

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

Centers for Disease Control and Prevention (CDC)

Building the Capacity of Provincial Medical Offices (PHOs) in the Republic of Zambia to Provide Comprehensive and Sustainable HIV/AIDS Prevention, Care, Support, and Treatment Services in Eastern, Lusaka, and Western Provinces of the Republic of Zambia under the President's Emergency Plan for AIDS Relief (PEPFAR)

I. AUTHORIZATION AND INTENT

Announcement Type: New

Funding Opportunity Number: CDC-RFA-GH11-1122

Catalog of Federal Domestic Assistance Number: 93.067

Key Dates:

Application Deadline Date: April 7, 5:00pm Eastern Standard Time

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 five year period, 2009 - 2014 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 to 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.
- Developing, validating and/or evaluating public health programs to inform, improve and target appropriate interventions, as related to the prevention, care and treatment of HIV/AIDS, TB and opportunistic infections.

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 increase capacity of local Zambian government institutions to provide HIV/AIDS Prevention, Care, & Support, and Treatment services that were initiated in 2004 under the PEPFAR-funded HHS/CDC and HHS/HRSA HIV clinical services and antiretroviral treatment program, and to further promote through this award the transitioning of US government-funded health programs to host country ownership for improved sustainability within existing facilities and appropriately scale-up services to new sites over the project period.

This funding opportunity announcement (FOA) is open only to Eastern, Lusaka and Western provincial medical offices (regional medical offices) and covers a wide range of activities within the spectrum of HIV services to strengthen capacity and expand activities in Eastern, Lusaka and Western provinces in the program areas of:

- 1. HIV care, support, and treatment;**
- 2. Prevention of Mother to Child HIV transmission (PMTCT)**
- 3. Laboratory services to support HIV care, support, treatment and PMTCT services**
- 4. Community Mobilization and Behavior Change**
- 5. Male circumcision**
- 6. Other prevention**
- 7. TB/HIV program**

Measurable outcomes of the program will be in alignment with one (or more) of the following performance goal(s):

EASTERN PROVINCE PROGRAMS MEASURABLE OUTCOMES

1. HIV Care and Treatment Services: Patients Newly Initiating on ART:

- a. By the end of the first reporting period, at least 100 children will be newly initiated on ART.
- b. By the end of the first reporting period, at least 600 adults will be newly initiated on ART.
- c. By the end of the second reporting period, at least 200 children will be newly initiated on ART.
- d. By the end of the second reporting period, at least 700 adults will be newly initiated on ART.
- e. By the end of the third reporting period, at least 300 children will be newly initiated on ART.
- f. By the end of the third reporting period, at least 800 adults will be newly initiated on ART.
- g. By the end of the fourth reporting period, at least 400 children will be newly initiated on ART.
- h. By the end of the fourth reporting period, at least 900 adults will be newly initiated on ART.
- i. By the end of the fifth reporting period, at least 500 children will be newly initiated on ART.

j. By the end of the fifth reporting period, at least 1000 adults will be newly initiated on ART.

2. HIV Care and Treatment Services: Currently (pre existing + new patients in the program) Enrolled ART Patients. Applicant will progressively assume responsibility of pre existing PEPFAR-supported patients in government clinics:

- a. By the end of the first reporting period, a cumulative total of 5,000 adults and children will be enrolled on ARTs.
- b. By the end of the second reporting period, a cumulative total of 7,000 adults and children will be enrolled on ARTs.
- c. By the end of the third reporting period, a cumulative total of 9,000 adults and children will be enrolled on ARTs.
- d. By the end of the fourth reporting period, a cumulative total of 17,000 adults and children will be enrolled on ARTs.
- e. By the end of the fifth reporting period, a cumulative total of 21,000 adults and children will be enrolled on ARTs.

HIV Care and Treatment Services: Performance Indicators:

- **Cotrimoxazole Prophylaxis:** By the end of the project period, at least 95% of all newly enrolled HIV infected adult clients (both pre-ART and ART) will be initiated on cotrimoxazole prophylaxis

HIV Care and Treatment Services: Cluster Difference 4 (CD4) Monitoring:

- a. By the end of the first reporting period, at least 75% of the HIV infected and pre-ART adults and children will have had CD4 testing within six months.

- b. By the end of the first reporting period, at least 90% of the HIV infected adults and children receiving ARTs will have had CD4 testing within six months and ongoing CD4 monitoring.
- c. By the end of the second reporting period, at least 80% of the HIV infected and pre-ART adults and children will have had CD4 testing within six months.
- d. By the end of the second reporting period, at least 95% of the HIV infected adults and children receiving ARTs will have had CD4 testing within six months and ongoing CD4 monitoring.
- e. By the end of the third reporting period, at least 80% of the HIV infected and pre-ART adults and children will have had CD4 testing within six months.
- f. By the end of the third reporting period, at least 95% of the HIV infected adults and children receiving ARTs will have had CD4 testing within six months and ongoing CD4 monitoring.
- g. By the end of the fourth reporting period, at least 85% of the HIV infected and pre-ART adults and children will have had CD4 testing within six months.
- h. By the end of the fourth reporting period, at least 95% of the HIV infected adults and children receiving ARTs will have had CD4 testing within six months and ongoing CD4 monitoring.
- i. By the end of the fifth reporting period, at least 85% of the HIV infected and pre-ART adults and children will have had CD4 testing within six months.

- j. By the end of the fifth reporting period, at least 95% of the HIV infected adults and children receiving ARTs will have had CD4 testing within six months and ongoing CD4 monitoring

3. Prevention of Mother to Child Transmission (PMTCT) measurable

outcomes:

The following indicators will be reported on program implementation over the project period

- a. Direct support to outlets that provide at least the minimum package of CT and ARV's for PMTCT will gradually be transitioned from an international partner organization to the government Provincial Health Office. In addition, the Provincial Health Office will scale-up support to new rural sites over the project period
 - 1) By the end of the first reporting period, at least 23 existing and 10 new PMTCT facilities will be receiving support for delivery of comprehensive PMTCT services
 - 2) By the end of the second reporting period, at least 46 existing and 20 new PMTCT facilities will be receiving support for delivery of comprehensive PMTCT services
 - 3) By the end of the third reporting period, at least 70 existing and 30 new PMTCT facilities will be receiving support for delivery of comprehensive PMTCT services

- 4) By the end of the fourth reporting period, at least 90 existing and 40 new PMTCT facilities will be receiving support for delivery of comprehensive PMTCT services
 - 5) By the end of the fifth reporting period, at least 110 existing and 50 new PMTCT facilities will be receiving support for delivery of comprehensive PMTCT services
4. A proportion of at least 50% of MCH service sites should have become integrated PMTCT and ART sites by end of project period;
 5. HIV positive pregnant women in Antenatal Care (ANC) assessed for Highly Active Antiretroviral Therapy (HAART) eligibility:
 - a. By the end of the first reporting period, at least 1,870 HIV positive pregnant mothers will have been assessed for HAART eligibility.
 - b. By the end of the second reporting period, at least 3,850 HIV positive pregnant mothers will have been assessed for HAART eligibility
 - c. By the end of the third reporting period, at least 5,900 HIV positive pregnant mothers will have been assessed for HAART eligibility
 - d. By the end of the fourth reporting period, at least 8,130 HIV positive pregnant mothers will have been assessed for HAART eligibility
 - e. By the end of the fifth reporting period, at least 8,320 HIV positive pregnant mothers will have been assessed for HAART eligibility
 6. ANC HIV Counseling and Testing (CT) Services:

- a. By the end of the first reporting period, at least 13,280 ANC attendees will be counseled and tested for HIV and will have received their results
 - b. By the end of the second reporting period, at least 27,290 ANC attendees will be counseled and tested for HIV and will have received their results
 - c. By the end of the third reporting period, at least 42,000 ANC attendees will be counseled and tested for HIV and will have received their results
 - d. By the end of the fourth reporting period, at least 57,600 ANC attendees will be counseled and tested for HIV and will have received their results
 - e. By the end of the fifth reporting period, at least 59,000 ANC attendees will be counseled and tested for HIV and will have received their results
7. At the end of each reporting period, report the number of known HIV positive pregnant women registering for ANC;
 8. Delivery of more efficacious antiretroviral (ARV) prophylaxis regimen for PMTCT according to national guidelines:
 - a. By the end of the first reporting period, at least 1,870 HIV positive pregnant mothers will have received a complete course of a specified efficacious ARV prophylaxis regimen

- b. By the end of the second reporting period, at least 3,850 HIV positive pregnant mothers will have received a complete course of a specified efficacious ARV prophylaxis regimen
- c. By the end of the third reporting period, at least 5,900 HIV positive pregnant mothers will have received a complete course of a specified efficacious ARV prophylaxis regimen
- d. By the end of the fourth reporting period, at least 8,130 HIV positive pregnant mothers will have received a complete course of a specified efficacious ARV prophylaxis regimen
- e. By the end of the fifth reporting period, at least 8,320 HIV positive pregnant mothers will have received a complete course of a specified efficacious ARV prophylaxis regimen

9. Training activities:

Health worker training in PMTCT based on national guidelines

- a. By the end of the first reporting period, at least 50 health workers will have been trained based on the National PMTCT guidelines and in TB screening
- b. By the end of the second reporting period, at least 50 health workers will have been trained based on the National PMTCT guidelines and in TB screening

- c. By the end of the third reporting period, at least 50 health workers will have been trained based on the National PMTCT guidelines and in TB screening
- d. By the end of the fourth reporting period, at least 50 health workers will have been trained based on the National PMTCT guidelines and in TB screening
- e. By the end of the fifth reporting period, at least 50 health workers will have been trained based on the National PMTCT guidelines and in TB screening

Health worker training in Quality Assurance/ Quality Improvement (QA/QI)

- a. By the end of the first reporting period, at least 25 health workers will have been trained in QA/QI
- b. By the end of the second reporting period, at least 50 health workers will have been trained in QA/QI
- c. By the end of the third reporting period, at least 75 health workers will have been trained in QA/QI
- d. By the end of the fourth reporting period, at least 100 health workers will have been trained in QA/QI
- e. By the end of the fifth reporting period, at least 125 health workers will have been trained in QA/QI

Community agents training

- a. By the end of the first reporting period, at least 150 community agents will have been trained in community tracking and support of mother-baby pairs.
- b. By the end of the second reporting period, at least 150 community agents will have been trained in community tracking and support of mother-baby pairs.
- c. By the end of the third reporting period, at least 150 health workers will have been trained based on the revised (2010) National PMTCT guidelines and in TB screening
- d. By the end of the third reporting period, at least 75 community agents will have been trained in community tracking and support of mother-baby pairs.
- e. By the end of the fourth reporting period, at least 75 community agents will have been trained in community tracking and support of mother-baby pairs.
- f. By the end of the fifth reporting period, at least 50 community agents will have been trained in community tracking and support of mother-baby pairs.

PMTCT Performance Indicators:

- a. 95% of HIV negative pregnant women/mothers in discordant relationships re-testing in ANC and post natal (breastfeeding mothers) according to national guidelines
- b. 85% of HIV exposed babies have all scheduled DBS at 6 weeks, 6 months and final HIV serology test at 18 months.
- c. 85 % of HIV exposed infants received ARVs to reduce the risk of MTCT in labor and delivery settings.

- d. 50% of all ANC attendees counselled, tested, and received a result with their partner
- e. 50% of siblings of HIV exposed infants will have an HIV test
- f. 100% of partners testing HIV positive will be linked to Treatment programs
- g. 95% CT sites in facilities where partner operates have Family Planning services integrated with CT services for prevention of pregnancy for all HIV positive and those of unknown status
- h. 50% PMTCT sites where partner operates will have Youth friendly services integrated with PMTCT
- i. 85% of HIV positive pregnant women attending ANC will have been screened for TB in MCH
- j. 95% of all ANC attendees in each district where partner operates will be tested for HIV, provided counseling and receive their results through direct activities
- k. 85% of HIV positive pregnant women will receive a complete course of more efficacious antiretroviral (ARV) prophylaxis regimen according to national guidelines.
- l. Reduce the proportion of of HIV exposed babies who become HIV infected to less than 5%.

Laboratory Services measurable outcomes:

By the end of the project period:

- a. The Provincial Health Offices (PHO) will be fully supporting the initiation and the process of strengthening quality systems and laboratory management toward accreditation in select laboratories under the guidance of the Ministry of Health (MOH).
- b. The PHO will support the establishment of a relay system for the implementation of the Ministry of Health/ University Teaching Hospital (MOH/UTH) led national External Quality Assessment (EQA) program.
- c. Training and refresher course will be provided to all personnel performing HIV Rapid test, AFB sputum smear microscopy, and Sexually Transmitted Infections (STI) and OI laboratory diagnosis, and ART monitoring tests.
- d. An electronic Laboratory information system for the public Health laboratories will be piloted in select sites in the provinces.
- e. There shall be an effective and efficient specimen transport referral system.
- f. 75-80% of HIV exposed infants will have been screened for EID of HIV preferably at 6-8 weeks.
- g. At least 90% of HIV infected adults and children on ART and pre ART, will be accessing CD4, and other Clinical/ Biochemical profiles.
- h. The existing TB Acid Fast Bacillus (AFB) smear microscopy EQA program will be strengthened
- i. AFB smear microscopy services to HIV/AIDS patients and HIV Rapid testing to TB patients will be strengthened and intensified.
- j. At least 60% of all laboratories will be participating satisfactorily in the national EQA schemes.

- k. There will be a strong support system to an efficient and sustainable equipment maintenance and safety program.
- l. Will have proper functional laboratories with adequate working space.
- m. Quarterly supervisory visits from the provincial medical offices and onsite technical support to health personnel in district Health facilities will be strengthened.

Male Circumcision (MC) services measurable outcomes:

The applicant will meet the following targets in the project period:

Number of males circumcised as part of the minimum package of MC for HIV prevention services in first reporting period:

- a. Number of males circumcised as part of the minimum package of MC for HIV prevention services:
 - i. Under one year of age: at least 500
 - ii. Between one year of age through 14 years of age: at least 1,000
 - iii. Over 15 years of age: at least 3,000
- b. Number of clients circumcised who experienced one or more moderate or severe adverse event(s) within the reporting period: less than 3%
- c. Number of males circumcised as part of the minimum package of MC for HIV prevention services in second reporting period:

Under one year of age: at least 600

Between one year of age through 14 years of age: at least 2,000

Over 15 years of age: at least 3,500

- d. Number of males circumcised as part of the minimum package of MC for HIV prevention services in third reporting period:
 - i. Under one year of age: at least 700
 - ii. Between one year of age through 14 years of age: at least 3,000
 - iii. Over 15 years of age: at least 4,000
- e. Number of males circumcised as part of the minimum package of MC for HIV prevention services in fourth reporting period:
 - i. Under one year of age: at least 800
 - ii. Between one year of age through 14 years of age: at least 4,000
 - iii. Over 15 years of age: at least 5,000
- f. Number of males circumcised as part of the minimum package of MC for HIV prevention services in fifth reporting period:
 - i. Under one year of age: at least 900
 - ii. Between one year of age through 14 years of age: at least 5,000
 - iii. Over 15 years of age: at least 6,000

Community Mobilization measureable outcomes:

People counseled tested and linked to treatment and care services:

- a. By the end of the first reporting period at least 3,000 will have received testing and counseling services for HIV, received their test results and linked to treatment and care services.

- b. By the end of the second reporting period at least 6,000 will have received testing and counseling services for HIV and received their test results and linked to treatment and care services.
- c. By the end of the third reporting period at least 10,000 will have received testing and counseling services for HIV and received their test results and linked to treatment and care services.
- d. By the end of the fourth reporting period at least 20,000 will have received testing and counseling services for HIV and received their test results and linked to treatment and care services.
- e. By the end of the fifth reporting period at least 35,000 will have received testing and counseling services for HIV and received their test results and linked to treatment and care services.

Training of community health workers:

- a. By the end of the first reporting period, at least 40 community health workers will be supported and trained to provide treatment adherence, defaulters tracing and patient/family education;
- b. By the end of the second reporting period, at least 45 community health workers will be supported and trained to provide treatment adherence, defaulters tracing and patient/family education;
- c. By the end of the third reporting period, at least 50 community health workers will be supported and trained to provide treatment adherence, defaulters tracing and patient/family education

- d. By the end of the fourth reporting period, at least 55 community health workers will be supported and trained to provide treatment adherence, defaulters tracing and patient/family education
- e. By the end of the fifth reporting period, at least 60 community health workers will be supported and trained to provide treatment adherence, defaulters tracing and patient/family education

Patients reached for adherence and psychosocial support:

- a. By the end of the first reporting period at least 80% of patients will be reached with adherence counseling and psychosocial support;
- b. By the end of the second reporting period at least 85% of patients will be reached with adherence counseling and psychosocial support ;
- c. By the end of the third reporting period at least 90% of patients will be reached with adherence counseling and psychosocial support;
- d. By the end of the fourth reporting period at least 95% of patients will be reached with adherence counseling and psychosocial support;
- e. By the end of the fifth reporting period at least 95% of patients will be reached with adherence counseling and psychosocial support;

Prevention with positive (PwP) activities:

- a. By the end of the first reporting period at least 60% pre and ART patients will be reached with a minimum package of PwP interventions;
- b. By the end of the second reporting period at least 70% pre and ART patients will be reached with a minimum package of PwP interventions;

- c. By the end of the third reporting period at least 80% pre and ART patients will be reached with a minimum package of PwP interventions;
- d. By the end of the fourth reporting period at least 90% pre and ART patients will be reached with a minimum package of PwP interventions;
- e. By the end of the fifth reporting period at least 95% pre and ART patients will be reached with a minimum package of PwP interventions;

Establishment of support groups:

- a. By the end of the first reporting period, at least 20 support groups of people living with HIV(PLWHIV) will be established and trained to provide information and support to promote access to treatment, care, prevention and adherence counseling;
- b. By the end of the second reporting period, at least 30 support groups of PLWHIV will be established and trained to provide information and support to promote access to treatment, care, prevention and adherence counseling;
- c. By the end of the third reporting period, at least 40 support groups of PLWHIV will be established and trained to provide information and support to promote access to treatment, care, prevention and adherence counseling;
- d. By the end of the fourth reporting period, at least 50 support groups of PLWHIV will be established and trained to provide information and support to promote access to treatment, care, prevention and adherence counseling;

- e. By the end of the fifth reporting period, at least 50 support groups of PLWHIV will be established and trained to provide information and support to promote access to treatment, care, prevention and adherence counseling;

Community leadership and participation:

- a. By the end of the first reporting period, at least 10 meetings/workshops with communities leaders will be held to encourage participation and empowerment in the areas of HIV prevention and appropriate health seeking behavior to enhance access to CT, treatment, care and support services;
- b. By the end of the second reporting period, at least 15 meetings/workshops with communities leaders will be held to encourage participation and empowerment in the areas of HIV prevention and appropriate health seeking behavior to enhance access to CT, treatment, care and support services;
- c. By the end of the third reporting period, at least 20 meetings/workshops with communities leaders will be held to encourage participation and empowerment in the areas of HIV prevention and appropriate health seeking behavior to enhance access to CT, treatment, care and support services;
- d. By the end of the fourth reporting period, at least 20 meetings/workshops with communities leaders will be held to encourage participation and empowerment in the areas of HIV prevention and appropriate health seeking behavior to enhance access to CT, treatment, care and support services;
- e. By the end of the fourth reporting period, at least 20 meetings/workshops with communities leaders will be held to encourage participation and empowerment in

the areas of HIV prevention and appropriate health seeking behavior to enhance access to CT, treatment, care and support services;

Other Prevention measurable outcomes

HIV Prevention among community members:

- a. By the end of the first reporting period, at least 2,000 individuals will be reached through community interventions that promote other prevention;
- b. By the end of the second reporting period, at least 3,000 individuals will be reached through community interventions that promote other prevention;
- c. By the end of the third reporting period, at least 4,000 individuals will be reached through community interventions that promote other prevention;
- d. By the end of the fourth reporting period, at least 5,000 individuals will be reached through community interventions that promote other prevention;
- e. By the end of the fifth reporting period, at least 6,000 individuals will be reached through community interventions that promote other prevention;

- f. By the end of the first reporting period, at least 150 individuals who will be trained in HIV/AIDS prevention programs that promote abstinence and/or being faithful;
- g. By the end of the second reporting period, at least 160 individuals who will be trained in HIV/AIDS prevention programs that promote abstinence and/or being faithful;

- h. By the end of the third reporting period, at least 170 individuals who will be trained in HIV/AIDS prevention programs that promote abstinence and/or being faithful;
- i. By the end of the fourth reporting period, at least 180 individuals who will be trained in HIV/AIDS prevention programs that promote abstinence and/or being faithful;
- j. By the end of the fifth reporting period, at least 200 individuals who will be trained in HIV/AIDS prevention programs that promote abstinence and/or being faithful;

- k. By the end of the first reporting period, at least 2,000 individuals who received Testing and Counseling services for HIV will receive their test results:
- l. By the end of the second reporting period, at least 3000 individuals who received Testing and Counseling services for HIV will receive their test results:
- m. By the end of the third reporting period , at least 4,000 individuals who received Testing and Counseling services for HIV will receive their test results:
- n. By the end of the fourth reporting period, at least 5,000 individuals who received Testing and Counseling services for HIV will receive their test results:
- o. By the end of the fifth reporting period, at least 6,000 individuals who received Testing and Counseling services for HIV will receive their test results:

HIV Prevention among youths:

- a. By the end of the first reporting period, at least 2,000 individuals will be reached with interventions focused on abstinence and/or being faithful;

- b. By the end of the second reporting period, at least 3,000 individuals will be reached with interventions focused on abstinence and/or being faithful;
- c. By the end of the third reporting period, at least 4,000 individuals will be reached with interventions focused on abstinence and/or being faithful;
- d. By the end of the fourth reporting period, at least 5,000 individuals will be reached with interventions focused on abstinence and/or being faithful;
- e. By the end of the fifth reporting period, at least 6,000 individuals will be reached with interventions focused on abstinence and/or being faithful;
- f. By the end of the first reporting period, at least 2,000 individuals will be reached with interventions on condom use and other risk reduction methods;
- g. By the end of the second reporting period, at least 3,000 individuals will be reached with interventions on condom use and other risk reduction methods;
- h. By the end of the third reporting period, at least 4,000 individuals will be reached with interventions on condom use and other risk reduction methods;
- i. By the end of the fourth reporting period, at least 5,000 individuals will be reached with interventions on condom use and other risk reduction methods;
- j. By the end of the fifth reporting period, at least 6,000 individuals will be reached with interventions on condom use and other risk reduction methods;
- k. By the end of the first reporting period, at least 80 peer educators will be trained to promote abstinence and/or being faithful and condom use;
- l. By the end of the second reporting period, at least 100 peer educators will be trained to promote abstinence and/or being faithful and condom use;

- m. By the end of the third reporting period, at least 110 peer educators will be trained to promote abstinence and/or being faithful and condom use;
- n. By the end of the fourth reporting period, at least 120 peer educators will be trained to promote abstinence and/or being faithful and condom use;
- o. By the end of the fifth reporting period, at least 130 peer educators will be trained to promote abstinence and/or being faithful and condom use;

STI Prevention and Management:

- a. By the end of the first reporting period, at least 40 health workers will be trained in Syndromic Management of sexually transmitted infections to improve case management;
- b. By the end of the second reporting period, at least 80 health workers will be trained in Syndromic Management of sexually transmitted infections to improve case management;
- c. By the end of the third reporting period, at least 100 health workers will be trained in Syndromic Management of sexually transmitted infections to improve case management;
- d. By the end of the fourth reporting period, at least 120 health workers will be trained in Syndromic Management of sexually transmitted infections to improve case management;
- e. By the end of the fifth reporting period, at least 140 health workers will be trained in Syndromic Management of sexually transmitted infections to improve case management;

Community participation:

- a. By the end of the first reporting period, at least 20 meetings/workshops with communities leaders will be held to encourage participation and empowerment in the areas of HIV prevention;
- b. By the end of the second reporting period, at least 30 meetings/workshops with communities leaders will be held to encourage participation and empowerment in the areas of HIV prevention;
- c. By the end of the third reporting period, at least 40 meetings/workshops with communities leaders will be held to encourage participation and empowerment in the areas of HIV prevention;
- d. By the end of the fourth reporting period, at least 50 meetings/workshops with communities leaders will be held to encourage participation and empowerment in the areas of HIV prevention;
- e. By the end of the fifth reporting period, at least 60 meetings/workshops with communities leaders will be held to encourage participation and empowerment in the areas of HIV prevention;
- f. By the end of the first reporting period, at least 40 community health workers will be trained in community mobilization, HIV prevention and income-generating activities;
- g. By the end of the second reporting period, at least 80 community health workers will be trained in community mobilization, HIV prevention and income-generating activities;

- h. By the end of the third reporting period, at least 120 community health workers will be trained in community mobilization, HIV prevention and income-generating activities;
- i. By the end of the fourth reporting period, at least 150 community health workers will be trained in community mobilization, HIV prevention and income-generating activities;
- j. By the end of the fifth reporting period, at least 200 community health workers will be trained in community mobilization, HIV prevention and income-generating activities;

LUSAKA PROVINCE PROGRAMS MEASURABLE OUTCOMES

1. Provision of ART according to national guidelines: Patients Newly Initiating on

ART:

Children:

- a. By the end of the first reporting period, at least 500 children will be newly initiated on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.
- b. By the end of the second reporting period, at least 600 children will be newly initiated on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.
- c. By the end of the third reporting period, at least 700 children will be newly initiated on ART, screened for TB, STI, treated for OI where applicable and

receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.

- d. By the end of the fourth reporting period, at least 800 children will be newly initiated on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.
- e. By the end of the fifth reporting period, at least 1,000 children will be newly initiated on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.

Adults:

- a. By the end of the first reporting period, at least 500 adults will be newly initiated on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.
- b. By the end of the second reporting period, at least 1,000 adults will be newly initiated on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.
- c. By the end of the third reporting period, at least 2,000 adults will be newly initiated on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.

- d. By the end of the fourth reporting period, at least 3,000 adults will be newly initiated on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.
- e. By the end of the fifth reporting period, at least 5,000 adults will be newly initiated on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.

HIV Care and Treatment Services: Currently (pre existing + new patients on the program) Enrolled ART Patients. Applicant will progressively assume responsibility of pre existing PEPFAR supported patients in government clinics:

- a. By the end of the first reporting period, a cumulative total of at least 6,000 adults and children will be enrolled on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.
- b. By the end of the second reporting period, a cumulative total of at least 12,000 adults and children will be enrolled on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.
- c. By the end of the third reporting period, a cumulative total of at least 20,000 adults and children will be enrolled on ART, screened for TB, STI, treated for OI

where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.

- d. By the end of the fourth reporting period, a cumulative total of at least 30, 000 adults and children will be enrolled on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.
- e. By the end of the fifth reporting period, a cumulative total of at least 45, 000 adults and children will be enrolled on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.

HIV Care and Treatment Service Performance Indicators:

HIV Care and Treatment Services: Cotrimoxazole Prophylaxis:

- By the end of every reporting project period, at least 95% of all newly enrolled and eligible HIV infected clients (both pre-ART and ART) will be initiated on cotrimoxazole prophylaxis.

HIV Care and Treatment Services: CD4 Monitoring:

- a. By the end of the first reporting period, at least 75% of the HIV infected and pre-ART adults and children will have had CD4 testing within six months.
- b. By the end of the first reporting period, at least 90% of the HIV infected adults and children receiving ARTs will have had CD4 testing within six months and ongoing CD4 monitoring.

- c. By the end of the second reporting period, at least 80% of the HIV infected and pre-ART adults and children will have had CD4 testing within six months.
- d. By the end of the second reporting period, at least 95% of the HIV infected adults and children receiving ARTs will have had CD4 testing within six months and ongoing CD4 monitoring.
- e. By the end of the third reporting period, at least 80% of the HIV infected and pre-ART adults and children will have had CD4 testing within six months.
- f. By the end of the third reporting period, at least 95% of the HIV infected adults and children receiving ARTs will have had CD4 testing within six months and ongoing CD4 monitoring.
- g. By the end of the fourth reporting period, at least 85% of the HIV infected and pre-ART adults and children will have had CD4 testing within six months.
- h. By the end of the fourth reporting period, at least 95% of the HIV infected adults and children receiving ARTs will have had CD4 testing within six months and ongoing CD4 monitoring.
- i. By the end of the fifth reporting period, at least 85% of the HIV infected and pre-ART adults and children will have had CD4 testing within six months.
- j. By the end of the fifth reporting period, at least 95% of the HIV infected adults and children receiving ARTs will have had CD4 testing within six months and ongoing CD4 monitoring

Prevention of Mother to Child Transmission (PMTCT) measurable outcomes:

The following indicators will be reported on program implementation over the project period:

Direct support to outlets that provide at least the minimum package of CT and ARV's for PMTCT will gradually be transitioned from an international partner organization to the government Provincial Health Office. In addition, the Provincial Health Office will scale-up support to new rural sites over the project period.

- a. By the end of the first reporting period, at least 15 existing and 5 new PMTCT facilities will be receiving support for delivery of comprehensive PMTCT services
- b. By the end of the second reporting period, at least 30 existing and 10 new PMTCT facilities will be receiving support for delivery of comprehensive PMTCT services
- c. By the end of the third reporting period, at least 35 existing and 15 new PMTCT facilities will be receiving support for delivery of comprehensive PMTCT services
- d. By the end of the fourth reporting period, at least 50 existing and 20 new PMTCT facilities will be receiving support for delivery of comprehensive PMTCT services
- e. By the end of the fifth reporting period, at least 65 existing and 25 new PMTCT facilities will be receiving support for delivery of comprehensive PMTCT services
- f. A proportion of at least 50% of MCH service sites will have become integrated PMTCT and ART sites by end of project period

HIV positive pregnant women in ANC assessed for HAART eligibility:

- a. By the end of the first reporting period, at least 2,620 HIV positive pregnant mothers will have been assessed for HAART eligibility.
- b. By the end of the second reporting period, at least 5,380 HIV positive pregnant mothers will have been assessed for HAART eligibility
- c. By the end of the third reporting period, at least 8,300 HIV positive pregnant mothers will have been assessed for HAART eligibility
- d. By the end of the fourth reporting period, at least 11,360 HIV positive pregnant mothers will have been assessed for HAART eligibility
- e. By the end of the fifth reporting period, at least 11,670 HIV positive pregnant mothers will have been assessed for HAART eligibility

ANC HIV Counseling and Testing Services:

- a. By the end of the first reporting period, at least 18,580 ANC attendees will be counseled and tested for HIV and will have received their results
- b. By the end of the second reporting period, at least 38,160 ANC attendees will be counseled and tested for HIV and will have received their results
- c. By the end of the third reporting period, at least 58,800 ANC attendees will be counseled and tested for HIV and will have received their results
- d. By the end of the fourth reporting period, at least 80,550 ANC attendees will be counseled and tested for HIV and will have received their results

- e. By the end of the fifth reporting period, at least 82,750 ANC attendees will be counseled and tested for HIV and will have received their results
- f. At end of each reporting period report the number of known HIV positive pregnant women registering for ANC

Delivery of more efficacious antiretroviral (ARV) prophylaxis regimen for PMTCT according to national guidelines.

- a. By the end of the first reporting period, at least 2,620 HIV positive pregnant mothers will have received a complete course of a specified efficacious ARV prophylaxis regimen
- b. By the end of the second reporting period, at least 5,380 HIV positive pregnant mothers will have received a complete course of a specified efficacious ARV prophylaxis regimen
- c. By the end of the third reporting period, at least 8,300 HIV positive pregnant mothers will have received a complete course of a specified efficacious ARV prophylaxis regimen
- d. By the end of the fourth reporting period, at least 11,360 HIV positive pregnant mothers will have received a complete course of a specified efficacious ARV prophylaxis regimen
- e. By the end of the fifth reporting period, at least 11,670 HIV positive pregnant mothers will have received a complete course of a specified efficacious ARV prophylaxis regimen

Training activities:

Health worker training in PMTCT based on national guidelines:

- a. By the end of the first reporting period, at least 50 health workers will have been trained based on the National PMTCT guidelines and in TB screening
- b. By the end of the second reporting period, at least 60 health workers will have been trained based on the National PMTCT guidelines and in TB screening
- c. By the end of the third reporting period, at least 60 health workers will have been trained based on the National PMTCT guidelines and in TB screening
- d. By the end of the fourth reporting period, at least 75 health workers will have been trained based on the National PMTCT guidelines and in TB screening
- e. By the end of the fifth reporting period, at least 75 health workers will have been trained based on the revised National PMTCT guidelines and in TB screening

Health worker training in QA/QI:

- a. By the end of the first reporting period, at least 15 health workers will have been trained in QA/QI
- b. By the end of the second reporting period , at least 30 health workers will have been trained in QA/QI
- c. By the end of the third reporting period, at least 45 health workers will have been trained in QA/QI
- d. By the end of the fourth reporting period, at least 60 health workers will have been trained in QA/QI

- e. By the end of the fifth reporting period, at least 75 health workers will have been trained in QA/QI

Community agents training:

- a. By the end of the first reporting period, at least 100 community agents will have been trained in community tracking and support of mother-baby pairs.
- b. By the end of the second reporting period, at least 100 community agents will have been trained in community tracking and support of mother-baby pairs.
- c. By the end of the third reporting period, at least 50 community agents will have been trained in community tracking and support of mother-baby pairs.
- d. By the end of the fourth reporting period, at least 50 community agents will have been trained in community tracking and support of mother-baby pairs.
- e. By the end of the fifth reporting period, at least 25 community agents will have been trained in community tracking and support of mother-baby pairs.

PMTCT Performance Indicators:

- a. At least 95% of HIV negative pregnant women/mothers in discordant relationships will be re-tested in ANC and post natal (breastfeeding mothers) according to national guidelines
- b. At least 85% of HIV exposed babies have all scheduled DBS at 6 weeks, 6 months and final HIV serology test at 18 months.
- c. At least 85 % of HIV exposed infants received ARVs to reduce the risk of MTCT in labor and delivery settings.

- d. At least 50% of all ANC attendees counselled, tested, and received a result with their partner
- e. At least 50% of siblings of HIV exposed infants will have an HIV test
- f. At least 100% of partners testing HIV positive will be linked to Treatment programs
- g. At least 95% CT sites in facilities where partner operates will have FP services integrated with CT services for prevention of pregnancy for all HIV positive and those of unknown status
- h. At least 50% PMTCT sites where partner operates will have Youth friendly service integrated with PMTCT
- i. At least 85% of HIV positive pregnant women attending ANC will have been screened for TB in MCH
- j. At least 95% of all ANC attendees in each district where partner operates will be tested for HIV, provided counseling and receive their results through direct activities
- k. At least 85% of HIV positive pregnant women will receive a complete course of more efficacious antiretroviral (ARV) prophylaxis regimen according to national guidelines.
- l. Reduce the proportion of HIV exposed babies who become infected to less than 5%.

Laboratory Services measurable outcomes:

By the end of the funding period:

- a. The PHO will be fully supporting the initiation and the process of strengthening quality systems and laboratory management toward accreditation in select laboratories under the guidance of the MOH.
- b. The PHO will support the establishment of a relay system for the implementation of the MOH/UTH led national EQA program.
- c. Training and refresher course will be provided to all personnel performing HIV Rapid test, AFB sputum smear microscopy, and Sexually Transmitted Infections (STI) and OI laboratory diagnosis, and ART monitoring tests.
- d. An electronic Laboratory information system for the public Health laboratories will be piloted in select sites in the provinces.
- e. There shall be an effective and efficient specimen transport referral system.
- f. At least 75-80% of HIV exposed infants will have been screened for EID of HIV preferably at 6-8 weeks.
- g. At least 90% of HIV infected adults and children on ART and pre ART, will be accessing CD4, and other Clinical/ Biochemical profiles.
- h. The existing TB AFB smear microscopy EQA program will be strengthened
- i. AFB smear microscopy services to HIV/AIDS patients and HIV Rapid testing to TB patients will be strengthened and intensified.
- j. At least 60% of all laboratories will be participating satisfactorily in the national EQA schemes.
- k. There will be a strong support system to an efficient and sustainable equipment maintenance and safety program.
- l. Will have proper functional laboratories with adequate working space.

- m. Quarterly supervisory visits from the provincial medical offices and onsite technical support to health personnel in district Health facilities will be strengthened.

Male Circumcision measurable outcomes:

- a. Number of males circumcised as part of the minimum package of MC for HIV prevention services in first reporting period:
- b. Number of males circumcised as part of the minimum package of MC for HIV prevention services:
 - i. Under one year of age: at least 600
 - ii. Between one year of age through 14 years of age: at least 2,000
 - iii. Over 15 years of age: at least 4,000
- c. Number of clients circumcised who experienced one or more moderate or severe adverse event(s) within the reporting period: less than 3%
- d. Number of males circumcised as part of the minimum package of MC for HIV prevention services in second reporting period:
 - iv. Under one year of age: at least 700
 - v. Between one year of age through 14 years of age: at least 3,000
 - vi. Over 15 years of age: at least 4,000
- e. Number of males circumcised as part of the minimum package of MC for HIV prevention services in third reporting period:

- vii. Under one year of age: at least 800
 - viii. Between one year of age through 14 years of age: at least 4,000
 - ix. Over 15 years of age: at least 5,000
- f. Number of males circumcised as part of the minimum package of MC for HIV prevention services in fourth reporting period:
- x. Under one year of age: at least 900
 - xi. Between one year of age through 14 years of age: at least 5,000
 - xii. Over 15 years of age: at least 6,000
- g. Number of males circumcised as part of the minimum package of MC for HIV prevention services in fifth reporting period:
- xiii. Under one year of age: at least 1,000
 - xiv. Between one year of age through 14 years of age: at least 6,000
 - xv. Over 15 years of age: at least 7,000

Community Mobilization measurable outcomes:

People counseled tested and linked to treatment and care services:

- a. By the end of the first reporting period at least 16,000 will have received testing and counseling services for HIV, received their test results and linked to treatment and care services.
- b. By the end of the second reporting period at least 20,000 will have received testing and counseling services for HIV and received their test results and linked to treatment and care services.

- c. By the end of the third reporting period at least 25,000 will have received testing and counseling services for HIV and received their test results and linked to treatment and care services.
- d. By the end of the fourth reporting period at least 35,000 will have received testing and counseling services for HIV and received their test results and linked to treatment and care services.
- e. By the end of the fifth reporting period at least 40,000 will have received testing and counseling services for HIV and received their test results and linked to treatment and care services.

Training of community health workers:

- a. By the end of the first reporting period at least 40 community health workers will be supported and trained to provide treatment adherence, defaulters tracing and patient/family education;
- b. By the end of the second reporting period at least 40 community health workers will be supported and trained to provide treatment adherence, defaulters tracing and patient/family education;
- c. By the end of the third reporting period at least 40 community health workers will be supported and trained to provide treatment adherence, defaulters tracing and patient/family education
- d. By the end of the fourth reporting period at least 40 community health workers will be supported and trained to provide treatment adherence, defaulters tracing and patient/family education

- e. By the end of the fifth reporting period at least 40 community health workers will be supported and trained to provide treatment adherence, defaulters tracing and patient/family education

Patients reached for adherence and psychosocial support:

- a. By the end of the first reporting period at least 80% of patients will be reached with adherence counseling and psychosocial support;
- b. By the end of the second reporting period at least 85% of patients will be reached with adherence counseling and psychosocial support ;
- c. By the end of the third reporting period at least 90% of patients will be reached with adherence counseling and psychosocial support;
- d. By the end of the fourth reporting period at least 95% of patients will be reached with adherence counseling and psychosocial support;
- e. By the end of the fifth reporting period at least 95% of patients will be reached with adherence counseling and psychosocial support;

Prevention with positive activities:

- a. By the end of the first reporting period at least 60% pre and ART patients will be reached with a minimum package of PwP interventions;
- b. By the end of the second reporting period at least 70% pre and ART patients will be reached with a minimum package of PwP interventions;
- c. By the end of the third reporting period at least 80% pre and ART patients will be reached with a minimum package of PwP interventions;

- d. By the end of the fourth reporting period at least 90% pre and ART patients will reached with a minimum package of PwP interventions;
- e. By the end of the fifth reporting period at least 95% pre and ART patients will reached with a minimum package of PwP interventions;

Establishment of support groups:

- a. By the end of the first reporting period at least 20 support groups of people living with HIV(PLWHIV) will be established and trained to provide information and support to promote access to treatment, care, prevention and adherence counseling;
- b. By the end of the second reporting period at least 30 support groups of PLWHIV will be established and trained to provide information and support to promote access to treatment, care, prevention and adherence counseling;
- c. By the end of the third reporting period at least 40 support groups of PLWHIV will be established and trained to provide information and support to promote access to treatment, care, prevention and adherence counseling;
- d. By the end of the fourth reporting period at least 50 support groups of PLWHIV be established and trained to provide information and support to promote access to treatment, care, prevention and adherence counseling;
- e. By the end of the fifth reporting period at least 50 support groups of PLWHIV will be established and trained to provide information and support to promote access to treatment, care, prevention and adherence counseling;

HIV Prevention targeting populations:

- a. By the end of the first reporting period at least 100,000 individuals will be reached with interventions on condom use and other risk reduction methods;
- b. By the end of the second reporting period at least 150,000 individuals will be reached with interventions on condom use and other risk reduction methods;
- c. By the end of the third reporting period at least 200,000 individuals will be reached with interventions on condom use and other risk reduction methods;
- d. By the end of the fourth reporting period at least 250,000 individuals will be reached with interventions on condom use and other risk reduction methods;
- e. By the end of the fifth reporting period at least 300,000 individuals will be reached with interventions on condom use and other risk reduction methods;
- f. By the end of the first reporting period at least 50 individuals who will be trained to promote abstinence and/or being faithful;
- g. By the end of the second reporting period at least 100 individuals who will be trained to promote abstinence and/or being faithful;
- h. By the end of the third reporting period at least 150 individuals who will be trained to promote abstinence and/or being faithful;
- i. By the end of the fifth reporting period at least 200 individuals who will be trained to promote abstinence and/or being faithful;
- j. By the end of the first reporting period at least 250 individuals who will be trained to promote abstinence and/or being faithful;
- k. By the end of the first reporting period at least 15,000 individuals who received Testing and Counseling services for HIV and received their test results:

- l. By the end of the second reporting period at least 20,000 individuals who received Testing and Counseling services for HIV and received their test results:
- m. By the end of the third reporting period at least 30,000 individuals who received Testing and Counseling services for HIV and received their test results:
- n. By the end of the fourth reporting period at least 40,000 individuals who received Testing and Counseling services for HIV and received their test results:
- o. By the end of the fifth reporting period at least 50,000 individuals who received Testing and Counseling services for HIV and received their test results:

HIV Prevention among youths:

- a. By the end of the first reporting period at least 100,000 individuals will be reached with interventions focused on abstinence and/or being faithful;
- b. By the end of the second reporting period at least 150,000 individuals will be reached with interventions focused on abstinence and/or being faithful;
- c. By the end of the third reporting period at least 200,000 individuals will be reached with interventions focused on abstinence and/or being faithful;
- d. By the end of the fourth reporting period at least 250,000 individuals will be reached with interventions focused on abstinence and/or being faithful;
- e. By the end of the fifth reporting period at least 300,000 individuals will be reached with interventions focused on abstinence and/or being faithful;
- f. By the end of the first reporting period at least 60 peer educators will be trained to promote condom use and other risk reduction strategies;
- g. By the end of the second reporting period at least 90 peer educators will be trained to promote condom use and other risk reduction strategies;

- h. By the end of the third reporting period at least 120 peer educators will be trained to promote condom use and other risk reduction strategies;
- i. By the end of the fourth reporting period at least 150 peer educators will be trained to promote condom use and other risk reduction strategies;
- j. By the end of the fifth reporting period at least 200 peer educators will be trained to promote condom use and other risk reduction strategies;

STI Prevention and Management:

- a. By the end of the first reporting period at least 40 health workers will be trained in Syndromic Management of sexually transmitted infections to improve case management;
- b. By the end of the second reporting period at least 80 health workers will be trained in Syndromic Management of sexually transmitted infections to improve case management;
- c. By the end of the third reporting period at least 100 health workers will be trained in Syndromic Management of sexually transmitted infections to improve case management;
- d. By the end of the fourth reporting period at least 120 health workers will be trained in Syndromic Management of sexually transmitted infections to improve case management;
- e. By the end of the fifth reporting period at least 140 health workers will be trained in Syndromic Management of sexually transmitted infections to improve case management;

Community participation:

- a. By the end of the first reporting period at least 20 sensitization meetings/workshops with communities leaders will be held to promote HIV prevention and early treatment seeking for STIs;
- b. By the end of the second reporting period at least 30 sensitization meetings/workshops with communities leaders will be held to promote HIV prevention and early treatment seeking for STIs;
- c. By the end of the third reporting period at least 40 sensitization meetings/workshops with communities leaders will be held to promote HIV prevention and early treatment seeking for STIs;
- d. By the end of the fourth reporting period at least 50 sensitization meetings/workshops with communities leaders will be held to promote HIV prevention and early treatment seeking for STIs;
- e. By the end of the fifth reporting period at least 60 sensitization meetings/workshops with communities leaders will be held to promote HIV prevention and early treatment seeking for STIs;

WESTERN PROVINCE PROGRAMS MEASURABLE OUTCOMES

1. HIV Care and Treatment Services: Patients Newly Initiating on ART

Children:

- a. By the end of the first reporting period at least 100 children will be newly initiated on ART, screened for TB, STI, treated for OI where applicable and

receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.

- b. By the end of the second reporting period at least 200 children will be newly initiated on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.
- c. By the end of the third reporting period at least 250 children will be newly initiated on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.
- d. By the end of the fourth reporting period at least 300 children will be newly initiated on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.
- e. By the end of the fifth reporting period at least 400 children will be newly initiated on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.

Adults:

- a. By the end of the first reporting period at least 500 adults will be newly initiated on ART, screened for TB, STI, treated for OI where applicable and receive

clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.

- b. By the end of the second reporting period at least 1,000 adults will be newly initiated on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.
- c. By the end of the third reporting period at least 1,500 adults will be newly initiated on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.
- d. By the end of the fourth reporting period at least 2,000 adults will be newly initiated on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.
- e. By the end of the fifth reporting period at least 2,500 adults will be newly initiated on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.

HIV Care and Treatment Services: Currently (existing + new) Enrolled ART Patients. Applicant will progressively assume responsibility of pre existing PEPFAR supported patients in government clinics:

- a. By the end of the first reporting period at least 5,000 adults and children will be enrolled on ART, screened for TB, STI, treated for OI where applicable and

receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.

- b. By the end of the second reporting period at least 7,000 adults and children will be enrolled on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.
- c. By the end of the third reporting period at least 9,000 adults and children will be enrolled on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.
- d. By the end of the fourth reporting period at least 17,000 adults and children will be enrolled on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.
- e. By the end of the fifth reporting period at least 21,000 adults and children will be enrolled on ART, screened for TB, STI, treated for OI where applicable and receive clinical monitoring, adherence counseling, evaluated and managed for any adverse drugs events.

HIV Care and Treatment Performance Indicators:

HIV Care and Treatment Services: Cotrimoxazole Prophylaxis:

- By the end of each reporting period at least 95% of all newly enrolled and eligible HIV infected clients (both pre-ART and ART) will be initiated on cotrimoxazole prophylaxis.

HIV Care and Treatment Services: CD4 Monitoring:

- a. By the end of the first reporting period at least 75% of the HIV infected and pre-ART adults and children will have had CD4 testing within six months.
- b. By the end of the first reporting period at least 90% of the HIV infected adults and children receiving ARTs will have had CD4 testing within six months and ongoing CD4 monitoring.
- c. By the end of the second reporting period at least 80% of the HIV infected and pre-ART adults and children will have had CD4 testing within six months.
- d. By the end of the second reporting period at least 95% of the HIV infected adults and children receiving ARTs will have had CD4 testing within six months and ongoing CD4 monitoring.
- e. By the end of the third reporting period at least 80% of the HIV infected and pre-ART adults and children will have had CD4 testing within six months.
- f. By the end of the reporting period at least 95% of the HIV infected adults and children receiving ARTs will have had CD4 testing within six months and ongoing CD4 monitoring.
- g. By the end of the fourth reporting period at least 85% of the HIV infected and pre-ART adults and children will have had CD4 testing within six months.

- h. By the end of the fourth reporting period at least 95% of the HIV infected adults and children receiving ARTs will have had CD4 testing within six months and ongoing CD4 monitoring.

PMTCT measurable outcomes:

Direct support to outlets that provide at least the minimum package of PMTCT services CT and ARV's for PMTCT will gradually be transitioned from an international partner organization to the government Provincial Health Office. In addition, the Provincial Health Office will scale-up support to new rural sites over the project period.

- a. By the end of the first reporting period at least 27 existing and 10 new PMTCT facilities will be receiving support for delivery of comprehensive PMTCT services
- b. By the end of the second reporting period at least 54 existing and 20 new PMTCT facilities will be receiving support for delivery of comprehensive PMTCT services
- c. By the end of the third budget period, 80 existing and 30 new PMTCT facilities will be receiving support for delivery of comprehensive PMTCT services
- d. By the end of the fourth reporting period at least 100 existing and 40 new PMTCT facilities will be receiving support for delivery of comprehensive PMTCT services
- e. By the end of the fifth reporting period at least 130 existing and 50 new PMTCT facilities will be receiving support for delivery of comprehensive PMTCT services

- f. A proportion of at least 50% of MCH service sites that should have become integrated PMTCT and ART sites by end of project period

HIV positive pregnant women in ANC assessed for HAART eligibility:

- a. By the end of the first reporting period at least 980 HIV positive pregnant mothers will have been assessed for HAART eligibility.
- b. By the end of the second reporting period at least 2,000 HIV positive pregnant mothers will have been assessed for HAART eligibility
- c. By the end of the third reporting period at least 3,200 HIV positive pregnant mothers will have been assessed for HAART eligibility
- d. By the end of the fourth reporting period at least 4,270 HIV positive pregnant mothers will have been assessed for HAART eligibility
- e. By the end of the fifth reporting period at least 4,360 HIV positive pregnant mothers will have been assessed for HAART eligibility

ANC HIV counseling and Testing Services:

- a. By the end of the first reporting period at least 6,980 ANC attendees will be counseled and tested for HIV and will have received their results
- b. By the end of the second reporting period at least 14,340 ANC attendees will be counseled and tested for HIV and will have received their results
- c. By the end of the third reporting period at least 22,100 ANC attendees will be counseled and tested for HIV and will have received their results

- d. By the end of the fourth reporting period at least 30,280 ANC attendees will be counseled and tested for HIV and will have received their results
- e. By the end of the fifth reporting period at least 30,940 ANC attendees will be counseled and tested for HIV and will have received their results
- f. At the end of each reporting period, report the number of known HIV positive pregnant women registering for ANC

Delivery of more efficacious antiretroviral (ARV) prophylaxis regimen for PMTCT according to national guidelines:

- a. By the end of the first reporting period at least 980 HIV positive pregnant mothers will have received a complete course of a specified efficacious ARV prophylaxis regimen
- b. By the end of the second reporting period at least 2,000 HIV positive pregnant mothers will have received a complete course of a specified efficacious ARV prophylaxis regimen
- c. By the end of the third reporting period at least 3,200 HIV positive pregnant mothers will have received a complete course of a specified efficacious ARV prophylaxis regimen
- d. By the end of the fourth reporting period at least 4,270 HIV positive pregnant mothers will have received a complete course of a specified efficacious ARV prophylaxis regimen

- e. By the end of the fifth reporting period at least 4,360 HIV positive pregnant mothers will have received a complete course of a specified efficacious ARV prophylaxis regimen

Training activities:

Health Worker Training in PMTCT based on national guidelines:

- a. By the end of the first reporting period at least 60 health workers will have been trained based on the National PMTCT guidelines and in TB screening
- b. By the end of the second reporting period at least 60 health workers will have been trained based on the National PMTCT guidelines and in TB screening
- c. By the end of the third reporting period at least 60 health workers will have been trained based on the National PMTCT guidelines and in TB screening
- d. By the end of the fourth reporting period at least 60 health workers will have been trained based on the National PMTCT guidelines and in TB screening
- e. By the end of the fifth reporting period at least 60 health workers will have been trained based on the revised National PMTCT guidelines and in TB screening

Health worker training in QA/QI:

- a. By the end of the first reporting period at least 30 health workers will have been trained in QA/QI
- b. By the end of the second reporting period at least 60 health workers will have been trained in QA/QI

- c. By the end of the third reporting period at least 90 health workers will have been trained in QA/QI
- d. By the end of the fourth reporting period at least 120 health workers will have been trained in QA/QI
- e. By the end of the fifth reporting period at least 150 health workers will have been trained in QA/QI

Community agents training:

- a. By the end of the first reporting period at least 300 community agents will have been trained in community tracking and support of mother-baby pairs.
- b. By the end of the second reporting period at least 300 community agents will have been trained in community tracking and support of mother-baby pairs.
- c. By the end of the third reporting period at least 150 community agents will have been trained in community tracking and support of mother-baby pairs.
- d. By the end of the fourth reporting period at least 150 community agents will have been trained in community tracking and support of mother-baby pairs.
- e. By the end of the fifth reporting period at least 75 community agents will have been trained in community tracking and support of mother-baby pairs.

PMTCT Performance Indicators:

- a. At least 95% of HIV negative pregnant women/mothers in discordant relationships re-testing in ANC and post natal (breastfeeding mothers) according to national guidelines

- b. At least 85% of HIV exposed babies have all scheduled DBS at 6 weeks, 6 months and final HIV serology test at 18 months.
- c. At least 85 % of HIV exposed infants received ARVs to reduce the risk of MTCT in labor and delivery settings.
- d. At least 50% of all ANC attendees counselled, tested, and received a result with their partner
- e. At least 50% of siblings of HIV exposed infants will have an HIV test
- f. At least 100% of partners testing HIV positive will be linked to Treatment programs
- g. At least 95% CT sites in facilities where partner operates have Family Planning services integrated with CT services for prevention of pregnancy for all HIV positive and those of unknown status
- h. At least 50% PMTCT sites where partner operates will have Youth friendly services integrated with PMTCT
- i. At least 85% of HIV positive pregnant women attending ANC will have been screened for TB in MCH
- j. At least 95% of all ANC attendees in each district where partner operates will be tested for HIV, provided counseling and receive their results through direct activities
- k. At least 85% of HIV positive pregnant women will receive a complete course of more efficacious antiretroviral (ARV) prophylaxis regimen according to national guidelines.

1. Reduce the proportion of HIV exposed babies who become HIV infected to less than 5%.

Laboratory Services measureable outcomes:

By the end of the funding period:

- a. The PHO will be fully supporting the initiation and the process of strengthening quality systems and laboratory management toward accreditation in select laboratories under the guidance of the MOH.
- b. The PHO will support the establishment of a relay system for the implementation of the MOH/UTH led national EQA program.
- c. Training and refresher course will be provided to all personnel performing HIV Rapid test, AFB sputum smear microscopy, and Sexually Transmitted Infections (STI) and OI laboratory diagnosis, and ART monitoring tests.
- d. An electronic Laboratory information system for the public Health laboratories will be piloted in select sites in the provinces.
- e. There shall be an effective and efficient specimen transport referral system.
- f. At least 75-80% of HIV exposed infants will have been screened for EID of HIV preferably at 6-8 weeks.
- g. At least 90% of HIV infected adults and children on ART and pre ART, will be accessing CD4, and other Clinical/ Biochemical profiles.
- h. The existing TB AFB smear microscopy EQA program will be strengthened
- i. AFB smear microscopy services to HIV/AIDS patients and HIV Rapid testing to TB patients will be strengthened and intensified.

- j. At least 60% of all laboratories will be participating satisfactorily in the national EQA schemes.
- k. There will be a strong support system to an efficient and sustainable equipment maintenance and safety program.
- l. Will have proper functional laboratories with adequate working space.
- m. Quarterly supervisory visits from the provincial medical offices and onsite technical support to health personnel in district Health facilities will be strengthened.

Male Circumcision measurable outcomes:

The applicant will meet the following targets in the project period:

- a. Number of males circumcised as part of the minimum package of MC for HIV prevention services in first reporting period:
- b. Number of males circumcised as part of the minimum package of MC for HIV prevention services:
 - i. Under one year of age: at least 500
 - ii. Between one year of age through 14 years of age: at least 1,000
 - iii. Over 15 years of age: at least 3,000
- c. Number of clients circumcised who experienced one or more moderate or severe adverse event(s) within the reporting period: less than 3%

- d. Number of males circumcised as part of the minimum package of MC for HIV prevention services in second reporting period:
 - iv. Under one year of age: at least 600
 - v. Between one year of age through 14 years of age: at least 2,000
 - vi. Over 15 years of age: at least 3,500
- e. Number of males circumcised as part of the minimum package of MC for HIV prevention services in third reporting period:
 - vii. Under one year of age: at least 700
 - viii. Between one year of age through 14 years of age: at least 3,000
 - ix. Over 15 years of age: at least 4,000
- f. Number of males circumcised as part of the minimum package of MC for HIV prevention services in fourth reporting period:
 - x. Under one year of age: at least 800
 - xi. Between one year of age through 14 years of age: at least 4,000
 - xii. Over 15 years of age: at least 5,000
- g. Number of males circumcised as part of the minimum package of MC for HIV prevention services in fifth reporting period:
 - xiii. Under one year of age: at least 900
 - xiv. Between one year of age through 14 years of age: at least 5,000
 - xv. Over 15 years of age: at least 6,000

Community Mobilization measurable outcomes:

People counseled tested and linked to treatment and care services:

- a. By the end of the first reporting period at least 16,000 will have received testing and counseling services for HIV, received their test results and linked to treatment and care services.
- b. By the end of the second reporting period at least 20,000 will have received testing and counseling services for HIV and received their test results and linked to treatment and care services.
- c. By the end of the third reporting period at least 25,000 will have received testing and counseling services for HIV and received their test results and linked to treatment and care services.
- d. By the end of the fourth reporting period at least 30,000 will have received testing and counseling services for HIV and received their test results and linked to treatment and care services.
- e. By the end of the fifth reporting period at least 35,000 will have received testing and counseling services for HIV and received their test results and linked to treatment and care services.

Training of community health workers:

- a. By the end of the first reporting period at least 80 community health workers will be supported and trained to provide treatment adherence, defaulters tracing and patient/family education;
- b. By the end of the second reporting period at least 80 community health workers will be supported and trained to provide treatment adherence, defaulters tracing and patient/family education;

- c. By the end of the third reporting period at least 80 community health workers will be supported and trained to provide treatment adherence, defaulters tracing and patient/family education
- d. By the end of the fourth reporting period at least 80 community health workers will be supported and trained to provide treatment adherence, defaulters tracing and patient/family education
- e. By the end of the fifth reporting period at least 80 community health workers will be supported and trained to provide treatment adherence, defaulters tracing and patient/family education

Patients reached for adherence and psychosocial support:

- a. By the end of the first reporting period at least 80% of patients will be reached with adherence counseling and psychosocial support;
- b. By the end of the second reporting period at least 85% of patients will be reached with adherence counseling and psychosocial support ;
- c. By the end of the third reporting period at least 90% of patients will be reached with adherence counseling and psychosocial support;
- d. By the end of the fourth reporting period at least 95% of patients will be reached with adherence counseling and psychosocial support;
- e. By the end of the fifth reporting period at least 95% of patients will be reached with adherence counseling and psychosocial support;

Prevention with positive (PwP) activities:

- a. By the end of the first reporting period at least 60% pre and ART patients will be reached with a minimum package of PwP interventions;
- b. By the end of the second reporting period at least 70% pre and ART patients will be reached with a minimum package of PwP interventions;
- c. By the end of the third reporting period at least 80% pre and ART patients will be reached with a minimum package of PwP interventions;
- d. By the end of the fourth reporting period at least 90% pre and ART patients will be reached with a minimum package of PwP interventions;
- e. By the end of the fifth reporting period at least 95% pre and ART patients will be reached with a minimum package of PwP interventions;

Establishment of support groups:

- a. By the end of the first reporting period at least 20 support groups of people living with HIV(PLWHIV) will be established and trained to provide information and support to promote access to treatment, care, prevention and adherence counseling;
- b. By the end of the second reporting period at least 25 support groups of PLWHIV will be established and trained to provide information and support to promote access to treatment, care, prevention and adherence counseling;
- c. By the end of the third reporting period at least 25 support groups of PLWHIV will be established and trained to provide information and support to promote access to treatment, care, prevention and adherence counseling;

- d. By the end of the fourth reporting period at least 30 support groups of PLWHIV be established and trained to provide information and support to promote access to treatment, care, prevention and adherence counseling;
- e. By the end of the fifth reporting period at least 35 support groups of PLWHIV will be established and trained to provide information and support to promote access to treatment, care, prevention and adherence counseling;

Other Prevention measurable outcomes:

HIV Prevention in the general population:

- a. By the end of the first reporting period at least 300,000 individuals will be reached with other prevention strategies including condom promotion;
- b. By the end of the second reporting period at least 350,000 individuals will be reached with other prevention strategies including condom promotion;
- c. By the end of the third reporting period at least 400,000 individuals will be reached with other prevention strategies including condom promotion;
- d. By the end of the fourth reporting period at least 450,000 individuals will be reached with other prevention strategies including condom promotion;
- e. By the end of the fifth reporting period at least 500,000 individuals will be reached with other prevention strategies including condom promotion;
- f. By the end of the first reporting period at least 30 individuals will be trained in other prevention including condom promotion;
- g. By the end of the second reporting period at least 50 individuals will be trained in other prevention including condom promotion;

- h. By the end of the third reporting period at least 70 individuals will be trained in other prevention including condom promotion;
- i. By the end of the fourth reporting period at least 90 individuals will be trained in other prevention including condom promotion;
- j. By the end of the fifth reporting period at least 100 individuals will be trained in other prevention including condom promotion;
- k. By the end of the first reporting period at least 15,000 individuals will receive Testing and Counseling services for HIV and receive their test results;
- l. By the end of the second reporting period at least 25,000 individuals will receive Testing and Counseling services for HIV and receive their test results
- m. By the end of the third reporting period at least 35,000 individuals will receive Testing and Counseling services for HIV and receive their test results
- n. By the end of the fourth reporting period at least 45,000 individuals will receive Testing and Counseling services for HIV and receive their test results
- o. By the end of the fifth reporting period at least 55,000 individuals will receive Testing and Counseling services for HIV and receive their test results

HIV Prevention among youths:

- a. By the end of the first reporting period at least 20,000 individuals will be reached with interventions focused on abstinence and/or being faithful;
- b. By the end of the second reporting period at least 30,000 individuals will be reached with interventions focused on abstinence and/or being faithful;

- c. By the end of the third reporting period at least 40,000 individuals will be reached with interventions focused on abstinence and/or being faithful;
- d. By the end of the fourth reporting period at least 50,000 individuals will be reached with interventions focused on abstinence and/or being faithful;
- e. By the end of the fifth reporting period at least 60,000 individuals will be reached with interventions focused on abstinence and/or being faithful;
- f. By the end of the first reporting period at least 40 peer educators will be trained to promote condom use and other risk reduction strategies;
- g. By the end of the second reporting period at least 60 peer educators will be trained to promote condom use and other risk reduction strategies;
- h. By the end of the third reporting period at least 90 peer educators will be trained to promote condom use and other risk reduction strategies;
- i. By the end of the fourth reporting period at least 110 peer educators will be trained to promote condom use and other risk reduction strategies;
- j. By the end of the fifth reporting period at least 220 peer educators will be trained to promote condom use and other risk reduction strategies;

Prevention with Positives (PwP):

- a. By the end of the first reporting period at least 1,000 people living with HIV/AIDS (PLHIV) will be reached with a minimum package of PwP interventions;
- b. By the end of the second reporting period at least 1,300 people living with HIV/AIDS (PLHIV) will be reached with a minimum package of PwP interventions

- c. By the end of the third reporting period at least 1,600 people living with HIV/AIDS (PLHIV) will be reached with a minimum package of PwP interventions
- d. By the end of the fourth reporting period at least 1,800 people living with HIV/AIDS (PLHIV) will be reached with a minimum package of PwP interventions
- e. By the end of the fifth reporting period at least 2,000 people living with HIV/AIDS (PLHIV) will be reached with a minimum package of PwP interventions

STI Prevention and Management:

- a. By the end of the first reporting period at least 80 health workers will be trained in Syndromic Management of sexually transmitted infections to improve case management:
- b. By the end of the second reporting period at least 100 health workers will be trained in Syndromic Management of sexually transmitted infections to improve case management
- c. By the end of the third reporting period at least 120 health workers will be trained in Syndromic Management of sexually transmitted infections to improve case management
- d. By the end of the fourth reporting period at least 140 health workers will be trained in Syndromic Management of sexually transmitted infections to improve case management

- e. By the end of the fifth reporting period at least 160 health workers will be trained in Syndromic Management of sexually transmitted infections to improve case management

Prevention with Most at Risk Populations (MARPs) and hard –to-reach populations:

- a. By the end of the first reporting period at least 1,000 Most at Risk Populations (MARP) will be reached with evidence-based interventions and/or meet the minimum standards;
- b. By the end of the second reporting period at least 1,200 Most at Risk Populations (MARP) will be reached with evidence-based interventions and/or meet the minimum standards;
- c. By the end of the third reporting period at least 1,300 Most at Risk Populations (MARP) will be reached with evidence-based interventions and/or meet the minimum standards;
- d. By the end of the fourth reporting period at least 1,400 Most at Risk Populations (MARP) will be reached with evidence-based interventions and/or meet the minimum standards;
- e. By the end of the fifth reporting period at least 1,500 Most at Risk Populations (MARP) will be reached with evidence-based interventions and/or meet the minimum standards;

Community participation:

- a. By the end of the first reporting period at least 40 meetings/workshops with communities leaders will be held to encourage participation and empowerment in the areas of HIV prevention;
- b. By the end of the second reporting period at least 50 meetings/workshops with communities leaders will be held to encourage participation and empowerment in the areas of HIV prevention;
- c. By the end of the third reporting period at least 60 meetings/workshops with communities leaders will be held to encourage participation and empowerment in the areas of HIV prevention;
- d. By the end of the fourth reporting period at least 70 meetings/workshops with communities leaders will be held to encourage participation and empowerment in the areas of HIV prevention;
- e. By the end of the fifth reporting period at least 80 meetings/workshops with communities leaders will be held to encourage participation and empowerment in the areas of HIV prevention;
- f. By the end of the first reporting period at least 60 community health workers will be trained in community mobilization, HIV prevention and income-generating activities;
- g. By the end of the second reporting period at least 80 community health workers will be trained in community mobilization, HIV prevention and income-generating activities;

- h. By the end of the third reporting period at least 120 community health workers will be trained in community mobilization, HIV prevention and income-generating activities;
- i. By the end of the fourth reporting period at least 150 community health workers will be trained in community mobilization, HIV prevention and income-generating activities;
- j. By the end of the fifth reporting period at least 200 community health workers will be trained in community mobilization, HIV prevention and income-generating activities;

TB/HIV measurable outcomes:

By end of the budget period the grantee would have:

- a. Counseled and Tested for HIV, at least 95% of TB patients on treatment.
- b. Conducted screening on at least 80% of HIV infected individuals for TB
- c. Provided Cotrimoxazole prophylaxis to at least 90% of the TB co-infected patients
- d. Provided training to at least 50 health care workers in the revised World Health Organization TB modules and Multi-Drug TB management
- e. Provided training to at least 100 community health care providers in the revised facilitators manual for training TB treatment supporters
- f. Conducted quarterly TB and TB/HIV data review and TB/HIV coordinating meetings at the province and the districts
- g. Conducted quarterly technical support supervision to the districts to provide capacity to the health care providers

- h. Conducted renovations to four facilities in each district to accommodate TB/HIV activities.

This announcement is only for non-research activities supported by the Centers for Disease Control and Prevention within HHS (HHS/CDC). If research is proposed, the application will not be reviewed. For the definition of research, please see the CDC Web site at the following Internet address:

<http://www.cdc.gov/od/science/regs/hrpp/researchDefinition.htm>

II. PROGRAM IMPLEMENTATION

Recipient Activities:

Partners receiving HHS/CDC funding must place a clear emphasis on developing local indigenous capacity to deliver HIV/AIDS related services to the *Zambian* population and must also coordinate with activities supported by *Zambian*, international or 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) of these funds is responsible for activities in multiple program areas.

The grantee will implement activities both directly and, where applicable, through sub-grantees; the 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. The grantee must show measurable progressive reinforcement of the capacity of 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 **Zambia**. The grantee will produce an annual operational plan, which the U.S. Government Emergency Plan team on the ground in **Zambia** will review as part of the annual Emergency Plan review-and-approval process managed by the Office of the U.S. Global AIDS Coordinator.

The 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:

Strengthen the National Electronic Health Record system and provide creative solutions to fill gaps in the system, particularly related to the areas of service delivery, workforce

capacity and development, the medical product supply chain, health information systems, financing and leadership or governance. This may include, for example, supporting specific pre-service or in-service training sessions, human resource support, improvement to data systems, or supporting an integrated supply chain.

1. HIV care, support, and treatment:

- a. Provide comprehensive care including appropriate prophylaxis and treatment for opportunistic infections (OI) including tuberculosis (TB) and sexually transmitted infections (STIs), according to national guidelines.
- b. Provide ART according to national guidelines and algorithms that cover when and how to initiate therapy, use first- and second-line regimens, and use regimens for special circumstances, such as pregnancy, co-infection with TB, and where appropriate, children.
- c. Evaluate and manage adverse effects of drugs.
- d. Maintain adequate clinical records.
- e. Provide referrals for additional care and support needs.
- f. Provide monitoring and care for HIV-infected persons not yet eligible by medical criteria for ART.
- g. Provide leadership in the implementation of comprehensive HIV treatment services to the district medical offices (DMO) and other partners in the province;
- h. Strengthen the mentorship program aimed at improving quality of care through support to clinical care teams;

- i. Strengthen existing ART sites by providing continuing medical education to staff trained in ART;
- j. Ensure that ART is readily available for HIV positive pregnant women;
- k. Train health workers in the provision of quality and cost effective care for ART patients;
- l. Support DMO to provide mobile ART services in remote and hard to reach areas;
- m. Strengthen early detection and management of cervical cancer (CC) in HIV patients;
- n. Train health workers in cervical cancer(CC) screening and sensitization of the community in all the ART sites;
- o. Procure CC screening supplies to integrate screening of CC in ART sites;
- p. Assess ART sites, provide technical and logistical support to the ART sites in order for them to attain Medical Council of Zambia accreditation standards.
Regional medical offices will support infrastructure improvements at ART sites in order to increase ART access;
- q. Host bi-annual clinical symposia to improve HIV/AIDS management and allow exchange of experience and views by clinicians;
- r. Strengthen the clinical mentorship program that is improving the quality of care for TB and HIV/AIDS patients in the province; and

2. Prevention of Mother to Child Transmission (PMTCT):

While PMTCT programs are on-going under an existing award with an international partner, implementation under this funding announcement will be transitioned gradually to a local partner and scaled-up over the period of the project.

This set of activities are being implemented and will need to continue under this award

- a. Continue scaling-up number of PMTCT Sites in the province to optimize geographical coverage of services
- b. Continue to scale-up on the number of maternal child health sites with ART/PMTCT Integrated services for optimized delivery of more efficacious regimens and access by ANC clients to full ART services
- c. Scale-up & sustain ANC HIV counseling and testing rates
- d. Training health workers in PMTCT based on the MOH guidelines
- e. Training health workers in quality improvement and assurance (QI/QA) for full institutionalization of QI/QA systems in all implementing sites
- f. Training community health workers, traditional birth attendants (TBA), and peer educators in community tracking of mother-baby pairs for prevention of defaulting, community mobilization and community support to affected/infected families
- g. Support community work aimed at community tracking of mother-baby pairs for prevention of defaulting, community mobilization and community support to affected/infected families
- h. Training/orient MCH health personnel in TB screening
- i. Provide supervision and mentoring to all implementing sites on regular basis

- j. Continue to implement innovative and contextually appropriate strategies for improved dried blood spots (DBS) turnaround time
- k. Promote re-testing of HIV negative clients and particularly those in discordant relationships antenatally and throughout the Breast Feeding period
- l. Promote retention of HIV exposed babies and their mothers in care and treatment services for early infant diagnosis (EID), care, support, and appropriate treatment.
- m. Promote couple CT and male involvement in ANC through implementation of innovative strategies, contextually tailored towards rural, peri-urban and urban settings
- n. Implement strategies for HIV screening of siblings of the index child
- o. Implement activities for enhanced linkage of post partum women & their partners/other children to care and treatment services
- p. Implement innovative and contextually relevant strategies to ensure effective integration of HIV CT programs with family planning services and integration of PMTCT activities with youth friendly sexual and reproductive health services at all levels
- q. Implement programs for strengthening of TB screening for all HIV positive pregnant women within MCH facilities

3. Strengthen laboratory services to support HIV care, support, treatment and

PMTCT services:

- a. Offer comprehensive and quality clinical laboratory services in HIV rapid test Hematology, Chemistry, and CD4 counts to HIV/AIDS patients.
- b. Conduct Early infant Diagnosis (EID) to HIV exposed infants

- c. Improving and strengthening laboratory information / communication and results reporting systems
- d. Improve and strengthen the specimen referral system from health facilities to the diagnostic centers thus improving on the turnaround time (TAT).
- e. Establish / strengthen and enhance Laboratory diagnostic capacities for Microbiology, OI and sexually transmitted infections (STI)
- f. Trainings to be conducted in relevant clinical disciplines including OI.
- g. Improve Laboratory infrastructure and strengthen equipment maintenance and laboratory safety.
- h. Improve and sustain energy source through design, installation and maintenance of appropriate energy system to ensure continuous supply of electricity for the laboratories within its network.

4. Community Mobilization and behavior Change:

The successful grantee will promote community-based HIV/AIDS service delivery systems and activities, while supporting creative community-based HIV/AIDS treatment, care and support initiatives and establishing linkages with non-governmental, community-based, and faith-based organization (NGO/CBO/FBO) settings. They will also progressively expand population and geographical coverage with quality treatment and care interventions, and build capacity for community leadership, support and involvement of these programs. The grantee will provide and support activities that include:

- a. Facility and community/home-based counseling and testing aimed at early identification of HIV-infected persons, and their linkage to and retention in HIV treatment, care and prevention services.
- b. Train community health workers to conduct outreach activities to promote health seeking behavior, defaulter tracing and adherence education for HIV patients including pre ART patients.
- c. Support to community prevention services that incorporate the “prevention with positives” (PwP), HIV testing and counseling of sex partners and family members; support for disclosure of HIV test results to sex partners and family members,
- d. Provide psychosocial support, which may include mental health care, group and individual counseling, training and support for caregivers in treatment adherence;
- e. Encourage the establishment of self-support groups among HIV positive patients that will encourage patients access to treatment, care and support, adherence and prevention with positives;

5. Male circumcision services:

- a. Increase access to safe male circumcision (MC) by increasing the number of health facilities offering comprehensive MC that includes CT for HIV and surgical removal of the foreskin, renovating the existing infrastructure, and building capacity of the clinic staff and community health workers;
- b. Expand MC services to all the major hospitals and health centers in the provinces.
- c. Establish MC teams at each health facility in order to create favorable and safe MC environment;

- d. Procure necessary MC surgical equipment, and translation of MC information in local languages;
- e. Ensure stronger community participation through community mobilization and sensitization;
- f. Integrate MC services as part of routine health services and create linkages between MC and ART sites and a strong referral system for those testing positive for early access to ART services;
- g. Integrate MC interventions with strong HIV prevention messages and HIV CT services;
- h. Engage and educate community leaders to assist in community mobilization for MC services; and
- i. Train already present community health workers to include MC messaging in their package of community health education.

6. Other Sexual Prevention:

The grantee will coordinate and implement HIV prevention activities that include comprehensive HIV education among the general population, in and out of school youths and among high-risk groups and other vulnerable populations (MARPs). Activities should be designed to achieve clear behavior change objectives by addressing individual behaviors, social norms and structural barriers to prevention and use biomedical interventions relevant to the population and setting. They will promote comprehensive and combination prevention interventions at facility and community levels to influence positive behavioral outcomes that contribute to reduced risk taking in order to achieve reductions in HIV infection rates.

Grantee activities for this program will include, but not limited to, the following:

HIV Prevention among the general population:

- Support activities and training to promote abstinence, including delay of sexual activity or secondary abstinence, fidelity, partner reduction and related social and community norms as part of a balanced prevention message approach, with elements of abstinence and be faithful programs done in tandem with condom social marketing where appropriate. Activities should also educate individuals on the availability of routine, confidential counseling and testing.

HIV Prevention among youths:

- a. Intensify HIV prevention services targeting young people through youth based life-skills training, education on and distribution of male and female condoms, and promotion of overall Adolescent Sexual Reproductive Health services in all districts;
- b. Collaborate with the Ministry of Education to develop and implement HIV prevention programs within the school health programs, including training of health care providers and teachers in behavior change communication and skills building to prepare youths for delayed, safer and healthier transition to sexual activity;
- c. Improve and strengthen youth friendly corners in all districts and facilities for out of school youth;
- d. Train peer educators in all districts and facilitate the role-out of peer education programs at health facility and community levels to address HIV prevention;

Condom and other prevention strategies:

- a. Support the purchase and promotion of condoms and improve the dissemination of messages that promote consistent and correct use of condoms as an effective means of reducing the risk of infections by persons engaged in high-risk behaviors;
- b. Support and implement prevention with positives (PwP) approach that include HIV testing and counseling of sex partners and other family members; support for disclosure of HIV test results to sex partners and family members and promote condom use and other risk reduction measures;

STI Prevention and Management:

- a. Improving the care and treatment of sexually transmitted infections (STIs) by improving STI diagnostic and management capacities and strengthen community education on STI prevention, partners notification and treatment compliance;
- b. Train health workers in syndromic Management of sexually transmitted infections to improve case detection and management;

Prevention with MARPs:

- Coordinate and implement interventions targeted at most at high-risk groups such a men who have sex with men (MSM), female sex workers (FSW), transportation workers (TW), uniformed servicemen, prison populations and other vulnerable individuals and groups;

Community participation:

- a. Strengthen partnerships with the community by engaging community leaders in driving prevention activities; conducting prevention group meetings and train

community health workers in behavior change communication for more effective community outreach activities;

- b. Support HIV prevention programs on community radio stations and lead the development and dissemination of behavior change communication materials in local languages in order to promote and facilitate community and household dialogue around HIV prevention;
- c. Promote community leadership and positive social norms that encourage men to take a lead in matters of HIV prevention and to recognize and support the fight against gender based violence and other gender based vices and inequalities that contributes to the spread of HIV;
- d. Provide psychological and social support, which may include mental health care, group and individual counseling including social support in vocational training, income-generating activities, social and legal protection, and training and support for community health workers to enhance HIV prevention;

Workplace programs:

- a. Promote workplace HIV policies and program that incorporate counseling and testing of employees and family members;
- b. Train managers in each district to implement the MOH HIV work-place policy and programs;

7. TB/HIV program:

- a. Provide Counseling and Testing for HIV to all TB patients and provide strong linkages between the TB and HIV programs for early referral of co-infected patients to ART services to determine eligibility.

- b. Conduct screening of HIV infected individuals for TB and refer patients with active TB disease to the TB program for management
- c. Provide Cotrimoxazole prophylaxis to co-infected TB patients
- d. Provide training to health care providers in the revised World Health organization TB and TB/HIV modules and Multi Drug Resistant TB
- e. Provide training to community health care providers in the revised Facilitators manual for training TB treatment supporters
- f. Conduct provincial and district quarterly TB and TB/HIV data review meetings to identify the weaknesses and strength of the program and share best practices
- g. Conduct quarterly provincial and district TB/HIV coordinating body meetings
- h. Conduct quarterly technical support supervision to the districts to build capacity among the health care providers
- i. Conduct renovations to infrastructure to accommodate TB and HIV programs and ensure to facilitate TB infection control.

8. Strategic Information:

- a. Continue to develop and sustain Software Development human capacity that can sustain and Support the National EHR system
- b. Strengthen provision of logistical and financial support for routine provincial supervisory visits to assure laid down procedures on normal EHR operations are being adhered to;
- c. Strengthen health data flow process and mechanisms from the facility level to the national level by ensuring adherence to data flow procedures at all levels of the Ministry of Health hierarchy;

- d. Continue support for trainings for various health staff related to the implementation and support of the National EHR;
- e. Provide feedback in the development, implementation and routine review of the National EHR system training curriculum;
- f. Continued provision of financial support for the purchase of equipment and consumables as well as the subsequent deployments and maintenance required for the effective operations of the national EHR system in the province.
- g. Develop and implement reusable National EHR training materials for facility, District and Provincial and levels
- h. Provide stewardship for overall provincial implementation, maintenance and use of data for the National EHR system
- i. Disseminate guidelines and policies that assure effective functionality of the National EHR system
- j. Continue strengthening and maintenance of the Health Care Information and Communication Technology (ICT) Infrastructure to provide an effective, reliable, timely and sustainable EHR.

CDC Activities:

The selected applicant 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 is 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 the grantee to brief it 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 as necessary to the process used by the 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 to the 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 to the 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 the grantee to assess monthly expenditures in relation to approved work plan and modify plans, as necessary.

6. Meet on a quarterly basis with the grantee to assess quarterly technical and financial progress reports and modify plans as necessary.
7. Meet on an annual basis with the 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 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 the 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 the 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 the grantee with protocols for related evaluations.
17. Work with the US Government Interagency Team and other implementing partners, at the regional and district level to select districts and provinces for support activities, to align activities, avoid duplication, and achieve program efficiencies using PEPFAR Funds. Collaborate with CDC and USG Interagency teams in evaluating needs and support for the Government of Zambia

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.

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

Fiscal Year Funds: FY 2011

Approximate Current Fiscal Year Funding: \$7,395,000

Approximate Total Project Period Funding: \$175,000,000 (This amount is an estimate, and is subject to availability of funds and includes direct costs for international organizations for all years.)

Approximate Number of Awards: 3

Approximate Average Award: \$2,465,000 (This amount is for the first 12 month budget period, and includes direct costs for international organizations.)

Floor of Individual Award Range: None

Ceiling of Individual Award Range: None (This ceiling is for the first 12 month budget period and includes direct costs for international organizations.)

Anticipated Award Date: September 2011

Budget Period Length: 12 months

Project Period Length: Five Years

Throughout the project period, CDC's commitment to continuation of awards will be conditioned on the availability of funds, evidence of satisfactory progress by the recipient (as documented in required reports), and the determination that continued funding is in the best interest of the Federal government.

IV. ELIGIBILITY

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

1. Lusaka Provincial Health Office (LPHO);
2. Eastern Provincial Health Office (EPHO); and
3. Western Provincial Health Office (WPHO)

Justification:

Zambia is administratively divided into nine provinces and 72 districts. In the health sector, the provincial medical offices (PMOs) provide overall leadership, technical assistance, and technical supportive supervision to the district health offices in the areas of service-delivery management, the planning of health programs, priority-setting, and the use of resources. The PMOs are an arm of the Government of the Republic of Zambia (GRZ) under the Ministry of Health (MOH) and therefore have the authority to conduct core public health. The MOH is the governmental body that sets the standards and protocols involving health care and delegates only to SPMO to implement, coordinate, and monitor provincial public health policy and activities through the District Health Offices (DHO) in the provinces of Zambia.

As a governmental office, the PMOs also have the unique ability and authority to 1) collect clinical and public information, 2) train staff, and 3) advocate for policy based on the experiences learned from implementing the activities described in this announcement. The PMOs are uniquely qualified for this award because of its comprehensive technical and management relationship with the Zambian national Ministry of Health, nongovernmental organizations (NGOs), and community- and faith-based institutions that are currently implementing activities to address the HIV/AIDS epidemic in provinces in Zambia.

The PMOs are the only entities that have the authority and ability to decentralize and strengthen activities at district and health facility levels by ensuring that the bulk of funds for capacity development, infrastructure improvement, technical support, district and

health centre specific performance improvement activities, and training are directly disbursed to the DHOs. While the DHOs do primary implementation at health facility level, the PMO technical implementation teams focus on facilitating initiatives including program development, monitoring and evaluation, technical support supervision, and delivering technical assistance.

The Lusaka, Eastern, and Western PMOs are the GRZ mandated leads on coordinating and providing oversight to all public health interventions and partners in their respective provinces. A system of quarterly partnership coordination meetings which provide an opportunity for the PMOs and partners to collectively plan, implement, monitor and review activities already exists.

Since 2006, CDC has partnered with Eastern, and Western Provincial Health Offices and since 2008, CDC has partnered with Lusaka Provincial Health office via five year cooperative agreements. These PHOs and CDC have developed a working relationship that has resulted in intensive capacity building and system strengthening. The PHOs have used PEPFAR funds to strengthen their capability to set provincial health policy priorities and strategic plans, monitor and evaluate health care delivery, and coordinate between the districts of the respective provinces and the national Ministry of Health. PEPFAR funds support LPHO, EPHO, and WPHO to oversee a network of district level health offices and management teams and assist in the development of quality assurance, referral, surveillance, and evaluation systems. PEPFAR funds enhance the PHOs' ability

to address the health issues of HIV, sexually transmitted infections (STI), and TB at all levels of the health care system and with the appropriate technical expertise.

With the advent of PEPFAR II, sustainability and capacity building of local organizations are key elements to the program in Zambia. Developing host government country ownership and leadership is the cornerstone of the Partnership Framework which is currently being developed by the USG and Government of the Republic of Zambia. In this spirit, this funding opportunity announcement is designed to transition the provision of HIV/AIDS care, treatment, and prevention services from international NGOs to the local Zambian government. The activities specified in this project are specific to the provincial health offices.

The new project as outlined in this funding opportunity announcement will continue to support the activities of the expiring cooperative agreements and the mission of the Ministry of Health in Eastern, and Western Province of Zambia. In Lusaka Province, this announcement will expand activities to include the provision of ART care and treatment. As the majority of staff working on the cooperative agreements in the provinces are MOH salaried civil servants, both the expiring and current cooperative agreements and this FOA are truly supporting the GRZ and MOH mandate in the HIV/AIDS sector. The past five years of working with CDC has facilitated the establishment and strengthening of systems in order for the health sector to respond to the challenges of HIV/AIDS and TB in a more structured and systematic manner in Lusaka, Eastern, and Western Provinces. The support has improved human and infrastructure capacities, overall

partner coordination and guidance, and development of innovations and initiatives which have been recognized and adopted as standards at national level.

SPECIAL ELIGIBILITY CRITERIA: Licensing/Credential/Permits

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.

Maintenance of Effort

Maintenance of Effort is not required for this program.

Special Requirements:

1. 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.

2. 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.
- If the total amount of appendices includes more than 80 pages, the application will not be considered for review. For this purpose, all appendices must have page numbers and must be clearly identified in the Table of Contents.
- An HIV/AIDS related funding matrix must be submitted in order for the application to be considered for review. All applicants must indicate whether they are receiving other HIV/AIDS related funding. If the applicant is receiving or has applied for other HIV/AIDS related funding, the following information must be submitted:
 - ✓ Funding mechanism (i.e. contract, CoAg, grant)
 - ✓ Amount of award
 - ✓ Period performance
 - ✓ Funding agency
 - ✓ Contact details for funding agency

- ✓ Brief description of program activities
- 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.

Intergovernmental Review of Applications

Executive Order 12372 does not apply to this program.

V. APPLICATION CONTENT

Unless specifically indicated, this announcement requires submission of the following information:

A Project Abstract must be completed in the Grants.gov application forms. 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.

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.

A Project Narrative must be submitted with the application forms. The project narrative 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
- *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);
- *Evidence of Legal Organizational Structure; and*
- *If applying as a Local Indigenous Partner*, provide documentation to self-certify the applicant meets the PEPFAR local partner definition listed in “Special Requirements,” Part IV. ELIGIBILITY section of the FOA.

Additional requirements for additional documentation with the application are listed in Section VII. Award Administration Information, subsection entitled “Administrative and National Policy Requirements.”

APPLICATION SUBMISSION

Registering your organization through www.Grants.gov, the official agency-wide E-grant website, is the first step in submitting an application online. Registration information is located on the “Get Registered” screen of www.Grants.gov. Please visit www.Grants.gov at least 30 days prior to submitting your application to familiarize yourself with the registration and submission processes. The “one-time” registration process will take three to five days to complete. However, the Grants.gov registration process also requires that you register your organization with the Central Contractor

Registry (CCR) annually. The CCR registration can require an additional one to two days to complete.

International organizations also require a NATO CAGE Code (NCAGE). The NCAGE request may take from two business days to two weeks to complete. NCAGE is needed before registering with the Central Contractor Registry (CCR). After registering with CCR, the applicant can proceed to register with Grants.gov. (See “Other Submission Requirements” session below for more information)

Submit the application electronically by using the forms and instructions posted for this funding opportunity on www.Grants.gov. If access to the Internet is not available or if the applicant encounters difficulty in accessing the forms on-line, contact the HHS/CDC Procurement and Grant Office Technical Information Management Section (PGO-TIMS) staff at (770) 488-2700 for further instruction.

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” email 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 check the status of their application to ensure submission of their application package is complete and no submission errors exists. To guarantee that you comply with the application deadline published in the Funding Opportunity Announcement, applicants are also 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 application deadline date.

In the event that you do not receive a “validation” email within two (2) business days of application submission, please contact Grants.gov. Refer to the email 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.

Other Submission Requirements

A letter of intent is not applicable to this funding opportunity announcement.

Dun and Bradstreet Universal Number (DUNS)

The applicant is required to have a Dun and Bradstreet Data Universal Numbering System (DUNS) identifier to apply for grants or cooperative agreements from the Federal government. The DUNS is a nine-digit number which uniquely identifies business entities. There is no charge associated with obtaining a DUNS number. Applicants may obtain a DUNS number by accessing the Dun and Bradstreet website or by calling 1-866-705-5711. This is a requirement for domestic and international organizations.

Central Contractor Registration (CCR)

The applicant is required to have a CCR registration to apply for grants or cooperative agreements from the Federal government. For more information on CCR and how to register go to www.ccr.gov.

Other Submission Requirement for International Organizations:

NATO CAGE Code (NCAGE)

After obtaining DUNS, the applicant is required to have a NATO CAGE Code in order to apply for grants or cooperative agreements from the Federal government. Applicants can complete the request online at www.dlis.dla.mil/forms/Form_AC135.asp. If the organization cannot submit this form by Internet, the organization can obtain an NCAGE by contacting the National Codification Bureau of the country where the organization is located. For a list of addresses, go to www.dlis.dla.mil/nato_poc.asp. Please note that NCAGE code is required for international organizations in order to register with the Central Contractor Registration (CCR) and Grants.gov.

Electronic Submission of Application:

Applications must be submitted electronically at www.Grants.gov. Electronic applications will be considered as having met the deadline if the application has been successfully made available to CDC for processing from Grants.gov on the deadline date.

The application package can be downloaded from www.Grants.gov. Applicants can complete the application package off-line, and then upload and submit the application via the Grants.gov Web site. The applicant must submit all application attachments using a PDF file format when submitting via Grants.gov. Directions for creating PDF files can be found on the Grants.gov Web site. Use of file formats other than PDF may result in the file being unreadable by staff.

Applications submitted through Grants.gov (<http://www.grants.gov>), are electronically time/date stamped and assigned a tracking number. The AOR will receive an e-mail notice of receipt when HHS/CDC receives the application. The tracking number serves to document submission and initiate the electronic validation process before the application is made available to CDC for processing.

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 except federal holidays. 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.

Organizations that encounter technical difficulties in using www.Grants.gov to submit their application must attempt to overcome those difficulties by contacting the Grants.gov Support Center (1-800-518-4726, support@grants.gov). After consulting with the Grants.gov Support Center, if the technical difficulties remain unresolved and electronic submission is not possible to meet the established deadline, organizations may submit a request prior to the application deadline by email to PGO TIMS for permission to submit a paper application. An organization's request for permission must: (a) include the Grants.gov case number assigned to the inquiry, (b) describe the difficulties that prevent electronic submission and the efforts taken with the Grants.gov

Support Center (c) be submitted to PGO TIMS at least 3 calendar days prior to the application deadline. Paper applications submitted without prior approval will not be considered.

If a paper application is authorized, the applicant will receive instructions from PGO TIMS to submit the original and two hard copies of the application by mail or express delivery service.

Submission Dates and Times

This announcement is the definitive guide on application content, submission, and deadline. It supersedes information provided in the application instructions. If the application submission does not meet the deadline published herein, it will not be eligible for review and the applicant will be notified the application did not meet the submission requirements.

Application Deadline Date: April 7, 2011, 5:00pm U.S. Eastern Standard Time

VI. APPLICATION REVIEW INFORMATION

Eligible 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 of effectiveness must be objective, quantitative and measure the intended outcome of the proposed program. The measures

of effectiveness must be included in the application and will be an element of the evaluation of the submitted application.

Evaluation Criteria

Eligible applications will be evaluated against the following criteria:

Ability to Carry Out the Proposal (20 points):

The applicant should be a Zambian government provincial office and must demonstrate local experience in the respective province of Zambia and institutional capacity (both management and technical) to achieve the goals of the project with documented good governance practices. Does the applicant have and demonstrate the ability to coordinate and collaborate with the Zambian government activities, 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? Does the applicant show evidence of leadership support and evidence of current or past efforts to enhance HIV prevention and should have the capacity to reach rural and other underserved populations in Zambia? Does the applicant have the ability to target audiences that frequently fall outside the reach of the traditional media, and in local languages and should provide letters of support from the Regional medical offices?

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 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 proposal build on and complement the current national response 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 (e.g., the numbers of sites to be supported, number of clients the program will reach)? Does the applicant show the extent they 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 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? Does the capacity building plan clearly describe how it will contribute to a) improved quality and geographic coverage of service delivery to achieve the "3,12,12"¹ targets of the President's Emergency Plan?

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

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 applicant's plan include indicators developed for each program milestone, and incorporated into the financial and programmatic reports and are the indicators consistent with the President's Emergency Plan Indicator Guide? The system must be 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. The plan must be able to measure outcomes of the intervention, and the manner in which they will be provided. The monitoring and evaluation plan must be consistent with the principles of the "Three Ones."² "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.

million HIV infected and affected persons, including five million orphans and vulnerable children; and prevent twelve million infections worldwide.

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.

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 and must display an understanding of the Five-Year Strategy and goals of the President's Emergency Plan? The applicant must justify the need for this program within the target community.

Personnel (10 points):

The organization's staff who will work on this project must be fluent in local languages and must have clearly defined staff roles. The staff must be sufficient to meet the goals of the proposed project. The staff involved in this project must be qualified to perform the tasks described and their curricula vitae provided should demonstrate 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):

The applicant must 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. The management structure for the project must be sufficient to ensure speedy implementation of the project. The applicant must 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. The 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?

Funding Restrictions

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

- Recipients may not use funds for research.
- Recipients may only expend funds for reasonable program purposes, including personnel, travel, supplies, and services, such as contractual.
- The direct and primary recipient 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.
- Reimbursement of pre-award costs is not allowed.

- 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 the grantees fiscal year, the 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). The 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 the 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 applicant can obtain guidance for completing a detailed justified budget on the CDC website, at the following Internet address:

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

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) 2011, the limit is no more than 8 percent of the country's FY 2011 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 percent/\$2 million single partner ceiling. Single-partner funding limits will be determined by PEPFAR after the submission of the COP(s). Exclusions from the 8 percent/\$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 percent 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 percent/\$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 2011 grants and cooperative agreements (for as many fiscal years as applicable) in Zambia. 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 (“recipient”) 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 recipient 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 the recipient has a religious or moral objection. Any information provided by recipients 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 recipient 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 recipients 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. Recipients must agree that HHS may, at any reasonable time, inspect the documents and materials maintained or prepared by the recipient in the usual course of its operations that relate to the organization’s compliance with this section, “Prostitution and Related Activities.”

All prime recipients that receive U.S. Government funds (“prime recipients”) 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 recipient's name] certifies compliance with the section, ‘Prostitution and Related

Activities.’”) addressed to the agency’s grants officer. Such certifications by prime recipients are prerequisites to the payment of any U.S. Government funds in connection with this document.

Recipients' 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. The recipient shall refund to HHS the entire amount furnished in connection with this document in the event HHS determines the recipient has not complied with this section, “Prostitution and Related Activities.”

Any enforcement of this clause is subject to Alliance for Open Society

International v. USAID, 05 Civ. 8209 (S.D.N.Y., orders filed on June 29, 2006 and August 8, 2008)(orders gaining preliminary injunction) for the term of the Orders.

The List of the members of GHC and InterAction is found at:

http://www.usaid.gov/business/business_opportunities/cib/pdf/GlobalHealthMemberlist.pdf.

Application Review Process

All eligible applications will be initially reviewed for completeness by the Procurement and Grants Office (PGO) staff. In addition, eligible applications will be jointly reviewed for responsiveness by HHS/CDC Global AIDS Program staff and PGO. 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 eligibility and/or published submission requirements.

An objective review panel will evaluate complete and responsive applications according to the criteria listed in Section VI. Application Review Information, subsection entitled “Evaluation Criteria”. The panel may include both U.S. Federal Government and non-U.S. Federal Government participants.

Applications Selection Process

Applications will be funded in order by score and rank determined by the review panel unless funding preferences or other considerations stated in the FOA apply.

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

VII. AWARD ADMINISTRATION INFORMATION

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 the recipient and CDC. The NoA will be signed by an authorized Grants Management Officer and e-mailed to the program director. A hard copy of the NoA will be mailed to the recipient fiscal officer identified in the application.

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

Administrative and National Policy Requirements

Successful applicants must comply with the administrative requirements outlined in 45 Code of Federal Regulations (CFR) Part 74 or 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-15 Proof of Non-Profit Status
- AR-21 Small, Minority, and Women-Owned Business
- 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
- AR-29 Compliance with EO13513, “Federal Leadership on Reducing Text Messaging while Driving”, October 1, 2009
- AR-30 Section 508 Compliance

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>.

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

Reporting Requirements

Each funded applicant must provide CDC with an annual Interim Progress Report submitted via www.grants.gov:

1. The interim progress report is due no less than 90 days before the end of the budget period. The Interim Progress Report will serve as the non-competing continuation application, and must contain the following elements:
 - a. Standard Form (“SF”) 424S Form.
 - b. SF-424A Budget Information-Non-Construction Programs.
 - c. Budget Narrative.
 - d. Indirect Cost Rate Agreement.
 - e. Project Narrative.
 - f. Activities and Objectives for the Current Budget Period;

- g. Financial Progress for the Current Budget Period;
- h. Proposed Activity and Objectives for the New Budget Period Program;
- i. Budget;
- j. Measures of Effectiveness, including progress against the numerical goals of the President's Emergency Plan for AIDS Relief for Zambia; and
- k. Additional Requested Information;

Additionally, funded applicants must provide CDC with an original, plus two hard copies of the following reports:

- 2. Financial Status Report (SF 269), no more than 90 days after the end of the budget period.
- 3. Final performance and Financial Status Reports, no more than 90 after the end of the project period.

These reports must be submitted to the attention of the Grants Management Specialist listed in the Section VIII below entitled “Agency Contacts”.

VIII. AGENCY CONTACTS

CDC encourages inquiries concerning this announcement.

For **programmatic technical assistance**, contact:

Dr. Alwyn Mwinga, Project Officer

Department of Health and Human Services

Centers for Disease Control and Prevention

American Embassy Lusaka Zambia

PO Box 31617

Telephone: +260-211-250-955

E-mail: MwingaA@zm.cdc.gov

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

Teresa Kidd, Grants Management Specialist

Department of Health and Human Services

CDC Procurement and Grants Office

2920 Brandywine Road, MS: K-75

Atlanta, GA 30341

Telephone: 770-488-2793

E-mail: ibq5@cdc.gov

For **assistance with submission difficulties**, contact Grants.gov (see page 103):

Phone: 1-800-518-4726

Email: support@grants.gov

Hours of Operation: 24 hours a day, 7 days a week. Closed on Federal holidays.

For **application submission** questions, contact:

Technical Information Management Section

Department of Health and Human Services

CDC Procurement and Grants Office

2920 Brandywine Road, MS E-14

Atlanta, GA 30341

Telephone: 770-488-2700

Email: pgotim@cdc.gov

CDC Telecommunications for the hearing impaired or disabled is available at:

TTY 1-888-232-6348

Other Information

Other CDC funding opportunity announcements can be found on Grants.gov Web site,

Internet address: <http://www.grants.gov>.