

This is an amendment to funding opportunity number CDC-RFA-PS10-1085

Page 58-62: Appendix A.

**Questions & Answers for Funding Opportunity Announcement
CDC-RFA- PS10-1085**

- If CDC intends to make two awards – how will the SOW be defined for each award and will CDC define the breakdown for each award? Will each grantee be responsible for different target populations and different geographic areas; and how will the work with the central GOM be allocated?

CDC may make up to two awards, but will not necessarily make two awards. If two awards are granted, it will be on the basis of comparative strengths of the applicants and coordinated accordingly. Additionally, this will depend on availability of funds.

- “Approximate Total Project Period Funding = \$9,000,000:” does this mean that each of the two grantees should plan on \$4.5 million for five years which works out to about \$900,000 per year?

The total estimated funding available for this five year project is \$9,000,000. If two awards are made, at least 50% of funds will be allocated to the top ranked applicant; beyond this there is no pre-determined limit to the amount of one award compared to the other.

- Ceiling of Individual Award Range = \$1,946,000 (This ceiling is for the first 12 month budget period and includes direct costs and indirect costs in the case of domestic grantees.) “ Does this mean that both of the two grantees will be able to front load their costs and bill up to \$1,946,000 in the first 12 months, i.e. will CDC obligate \$3.892 million in the first year?

No. The total estimated amount available for this five year project is \$9,000,000; if two awards are made this total estimated amount available will not change, and the ceiling will not change. Rather, the total estimated amount (and the amount under the ceiling of individual award) will be shared among grantees.

- Page 13 “Broadly, recipients of these funds will be required to ensure continuity of services of the existing HHS/CDC PEPFAR program activities, as well as support expansion in both geographical and technical scope” What are the existing program activities and services and what groups are being served?

Currently served groups: commercial sex workers; men who have sex with men; drug users. Program activities: Capacity building of local NGOs; training of these organizations’ staff and target groups in BCC strategies; development of tools for BCC (videos with CSW and DU); outreach activities.

- Sub: HIV Prevention Service. Tender No.: CDC-RFA-PS-10-1085. Euclid Infotech is a company based in Mumbai, India. We are interested in participating in the tender mentioned above hence want to get more information about the same. Considering the geographical constraint of personally reviewing the document, I request you to provide us the following details before we buy the document: 1) List of Items, Schedule of Requirements, Scope of Work, Terms of Reference, Bill of Materials required. 2) Soft Copy of the Tender Document through email.3) Names of countries that will be eligible to participate in this tender. 4) Information about the Tendering Procedure and Guidelines5) Estimated Budget for this Purchase 6) Any Extension of Bidding Deadline?7) Any Addendum or Pre Bid meeting Minutes?We will submit our offer for the same if the goods or services required fall within our purview. Also we would like to be informed of future tenders from your organization. Hence, we request you to add our name to your bidder's list and do inform us about upcoming Projects, Tenders.

All of the information requested is available at the website:
<http://grants.gov/>. You can use the funding opportunity number CDC-RFA-PS-10-1085 to search for more information.

- Re tender notice CDC-RFA-PS-10-1085. Dear Sir or Madam, Could you please send tender documents related to the above tender notice or alternatively let me know where I can assess them from?

All of the information requested is available at the website:
<http://grants.gov/>. You can use the funding opportunity number CDC-RFA-PS-10-1085 to search for more information.

- The RFA mentions on P.14 that "Grantee activities will be conducted at central level with GoM and in seven provinces where HHS/CDC is supporting clinical services partners: Cabo Delgado, Nampula, Zambezia, Inhambane, Gaza, Maputo, and Maputo City." However, Beira, Chimoio and Sofala Province are mentioned in the RFA several times. In addition, the I-RARE study found very high HIV prevalence and risk behaviors among target groups in Beira. We request further information on the possibility of implementing MARP interventions in Manica and Sofala considering that the RFA mentions these areas and the existence of significant MARP populations (including FSWs, truckers and mobile populations, MSM, etc) there and the existing MARP activities in Manica and Sofala (100% Vida for sex workers and partners in Beira, Caia, Inchope and Manica). Can the grantee include targeted activities in these specific geographic areas?

The geographic scope of this FOA is to be limited to CABO DELGADO, NAMPULA, and INHAMBANE PROVINCES ONLY. Focus populations are to include FEMALE SEX WORKERS AND CLIENTS; MEN WHO HAVE SEX WITH MEN; DRUG USERS (IDU and non-IDU); and MOBILE POPULATIONS (including truck drivers and miners).

- The RFA mentions that there are 2 approximate awards (P. 23) with a ceiling of \$1,946,000 in year 1. Is this the ceiling amount per award or the combined total available for all awards?

This is the combined total for all awards.

- Can you please send us the final report of the I-RARE study report as well in better inform our proposal development?

Final report has not yet been completed; results have been shared as summary presentations, which will be provided.

- Can you please confirm that applications need to include a budget only for the first year of the program?

Confirmed.

- Page 37 of the solicitation states the following, "With the exception of the American University, Beirut and the World Health Organization, Indirect Costs will not be paid (either directly or through sub-award) to organizations located outside the territorial limits of the United States or to international organizations regardless of their location." Can you confirm that international organizations headquartered and registered in the United States with offices operating in

Mozambique are able to include their indirect costs in the form of their Negotiated Indirect Cost Rate Agreement (NICRA)?

US NGOs or any other international NGO that has a NICRA must use that as their indirect costs and should be included in the application.

- Does ‘no research’ mean no formal evaluation? Would this have implications for the protocol we have already submitted?

Research activities are not supported through the current funding opportunity. Existing / ongoing activities with funding sources other than this funding opportunity are not subject to the parameters of this funding opportunity.

- Could you clarify the role of “local partnership” (defined in some detail in section IV.3.Other) and whether that means something beyond just building capacity in/working with local organizations.

This is to increase sustainability and local ownership.

- A related question is how/whether the issue of “local partnership” relates to the issue of “transitioning to an indigenous partner” as stipulated in section VI.3 Applications Selection Process. As you may know, GHC is committed to setting up GHC-Mozambique as an completely autonomous entity (perhaps calling upon GHC-Atlanta technical assistance when needed, but legally constituted within Mozambique and directed by Mozambicans)—would that be an example of what is meant by an “indigenous”/”local” partner?

Section IV.3 includes a detailed definition of "Local Partner." The specifics of any autonomous entity would need to confirm to this definition in order to be considered a local partner.

- In Section III Approximate Total Project Period Funding does “domestic grantee” mean U.S.-based?

Project period is 5 years; domestic means US based.

- Is CDC asking that we limit ourselves to working in the provinces of “Cabo Delgado, Nampula, Zambezia, Inhambane, Gaza, Maputo, and Maputo City”? In the case of corridor work with mobile populations, some of the greatest need is in Tete, for instance.

The geographic scope of this FOA is to be limited to CABO DELGADO, NAMPULA, and INHAMBANE PROVINCES ONLY. Focus populations are to include FEMALE SEX WORKERS AND CLIENTS; MEN WHO HAVE SEX WITH MEN; DRUG USERS (IDU and non-IDU); and MOBILE POPULATIONS (including truck drivers and miners).

- GHC would like to partner with another US-based organization (with a local staff in Mozambique) to complement our expertise in behavior change and community mobilization. Is it possible for GHC and a partner to be “co-primes” or is it necessary for one organization to be the prime and the other a subprime? Can you direct us to any verbiage about such relationships?

One serves as the prime; the other is a secondary unless there is consortium developed although even here there is still only one organization that serves as the overall responsible agency.

- Formatting question: is it acceptable to use a text box as a kind of “figure” in the narrative? For instance, it would break up the body of the narrative to go into detail about the RAMP Change Fair, but a small text box entitled “RAMP Change Fair” that gives about a paragraph of information would work very well (although the font would be smaller, understandably). I wouldn’t want this to be seen as circumventing the rules on layout, and that is definitely not our purpose.

Yes.

- We are wondering if it’s possible to partner with a Ministry other than MISAU for future activities. I imagine this must be possible, but is there a mechanism for funding another Ministry, like the Ministry of Information or Ministry of Interior? Would this mean setting up a new cooperative agreement, or would there be some other way to channel funds or pay for staff time and travel?

Applicants may propose any partnerships. This funding opportunity announcement does not provide specifics regarding funding mechanisms.

- I saw a CDC call for proposals on MARPs – can you please advice me whether IOM would be eligible to apply or not?

Please note that eligibility criteria are described in detail on page 24 of the opportunity announcement (available on [grants.gov](https://www.grants.gov)).

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

Centers for Disease Control and Prevention (CDC)

HIV Prevention for Most-at-Risk Populations (MARPs), Republic of Mozambique,

Under the President’s Emergency Plan for AIDS Relief (PEPFAR)

I. Authorization of Intent

Announcement Type: New

Funding Opportunity Number: CDC-RFA-PS-10-1085

Health Impact Number: 3017

Catalog of Federal Domestic Assistance Number: 93.067

Application Deadline: March 31, 2010

Key Dates:

Note: Application submission is not concluded until successful completion of the validation process.

After submission of your application package, applicants will receive a “submission receipt” e-mail generated by Grants.gov. Grants.gov will then generate a second e-mail message to applicants which will either validate or reject their submitted application package. This validation process may take as long as two (2) business days. Applicants are strongly encouraged to check the status of their application to ensure submission of their application is complete and no submission errors exist. To guarantee that you comply with the application deadline published in the Funding Opportunity Announcement, applicants are strongly encouraged to allocate additional days prior to the published deadline to file their application. Non-validated applications will not be accepted after the published deadline date.

In the event that you did not receive a “validation” e-mail within two (2) business days of application submission, please contact Grants.gov. Refer to the e-mail message generated at the time of application submission for instructions on how to track your application or the Application User Guide, Version 3.0, page 57.

Authority:

This program is authorized under Public Law 108-25 (the United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003) [22 U.S.C. 7601, et seq.] and Public Law 110-293 (the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008).

Background:

The President's Emergency Plan for AIDS Relief (PEPFAR) has called for immediate, comprehensive and evidence based action to turn the tide of global HIV/AIDS. As called for by the PEPFAR Reauthorization Act of 2008, initiative goals over the period of 2009 through 2013 are to treat at least three million HIV infected people with effective combination anti-retroviral therapy (ART); care for twelve million HIV infected and affected persons, including five million orphans and vulnerable children; and prevent twelve million infections worldwide (3,12,12). To meet these goals and build sustainable local capacity, PEPFAR will support training of at least 140,000 new health care workers in HIV/AIDS prevention, treatment and care. The Emergency Plan *Five-Year Strategy* for the initial five year period, 2003 - 2008 is available at the following Internet address: <http://www.pepfar.gov>.

Purpose:

Under the leadership of the U.S. Global AIDS Coordinator, as part of the President's Emergency Plan, the U.S. Department of Health and Human Services' Centers for Disease Control and Prevention (HHS/CDC) works with host countries and other key partners to assess the needs of each country and design a customized program of assistance that fits within the host nation's strategic plan and partnership framework.

HHS/CDC focuses primarily on two or three major program areas in each country. Goals and priorities include the following:

- Achieving primary prevention of HIV infection through activities such as expanding confidential counseling and testing programs linked with evidence based behavioral change and building programs to reduce mother-to-child transmission;
- Improving the care and treatment of HIV/AIDS, sexually transmitted infections (STIs) and related opportunistic infections by improving STI management, enhancing laboratory diagnostic capacity and the care and treatment of opportunistic infections, interventions for intercurrent diseases impacting HIV infected patients including tuberculosis (TB), and initiating programs provide anti-retroviral therapy (ART);
- Strengthening the capacity of countries to collect and use surveillance data and manage national HIV/AIDS programs by expanding HIV/STI/TB surveillance programs and strengthening laboratory support for surveillance, diagnosis, treatment, disease monitoring and HIV screening for blood safety.

In an effort to ensure maximum cost efficiencies and program effectiveness, HHS/CDC also supports coordination with and among partners and integration of activities that promote Global Health Initiative principles. As such, grantees may be requested to participate in programmatic activities that include the following activities:

- Implement a woman- and girl-centered approach;
- Increase impact through strategic coordination and integration;
- Strengthen and leverage key multilateral organizations, global health partnerships and private sector engagement;

- Encourage country ownership and invest in country-led plans;
- Build sustainability through investments in health systems;
- Improve metrics, monitoring and evaluation; and
- Promote research, development and innovation.

The purpose of this program is to improve HIV prevention activities among most-at-risk populations (MARPs).

HIV prevalence in Mozambique is approximately 16%. Although the majority of new infections occur in the general population, some population sub-groups are at significantly elevated risk, including persons engaged in sex work; clients of persons engaged in sex work; drug-using populations; men who have sex with men (MSM); military/police and other uniformed services; men and women engaging in transactional sex; incarcerated persons; mobile populations (e.g. migrant workers, truck drivers); street youth; and persons who engage in alcohol-associated HIV sexual risk behaviors.

According to a UNAIDS modes of transmission evaluation (2009, in press), 27% of new infections are attributable to most-at-risk and bridge populations: 2% among female sex workers (FSW), 7% among their clients, and 10% among partners of clients; 5% among MSM; and 3% among intravenous drug users (IDU). In addition to FSW and IDU, MARPs and bridge populations include individuals who engage in risky sexual behavior, including mobile populations such as truckers, miners and other migrant workers, as well as settled non-migrant men who engage in commercial, transactional or casual sex;

police, armed forces and uniformed personnel; and members of communities at elevated risk, such as mining towns, major transit points along transportation corridors, and other hotspots. Bridge populations may include women who engage in transactional sex on an intermittent basis, FSW clients, and partners of MARPs. Data are lacking on incarcerated populations, but this group may play a significant role as a bridge population as well.

In general, these MARPs and bridge populations have not been priority groups for prevention activities in Mozambique. Limited FSW and IDU data are currently available from the International Rapid Assessment Response and Evaluation (I-RARE) study. Additional data are expected to be available from a behavioral surveillance survey (BSS) study that will start in 2010, although MSM are not included in this study. There is a separate MSM size estimation study currently being developed.

Preliminary estimates indicate that there are about 380,000 FSWs in Mozambique. Social factors (unemployment, single or widowed mothers, burden of caring for the family, etc.) were among the most reported reasons for engaging in sex work in FSWs participating in the I-RARE study and there were important references to desire to quit if an alternative source of income option became available. Among FSWs, available data reveal high awareness of modes of HIV transmission but low knowledge of two or more methods of prevention. Overall, risk perception among FSWs is low, and very few have ever been tested for HIV. HIV prevalence was 48% in a small sample of FSWs tested in the cities of Maputo, Beira and Nacala, although the response rate for HIV testing was very low. I-RARE documented high risk behaviors among FSWs and clients, including inconsistent

use of condoms and consumption of alcohol and drugs to facilitate sexual encounters. FSWs reported infrequent and inconsistent condom use primarily because clients are willing to pay more for sex without a condom. Condom use was not reported for oral and anal sex practices. Several FSW organizations exist in Mozambique, and are currently working to advocate for and address the needs of this highly vulnerable and marginalized population.

Migrant and mobile populations are comprised of several groups in Mozambique, including miners (in remote domestic areas as well as in South Africa), long-haul truck drivers, and workers participating in distant economic opportunities in the commercial farming, manufacturing, informal trading (including cross-border trading) and construction sectors. Risks and vulnerabilities relating to HIV are often specific to each industry and sector. Among miners, the prevalence of sex work and alcohol-related business in mining communities renders both migrant workers and the local population vulnerable to infection. Among truckers, border-crossings and truck-stops have become HIV “hotspots,” as truckers wait for extended periods of time, attracting FSWs and informal traders. Truckers often spend weeks or months away from their families, and often have sexual partners at various stops along their routes. The wives they leave behind may have other partners while their husbands are traveling.

Among MSM in African countries for which data are available, HIV prevalence is several times higher than in males in the general population. Data from other countries also show low risk perception and low rates of preventive behaviors such as condom use

among MSM. Significant proportions of men who have sex with men also have wives or other female partners, and social exclusion causes many MSM to remain “hidden,” making it more difficult to provide services for this population. In Mozambique, there is only one civil society organization (Lambda Group) representing gay, bisexual and transgendered persons. An MSM size estimation study supported by HHS/CDC Mozambique is currently in the planning phase.

Preliminary results from the I-RARE study in Maputo, Beira and Nacala confirms illicit drug trafficking and injecting drug use in the three cities. Among a small sample of IDU in this study, HIV prevalence was 43%. Drug users participating in the study reported sharing needles, and female drug users also said that they exchanged sex for drugs or money to acquire drugs. Both male and female drug users reported inconsistent use of condoms when having sex after drug consumption.

Uniformed services personnel, such as the military and police, are at high risk for HIV due in part to their mobility, age and living situations which may be far from their regular partners for extended periods of time. A limited number of activities, coordinated with the Ministry of the Interior, are providing prevention activities [mainly counseling and testing, peer education and information, education and communication (IEC)] to police and police recruits.

There are limited data available about incarcerated populations, including information about patterns of incarceration and parole that would help understand the impact of

incarcerated populations as bridge populations between most-at-risk populations and the general population. In 2008 the United Nations Office on Drugs and Crime (UNODC) conducted a review of studies done in Mozambican prisons and one of them shows results of a study done in 592 subjects from the Cadeia Central de Maputo and 76 from the N'dlavela female prison. In this study, HIV prevalence was 32.1% among women and 28.8% among men. In another study of this review done in 8 prisons with a sample of 715 prisoners it was found that 75% of them reported having had sex without condoms and 71% of those using drugs reported sharing needles. These data suggest that incarcerated populations may play a significant role as a bridge population as well. A limited number of organizations in Nampula Province and Maputo City and Province are providing assistance to incarcerated populations, including trainings of peer educators for HIV prevention, counseling and testing, and antiretroviral treatment for prisoners in need.

Alcohol consumption and its consequences together with HIV/AIDS are major public health burdens in many parts of the world, and there is growing evidence that alcohol consumption may play an important role in sexual transmission, susceptibility to infection, and progression of HIV disease. However, the significant role of alcohol in HIV transmission and treatment has not been addressed substantially in Mozambique. The PEPFAR Mozambique team began to address alcohol abuse through a 2008 assessment of alcohol abuse in rural settings. Bar and workplace based interventions will strongly target men, especially those in the bridge and most-at-risk populations in urban settings. Activities will also help develop an understanding of the factors related to

problematic alcohol use and increase risk perception about alcohol-related sexual disinhibition and provide referrals to substance abuse treatment where available.

There are a number of organizations, unions and associations working to improve the conditions of migrant and mobile populations. Other donors, most notably, the International Labor Organization (ILO) and International Organization on Migration (IOM), work with the Ministries of Labor and Transport, private sector representatives and workers' unions on prevention and HIV mitigation. United Nations Office on Drug and Crime (UNODC) works specifically to address HIV prevention in prison settings. New HHS/CDC-supported programs will collaborate with and support existing efforts aimed at these populations. Local organizations have been identified with potential of playing an important role in sustainability of program implementation and an ongoing training in organizational capacity to build organizations' skills for better program implementation is being conducted through an international partner organization.

Related HHS/CDC Mozambique support, to date, has included training for members of these organizations, with emphasis on innovative behavior change communication (BCC) strategies, including the Reflection and Action within Most-at-Risk Populations (RAMP) methodology. RAMP is an approach to behavior change that works with small groups of the target population using stories to generate reflection on behavior and action toward positive change. After theoretically-sound behavior change stories are created in close collaboration with members of the population, a series of "action phases" are conducted

with other members of the population: two group activities followed by a Change Fair and an additional individual session.

Peer education for FSWs is being implemented in Maputo and Nacala cities with the perspective to expand to Maputo Province, Nampula and Beira cities. With the full participation of FSWs from Maputo, a video tracing their life stories was produced to support BCC messaging with their peer sex workers, and another is being produced for drug users.

In this context, the goal of this project is to improve HIV prevention activities among most-at-risk populations (MARPs) and ultimately impact HIV transmission rates in Mozambique. An effective program for MARPs and bridge populations in Mozambique will require a combination approach, building on available information, existing activities, addressing gender related vulnerabilities and innovative approaches to expand the scope and coverage of interventions for key populations. Priority groups include, but are not limited to, FSWs and clients; MSM; drug users [IDU and non-intravenous drug users (NIDU) including alcohol abuse]; and incarcerated populations. Grantees will be expected to collaborate closely with the Government of Mozambique and implementing partners to continue the implementation of existing services, based on achievements in Mozambique and seeking to improve interventions and scale up access to services.

Measurable outcomes of the program will be in alignment with one (or more) of the following performance goal(s) for PEPFAR. Outcomes are based on duration of the

project (5 years), and annual outcome targets are weighted with 10% of project targets to be achieved in year 1; 15% in year 2; 20% in year 3; 25% in year 4; and 30% in the final year of the project:

1. Number of individuals trained to implement MARP interventions:
 - a. A minimum of 1,000 individuals, tracked by population group (e.g. commercial sex workers, MSM) or professional cadre (e.g. prison guard, nurse) and geographic area, defined at provincial and district level, will be trained during the duration of this project; and
 - b. A minimum of 30 facilitators, tracked by cadre and geographic area, will be trained to provide MARP intervention training.
2. Number of individuals reached with MARP interventions: A minimum of 200,000 individuals, tracked by age, sex, location, and MARP bridge population category, will be reached during the duration of this project.
3. Capacity building for sustainable interventions, including demonstrated evolution of organizational capacity of local organizations: at least two local organizations will have administrative and technical capacity to take over effective projects for implementation of MARP activities by the end of the project.

Other measurable outcomes will include:

1. Detailed mapping of MARP/bridge population interventions in relevant geographic areas.
2. Elaborated/adapted evidence-based curricula based on international standards for IEC, BCC, risk reduction, etc.

3. Demonstrated existence of policy enabling implementation of interventions, including catalog of approved and disseminated policy and materials for MARP interventions, either at national level or individual provincial level.
4. Demonstrated strengthened linkages of MARPs with care and treatment facilities (referral charts, monitoring instruments), establishment of moonlight clinics, etc.

This announcement is intended for non-research activities supported by the Centers for Disease Control and Prevention within HHS (HHS/CDC). If an applicant proposes research activities, HHS/CDC will not review the application. For the definition of “research,” please see the HHS/CDC Web site at the following Internet address:
<http://www.cdc.gov/od/science/regs/hrpp/researchdefinition.htm>.

II. Program Implementation

Activities:

Partners receiving HHS/CDC funding must place a clear emphasis on developing local indigenous capacity to deliver HIV/AIDS related services to the Mozambican population and must also coordinate with activities supported by Mozambicans, international or U.S. Government (USG) agencies to avoid duplication. Partners receiving HHS/CDC funding must collaborate across program areas whenever appropriate or necessary to improve service delivery.

The selected applicant(s) (grantee) of these funds are responsible for activities in multiple program areas.

Each grantee will implement activities both directly and, where applicable, through sub-grantees; each grantee will, however, retain overall financial and programmatic management under the oversight of HHS/CDC and the strategic direction of the Office of the U.S. Global AIDS Coordinator. Each grantee must show measurable progressive reinforcement of the capacity of tertiary health facilities to respond to the national HIV epidemic as well as progress towards the sustainability of activities.

Applicants should describe activities in detail that reflect the policies and goals outlined in the *Five-Year Strategy* for the President's Emergency Plan and the Partnership Framework for Republic of Mozambique. Each grantee will produce an annual operational plan, which the U.S. Government Emergency Plan team on the ground in for Republic of Mozambique will review as part of the annual Emergency Plan review-and-approval process managed by the Office of the U.S. Global AIDS Coordinator.

Each grantee may work on some of the activities listed below in the first year and in subsequent years, and then progressively add others from the list to achieve all of the Emergency Plan performance goals as cited in the previous section. HHS/CDC, under the guidance of the U.S. Global AIDS Coordinator, will approve funds for activities on an annual basis, based on availability of funding and USG priorities, and based on documented performance toward achieving Emergency Plan goals, as part of the annual Emergency Plan for AIDS Relief Country Operational Plan review-and-approval process.

Grantee activities for this program are as follows:

Broadly, recipients of these funds will be required to ensure continuity of services of the existing HHS/CDC PEPFAR program activities, as well as support expansion in both geographical and technical scope. Potential grantee activities for this program are included in this section; this list is illustrative and applicants are encouraged to propose additional, evidence-based and/or best practice interventions and innovations. All activities are to be pursued in coordination with HHS/CDC and the PEPFAR team, the Government of Mozambique, and other implementing partners. New activities will build upon and replicate successful MARP programs currently supported. There is substantial evidence for the effectiveness of a core set of interventions for populations at high risk for HIV. These interventions illustrate a minimum package of services for MARPs. Activities should focus on MARP populations that represent the most significant burden of disease, based on population size estimate and impact of HIV, including specific focus on FSW and clients, drug users, MSM, and incarcerated populations. Grantee activities will be conducted at central level with GoM, and in seven provinces where HHS/CDC is supporting clinical services partners: Cabo Delgado, Nampula, Zambezia, Inhambane, Gaza, Maputo, and Maputo City. As other organizations receiving PEPFAR funding are also implementing MARPs targeted activities, mapping will be necessary to identify gaps to guide geographical expansion and prevent duplication of effort with other projects.

Activities should be conducted as part of comprehensive programming that includes a minimum package of services for implementing, monitoring, and improving comprehensive HIV prevention programs for MARPs and other vulnerable populations.

These programs include core public health components of outreach, HIV counseling and testing (CT), risk reduction counseling, condom distribution, education and promotion, screening and treatment of sexually transmitted infections (STI). Referral to prevention of mother to child transmission (PMTCT) services and HIV care and treatment is included for HIV-infected MARPS and other vulnerable populations. Sex workers may require more comprehensive programs. Program activities may include referral to family planning and other reproductive health services, psychosocial and legal services, including substance abuse treatment and linkages to income generation programs for those wishing to quit sex work. Activities for incarcerated people will need to target males and females and also to include prison guards.

Illustrative examples of activities include:

1. Technical assistance, advocacy and policy development to create an enabling environment for effective interventions;
2. HIV counseling and testing (CT). Evidence shows that most HIV positive persons who know their status will reduce their risk behaviors to protect their sexual and injection partners and that hidden populations face substantial barriers in obtaining high quality CT. Innovative and tailored models for delivering HIV testing to drug users, sex workers, and MSM are needed;
3. Risk reduction activities and counseling. This is an effective intervention for MARPs, whether delivered through peer outreach or in clinic settings and can address both drug and sexual risk behaviors;

4. Peer education and outreach / venue and peer-based interpersonal communication activities. This is effective in reducing risk behaviors, especially when accompanied by risk reduction counseling and provision of commodities (e.g. condoms). Peer outreach relies on indigenous community members to reach hidden populations with HIV prevention information, and referrals to important services. For key populations, messages need to be tailored to address the findings of the I-RARE study (e.g. gaps in translating prevention knowledge into practice, including condom use, needle sharing, etc);
5. Behavior change communication (BCC). Current activities in Mozambique include implementation of RAMP and Pathways to Change methodologies;
 - **RAMP (Reflection and Action within Most-at-risk Populations)** is an approach to behavior change that works with small groups of the target population using stories to generate reflection on behavior and action toward positive change. After theoretically-sound behavior change stories are created in close collaboration with members of the population, a series of “action phases” are conducted with other members of the population: two group activities followed by a “Change Fair “and an additional individual session.
 - **Pathways to Change** is a set of tools to support behavior-change that uses narratives such as short fiction videos, audio-dramas and comic books carefully created that ensure the integration of current epidemiological research and behavior change theory. The stories are developed with extensive input from the most-at-risk populations that tell the story of a character’s attempt to change HIV risk behavior. Upon the viewing/listening/reading of

these narratives, a trained RAMP facilitator takes participants through a set of action phases.

6. Alcohol intervention activities will be designed to reduce alcohol use and associated sexual risk behaviors. During regular clinic or community visits with trained providers, clients will be assessed for their level of alcohol consumption and related behavioral patterns such as sexual risk, poly-substance use, social context and knowledge/attitudes. A brief intervention using motivational interviewing will be implemented in clinic and community settings, based on the risk reduction counseling model, including behavioral self-management and sexual communication skills building that can identify triggers and solutions for high-risk situations;
7. Targeted condom promotion and negotiation skills / targeted promotion and distribution of condoms and lubricants (ensuring that education on consistent and correct use is emphasized);
8. Mobile counseling and testing targeting MARPS;
9. Sexually Transmitted Infections (STI) diagnosis and treatment. STI control programs reduce STIs in CSWs and their clients; however, evidence for the impact of STI control in reducing HIV among sex workers remains mixed. Approaches to STI control for sex workers vary based on local STI prevalence; however, general principles call for defining a basic package of confidential services with well-defined treatment components, screening intervals, and standards for delivery;

10. Post-exposure prophylaxis (PEP), especially for FSW victims of violence and coercive sex, as well as active linkages to clinical care and treatment;
11. Drop-in centers and community mobilization to increase demand for services;
12. Adapt and/or develop and disseminate appropriate information, education, and communication/behavior change communication (IEC/BCC) prevention materials targeting relevant populations;
13. Linkages to HIV care, treatment and PMTCT. Access to antiretroviral therapy (ART), adherence support, treatment of co-morbidities, opportunistic infection prophylaxis, and access to primary health care improves quality of life, reduces HIV-related morbidity and mortality, restores and preserves immunologic function and suppresses viral load. ART is as effective in drug users and sex workers as in other populations in spite of the widely held view that drug users are poor candidates for ART. Adherence is possible for MARPs if specific approaches are implemented to facilitate access and reduce barriers;
14. Wrap around components (family planning, food and nutrition, literacy/education, employability programs, income generation); and
15. Future expansion of activities may also include attention to miners and police, as well as IDU interventions such as access to sterile syringes and medication-assisted substitution therapies. Other core components for select populations may include attention to legal and policy issues, social norms, and biomedical interventions such as male circumcision.

Grantees are expected to help build capacity in Mozambique for sustainable implementation of relevant interventions, through close work with non-governmental organizations (NGOs) and community-based organizations (CBOs) reaching higher risk populations that advocate for and provide targeted services to marginalized, clandestine and mobile populations.

Each grantee must work and collaborate with other implementing agencies as well as the Government of Mozambique at all levels. Non-local grantees will be expected to establish capacity building “twinning” relationships with local organizations, to develop both comprehensive HIV services and plans to transition the program to an indigenous partner. In this case, each grantee will be expected to demonstrate measurable, progressive reinforcement of the capacity of indigenous organizations and local communities to support MARP activities in response to the national HIV epidemic, and towards the sustainability of activities.

Activities must be evidence-based and in line with the Government of Mozambique National guidelines and strategies, as well as PEPFAR technical approaches and strategies. Each grantee will produce an annual operational plan, which the PEPFAR-Mozambique team will review as part of the annual Country Operational Plan (COP).

Initial activities will include:

1. Completion of a mapping exercise that reflects existing services and identifies existing program gaps within the first (1) month of the award.

2. Development of a detailed implementation plan within the first two (2) months of the award;
3. Monitoring of individual components of the intervention to track inputs, and outputs and other process measures;
4. Adhering to all reporting requirements established by HHS/CDC; and
5. Expanding activities and developing larger scale programming, in scope and geographic distribution, depending on availability of funds.

CDC Activities:

The selected applicants (grantees) of this funding competition must comply with all HHS/CDC management requirements for meeting participation and progress and financial reporting for this cooperative agreement (See HHS/CDC Activities and Reporting sections below for details), and comply with all policy directives established by the Office of the U.S. Global AIDS Coordinator.

In a cooperative agreement, CDC staff are substantially involved in the program activities, above and beyond routine grant monitoring. CDC activities for this program are as follows:

1. Organize an orientation meeting with each grantee for a briefing on applicable U.S. Government, HHS, and Emergency Plan expectations, regulations and key management requirements, as well as report formats and contents. The orientation could include meetings with staff from HHS agencies and the Office of the U.S. Global AIDS Coordinator.

2. Review and make recommendations on the process used by each grantee to select key personnel and/or post-award subcontractors and/or subgrantees to be involved in the activities performed under this agreement, as part of the Emergency Plan for AIDS Relief Country Operational Plan review and approval process, managed by the Office of the U.S. Global AIDS Coordinator.
3. Review and make recommendations on each grantee's annual work plan and detailed budget, as part of the Emergency Plan for AIDS Relief Country Operational Plan review-and-approval process, managed by the Office of the U.S. Global AIDS Coordinator.
4. Review and make recommendations on each grantee's monitoring and evaluation plan, including for compliance with the strategic-information guidance established by the Office of the U.S. Global AIDS Coordinator.
5. Meet on a monthly basis with each grantee to assess monthly expenditures in relation to approved work plan and modify plans, as necessary.
6. Meet on a quarterly basis with each grantee to assess quarterly technical and financial progress reports and modify plans as necessary.
7. Meet on an annual basis with each grantee to review annual progress report for each U.S. Government Fiscal Year, and to review annual work plans and budgets for subsequent year, as part of the Emergency Plan for AIDS Relief review and approval process for Country Operational Plans, managed by the Office of the U.S. Global AIDS Coordinator.
8. Provide technical assistance, as mutually agreed upon, and revise annually during validation of the first and subsequent annual work plans. This could include

expert technical assistance and targeted training activities in specialized areas, such as strategic information, project management, confidential counseling and testing, palliative care, treatment literacy, and adult-learning techniques.

9. Provide in-country administrative support to help each grantee meet U.S. Government financial and reporting requirements approved by the Office of Management and Budget (OMB) under 0920-0428 (Public Health Service Form 5161).
10. Collaborate with each grantee on designing and implementing the activities listed above, including, but not limited to the provision of technical assistance to develop program activities, data management and analysis, quality assurance, the presentation and possibly publication of program results and findings, and the management and tracking of finances.
11. Provide consultation and scientific and technical assistance based on appropriate, HHS/CDC and Office of the U.S. Global AIDS Coordinator documents to promote the use of best practices known at the time.
12. Assist each grantee in developing and implementing quality-assurance criteria and procedures.
13. Facilitate in-country planning and review meetings for technical assistance activities.
14. Provide technical oversight for all activities under this award.
15. Provide ethical reviews, as necessary, for evaluation activities, including from HHS/CDC headquarters.
16. Supply each grantee with protocols for related evaluations.

Please note: Either HHS staff or staff from organizations that have successfully competed for funding under a separate HHS contract, cooperative agreement or grant will provide technical assistance and training.

III. Award Information and Requirements

Type of Award: Cooperative Agreement.

HHS/CDC's involvement in this program is listed in the Activities Section above.

Award Mechanism: U2G – Global HIV/AIDS Non-Research Cooperative Agreements

Fiscal Year Funds: 2010

Approximate Fiscal Year Funding: \$1,946,000

Approximate Total Project Period Funding: \$9,000,000 (This amount is an estimate, and is subject to availability of funds and includes direct costs and indirect costs in the case of domestic grantees.)

Approximate Number of Awards: 2

Approximate Average Award: \$1,800,000 (This amount is for the first 12 month budget period, and includes direct costs and indirect costs in the case of domestic grantees.)

Floor of Individual Award Range: None

Ceiling of Individual Award Range: \$1,946,000 (This ceiling is for the first 12 month budget period and includes direct costs and indirect costs in the case of domestic grantees.)

Anticipated Award Date: September 30, 2010

Budget Period Length: 12 Months.

Project Period Length: Five Years.

Throughout the project period, HHS/CDC's commitment to continuation of awards will be conditioned on the availability of funds, evidence of satisfactory progress by each grantee (as documented in required reports), and the determination that continued funding is in the best interest of the U.S. Government, through the Emergency Plan review and approval process for Country Operational Plans, managed by the Office of the U.S. Global AIDS Coordinator.

IV. Eligibility

IV.1. Eligible applicants

Eligible applicants that can apply for this funding opportunity are listed below:

- Public nonprofit organizations
- Private nonprofit organizations
- For profit organizations
- Small, minority, women-owned business
- Universities
- Colleges
- Research institutions
- Hospitals
- Community-based organizations
- Faith-based organizations

- Federally recognized Indian tribal organizations
- Alaska Native tribal governments
- Indian tribes
- Tribal Epidemiology centers
- Indian tribal organizations
- State and local governments or their Bona Fide Agents (this includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau)
- Political subdivisions of States (in consultation with States)
- Non-domestic (non U.S.) entity

A Bona Fide Agent is an agency/organization identified by the state as eligible to submit an application under the state eligibility in lieu of a state application. If applying as a bona fide agent of a state or local government, a letter from the state or local government as documentation of the status is required. Attach with “Other Attachment Forms” when submitting via www.grants.gov.

IV.2. Cost Sharing or Matching

Cost sharing or matching funds are not required for this program. If applicants receive funding from other sources to underwrite the same or similar activities, or anticipate receiving such funding in the next 12 months, they must detail how the disparate streams of financing complement each other.

IV.3. Other

If a funding amount greater than the ceiling of the award range is requested, the application will be considered non-responsive and will not be entered into the review process. The applicant will be notified that the application did not meet the submission requirements.

The successful applicants may be responsible for planning, implementing and coordinating infrastructure development requirements supporting the primary public health purpose of this FOA.

PEPFAR Local Partner definition:

A “local partner” may be an individual or sole proprietorship, an entity, or a joint venture or other arrangement. However, to be considered a local partner in a given country served by PEPFAR, the partner must meet the criteria under paragraph (1), (2), or (3) below within that country: *

(1) an individual must be a citizen or lawfully admitted permanent resident of and have his/her principal place of business in the country served by the PEPFAR program with which the individual is or may become involved, and a sole proprietorship must be owned by such an individual; or

(2) an entity (e.g., a corporation or partnership): (a) must be incorporated or legally organized under the laws of, and have its principal place of business in, the country served by the PEPFAR program with which the entity is or may become

involved; (b) must be at least 51% for FY 2009-10; 66% for FY 2011-12; and 75% for FY 2013 beneficially owned by individuals who are citizens or lawfully admitted permanent residents of that same country, per sub-paragraph (2)(a), or by other corporations, partnerships or other arrangements that are local partners under this paragraph or paragraph (3); (c) at least 51% for FY 2009-10; 66% for FY 2011-12; and 75% for FY 2013 of the entity's staff (senior, mid-level, support) must be citizens or lawfully admitted permanent residents of that same country, per sub-paragraph (2)(a), and at least 51% for FY 2009-10; 66% for FY 2011-12; and 75% for FY 2013 of the entity's senior staff (i.e., managerial and professional personnel) must be citizens or lawfully admitted permanent residents of such country; and (d) where an entity has a Board of Directors, at least 51% of the members of the Board must also be citizens or lawfully admitted permanent residents of such country; or

(3) a joint venture, unincorporated association, consortium, or other arrangement in which at least 51% for FY 2009-10; 66% for FY 2011-12; and 75% for FY 2013 of the funding under the PEPFAR award is or will be provided to members who are local partners under the criteria in paragraphs (1) or (2) above, and a local partner is designated as the managing member of the organization.

Host government ministries (e.g., Ministry of Health), sub-units of government ministries, and parastatal organizations in the country served by the PEPFAR program are considered local partners. ** A parastatal organization is defined as a fully or partially government-owned or government-funded organization. Such enterprises may

function through a board of directors, similar to private corporations. However, ultimate control over the board may rest with the government.

The Global AIDS Coordinator may waive the above criteria where justified to address the circumstances in a specific case.

* HHS will only implement paragraph 2 (entity) of the definition.

** USAID and its partners are subject to restrictions on parastatal eligibility for USAID funding. See 22 CFR 228.33

Special Requirements:

If the application is incomplete or non-responsive to the special requirements listed in this section, it will not be entered into the review process. The applicant will be notified that the application did not meet submission requirements.

- Late submissions will be considered non-responsive. See section “V.3. Submission Dates and Times” for more information on deadlines.
- Note: Title 2 of the United States Code Section 1611 states that an organization described in Section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive U.S. Government funds constituting a grant, loan, or an award.

V. Application Content

V.1. Address to Request Application Package

To apply for this funding opportunity, the application forms package posted in Grants.gov must be used.

Electronic Submission:

HHS/CDC requires applicants to submit applications electronically by utilizing the forms and instructions posted for this announcement on www.Grants.gov, the official U.S. Government agency wide e-grant website. Only applicants who apply online may forego submitting paper copies of all application forms.

Registering an applicant organization through www.Grants.gov is the first step in submitting applications online. Registration information is located in the “Get Registered” screen of www.Grants.gov. Applicants are required to use this online tool. Please visit www.Grants.gov at least 30 days prior to filing an application to become familiar with the registration and submission processes. Under “Get Registered,” the one time registration process will take three to five days to complete. Only the person who registers the organization on grants.gov can submit the application. This is important to remember if the person who originally registered an organization on grants.gov is no longer working for that particular organization. HHS/CDC suggests submitting electronic applications prior to the closing date so if difficulties are encountered in Grants.gov, a hardcopy of the application can be submitted prior to the deadline.

Foreign organizations must include a NATO Commercial and Governmental Entity (NCAGE) Code to complete their Grants.gov registration. Instructions for obtaining an

NCAGE Code may be found at:

http://www.cdc.gov/od/pgo/funding/NATO_Commercial_and_Governmental_Entity_12-18-06.doc.

If the applicant encounters technical difficulties with Grants.gov, the applicant should contact Grants.gov Customer Service. The Grants.gov Contact Center is available 24 hours a day, 7 days a week. The Contact Center provides customer service to the applicant community. The extended hours will provide applicants support around the clock, ensuring the best possible customer service is received any time it's needed. You can reach the Grants.gov Support Center at 1-800-518-4726 or by email at support@grants.gov. Submissions sent by e-mail, fax, CD's or thumb drives of applications will not be accepted.

V.2. Content and Form of Submission

Application:

A Project Abstract must be submitted with the application forms. All electronic project abstracts must be uploaded in a PDF file format when submitting via Grants.gov. The abstract must be submitted in the following format:

- Maximum of 2-3 paragraphs;
- Font size: 12 point unreduced, Times New Roman;
- Single spaced;
- Paper size: 8.5 by 11 inches (preferred), or generally accepted paper size; and

- Page margin size: One inch.

The project abstract must contain a summary of the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible understandable to a technically literate lay reader. This abstract must not include any proprietary/confidential information.

A Project Narrative must be submitted with the application forms. All electronic narratives must be uploaded in a PDF file format when submitting via Grants.gov. The narrative **MUST** be submitted in the following format:

- Maximum number of pages: 25 (If your narrative exceeds the page limit, only the first pages which are within the page limit will be reviewed.);
- Font size: 12 point, unreduced, Times New Roman;
- Double spaced;
- Paper size: 8.5 by 11 inches (preferred), or generally accepted paper size;
- Page margin size: One inch;
- Number all pages of the application sequentially from page one (Application Face Page) to the end of the application, including charts, figures, tables, and appendices; and

- If paper application submission is applicable, the application should be printed only on one side of each page and should be held together only by rubber bands or metal clips; not bound in any other way.

The narrative should address activities to be conducted over the entire project period and must include the following items in the order listed:

- *Project Context and Background (Understanding and Need):* Describe the background and justify the need for the proposed project. Describe the current infrastructure system; targeted geographical area(s), if applicable; and identified gaps or shortcomings of the current health systems and AIDS control projects;
- *Project Strategy - Description and Methodologies:* Present a detailed operational plan for initiating and conducting the project. Clearly describe the applicant's technical approach/methods for implementing the proposed project. Describe the existence of, or plans to establish partnerships necessary to implement the project. Describe linkages, if appropriate, with programs funded by the U.S. Agency for International Development;
- *Project Goals and Objectives:* Describe the overall goals of the project, and specific objectives that are measurable and time phased, consistent with the objectives and numerical targets of the Emergency Plan and for this Cooperative Agreement program as provided in the "Purpose" Section at the beginning of this Announcement;

- *Project Outputs:* Be sure to address each of the program objectives listed in the “Purpose” Section of this Announcement. Measures must be specific, objective and quantitative so as to provide meaningful outcome evaluation;
- *Project Contribution to the Goals and Objectives of the Emergency Plan:* Provide specific measures of effectiveness to demonstrate accomplishment of the objectives of this program;
- *Work Plan and Description of Project Components and Activities:* Be sure to address each of the specific tasks listed in the activities section of this announcement. Clearly identify specific assigned responsibilities for all key professional personnel;
- *Performance Measures:* Measures must be specific, objective and quantitative;
- *Timeline* (e.g., GANTT Chart); and
- *Management of Project Funds and Reporting.*

Additional information may be included in the application appendices. The appendices will not be counted toward the narrative page limit. **The total amount of appendices must not exceed 80 pages and can only contain information related to the following:**

- *Project Budget Justification:*
With staffing breakdown and justification, provide a line item budget and a narrative with justification for all requested costs. Be sure to include, if any, in-kind support or other contributions provided by the national Government and its donors as part of the total project, but for which the applicant is not requesting funding.

Budgets must be consistent with the purpose, objectives of the Emergency Plan and the program activities listed in this announcement and must include the following: line item breakdown and justification for all personnel, i.e., name, position title, annual salary, percentage of time and effort, and amount requested.

The recommended guidance for completing a detailed budget justification can be found on the HHS/CDC Web site, at the following Internet address:

<http://www.cdc.gov/od/pgo/funding/budgetguide.htm>.

For each contract, list the following: (1) name of proposed contractor; (2) breakdown and justification for estimated costs; (3) description and scope of activities the contractor will perform; (4) period of performance; (5) method of contractor selection (e.g., competitive solicitation); and (6) methods of accountability. Applicants should, to the greatest extent possible, employ transparent and open competitive processes to choose contractors:

- *Curricula vitae* of current key staff who will work on the activity;
- *Job descriptions* of proposed key positions to be created for the activity;
- *Applicant's Corporate Capability Statement*;
- *Letters of Support* (5 letters maximum), and
- *Evidence of Legal Organizational Structure*.

If the total amount of appendices includes more than 80 pages, the application won't be considered for review.

The agency or organization is required to have a Dun and Bradstreet Data Universal Numbering System (DUNS) number to apply for a grant or cooperative agreement from the Federal government. The DUNS number is a nine-digit identification number, which uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access the Dun and Bradstreet website or call 1-866-705-5711.

Guidance that may require the submission of additional documentation with the application is listed in section “VII.2. Administrative and National Policy Requirements.”

V.3. Submission Dates and Times

Note: T Note: Application submission is not concluded until successful completion of the validation process.

After submission of your application package, applicants will receive a “submission receipt” e-mail generated by Grants.gov. Grants.gov will then generate a second e-mail message to applicants which will either validate or reject their submitted application package. This validation process may take as long as two (2) business days. Applicants are strongly encouraged to check the status of their application to ensure submission of their application is complete and no submission errors exist. To guarantee that you comply with the application deadline published in the Funding Opportunity Announcement, applicants are strongly encouraged to allocate additional days prior to the published deadline to file their application. Non-validated applications will not be accepted after the published deadline date.

In the event that you did not receive a “validation” e-mail within two (2) business days of application submission, please contact Grants.gov. Refer to the e-mail message generated at the time of application submission for instructions on how to track your application or the Application User Guide, Version 3.0, page 57. The application is not complete until the applicant has completed the validation process. After the applicant receives the submission receipt email, the next email applicants will receive will be a message validating or rejecting the applicant’s submitted application

package with errors. Validation may take at least two (2) calendar days; however, applicants may check the status of their specific application to ensure submission is complete. To guarantee that the applicant complies with the Funding Opportunity Announcement, allocate additional days to file. Non-validated applications will not be accepted after the due date. If no validation is received within two (2) calendar days of submission, the applicant may contact Grants.gov. Please refer to the email message generated at the time of application submission for instructions on how to track a specific application or the Application User Guide, Version 3.0 page 57.

Application Deadline Date: March 31, 2010

Explanation of Deadlines: The HHS/CDC Procurement and Grants Office must receive applications by 11:59 p.m. Eastern Time on the deadline date.

Electronic Submissions:

Applications may be submitted electronically at www.Grants.gov. Applications completed on-line through Grants.gov are considered formally submitted when the applicant organization's Authorizing Organization Representative (AOR) electronically submits the application to www.Grants.gov. Electronic applications will be considered as having met the deadline if the application has been successfully submitted electronically by the applicant organization's AOR to Grants.gov on or before the deadline date and time.

When submission of the application is done electronically through Grants.gov (<http://www.grants.gov>), the application will be electronically time/date stamped and a tracking number will be assigned, which will serve as receipt of submission. The AOR will receive an e-mail notice of receipt when HHS/CDC receives the application.

V.4. Intergovernmental Review of Applications

Executive Order 12372 does not apply to this program.

V.5. Funding restrictions

Restrictions, which must be taken into account while writing the budget, are as follows:

- Grantees may not use funds for research.
- Grantees may only expend funds for reasonable program purposes, including personnel, travel, supplies, and services, such as contractual.
- The direct and primary grantee in a cooperative agreement program must perform a substantial role in carrying out project objectives and not merely serve as a conduit for an award to another party or provider who is ineligible.
- The costs that are generally allowable in grants to domestic organizations are allowable to foreign institutions and international organizations, with the following exception: With the exception of the American University, Beirut and the World Health Organization, Indirect Costs will not be paid (either directly or through sub-award) to organizations located outside the territorial limits of the United States or to international organizations regardless of their location.
- The applicant may contract with other organizations under this program; however the applicant must perform a substantial portion of the activities (including program management and operations, and delivery of prevention services for which funds are required.)

- All requests for funds contained in the budget, shall be stated in U.S. dollars.
Once an award is made, CDC will not compensate foreign grantees for currency exchange fluctuations through the issuance of supplemental awards.
- Foreign grantees are subject to audit requirements specified in 45 CFR 74.26(d).
A non-Federal audit is required, if during each grantees fiscal year, each grantee expended a total of \$500,000.00 or more under one or more HHS awards (as a direct grantee and/or as a sub-grantee). Each grantee either may have (1) A financial related audit (as defined in the Government Auditing Standards, GPO stock #020-000-00-265-4) of a particular award in accordance with Government Auditing Standards, in those case where each grantee receives awards under only one HHS program; or, if awards are received under multiple HHS programs, a financial related audit of all HHS awards in accordance with Government Auditing Standards; or (2) An audit that meets the requirements contained in OMB Circular A-133.
- A fiscal Grantee Capability Assessment may be required, prior to or post award, in order to review the applicant’s business management and fiscal capabilities regarding the handling of U.S. Federal funds.

The 8% Rule

The President’s Emergency Plan for AIDS Relief (PEPFAR) seeks to promote sustainability for programs through the development, use, and strengthening of local partnerships. The diversification of partners also ensures additional robust capacity at the local and national levels.

To achieve this goal, the Office of the Global AIDS Coordinator (OGAC) establishes an annual funding guideline for grants and cooperative agreement planning. Within each annual PEPFAR country budget, OGAC establishes a limit for the total amount of U.S. Government funding for HIV/AIDS activities provided to a single partner organization under all grant and cooperative agreements for that country. **For U.S. Government fiscal year (FY) 2010, the limit is no more than 8% of the country's FY 2010 PEPFAR program funding (excluding U.S. Government management and staffing costs), or \$2 million, whichever is greater.** The total amount of funding to a partner organization includes any PEPFAR funding provided to the partner, whether directly as prime partner or indirectly as sub-grantee. In addition, subject to the exclusion for umbrella awards and drug/commodity costs discussed below, all funds provided to a prime partner, even if passed through to sub-partners, are applicable to the limit. PEPFAR funds provided to an organization under contracts are not applied to the 8% or \$2 million single partner ceiling. PEPFAR publishes the single-partner funding limits annually as part of guidance for preparing the Country Operational Plan (COP). U.S. Government Departments and agencies must use the limits in the planning process to develop Requests for Applications (RFAs), Annual Program Statements (APSs), or Funding Opportunity Announcements (FOAs). However, as PEPFAR country budgets are not final at the COP planning stage, the single partner limits remain subject to adjustment. The current limit applicable to this FOA is \$18,110,245 (8% or \$2 million, whichever is greater, of the country's PEPFAR program funding). Please note that the current limit is based on an estimated country budget developed for planning purposes; thus, the limit is also an estimate and subject to

change based on actual appropriations and the final approved country budget.”)

Exclusions from the 8% or \$2 million single-partner ceiling are made for (a) umbrella awards, (b) commodity/drug costs, and (c) Government Ministries and parastatal organizations. A parastatal organization is defined as a fully or partially state-owned corporation or government agency. For umbrella awards, grants officers will determine whether an award is an umbrella for purposes of exception from the cap on an award-by-award basis. Grants or cooperative agreements in which the primary objective is for the organization to make sub-awards and at least 75% of the grant is used for sub-awards, with the remainder of the grant used for administrative expenses and technical assistance to sub-grantees, will be considered umbrella awards and, therefore, exempted from the cap. Agreements that merely include sub-grants as an activity in implementation of the award but do not meet these criteria will not be considered umbrella awards, and the full amount of the award will count against the cap. All commodity/drug costs will be excluded from partners’ funding for the purpose of the cap. The remaining portion of awards, including all overhead/management costs, will be counted against the cap.

Applicants should be aware that evaluation of proposals will include an assessment of grant/cooperative agreement award amounts applicable to the applicant by U.S.

Government fiscal year in the relevant country. An applicant whose grants or cooperative agreements have already met or exceeded the maximum, annual single-partner limit may submit an application in response to this RFA/APS/FOA. However, applicants whose total PEPFAR funding for this country in a U.S. Government fiscal year exceeds the 8% or \$2 million single partner ceiling at the time of award decision will be ineligible to

receive an award under this RFA/APS/FOA unless the U.S. Global AIDS Coordinator approves an exception to the cap. Applicants must provide in their proposals the dollar value by U.S. Government fiscal year of current grants and cooperative agreements (including sub-grants and sub-agreements) financed by the Emergency Plan, which are for programs in the country(ies) covered by this RFA/APS/FOA. For example, the proposal should state that the applicant has \$_____ in FY 2009 grants and cooperative agreements (for as many fiscal years as applicable) in the Republic of Mozambique. For additional information concerning this RFA/APS/FOA, please contact the Grants Officer for this RFA/APS/FOA.

Prostitution and Related Activities

The U.S. Government is opposed to prostitution and related activities, which are inherently harmful and dehumanizing, and contribute to the phenomenon of trafficking in persons.

Any entity that receives, directly or indirectly, U.S. Government funds in connection with this document “grantee” cannot use such U.S. Government funds to promote or advocate the legalization or practice of prostitution or sex trafficking. Nothing in the preceding sentence shall be construed to preclude the provision to individuals of palliative care, treatment, or post-exposure pharmaceutical prophylaxis, and necessary pharmaceuticals and commodities, including test kits, condoms, and, when proven effective, microbicides.

A grantee that is otherwise eligible to receive funds in connection with this document to prevent, treat, or monitor HIV/AIDS shall not be required to endorse or utilize a multisectoral approach to combating HIV/AIDS, or to endorse, utilize, or participate in a prevention method or treatment program to which each grantee has a religious or moral objection. Any information provided by grantees about the use of condoms as part of projects or activities that are funded in connection with this document shall be medically accurate and shall include the public health benefits and failure rates of such use.

In addition, any grantee must have a policy explicitly opposing prostitution and sex trafficking. The preceding sentence shall not apply to any “exempt organizations” (defined as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Health Organization and its six Regional Offices, the International AIDS Vaccine Initiative or to any United Nations agency).

The following definition applies for purposes of this clause:

Sex trafficking means the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act. 22 U.S.C. § 7102(9).

All grantees must insert provisions implementing the applicable parts of this section, “Prostitution and Related Activities,” in all subagreements under this award. These provisions must be express terms and conditions of the subagreement, must acknowledge that compliance with this section, “Prostitution and Related Activities,” is a prerequisite to receipt and expenditure of U.S. government funds in connection with this document,

and must acknowledge that any violation of the provisions shall be grounds for unilateral termination of the agreement prior to the end of its term. Grantees must agree that HHS may, at any reasonable time, inspect the documents and materials maintained or prepared by each grantee in the usual course of its operations that relate to the organization's compliance with this section, "Prostitution and Related Activities."

All prime grantees that receive U.S. Government funds ("prime grantees") in connection with this document must certify compliance prior to actual receipt of such funds in a written statement that makes reference to this document (e.g., "[Prime grantee's name] certifies compliance with the section, 'Prostitution and Related Activities.'" addressed to the agency's grants officer. Such certifications by prime grantees are prerequisites to the payment of any U.S. Government funds in connection with this document.

Grantees' compliance with this section, "Prostitution and Related Activities," is an express term and condition of receiving U.S. Government funds in connection with this document, and any violation of it shall be grounds for unilateral termination by HHS of the agreement with HHS in connection with this document prior to the end of its term. Each grantee shall refund to HHS the entire amount furnished in connection with this document in the event HHS determines each grantee has not complied with this section, "Prostitution and Related Activities."

VI. Application Review Information

VI.1.Criteria

Applicants are required to provide measures of effectiveness that will demonstrate the accomplishment of the various identified objectives of the cooperative agreement.

Measures of effectiveness must relate to the performance goals stated in the “Purpose” section of this announcement. Measures must be objective and quantitative and must measure the intended outcome. The measures of effectiveness must be submitted with the application and will be an element of evaluation.

The application will be evaluated against the following criteria:

Ability to Carry Out the Proposal (20 points)

Does the applicant demonstrate the local experience in the Republic of Mozambique and institutional capacity (both management and technical) to achieve the goals of the project with documented good governance practices? Does the applicant have the ability to coordinate and collaborate with existing Emergency Plan partners and other donors, including the Global Fund and other U.S. Government Departments and agencies involved in implementing the President’s Emergency Plan, including the U.S. Agency for International Development? Is there evidence of leadership support and evidence of current or past efforts to enhance HIV prevention? Does the applicant have the capacity to reach rural and other underserved populations in the Republic of Mozambique? Does the organization have the ability to target audiences that frequently fall outside the reach of the traditional media, and in local languages? To what extent does the applicant provide letters of support?

Technical and Programmatic Approach (20 points)

Does the application include an overall design strategy, including measurable time lines, clear monitoring and evaluation procedures, and specific activities for meeting the proposed objectives? Does the applicant display knowledge of the strategy, principles and goals of the President's Emergency Plan, and are the proposed activities consistent with and pertinent to that strategy and those principles and goals? Does the applicant describe activities that are evidence based, realistic, achievable, measurable and culturally appropriate to achieve the goals of the President's Emergency Plan? Does the application propose to build on and complement the current national response in with evidence-based strategies designed to reach underserved populations and meet the goals of the President's Emergency Plan? Does the application include reasonable estimates of outcome targets? (For example, the numbers of sites to be supported, number of clients the program will reach.) To what extent does the applicant propose to work with other organizations? The reviewers will assess the feasibility of the applicant's plan to meet the target goals, whether the proposed use of funds is efficient, and the extent to which the specific methods described are sensitive to the local culture.

Capacity Building (15 points)

Does the applicant have a proven track record of building the capacity of indigenous organizations and individuals? Does the applicant have relevant experience in using participatory methods, and approaches, in project planning and implementation? Does the applicant describe an adequate and measurable plan to progressively build the capacity of

local organizations and of target beneficiaries to respond to the epidemic? If not a local indigenous organization, does the applicant articulate a clear exit strategy which will maximize the legacy of this project in the intervention communities? Does the capacity building plan clearly describe how it will contribute to a) improved quality and geographic coverage of service delivery to achieve the "3,12,12¹" targets of the President's Emergency Plan, and b) (if not a local indigenous organization) an evolving role of the prime beneficiary with transfer of critical technical and management competence to local organizations/sites in support of a decentralized response?

Monitoring and Evaluation (15 points)

Does the applicant demonstrate the local experience and capability to implement rigorous monitoring and evaluation of the project? Does the applicant describe a system for reviewing and adjusting program activities based on monitoring information obtained by using innovative, participatory methods and standard approaches? Does the plan include indicators developed for each program milestone, and incorporated into the financial and programmatic reports? Are the indicators consistent with the President's Emergency Plan Indicator Guide? Is the system able to generate financial and program reports to show disbursement of funds, and progress towards achieving the numerical objectives of the President's Emergency Plan? Is the plan to measure outcomes of the intervention, and the

¹ The President's Emergency Plan for AIDS Relief (PEPFAR) has called for immediate, comprehensive and evidence based action to turn the tide of global HIV/AIDS. As called for by the PEPFAR Reauthorization Act of 2008, initiative goals over the period of 2009 through 2013 are to treat at least three million HIV infected people with effective combination anti-retroviral therapy (ART); care for twelve million HIV infected and affected persons, including five million orphans and vulnerable children; and prevent twelve million infections worldwide.

manner in which they will be provided, adequate? Is the monitoring and evaluation plan consistent with the principles of the "Three Ones²?" Applicants must define specific output and outcome indicators must be defined in the proposal, and must have realistic targets in line with the targets addressed in the Activities section of this announcement.

Understanding of the Problem (10 points)

Does the applicant demonstrate a clear and concise understanding of the current national HIV/AIDS response and the cultural and political context relevant to the programmatic areas targeted? Does the applicant display an understanding of the Five-Year Strategy and goals of the President's Emergency Plan? To what extent does the applicant justify the need for this program within the target community?

Personnel (10 points)

² The Emergency Plan supports the multi-sectoral national responses in host nations, adapting U.S. support to the individual needs and challenges of each nation where the Emergency Plan is at work. Countries and communities are at different stages of HIV/AIDS response and have unique drivers of HIV, distinctive social and cultural patterns (particularly with regard to the status of women), and different political and economic conditions. Effective interventions must be informed by local circumstances and coordinated with local efforts. In April 2004, OGAC, working with UNAIDS, the World Bank, and the U.K. Department for International Development (DfID), organized and co-chaired a major international conference in Washington for major donors and national partners to consider and adopt key principles for supporting coordinated country-driven action against HIV/AIDS. These principles became known as the "**Three Ones**": - **one national plan, one national coordinating authority, and one national monitoring and evaluation system** in each of the host countries in which organizations work. Rather than mandating that all contributors do the same things in the same ways, the Three Ones facilitate complementary and efficient action in support of host nations.

Does the organization employ staff fluent in local languages who will work on this project? Are the staff roles clearly defined? As described, will the staff be sufficient to meet the goals of the proposed project? If not an indigenous organization, does the staff plan adequately involve local individuals and organizations? Are staff involved in this project qualified to perform the tasks described? Curricula vitae provided should include information that they are qualified in the following: management of HIV/AIDS prevention activities, especially confidential, voluntary counseling and testing; and the development of capacity building among and collaboration between Governmental and non-governmental partners.

Administration and Management (10 points)

Does the applicant provide a clear plan for the administration and management of the proposed activities, and to manage the resources of the program, prepare reports, monitor and evaluate activities, audit expenditures and produce collect and analyze performance data? Is the management structure for the project sufficient to ensure speedy implementation of the project? If appropriate, does the applicant have a proven track record in managing large laboratory budgets; running transparent and competitive procurement processes; supervising consultants and contractors; using subgrants or other systems of sharing resources with community based organizations, faith based organizations or smaller non-governmental organizations; and providing technical assistance in laboratory or pharmacy management? Each grantee must demonstrate an ability to submit quarterly reports in a timely manner to the HHS/CDC office.

Budget (Reviewed, but not scored)

Is the itemized budget for conducting the project, along with justification, reasonable and consistent with stated objectives and planned program activities? Is the budget itemized, well justified and consistent with the goals of the President's Emergency Plan for AIDS Relief? If applicable, are there reasonable costs per client reached for both year one and later years of the project?

VI.2. Application Review Process

Applications will be reviewed for completeness and for responsiveness jointly by the Procurement and Grants Office (PGO) and HHS/CDC Global AIDS Program staff.

Incomplete applications and applications that are non-responsive to the eligibility criteria will not advance through the review process. Applicants will be notified the application did not meet submission requirements.

An objective review panel will evaluate complete and responsive applications according to the criteria listed in the “VI.1. Criteria” section above. All persons who serve on the panel will be external to the U.S. Government Country Program Office. The panel may include both U.S. Federal Government and non-U.S. Federal Government participants.

VI.3. Applications Selection Process

Applications will likely be funded in the order by score and rank determined by the review panel. However, the following “*Funding Preferences*” may affect the funding decision:

1. Length of Experience - at least five years of documented experience in implementing MARPs activities in resource limited settings in sub-Saharan Africa, with preference given to activities conducted in Mozambique.
2. Programmatic/Technical - Strong evidence of successful implementation of MARP interventions in resource limited settings in sub-Saharan Africa. Documented institutional technical and management capacity and experience in the implementation of comprehensive MARP programs.
3. Administrative/Management (Sub-contracting / Capacity Building) - Experience in managing subcontractors. Experience in human capacity-development for the management of HIV programs in resource-constrained settings. Evidence of capacity-building and training activities in HIV/AIDS leadership and management that involve relevant African Ministries, districts and local HIV/AIDS organizations. Experience in supporting local HIV/AIDS organizations to evaluate programs, translate those findings into changes in programs and develop pilot activities to inform program management.
4. Collaboration - Preference in funding will be afforded to organizations that demonstrate ability to work with local organizations and community-based organizations in Mozambique. For indigenous organizations, preference in funding will be afforded to organizations that demonstrate ability to utilize support from international affiliations.

5. Country / Region - Activities will be performed in several regions throughout the country. Consideration will be given to applications that are reaching several regions of the country.
6. Language - Competency in Portuguese, plus ability to adapt approach for local language needs.
7. Transition Plan - Funding preference will be given to applications which include plans to transition the program to an indigenous partner during the first three years of the project period to ensure continuity of these critical services to MARPs.

CDC will provide justification for any decision to fund out of rank order.

VI.4. Anticipated Award Announcement Date

The anticipated date for announcing the award is **September 30, 2010**.

VII. Award Administration Information

VII.1. Award Notices

Successful applicants will receive a Notice of Award (NoA) from the CDC Procurement and Grants Office. The NoA shall be the only binding, authorizing document between each grantee and CDC. The NoA will be signed by an authorized Grants Management Officer and emailed to the program director and a hard copy mailed to each grantee fiscal officer identified in the application.

Unsuccessful applicants will receive notification of the results of the application review by mail.

VII.2. Administrative and National Policy Requirements

Successful applicants must comply with the administrative requirements outlined in 45 CFR Part 74 and Part 92, as appropriate. The following additional requirements apply to this project:

- AR-4 HIV/AIDS Confidentiality Provisions
- AR-6 Patient Care
- AR-8 Public Health System Reporting Requirements
- AR-9 Paperwork Reduction Act Requirements
- AR-10 Smoke-Free Workplace Requirements
- AR-12 Lobbying Restrictions
- AR-14 Accounting System Requirements
- AR-16 Security Clearance Requirement
- AR-23 States and Faith-Based Organizations
- AR-24 Health Insurance Portability and Accountability Act Requirements
- AR-25 Release and Sharing of Data
- AR-27 Conference Disclaimer and Use of Logos

Additional information on the requirements can be found on the CDC Web site at the following Internet address: http://www.cdc.gov/od/pgo/funding/Addtl_Reqmnts.htm.

For more information on the Code of Federal Regulations, see the National Archives and Records Administration, at the following Internet address:

<http://www.access.gpo.gov/nara/cfr/cfr-table-search.html>

Applicants must include an additional Certifications form from the PHS5161-1 application in the Grants.gov electronic submission only. Applicants should refer to the following Internet address:

<http://www.cdc.gov/od/pgo/funding/PHS5161-1-Certificates.pdf>. Once the applicant has filled out the form, it should be attached to the Grants.gov submission as an Other Attachments Form.

CDC Assurances and Certifications can be found on the CDC Web site at the following Internet address: <http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm>

Terms and Conditions

VII.3. Reporting Requirements

The applicant must provide HHS/CDC with an original, plus two hard copies, of the following reports:

1. Interim progress report, due no less than 90 days before the end of the budget period. The progress report will serve as the non-competing continuation application, and must contain the following elements:
 - a. Activities and Objectives for the Current Budget Period;
 - b. Financial Progress for the Current Budget Period;

- c. Proposed Activity and Objectives for the New Budget Period Program;
 - d. Budget and Budget Narrative;
 - e. Measures of Effectiveness, including progress against the numerical goals of the President's Emergency Plan for AIDS Relief for the Republic of Mozambique; and
 - f. SF424a;
 - g. Additional Requested Information.
2. Annual progress report, due 90 days after the end of the budget period. Reports should include progress against the numerical goals of the President's Emergency Plan for AIDS Relief for the Republic of Mozambique;
 3. Financial status report, due no more than 90 days after the end of the budget period; and
 4. Final financial FSR and progress reports, due no more than 90 days after the end of the project period.

These reports must be mailed to the Grants Management Specialist listed in the "VIII. Agency Contacts" section of this announcement.

VIII. Agency Contacts

HHS/CDC encourages inquiries concerning this announcement.

For program technical assistance, contact:

Daniel Shodell, MD, MPH

JAT Complex 4, Zedequias Manganhela Ave, 267

7th Floor, Maputo, Mozambique

Telephone: 258-21314 747/8

Email: ShodellD@mz.cdc.gov

For financial, grants management, or budget assistance, contact:

Valerie Brock, Grants Management Specialist

Centers for Disease Control and Prevention

P.O. Box 9536

Pretoria, 0001 South Africa

Telephone: 27 012 424 9011

Email: NaglichV@sa.cdc.gov

For general questions, contact:

Technical Information Management Section

Procurement and Grants Office

Centers for Disease Control and Prevention

U.S. Department of Health and Human Services

2920 Brandywine Road, Mail Stop E-14

Atlanta, GA 30341

Telephone: 770-488-2700

Email: pgotim@cdc.gov

IX. Other Information

Other CDC funding opportunity announcements can be found on the CDC Web site,
Internet address: <http://www.cdc.gov/od/pgo/funding/FOAs.htm> and on the website of
the HHS Office of Global Health Affairs, Internet address: www.globalhealth.gov.

Questions & Answers for Funding Opportunity Announcement CDC-RFA- PS10-1085

- If CDC intends to make two awards – how will the SOW be defined for each award and will CDC define the breakdown for each award? Will each grantee be responsible for different target populations and different geographic areas; and how will the work with the central GOM be allocated?

CDC may make up to two awards, but will not necessarily make two awards. If two awards are granted, it will be on the basis of comparative strengths of the applicants and coordinated accordingly. Additionally, this will depend on availability of funds.

- “Approximate Total Project Period Funding = \$9,000,000:” does this mean that each of the two grantees should plan on \$4.5 million for five years which works out to about \$900,000 per year?

The total estimated funding available for this five year project is \$9,000,000. If two awards are made, at least 50% of funds will be allocated to the top ranked applicant; beyond this there is no pre-determined limit to the amount of one award compared to the other.

- Ceiling of Individual Award Range = \$1,946,000 (This ceiling is for the first 12 month budget period and includes direct costs and indirect costs in the case of domestic grantees.) “ Does this mean that both of the two grantees will be able to front load their costs and bill up to \$1,946,000 in the first 12 months, i.e. will CDC obligate \$3.892 million in the first year?

No. The total estimated amount available for this five year project is \$9,000,000; if two awards are made this total estimated amount available will not change, and the ceiling will not change. Rather, the total estimated amount (and the amount under the ceiling of individual award) will be shared among grantees.

- Page 13 “Broadly, recipients of these funds will be required to ensure continuity of services of the existing HHS/CDC PEPFAR program activities, as well as support expansion in both geographical and technical scope” What are the existing program activities and services and what groups are being served?

Currently served groups: commercial sex workers; men who have sex with men; drug users. Program activities: Capacity building of local NGOs; training of these organizations’ staff and target groups in BCC strategies; development of tools for BCC (videos with CSW and DU); outreach activities.

- Sub: HIV Prevention Service. Tender No.: CDC-RFA-PS-10-1085. Euclid

Infotech is a company based in Mumbai, India. We are interested in participating in the tender mentioned above hence want to get more information about the same. Considering the geographical constraint of personally reviewing the document, I request you to provide us the following details before we buy the document: 1) List of Items, Schedule of Requirements, Scope of Work, Terms of Reference, Bill of Materials required. 2) Soft Copy of the Tender Document through email.3) Names of countries that will be eligible to participate in this tender. 4) Information about the Tendering Procedure and Guidelines5) Estimated Budget for this Purchase 6) Any Extension of Bidding Deadline?7) Any Addendum or Pre Bid meeting Minutes?We will submit our offer for the same if the goods or services required fall within our purview. Also we would like to be informed of future tenders from your organization. Hence, we request you to add our name to your bidder's list and do inform us about upcoming Projects, Tenders.

All of the information requested is available at the website:
<http://grants.gov/>. You can use the funding opportunity number CDC-RFA-PS-10-1085 to search for more information.

- Re tender notice CDC-RFA-PS-10-1085. Dear Sir or Madam, Could you please send tender documents related to the above tender notice or alternatively let me know where I can assess them from?

All of the information requested is available at the website:
<http://grants.gov/>. You can use the funding opportunity number CDC-RFA-PS-10-1085 to search for more information.

- The RFA mentions on P.14 that "Grantee activities will be conducted at central level with GoM and in seven provinces where HHS/CDC is supporting clinical services partners: Cabo Delgado, Nampula, Zambezia, Inhambane, Gaza, Maputo, and Maputo City." However, Beira, Chimoio and Sofala Province are mentioned in the RFA several times. In addition, the I-RARE study found very high HIV prevalence and risk behaviors among target groups in Beira. We request further information on the possibility of implementing MARP interventions in Manica and Sofala considering that the RFA mentions these areas and the existence of significant MARP populations (including FSWs, truckers and mobile populations, MSM, etc) there and the existing MARP activities in Manica and Sofala (100% Vida for sex workers and partners in Beira, Caia, Inchope and Manica). Can the grantee include targeted activities in these specific geographic areas?

The geographic scope of this FOA is to be limited to CABO DELGADO, NAMPULA, and INHAMBANE PROVINCES ONLY. Focus populations are to include FEMALE SEX WORKERS AND CLIENTS; MEN WHO HAVE SEX WITH MEN; DRUG USERS (IDU and non-IDU); and MOBILE POPULATIONS (including truck drivers and miners).

- The RFA mentions that there are 2 approximate awards (P. 23) with a ceiling of \$1,946,000 in year 1. Is this the ceiling amount per award or the combined total available for all awards?

This is the combined total for all awards.

- Can you please send us the final report of the I-RARE study report as well in better inform our proposal development?

Final report has not yet been completed; results have been shared as summary presentations, which will be provided.

- Can you please confirm that applications need to include a budget only for the first year of the program?

Confirmed.

- Page 37 of the solicitation states the following, "With the exception of the American University, Beirut and the World Health Organization, Indirect Costs will not be paid (either directly or through sub-award) to organizations located outside the territorial limits of the United States or to international organizations regardless of their location." Can you confirm that international organizations headquartered and registered in the United States with offices operating in

Mozambique are able to include their indirect costs in the form of their Negotiated Indirect Cost Rate Agreement (NICRA)?

US NGOs or any other international NGO that has a NICRA must use that as their indirect costs and should be included in the application.

- Does ‘no research’ mean no formal evaluation? Would this have implications for the protocol we have already submitted?

Research activities are not supported through the current funding opportunity. Existing / ongoing activities with funding sources other than this funding opportunity are not subject to the parameters of this funding opportunity.

- Could you clarify the role of “local partnership” (defined in some detail in section IV.3.Other) and whether that means something beyond just building capacity in/working with local organizations.

This is to increase sustainability and local ownership.

- A related question is how/whether the issue of “local partnership” relates to the issue of “transitioning to an indigenous partner” as stipulated in section VI.3 Applications Selection Process. As you may know, GHC is committed to setting up GHC-Mozambique as an completely autonomous entity (perhaps calling upon GHC-Atlanta technical assistance when needed, but legally constituted within Mozambique and directed by Mozambicans)—would that be an example of what is meant by an “indigenous”/”local” partner?

Section IV.3 includes a detailed definition of "Local Partner." The specifics of any autonomous entity would need to confirm to this definition in order to be considered a local partner.

- In Section III Approximate Total Project Period Funding does “domestic grantee” mean U.S.-based?

Project period is 5 years; domestic means US based.

- Is CDC asking that we limit ourselves to working in the provinces of “Cabo Delgado, Nampula, Zambezia, Inhambane, Gaza, Maputo, and Maputo City”? In the case of corridor work with mobile populations, some of the greatest need is in Tete, for instance.

The geographic scope of this FOA is to be limited to CABO DELGADO, NAMPULA, and INHAMBANE PROVINCES ONLY. Focus populations are to include FEMALE SEX WORKERS AND CLIENTS; MEN WHO HAVE SEX WITH MEN; DRUG USERS (IDU and non-IDU); and MOBILE POPULATIONS (including truck drivers and miners).

- GHC would like to partner with another US-based organization (with a local staff in Mozambique) to complement our expertise in behavior change and community mobilization. Is it possible for GHC and a partner to be “co-primes” or is it necessary for one organization to be the prime and the other a subprime? Can you direct us to any verbiage about such relationships?

One serves as the prime; the other is a secondary unless there is consortium developed although even here there is still only one organization that serves as the overall responsible agency.

- Formatting question: is it acceptable to use a text box as a kind of “figure” in the narrative? For instance, it would break up the body of the narrative to go into detail about the RAMP Change Fair, but a small text box entitled “RAMP Change Fair” that gives about a paragraph of information would work very well (although the font would be smaller, understandably). I wouldn’t want this to be seen as circumventing the rules on layout, and that is definitely not our purpose.

Yes.

- We are wondering if it’s possible to partner with a Ministry other than MISAU for future activities. I imagine this must be possible, but is there a mechanism for funding another Ministry, like the Ministry of Information or Ministry of Interior? Would this mean setting up a new cooperative agreement, or would there be some other way to channel funds or pay for staff time and travel?

Applicants may propose any partnerships. This funding opportunity announcement does not provide specifics regarding funding mechanisms.

- I saw a CDC call for proposals on MARPs – can you please advice me whether IOM would be eligible to apply or not?

Please note that eligibility criteria are described in detail on page 24 of the opportunity announcement (available on [grants.gov](https://www.grants.gov)).