

AMENDMENT I (02/20/2013)

1. Page 1 – Correct due date to be April 15, 2013
2. Pages 19-20 – added the following:
 - D. Tete
 - E. Sofala
 - F. Manica
 - G. Niassa
3. Pages 45-46 – added the following:
 - D. Tete DPS
 - E. Sofala DPS
 - F. Manica DPS
 - G. Niassa DPS
4. Page 50 – Correct due date to be April 15, 2013
5. Page 86 – Delete: CDC will accept Q&As from applicants until 10 days prior to application due date. No amendments or Q&As will be accepted past this date.

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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: “Improving Implementation of Programs for Care & Treatment of HIV/AIDS in the Republic of Mozambique under the President’s Emergency Plan for AIDS Relief (PEPFAR)”

Announcement Type: New – Type 1

Agency Funding Opportunity Number: CDC-RFA-GH GH13-1317

Catalog of Federal Domestic Assistance Number: 93.067

Key Dates:

Application Deadline Date: April 15, 2013 on www.grants.gov, 11:59 pm Eastern Standard Time.

Program outcomes will include:

Program Area: Biosafety

FOA Objective(s): Scale up and strengthen the healthcare worker (HCW) infection prevention and control (IPC) program at central, provincial and Facility levels reinforcing the institutionalization of the program and reducing transmission of HIV and other health care associated infection (HCAI) among health care workers and patients.

- Outcomes:
 - Expanded IPC program implementation managed by functional facility-based IPC committees to 50% of facilities implementing ARV
 - Improved the % of HCW receiving appropriate post-exposure prophylaxis (PEP) for occupational exposure
 - Improved the compliance of facilities with IPC standards to 80% of facilities implementing ARV complying with 60% of IPC standards
 - IPC program institutionalized within MOH systems at 80% of TARV implementing facilities
 - Improved surveillance system operational for selected HCAI at MOH

- Reduced number of HCW hazards/incidents/occupational exposure to HIV and other HCAI

Program Area: Cervical Cancer

FOA Objective(s): To improve early diagnosis and treatment at primary health care level.

- Outcomes:
 - Improved workforce capabilities to implement cervical cancer screen and treat programs
 - Improved organizational capacity and availability of supplies and equipment for visual inspection with acetic acid (VIA) and cryotherapy
 - Expanded access to cervical cancer screening and treatment programs at primary health care facilities
 - Expanded implementation of cervical cancer screening and treatment programs at primary health care facilities
 - Improved detection and treatment of cervical cancer at primary health facilities

Program Area: HIV in the workplace

FOA Objective(s): Promote healthier health care force, reduce new HIV infections and mitigate HIV impact amongst Health Care Workers (HCW) and families.

- Outcomes:
 - Increased awareness about HIV, post-exposure prophylaxis (PEP) and workplace safety (WPS) among HCW
 - Improved organizational capacity to manage occupational exposures with 80% of facilities implementing comprehensive flowchart for cases of occupational exposure to biological hazards, and actively notifying all exposures to HIV in the workplace
 - Expanded workplace safety and health programs established in all health settings

- Reduced number of HIV infections among HCW as a result of occupational exposures

Program Area: Counseling and Testing

FOA Objective(s): Strategically scale up, intensify and improve quality of Counseling and Testing (CT) to link as many HIV positive people and their partners to appropriate services.

- Outcomes:
 - Increased number ARV sites implementing provider initiated counseling and testing (PICT)
 - Increased # of institutions strategically offering community CT to target populations
 - Increased capability of health staff in and outside of health units to offer quality HIV testing and counseling (HTC) services
 - Increased capacity of MOH staff to manage, supervise, monitor and evaluate the HTC program
 - Improved quality of HTC services offered at all locations, with effective linkages of patients to other prevention, care and treatment services

Program Area: Human Resources for Health

FOA Objective(s): Strengthen the capacity of the MOH to plan, source, coordinate, manage and retain human resources for health through improvements in policy, infrastructure, information and quality assurance systems.

- Outcomes:
 - Human Resources for Health Information System (HRIS) is implemented and in use for human resource management decision-making in all Provinces, and at least piloted in 2 Districts per Province
 - Training Information System(TIS) for pre-service and in-service TIS is effectively used for HCW training decision-making in all Health Science Institutes and Provinces

- Health Institutes and Provinces are better able to forecast needed resources to expand the training of human resources to keep pace with the accelerated plan
- Web-based system established, increasing numbers of health workers trained via the web-based system
- 100% of the Health Science Institutes have adequate resources to provide quality of training for needed health resources
- Improved production of graduates of health sciences in accordance with the quota needs of the accelerated plan.
- The number and focus of Health Science Institutes is expanded to meet changing health needs of the population
- Management and functioning of the district and provincial health system becomes more efficient, with better resource allocation, better planning of supply chain, human resource needs, fiscal management
- Essential information on health trainee numbers, expected availability by area and specific career, and forecasting capacity of needs, is made available and improved through appropriate utilization, analyses and reporting of quality health training data

Program Area: Laboratory

FOA Objective(s): Strategically expand access to quality laboratory services to support disease detection, treatment, control and prevention, increase the quality and quantity of laboratory workforce and strengthen the management structure of the laboratory network at central, provincial and district levels.

- Outcomes:
 - Access to laboratory testing services for HIV increased to reach 85% coverage
 - Recruitment and retention of laboratory personnel increased by 75%
 - At least 6 clinical laboratories accredited according to International Standards
 - Dependency of MOH on PEPFAR for laboratory reagents decreased by 80%
 - Dependency of MOH on PEPFAR program support for lab maintenance contracts decreased by 80%
 - MOH ownership , leadership and management of lab strengthening programs

Program Area: Most at Risk Populations and Mental Health

FOA Objective(s): Improve access to related health services and contribute to the efforts of the Government of Mozambique to prevent new HIV infections by reducing HIV transmission rates among most at risk populations.

- Outcomes:
 - Health units with registration, and referral systems for key populations in use in place
 - Condoms available for distribution in all key services
 - Improved % of healthcare professionals promoting consistent and proper use of condoms
 - Improved availability of consumables rapid test kits for drug screening, HIV and hepatitis
 - National guidelines for prevention, care and treatment of most at risk populations fully disseminated and being implemented
 - Improved awareness of risk behaviors among most at risk populations
 - 100% of mental health professionals with strengthened capability to serve most at risk populations

Program Area: Positive Prevention

FOA Objective(s): Scale up provision of positive prevention services to improve well-being of people living with HIV (PLHIV) and reduce onward transmission of HIV.

- Outcomes:
 - Increase implementation of prevention with positives (PP) package
 - Improved quality of PP services delivered
 - Increased number of PLHIV accessing quality PP services
 - National prevention with positives strategy disseminated and in implementation
 - PP data available at national level to inform program planning
 - MOH demonstrates increased leadership and ownership of PP program

- Improved adherence to HIV care by PLHIV and improved quality of life of PLHIV

Program Area: Prevention of Mother to Child Transmission (PMTCT)

FOA Objective(s): To eliminate MTCT (up to < 5% by year 2015) and keeping their mothers alive through provision of universal access to ART to 90% of HIV+ pregnant and lactating women.

- Outcomes:
 - Increased people with access to HIV primary prevention
 - Increased number of women who know their serostatus in MCH services
 - Increased awareness on sexual and reproductive rights among adolescents and
Increased number of women with access to family planning
 - Increased utilization of maternal, neonatal, and child health (MNCH) services
 - Increased provision of comprehensive and integrated PMTCT services
 - Improved capabilities of PMTCT service providers for management of HIV infection including the provision of ART
 - Increased identification of women eligible for PMTCT
 - Increased number of pregnant women who receive ARVs
 - Increased number of defaulter women identified
 - Increased number of pregnant women adhering to PMTCT services
 - Increased provision of follow up services to HIV exposed infants (HEI)
 - Improved rate of infected HEI identified early and with timely referred for care and treatment
 - Reduced HIV infection among women of childbearing age
 - Reduced unwanted pregnancies , particularly among HIV+ women
 - Reduced MTCT of HIV to <5% by 2015

Program Area: Strategic Information

FOA Objective(s): Improve strategic information systems for health through support for the HIS and M&E of National Strategic Plans

- Outcomes:
 - Increased capacity of provincial and district staff to collect and use data for decision making
 - Increased in implementation of data quality assurance (DQA) activities for HIV
 - National norms and standards implemented and monitored for strategic information systems
 - Improved integration and harmonization of HIV strategic information systems into health information systems
 - Increase in availability and quality of key data for use by MOH staff for HIV program planning, monitoring and evaluation
 - Data quality improved by 80%
 - Improved health services decision-making based on accessible, high quality data
 - Increased DPS ownership and leadership of strategic information systems

Program Area: Sexually Transmitted Infections

FOA Objective(s): To improve early diagnosis and treatment at primary health care level.

- Outcomes;
 - Improved integration of sexually transmitted infection (STI) services at pre ART and ART service sites
 - Improved access, early diagnosis and appropriate treatment of STIs among patients and their sexual partners
 - Improved capability of health care providers at pre-ART and ART sites to provide STI screening and management services to patients
 - Improved detection of syphilis in primary health facilities
 - Improved supervision of STI services at treatment sites
 - Improved quality of STI services through early diagnosis and effective treatment

Program Area: Traditional Medicine

FOA Objective(s): Involve Traditional Medicine Practitioners (TMPs) in activities such as referral and linkages with health facilities of the patients to receive clinical care.

- Outcomes:
 - Increased number of empowered TMPs in prevention and transmission of disease matters
 - Referral system between TMPs and health facilities in place
 - Increased number of TMPs performing community HIV services
 - M& E System in place for TMP programs
 - TMP's trained to form groups of associated health interventions at their places of work / residence
 - Communities and health personnel with a closer link between the TMPs and other community activists
 - Myths and taboos about pollution, food and health in general reduced the locations where they operate the PMT's trained.
 - Community health programs with greater involvement of TMP's

Program Area: Tuberculosis/HIV

FOA Objective(s): To reduce the prevalence and mortality in TB and HIV co-infected patients through early diagnosis and provision of appropriate treatment in adults and children.

- Outcomes
 - Availability of educational material in health facilities increased.
 - Number and percentage of TB and HIV receiving treatment for TB and HIV increased
 - Increase in availability of reliable data on TB services
 - Improved access, early diagnosis and appropriate treatment for both TB and HIV improved
 - Number of health facilities treating drug-resistant tuberculosis (DR-TB) patients using updated norms increased
 - DR-TB patient's outcomes improved

- Improved management of DR-TB cases based on the use of quality data for decision making
- Improved access, early diagnosis and appropriate treatment DR-TB
- Increased TB case detection rate
- Decreased mortality due to TB and HIV

Program Area: Pre-Antiretroviral Therapy (ART)

FOA Objective(s): To reduce early death and lost to follow-up of pre-ART patients through integrated HIV care and treatment services.

- Outcomes:
 - Improved capability of health care providers in HIV care and diagnosis of opportunistic infections
 - Increased pre ART retention to 70% at 12 months
 - Increased pre ART patients receiving CTX prophylaxis to 80%
 - Improved integration of care and treatment services
 - Improved access, early diagnosis and appropriate treatment.
 - Reduced mortality and lost to follow-up

Program Area: Adult and Pediatric Treatment

FOA Objective(s): To scale-up treatment coverage for the adult and pediatric treatment eligible population in Mozambique, improve counseling and support and expand universal treatment.

- Outcomes:
 - Expanded use of single dose TDF/3TC/EFV in 100% of ART sites
 - Strengthened linkages between community and clinic services in 75% of ART sites
 - Strengthened use of clinical data and quality improvement in ART and PMTCT sites
 - Improved quality of services in ART and PMTCT sites
 - Improved pre-ART retention rate from 40% to 80%
 - Increase ART coverage to 80% in both children and adults

- Reduced HIV related mortality in adults and children by 40%
- Retention after 36 months on ART increased to 70 %
- Improved management of treatment failure to 90% of confirmed patients with ART failure switched to 2nd line treatment
- Effective linkages established between community and clinic services in 75% of ART sites

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; and

- 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 (research is not supported in this FOA).

The rapid scale up of HIV/AIDS programs in recent years in Mozambique requires improved approaches to technical assistance and capacity building to achieve the goals laid out by the Mozambique Ministry of Health (MoH), the President's Emergency Plan for AIDS Relief (PEPFAR) and the Partnership Framework that was signed between the US Government (USG) and the Government of Mozambique (GoM) in August 2010. Program sustainability and government management of programs are a priority in this Partnership Framework over the next five years. Included in the Partnership Framework, is language referring to the USG PEPFAR program plans to transition management and ownership of programs from international non-governmental organizations (NGOs) to the GoM and Mozambican organizations and support the multisectoral efforts to increase the capacity of civil society to lead the response against HIV in Mozambique.

The goal and objectives of the program in Mozambique is to develop and strengthen the direct implementation of HIV care and treatment services by the provincial level government in Mozambique. This will engage the provincial governments in the continued expansion and sustenance of quality HIV services without life-threatening disruptions of services to the people who need them.

Once awarded, CDC will work with the implementing partner to identify priority activities for the first year. The objectives below represents a comprehensive list of all possible activities that could occur throughout the 5-year project period.

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

Laboratory

1. Appropriately staff and capacitate personnel within the provincial Laboratory Department.
2. Increase laboratory personnel at provincial level to manage the expanding laboratory network and point of care testing.
3. Implement Logistic Management Information System in all district laboratories to strengthen the laboratory commodity supply chain to reduce stockouts of reagents and consumables at health facility level.
4. Transition reagent management from PEPFAR to the province.
5. Implement revised pre-service laboratory curriculum in respective Centros de Formacao.
6. Establish provincial capacity to deliver in-service laboratory training
7. Transition implementation and management of Laboratory Information Systems to the Provincial Health Directorate (DPS).
8. Use data from Lab Information Systems and Provincial Laboratory Indicators to monitor performance of laboratory network.
9. Implement and monitor Provincial Laboratory Quality Program.

10. Guarantee the quality of laboratory testing through international accreditation of central and provincial laboratories and national certification of district and health center laboratories.

Biosafety

1. Improve healthcare worker (HCW) infection prevention and control (IPC) practices at facility level.
2. Disseminate and coordinate implementation of IPC policies, guidelines and protocols in the province.
3. Introduce a Surveillance system for selected healthcare associated infections (HCAI).
4. Improve and disseminate updated reference and training materials for IPC.
5. Develop and implement standard indicator to monitor IPC implementation.
6. Increase the number of health facilities with IPC committee established and fully implementing the program.
7. Increase number of HCW receiving post-exposure prophylaxis (PEP) timely for occupational exposure.

Cervical Cancer

1. Improve access to cervical cancer prevention, care and treatment services.
2. Increase awareness about the disease and its risk factors.
3. Strengthen health systems through training of health professionals, integration of services, surveillance and monitoring and evaluation.

HIV in the workplace

1. Promote key workplace safety interventions.
2. Improve HCW IPC practices at facility level.
3. Ensure that all health facilities have a PEP manager.
4. Ensure that at least 80% of workers are trained in PEP.
5. Implement WPS activities including the “worker consultation”, prioritizing HIV, TB and immunization.
6. Increase acceptability and access to Care and Treatment (C&T) and ART to HCW and families.
7. Reduce stigma and discrimination among HCW and patients.

Counseling and Testing

1. Strengthen, mainstream into standard health services, and strategically scale up Provider-initiated Counseling and Testing (PICT) activities focusing on health services with the highest diagnostic yield (TB services, antenatal care (ANC), STI) in target areas (*high population density, high HIV prevalence*).
2. Strengthen Counseling and Testing in Health (ATS) to reach persons at health facilities not reached through PICT and those who walk in voluntarily.
3. Strategically scale up community-based CT to access **target populations** (*partners of PLH; MARPs; Adolescent girls; men; couples*) **in target areas** (*high population density, high HIV prevalence*) and link them to appropriate follow-up services.
4. Strengthen the linkages between HTC services and other prevention, care and treatment services.

Human Resources for Health

1. Strengthen HRH management and utilization through the implementation of appropriate policy changes.
2. Expand Health Institutes capacity for training so that increasing numbers of quality trained health workers are available to meet the increasing demands of the health system.
3. Strengthen planning, forecasting and decision capacity at the DPS's Human Resources Department through improvements on information systems at Provincial and District levels.

Most At-Risk Populations (MARPS)

1. Increase access and strengthen the capacity of health services to provide quality of health care to key populations.
2. Increase uptake of CT and linkages to HIV care and treatment services as well male circumcision.
3. Decrease reporting of vaginal and anal STIs.
4. Increase correct and consistent use of condoms (male and female) and adherence to health care services.
5. Implement Guidelines on MARPS assistance.

6. Implement treatment programs and rehabilitation for individuals with alcohol dependence and drug rehabilitation.

Positive Prevention

1. Integrate PP services so that they are provided to HIV-positive patients on an ongoing basis.
2. Develop and implement standard methods for documenting PP services.
3. Integrate PP Monitoring and Evaluation (M&E) in the existing M&E MOH monitoring system.
4. Strengthen the human resource capacity of the Ministry of Health in Mozambique to implement, document, monitor PP implementation.
5. Increase the number of health providers trained in PP.
6. Design and implement a national APSS/PP strategy.

Prevention of Mother to Child Transmission

1. Increase primary prevention of HIV interventions among women of childbearing age in health facilities with Prevention of Mother-to-Child Transmission. (PMTCT) services by strengthening provider-initiated testing, promotion of male involvement, expansion of couples and partner testing and, expansion of condom availability and utilization.
2. Strengthen the prevention of unwanted pregnancies among women of child bearing age, and particularly of HIV+ women
3. Increase access to more efficacious ARV prophylaxis for HIV+ pregnant women by scaling up Option A implementation and universal access to ART (Option B+) in facilities providing ART and PMTCT services.
4. Strengthen the follow up services for HIV exposed children: early infant diagnosis, provision of ARV and cotrimoxazole prophylaxis, adherence and retention in follow up services.
5. Ensure better linkages between PMTCT and ART services for both HIV+ women and children, as well as linkages with communities.

Strategic Information

1. Strengthen the human resource capacity of the DPS in the province to collect and use strategic information to manage national HIV/AIDS and other key health programs / Increase the number of trained SI-related human resource at all levels
2. Increase the availability, quality and use of data to assess and improve the quality of services provided to the population living with HIV/AIDS and other key health issues and for measuring impact.
3. Develop and implement national standards and norms in strategic information systems to ensure the alignment and harmonization of systems developed.

Sexually Transmitted Infections

1. Improve access to STI prevention, care and treatment services in all health facilities in the province.
2. Integrate STI screening and syndromic management into HIV care and treatment services.
3. Strengthen surveillance and monitoring and evaluation systems.

Traditional Medicine

Involve TMP's in activities that may reduce the number of STD, HIV/AIDS, tuberculosis, malaria, diarrhea, malnutrition, maternal and child deaths in the community, in order to support the achievement of the Millennium Development Goals.

Tuberculosis/HIV

1. Reduce stigma and delay in seeking through community education about TB in general, TB/HIV and services available.
2. Increase the proportion of HIV/TB co-infected patients receiving both treatment for TB and HIV.
3. Strengthen the management of DR-TB.
4. Improve patient's registration, monitoring and devaluation.

Pre-ART

1. Improve linkages between HIV testing and HIV clinical care services.
2. Implement a standardized pre-ART package of services.
3. Decrease mortality from preventable cause in the pre-ART population.
4. Ensure early ART initiation for all eligible patients in care.

5. Improve pre-ART retention.

Pediatric and Adult Treatment

1. Scale-up treatment coverage for 80% of the adult and pediatric treatment eligible population in the province.
2. Expand the number of health facilities offering ART in the province
3. Increase retention of ART patients throughout the province
4. Improve the quality of care in the national ART program through standardized, harmonized quality improvement strategies
5. Implement efficacious ART regimens.
6. Expand the universal treatment of HIV infected pregnant women.
7. Expand the universal treatment of HIV/TB co-infected patients.
8. Expand the universal treatment of all children under the designated age cut-off (norms are actively changing and a final decision will be made after publication of the FOA).
9. Improve linkages between health facilities and communities.
10. Improve counseling and support of ART patients.
11. Improve effective monitoring of treatment failure through roll-out of routine viral load monitoring.
12. Improve the routine supportive supervision of healthcare providers.

The purpose of this FOA is to engage the provincial governments in the continued expansion and sustenance of quality HIV services without life-threatening disruptions of services to the people who need these services. This FOA covers a wide range of activities primarily within the spectrum of HIV treatment services but also includes other services such as HIV prevention and care.

Applicants are expected to respond to one or more of the following provinces:

- A. Gaza**
- B. Nampula**
- C. Maputo City**

D. Tete

E. Sofala

F. Manica

G. Niassa

Applicants must submit a separate application for the provinces they intend to work in. In addition to the program narrative, the applicant must include a separate budget for each proposed province and in form SF 424 item number 14, the applicant should state the provinces they are applying to work in. Failure to indicate the area of work will make the application non-responsive. Applicants should consider linkages between the various program areas within their application, either by proposing to provide linked services or by proposing to ensure linkages to existing services not specifically provided by the applicant. Competitive advantage is not given based on the number of activities proposed across provinces. Applicants will be evaluated according to the strength of their responses per province. More than one applicant will not be funded for the same province under this award.

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 Mozambican population and must also coordinate with activities supported by Mozambique, 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 Mozambique. The grantee will produce an annual operational plan, which the U.S. Government Emergency Plan team on the ground in Mozambique will review as part of the annual Emergency Plan review-and-approval process managed by the Office of the U.S. Global AIDS Coordinator and HHS/CDC.

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 and HHS/CDC, 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 and associated outputs for this program are as follows:

Program Area: Biosafety

FOA Objective(s): Scale up and strengthen the IPC program at central, provincial and Facility levels reinforcing the institutionalization of the program and reducing transmission of HIV and other Health Care Associated Infection (HCAI) among Health Care workers and patients.

Activities: Support IPC program scale up at all levels and performance measurement (Internal & external Audits). Support purchase and distribution of IPC materials and supplies as needed. Support IPC trainings, supervision and monitoring visits to implementing sites. Support local, provincial and national coordinator meetings. Support development on national guidelines and Information, Education, and Communication (IEC) materials. Advocate for PEP Kits timely availability at all facilities.

Outputs: Increased number of health facilities with IPC committees established. Increased number of Internal and external audits conducted. Increased number of persons trained and supportive supervisions/monitoring visits conducted. Guidelines developed disseminated and in use by providers. Increased number of HCW documenting occupational exposure and receiving PEP timely.

Program Area: Cervical Cancer

FOA Objective(s): To improve early diagnosis and treatment at primary health care level.

Activity 1: Expansion of screen and treat program in the provinces.

Output 1: Increase the number of sites by 50% by the end of fiscal year 2013.

Activity 2: Perform on the job training to provincial and district professionals.

Output 2: Train at least two MCH nurses in each new site.

Activity 3: Purchase of equipment to new sites.

Output 3: Ensure equipment for VIA and cryotherapy in each of the new sites.

Program Area: HIV in the Workplace

FOA Objective(s): Promote healthier health care force, reduce new HIV infections and mitigate HIV impact amongst Health Care Workers (HCW) and families.

Activities: Ensure that at least 80% of facilities has PEP/WPS managers. Conduct TOT and on-job training for PEP/WPS for HCW. Conduct supportive supervision to sites implementing PEP and WPS activities. Promote one-day lectures/presentations at Pre-Service training institutions about PEP/WPS. Develop/update, print and disseminate IEC and training materials. Conduct HCW family days to promote HIV testing and health in general for HCW and families. Develop/Finalize and disseminate strategy/guidelines for WPS program implementation with partners support. Advocate for PEP Kits timely availability at all facilities. Develop/update and institutionalize a monitoring system for PEP and WPS activities.

Outputs: Increased number of health facilities with PEP/WPS program institutionalized. Increased number of TOT and on-job trains conducted. Increased number of supportive supervision conducted. Increased number of presentations conducted at Pre-Service institutions about PEP/WPS. Strategy/guidelines developed disseminated and in use. PEP and WPS integrated in DPS monitoring system with data flow established.

Program Area: Counseling and Testing

FOA Objective(s): Strategically scale up, intensify and improve quality of Counseling and Testing to link as many HIV positive people and their partners to appropriate services.

Activities: Support PICT scale-up to assure that 100% of sites offering ARV also offer Provider Initiated HTC. Support the training of health staff in PICT provision. Support

and advocate for the inclusion of PICT curricula in ALL health staff training. Support the reproduction of PICT training material as well as job aids for all sites offering PICT. Support PICT site supervision by DPS. Support ATS scale-up to assure that 50% of sites offering ARV also offer ATS. Support lay counselor's training and/or recycling on ATS. Support ATS site supervision by DPS. Support the implementation of door to door HTC for specific target groups (partners and families of PLHIV, MARPS, HHs with TB patients) in places with HIV prevalence. Support the implementation of community HTC campaigns for specific target groups (i.e., Night testing campaigns for commercial sex workers (CSWs), weekend testing campaigns for couples, workplace testing campaigns for men). Develop and pilot a strategy to ensure the linkage of THC (clinical, voluntary, and from the community) clients to prevention, care and treatment services in the province. Develop and pilot an M&E system to measure the effectiveness of the linkage strategy (e.g. to measure the # of HIV+ people that were effectively linked to other services) in the province.

Outputs: Increased number of ARV sites implementing PICT. Increased number of health staff trained in PICT. Inclusion of PICT curricula in all health staff training materials. Increased number of sites offering PICT with appropriate PICT training materials and job aids. Increased number of DPS and district supervisory visits to PICT sites. Increased number of ARV sites offering ATS. Increased number of lay counselors trained and/or recycled in ATS. Increased number of DPS supervisory visits to ATS sites. Increased number of institutions implementing door to door strategies for target populations. Increased number of ATSC campaigns implemented. Linkage strategy developed and implemented. Linkage M&E system developed and implemented.

Program Area: Human Resources for Health

FOA Objective(s): Strengthen the capacity of the MOH to plan, source, coordinate, manage and retain human resources for health through improvements in policy, infrastructure, information and quality assurance systems.

Activity 1: Support the implementation of a strategy to improve management capacity of health workers by incorporating special modules preparing them for specific tasks / job descriptions. For example, short training for District Health Officer.

Output 1: Implementation of an applied, on the job training courses aimed at improving management capacity at the district level, for example a curriculum for newly appointed District Medical Officers focusing on management, M&E, public health evaluation, fiscal and human resources oversight. Based on the revised set of basic public health functions, and other recommendations, provide applied training for the appropriate HR level.

Activity 2: Support the implementation of the two HRH information systems: Training Information System (TIS) (Pre-service and In-service) and the Human Resources for Health Information System (HRIS) by providing and coordinating technical assistance, training, and quality assurance in the continuing deployment of this system to the Provinces and Districts.

Output 2: Quality data is collected at the Provincial and District levels on the human resource status and needs of the health system. Quality reports are made available in a timely manner about the ongoing human resource needs of the health system, and where improvements are needed. Quality data by Province is collected and made usable for routine deployment decision-making and for forecasting numbers of health workers available to meet demands of the accelerated plan.

Activity 3: Increase the number of students successfully completing pre-service training in key understaffed careers, such as pharmacists, laboratory technicians, clinical officers, general and maternal child nurses, community health workers (Agents Polivalentes Elementares) and other cadres.

Output 3: Increasing the number of graduates from Health Sciences Institutes in key careers and Provinces where shortages are expected throughout the funding period (i.e., high prevalence provinces).

Activity 4: Strengthen the coverage, quality and sustainability of key priority in-service training that allows for task shifting within the health system to accommodate growth and achievement of the accelerated plan.

Output 4: Increased number of health workers successfully trained in priority areas identified for expansion to achieve the goal of the accelerated plan, in key careers and Provinces where shortages are expected throughout the funding period. National standardization and coordination of priority in-service training, with a focus on sustainable delivery of training by Mozambique institutions. Continuing professional development programs established for key health professions.

Activity 5: Increase supervisory visits and quality of supervision from HR Dept. to the Health Sciences Institutes, Provincial HR Depts. and other institutions carrying out pre-service and in-service trainings.

Output 5: Increasing the quality of preparation of the new and existing health work force to accommodate the accelerated program expansion through increased efficiency.

Activity 6: Increase availability of trainings in hard to reach under-served areas by planning and coordinating the development and implementation of a web-based distance learning system.

Output 6: Increasing the capacity of the government institutions to train and re-train workers in underserved areas.

Activity 7: Improve the quality of training at the Health Science Institutes, by providing better teaching resources (e.g. including kits, books, electronic resources and computer systems), updating and reviewing curricula, and strengthening skills labs and clinical practical opportunities to the Health Science Institutes and Provinces.

Output 7: Continuing to strengthen teaching resources, procure and distributing books and multimedia resources for libraries of training institutions in different disciplines, including nursing, clinical officer students, laboratory and pharmacy. This procurement includes basic equipment “kits” for practical sessions and demonstrations for students.

Program Area: Laboratory

FOA Objective(s): Strategically expand access to quality laboratory services to support disease detection, treatment, control and prevention, increase the quality and quantity of laboratory workforce and strengthen the management structure of the laboratory network at central, provincial and district levels.

Activity 1: Establish adequate laboratory infrastructure and strengthen laboratory capacity to support achievement of MOH targets for HIV, TB, malaria and other priority diseases.

Output 1: Standard designs for laboratory infrastructure developed and implemented. Minimum test menu for clinical labs by level defined, sufficient equipment installed, specimen referral systems functioning, SMS technology to return lab results expanded to include viral load, CD4, and referral TB testing, maintenance contracts in place, laboratory management information system (LMIS) and laboratory information system (LIS) implemented and functioning, pre-service lab courses revised and implemented, sufficient human resources trained and deployed.

Activity 2: Improve the quality of laboratory services and results.

Output 2: Quality improvement strategy developed and implemented. Provincial and Central laboratories accredited according to World Health Organization Regional Office for Africa (WHO-AFRO) standards, General, Rural, and District Hospital labs accredited according to National Standards.

Activity 3: Implement external quality assurance visits by provincial laboratory departments to every health facility with lab testing capacity in the province.

Output 3: Percent of functional labs that have received an external quality assurance (EQA) visit in the past 3 months.

Activity 4: Implement annual supervision visits by the provincial laboratory departments to every laboratory in the province.

Output 4: Percent of labs that have received one or more supervision visits in the past year.

Activity 5: Preventive maintenance visits for lab equipment are performed once per year and ensured by the provincial laboratory department

Output 5: Percent of planned preventive maintenance visits for lab equipment performed in the last year.

Program Area: Most at Risk Populations and Mental Health

FOA Objective(s): Improve access to related health services and contribute to the efforts of the Government of Mozambique to prevent new HIV infections by reducing HIV transmission rates among most at risk populations.

Activity 1: Training and provide capacity building to health care professionals to provide comprehensive health care services for most at risk populations with special emphasis on the quality of CT, STI and FP. Develop mechanism to ensure referrals and linkages between services and within the health system provision of HIV treatment and care services.

Output 1: Referral health units. Health care providers trained in each of the referral health units. Development of flow charts, job aids, registration, and referral forms.

Activity 2: Provision and distribution of male and female condoms as well as lubricants to population with high sexual risk behavior in all key services within health facilities.

Output 2: Condoms available for distribution in all key services. Health care professionals promoting consistent and proper use of condoms.

Activity 3: Development of IEC materials for HIV prevention (including drug consumption and high risk sexual behavior) targeting at the different MARPs groups.

Output 3: IEC targeted material produced and distributed.

Activity 4: Implementation of National Guidelines for prevention, Care and Treatment of Most at risk populations.

Output 4: Dissemination of National Guidelines. Provincial workshops held to develop provincial work plans to disseminate & implement guidelines.

Activity 5: Dissemination of IEC targeted material for Most at Risk Populations in the province.

Output 5: Reproduction of epidemiological bulletins and AOD reports. Elaboration of brochures (risk behavior).

Activity 6: In service and continuous training of mental health professionals to address the needs related to HIV in substance abusing populations.

Output 6: Mental Health Professionals in all provinces and of all cadres trained and better equipped to provide quality.

Program Area: Positive Prevention

FOA Objective(s): Scale up provision of positive prevention services to improve well-being of people living with HIV (PLHIV) and reduce onward transmission of HIV.

Activities: Develop IEC materials for increasing knowledge among providers and patients. Develop a provincial plan for health care provider training in PP using MOH standard materials. Train health providers in PP. Integrate PP in services offered to PLHIV at facility (ex: HCT; PMTCT; TB; TARV). Implement standard methods for documenting PP services throughout the province. Integrate PP components into existing clinic data collection. Conduct regular PP supportive supervision to providers.

Outputs: Increased number of materials developed and approved for dissemination. Provincial plan developed. Increased number of persons trained in PP. Increased number of facility services that offers PP services in a regular basis to PLHIV. PP tool approved and used by health providers. PP components integrated into existing tools. Increased number of supportive supervision conducted /district.

Program Area: Prevention of Mother to Child Transmission (PMTCT)

FOA Objective(s): To eliminate Mother-to-Child Transmission (MTCT) (up to < 5% by year 2015) and keeping their mothers alive through provision of universal access to ART to 90% of HIV+ pregnant and lactating women.

Activity 1: Implement the basic package of services for HIV primary prevention in health facilities with PMTCT. Implement/expand CT for HIV to all MCH services. Implement friendly environment (night/weekend consultations, priority for couples testing, etc) for male participation (men friendly services). Disseminate information about sexual and reproductive rights of adolescents and youth through radio spots, community information sections in schools and health facilities.

Output 1: Increased number of health facilities implementing the basic package of services for HIV primary prevention. Increased number of health facilities implementing CT for HIV in all MCH services. Increased number of health facilities

implementing friendly environment for male participation. Increased number of districts where information about sexual and reproductive rights of adolescents and youth is disseminated.

Activity 2: Integrate provision of family planning in post partum care. Integrate provision of FP in HIV care and treatment services (ART services). Scale up distribution of oral contraceptives at community level.

Output 2: Increased number of health facilities with FP integrated in post partum care. Increased number of ART services providing FP. Increased number of districts with oral contraceptives distributed at community level.

Activity 3: Scale up Option A to all peripheral facilities providing PMTCT only. Scale up ART for pregnant women (Option B+) at all co-located PMTCT-ART sites. Implement one stop model approach in all facilities with co – located PMTCT and ART services. Scale up point-of-care (POC) technology (hemoccues, PIMA) to PMTCT sites. Train MCH nurses of health facilities implementing Option A, in the management of HIV opportunistic infections for pregnant women. Establish standardized referral flow for all HIV+ pregnant and lactating women from non ART facilities to ART facilities.

Output 3: Increased number of peripheral health facilities implementing Option A. Increased number of ART-PMTCT co-located sites implementing Option B+. Increased number of health facilities implementing the one stop model. Increased number of health facilities with PIMA. Increased number of health facilities with hemoccues. Increased number of MCH nurses trained in the management of opportunistic infections. Increased number of districts with standardized referral flow.

Activity 4: Revitalize exposed infants (HEI) follow up services (CCR) in all health facilities with PMTCT. Train MCH nurses in the follow up of HEI at CCR. Scale up early infant diagnosis of HIV including provision of SMS printers. Implement adherence

and retention strategies (lay counselors, peer educators, etc) to CCR for the HEI. Adapt and implement the “fast track” strategy for children with a positive PCR result.

Output 4: Increased number of health facilities with PMTCT that have CCR services. Increased number of health facilities with MCH nurses trained in HEI follow up. Increased number of facilities implementing early infant diagnosis (EID). Increased number of facilities implementing EID that have SMS printers. Increased number of facilities implementing adherence and retention strategies. Increased number of facilities with strategies to track HEI with PCR positive result.

Activity 5: Establish linkages with communities to increase utilization of MNCH services including demand creation for institutional delivery. Integrate HIV+ women in already existing institutional and community support groups. Adapt and implement the “fast track” strategy for HIV+ pregnant and lactating women.

Output 5: Increased number of districts with created linkages between health facilities and communities. Increased number of health facilities with HIV+ women integrated in support groups. Increased number of health facilities with “fast track” strategy for HIV+ pregnant and lactating women.

Program Area: Strategic Information

FOA Objective(s): Improve strategic information systems for health through support for the HIS and M&E National Strategic Plans.

Activity 1: Support the training of DPS and district staff in strengthening SI skills.

Output 1: Increased number of curricula/training materials developed and approved for implementation. Increased number of persons trained in SI.

Activity 2: Develop and implement new tools to increase the availability and accessibility of HIV and health data. Implement activities to improve data quality. Implement national tools for promoting data analysis and use.

Output 2: Increased number of tools developed to increase the availability and accessibility of HIV and health data. Increased number of activities implemented to improve data quality. Increased number of tools promoting data analysis and use.

Activity 3: Implement national standards and norms in strategic information systems to ensure the alignment and harmonization of systems. Develop governance structures to develop and monitor norms and standards.

Output 3: Increased number of national norms and standards in SI implemented.

Activity 4: Pilot appropriate technology to ensure available quality strategic information.

Output 4: Increased number of pilots for appropriate technology to strengthen SI implemented.

Activity 5: Conduct annual data verification visits to every health facility that provides HIV services.

Output 5: Percent of districts where data are verified in at least one HIV-related service each year by a team of DPS.

Activity 6: DPS M&E unit conducts supervision visits focusing on HMIS/M&E at least two times per year.

Output 6: Percent of districts in which there was a DPS supervision visit focusing on HMIS/M&E (NEP to NED) at least two times per year.

Activity 7: Define and maintain up to date HIS architecture in the province. Develop and pilot appropriate technology to ensure available quality strategic information. Strengthen functional, secure and competitive environment for the use and integration of effective HIS.

Output 7: HIS architecture defined and updated. Increased number of pilots for appropriate technology to strengthen SI implemented.

Program Area: Sexually Transmitted Infections

FOA Objective(s): To improve early diagnosis and treatment at primary health care level.

Activity 1: Ensure systematic screening of STIs to all HIV infected patients at Pre-ART and ART services in the provinces.

Output 1: Increase the number HIV patients screened for STIs.

Activity 2: Improve screening and management of STI s among sexual partners.

Output 2: Increase the number partners screened for STIs.

Activity 3: Perform refresher training to all provincial trainers.

Output 3: Train at least one trainer in the province.

Activity 4: Ensure systematic testing for syphilis according to national guidelines.

Output 4: Use of rapid testing for early detection of syphilis in all primary health care (PHC) facilities.

Activity 5: Perform regular supervision to treatment sites.

Output 5: Improve technical knowledge of health professionals.

Program Area: Traditional Medicine

FOA Objective(s): To reduce the number of STD, HIV/AIDS, tuberculosis, malaria, diarrhea, malnutrition, maternal and child deaths in the community.

Activity 1: Training Traditional Medicine Practitioners to improve their approach to health problems in the community.

Output 1: Increased number of Traditional Medicine Practitioners trained in health care including Primary Care Domicile and the community-based directly observed treatment (DOTC). Increased number of Traditional Medicine Practitioners trained in the community (home care activists, including prevention of DOTC and the distribution of condoms).

Activity 2: Train the TMPs on negotiating techniques for prevention and counseling for those with AIDS / TB / other chronic illnesses and their families.

Output 2: Increased number of TMPs trained in areas of h TB and HIV both at and being able to refer patients to health Facilities.

Activity 3: Integrate the TMPs in the group of community workers to distribute condoms, as well as hygiene and nutrition in communities.

Output 3: Increased number of TMP trained in issues related to prevention: Condom distribution, hygiene including water and sanitation as well as Nutrition education at community level.

Activity 4: To sensitize the TMPs on the need to be part of a network of community activists Health to serve as liaison between the community and health facilities.

Output 4: Increased number of TMP trained and equipped in referral system procedures. Informed on how to refer patient to the health facility.

Activity 5: Raising awareness on creating counseling centers in local communities.

Output 5: Increased number of TMP informed about how to create the counseling centers.

Activity 6: Involve the TMP's in Community Health Committees, Committees of maternal deaths, among other groups.

Output 6: Increased number of TMP's trained and involved different health programs at community level: PMTC, CT, Nutrition, Positive Prevention.

Program Area: Tuberculosis/HIV

FOA Objective(s): To reduce the prevalence and mortality in TB and HIV co-infected patients through early diagnosis and provision of appropriate treatment in adults and children.

Activity 1: Disseminate educational flyers. Disseminate information through community radios. Inclusion of TB related activities in health fairs.

Output 1: Increased number and type of educational material disseminated. Increased number of community radios disseminating TB and TB/HIV messages. Increased number of health with TB related activities included.

Activity 2: Train clinical staff in C&T, TB, opportunistic infections (OI) and ART. Intensify TB screening in patients population with high risk for TB. Provision of IPT to HIV+ patients with no active TB. Provision of ART in TB and HIV co-infected patients regardless of CD4 count. Implement the One stop Model of care TB screening in

targeted patients population with high risk of TB in all entry points at the health facility. Develop and implement infection control plans in selected health facilities.

Output 2: Increased number clinical staff trained. Increased number of HIV+ patients receiving IPT increased. Increased number and percentage of TB/HIV co-infected on ART increased. Increased number of Health facilities implementing the one stop model of care. Increased number of health facility with implementing IC measures.

Activity 3: Disseminate the Programmatic management of Drug Resistant TB Strategy (PMDT). Update the DR-TB manual. Train clinical staff on the management of DR-TB. Conduct supportive supervision.

Output 3: Increased number of health facilities with a copy of the PMDT strategy. Increased number of health revised manuals printed and distributed. Increased number clinical staff trained on the management of DR-TB. Increased number of supervision conducted.

Activity 4: Implement recording and reporting tools. Implement an electronic DR—TB at the district and provincial and central levels. Train TB staff on how to use the new tools.

Output 4: Increased number revised tools developed. Electronic DR-TB register available at the district, provincial and central levels. Increased number of health with personal trained and using revised tools.

Program Area: Pre-Antiretroviral Therapy (ART)

FOA Objective(s): To reduce early death and lost to follow-up of pre-ART patients through integrated HIV care and treatment services.

Activity 1: Implement the pre-ART package in all health facilities providing ART.

Output 1: Increased pre-ART retention (70% at 12-months).

Activity 2: Improve the provision of cotrimoxazole (CTX) prophylaxis to adults, children <5 years old and pregnant women.

Output2: 0% of pre-ART patients receiving CTX prophylaxis.

Activity 3: Perform refresher training in HIV care (including pre-ART care) and diagnosis of OI's.

Output 3: # of health facilities providing HIV care and treatment with health workers who are trained in HIV care

Program Area: Adult and Pediatric Treatment

FOA Objective(s): To scale-up treatment coverage for the adult and pediatric treatment eligible population in Mozambique, improve counseling and support and expand universal treatment.

Activity 1: Expand the use of short message service (SMS) technologies to report CD4 and DNA test results to sites that do not have onsite CD4 testing capacity.

Output 1: Year 1: 50% ART sites. Year 2: 60% ART sites. Year 3: 70% ART sites.

Activity 2: Ensure all ART sites conduct a thorough review of patient archived files to identify pre-ART defaulters and patients lost to follow-up and determine eligibility for ART initiation (year 1).

Output 2: Increased number of health facilities completed a clean-up of archived patients files by year 1.

Activity 3: Ensure that 80% of adults and children >5 years of age receive cotrimoxazole prophylaxis when eligible.

Output 3: Implementation of pre-ART package of services in 80% of ART and PMTCT sites.

Activity 4: Implement criteria for opening of a new ART site.

Output 4: Expand coverage of ART services in the province in accordance with national scale up plan.

Activity 5: Establish child-friendly services in 50% of ART sites by the end of year 5.

Output 5: Child-friendly corners implemented in 15% of ART sites by year 1.

Activity 6: Implement universal access to ART for children as per WHO guidelines.

Output 6: 90% of HIV infected children (per WHO guidelines) started on ART each year.

Activity 7: Develop and implement a plan for provision of ART to HIV infected partners of uninfected pregnant and lactating women regardless of CD4 count in 442 sites (by year 1).

Output 7: Increased number of ART sites providing ART for HIV infected partners of uninfected pregnant and lactating women who are HIV negative regardless of their CD4 count.

Activity 8: Prioritize ART initiation for children, pregnant women and lactating women and TB/HIV co-infected patients.

Output 8: Increased number of eligible adults and children initiate ART within 1 month of enrollment in HIV care.

Activity 9: Ensure that 75% of patients with suspected treatment failure receive their viral load test results.

Output 9: 90% of confirmed patients with ART failure switched to 2nd line treatment (year 1: 30%).

Activity 10: Ensures that nutritional assessment and Counseling is provided to 90% of patients.

Output 10: 80% ART sites routinely conduct nutrition assessments.

Activity 11: Expand the use of one dose per day TDF/3TC/EFV in 100% of ART sites by 2015.

Output 11: Year 1: one dose per day TDF/3TC/EFV implemented in the province according to the national and provincial plan.

Activity 12: Implement quarterly supportive and technical visits to all sites implementing the Community Adherence support group strategy (GAAC) strategy.

Output 12: GAAC strategy implemented in 80% of ART sites by year 3-5 (Year 1: 25% of ART sites).

Activity 13: Implement 3 (three) monthly supply of ARVs to patients who are stable and adherent on ART.

Output 13: 40% of ART patients receive three (3) monthly supply of ARVs by year 1 (and 80% by year 3-5).

Activity 14: Implement and revitalize the role of community health workers (APE) as focal points to link the community with health facility.

Output 14: Increased number of community health workers assigned per ART facility.

Activity 15: Ensure that all sites conduct a biannual follow up and analysis of data from quality improvement cycles.

Output 15: 100% of PMTCT and ART sites implement quality improvement cycles using standardized tools (Year 1:- 30% ART and PMTCT sites).

Activity 16: Conduct clinical mentoring visits to health facilities every 2 months in the province.

Output 16: % of sites receiving bi-monthly clinical mentoring activities.

Activity 17: DPS conducts supportive visits to all districts every quarter.

Output 17: % of districts in which a DPS supervision visit takes place during the reporting period.

Activity 18: DPS ensures that monthly district health management committee meetings to discuss program data are held.

Output 18: % of districts in which monthly health management committee meetings took place during the reporting period.

CDC Activities:

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 track finances.
11. Provide technical assistance or advice on any data collections on 10 or more people that are planned or conducted by the awardee. All such data collections-- where CDC staff will be or are approving, directing, conducting, managing, or owning data-- must undergo OMB project determinations by CDC and may require OMB PRA clearance prior to the start of the project.
12. 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.
13. Assist the grantee in developing and implementing quality-assurance criteria and procedures.
14. Facilitate in-country planning and review meetings for technical assistance activities.
15. CDC will provide technical assistance for activities.
16. Conduct service delivery site visits through the Site Monitoring System (SMS) to monitor and evaluate site capacity to provide high-quality HIV/AIDS services in

all program areas by assessing and scoring key program area elements of site performance and work with the grantee on identified gaps and continuous quality improvement.

17. Provide ethical reviews, as necessary, for evaluation activities, including from HHS/CDC headquarters. Evaluations can be process, outcome or impact.
 - a. Process Evaluation: measures how the intervention was delivered, what worked/did not, differences between the intended population and the population served, and access to the intervention.
 - b. Outcome Evaluation: determines effects of intervention in target population(s) (e.g., change in knowledge, attitudes, behavior, capacity, etc.).
 - c. Impact Evaluation: measures net effects of program and prove of causality
18. Supply the grantee with protocols for related evaluations.
17. CDC will work with grantee to adjust program activities as needed in order to avoid overlap and duplication of services in areas where other USG implementing partners are working in order to maximize and efficiently utilize resources, to complement the national HIV/AIDS program, and to continue to strengthen the Mozambican national health system's leadership and management of HIV/AIDS services.

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

II. AWARD INFORMATION

Type of Award: Cooperative Agreement.

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

Fiscal Year Funds: FY2013

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

Approximate Total Project Period Funding: \$8,000,000 (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: \$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: N/A.

Ceiling of Individual Award Range: \$1,000,000. (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.)

Anticipated Award Date: August 30, 2013.

Budget Period Length: Twelve 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 floor of the individual award range and the ceiling of the individual award range. The proposed budget for the first budget period must not exceed the ceiling of the individual award range. If a funding amount greater than the ceiling of the individual award range is requested, the application will be considered non-responsive and will not be entered into the review process.

III. ELIGIBILITY INFORMATION

Eligible Applicants

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

A. Gaza Provincial Health Directorate (DPS)

B. Nampula DPS

C. Maputo City DPS

D. Tete DPS

E. Sofala DPS

F. Manica DPS

G. Niassa DPS

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.

PEPFAR Local Partner definition:

Under PEPFAR, 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:

(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 75% for FY2013 beneficially owned by individuals who are citizens or lawfully admitted permanent residents of that same country, per subparagraph (2)(a), or by other corporations, partnerships or other arrangements that are local partners under this paragraph or paragraph (3);

(c) at least 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 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 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. Partner 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 organization rests with the government.

Note: To be considered a local partner, the applicant must submit supporting documentation demonstrating their organization meets one of the three criteria listed above.

Under PEPFAR legislation, HHS/CDC is authorized to transition leadership of programs and services (including ART services) to local ownership, with the ultimate aim of full transition of all appropriate activities to the Ministries of Health and other governmental entities that have the jurisdictional authority to directly finance and perform these programs and services. The Limited Eligibility Justification is to support the gradual transition of program responsibilities to governmental entities that have the jurisdictional authority to directly finance and perform these services, in this case Provincial Health Directorates, while ensuring continuity of care and ART service delivery. The Provincial Health Directorates in Mozambique are government organizations established by law and are mandated to plan, manage, administer and coordinate all health-related activities including HIV/AIDS activities in their respective regions.

The transitioning of programs and services to local ownership of the Ministry of Health and governmental provision will foster the long-term capacity and sustainable development of all aspects of the health system. This is in direct alignment with the Governments of Mozambique decentralization process to the Provincial and District Health governments.

Required Registrations

There are a total of three registrations needed to submit an application on www.grants.gov.

- a. **Data Universal Numbering System:** 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 awards or cooperative agreements. The DUNS number is a nine-digit number assigned by Dun and Bradstreet Information Services. An Authorized Organization Representative (AOR) should be consulted to determine the appropriate number. If requested by telephone, a DUNS number will be provided immediately at no charge. If requested via the internet, obtaining a DUNS number may take one to two days at no charge. If your organization does not know its DUNS number or needs to register for one, visit Dun & Bradstreet at <http://fedgov.dnb.com/webform/displayHomePage.do>. An AOR should complete the US D&B D-U-N-S Number Request Form online or contact DUN and Bradstreet by telephone directly at 1-866-705-5711 (toll-free) to obtain one. This is an organizational number. Individual Program Directors do not need to register for a DUNS number.

If funds are awarded to an applicant organization that includes sub-awardees, sub-awardees' must provide their DUNS numbers prior to accepting any sub-awards.

- b. **System for Award Management:** All applicant organizations must register in the System for Award Management (SAM). The SAM 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 an awardee. The SAM number must be maintained 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. The SAM registration process requires three to five business days to complete. SAM registration must be renewed annually. Additional information about registration procedures may be found at www.SAM.gov.

- c. Grants.gov: Registering your organization through www.grants.gov, the official HHS E-grant website, is the first step in submitting an application online. The “one-time” registration process will take three to five days to complete. However, it is best to start the registration process as early as possible.

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 individual 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:

- 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 90 pages, any pages after page 90 of 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 as appendices.

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

Application Deadline Date: April 15, 2013 on www.grants.gov, 11:59 pm Eastern Standard Time.

Applicants must download the SF424 application package associated with this funding opportunity from 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 7:00am – 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 www.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

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 www.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 www.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.

Note: The applicant should take into consideration the Criteria listed in “Section V. Application Review Information” when composing the project narrative.

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 (i.e. outputs) 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 (i.e. outcomes) 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 with robust data quality assurance and assessment procedures for reported data.

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 detailed budget should identify costs associated with potential data collection activities from persons, personal records, or for laboratory specimen collection and testing that may result in a public report. For each of the potential data collection activities also state the costs for any preparatory activities (e.g., protocol development, training, equipment, reagents, and site

preparation).

The Project Budget Justification must be included as a separate attachment of the application, not to be counted in the narrative page limit. All budget justification pages must be numbered.

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 90 pages and can only contain information related to the following:**

- ***Project Evaluation:*** Include an evaluation plan that will describe how outputs and outcomes will be evaluated. The plan should address the following:
 1. *list up to 3 evaluation questions to be answered about the main activity or intervention addressed in this project (e.g., Is the intervention implemented as intended? (process evaluation) What barriers do clients experience in accessing the intervention? (process evaluation) Did the intervention cause the expected outcomes? (outcome evaluation)*
 2. *specify how you will engage stakeholders (national and others)*
 3. *specify briefly data sources and methods for each evaluation question (up to 1 page per evaluation question, if needed)*
 4. *specify how results will be disseminated and used*

- *Curricula vitae* of current key staff who will work on the activity: DPS, Medico Chefe, and Senior Financial Manager;
- *Job descriptions* of proposed key positions to be created for the activity;
- *Applicant’s Corporate Capability Statement*;
- *Letters of Support* (5 letters maximum): MOH, Direccção Nacional de Assistência Médica (DNAM);
- *Evidence of Legal Organizational Structure*;
- *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.

Additional information submitted via www.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.

- Human subjects data collection 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.
- 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.
- The recipient must use funds provided under the agreement for costs incurred in carrying out the purposes of the award which are reasonable, allocable, and allowable in accordance with applicable cost principles. Unallowable costs will be determined in accordance with the applicable cost principles.
 1. “Reasonable” means the costs do not exceed those that would ordinarily be incurred by a prudent person in the conduct of normal business.
 2. “Allocable” means the costs are necessary to the award.
 3. “Allowable” means the costs are reasonable and allocable, and conform to any limitations set forth in the award.
- The recipient is encouraged to obtain the Grants Management Officer’s written determination in advance whenever the recipient is uncertain as to whether a cost will be allowable.
- 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.
- Public Financial Management Assessment Clause: The Parties acknowledge that HHS/CDC has assessed the recipient's systems required to manage the activities supported with US Government funds under this Agreement and that this Agreement is expressly conditioned upon that assessment, as well as any measures, mitigation or means by which the recipient has or will address the vulnerabilities or weaknesses, if any, found in that assessment. The recipient agrees to take the necessary action(s) to address the recommendations or requirements of the assessment as agreed separately in writing with HHS/CDC in accordance with an action plan to be jointly developed to address such recommendations or as otherwise contained in this agreement.
- Prohibition on Funding for Abortions and Involuntary Sterilization: None of the funds made available to carry out part I of the Foreign Assistance Act of 1961, as amended, may be used to pay for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions. None

of the funds made available to carry out part I of the Foreign Assistance Act of 1961, as amended, may be used to pay for the performance or involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations. None of the funds made available to carry out part I of the Foreign Assistance Act of 1961, as amended, may be used to pay for any biomedical research which relates in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning. None of the funds made available to carry out part I of the Foreign Assistance Act of 1961, as amended, may be obligated or expended for any country or organization if the President certifies that the use of these funds by any such country or organization would violate any of the above provisions related to abortions and involuntary sterilizations.

- Requirements for Voluntary Family Planning Projects

(1) A family planning project must comply with the requirements of this paragraph.

(2) A project is a discrete activity through which a governmental or nongovernmental organization or Public International Organization (PIO) provides family planning services to people and for which funds obligated under this award, or goods or services financed with such funds, are provided under this award, except funds solely for the participation of personnel in short-term, widely attended training conferences or programs.

(3) Service providers and referral agents in the project must not implement or be subject to quotas or other numerical targets of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning. Quantitative estimates or indicators of the number of births, acceptors, and acceptors of a particular method that are used for the purpose of budgeting, planning, or reporting with respect to the project are not quotas or targets under this paragraph, unless service providers or referral agents in the project are required to achieve the estimates or indicators.

(4) The project must not include the payment of incentives, bribes, gratuities or financial rewards to (i) any individual in exchange for becoming a family planning acceptor, or (ii) any personnel performing functions under the project for achieving a numerical quota or target of total number of births, number of family planning

acceptors, or acceptors of a particular method of contraception. This restriction applies to salaries or payments paid or made to personnel performing functions under the project if the amount of the salary or payment increases or decreases based on a predetermined number of births, number of family planning acceptors, or number of acceptors of a particular method of contraception that the personnel affect or achieve.

(5) A person must not be denied any right or benefit, including the right of access to participate in any program of general welfare or health care, based on the person's decision not to accept family planning services offered by the project.

(6) The project must provide family planning acceptors comprehensible information about the health benefits and risks of the method chosen, including those conditions that might render the use of the method inadvisable and those adverse side effects known to be consequent to the use of the method. This requirement may be satisfied by providing information in accordance with the medical practices and standards and health conditions in the country where the project is conducted through counseling, brochures, posters, or package inserts.

1. The recipient must notify CDC when it learns about an alleged violation in the requirements for voluntary family planning projects described in paragraphs (3), (4), or (5), above.
 2. The recipient must investigate and take appropriate corrective action, if necessary, when it learns about an alleged violation and must notify CDC about violations in a project affecting a number of people over a period of time that indicate there is a systemic problem in the project.
 3. iii) The recipient must provide CDC such additional information about violations as CDC may request.
- Impact on Jobs in the United States: None of funds appropriated under titles III through VI of the FY12 Foreign Operations Appropriations Act may be obligated or expended to provide:
 1. Any financial incentive to a business enterprise currently located in the United States for the purpose of inducing such an enterprise to relocate outside the United States if such incentive or inducement is likely to reduce the number of employees of such business enterprise in the United

States because United State production is being replaced by such enterprise outside the United States; or

2. Assistance for any program, project, or activity that contributes to the violation of internationally recognized workers rights, as defined in section 507(4) of the Trade Act of 1974, of workers in the recipient country, including any designated zone or area in that country: Provided, that the application of section 507(4)(d) and (e) of such Act should be commensurate with the level of development of the recipient country and sector, and shall not preclude assistance for the informal sector in such country, micro and small-scale enterprise, and smallholder agriculture.
- Defense Base Act: Under a contract approved and financed by the United States or any executive department, independent establishment, or agency thereof (including any corporate instrumentality of the United States), or any subcontract or subordinate contract with respect to such contract, where such contract is to be performed outside the continental United States, under the Mutual Security Act of 1954, as amended (other than title II of chapter II thereof unless the Secretary of Labor, upon the recommendation of the head of any department or other agency of the United States, determines a contract financed under a successor provision of any successor Act should be covered by this section), and not otherwise within the coverage of this section, and every such contract shall contain provisions requiring that the contractor (and subcontractor or subordinate contractor with respect to such contract):
 1. Shall, before commencing performance of such contract, provide for securing to or on behalf of employees engaged in work under such contract the payment of compensation and other benefits under the provisions of this chapter, and
 2. Shall maintain in full force and effect during the term of such contract, subcontract, or subordinate contract, or while employees are engaged in work performed thereunder, the said security for the payment of such compensation and benefits, but nothing in this paragraph shall be construed to apply to any

employee of such contractor or subcontractor who is engaged exclusively in furnishing materials or supplies under his contract.

- Prohibition of Payments to United Nations Members: None of the funds appropriated or made available pursuant to titles III through VI of the FY12 Foreign Operations Appropriations Act for carrying out the Foreign Assistance Act of 1961, may be used to pay in whole or in part any assessments, arrearages, or dues of any members of the United Nations, or, from funds appropriated by this Act to carry out chapter 1 of Part I of the Foreign Assistance Act of 1961, the costs for participation of another country's delegation at international conferences held under the auspices of multilateral or international organizations.
- Prohibition on Police Training: None of the funds made available to carry out this award, and none of the local currencies generated, shall be used to provide training or advice, or provide any financial support for police, prisons, or other law enforcement forces for any foreign government or any program of internal intelligence or surveillance on behalf of any foreign government with the United States or abroad.
- Prohibition on Military Assistance and Training: No funds awarded as part of this agreement may be used for military assistance or military training for a country.
- Prohibition on Assistance to Governments Supporting International Terrorism: The United States shall not provide any assistance to any country if the Secretary of State determines that the government of that country has repeatedly provided support for acts of international terrorism.
- Source and Nationality Restrictions: In carrying out programs under the Foreign Assistance Act, of 1961 as amended, the President shall take all appropriate steps to assure that, to the maximum extent possible, (1) countries receiving assistance under this Act contribute local currencies to meet the cost of contractual and other services rendered in conjunction with such programs, and (2) foreign currencies owned by the United States are utilized to meet the costs of such contractual and other services.
- Procurement Restrictions: Funds made available for assistance under the Foreign Assistance Act of 1961, as amended may be used for procurement—

1. In the United States, the independent states of the former Soviet Union, or a developing country or
 2. In any other country, but only if—
 - a) The provision of such assistance requires commodities or services of a type that are not produced in and available for purchase in any country specified in paragraph 1; or
 - b) The President determines, on a case-by-case basis, that procurement in such other country is necessary
 - i. To meet unforeseen circumstances, such as emergency situations, where it is important to permit procurement in a country not specified in paragraph 1, or
 - ii. To promote efficiency in the use of United States foreign assistance resources, including to avoid impairment of foreign assistance objectives.
- **Cargo Preference Act:** When the United States Government procures, contracts for, or otherwise obtains for its own account, or furnishes to or for the account of a foreign country, organization, or persons without provision for reimbursement, any equipment, materials, or commodities, or provides financing in any way with Federal funds for the account of any persons unless otherwise exempted, within or without the United States, or advances funds or credits, or guarantees the convertibility of foreign currencies in connection with the furnishing or obtaining of the equipment, materials, or commodities, the appropriate agencies shall take steps necessary and practicable to ensure that at least 50 percent of the gross tonnage of the equipment, materials, or commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) which may be transported on ocean vessels is transported on privately-owned commercial vessels of the United States, to the extent those vessels are available at fair and reasonable rates for commercial vessels of the United States, in a manner that will ensure a fair and reasonable participation of commercial vessels of the United States in those cargoes by geographic areas.

- Fly America Act: Federal employees and their dependents, consultants, contractors, grantees, and others must use U.S.-flag air carriers for U.S. Government-financed international air travel and transportation of their personal effects or property, if available.
- All PEPFAR-funded programs or activities must adhere to PEPFAR branding guidance, which includes guidance on the use of the PEPFAR logo and/or written attribution to PEPFAR. PEPFAR branding guidance can be found at <http://www.pepfar.gov/guidance/branding/index.htm>.

The 8% Rule

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

To achieve this goal, the Office of the Global AIDS Coordinator (OGAC) establishes an annual funding guideline for grants and cooperative agreement planning. Within each annual PEPFAR country budget, OGAC establishes a limit for the total amount of U.S. Government funding for HIV/AIDS activities provided to a single partner organization under all grant and cooperative agreements for that country. **For U.S. Government fiscal year (FY) 2013, the limit is no more than 8 percent of the country's FY 2013 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 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 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 FOA.** For example, the proposal should state that the applicant has \$_____ in FY 2013 grants and cooperative agreements (for as many fiscal years as applicable) in Mozambique. For additional information concerning this FOA, please contact the Grants Management Officer for this FOA.

Prostitution and Related Activities

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

Any entity that receives, directly or indirectly, U.S. Government funds in connection with this document (“recipient”) cannot use such U.S. Government funds to promote or advocate the legalization or practice of prostitution or sex trafficking. Nothing in the preceding sentence shall be construed to preclude the provision to individuals of palliative care, treatment, or post-exposure pharmaceutical prophylaxis, and necessary pharmaceuticals and commodities, including test kits, condoms, and, when proven effective, microbicides. A recipient that is otherwise eligible to receive funds in connection with this document to prevent, treat, or monitor HIV/AIDS shall not be required to endorse or utilize a multisectoral approach to combating HIV/AIDS, or to endorse, utilize, or participate in a prevention method or treatment program to which the recipient has a religious or moral objection. Any information provided by recipients about the use of condoms as part of projects or activities that are funded in connection with this document shall be medically accurate and shall include the public health benefits and failure rates of such use.

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

The following definition applies for purposes of this clause:

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

All recipients must insert provisions implementing the applicable parts of this section, “Prostitution and Related Activities,” in all subagreements under this award. These provisions must be express terms and conditions of the subagreement, must acknowledge that compliance with this section, “Prostitution and Related Activities,” is a prerequisite to receipt and expenditure of U.S. government funds in connection with this document, and must acknowledge that any violation of the provisions shall be grounds for unilateral termination of the agreement prior to the end of its term. Recipients must agree that HHS may, at any reasonable time, inspect the documents and materials maintained or prepared by the recipient in the usual course of its operations that relate to the organization’s compliance with this section, “Prostitution and Related Activities.”

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

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

Any enforcement of this clause is subject to *Alliance for Open Society International v. USAID, 05 Civ. 8209* (S.D.N.Y., orders filed on June 29, 2006 and August 8, 2008) (orders gaining preliminary injunction) for the term of the Orders.

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

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

Additional Submission Requirements

Electronic Submission

Submit the application electronically by using the forms and instructions posted for this funding opportunity on www.grants.gov (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 www.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 www.grants.gov website. The applicant must submit all application attachments using a PDF file format when submitting via www.grants.gov. Directions for creating PDF files can be found on the www.grants.gov website. Use of file formats other than PDF may result in the file being unreadable by staff.

Applications submitted through Grants.gov (<http://www.grants.gov>), are electronically time/date stamped and assigned a tracking number. The AOR will receive an e-mail notice of receipt when www.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 www.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 is needed. You can reach the Grants.gov Support Center at 1-800-518-4726 or by email at support@www.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@www.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 Grants Management Officer [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 by the Grants.gov support desk;*
- (b) describe the difficulties that prevented electronic submission and the efforts taken with the Grants.gov Support Center; and*
- (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.

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

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 GH13-1317. 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:

Plan to Strengthen their Technical and Programmatic Approach (30 points):

Does the application include an overall plan and strategy, including measurable time lines, clear monitoring and evaluation procedures, and specific activities for strengthening and growing their ability to implement the intended activities? (10 points)

Does the applicant describe activities that are evidence based, realistic, achievable, measurable and culturally appropriate for the Mozambique context? (10 points) 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.) (10 points) To what extent does the applicant propose to work with or receive Technical Assistance from other organizations in order to ensure the quality of service delivery?

Plans for Strengthening Management Systems (30 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? (10 points) Does the applicant describe an adequate and measurable arrangement to progressively build their internal capacity to continue to transition additional funds and activities to the DPS directly (10 points) Is the system able to generate financial and program reports to show disbursement of funds, and progress towards achieving the service delivery objectives of the cooperative agreement? (10 points)

Monitoring and Evaluation (15 points):

Does the applicant demonstrate the local experience and capability to implement monitoring and rigorous evaluation of the project? Does the applicant describe a monitoring system used to routinely review information and adjust program activities accordingly? Is the monitoring and evaluation plan consistent with the principles of the "Three Ones"? Does the monitoring 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 and other HHS/CDC requirements? 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 and HHS/CDC priorities? (10 points) Does the evaluation plan address the components listed specified under the program evaluation section (i.e. evaluation questions, engagement of stakeholders, data sources and methods, results dissemination and use)? Is the evaluation plan feasible, ethical, methodologically sound and engage national stakeholders? (5 points) "Applicants must define specific output and outcome indicators in the proposal, and must have realistic targets in line with the targets addressed in the Activities section of this announcement.

Engagement with District Health Directorates (10 points):

Does the applicant have clear plans to directly engage with the district health directorates in their province with measurable benchmarks of direct support to the districts? These plans should include the provision of supportive supervision, technical assistance, financial assistance, and monitoring & evaluation of the activities the districts will be tasked with carrying out.

Personnel (15 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.

Budget (SF 424A) and Budget Narrative (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 [Www.grants.gov](http://www.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>.

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 this FOA apply.

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

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-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
- AR-32 FY 2012 Enacted General Provisions

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

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

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

Applicants must include an additional Certifications form from the PHS5161-1 application in the Grants.gov electronic submission only. Applicants should refer to the following Internet address: <http://www.cdc.gov/od/pgo/funding/PHS5161-1-Certificates.pdf>. Once the applicant has filled out the form, it should be attached to the Grants.gov submission as an Other Attachments Form. CDC Assurances and Certifications can be found on the CDC Web site at the following Internet address:

<http://www.cdc.gov/od/pgo/funding/grants/foamain.shtm>

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 sub-awards/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

1. Interim Progress Report: Each funded applicant must provide CDC with an annual Interim Progress Report submitted via www.grants.gov. 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 Federal Financial Report (SF 425) 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 Mozambique and HHS/CDC guidance
- 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. Programmatic Impact Reporting:

- A. The recipient is responsible for managing and monitoring each project, program, subaward, function or activity supported through this Agreement. Recipients must monitor subawards to ensure that subrecipients have met the programmatic impact requirements as set forth in the subrecipient's agreement.
- B. The recipient must submit the original and two copies of annual and QUARTERLY Performance reports. Annual reports must be due 90 calendar days after the award year and QUARTERLY reports must be due 30 days after the reporting period. The final performance reports are due 90 calendar days after the expiration or termination of this Agreement.
- C. Performance reports must generally contain, for each award, brief information on each of the following:
 - i. A comparison of actual accomplishments with the goals and objectives previously established for the period, including metrics outlined in the monitoring and evaluation plan (section on M&E), any findings of an

external entity, or both. Whenever appropriate and the output of programs or projects can be readily quantified, such quantitative data must be included in the reports and be related to cost data for computation of unit costs. Also included should be a brief description of the methods used to assure and assess the quality of the quantitative data, including any remediation taken to improve findings of poor data quality.

- ii. Reasons why established goals for the performance period were not met, if appropriate.
 - iii. Other pertinent information including, when appropriate, statutory or Congressional reporting requirements, analysis and explanation of cost overruns or high unit costs reported in financial reports.
 - iv. The recipient must immediately notify the awarding agency of developments that have a significant impact on the award-supported activities. Also, recipients must give notification immediately in the case of problems, delays, or adverse conditions which materially impair the ability to meet the objectives of the award. This notification must include a statement of the action taken or contemplated, and any assistance needed to resolve the situation.
 - v. The recipient is required to submit in a timely manner both semi-annual and annual program results for all relevant programmatic indicators in accordance with U.S. government guidance.
3. Financial Reporting Clause (Federal Financial Report – SF-425): The recipient must submit the *Federal Financial Report* (FFR) SF-425 on a quarterly or annual basis. Additional financial information may be requested as required and directed by HHS/CDC. The following reporting period end dates must be used for quarterly reports: March 31st, June 30th, September 30th, or December 31st. Quarterly FFR reports must be submitted no later than 30 days after the end of each reporting period. Annual reports must be submitted no later than 90 days after the end of the calendar quarter in which the budget period ends. A final *FFR* must be submitted no later than 90 days after the project or grant period end date at the completion of the award

agreement.

Electronic versions of SF-425 can be downloaded into Adobe Acrobat and Completed online by reviewing,

http://www.whitehouse.gov/sites/default/files/omb/grants/approved_forms/SF-425.pdf (reporting form) and

http://www.whitehouse.gov/sites/default/files/omb/grants/approved_forms/sf-425a.pdf (attachment).

4. Monitoring and Evaluation Reports:
 - A. The recipient must submit a monitoring and evaluation plan for approval, and carry out monitoring and evaluation activities in accordance with the approved monitoring and evaluation plan. HHS/CDC will review and approve the recipient's monitoring and evaluation plan to ensure that it is appropriate for the activities to be undertaken as part of the agreement, for compliance with the monitoring and evaluation guidance established by HHS/CDC or other guidance otherwise applicable to this Agreement.
 - B. HHS/CDC or its designee will also undertake monitoring and evaluation of the defined activities within the agreement. The recipient must ensure reasonable access by HHS/CDC or its designee to all necessary sites, documentation, individuals and information to monitor, evaluate and verify the appropriate implementation the Activities and use of HHS/CDC funding under this Agreement, must require a provision to this effect in all sub-awards or contracts financed by funds under this Agreement. Where applicable, this includes support for, and response to, activities associated with the Site Monitoring System and implementation of Data and Service Quality Assessments.
5. Expenditure Analysis: Recipients of PEPFAR funds are required to report annually on program expenditures. Specifically, annual completion of PEPFAR Program Expenditures (Form DS-4213, approved by OMB 1405-0208, or the relevant OMB-

approved format) will be required in conjunction with the PEPFAR Annual Progress Report at the completion of the USG fiscal year.

6. Audit, Books and Records Clause:

- A. Reports and Information. The recipient must furnish HHS/CDC accounting records and such other information and reports relating to the Agreement as HHS/CDC may reasonably request.
- B. The Recipient Agreement Books and Records. The recipient must maintain accounting books, records, documents and other evidence relating to the Agreement, adequate to show, without limitation, all costs incurred by the recipient, the receipt and use of goods and services acquired by the recipient, agreed-upon cost sharing requirements, the nature and extent of solicitations of prospective suppliers of goods and services acquired by the recipient, the basis of award of recipient contracts and orders, and the overall progress of the Agreement toward completion ("Agreement books and records"). The recipient must maintain Agreement books and records in accordance with generally accepted accounting principles prevailing in the United States, or at the recipient's option, with approval by HHS/CDC, other accounting principles, such as those (1) prescribed by the International Accounting Standards Committee (an affiliate of the International Federation of Accountants), or (2) prevailing in the country of the recipient. Agreement books and records must be maintained for at least three years after the date of last disbursement by HHS/CDC or for such longer period, if any, required to resolve any litigation, claims or audit findings.
- C. Partner Government Audit. If \$300,000 or more of US Government funds are expended by the recipient in its fiscal year under the Agreement, the recipient must have financial audits made of the expenditures in accordance with the following terms, except as the Parties may otherwise agree in writing:
 - i. The recipient must use its Supreme Audit Institution (SAI), if the SAI is approved by HHS/CDC, or select an independent auditor to perform the audit in accordance with the guidelines issued by HHS/CDC.
 - ii. The audit must determine whether the receipt and expenditure of the funds

provided under the Agreement are presented in accordance with generally accepted accounting principles agreed to in Section 2 above and whether the recipient has complied with the terms of the Agreement. Each audit must be submitted to HHS/CDC no later than nine months after the close of the recipient's year under audit.

D. Sub-recipient Audits. The recipient, except as the Parties may otherwise agree in writing, must ensure that "covered" sub-recipients, as defined below, are audited, and submit to HHS/CDC, no later than the end of the recipient's year under audit, in form and substance satisfactory to HHS/CDC, a plan for the audit of the expenditures of "covered" sub-recipients, as defined below, that receive funds under this Agreement pursuant to a direct contract or agreement with the recipient.

- i. "Covered" sub-recipient is one who expends \$300,000 or more in its fiscal year in "US Government awards" (i.e. as recipients of US Government cost reimbursable contracts, grants or cooperative agreements).
- ii. The plan must describe the methodology to be used by the recipient to satisfy its audit responsibilities for covered sub-recipients. The recipient may satisfy such audit responsibilities by relying on independent audits of the sub-recipients; expanding the scope of the independent financial audit of the recipient to encompass testing of sub-recipients' accounts; or a combination of these procedures.
- iii. The plan must identify the funds made available to sub-recipients that will be covered by audits conducted in accordance with audit provisions that satisfy the recipient's audit responsibilities.
- iv. The recipient must ensure that covered sub-recipients under direct contracts or agreements with the recipient take appropriate and timely corrective actions; consider whether sub-recipients' audits necessitate adjustment of its own records; and require each such sub-recipient to permit independent auditors to have access to records and financial statements as necessary.

- E. Audit Reports. The recipient must furnish or cause to be furnished to HHS/CDC an audit report for each audit arranged for by the recipient in accordance with this Section within 30 days after completion of the audit and no later than nine months after the end of the period under audit.
 - F. Cost of Audits. Subject to HHS/CDC approval in writing, costs of audits performed in accordance with the terms of this Section may be budgeted for, and charged to, the Agreement so long as such costs are allowable, allocable, and reasonable as defined in the Cost Allowability section of this Agreement.
 - G. Audit by HHS/CDC. HHS/CDC retains the right to perform the audits required under this Agreement on behalf of the recipient conduct a financial review, or otherwise ensure accountability of organizations expending US Government funds regardless of the audit requirement.
 - H. Opportunity to Audit or Inspect. The recipient must afford authorized representatives of HHS/CDC the opportunity at all reasonable times to audit or inspect activities financed under the Agreement, the utilization of goods and services financed by HHS/CDC, and books, records and other documents relating to the Agreement.
 - I. Sub-recipient Books and Records. The recipient will incorporate paragraphs (1), (2), (4), (5), (6), (7) and (8) of this provision into all sub-agreements with non-U.S. organizations which meet the \$300,000 threshold of paragraph (3) of this provision. Sub-agreements with non-U.S. organizations, which do not meet the \$300,000 threshold, must, at a minimum, incorporate paragraphs (7) and (8) of this provision. Sub-agreements with U.S. organizations must state that the U.S. organization is subject to the audit requirements contained in OMB Circular A-133.
7. Reporting of Foreign Taxes
- a. Valued Added Tax (VAT) and Customs Duties – Customs and import duties, consular fees, customs surtax, valued added taxes, and other related charges are hereby authorized as an allowable cost for costs incurred from the effective date of September 13, 2012 until September 12, 2013. This waiver does not apply to

countries where a bilateral agreement (or similar legal document) is already in place providing applicable tax exemptions and it is not applicable to Ministries of Health.

b. The U.S. Department of State requires that agencies collect and report information on the amount of taxes assessed, reimbursed and not reimbursed by a foreign government against commodities financed with funds appropriated by the U.S. Department of State, Foreign Operations and Related Programs Appropriations Act (SFOAA) (“United States foreign assistance funds”). Outlined below are the specifics of this requirement:

- a) Annual Report. The grantee must submit a report on or before November 16 for each foreign country on the amount of foreign taxes charged, as of September 30 of the same year, by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant during the prior United States fiscal year (October 1 – September 30), and the amount reimbursed and unreimbursed by the foreign government. [Reports are required even if the grantee did not pay any taxes during the reporting period.]
- b) Quarterly Report. The grantee must quarterly submit a report on the amount of foreign taxes charged by a foreign government on commodity purchase transactions valued at 500 USD or more financed with United States foreign assistance funds under this grant. This report shall be submitted no later than two weeks following the end of each quarter: April 15, July 15, October 15 and January 15.
- c) Terms: For purposes of this clause:
 - i. “Commodity” means any material, article, supplies, goods, or equipment;
 - ii. “Foreign government” includes any foreign government entity;

- iii. “Foreign taxes” means value-added taxes and custom duties assessed by a foreign government on a commodity. It does not include foreign sales taxes.
 - d) Where: Submit the reports to the Director and Deputy Director of the CDC office in the country(ies) in which you are carrying out the activities associated with this cooperative agreement. In countries where there is no CDC office, send reports to VATreporting@cdc.gov.
 - e) Contents of Reports. The reports must contain:
 - i. grantee name;
 - ii. contact name with phone, fax, and e-mail;
 - iii. agreement number(s) if reporting by agreement(s);
 - iv. reporting period;
 - v. amount of foreign taxes assessed by each foreign government;
 - vi. amount of any foreign taxes reimbursed by each foreign government;
 - vii. amount of foreign taxes unreimbursed by each foreign government.
 - f) Subagreements. The grantee must include this reporting requirement in all applicable subgrants and other subagreements.
8. Final performance and Federal Financial Report (SF-425) - Due no more than 90 days after the end of the project period.

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

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

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.

BANKING & PAYMENT PROCEDURES

Non-Governmental Partners: Non-governmental partners are required to open a commercial bank account. Payment will be made directly from the US Treasury to the specified commercial bank through the US Government's Health and Human Services Payment Management System.

Host Government Partners: For agreements with host government partners, the choice of payment procedure shall be based on CDC's standardized assessment of the strength of the partner government's financial systems. CDC will determine based on this assessment whether to make payments directly through the recipient government's financial systems (e.g. a designated central bank, treasury account or other partner government account) or via a commercial bank account.

VII. AGENCY CONTACTS

CDC encourages inquiries concerning this announcement.

For programmatic technical assistance, contact:

Stephanie Griswold, Project Officer
Department of Health and Human Services
Centers for Disease Control and Prevention
JAT Complex 4 Ave. Zedequias Manganhela, 267

Maputo, Mozambique

Telephone: (258) 21 314 747, ext 119; (258) 84 308 4896

E-mail: griswolds@mz.cdc.gov

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

Darlene Harris, Grants Management Specialist

Department of Health and Human Services

CDC Procurement and Grants Office

2920 Brandywine Road, MS: K-75

Atlanta, GA 30341

Telephone: 770-488-3081

E-mail: Dharris2@cdc.gov

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

[Www.grants.gov](http://www.grants.gov) Contact Center Phone: 1-800-518-4726.

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 www.grants.gov following the approval of CDC.

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 website, at the following internet address: <http://www.grants.gov>.