding or an exemption for no branding is indicated.	Visual
Program public awareness, advocacy and behavior change materials and activities	The USAID logo will appear on each material based on the purpose and type of material, target audience and how to be used. Design follows guidelines for exclusive branding unless co-branding or an exemption for no branding is indicated.	Visual, Textual or Verbal

Web portal and social media platforms (Facebook, Twitter, Flickr, blogs, others)	Follow guidelines in ADS 558 for appropriate branding and marking.	Visual Textual
Institutional Communication		
Photographs, Infographics	The USAID logo or "USAID" in text will appear on the material; design follows guidelines for exclusive branding unless co-branding or an exemption for no branding is indicated.	Visual Textual — Consider Disclaimer on Infographics
Collateral, print information material (i.e., success stories, fact sheets, articles, feature stories, others)	The USAID logo will appear on printed materials; design follows guidelines for exclusive branding.	Visual Textual
Commodities and Equipment	The USAID logo will appear on items; exclusive branding unless co-branding is acceptable or an exemption for no branding is indicated.	Visual

Table 2. Exceptions to Contract Marking Requirements

Use one or several of the following exceptions to fill out Table 2, depending on the circumstances.

2 CFR 700.16 (h) Presumptive Exceptions

The following exceptions reflect USAID's usual, non-emergency practices in not marking certain communication materials for programmatic reasons. The AO, in consultation with the Activity Manager/AOR, has the authority to determine that marking in accordance with is not appropriate:

a. Compromise the intrinsic independence or neutrality of a program or materials where independence or neutrality is an inherent aspect of the program and materials. This includes, but is not limited to, the following:
    - Election monitoring or ballots, and voter information literature;
    - Political party support or public policy advocacy or reform;
    - Independent media, such as television and radio broadcasts, and newspaper articles and editorials; and
    - PSAs or public opinion polls and surveys.
b. Diminish the credibility of audits, reports, analyses, studies, or policy recommendations whose data or findings must be seen as independent.
c. Undercut host-country government "ownership" of constitutions, laws, regulations, policies, studies, assessments, reports, publications, surveys or audits, PSAs, or other communications better positioned as "by" or "from" a cooperating country ministry, organization, or government official.
d. Impair the functionality of an item, such as sterilized equipment or spare parts.
e. Incur substantial costs or be impractical, such as items too small or other otherwise unsuited for individual marking, such as food in bulk.
f. Offend local cultural or social norms, or be considered inappropriate on such items as condoms, toilets, bed pans, or similar commodities.
g. Conflict with international law, such as the international recognized neutrality of the International Red Cross (IRC) or other organizations.
h. Deter achievement of program goals, such as cooperating with other donors or ensuring repayment of loans.

Category/Material for exception	**Specific Exception(s)**	**Visual, Verbal, Textual**
Administrative		
Program Communication		
Institutional Communication		
Commodities and Equipment		