

AMENDMENT II (3/22/2012):

- i) *Page 6 – The application deadline date has been extended from March 26, 2012 to April 9, 2012.*
- ii) *Pages 23-24 - The following language has been revised under Award Information:*
Approximate Current Fiscal Year Funding: \$10,000,000
Approximate Total Project Period Funding: \$70,000,000 (This amount is an estimate, and is subject to availability of funds and includes direct costs for international organizations or direct and indirect costs for domestic grantees for all years.)
Approximate Average Award: \$3,333,333 (This amount is for the first 12 month budget period, and includes direct costs for international organizations or direct and indirect costs for domestic grantees.)
Ceiling of Individual Award Range: \$10,000,000 (This ceiling is for the first 12 month budget period and includes direct costs for international organizations or direct and indirect costs for domestic grantees.)
Budget Year 2 Ceiling amount: \$15,000,000
Budget Year 3 Ceiling amount: \$15,000,000
Budget Year 4 Ceiling amount: \$15,000,000
Budget Year 5 Ceiling amount: \$15,000,000
- iii) *Page 32 - The following language has been added under The 8% Rule: Under PEPFAR, US Government agencies in Malawi, including CDC and USAID, coordinate to efficiently support implementation of Malawi's Health Sector Strategic Plan. The Office of the Global AIDS Coordinator has issued the following guidance to USG agencies in reference to the use of PEPFAR funds: "avoid duplication of resources programmed by different USG agencies to the same implementing organization for the same purposes (e.g., two USG agencies funding the same partner to provide the same assistance to orphans or antiretroviral treatment). This will minimize the burden on the partner as well as USG staff." As such, PEPFAR Malawi would like to avoid situations where different USG agencies program resources to the same implementing organization for the same purpose. This guidance and the USG partners and partner activities existing at the time will be considered when award selection(s) are made.*

When choosing districts for this solicitation, it should be kept in mind that potential future CDC awards will not duplicate work being conducted in areas currently covered by existing USAID awards.

AMENDMENT I (2/16/2012):

- i) Questions and answers:*
- 1. Can CDC please clarify whether the Cooperative Agreement will be awarded for the entire project period, with levels of funding determined on an annual basis?**
 - *This is a 5 year Cooperative Agreement with levels of funding determined annually based on performance and available funding*
 - 2. Can CDC please clarify the process for obtaining award funding after Year 1 (for Years 2 – 5)?**
 - *A continuation application is submitted each year for approval*
 - 3. What amount or percentage of program funds does CDC expect to be granted directly to districts targeted through the project? (Reference: Task 1.9, page 18)**
 - *This will depend on the needs and capacity of the districts*
 - 4. Will the cost of infrastructure/refurbishing come directly from awardee budget and if so what amount or proportion of the budget does CDC expect to be expended on these activities? (Reference: Task 4.1, page 19)**
 - *Cost of refurbishing will come from the awardee budget*
 - 5. Reference: Activity #6, page 21 – does CDC expect that the tasks and corresponding outcomes listed under Activity 6 will be achieved through implementation of tasks under Activities 1 – 5, or does CDC expect the applicant to propose additional interventions in support of the tasks under Activity 6?**
 - *Interventions should be included which address each of the tasks to the extent possible*
 - 6. Can CDC please confirm that the Project Narrative is to be double-spaced? We are concerned that we will not be able to present an adequate response, describing strategy and activities to be conducted during the project period, nor address all of the evaluation criteria, in the space allotted (25 pages, double spaced or 12.5 pages, single-spaced).**
 - *The Project narrative must be double-spaced and page limited as per pages 28 of the announcement*
 - 7. Are applicants permitted to use different font and spacing in tables/matrices presented in the Project Narrative?**
 - *As above, and as per the announcement:*
 - *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;*
 - *Page margin size: One inch;*

- *Number all narrative pages; not to exceed the maximum number of pages.*
8. *Does the guidance on the font, spacing, and margins apply to the appendices? (Reference: guidance on appendices on page 30)*
 - *Yes*
 9. *Reference: Project Narrative instructions, page 28 - Can CDC please clarify whether this presentation of the Project Narrative is to be followed in the application, or whether applicants are expected to follow the evaluation criteria beginning on page 31? We are concerned that strict adherence to the outline on pages 23 & 24 will not allow applicants to fully address the evaluation criteria.*
 - *Applicants should follow the instructions regarding the project narrative outline while including information necessary to evaluate the proposal as per the criteria*
 10. *Reference: Project Narrative instructions, pages 23 and 24 – Are applicants permitted to combine such items as project goals and objectives, project outputs, project outcomes and performance indicators into one presentation of the performance monitoring plan? Likewise, may the applicant present the project workplan with a timeline included?*
 - *Yes*
 - *Yes*
 11. *Reference: V. Application Review Information (first paragraph), page 31 - Can CDC please clarify whether the phrase “measures of effectiveness” are intended to apply to the Measurable Outcomes on pages 2 – 8 of the RFA?*
 - *Yes*
 12. *Will information included in appendices be taken into consideration with the evaluation criteria/scoring?*
 - *Yes, but please note the restrictions around what can be included in the appendices*
 13. *Page 11 of the RFA states that “this program will have up to three distinct levels of engagement (or “models”) within districts”. Please clarify if CDC will confirm models for each district or if it is up to the applicant to suggest models for focus districts*
 - *The levels of engagement can be suggested by the applicant, but will ultimately depend on districts selected for prioritization in collaboration with MOH and CDC, and on what ongoing activities are already in those districts*
 14. *Page 11 states that this program will provide direct funding to zones or districts through subgrants. Similarly, page 13 states that this program will provide subgrants to zones or districts for implementation of activities. Please clarify if this means that applicants should provide direct subgrants to Government zones and*

- districts or if it means that applicants should provide subgrants to implementing partners (NGOs) in the districts/zones.*
- *Applicants should provide direct subgrants to the Government of Malawi (zones or districts) for implementation of activities*
15. *Page 18 states that CDC will issue 1-3 awards. Please clarify if these 3 awards will be organized by geographic regions. If not, please clarify how the different awards will be divided*
- *This will be determined at the time awards are made, based on the applications*
16. *Page 23 of the RFA states the project narrative must be a maximum of 25 pages. Please clarify whether a title page, table of contents, and acronym list will be counted towards the page limit.*
- Please follow the outline of documents to be submitted in Grants.gov. You will see Mandatory Documents and Optional Documents*
17. *Please confirm if the technical application must be structured in line with the instructions provided on page 23 (Project context and background, project strategy: description of methodologies, project goals and objective etc.)*
- *Yes*
18. *Please confirm the amount of US Government PEPFAR funding in Malawi for FY 2012.*
- *A final figure is not yet available*
19. *On page 28, it says that applicants must provide in their proposals the dollar value by US 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.” Please confirm that this as a requirement for the prime applicant only.*
- *Please provide information for all sub-applicants*
20. *Page 28 states that evidence of legal organizational structure can be included in an appendix. Please clarify that it is sufficient for the prime applicant to include this information.*
- *This information should be included for any sub-partners in the application*
21. *Page 28 states “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 III. ELIGIBILITY INFORMATION section of the FOA; and Organizational Chart, Organizational History and Governance, History of Work in Malawi, and Established Roles in the Malawi health sector. Please clarify that this only applies to a local organization applying as a prime applicant.*
- *This information should be included for any sub-partners in the application*
22. *Our understanding is that CDC’s design of the project may require additional facility staff and/or increased salaries of current facility staff, from what source are these funds expected to come?*

- *From this Cooperative Agreement*
23. *The FOA mentions that in order to improve the basic health infrastructure of facilities, equipment and facility renovations and/or refurbishments may be required, what is the expected source of funds for these types of activities?*
- *This Cooperative Agreement along with other existing sources of funds*
24. *What role is anticipated for this project in supply chain management directly versus ensuring collaboration with other USG projects like DELIVER? For example, would project funds be used to purchase drug and test kit supplies and improve drug storage?*
- *This will depend on what the critical needs are at the district level and what other funding sources are available*
 - *Infrastructure improvements are a possibility depending on the district(s) chosen*
25. *We have a few questions regarding the districts and models.*
- *Based on our experience implementing HIV and health service delivery interventions using a district approach, we are capable of working in all three of the levels of engagement models. Do you expect the proposal to respond to one, two, or all three of the proposed models, or will that depend on the extent of the scope proposed by the organization in its application?*
 - *This will depend on the needs of the districts prioritized by MOH*
 - *Will activities be expected to occur in a total of 16 districts with four districts under the “intense” model, eight under the “light” model, and four under the “shared” model?*
 - *The final number is not yet determined*
 - *Have districts already been identified for each of the three models, or will this discussion occur after award?*
 - *Identification of districts will occur post-award*
 - *Are you expecting applicants to work in all 16 districts (4 intense, 8 light, 4 shared), as noted on FOA pg. 11?*
 - *The final number is not yet determined*
26. *Do you expect applicants to meet all the measurable outcomes in all three models? Or do you expect applicants to meet all the measurable outcomes in the intense model and only some of measurable outcomes in the light and shared models? Are there specific outcomes you would like to see in particular districts?*
- *All outcomes are expected in all districts as possible given available funding*
27. *How will the participating districts be selected, and does the COAG partner have a role in selecting districts?*
- *This will be determined by CDC and MOH, with discussion with the awardee*
28. *Are expensive infrastructure interventions described in the outcomes to be supported by the grant or by the Ministry, or by some combination effort?*
- *This will need to be determined based on district needs and available resources through this award and other resources, in collaboration with CDC and the District officials*
29. *Is the budget justification included in the 80 page allotment for appendices?*

- *Budget justification is part of the Mandatory documents to be uploaded in www.grants.gov. It should not be in appendices*

30. Do you have a page limit on individual CVs, or a recommended length?

- *No*

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PART 1. OVERVIEW INFORMATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Federal Agency Name: Centers for Disease Control and Prevention (CDC)

Funding Opportunity Title: District Health System Strengthening and Quality Improvement for Service Delivery in Malawi under the President’s Emergency Plan for AIDS Relief (PEPFAR)

Agency Funding Opportunity Number: CDC-RFA-GH12-1248

Catalog of Federal Domestic Assistance Number: 93.067

Key Dates:

To receive notification of any changes to **CDC-RFA-GH12-1248**, return to the synopsis page of this announcement at www.grants.gov and click on the “Send Me Change Notification Emails” link. An email address is needed for this service.

Application Deadline Date: *April 9, 2012*, 5:00pm U.S. Eastern Standard Time

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

Measurable Outcome #1: By the end of Year 2:

- a) Districts have a comprehensive annual health plan;
- b) Zonal Health Offices have reviewed District Implementation Plans (DIPs) for completeness and quality as per central Ministry of Health (MOH) guidance;
- c) Districts are implementing and monitoring the activities in the annual health plan with quarterly reviews.

MO 1.1: By the end of Year 1, a situation analysis with district specific information will be completed, demonstrating a comprehensive perspective of the local district planning context.

MO 1.2a: By the end of Year 1, a comprehensive toolkit will be developed to support the planning process and identify areas to be changed to improve the delivery of health interventions (e.g. driver diagrams).

MO 1.2b: By the end of Year 1, the toolkit will include a module on “Using Health Management Information System (HMIS) Data for decision-making.”

MO 1.3: By the end of Year 1, target districts will have created program implementation plans in collaboration with implementation partners who support the DIP process.

MO 1.4a: By the end of Year 1, extended District Health Management Teams (DHMTs) in target districts have been individually assessed and trained to utilize fiscal, infrastructure and pharmaceutical systems information for planning.

MO1.4b: By the end of Year 1, all committees have clear Terms of Reference (TORs).

MO 1.5: By the end of Year 1, robust, costed annual district health plans will be developed which link activities and funding to outputs, and where possible, to health outcomes.

MO 1.6a: By the end of Year 2, meeting minutes from District health planning meetings will document the presence of implementing partners in the district.

MO 1.6b: By the end of Year 2, quarterly stakeholder meetings will be held to review progress towards objectives, avoid duplication and ensure rational allocation and use of resources.

MO 1.7: By the end of Year 3, 80% of non-MOH facilities will have appropriate Service Level Agreements (SLAs) in place.

MO 1.8: At least one specific strategic information activity will be successfully completed each year and integrated within district planning processes.

MO 1.9: By the end of Year 2, each district will have a subgrant either directly or through a zonal health support office, to implement the activities of this award.

MO 1.10: By the end of Year 2, annual district health plans will include emerging evidence-based health programs.

MO 1.11: By the end of Year 1, reports to CDC will include updates on collaborative efforts of PEPFAR partners in the district.

Measurable Outcome #2: By the end of Year 1, district program implementation plans will clearly cite rationale for approach and source of credible data.

MO 2.1: By the end of Year 1, in collaboration with stakeholders (zones, districts and implementing partners), the partner will have developed a district plan for routine health information systems and a template for use at the district level to feed into HMIS results and interpret into program improvements, and related tools (i.e. LiST, Marginal Budgeting for Bottlenecks [MBB], and Equity Analyses) developed to support facility-based audits to improve clinical care of in-patient services, in addition to maternal death audits.

MO 2.2a: By the end of Year 2, all DHMT and program supervisors will be trained in the use of data for decision-making and conducting data-quality checks.

MO 2.2b: By the end of Year 2, extended DHMTs will be assessed on performance of community level initiatives.

MO 2.3: By the end of Year 2, target districts will have submitted all HMIS and other reportable data by MOH deadlines.

MO 2.4: By the end of Year 3, data from village registers will be routinely compared to health program data to identify under-reporting of illnesses, deaths, home-births, and ensuring community-based maternal death audits are conducted.

MO 2.5a: By the end of Year 3, sustainable and robust electronic information systems will be installed and functioning in all high burden health facilities.

MO 2.5b: By the end of Year 3, complete paper records will be maintained at low burden sites as per MOH guidelines, with all sites in district submitting reports on time.

MO 2.5c: By the end of Year 3, Problem Identification and Program planning modules will be piloted and scaled-up, as an expansion to existing Electronic Medical Records (EMR) modules, to enable analysis of patient care and outcomes to aid clinical audit and for a basis for refining standard operating procedures (SOPs).

Measurable Outcome #3: By the end of Year 2, health facilities in target districts will reach and maintain minimum staffing levels, as per MOH standards.

MO 3.1: By the end of Year 2, each target district will have human resources (HR) Management Policy and SOPs in effect.

MO 3.2: By the end of Year 2, target districts will have identified the number of each cadre required to meet minimum staffing levels; newly graduating staff will have been identified to fill gaps.

MO 3.3: By the end of Year 3, HR monitoring database system will be implemented in target districts (Human Resources Information System).

MO 3.4: By the end of Year 2, performance-based financing (PBF) will be implemented in target districts with criteria including staffing levels and monitoring.

MO 3.5a: By the end of Year 2, each site will have a documented supportive supervision visit once per quarter.

MO 3.5b: By the end of Year 2, each service provider will have been assessed for training/mentoring needs.

MO 3.5c: By the end of Year 2, each district will have reduced critical district and facility level staffing shortages.

Measurable Outcome #4: By the end of Year 2, health facilities in target districts will reach minimum functionality as per MOH standards.

MO 4.1a: By the end of Year 2, each facility will have a documented infrastructure assessment form completed.

MO 4.1b: By the end of Year 2, a plan for renovation, repairs and equipment replacement will be developed.

MO 4.1c: By the end of Year 2, 100% of facilities in target districts will meet minimum standards for basic medical equipment and furniture.

MO 4.1d: By the end of Year 2, 100% of facilities requiring renovations in order to provide SOPs will be supported with infrastructure renovation.

MO 4.2: By the end of Year 1, all DHMT members will have been assessed for knowledge and skills gaps and a plan identified to train them to minimum standards needed for effective district planning, implementation and evaluation.

MO 4.3: By the end of Year 1, the district transportation plan will be developed or revised, including maintenance and insurance components, and driver's training (driving and emergency delivery care).

MO 4.4a: By the end of Year 3, monitoring tools for emergency referral services will be developed/adapted for use in target districts, with reports generated on a quarterly basis.

MO 4.4b: By the end of Year 3, the availability of maternity waiting homes at sub-district hospitals will have increased by 50%.

MO 4.4c: By Year 3, at least 50% of health facilities in the targeted districts will have a minimum of two functional bicycle ambulances operational within their catchment area.

MO 4.4d: By the end of Year 3, an innovative communication system will be piloted in at least one target district, with capability at all facilities in the district.

MO 4.5: By the end of Year 2, each facility will have an annually updated list of support groups and other community-based programs which can strengthen patient referral and follow-ups.

Measurable Outcome #5: By the end of Year 5, 70% of facilities in target districts will reach minimum program and patient outcome targets as per MOH guidance.

MO 5.1a: By the end of Year 1, comprehensive SOPs with an emphasis on integration will be developed and approved by relevant partners and stakeholders.

MO 5.1b: By the end of Year 2, SOPs will be implemented in at least four districts.

MO 5.1c: By the end of Year 2, 90% of staff in target districts will be oriented to operational guidelines.

MO 5.1d: By the end of Year 1, 100% of health facilities in target districts will be included in integrated service delivery plans, which include an assessment of capacity gaps and action plans.

MO 5.1e: By the end of Year 2, an integrated district level Quality Improvement (QI) strategy will be developed.

MO 5.1f: By the end of Year 2, an integrated clinical and health systems mentoring curricula and job aids will be developed, including distance learning training materials, and accredited by Medical and Nursing councils for continuous professional development.

MO 5.2a: By the end of Year 4, 60% of facilities will receive PBF based on improved performance indicators.

MO 5.2b: By the end of Year 4, an assessment of treatment outcomes and patient satisfaction will have been conducted.

MO 5.2b: By the end of Year 3, at least one presentation will have been made domestically and one presentation internationally to disseminate results and best practices.

MO 5.3a: By the end of Year 3, 50% of facilities will receive awards for excellent services provided in the previous quarter.

MO 5.4: By the end of Year 2, 100% of facilities will have an award recognition system with objective criteria implemented to ensure high performing service providers are acknowledged.

MO 5.5: By the end of Year 3, 30% of health care workers will have received an individual recognition award for excellent services provided.

MO 5.5: By the end of Year 3, 100% of district health workers will have been assessed and received training, and can be classified using objective criteria as having the knowledge and skills needed to provide high quality services consistently.

MO 5.6: By the end of Year 3, 100% of facilities will have a comprehensive list of community-based support groups and other programs in the community to support bi-directional referrals, which will be updated semi-annually.

MO 5.7: By the end of year 2, all facilities in target districts will have been assessed for service quality.

MO 5.8 By the end of Year 2, each facility will reach at least 80% of patients screened and/or tested for HIV in antenatal care (ANC), maternity, Tuberculosis (TB), Nutrition Rehabilitation Unit (NRU) and Sexually Transmitted Infections (STI).

Measurable Outcome #6: 100% of direct support activities supported by CDC through this mechanism will be accounted for each year.

MO 6.1a: By the end of Year 3, 50% of sites will be awarded for reaching priority Essential Health Package (EHP) health outcome targets.

MO 6.1b: By the end of Year 3, 50% of facilities will report 0 days out of stock for select tracer items.

By the end of Year 4:

MO 6.2a: 80% of facilities will offer minimum package of integrated HIV services.

MO 6.2b: 50% of clients will have received family planning.

MO 6.2c: 80% of clients will have received Provider Initiated Testing and Counseling (PITC) in high risk settings including TB, STI, ANC, and NRU.

MO 6.2d: 80% of known HIV-positive women in ANC will receive ARVs for Prevention of Mother to Child Transmission (PMTCT).

MO 6.2e: 80% of HIV-positive women in ANC received Cotrimoxazole Preventive Treatment (CPT).

MO 6.2f: 80% of HIV-positive pregnant women will have received antiretrovirals (ARVs) for neonate.

MO 6.2g: 50% of infants receive a PCR test by 8 weeks of age, and have results by 16 weeks of age.

MO 6.2h: 80% of antiretroviral therapy (ART) sites will have <10% loss-to-follow-up.

MO 6.2i: 80% of new patients in ART/pre-ART will have received clinical staging or CD4 count to determine ART eligibility.

MO 6.2j: 80% of those determined as ART-eligible are initiated on ART.

MO 6.2k: 50% of service providers in target districts trained in Male Circumcision (MC).

By the end of Year 3, among HIV-affected populations:

MO 6.3a: 50% of pregnant women will be tested for syphilis;

MO 6.3b: 90% of Emergency Obstetric and Neonatal Care (EmONC) sites will be fully functional;

MO 6.3c: Mortality rate for women with direct obstetric complications will be reduced to <2%.

MO 6.3d: “Fresh stillbirths” and “neonatal deaths before discharge” will be reduced by 50%;

MO 6.3e: At least 50% of EmONC sites will offer post-abortion care;

MO 6.3f: At least 5% of deliveries in target districts will be by caesarian.

MO 6.4a: By the end of Year 3, among HIV-affected populations, 80% of suspected malaria cases will be confirmed using rapid tests.

MO 6.4b: By the end of Year 3, among HIV-affected populations, in-patient case-fatality rate for malaria will be reduced by at least 25%.

MO 6.5: By the end of Year 2, 70% of health facilities will provide the minimum package of community-based EHP services.

This announcement is only for non-research activities supported by 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/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf>.

PART 2. FULL TEXT OF THE ANNOUNCEMENT

I. FUNDING OPPORTUNITY DESCRIPTION

Statutory 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>. The overarching purpose of this FOA is to fund activities to prevent or control disease or injury and improve health, or to improve a public health program or service. Recipients may not use funds for research. Certain activities that may require human subjects review due to institutional requirements but that are generally considered *not* to constitute research (e.g., formative assessments, surveys, disease surveillance, program monitoring and evaluation, field evaluation of diagnostic tests, etc.) may be funded through this mechanism.

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 reduce overall population morbidity and mortality, with an emphasis on HIV, and tuberculosis, mother to child transmission of HIV and maternal and child health. This reduction in population morbidity and mortality will be realized through increasing the effectiveness, sustainability, equity and efficiency of district-based planning, budgeting and implementation processes in selected districts in Malawi, and supporting evidence-based prevention, care and treatment interventions at the facility level. Health systems are dynamic, underpinning the need for districts to develop context specific activities to achieve the desired outcomes, and the need to empower management teams to adapt approaches to effectively scale-up interventions. This will be supported by capacity building which includes both clinical and health systems mentorship and coaching.

This program will be fully aligned with district health service and budget planning processes to ensure full harmonization and district level ownership, in districts identified collaboratively with the Government of Malawi. In addition, evaluation processes to support real-time feedback will be piloted, not only to assess whether interventions work, but also why and how interventions work. The planning and implementation process will be iterative, to allow for adjustments to local contexts and situations and support the identification of key elements to be addressed to strengthen program performance.

This mechanism will develop or adapt performance-based financing at district and facility levels, promoting the provision of improved health services by strengthening leadership and governance, the management of health workforce, information systems, laboratory and other health system components at district level using quality improvement approaches. In addition, this program will optimize health impact across multiple disease areas by supporting specific critical health services (bottleneck areas affecting health outcomes) as defined in district planning, and consistent with priorities identified in Malawi's Health Sector and HIV Strategic Plans. This program will also be aligned with the USG's Malawi Global Health Initiative Strategy and Partnership Framework. This program should use PEPFAR funds to have an impact on health systems strengthening and health impact beyond HIV, but within the legislative limits on the use of PEPFAR funds.

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 *Malawian* population and must also coordinate with activities supported by *Malawian*, international or USG agencies to avoid duplication. Capacity-building plans should address systems, policy, organizational and workforce requirements for strengthening sustainable indigenous capacity to respond to the epidemic. 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 *Malawi*. The grantee will produce an annual operational plan, which the U.S. Government Emergency Plan team on the ground in *Malawi* 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:

This program will have up to three distinct levels of engagement (or “models”) within districts:

- An “intense” model will cover all activities described below in approximately four districts;
- A “light” model will employ activities jointly selected with the MOH and DHMT and will be implemented in approximately eight districts;
- A “shared” model will implement activities jointly selected by the MOH, DHMT and collaborating USG implementing partners in approximately four additional districts.

Key elements of this program include increasing alignment with government and mutual accountability through directly funding zones or districts through sub-grants, while carefully monitoring performance, providing direct financial and technical support to strengthen planning, budgeting, financial and expenditure processes, and integrating strategic information more effectively and directly in district planning. One important element is to assist districts in coordinating all organizations working within the district

to become integrated within and to support the existing district planning process, including the Annual Investment Plan and District Implementation Plan.

Activity #1: Strengthen the district health planning, financial management, implementation and monitoring processes to achieve a robust and effective district level health sector response.

Task 1.1: Carryout consultative meetings, desk reviews and needs assessments as appropriate to develop a thorough understanding of the local district planning context, best practices and previous lessons learned, and opportunities for collaboration and avoidance of duplication with the activities of existing partners.

Task 1.2: Develop a scalable comprehensive and standardized toolkit to support and consolidate district health services planning and strengthen the standardized “Guidelines for the District Implementation Plans,” using data generated at district level to guide planning processes, and including the existing situation analysis, training, procurement and capital investment plans.

Task 1.3: Develop District Program Implementation Plans using standardized toolkits. These plans will support coordination between the district and implementing partners, with direction and benchmarks to measure progress within each year.

Task 1.4: Assess and train the extended DHMTs to use data for decision-making, using appropriate fiscal, infrastructure and pharmaceutical data for planning and implementation. Conduct assessments, follow up on the assessments’ action points, and strengthen and clarify TORs in order to strengthen and build capacity of the committees.

Task 1.5: Directly strengthen the quality and efficiency of the district health planning process in order to arrive at an efficient and high-quality district plan. The plan should be costed, clearly and comprehensively describe the contribution of all partners in the district to different activities, and link activities and funding to outputs, and where possible, to outcomes.

Task 1.6: Ensure all implementing partners in the district(s) participate in planning, including in a situation analysis to guide scale-up, minimize duplication, and ensure rational allocation and use of resources. In addition, collaboratively working to make sure partner resources are maximally utilized towards improved district health outcomes.

Task 1.7: Improve and optimize district planning processes with respect to non-MOH service providers, and implement appropriate SLAs or other mechanisms to provide universal access to the Essential Health Package.

Task 1.8: Support district level strategic information activities aimed at strengthening the district planning process through understanding specific bottlenecks to achieving health impact, disparities and inequities in access to services and health outcomes across the district, and the estimated health impact of achieving different coverage levels of different interventions.

Task 1.9: Support alignment and mutual accountability through providing direct sub-grants to zones or districts for implementation of the activities in this program, starting within the first 6 months of the award. These sub-grants should be maximized to strengthen district ownership and alignment, and be within the capacity of the zones or districts to effectively absorb the funds.

Task 1.10: Support districts and their implementing partners to plan and coordinate the implementation of new health programs, including new guidelines for Clinical Management of HIV in Children and Adults, Elimination of Mother to Child Transmission (EMTCT), new approaches to reducing maternal and child mortality, and Voluntary Medical Male Circumcision (VMMC) for HIV prevention.

Task 1.11: Collaborate proactively with other CDC and PEPFAR partners in the district to ensure maximum impact for investment, and avoid duplication of efforts and resources.

Activity #2: Improve data use for program planning and monitoring

Task 2.1: Develop a district plan and tools to strengthen and integrate routine information systems, including: HMIS; vital registration and Integrated Disease Surveillance and Response (IDSR); and maternal death or near death audit. Develop routine processes of presenting and using data for decision making and creating actionable items resulting from data trends.

Task 2.2: Train DHMT and district program supervisors on use of data for guiding program decision-making, and support better capacity to use data for decisions by facility-level supervisors.

Task 2.3: Improve timely reporting of data from facility to district levels through use of PBF incentives.

Task 2.4: Integrate use of community-level data (i.e. Village Registers) to improve facility- and community-based programming.

Task 2.5: Support robust information systems (electronic and paper) at all levels of the health system within the selected districts.

Activity #3: Support strengthening of Human Resources for Health (HRH) within districts, including recruitment, deployment and retention of health workers using evidence-based and innovative strategies.

Task 3.1: Develop or strengthen an HR Management Policy and SOPs at district level which includes recruitment, deployment, training, and mentoring.

Task 3.2: Collaborate with MOH and Christian Health Association of Malawi (CHAM) to improve recruitment and assignment of newly graduating staff to the district(s), based on need ascertained through an effective HRH assessment tool.

Task 3.3: Implement a district-level database to ensure critical services have adequate staff and skills mix and to support monitoring of staffing levels at each health facility within the district.

Task 3.4: Develop or adapt systems strengthening PBF at district level to incentivize appropriate deployment and monitoring of staffing levels at facilities, so that districts which meet minimum staffing levels are rewarded accordingly.

Task 3.5: Support actions to reduce critical district and facility-level staffing shortages, as well as training, mentoring and supportive supervision, to reduce the key bottlenecks to achieving health impact.

Activity #4: Support Health System Strengthening at District and Facility levels using a multi-prong approach to directly improve health impact.

Task 4.1: Support the improvement of the basic health infrastructure through facility refurbishments and equipping.

Task 4.2: Support leadership, governance and management capacity and functions at the district and facility level, including facility and district level management of the supply chain for essential health commodities.

Task 4.3: Improve transport between facilities, to reduce key bottlenecks to achieving health impact.

Task 4.4: Strengthen emergency referral services through activities including: improving community to facility referrals; ensuring communication capability at facilities; reducing vehicle and provider response time; and maximizing placement of ambulances at sub-district hospitals

Task 4.5: Support sustainable linkages between the health facility and the community, in alignment with national policies.

Activity #5: Improve quality of service delivery at facilities in target districts.

Task 5.1: Consolidate evidence-based HIV and maternal and neonatal initiatives to improve patient outcomes (including HIV care and treatment, including pediatric ART and supporting Option B+, PMTCT including Early Infant Diagnosis (EID), TB and malaria case management, Emergency Obstetric and Neonatal Care (EmONC), Baby Friendly Hospital Initiative (BFHI), Integrated Management of Childhood Illness (IMCI), Emergency Triage Assessment and Treatment (ETAT), etc.). Adapt integrated quality improvement approaches, supported by clinical and health systems mentoring and the utilization of facility-level standard operating procedures (SOPs) which operationalize existing national clinical guidelines at the facility level, with consensus from relevant district and national partners.

Task 5.2: Expand performance-based financing to facility level for those sites which meet the new standards.

Task 5.3: Develop facility level recognition award for excellent services provided utilizing the new standards across program areas: Diagnostics, Care, Treatment, Support Services, and Program Monitoring.

Task 5.4: Develop individual staff recognition award system for excellent services provided across program areas: Diagnostics, Care, Treatment, Support Services, and Program Monitoring.

Task 5.5: Provide training and/or clinical mentoring for staff that consistently underperform in order to ensure skills and knowledge are equal to tasks required for service delivery.

Task 5.6: Link facility-based services with community follow-up and bi-directional referral and support services and strengthen the referral system between community and facility and vice versa.

Task 5.7: In collaboration with national technical working groups and stakeholders, develop, pilot and implement a simple information system for service quality assessment at the facility level, across diseases, which utilizes existing information and tools within districts.

Task 5.8: Ensure each facility has adequate staff to implement PITC in at least ANC, Maternity, TB, NRU, and STI clinics.

Activity #6: Through the above activities, using the PEPFAR definition of “Direct Support,” contribute to the following activities and corresponding outputs and outcomes:

Task 6.1: Support districts to increase coverage of integrated priority EHP services at all levels of care (priorities to be defined by the districts).

Task 6.2: Support districts to scale up integrated HIV and Sexual and Reproductive Health (SRH) services, providing supportive supervision and utilizing electronic systems and/or mobile technology where appropriate (i.e. High burden ART clinics, Return of lab results by SMS).

Task 6.3: Given the high rate of maternal, neonatal and infant mortality among HIV-infected individuals, expand the MOH supportive supervision model to strengthen facility provision of high quality Maternal, Neonatal and Child Health (MNCH) services, ensuring maximum coverage of HIV-affected populations and reducing HIV-related maternal and infant mortality and morbidity.

Task 6.4: Support districts to scale up quality malaria diagnostic and treatment services, ensuring maximum coverage of HIV-affected populations.

Task 6.5: Support districts to increase coverage of minimum standard of community-based EHP services, ensuring maximum coverage of HIV-affected populations and reducing HIV-related maternal and infant mortality and morbidity.

In a cooperative agreement, CDC staff is substantially involved in the program activities, above and beyond routine grant monitoring.

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 conduct of routine data quality assurance processes and periodic data quality assessments and for compliance with 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, to evaluate grantee's performance (including quality of products and achievement of project goals and objectives), 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, evaluate program implementation, manage and analyze data, conduct quality assurance, present and possibly publish program results and findings, and manage and track 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. Conduct periodic site visits and in depth strategic discussions with district officials in collaboration with the grantee and host government officials to target districts.
18. Meet with the grantee on a monthly basis to discuss progress and challenges in successfully implementing this program.
19. Hold regular joint meetings with the grantee and the Malawi Ministry of Health to discuss successes and challenges to successful implementation, and specific technical or administrative policy implications for the Ministry of Health.
20. Hold regular joint meetings between CDC, the grantee and other stakeholders to further define the technical approach to achieving the goals of this award.

II. AWARD INFORMATION

Type of Award: Cooperative Agreement.

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

Fiscal Year Funds: 2012

Approximate Current Fiscal Year Funding: *\$10,000,000*

Approximate Total Project Period Funding: *\$70,000,000* (This amount is an estimate, and is subject to availability of funds and includes direct costs for international organizations or direct and indirect costs for domestic grantees for all years.)

Approximate Number of Awards: 1-3

Approximate Average Award: *\$3,333,333* (This amount is for the first 12 month budget period, and includes direct costs for international organizations or direct and indirect costs for domestic grantees.)

Floor of Individual Award Range: \$250,000

Budget Year 2 Floor amount: \$250,000

Budget Year 3 Floor amount: \$250,000

Budget Year 4 Floor amount: \$250,000

Budget Year 5 Floor amount: \$250,000

Ceiling of Individual Award Range: *\$10,000,000* (This ceiling is for the first 12 month budget period and includes direct costs for international organizations or direct and indirect costs for domestic grantees.)

Budget Year 2 Ceiling amount: *\$15,000,000*

Budget Year 3 Ceiling amount: *\$15,000,000*

Budget Year 4 Ceiling amount: *\$15,000,000*

Budget Year 5 Ceiling amount: *\$15,000,000*

Anticipated Award Date: September 30, 2012

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.

Note: Applicants should only apply for the first budget period funding taking into consideration the first budget period floor and the first budget period ceiling.

III. ELIGIBILITY INFORMATION

Eligible Applicants

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

- Nonprofit with 501C3 IRS status (other than institution of higher education)
- Nonprofit without 501C3 IRS status (other than institution of higher education)
- For-profit organizations (other than small business)
- Small, minority, and women-owned businesses
- Universities
- Colleges
- Research institutions
- Hospitals
- Community-based organizations
- Faith-based organizations
- Federally recognized or state-recognized American Indian/Alaska Native tribal governments
- American Indian/Alaska native tribally designated organizations
- Alaska Native health corporations
- Urban Indian health organizations
- Tribal epidemiology centers
- State and local governments or their Bona Fide Agents (this includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau)
- Political subdivisions of States (in consultation with States)
- Non-domestic (non-U.S.) entity

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

Required Registrations

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). The CCR registration can require an additional one to two days to complete. You are required to maintain a current registration in CCR.

Central Contractor Registration and Universal Identifier Requirements

All applicant organizations **must obtain** a DUN and Bradstreet (D&B) Data Universal Numbering System (DUNS) number as the Universal Identifier when applying for Federal grants or cooperative agreements. The DUNS number is a nine-digit number assigned by Dun and Bradstreet Information Services. An AOR should be consulted to determine the appropriate number. If the organization does not have a DUNS number, an AOR should complete the **US D&B D-U-N-S Number Request Form** or contact Dun and Bradstreet by telephone directly at 1-866-705-5711 (toll-free) to obtain one. A DUNS number will be provided immediately by telephone at no charge. Note this is an organizational number. Individual Program Directors/Principal Investigators do not need to register for a DUNS number.

Additionally, all applicant organizations must register in the Central Contractor Registry (CCR) and maintain the registration with current information at all times during which it has an application under consideration for funding by CDC and, if an award is made, until a final financial report is submitted or the final payment is received, whichever is later. CCR is the primary registrant database for the Federal government and is the repository into which an entity must provide information required for the conduct of business as a recipient. Additional information about registration procedures may be found at the CCR internet site at www.ccr.gov.

If an award is granted, the grantee organization must notify potential sub-recipients that no organization may receive a subaward under the grant unless the organization has provided its DUNS number to the grantee organization.

Other Required Registration 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.

Cost Sharing or Matching

Cost sharing or matching funds are not required for this program.

Maintenance of Effort

Maintenance of Effort is not required for this program.

Other

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

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.

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 Federal funds constituting a grant, loan, or an award.

IV. Application and Submission Information

Submission Dates and Times

This announcement is the definitive guide on LOI and 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: March 26, 2012, 5:00pm U.S. Eastern Standard Time

Applicants must download the SF424 application package associated with this funding opportunity from 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 email: pgotim@cdc.gov, Monday-Friday 7:00am – 4:30pm U.S. Eastern Standard Time for further instruction. CDC Telecommunications for the hearing impaired or disabled is available at: TTY 1-888-232-6348.

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, with the exception of all 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.

Content and Form of Application Submission

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

All applicants are required to sign and submit CDC Assurances and Certifications that can be found on the CDC Web site at the following Internet address:
<http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm>.

Print, scan and upload as an additional attachment into the application package.

Letter of Intent (LOI):

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

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.

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;
- Page margin size: One inch;
- Number all narrative pages; not to exceed the maximum number of pages.

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

- *Project Context and Background (Understanding and Need):* Describe the background and justify the need for the proposed project. Describe the current infrastructure system; targeted geographical area(s), if applicable; and identified gaps or shortcomings of the current health systems and AIDS control projects;
- *Project Strategy - Description and Methodologies:* Present a detailed operational plan for initiating and conducting the project. Clearly describe the applicant's technical approach/methods for implementing the proposed project. Describe the existence of, or plans to establish partnerships necessary to implement the project.

Describe linkages, if appropriate, with programs funded by the U.S. Agency for International Development;

- *Project Goals and Objectives*: Include the goals of the project and its SMART objectives (specific, measurable, achievable, relevant, and time-bound). These need to be consistent with the expected targets of the Country/Regional Operational Plan and for this Cooperative Agreement program as provided in the “Purpose” Section at the beginning of this Announcement;
- *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;
- *Project Outputs*: List the products that will result from the activities to be implemented in this project and that are relevant to the objectives specified in the previous section (e.g., conduct data quality assessment once a year);
- *Project Outcomes*: Include the expected effects of project activities in the target populations and/or organizations (e.g., increased adherence to ART) that are relevant to the project goals and objectives. This will represent the project’s effectiveness;
- *Performance Indicators*: Include measures that will show progress in the achievement of project goals and objectives (e.g., percent of health care workers who graduated from a pre-service training at the end of the reporting period)
- *Timeline* (e.g., GANTT Chart); and
- *Management of Project Funds and Reporting*. Reporting should also address quarterly reports and PEPFAR Semi-Annual (SAPR) and Annual (APR) progress reports.

Project Budget Justification:

With staffing breakdown and justification, provide a line item budget and a narrative with justification for all requested costs *for the first budget period*. 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 project budget justification must be included as a separate attachment of the application, not to be counted in the narrative page limit.

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;

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:**

- *Curricula vitae* of current key staff who will work on the activity, i.e. Principal Investigator and all Senior Staff, including Financial, Administrative, Technical, and Monitoring and Evaluation Officers;
- *Job descriptions* of proposed key positions to be created for the activity;
- *Applicant's Corporate Capability Statement*;
- *Letters of Support* (5 letters maximum), including from the Ministry of Health;
- *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 III. ELIGIBILITY INFORMATION section of the FOA; *and*
- Organizational Chart, Organizational History and Governance, History of Work in Malawi, and Established Roles in the Malawi health sector.

Additional information submitted via Grants.gov should be uploaded in a PDF file format, and should be named accordingly. i.e.: Letters of support should be named "letters of support"

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

Funding Restrictions

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

- All plans for data collection from persons or personal records and for laboratory specimen collection and testing that are expected to result in public reports will require protocols for technical review and review of institutional human subjects protection considerations by CDC. Funds for implementing these activities will be restricted until all necessary institutional protocol approvals have been obtained. Funds for preparatory activities (e.g., protocol development, training, equipment, reagents, and site preparation) may be provided prior to protocol approval. To facilitate the early availability of funding, the budget and narrative should clarify which activities are preparatory.

- All plans for data collection from persons or personal records and for laboratory specimen collection and testing that are expected to result in public reports will require protocols for technical review and review of institutional human subjects protection considerations by CDC. Funds for implementing these activities will be restricted until all necessary institutional protocol approvals have been obtained. Funds for preparatory activities (e.g., protocol development, training, equipment, reagents, and site preparation) may be provided prior to protocol approval. To facilitate the early availability of funding, the budget and narrative should clarify which activities are preparatory.
- Needle Exchange – No funds appropriated under this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.
- Recipients may only expend funds for reasonable program purposes, including personnel, travel, supplies, and services, such as contractual.
- Awardees may not generally use HHS/CDC/ATSDR funding for the purchase of furniture or equipment. Any such proposed spending must be identified in the budget.
- 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.
- ADS funding restrictions which require submission of protocols will be submitted within six months of notification of such requirement, but no later than the end of the first budget year. Requests for exceptions to these deadlines will need to be submitted in writing to the Grants Management Officer.
All protocol approvals should be obtained no later than the end of the second budget period after the award or Continuation has been made, provided that the Grantee submits their protocol no later than the deadline.

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) 2012, the limit is no more than 8 percent of the country's FY 2012 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 2012 grants and cooperative agreements (for as many fiscal years as applicable) in Malawi. For additional information concerning this RFA/APS/FOA, please contact the Grants Officer for this RFA/APS/FOA.

Under PEPFAR, US Government agencies in Malawi, including CDC and USAID, coordinate to efficiently support implementation of Malawi's Health Sector Strategic Plan. The Office of the Global AIDS Coordinator has issued the following guidance to USG agencies in reference to the use of PEPFAR funds: "avoid duplication of resources programmed by different USG agencies to the same implementing organization for the same purposes (e.g., two USG agencies funding the same partner to provide the same assistance to orphans or antiretroviral treatment). This will minimize the burden on the partner as well as USG staff." As such, PEPFAR Malawi would like to avoid situations where different USG agencies program resources to the same implementing organization for the same purpose. This guidance and the USG partners and partner activities existing at the time will be considered when award selection(s) are made.

When choosing districts for this solicitation, it should be kept in mind that potential future CDC awards will not duplicate work being conducted in areas currently covered by existing USAID awards.

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.

Additional Submission Requirements

Electronic Submission

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 Email: pgotim@cdc.gov, Monday-Friday 7:30am - 4:30pm 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 www.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.

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 (www.grants.gov) are electronically time/date stamped and assigned a tracking number. The AOR will receive an e-mail notice of receipt when Grants.gov 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, with the exception of all 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 the GMO/GMS [See Section VII "Agency Contacts"], 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 prevented electronic submission and the efforts taken with the Grants.gov Support Center (c) be submitted to the GMO/GMS at least 3 calendar days prior to the application deadline. Paper applications submitted without prior approval will not be considered.

Intergovernmental Review

Executive Order 12372 does not apply to this program.

V. Application Review Information

Eligible applicants are required to provide measures of effectiveness that will demonstrate the accomplishment of the various identified objectives of the funding opportunity announcement **GH12-1248**. 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.

Criteria

Eligible applications will be evaluated against the following criteria:

Ability to Carry Out the Proposal (25 points):

Does the applicant demonstrate the local experience in Malawi and institutional capacity (both management and technical) to achieve the goals of the project with documented good governance practices? (10 points)

Does the applicant have the ability to coordinate and collaborate with existing Emergency Plan partners and other donors, including the Global Fund and other U.S. Government Departments and agencies involved in implementing the President’s Emergency Plan, including the U.S. Agency for International Development? (5 points)

Is there evidence of leadership support and evidence of current or past efforts to enhance HIV prevention? Does the applicant have the capacity to reach rural and other underserved populations in Malawi? Does the organization have the ability to target audiences that frequently fall outside the reach of the traditional media, and in local languages? To what extent does the applicant provide letters of support? (10 points)

Technical and Programmatic Approach (30 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? (10 points)

Does the applicant display knowledge of the strategy, principles and goals of the President’s Emergency Plan, and are the proposed activities consistent with and pertinent to that strategy and those principles and goals? Does the applicant describe activities that are evidence based, realistic, achievable, measurable and culturally appropriate to achieve the goals of the President’s Emergency Plan? (10 points)

Does the application propose to build on and complement the current national response in with evidence-based strategies designed to reach underserved populations and meet the goals of the President’s Emergency Plan? Does the application include reasonable estimates of outcome targets? (For example, the numbers of sites to be supported, number

of clients the program will reach.) To what extent does the applicant propose to work with other organizations? (10 points)

The reviewers will assess the feasibility of the applicant's plan to meet the target goals, whether the proposed use of funds is efficient, the proportion of funds used for invested in the health system through sub-grants, and the extent to which the specific methods described are sensitive to the local culture.

Capacity Building (15 points):

Does the applicant have a proven track record of building the capacity of indigenous organizations and individuals? Does the applicant have relevant experience in using participatory methods, and approaches, in project planning and implementation? Does the applicant describe an adequate and measurable plan to progressively build the capacity of local organizations and of target beneficiaries to respond to the epidemic? (10 points)

If not a local indigenous organization, does the applicant articulate a clear exit strategy which will maximize the legacy of this project in the intervention communities? Does the capacity building plan clearly describe how it will contribute to a) improved quality and geographic coverage of service delivery to achieve the "3,12,12¹" targets of the President's Emergency Plan, and b) (if not a local indigenous organization) an evolving role of the prime beneficiary with transfer of critical technical and management competence to local organizations/sites in support of a decentralized response? (5 points)

Monitoring and Evaluation (15 points):

Does the applicant demonstrate the local experience and capability to implement rigorous monitoring and evaluation of the project? (5 points)

Does the applicant describe a system for reviewing and adjusting program activities based on monitoring information obtained by using innovative, participatory methods and standard approaches? Does the plan include indicators developed for each program milestone, and incorporated into the financial and programmatic reports? Are the indicators consistent with the President's Emergency Plan Indicator Guide? Is the system able to generate financial and program reports to show disbursement of funds, and progress towards achieving the numerical objectives of the President's Emergency Plan? (5 points)

Is the plan to measure outcomes of the intervention, and the manner in which they will be provided, adequate? Is the monitoring and evaluation plan consistent with the principles

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

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. (5 points)

Understanding of the Problem (5 points):

Does the applicant demonstrate a clear and concise understanding of the current national HIV/AIDS response and the cultural and political context relevant to the programmatic areas targeted? Does the applicant display an understanding of the Five-Year Strategy and goals of the President's Emergency Plan? To what extent does the applicant justify the need for this program within the target community? (5 points)

Personnel (5 points):

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

Administration and Management (5 points):

Does the applicant provide a clear plan for the administration and management of the proposed activities, and to manage the resources of the program, prepare reports, monitor and evaluate activities, audit expenditures and produce collect and analyze performance data? Is the management structure for the project sufficient to ensure speedy implementation of the project? If appropriate, does the applicant have a proven track record in managing large laboratory budgets; running transparent and competitive procurement processes; supervising consultants and contractors; using subgrants or other systems of sharing resources with community based organizations, faith based organizations or smaller non-governmental organizations; and providing technical assistance in laboratory or pharmacy management? (5 points). The grantee must

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.

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?

If the applicants requests indirect costs in the budget, a copy of the indirect cost rate agreement is required. If the indirect cost rate is a provisional rate, the agreement should be less than 12 months of age. The indirect cost rate agreement should be uploaded as a PDF file with "Other Attachment Forms" when submitting via Grants.gov.

The indirect cost rate agreement does not apply to international applicants.

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>.

Funding Preferences (30 points):

In addition to direct consideration of findings from the Objective Review Panel, funding under this award will be subject to several preferences based on programmatic needs and in-country strategic priorities. **Applicants meeting the criteria set forth in these funding preferences will receive additional points beyond the possible total of 100 as follows:**

- A funding preference of 5 points will be applied to local and indigenous organizations.
- A funding preference of 10 points will be applied to organizations that focus on local indigenous partners (inclusive of local organizations referenced in point 1).
- A funding preference of 15 points will be applied to organizations with an established presence in Malawi, and an established role working in the Malawi health sector, with experience working at the district level.

Review and Selection Process

Review

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 Division of Global HIV/AIDS 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 V. Application Review Information, subsection entitled "Criteria". The panel may include both U.S. Federal Government and non-U.S. Federal Government participants.

Selection

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.

In addition, the following factors may affect the funding decision:

- Funding preference will be applied to local and indigenous organizations.
- Funding preference will be applied to organizations that focus on local indigenous partners (inclusive of local organizations referenced in point 1).
- Funding preference will be applied to organizations with an established presence in Malawi, and an established role working in the Malawi health sector, with experience working at the district level.

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

Pre-Application Workshops

CDC Malawi will host a pre-application workshop following posting of this announcement on www.grants.gov. Applicants interested in attending the pre-application workshop should contact Beth Tippet Barr (bbarr@mw.cdc.gov) regarding time, venue, and registration details no later than five days following the posting of this announcement.

VI. 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. Any application awarded in response to this FOA will be subject to the DUNS, CCR Registration and Transparency Act requirements.

Unsuccessful applicants will receive notification of the results of the application review by mail and/or e-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-5 HIV Program Review Panel Requirements
- 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-16 Security Clearance Requirement
- AR-18 Cost Recovery-ATSDR
- AR-19 Third Party Agreements-ATSDR
- AR-20 Conference Support
- 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-26 National Historic Preservation Act of 1966
(Public Law 89-665, 80 Stat. 915)
- AR-27 Conference Disclaimer and Use of Logos
- AR-29 Compliance with E.O. 13513 Federal Leadership on Reducing
Text Messaging While Driving, October 1, 2009.
- AR-30 Information Letter 10-006. – Compliance with Section 508 of the
Rehabilitation Act of 1973

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>.

Reporting

Federal Funding Accountability And Transparency Act Of 2006 (FFATA): Public Law 109-282, the Federal Funding Accountability and Transparency Act of 2006 as amended (FFATA), requires full disclosure of all entities and organizations receiving Federal funds including grants, contracts, loans and other assistance and payments through a single publicly accessible Web site, USASpending.gov. The Web site includes information on each Federal financial assistance award and contract over \$25,000, including such information as:

1. The name of the entity receiving the award
2. The amount of the award
3. Information on the award including transaction type, funding agency, etc.
4. The location of the entity receiving the award
5. A unique identifier of the entity receiving the award; and
6. Names and compensation of highly-compensated officers (as applicable)

Compliance with this law is primarily the responsibility of the Federal agency. However, two elements of the law require information to be collected and reported by recipients: 1) information on executive compensation when not already reported through the Central Contractor Registry; and 2) similar information on all subawards/subcontracts/consortiums over \$25,000.

For the full text of the requirements under the Federal Funding Accountability and Transparency Act of 2006, please review the following website:

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_bills&docid=f:s2590enr.txt.pdf

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. Interim Financial Status Report (SF-269) 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 Malawi; and
 - k. Pipeline Analysis – Expenditures versus budget as identified in work plan, description of challenges, and explanation of unexpected pipeline (high or low).

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

2. Financial Status Report (SF 269) - An annual progress report, due no more than 90 days after the end of the budget period.]
3. Final performance and Financial Status Reports - Due no more than 90 days after the end of the project period.
4. Quarterly Progress Reports – In addition to the Interim Progress Report and the Final performance and Financial Status Reports, quarterly reports are required 90 days after submission of the Final Performance and Financial Status Reports, and, 90 days after submission of the Interim Progress Report. Reports shall include:
 - a. Activities and Objectives for the current quarter;
 - b. Financial progress for the current quarter; and
 - c. Pipeline Analysis – Expenditures versus budget as identified in work plan, description of challenges, and explanation of unexpected pipeline (high or low) for the current quarter.

*Disclaimer: As of February 1, 2011, current Financial Status Report (FSR) requirements will be obsolete. Existing practices will be updated to reflect changes for implementation of the new Federal Financial Reporting (FFR) requirements.

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

Human Subjects Restrictions

Data collection protocols required for release of human subjects funding restrictions must be submitted to the DGHA Science Office within 6 months of notification of such restrictions, but no later than the end of the first budget year. Requests for exceptions to these deadlines will need to be submitted in writing to the Grants Management Officer.

All protocol approvals should be obtained no later than the end of the subsequent budget period after the award or continuation has been made, provided that the Grantee has not been granted an exception to the deadlines specified above.

VII. AGENCY CONTACTS

CDC encourages inquiries concerning this announcement.

For programmatic technical assistance, contact:

Beth Tippett Barr, Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention
Centers for Disease Control and Prevention
US Embassy
PO Box 30016
Lilongwe, Malawi
Telephone: +265 (0) 999 964 630
E-mail: bbarr@mw.cdc.gov

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

Kathy Raible, Grants Management Specialist
Department of Health and Human Services
CDC Procurement and Grants Office
2920 Brandywine Road, MS: K-75
Atlanta, GA 30341
Telephone: 770-488-2045
E-mail: kraible@cdc.gov

For assistance with **submission difficulties**, contact:

Grants.gov Contact Center 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 **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 770-488-2783.

VIII. Other Information

Amendments, Questions and Answers (Q&As)

Applicants must submit their Q&As, if any, to the Project Officer listed under the Agency Contacts Section of this announcement no later than 15 days after the publication date in www.grants.gov. All amendment and Q&As will be published in grants.gov following the approval of CDC. No amendments or Q&As will be accepted past the due date.

For additional information on reporting requirements, visit the CDC website at: http://www.cdc.gov/od/pgo/funding/grants/additional_req.shtm.

Other CDC funding opportunity announcements can be found on Grants.gov Web site, Internet address: <http://www.grants.gov>.