Issue Date: **November 10, 2020**
Questions Due: **November 18, 2020**
Closing Date: **December 10, 2020**
Closing Time: **17.00 Malawi Time**

Subject: **Notice of Funding Opportunity Number: 72061220RFA00015**
Request for Applications (RFA)

Program Title: **Client-Oriented Response for HIV Epidemic Control (CORE) Activity**

Catalog of Federal Domestic Assistance (CFDA) Number: 98.001

Ladies and Gentlemen:

The United States Agency for International Development (USAID) is seeking applications from qualified entities to implement the Client-Oriented Response for HIV Epidemic Control (CORE) Activity. **This procurement is restricted to Malawian and Regional (Southern Africa Development Community - SADC) Applicants.**

USAID intends to make two awards to Applicants who best meet the objectives of this funding opportunity based on the merit review criteria described in this notice of funding opportunity (NOFO) subject to a risk assessment. Eligible parties interested in applying are encouraged to read this NOFO thoroughly to understand the type of activities sought, application submission requirements, the merit review criteria, and the selection process.

To be eligible for award, an Applicant must provide all information as required in this NOFO and meet the eligibility standards in Section C of this NOFO. This funding opportunity is posted on http://www.grants.gov/, and may be amended. It is the responsibility of the Applicant to regularly check the website to ensure they have the latest information pertaining to this NOFO and to ensure that the NOFO has been downloaded from the internet in its entirety. USAID bears no responsibility for data errors resulting from transmission or the conversion process.

USAID may not award to an Applicant unless the Applicant has complied with all applicable unique entity identifier and System for Award Management (SAM) requirements detailed in Section D. The registration process may take many weeks to complete. Therefore, Applicants are encouraged to begin registration early in the process.

Please send any questions to the point(s) of contact identified in Section D. The deadline for questions is shown above. Responses to questions received prior to the deadline will be furnished to all potential Applicants through an amendment to this notice posted to http://www.grants.gov/.

All questions concerning this NOFO must be submitted to the Agreement Officer, Office of Acquisition and Assistance, USAID/Malawi, Lilongwe at e-mail: OAA-Malawi-Solicit@usaid.gov with a copy to gsuya@usaid.gov and smbeya@usaid.gov no later than the date and time stated above.

Applicants must submit all required information (Technical and Cost Application) as required in this NOFO to Dion Glisan, Supervisory Agreement Officer at OAA-Malawi-Solicit@usaid.gov with a copy to gsuya@usaid.gov and smbeya@usaid.gov no later than the date and time stated above.

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

Thank you for your interest in USAID programs.

Sincerely,

Dion Glisan

Digitally signed by Dion Glisan
Date: 2020.11.09 21:07:46 +02'00'

Dion Glisan
Agreement Officer

Attachments:

Section A – Program Description
Section B – Federal Award Information
Section C – Eligibility Information
Section D – Application and Submission Information
Section E – Application Review Information
Section F – Federal Award Administration Information
Section G – Federal Awarding Agency Contacts
Section H – Other Information

SECTION A: PROGRAM DESCRIPTION:

1. Introduction

Over the last two decades, Malawi has made significant progress in combating Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS). At the end of September 2019, an estimated 93 percent of all people living with HIV (PLHIV) knew their HIV status, 80 percent of PLHIV with known status were on Antiretroviral Therapy (ART), and 92 percent PLHIV on ART were virally suppressed showing the country's progress toward reaching the 95-95-95 UNAIDS goal. Despite this significant progress, AIDS remains a major cause of death for adults and children under five in Malawi. There are an estimated 12,667 HIV-related deaths annually, and an estimated 1,077,268 Malawians are living with HIV. There are also critical disparities by geography and populations that require action to reach epidemic control. In order to address these challenges, the Health, Population, and Nutrition (HPN) office designed the Client Oriented Response for HIV Epidemic Control (CORE) activity ***(here after the "activity")***, as part of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). This activity is designed in line with USAID/Malawi's Country Development Cooperation Strategy (CDCS) 2020-2025 and the Government of Malawi's (GOM's) National Strategic Plan for HIV/AIDS (NSP) 2020-2025.

The Malawi Health Sector Strategic Plan (HSSP) 2017-2022 guides the implementation of the NSP (2020-2025) that aims to put Malawi on track to end HIV as a public health threat by 2030. The NSP is specifically focused on building a strong leadership, governance structure, resilient, and sustainable systems including preserving the gains made over the last couple of decades. The NSP plans to achieve its goal mostly by building the public health capacity, which is the hallmark of Malawi's HIV program. It has 8 thematic areas namely, (i) Resilient and Sustainable Systems for Health; (ii) Combination Prevention; (iii) Differentiated HIV Testing Services; (iv) Treatment, care and support; (v) Tuberculosis (TB)/HIV; (vi) Vulnerable Children; (vii) Reducing Human Rights and Gender-Related Barriers to services; and (viii) Social Behavior Change Communication.[1] The NSP also highlights the need to focus interventions in high HIV/AIDS incidence geographic locations, with a specific priority of high-risk populations including AGYW, men, key populations, and breastfeeding women. Integration of care across diseases particularly tuberculosis, sexual reproductive health, non-communicable diseases, viral hepatitis, and mental health will be prioritized.

USAID/Malawi's CDCS also calls for a more self-reliant Malawi that is gender-equitable and democratically accountable to be achieved through three Development Objectives (DOs).

- DO1: Public sector is more accountable and effective at national and decentralized levels;
- DO2: Youth lead healthy, informed, and productive lives; and
- DO3: Private sector increases inclusive and sustainable wealth generation.

In line with the NSP and the CDCS, the purpose of this assistance activity is to accelerate progress towards attaining and sustaining HIV epidemic control in Malawi. This will be achieved through the implementation of cost-effective, quality, and innovative direct service delivery interventions to improve client-centered HIV testing and treatment services. As a result, this

[1] Malawi National Strategic Plan for HIV and AIDS 2020-2025: February 2020.

activity directly contributes to the CDCS's DO1 and DO2 objectives through health sector interventions such as health systems strengthening including addressing Malawi's chronic workforce constraints by partnering with the GOM to recruit, train, and deploy health workers at high HIV burden health facilities in USAID supported districts.

While this activity is directly responsible for provision of direct service delivery support per PEPFAR definition, which includes human resources, provision of equipment or supplies, and minimum standards for monitoring, it is also required to build the capacity of the public health system at all levels (Ministry of Health, District Health Offices, and health facilities) in support of the CDCS DO1 objective. By doing so, this activity will strengthen the overall delivery of quality goods and services (IR 1.2) to People Living with HIV (PLHIV) and those at higher risk of infection. At the site level, this activity will support direct service delivery through training and deployment of healthcare workers. The activity will also strengthen the planning, implementation, and monitoring capacity of health facilities and district health offices to ensure ownership and effective oversight of programs.

In addition, this activity will support DO2 objectives by directing health investments towards evidence-based, cross-sectoral, and gender-sensitive interventions targeted to specific groups with increased challenges in being retained in HIV care, including children and adolescents. According to Malawi's 2018 census, 51 percent of Malawi's population is under the age of 18. These individuals require interventions to be layered and sequenced to deliver age and gender appropriate goods and services. This will contribute to build youth agency and provide access to expanded opportunities and social services (IR 2.1), increase the capacity of providers to deliver appropriate youth-focused goods and services (IR 2.2), and indirectly the trained workforce will advocate for the creation of an enabling environment that supports, protects, prepares, and actively engages youth (IR 2.3).

In support of the CDCS IR 2.2, this activity will identify and support private facilities and pharmacies particularly in Antiretroviral Therapy (ART) and HIV Self Testing (HIVST) kit distributions.

Overall, in support of the NSP and CDCS goals, this activity under the Country Operational Plan 2020 (COP 20) and subsequent COPs will implement a direct service delivery model to improve client-centered care and support the GOM in both attaining and sustaining HIV epidemic control in Malawi.[2]

2. Background and Problem Statement

2.1 Context of HIV/AIDS in Malawi

According to the 2019 GOM's National Statistical Office publication, the population of Malawi is more than 17.56 million people.[3] Although a small country, Malawi's HIV prevalence, at 5.7

[2] Malawi Country Operational Plan 2020; Strategic Directive Summary; March 27, 2020.

[3] http://www.nsomalawi.mw/images/stories/data_on_line/general/malawi_in_figures/2019%20Malawi%20in%20Figures.pdf

percent overall and 13 percent and 18.2 percent, respectively for men and women 25+ years adults, is among the highest in the world.[4]

The 2020 Spectrum estimates further indicate that HIV prevalence varies widely by region, age, sex, and urban areas versus rural areas. It is highest in Southern Malawi and in the urban centers of Blantyre and Lilongwe (14.2 % among adults aged 15-64 with urban residence). The SDS also indicated that the vast majority of females are infected between the ages of 15-34 (HIV incidence: 0.38% among females 15-24, 0.83% among females 25-34), HIV prevalence is nearly twice as high among females 15-24 years old (3.4%), and nearly three times as high among females 25-29 years old (13.6%) than among males in the same age brackets (1.5% and 4.7%, respectively). Prevalence peaks among females 40-44 years old at 24.6 percent and among males 45-49 years old at 22.1 percent. In 2020, about 1.1 million Malawians are living with HIV; 57 percent of whom are women, 38 percent men, and 5 percent children under age 15.

Over the last two decades, Malawi has made tremendous gains in addressing challenges related to HIV and Acquired Immunodeficiency Syndrome (AIDS). At the end of September 2019, an estimated 93 percent of all PLHIV knew their HIV status, 80 percent of PLHIV with known status were on ART, and 92 percent of PLHIV on ART were virally suppressed showing the country's progress toward reaching the 90-90-90 UNAIDS goals.[5] Malawi pioneered the Prevention of Mother-to-Child Transmission (PMTCT) option B+ program (treating all HIV positive pregnant and breastfeeding women regardless of disease stage or immune status) and in the process witnessed a significant reduction in children acquiring HIV and remarkable increase in the number of HIV-positive women on treatment. ART and PMTCT services have been successfully decentralized to health centers, bringing services closer to those who need them. Currently, there are 739 ART sites spread across 28 districts of Malawi. Adoption of task shifting in the delivery of HIV services has enabled expanded coverage of PMTCT and ART interventions in a health system with comparatively low availability of human resources for health (HRH). The national ART program has continued its impressive growth with over 799,860 PLHIV now on treatment.[6] The number of new HIV infections in Malawi decreased from 89,000 in 2004 to approximately 32,211 in 2020.[7] Since 2010, AIDS-related deaths have decreased by 56 percent.

Despite this achievement, the battle is far from won. AIDS remains a major cause of death for adults and children under five in Malawi, contributing to a low life expectancy of 63 years.[8] There are an estimated 12,667 HIV-related deaths annually, and an estimated 1,077,268 Malawians are living with HIV. There are also critical disparities by geography and populations that require action to reach epidemic control. In 2019, the majority of PLHIV and the greatest gaps to reaching 90 percent ART coverage were in urban Blantyre, Lilongwe, and Zomba. Progress across 90-90-90 is consistently high for women, but ART coverage among men and adolescents is low (UNAIDS SPECTRUM Estimates for 2020). Section 2.3 below details the common Key Challenges for a successful HIV/AIDS program implementation in Malawi and the achievement and sustainability of epidemic control.

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[4] Spectrum 2020

[5] UNAIDS SPECTRUM estimates for 2020

[6] DATIM: FY20 Q1 Report

[7] UNAIDS SPECTRUM estimates for 2020

[8] World Bank (2017)

2.2 PEPFAR Program Implementation Factors and Geographic Focus

The Malawi Health Sector Strategic Plan (HSSP) 2017-2022 guides the implementation of program interventions aimed at improving the health status of the people of Malawi. The Ministry of Health (MOH), other government ministries, departments, health development partners, civil society organizations (CSOs), the private sector, and other stakeholders in the health sector were involved in the development of and now implementation of the HSSP.

In 2015, the GOM developed the NSP to fast track the national HIV/AIDS response supporting the HSSP. As set forth in the NSP, success of the national program rests on reaching three key targets by 2020:

- 90 percent of Malawians living with HIV know their status;
- 90 percent of all those who are diagnosed with HIV infection receive sustained ART; and
- 90 percent of all people receiving ART have viral suppression.

The achievement of 90-90-90 (as well as 95-95-95) objectives will be predicated upon coordinated implementation of targeted community prevention, care and support, and impact mitigation activities linked to provision of quality facility based HTS, care and treatment services. The MOH transitioned to a Test-and-Start approach to treatment initiation in 2016 to reduce barriers to significantly expand treatment coverage and improve patient outcomes. In 2018, the MOH adopted new HIV treatment guidelines and HIV Self-Testing Guidelines to ensure improved policies, interventions, medicines, and technologies are available to support epidemic control.

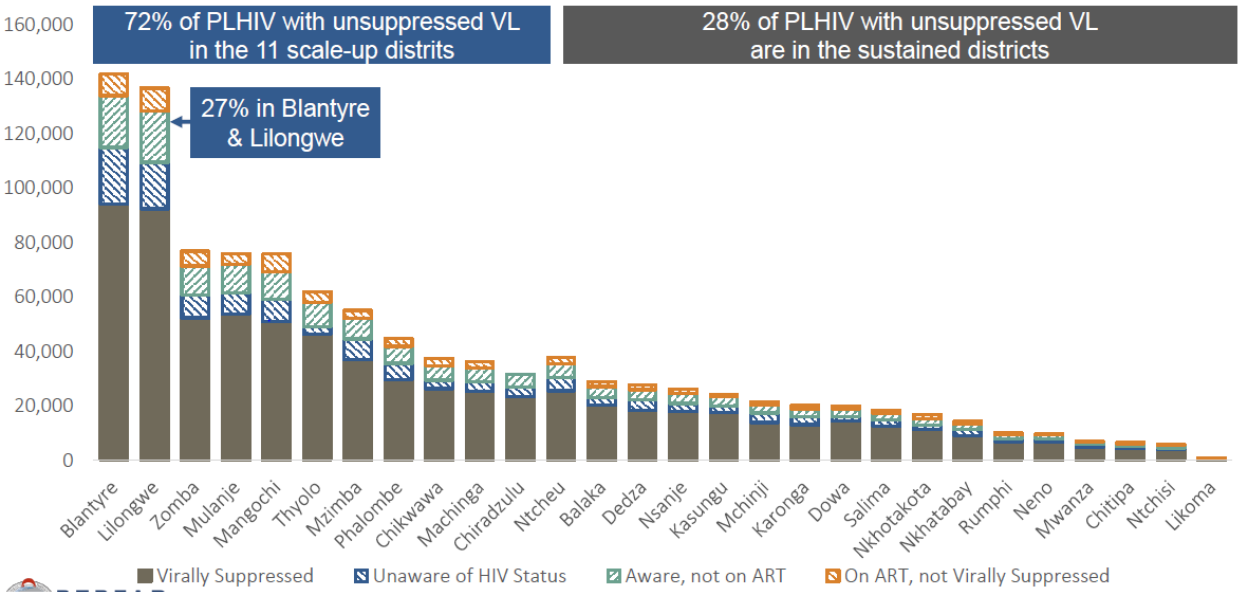
In support of the GOM's initiatives, the Malawi PEPFAR program investments comprise a wide spectrum of interventions targeting HIV-infected and -affected adults and children. The program also implements highly effective combination prevention strategies targeting priority and key populations. These activities support the work of the MOH, the National AIDS Commission, and others to mitigate the AIDS epidemic in the country. The PEPFAR care and treatment portfolio addresses several key gaps in the national HIV and AIDS response and complements contributions by other donors, including the Global Fund. PEPFAR supported care and treatment interventions are designed to work within the framework of national strategies and plans and to expand access to services while strengthening the national- and district-level capacity for program management and leadership.

In alignment with PEPFAR's goal of achieving Epidemic Control, PEPFAR Malawi aims to support the MOH to achieve the UNAIDS 90-90-90 goals by December 2020, while investing strategically to accelerate the national response targeting 95-95-95 by 2030. USG is also committed to supporting Malawi sustain epidemic control across districts and target populations. Accordingly, the USG emphasizes demonstration of cost-efficiencies to maximize impact of every dollar invested, increased transparency with validation and sharing of program data, and sustained control of the epidemic to save lives and avert new infections.

A PEPFAR strategic investment geographically is determined by district-level PLHIV burden, population group, status of ART saturation, and largest remaining gaps on viral load suppression. While PEPFAR operates in all 28 districts, most investments are prioritized in 11 scale up

districts where roughly three out of four PLHIV reside. With PEPFAR funding, USAID supports care and treatment activities in 14 districts while CDC operates in the remaining 14 districts. Despite the focus on the 11 scale-up districts, there is PEPFAR's commitment to continue supporting all districts to achieve and sustain epidemic control. For this procurement, the HIV/AIDS team proposes to divide district coverage into two awards with a comparable number of PLHIV to serve. Every year at the start of the COP planning, the PEPFAR team estimates the unmet need of PLHIV in each district - those left to find and put or bring back onto HIV treatment. Dividing the burden of clients between awards allows USAID the ability to compare performance as well as create opportunities for experience sharing between the two partners.

As a result, the USG PEPFAR program prioritized 438 sites in 11 "scale-up" districts of Malawi for HIV care and treatment in COP 20. As shown in the graph below, the 11 scale-up districts contribute to 72 percent of PLHIV in Malawi with unsuppressed viral load. The geographic distribution of this 'treatment gap' is illustrated in the figure below, which also illustrates the district categorization that guides PEPFAR's strategic investment in Malawi. While all districts currently receive some PEPFAR support, the level of effort will be driven by this categorization. USG is committed, for example, to provide support to other PEPFAR priority sites in the remaining 17 non-scale-up "sustained" districts with focus on passive case detection and enrollment in treatment, as well as support for a national sample transportation system and the MOH's Department of HIV's (DHA's) quarterly supportive supervision, yet the investment level will be lower than in the scale-up districts. This categorization is subject to change based on the annual COP process.



Within this broader landscape of USG support, this treatment follow-on activity will focus on interventions that contribute to an AIDS-free generation while demonstrating accountability, cost effectiveness, and impact. The activity specifically will provide intensive support for HIV service

delivery in multiple districts, spanning each of the two categories[9] noted above, in alignment with targets established in COP 20 and beyond. In the first year of implementation, the activity will support services in the districts shown below.

SNU Category	Component 1	Component 2
Scale up	Lilongwe[10], Chikwawa, Mulanje	Machinga, Mangochi, Phalombe
Sustained	Nsanje, Nkhotakota, Chitipa, Kasungu, Karonga, Dowa	Salima, Balaka

Importantly, the activity will have the capacity to work at this scale and the agility to expand coverage to additional sites or districts as epidemic control priorities shift and geographic priorities change. Any geographic shifts will be defined by USAID through the COP or the Operational Update (OPU) processes.

The activity will ensure that all interventions adhere to the latest PEPFAR guidance on prevention, treatment, care, and impact mitigation strategies and are implemented in alignment with the GOM's policies. The implementing partners will be responsible for monitoring and achieving implementation fidelity and ensuring a robust quality improvement approach. The activity will flexibly adapt as guidance and policy changes are effected.

2.3 Key Challenges

Lack of Uniform HIV/AIDS Treatment Coverage Among Male and Female Clients and Age Groups[11]: While the national treatment program has registered impressive results, progress has not been uniform across all target groups. Treatment coverage among men 25+ (76%) lags behind women 25+ years (93%). Men are more likely to come to clinics at an advanced stage of disease than women. According to the Malawi Population-Based HIV Impact Assessment (MPHIA), HIV case identification is the greatest challenge to achieving viral suppression at population level. Young people 15-24 years have lower treatment coverage and viral suppression compared to 25+ men and women. Despite having a high treatment coverage (85%), children have very low viral suppression (66%) mainly due to suboptimal ARV regimens.

Weak Health System: Shortage of testing personnel and private space for counseling remain key bottlenecks limiting implementation fidelity of HIV testing services (HTS) including active index testing across key entry points. Active index case testing is expanding but the uptake of testing by contacts is still low.

Task shifting has been a critical enabler for scaling HIV treatment in Malawi. Still, shortage of human resources is one of the major health systems challenges that constrain the HIV/AIDS response in Malawi. The doctor- and nurse-to-population ratio is one of the lowest in Africa. Similarly, there is a shortage of lay-cadre and other professional cadres such as psychosocial

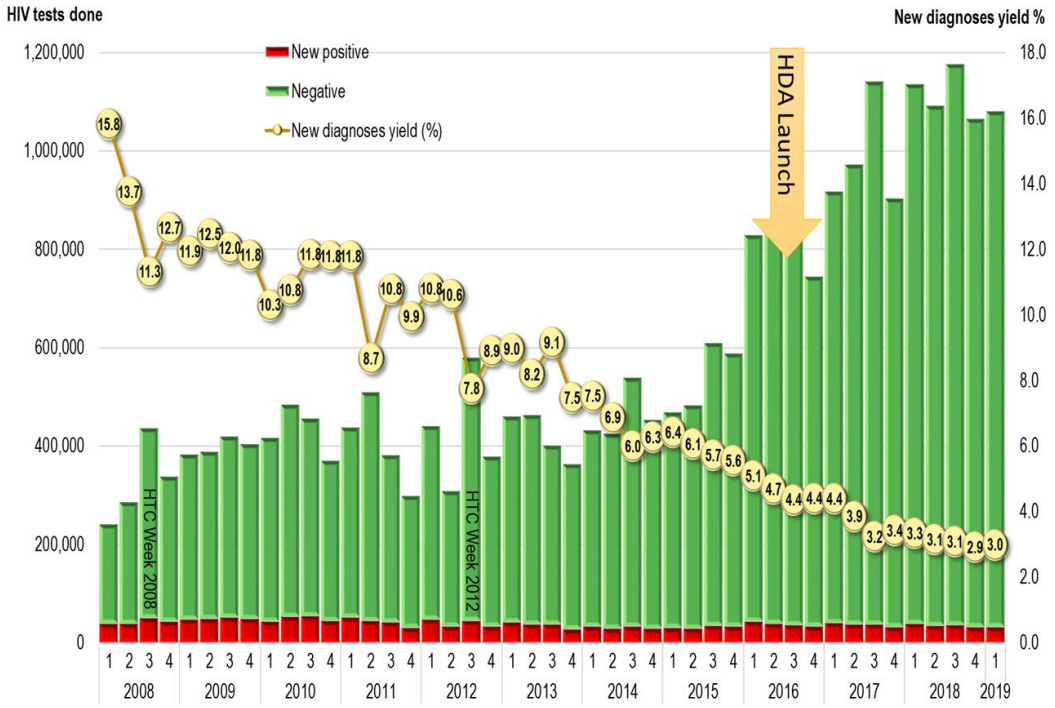
[9] While the Malawi program does not yet have an "Attained" district, it is anticipated many districts will achieve that status by the end of FY20.

[10] Lilongwe is supported by both USAID and CDC. Please see annex for USAID supported Lilongwe sites.

[11] COP20 Strategic Direction Summary (SDS)

counselors and social workers that play a key role in patient-centered care and life-long treatment retention. Many facilities were built decades ago and were not adequately renovated or expanded to accommodate the increasing patient volume and program needs. Storage space for HIV and other health commodities are also inadequate. Malawi has a strong national HIV monitoring and evaluation (M&E) system; however, use of data by facility staff for program monitoring and quality improvement is limited.

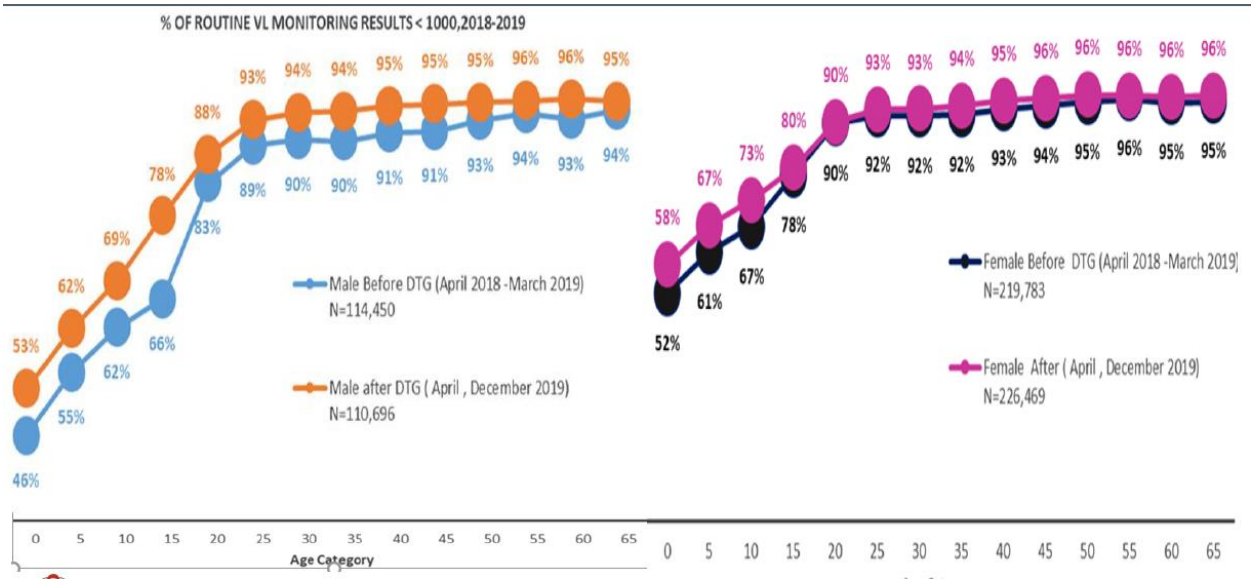
Over-testing: As shown in the MOH graph below, over the years, HIV testing volume has increased while yield has declined. Low-yield testing strategies, such as Outpatient Department (OPD) testing, divert facility-level human and infrastructure resources away from other more effective strategies as well as increase consumption of HIV testing kits. Absence of formally evaluated and agreed upon validated screening tools that maintain high yield make targeted testing in OPDs difficult.



Poor Patient Retention on Treatment: Long-term retention on ART is a critical challenge to HIV care and treatment programming in Malawi and to the attainment of high rates of viral suppression as a means of reducing HIV transmission and AIDS-related mortality. Annual treatment cohort growth lags far behind annual new enrollment on treatment suggesting potential patient loss and retention challenges. Several individual, community and facility level factors contribute to poor retention. Some of these factors include forgetting clinic appointments, social engagements, being unable to afford transportation costs, and unwelcoming provider attitudes.

Low pediatric viral load suppression: In April 2019, Malawi adopted the annual viral load testing policy and since then Viral Load (VL) testing volume has grown exponentially. While this is great progress, the VL monitoring program needs further optimization (ensuring higher coverage across all age/sex groups, reduced turn-around time including to clients, and improved

care for patients with unsuppressed viral load). With the introduction of Dolutegravir (DTG)-based regimens, overall viral suppression levels have improved (see figure below). However, children still have low viral suppression due to less efficacious pediatric ARV regimens. Malawi has adopted a Pediatric ART optimization policy. It aims at providing highly efficacious ART regimens to Children Living With HIV (CLHIV) to improve their VL suppression and treatment outcomes. The transition from less efficacious Nevirapine based regimens is underway at all ART sites.



Low TB Prevention Treatment Coverage: TB remains a significant cause of morbidity and mortality among PLHIV. Coverage of HIV testing of known TB cases and treatment of co-infected patients is very high. However, provision of TB Preventive Treatment (TPT) for ART patients has until recently been limited to five high TB burden districts and for life. In the five TPT districts, uptake has been high but completion of TPT is sub-optimal largely due to perceived or actual drug side effects and the additional pill burden. The recent MOH decision to expand services to all remaining districts, reduce IPT to six months as well as the introduction of 3-month regimen isoniazid-rifapentine (3HP) are expected to improve coverage and treatment completion.

Elimination of Mother-to-Child Transmission (eMTCT) goals not yet achieved: Malawi has made significant gains since the introduction of Option B+ in 2011. In FY19, 96 percent of pregnant women in Antenatal Care (ANC) had a known HIV status, and all positive mothers were started or were already on ART in PEPFAR supported sites. However, Malawi has not yet achieved the eMTCT goals mainly due to infection of infants during the breastfeeding period (68% of infections).[12]

High Cervical Cancer Rate: Women in Malawi are also at high risk for cervical cancer with data suggesting that Malawi has the highest cervical cancer incidence and mortality in the world.[13]

[12] Spectrum 2019

[13] Ferlay J, Soerjomataram I, Ervik M, Dikshit R, Eser S, Mathers C, Rebelo M, Parkin DM, Forman D, Bray F. GLOBOCAN 2012 v1.1, Cancer Incidence and Mortality Worldwide: IARC Cancer Base No. 11.Lyon: International Agency for Research on Cancer; 2014

Women with HIV have a higher prevalence of cervical precancerous lesions and may experience faster progression to cancer. While Malawi has made efforts to scale cervical cancer screening and treatment activities including with PEPFAR funds for women living with HIV, the coverage is limited.

2.4 Problem Statement Based on Lessons Learned from PEPFAR Activities

This activity is designed on the basis of findings from the Malawi Population Based HIV Impact Assessment (MPHIA), a rigorous analysis of an in country PEPFAR data used to inform the 2020 SDS for Malawi, and lessons learnt from specific studies and global experiences across PEPFAR countries guided by current Technical Considerations issued by the Office of Global AIDS Coordinator (which in turn is informed by global normative guidelines from WHO and PEPFAR countries' best practices).

Compared to women, men have lower treatment coverage.[14] Generally, men exhibit poor health-seeking behaviors resulting in low HIV risk perception and fear of stigma and discrimination at home, in health facilities and in their community if accessing HIV services or testing HIV-positive. This behavior among men is further reinforced by cultural and gender norms - including masculinity norms that view health seeking as both a burden and sign of weakness among men and perceptions of health facilities providing only women-centered services. Concerns regarding confidentiality, distance to services, and inconvenient hours exacerbate reluctance to utilize services. Furthermore, implementing partners' data also revealed difficulty to get to a health facility, forgetting ART appointment, poor healthcare provider conduct in reaction to late show for ART appointment, absence of symptoms, and side effects of ART medications are among the list of barriers that force clients to drop out from treatment.

District	ART Coverage, Scale-Up Districts FY20Q1								
	<15	F15-24	F25-34	F35-44	F45+	M15-24	M25-34	M35-44	M45+
Total	**85%**	**60%**	**84%**	**100%**	**64%**	**39%**	**42%**	**76%**	**69%**
Blantyre	70%	60%	69%	84%	57%	41%	34%	65%	63%
Chikwawa	107%	78%	104%	103%	60%	41%	53%	84%	66%
Chiradzulu	131%	81%	114%	186%	135%	69%	58%	136%	136%
Lilongwe	88%	63%	77%	89%	64%	47%	39%	74%	74%
Machinga	106%	61%	104%	115%	64%	36%	47%	86%	77%
Mangochi	89%	42%	76%	86%	50%	24%	33%	65%	56%
Mulanje	75%	56%	92%	97%	53%	28%	53%	81%	57%
Mzimba	74%	62%	80%	106%	77%	42%	38%	73%	74%
Phalombe	71%	71%	121%	117%	61%	31%	59%	73%	48%
Thyolo	108%	68%	94%	125%	70%	48%	59%	111%	87%
Zomba	81%	51%	77%	98%	64%	34%	37%	67%	60%

Implementing partners' performance data presented during the PEPFAR COP2020 Regional Planning Meeting in Johannesburg, South Africa from March 2-6, clearly indicated the need to re-orient the current implementation strategy for the remainder of FY2020 and beyond to improve

[14] COP20 SDS

PEPFAR's support to Malawi's national HIV response in order to achieve epidemic control. FY2020 PEPFAR data revealed losses in the treatment cohort in FY2019 Q4 and FY2020 Q1. While some of this loss can be attributed to data quality issues, real program loss (clients being lost to follow up and not retained in care and treatment) is a significant contributor across the Malawi program.

Moreover, FY2019 Q4 reporting on both human resources for health and expenditure data revealed a misalignment of staffing support at site level vs. staff supported at district level and sitting at the partner's head office in Lilongwe. Analysis of these data sources revealed that service delivery partners were spending a higher proportion of PEPFAR resources at the 'above-site' management level as compared to the site level where services are delivered.

In addition, based on patient level data and partner performance in Malawi, the 2020 SDS has identified the retention of clients as the single greatest threat to a sustainable HIV response in Malawi. Over the past three years, PEPFAR Malawi has been successful in identifying and initiating over 380,000 clients on ART, but only retained 125,000 clients in care. For Malawi to achieve the 95-95-95 UNAIDS goals, the COP20 Data Pack estimates that PEPFAR Malawi program will need to reach an additional 160,000 PLHIV with ART, retain the over 800,000 clients currently in care with client centered services and prevent transmission through accelerated treatment literacy efforts and scale and high impact prevention programs.[15]

While there were setbacks in FY2019, PEPFAR has identified the following interventions that will have significant contribution to HIV/AIDS treatment and care in Malawi:

- Strengthening HRH support for direct service delivery of testing and treatment services;
- Supervision and mentorship support to ensure compliance to national standards.
- Increasing access to and quality of service through infrastructure support (E.g. prefab, renovations);
- Joint partner reviews – sharing of best practices;
- Integrating continuous quality improvement (CQI) approach; and
- Use of granular data for program management.

The PEPFAR Malawi's COP20 strategy will focus on streamlining HIV testing services at the site level through the consolidation of provider-initiated testing and counseling (PITC) testing points, expansion of HIV self-testing (HIVST), continued implementation and validation of screening tools, and task-shifting of HDAs to identify high risk clients and reduce over testing as well as to support retention efforts. Case-finding efforts will be targeted in ANC, TB, and sexually transmitted infections (STI) settings with index modalities targeting men and high-risk individuals. Adherence to the 5Cs (consent, confidentiality, counseling, correct test results and connection to prevention/treatment) will be a key requirement for HIV testing services including index testing modalities, in addition to, site and personnel certifications, and intimate partner violence (IPV) screenings, provision of first line response and referral to clinical and non-clinical services. PEPFAR also requires establishment of a site level adverse event monitoring and reporting system.

[15] Malawi Country Operational Plan 2020; Strategic Directive Summary; March 27, 2020.

To improve retention, return clients back to care, and prevent new infections, PEPFAR Malawi activities will implement a surge retention strategy with the following seven key components to sustain epidemic control in Malawi:

1. New and evolved partnerships
2. Back to care surge and differentiated service delivery models
3. Optimized human resources for health (HRH)
4. Incorporating a risk stratification strategy
5. Shift from technical assistance to direct service delivery models
6. Intensified national treatment literacy efforts
7. Quality data for patient management

All existing PEPFAR Malawi implementing partners and newly designed activities will focus on improving services through optimizing human resources for health at site level to retain clients and improve their experiences accessing HIV care and treatment.

Therefore, this activity's approach will be to address the known barriers appropriate for the stage of the Malawi epidemic status. The implementation of this activity will benefit from a client-centered care approach, which aims to identify the needs of the clients and meet those needs in a tailored approach. Generally, the activity will accelerate a more targeted case finding (Index Testing: high yield, increased reach of men); increase focus on quality of care by rightsizing patient: client ratio by type of cadre (e.g. psychosocial workers and data clerks); and increase efficiency through screening for testing and risk stratification for retention. To reduce the frequency of travel to clinics and transportation cost, or lost time from work or family, the activity will accelerate the roll out of 6 months drug dispensing and other differentiated ART delivery models tailored to the needs of clients. HIV self-testing is also considered as a safe, accurate, and effective way to reach people who may not test otherwise, including people from key populations, men, and young people. These interventions coupled with intensified testing of biological children of adults living with HIV and timely reminders of their upcoming appointment will decrease drug discontinuation and improve retention of clients on treatment.

In order to do this, the activity will build the capacity of health care providers to implement index case testing and facilitate community outreach activities. This activity will also reinforce professional codes of conduct through mentorship and supervision to maintain privacy, confidentiality, respectful, non-judgmental services to PLHIV to improve ART coverage, retention, and viral load suppression.

Rigorous M&E (including continuous quality improvement approaches) will be integral to this activity's programming. This will enable the activity to identify and remediate issues quickly at the district and site-levels. Additionally, as new data and alternative high impact interventions become available – the program will make necessary course corrections that would foster better results.

3. USAID/MALAWI Program Coordination and Synergies

3.1 Stakeholder Consultations

The USG, including USAID, the Department of State (DoS), the Centers for Disease Control and Prevention (CDC), the Department of Defense (DOD), and Peace Corps, is one of the largest contributors to HIV programming in Malawi. All USG agencies work together closely as one PEPFAR country program, jointly defining strategies and targets on an annual basis through the COP process. This activity will serve as a pivotal implementation mechanism for USG support to control the HIV/AIDS epidemic in Malawi, in collaboration with other USAID and PEPFAR activities, including projects implemented by CDC, DOD, Peace Corps, and DoS, as well as a range of other stakeholders, to maximize synergies and share program learning and best practices.

The design of this activity is also informed by intensive stakeholder engagements that occur during COP planning and quarterly stakeholder meetings with the Ministry of Health, National AIDS Commission, civil society organizations, Global Fund, UNAIDS, WHO, other donors, implementing partners and others.

3.2 Integration and Synergies across GOM, CDCS, and Other Donors Investments

With a focus on integration of assistance efforts and greater linkages to current and planned activities under PEPFAR Malawi, this activity is highly cognizant of how its interventions will be embedded within, be supportive of, and leverage USAID/Malawi broader development goals in line with the GOM's NSP and the CDCS. The overarching goal of the NSP is to put Malawi on track to end HIV as a public health threat by 2030 and the CDCS goal is "A More Self-Reliant Malawi that is Gender-Equitable and Democratically Accountable." The activities under this Program Description are defined in the Integrated Health Project Appraisal Document, specifically contributing to the intermediate goal, Health Status of Malawians in target districts improved. This relationship between this activity's goal, expected results, and the CDCS development objective and goal is illustrated in the figure below.

I. GOM Priorities under the NSP

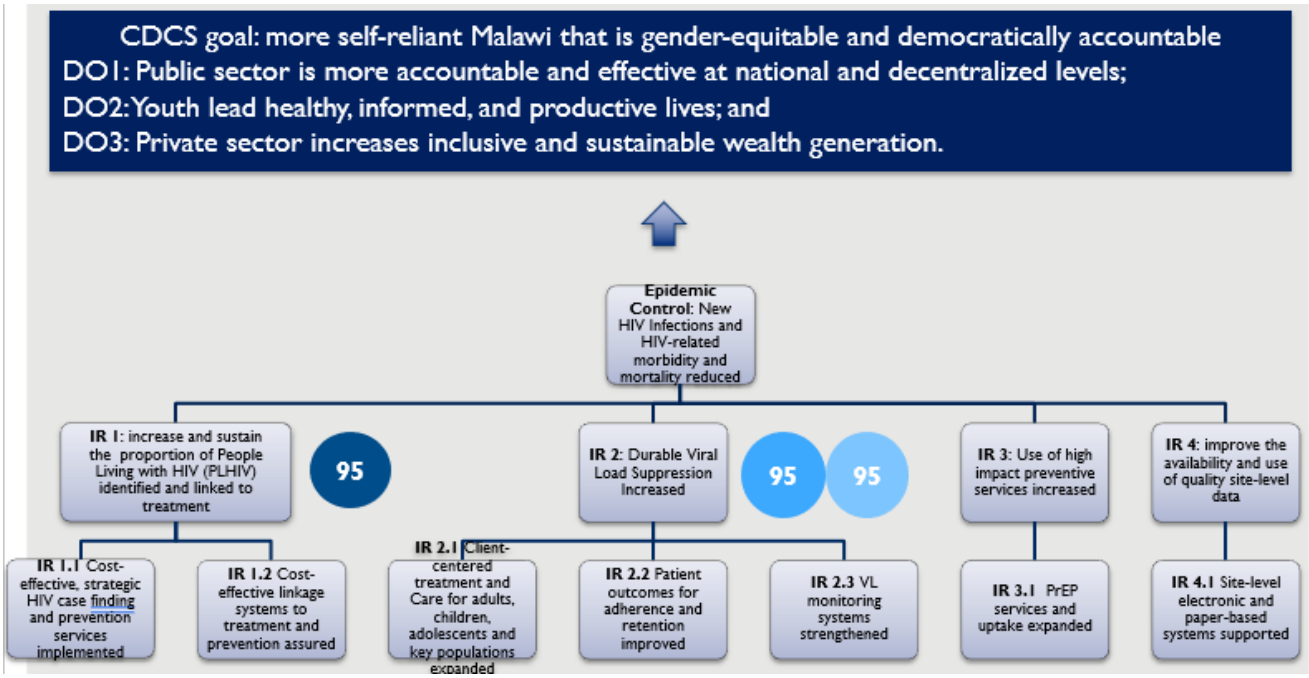
The NSP aims to put Malawi on track to end HIV as a public health threat by 2030 that is focused on building a strong leadership, governance structure, resilient, and sustainable systems including preserving the gains made over the last couple of decades. The NSP plans to achieve its goal mostly by building the public health capacity, which is the hallmark of Malawi's HIV program. It has 8 thematic areas namely, (i) Resilient and Sustainable Systems for Health; (ii) Combination Prevention; (iii) Differentiated HIV Testing Services; (iv) Treatment, care and support; (v) TB/HIV; (vi) Vulnerable Children; (vii) Reducing Human Rights and Gender-Related Barriers to services; and (viii) Social Behavior Change Communication.[16] The NSP also highlights the need to focus interventions in high HIV/AIDS incidence geographic locations, with a specific priority of high-risk populations. AGYW, men, key populations, and breastfeeding women. Integration of care across diseases particularly tuberculosis, sexual reproductive health, non-communicable diseases, viral hepatitis and mental health will be prioritized.

[16] Malawi National Strategic Plan for HIV and AIDS 2020-2025: February 2020.

II. USAID/Malawi CDCS

The CDCS calls for a more self-reliant Malawi that is gender-equitable and democratically accountable to be achieved through three Development Objectives (DOs).

- DO1: Public sector is more accountable and effective at national and decentralized levels;
- DO2: Youth lead healthy, informed, and productive lives; and
- DO3: Private sector increases inclusive and sustainable wealth generation.



While this activity is directly responsible for provision of direct service delivery support per PEPFAR definition, which includes human resources, provision of equipment or supplies, and minimum standards for monitoring, it is also required to build the capacity of the public health system at national, district and facility levels in support of the DO1 objective. According to the World Bank study document the GOM owns 69 percent of major health facilities and the Christian Health Association of Malawi (CHAM), a private not for profit organization, owns 29 percent of major health facilities in Malawi. The MOH also has a service level agreement with CHAM to provide essential health services. As such, most HIV service delivery is provided through public health facilities including CHAM. Therefore, this activity will closely work with the public health system at all levels (MOH, District Health Offices, and health facilities) to ensure PLHIV and those at higher risk of infection get the services they need.

At the site level, this activity will support direct service delivery through training, mentoring and deployment of healthcare workers. The activity will also strengthen the planning, implementation, and monitoring capacity of facilities and district health offices to ensure ownership and effective oversight of programs. By doing so, this activity will strengthen the overall delivery of quality goods and services (IR 1.2) to PLHIV and those at higher risk of infection.

On the other hand, this activity will support DO2 objectives by directing USAID/PEPFAR investments towards evidence-based, cross-sectoral, and gender-sensitive interventions. Young people make up a significant proportion of PLHIV in Malawi. Yet, 24-30 percent[17] of young people (15–24 years old) are not yet on treatment compared to 7-21 percent of adults 25+ years. This figure is particularly concerning given that the proportion of youth in the Malawian population is increasing substantially. In the absence of effective prevention interventions, young people are at higher risk of new infections. In support of the GOM's commitment to epidemic control by stopping transmission and preventing new HIV infections, this activity will ensure proven interventions, promising practices and innovative approaches targeting the youth. With focus on client-centered care, this activity will engage young people in the design, implementation, and monitoring of services. Post Gender-based Violence care and Pre-Exposure Prophylaxis services will also be integrated in the program so that young people with an elevated risk of new infections will be protected. These interventions will be layered and sequenced to deliver age and gender appropriate goods and services. This will contribute to build youth agency and provide access to expanded opportunities and social services (IR 2.1), increase the capacity of providers to deliver appropriate youth-focused goods and services (IR 2.2), and indirectly the trained workforce will advocate for the creation of an enabling environment that supports, protects, prepares, and actively engages youth (IR 2.3).

While most HIV clients access health services through public health facilities, there is an opportunity to leverage private health facilities in increasing access to and improving quality of health services and outcomes. This is particularly important in districts with urban and major trading centers. In support of the CDCS IR 2.2, this activity will identify and support private facilities and pharmacies particularly in ART and HIVST kit distributions.In the first year, this activity will assess the private sector landscape in USAID-supported districts (with focus on urban and major trading centers) or use findings from a planned USAID-funded private sector assessment for potential expansion opportunities. In collaboration with the Ministry of Health and district health offices, private facilities with a potential to decongest high volume ART facilities as well as increase access to other HIV/AIDS services will be supported.

To ensure the use of data driven solutions at any given time and to prompt programmatic changes to respond to any strategic shifts, this activity is designed with a strong collaborating, learning, and adapting approach throughout its implementation cycle. Thus, this activity will have the flexibility to propose a new private sector engagement approach during its implementation. However, given the core requirement for this activity to support the ongoing public sector, the private sector approach is likely to be a very small component of the activity.

a. Contribution to the Journey to Self-Reliance Country Roadmap

PEPFAR's core principle relies on empowering local organizations that will directly contribute to the Journey to Self-Reliance. USAID/Malawi uses a broad range of tools to strengthen local institutions and engage local actors as the drivers behind long-term, sustainable change. As such, the HPN office has an amended PAD dated February 6, 2019 that restricts competition requirements to local organizations designed to strengthen both technical and organizational skills of selected local partners. To this effect, PEPFAR has been supporting this effort by designing

[17] COP20 SDS

activities that would create partnership between international and local partners with the intent to transition the local partner over time to receive direct funding from USAID. Currently, there are two USAID local partners successfully implementing separate awards valued between $10-13 million annually. PEPFAR globally has an ambitious target of directing 70 percent of PEPFAR resources through local partners by the end of 2020.

Regional awards also now count toward PEPFAR's goal of local partners. Numerous other African organizations would be eligible if the solicitation were open to regional organizations. Continuing this tradition of ambitious yet demonstrated commitment to local ownership and capacity strengthening, these two awards will be restricted to local Malawian and regional organizations from the South African Development Community (SADC) that will continue to contribute in building the capacity of local organizations to implement this activity effectively. This activity has a strong mentorship and supervision strategy that will enhance the capacity of health facilities and effective use of MOH staff (e.g. Health Surveillance Assistants (HSAs) for index testing, community tracing) in HIV prevention, care, and treatment. The activity will increase use of technologies for mentorship and supervision of site and district level staff. Moreover, it will increase the use of site level electronic medical record systems for ongoing program management and remediation and will involve CSOs for community-led monitoring of program implementation. This will undoubtedly support sustainable programming, capacitate internal health systems, and maximize efficiencies and costs for the GOM to address the significant gaps in treatment coverage among target populations and demographic groups.

This activity therefore supports Malawi's journey to self-reliance through both an individual and systems approach by directly enhancing government and citizen capacity by expanding access and reducing barriers to utilize age-appropriate health services for men and women of reproductive age and children.

In keeping with the current CDCS focus on integration, the interventions proposed by this activity exemplify co-location, coordination, and collaboration with the GOM, other development partners, and other USAID/Malawi and PEPFAR activities. The aim of integration is for overall efficiency gains, including avoiding duplication or parallel structures, establishing synergies between investments, and adjusting to participant time and resource constraints. This activity will proactively collaborate with other partners and capitalize on windows of opportunity to improve services for beneficiaries and achieve programming efficiencies.

USAID investments in maternal, neonatal, and child health (MNCH), nutrition, family planning (FP), TB, malaria, and HIV prevention and care offer numerous opportunities for integration and synergies. Ana Patsogolo (APA) is a USAID/Malawi activity that will reach vulnerable households with children affected or infected with HIV, orphans and vulnerable children (OVC), and vulnerable adolescent girls and young women (AGYW) in Blantyre, Chikwawa, Zomba, Machinga, Mangochi, Mulanje, Phalombe and Thyolo with comprehensive DREAMS programming in Blantyre, Zomba and Machinga. APA will combine impact mitigation and prevention activities, through fostering linkages between community-based services and facility based HIV care and treatment services. This activity will work closely with APA and other PEPFAR OVC, DREAMS, and key populations implementing partners to ensure client-centered services are delivered to vulnerable populations and that community and facility linkages are

strengthened. Pakachere provides comprehensive HIV services for female sex workers in Blantyre, Mangochi, Lilongwe and Mzuzu and FHI 360 provides key populations programming for female sex workers in Zomba and Machinga. Other examples of relevant USAID/Malawi HIV prevention activities include voluntary medical male circumcision (VMMC) programming, integrated youth friendly mobile outreach (HIV and family planning-related services), and condom activities that operate both at the national and local levels as well as the USAID Global Health Supply Chain Procurement and Supply Management (GHSC-PSM) Program, which builds MOH's capacity for supply chain management. Similarly, this activity will coordinate facility-based support with PEPFAR -supported efforts to improve electronic medical records (EMRS), provide lab sample transport and results return, and to enhance MOH's supportive supervision at all HIV service delivery sites nationwide.

USAID's priority Family Health program, Organized Network of Services for Everyone's Health (ONSE) provides facility- and community-based services in 16 districts in Malawi. Successful leveraging of these and other USAID activities will help ensure program beneficiaries benefit from a broader package of high-quality health services. The activity is expected to complement relevant USAID activities and build partnerships that support the Mission's integrated vision of development. Annex 2 presents a table listing the districts supported by ONSE and HIV clinical cascade priority districts planned for year one implementation. Annex 3 contains a list of all health facilities targeted for this activity's year one implementation as defined in COP20.

b. Post-Epidemic Control

When the Malawi program reaches epidemic control, deliberate and focused effort will be required to sustain it. The activity will define intervention packages across the PEPFAR SNU categories: attained, scale up, and sustained. HRH investment which is a key aspect of PEPFAR's direct service delivery support, will be re-examined to ensure it is responsive to the needs on the ground. This activity will propose transition of PEPFAR-supported HRH for the life of the project to better alignment with Government of Malawi cadres to promote sustainability. With 90 percent of the PLHIV knowing their HIV status, case-finding efforts will be even more targeted by population, district, and HTS approaches. Implementation of active index testing with fidelity, expanding access to recency testing, and HIV testing using validated screening tools will be essential. In consultation with the Department of HIV/AIDS, some of the HTS direct service delivery could be transitioned to MOH cadres.

Once epidemic control is achieved, close to 1 million PLHIV will be on ART in the Malawi HIV Program. Major priority should be on providing client-centered care and treatment services that ensure high levels of adherence, retention, and viral suppression. Differentiated service delivery models will play a critical role in delivering client-centered services for both stable ART patients and those who need advanced care due to HIV-related comorbidity, or treatment failure. The activity will support the MOH and health facilities to ensure critical services such as annual viral load monitoring and management of patients with unsuppressed viral load are readily available. Implementing partners will also collaborate with PEPFAR lab partners to ensure access to genotyping services and effective drug resistance surveillance systems.

Treatment literacy of ART clients will be emphasized through facility and community approaches. For these efforts to succeed, implementing partners will engage PLHIV, civil society

organizations, faith and traditional leaders as well as service providers. Such broader engagement of stakeholders will assist identification of knowledge/information gaps, misconceptions, and guide the development of effective communication strategies and tools.

Availability of near "real-time" data and information is very important for patient care and strong program monitoring. Granular analyses of program and epidemiologic data will be critical to prioritize interventions and clearly define target population and districts. Implementing partners will therefore work closely with the Health Information System (HIS) partner to support EMR systems and use of data in health facilities.

c. Sustainability

PEPFAR aims to accelerate the epidemic control response in Malawi to rapidly reduce new infections through treatment saturation and expansion of effective prevention interventions. Only a shrinking epidemic can be financially sustainable. PEPFAR also recognizes that sustained epidemic control requires a deliberate approach to building systems and an enabling environment that will support this sustained response. For PEPFAR, sustainability of the HIV response means that a country has the enabling environment, services, systems, and resources required to effectively and efficiently control the HIV and AIDS epidemic. The enabling environment reflects the political will to address the epidemic, ensure key policies are adopted and implemented quickly, and establish the legal framework within which all systems, services and financing function; HIV services meet the HIV prevention and treatment needs of everyone in the populace; systems ensure quality, efficiency and effectiveness of HIV services; and resources provide the financial, human and organizational capital required to keep systems and services operating. This activity will be instrumental in influencing each of these factors. Through demonstration of successful implementation and innovation, it will be in a position to influence adoption of enabling policies, services, and systems. Through mentoring and targeted training efforts, the activity will build human capacity for quality service delivery at facility and district level. Finally, the activity will also seek opportunities to collaborate with and build the capacity of local Malawian organizations with a view to supporting PEPFAR's targets of direct programming through local organizations.

III. Other Donors Activities

The donor community in Malawi actively collaborates and coordinates around health issues to maximize the impact of donor resources. USAID's programming complements support provided by other donors to the national program. Collaborative funding of health assistance efforts is actively encouraged and sought by USAID. Implementation areas within this activity may also be of interest to other donors and opportunities for other donors to help finance or expand specific efforts are encouraged.

The USG is a significant investor in Malawi's HIV and AIDS response. The Global Fund is also a major source of support to the national HIV/AIDS response, specifically providing almost all HIV and TB drugs and commodities. The Global Fund is providing approximately $423 million dollars over 3 years to combat HIV and AIDS. This activity will ensure active coordination with other donor-funded activities at implementation level to ensure effective utilization of health program resources and maximum impact of USG investments.

The implementing partners will coordinate with both facility- and community-based partners implementing health interventions generally and HIV/AIDS specifically. The coordination will be handled through participation in regular national/district-level planning and program review meetings (e.g., Technical Working Group meetings, District Implementation Planning processes, etc.), holding one-on-one coordination meetings with other implementers working in the same district or technical areas to clarify the division of roles and explore opportunities to maximize impact through collaboration.

In line with the NSP, CDCS, and other donors priorities, to accelerate progress towards attaining and sustaining HIV epidemic control in Malawi, this activity will implement cost-effective, quality, and innovative direct service delivery interventions to improve client-centered HIV testing and treatment services by increasing HIV case finding, linkage to treatment for HIV, and viral load suppression among PLHIV. As a result, this activity directly contributes to the CDCS's DO1 and DO2 objectives through health sector interventions such as health systems strengthening including addressing Malawi's chronic workforce constraints by partnering with the GOM to recruit, train, and deploy health workers across the country.

4. Scope of Work

This activity will provide intensive support to improve access to and uptake of quality HIV clinical services in multiple districts of Malawi in alignment with the GOM's NSP, the PEPFAR Malawi strategy as defined through the annual COP process, and the CDCS. The activity will ensure the availability of efficient and targeted HTS, linkage to treatment, back to care services, comprehensive retention in care and treatment services for PLHIV (including viral load monitoring; TB screening, referral for treatment, and TPT; cervical cancer screening and treatment; and nutrition assessment, counseling and support), and differentiated service delivery models to enhance patient-centered care. This activity will enhance services to effectively target populations that are highly affected by HIV and/or have high-unmet needs. Implementation efforts, in conjunction with those of the MOH, shall ensure PLHIV are retained in care and achieve durable viral load suppression through improving retention, adherence, and quality of care.

This activity will serve as a key implementation platform of the COP strategy in Malawi and, as such, will be nimble and responsive to shifts in epidemiology and strategic direction by the MOH and PEPFAR. On an annual basis, the PEPFAR Malawi strategy will be recalibrated through the COP planning process. This strategy will be defined in the PEPFAR SDS, which articulates programming priorities and investments. Specific targets for districts and facilities served and service uptake results will be established on an annual basis through the COP process and defined in DATIM and the annual work plan. Similarly, strategic shifts may be made during the COP process that will require changes to the geographic scope of the activity. The implementing partners will actively participate in the COP development process and robust monitoring of COP implementation.

This activity will support services in 219 PEPFAR-designated high priority facilities (COP20). See Annex 3 for a complete listing of these sites by district and district categorization. The activity will ensure high quality implementation for comprehensive clinical cascade services in

these sites, according to the service package defined by district categorization in the SDS. See Annex 4 for a list of the primary performance targets established in COP 20.

4.1 Activity Rationale and Goal

USAID's assistance for Malawi's HIV and AIDS program is focused on interventions that are expected to have the greatest impact on achieving and sustaining epidemic control and are supported by a strong evidence base. This activity's primary goal is to reduce HIV incidence, and HIV-related morbidity and mortality. To achieve this goal, the results framework below will guide this activity.

Goal: New HIV infections and HIV morbidity and mortality reduced.

Objective 1: Increase and sustain the proportion of People Living with HIV (PLHIV) identified and linked to treatment.

Result 1.1 Cost-effective, strategic testing services implemented; and,
Result 1.2 Cost-effective linkage systems from testing to HIV prevention, care, and treatment services assured.

Objective 2: Durable viral load suppression increased.

Result 2.1 Quality care & treatment services for adults, including pregnant women, children, adolescents and key populations;
Result 2.2 Patient outcomes for adherence and retention improved; and
Result 2.3 Strengthening viral load monitoring systems.

Objective 3: Use of high impact preventive services increased.

Result 3.1 PrEP services and uptake expanded.

Objective 4: Improve the availability and use of quality site-level data

Result 4.1 Site-level electronic and paper-based systems supported.

The activity will achieve its goal by increasing access to and utilization of high-quality, comprehensive services across the continuum of HIV treatment and care within the sub-national units (SNUs) or districts where it operates. These results will support the goals of the NSP, PEPFAR's Strategy for Accelerating Epidemic Control, and implementation of the USAID/Malawi's CDCS, which has the overall goal of a more self-reliant Malawi that is gender-equitable and democratically accountable.

This activity will prioritize interventions to target populations that are highly affected by HIV and/or have high unmet need, especially men and youth, in order to increase ART coverage in those sex and age groups that have the lowest coverage.

The proposed interventions directly contribute mainly to two CDCS DOs: DO 1- Public sector is more accountable and effective at national and decentralized levels and DO 2- Youth lead healthy, informed, and productive lives, as illustrated in the figure above in B.2.2 depicting the relationship between this activity and the CDCS. Health sector interventions such as health

systems strengthening, and civil society activities are improving local government performance and transparency including addressing Malawi's chronic workforce constraints by partnering with the GOM to recruit, train, and deploy health workers across the country. These activities are contributing towards building a more accountable and effective public sector. Therefore, PEPFAR's strategic investments under DO 1 will enhance the ability of citizens to exercise their rights and responsibilities (IR 1.1), strengthen the public sectors' capacity to deliver quality goods and services (IR 1.2). DO 2 on the other hand will direct primarily health and education investments towards evidence-based, cross-sectoral, and gender-sensitive interventions. These interventions will be layered and sequenced to deliver age and gender appropriate goods and services. PEPFAR's strategic investments under DO2 will contribute to build youth agency and provide access to expanded opportunities and social services (IR 2.1), increase the capacity of providers to deliver appropriate youth-focused goods and services (IR 2.2), and create an enabling environment that supports, protects, prepares, and actively engages youth (IR 2.3). The activity results will contribute directly to DO 1 and DO 2 and their corresponding IRs listed above. The results area will require improvement in the availability of services and quality of services. Service utilization will be driven by both supply- and demand-side factors. Increased availability could include expanding access at additional entry points or by extending service days or hours. At the same time, uptake will also be driven by the quality and responsiveness of the service to patient needs.

While the activity will be directly responsible for provision of Direct Service Delivery (DSD) support per PEPFAR definition, which includes human resources, provision of equipment or supplies, and minimum standards for monitoring, this activity will build capacity of District Health Offices (DHOs) and health facilities to provide these services. Similarly, through contributions to National Technical Working Groups and programmatic Task Forces, implementing partners will participate in national governance structures for HIV and health-related policy making, sharing lessons learned from programmatic experience and operational research to inform national policy and practice.

PEPFAR/Malawi's support of the national 95-95-95 objectives and PEPFAR's epidemic control strategy entails the adoption of data-driven epidemic control strategies that target geographic locations and population groups with the highest unmet HIV service needs. PEPFAR investments nationally are focused on the highest HIV burden districts and at sub-national level, on the highest burden health facilities, 'sites'. This prioritization of sites is largely based on patient volume (TX curr), but is also related to HIV testing yield and unmet need. As these factors change over time, the activity is expected to adapt, which may entail increasing or decreasing the number of supported sites, and prioritization of available resources among these sites to respond to the epidemic.

Aligning with these CDCS intermediate results of increased public and private sectors capacity to deliver quality goods and services, the activity will provide a broad platform to expand access to comprehensive, patient-centered, high quality HIV/AIDS, HIV/TB, and cervical cancer services for PLHIV, and to support public health facilities to adopt new guidelines and innovative models to accelerate achievement of epidemic control. This approach requires support for implementation of a minimum intervention package defined by national guidelines for HTS and ART, and by PEPFAR including:

- Focused clinical and systems mentoring, training, and supervision;
- Direct service delivery through HRH, infrastructure, and material support to facilities to ensure:
    - quality HTS and initiation on treatment;
    - TB/HIV case finding, prevention, treatment initiation and patient support;
    - viral load monitoring for improved clinical care;
    - Viral load suppression, retention and adherence activities, including monitoring and tracing missed appointments and defaulter tracing;
- Targeted interventions for key and priority populations; and
- Optimization of the continuum of care, including care for adolescents and for patients who present in an advanced stage or are failing on treatment.

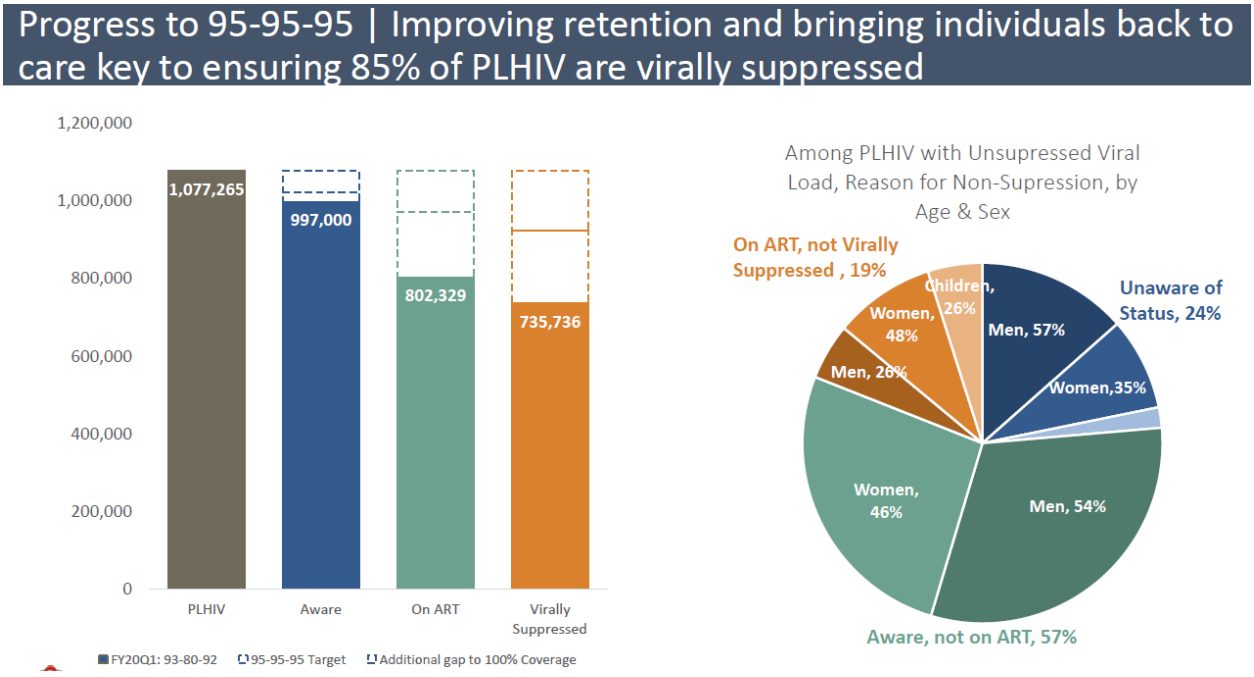
The activity will build upon the service-delivery foundation of the existing national program (including investments by USG partners) and optimize service delivery through innovative and evidence-based strategies to achieve the objectives of increased identification of PLHIV and linkage to treatment and durable viral load suppression. While it is anticipated that the main focus of this activity will be in the area of HIV and AIDS, implementing partners will also forge linkages with other health services as appropriate (particularly in the area of comprehensive care for children, and pregnant and breastfeeding women, family planning, nutrition, post-GBV care (in Machinga district as part of the DREAMS initiative), TB screening, TB diagnosis and TB treatment initiation).

4.2 Component and Objective Areas

Objective 1: Increase the Number and Proportion of PLHIV Identified and Linked to Treatment

According to the most recent MOH data (graph below),[18] 93 percent of PLHIV are estimated to be aware of their HIV status. To further increase the number of PLHIV who know their status (especially men and Key Populations), and achieve and sustain epidemic control goals, continued optimization of targeted HIV testing services is required. While available estimates of PLHIV who are aware of their status suggest that significant progress has been made in case identification, finding men and young people still require more effective HTS approaches. Earlier initiation of ART depends on more effective and efficient testing and linkage approaches to expand reach, maximize yield, and improve uptake.

[18] COP20 RPM meeting Out brief



1.1 Implement Cost-Effective Strategic Testing Services

The selection of HTS approaches and level of investment must be appropriately differentiated based on patterns of HIV prevalence, current unmet need among population groups, uptake, available resources, and program cost-effectiveness at national and district levels, as well as the preferences of the populations to be served and the context of the facility and/or community site where services are rendered. The intensity of HTS and level of effort with more resource-intensive approaches shall vary by PEPFAR district prioritization, as defined in the COP. As part of this strategic approach, reaching underserved and hard to reach populations shall be emphasized.

At this stage of the Malawi HIV epidemic and in line with Malawi's COP strategy, index-case testing will be the major case finding approach. Implementation of active index testing services (contract referral, provider referral and dual referral) will be managed in a manner that respects the privacy and autonomy of clients ensuring confidentiality and informed consent. Sites providing index testing services should meet PEPFAR's minimum service criteria. HTS services shall be made available to sexual partners and biological children of index clients at routine facility service delivery points, or at the community level. The efficiency and impact of various index testing approaches and service delivery venues shall be evaluated and refined.

Facility-based testing will focus on testing among pregnant women, presumptive TB patients and patients with sexually transmitted infections. HIV testing should be offered only based on symptoms or defined risk for HIV infection. The activity will therefore use a validated screening tool to target individuals with higher risk thereby reducing the number of unwanted tests with lower yields, and repeat testing.

Greater attention shall be given to ensuring HIV testing quality including adherence to the 5Cs

(consent, counselling, confidentiality, correct results, and connection), and national testing strategy and algorithm. Deployment of HIV Diagnostic Assistants (HDAs) in supported health facilities is a key component of PEPFAR's direct service delivery. As epidemic control is achieved, and in consultation with the GOM, some of the DSD efforts for HTS would be transitioned to MOH cadres. Along with the decreased HIV testing targets, HDAs will be assigned to supporting other HIV services especially Treatment Retention.

HIV Self-testing will be implemented with the aim of expanding access and uptake of services among people not reached with other HIV testing services. Integration of HIVST into index testing and HIVST distribution through a facility-linked outreach are approaches that could be instrumental in strengthening HIV case finding. Implementing partners will work with districts and facilities to establish or strengthen mechanisms for linking those who screen positive through HIVST to confirmatory testing. Similarly, the activity will ensure high-risk HIV-negative individuals are actively linked to effective HIV preventive services such as condoms, VMMC, and pre-exposure prophylaxis (PrEP).

HIV recency testing is a new surveillance tool in the effort to control and sustain HIV epidemic control. It will help countries to describe the HIV epidemic, identify ongoing or recent transmission, and intervene to stop further transmission. In collaboration with other PEPFAR implementing partners, the Treatment Activity will support facility-based HIV recency testing. Results on recent infection will be used to target timely prevention and treatment interventions.

Strong monitoring systems are critical to effectively measure progress towards national and PEPFAR goals including achievement of Epidemic Control, understand what is working and what is not, and adjust the program timely. Performance will be evaluated across all target populations. Near "real-time" collection, analysis and use of such data is required to enable timely program adjustment. Granular analyses of data at the district, site and population level will become even more critical once Epidemic Control has been achieved to determine HTS approaches that are appropriate for the stage of the epidemic.

Potential key performance indicators include (with age, sex, entry point disaggregation as applicable):

- Percentage of PLHIV who know their status
- Number of individuals tested and received their results (sex, age, result, entry point disaggregation)
- Percentage of new and relapse TB cases with documented HIV status disaggregated by test result, age and sex
- Index testing cascade (sex, age, result, entry point disaggregation for index clients, as well as contacts reached, tested and linked to treatment)
- Percentage of HIV-exposed infants that had DNA PCR by 8 weeks
- Percentage of final outcomes among HIV exposed infants registered in a birth cohort
- Percentage of pregnant women who were tested for HIV and received their results

1.2 Assure Cost-Effective Patient-Centered Linkage Systems from Testing to HIV Prevention, Care, and Treatment Services

Successful linkage is essential to reach epidemic control goals. Linkage to treatment (for newly diagnosed HIV cases) has been consistently high in FY19 and FY20.[19] This activity must ensure high levels of linkage rates across districts, sites and population groups.

Understanding the client-, social-, structural- and health-system-related factors that limit or facilitate linkage is critical. Approaches that tackle identified barriers and/or further improve current linkage rates will be implemented at scale according to site prioritization. In addition to linkage to treatment, both HIV-negative clients with ongoing risk of HIV acquisition and those who test positive will be linked to appropriate prevention services such as condoms, VMMC, STI screening and treatment, PrEP, etc. Linkage models will be continuously monitored with the lessons utilized for immediate remediation of services to initiate treatment.

Potential key performance indicators include:

- Percentage of newly diagnosed HIV-positive clients successfully started on treatment (with site-level sex and age analysis).
- Percentage of newly diagnosed HIV-positive patients who start treatment in the first 7 days after diagnosis
- Percentage of unlinked patients traced
- Percentage of unlinked patients traced and engaged in care

Objective 2: Increase Durable Viral Load Suppression

2.1 Expand Client-Centered Care and Treatment Services for Adults Including Pregnant Women, Children, Adolescents, men and Key Populations

To achieve epidemic control goals including PEPFAR's performance targets unmet needs must be addressed and retention in treatment must improve. The activity will assist the MOH to identify and implement effective models in making treatment accessible for varied populations including adolescents and men in different settings. Healthcare workers will be equipped to effectively manage ART patients for opportunistic infections, malnutrition, drug side effects, and treatment failure and to support patient-centered care. The activity will support continued implementation of the Test-and-Start approach, transition to new treatment regimens, rapid ART initiation (including same-day ART), prevention of TB co-infection through TB preventive therapy, and differentiated models of care. Similarly, it will support provision of services for managing patients with advanced HIV disease either onsite or through a functional referral system. Implementation of clinical mentoring approaches is a core requirement of this result area. Opportunities to integrate HIV services into other health services and vice versa will be maximized. The activity will also support cervical cancer screening and treatment services for women living with HIV in prioritized high-volume ART sites with outreach care in smaller health centers.

Along with increased access to services, there is a need to ensure available services meet quality

[19] Baylor and PIH program data

standards. Adherence to service standards, as stipulated in the national guidelines and PEPFAR Site Improvement Monitoring System (SIMS) Core Essential Elements (CEEs), will foster uptake of services and improve HIV outcomes. Quality assurance and quality improvement (QA/QI) interventions will support the HIV treatment cascade, including PMTCT, thereby minimizing losses at each step and increasing viral suppression. The quality management system will be applied consistently over an extended period to have a lasting and substantial effect. To this end, the activity will assist health facilities to develop and implement QI systems with the full buy-in and participation of the facility staff. These QI systems will be based on an in-depth analysis (root cause analysis) of district/community/facility-level factors that hamper treatment uptake among specific target populations such as men, children, and adolescents.

In addition to ART, the activity will ensure that facilities have the capacity to implement other care services such as TB screening and diagnosis, TB treatment, provision of TB preventive therapy and infection control, family planning, post GBV care, Nutrition Assessment Counseling and Support (NACS), etc. Similarly, it will integrate a Positive Prevention, Health and Dignity (PHDP) approach to service delivery and enhancing referrals with other service providers in the country. A strengthened continuum of response between GBV prevention and clinical post-violence response services should be integrated into the HIV cascade at key points (testing and treatment), including GBV prevention interventions, HIV testing (particularly index testing, recency testing, and partner notification), PrEP, HIV care and treatment, and PMTCT and ANC services.

Implementation efforts within this activity will ensure HIV-positive patients access non-facility-based prevention, care and support services through a well-monitored bi-directional referral system, implementation of alternative service delivery models (e.g., community ART distribution) and strong coordination with community-based partners.

Potential key performance indicators may include (with age, sex, site, target population disaggregation as applicable):

- Number of patients newly enrolled on treatment (disaggregated by time of initiation e.g., same day, 7 days, etc.);
- Number of patients currently on treatment;
- Treatment coverage (age/sex, district);
- Percentage of HIV-positive pregnant women who are started on treatment;
- The proportion of ART patients screened for TB in the (semiannual) reporting period who are receiving TB treatment;
- The number of HIV positive new and relapsed TB cases on ART during TB treatment;
- Number of ART patients who completed a standard course of TB preventive therapy within the (semiannual) reporting period;
- Proportion of ART clients who experienced GBV
- Number of women screened and treated for cervical cancer; and
- Number of people receiving post-gender-based violence care.

2.2 Improve Patient Outcomes for Adherence and Retention

To achieve and sustain suppressed viral load, an individual's strict adherence to ART regimen is essential. Non-adherence may result in treatment failure and increased morbidity and mortality, as well as the emergence of drug resistance and narrowing of future treatment options. Failure to suppress viral load could increase risk for HIV transmission, including through MTCT. Non-adherence could be a result of behavioral, structural, and/or psychosocial barriers. The activity will track, assess (e.g. screen for IPV/GBV), and remediate adherence barriers and address these at the facility and community levels in collaboration with community partners. A package of adherence interventions (prior to ARV initiation, during ART, and for patients with poor adherence) will be available for clients. The intervention approach will be tailored based on the facility/community context, an individual's unique needs, and feasibility.

Retention is critical for adherence and better HIV treatment outcomes. Interventions that ensure high levels of retention both in the short- and long-term will be implemented. These retention models will be monitored for successful outcomes and ongoing remediation will be part of the program intervention. Adherence and retention interventions initiated at facility level will synergize with similar interventions implemented by community-based partners. The activity should define a package of retention interventions based on risk-stratification. Addressing individual, community, and site-level factors that affect retention outcomes will be critical. HRH support at the site-level should ensure the right number of staff and skill mix to foster improved retention outcomes. Health facilities should be supported to create a welcoming environment for patients on treatment as well as those returning after treatment discontinuation. Deployment of lay cadres for peer support, tracing, and other related tasks is a core requirement of this result area.

Viral load suppression is the most reliable indicator of adherence; however, it does not provide an opportunity for real-time monitoring of adherence and prevent progression to treatment failure. Hence, VL monitoring will be used together with other methods of adherence monitoring such as pill count.

Potential key performance indicators include:

- TX_ML
- TX_RTT
- Retention rate at 6, 12, 24 months;
- Percentage of ART patients that had adherence assessment at last visit;
- Percentage of ART patients who take >95percent of their ARVs (pill count);
- Percentage of facilities implementing a fully-functional patient tracing system;
- Percentage of ART patients traced and brought back to care;
- Percentage of ART patients with suppressed viral load;
- Percentage of ART patients with high viral load that 1+ enhanced adherence counseling (EAC) sessions;
- Percentage of high viral load ART patients that have repeat viral load upon completion of the required EAC sessions; and,
- Percentage of high viral load ART patients that have repeat viral load upon completion of the required EAC sessions and re-suppress.

2.3 Strengthen Viral Load Monitoring System

Viral load monitoring is essential for monitoring and enhancing patient outcomes in HIV treatment programs. There are many challenges in administering VL monitoring systems in resource-poor settings. In keeping with the national strategy and in coordination with USG laboratory support partners, this activity will strengthen sample collection, results return to ART clients, and quality assurance of the intra-facility VL cascade. Deployment of HDAs for VL sample collection and implementation of clinical mentoring and continuous quality improvement approaches are core requirements of this results area. PEPFAR/CDC lab partners will strengthen sample transportation, results return from lab to health facilities, and quality assurance of laboratory systems that are critical to the national HIV/AIDS program, including VL monitoring. This activity will coordinate with these partners to address site and district level bottlenecks to effectively use viral load monitoring for clinical decision-making and improved quality of care.

Illustrative key performance indicators include:

- TX_PVLS (MER) which captures coverage and viral load suppression
- Percentage of eligible ART patients (based on VL milestone) who had VL test;
- Number and percentage of patients with high viral load who receive 1+ Enhanced Adherence Counseling (EAC);
- Number and percentage of patients receiving second line drug regimens; and,
- VL results turnaround time.

Objective 3: Use of high impact preventive services increased

Result 3.1 PrEP services and uptake expanded

Pre-exposure prophylaxis is one of the most promising biomedical prevention interventions that are available as part of the global HIV response. This activity will support the scale up of facility-level PrEP services to vulnerable groups especially sero-negative individuals in a discordant relationship. Index testing services will be the primary entry point for identifying individuals who will benefit from PrEP, particularly sero-discordant couples with the HIV-positive partner who may not be virally suppressed and individuals at high risk of HIV acquisition. This activity will collaborate with other PEPFAR partners implementing PrEP with focus on Key Populations and AGYW. Screening for intimate partner violence (IPV) should be integrated in PrEP service delivery so that new or suspected cases of IPV could be identified and provided with Gender-based violence response services.

Illustrative Indicators:

- PrEP_NEW
- PrEP_CURR

Objective 4: Availability of quality site-level data improved

Result 4.1 Site-level electronic and paper-based systems supported

Most PEPFAR supported facilities have electronic medical record systems which assist in patient

care, and serve as the main source of data for reporting as well as ongoing service improvement. Availability of quality data is critical to understand challenges to service delivery and implementation and adjust programming.

Activity will recruit data clerks for both POC and eMastercard sites (DSD and MOH-supported sites) in its clinical support districts. The treatment activity and data clerks will take on responsibility for clean up-to-date data and any back-data entry needed to clear back-logs if the system is down for any amount of time. Activity will also hire M&E officers (1 per district), who will be responsible for data quality and timeliness of PEPFAR and MOH reporting from electronic systems, in their districts. To facilitate big data management at district levels, Activity will also hire Data Managers. Data Managers will also support the use of site-generated data by site-level staff. District M&E officers and data clerks will collaborate with district-based ICT Officers hired by the HIS partner. ICT Officers will facilitate HIS maintenance, integrating closely with MOH structures. In addition, district ICT officers will maintain the EMR through a decentralized help desk and district M&E officers will ensure the use of data to improve district-level programs.

Illustrative Indicators:

- Percent of sites with evidence of regular data use at the site level
- Percent of sites with onsite data clerks

5. Gender Related Factors

Per ADS 201.3.12.6, it is mandatory that activity designs "address gender issues in a manner consistent with the analytical work performed during strategic plan development." The Mission recognizes the significant role that gender, and gender imbalances play in the HIV and AIDS epidemic and gender disparities in access to services as well as patient outcomes. USAID/Malawi is committed to promoting gender equity within all health activities.

Gender inequities, poverty, and economic vulnerability, including food insecurity, along with cultural factors and low education levels, have put women and girls at heightened risk of HIV acquisition, sexual and physical abuse, discrimination, and even mortality. HIV incidence in adolescent girls is high relative to incidence in young men of the same age cohort. The activity will explicitly ensure that the needs and challenges facing women and adolescent girls are addressed in the design of HIV prevention and treatment service delivery models. At the same time, men in Malawi are less likely to know their HIV status and to be virally suppressed than women. The activity will also strengthen male-friendly services and approaches to overcome the specific barriers men encounter when seeking HIV services. Male involvement to support family and community health needs including the prevention of GBV in communities as well as within their household will be emphasized. The activity will develop and/or deliver integrated counseling content and related services to help address gender-specific issues and cross-generational audiences. Patient confidentiality and engagement in their care is critical to ensure that harmful gender norms do not deter or stigmatize patients seeking or receiving high quality care. The activity will consider the findings of the PEPFAR Gender Assessment (2015) and explore the feasibility of implementing key recommendations including increasing the capacity of health workers to address gender-related barriers to care and consideration of gender-related factors in

testing and retention strategies and development of alternative service delivery models.

Gender disaggregated data will be a standard component of activity monitoring information systems to ensure that all population groups are effectively served. This activity will conform to PEPFAR guidance regarding the age and sex disaggregation of standard Monitoring, Evaluation, and Reporting (MER) indicators. Quarterly collection and analysis of these program data will ensure robust monitoring of program efforts to improve uptake of services among high priority target groups including men age 15-45 and young women 15-25. These data will support course correction and programmatic interventions to improve service uptake and patient outcomes among these population groups.

6. Monitoring, Evaluation, and Learning

PEPFAR has developed a robust Data & Systems Knowledge Center equipped with powerful analytics tools that foster collaboration, learning, and adapting across its country specific and global portfolios critical for its long-term planning and sustainability of HIV epidemic control. These tools include: 1) Data for Accountability, Transparency, Impact (DATIM) Global to enter and analyze data at the facility, community, national, and global levels and 2) PANORAMA to visualize PEPFAR data as charts and graphs for data analytics. Using these tools, PEPFAR collects and analyzes Monitoring, Evaluation, and Reporting (MER) data at the region, country/national, district, community, and facility levels. Data is collected through Site Improvement Through Monitoring System (SIMS), Data Quality Assessment (DQA), and through Surveys, Surveillance, Research, and Evaluation (SRE) tools. Additionally, it uses a Budget and Expenditure Reporting (ER) system to effectively allocate resources and guide a more meaningful and timelier strategic and programmatic adaptations. Through these tools, PEPFAR tracks near real time contextual shifts and effectively utilizes adaptive management approaches to prompt programmatic changes to respond to the shifts. The use of the PEPFAR Data & Systems Knowledge Center is what is broadly used to inform activity designs such as this one. This activity therefore will routinely engage with other USG inter-agency PEPFAR implementing partners, Global Fund, donor partners, GOM, CSOs, and other key stakeholders to share implementation challenges, solutions, joint learning and coordinate with national Technical Working Groups (TWGs). This approach will facilitate coordination of data-driven learning between stakeholders, offers an opportunity to capitalize on joint planning and alignment of operational plans, and contributes to accelerate the pace at which all stakeholders address the key barriers to epidemic control in Malawi.

Some proposed learning agenda will be:

- How has the programmatic shift in the activity moved the needle in terms of reaching men and young people, improved retention on ART, and improved viral load suppression?
- Which activities/approaches contributed to effective and sustainable service delivery for people living with HIV?
- How can we effectively engage government and civil society in program implementation and monitoring?

6.1 Performance Monitoring, Data Management, and Implementation Science

Gathering, analyzing and using high-quality data is an integral part of this activity. It will apply

strategic information methodologies and indicators that monitor implementation and gauge progress toward objectives. Emphasis will be placed on real-time site-level data use to enable programmatic course correction and re-prioritization of resources as required. It will also apply the principles of the latest PEPFAR guidance on accountability, transparency, and impact in programs.

Implementing partners will develop a Performance Management Plan (PMP) to monitor and evaluate activity performance. The PMP will embody "best practices" for performance monitoring and evaluation. In addition to clearly articulating anticipated results, indicators, activities, outcomes, and targets, the plan will demonstrate the linkages between proposed activities and anticipated results, and show how data (including baseline) will be collected, tracked, verified and reported on. Annual data quality assessments are also required and will be described in the PMP. The PMP will incorporate relevant PEPFAR indicators for the services supported or directly provided. The performance indicators selected will measure progress and achievement of the activity goal, purpose, outcomes, and outputs. The PMP includes the expected program results with indicators, quarterly milestones/benchmarks, and end-of-project results. For each indicator, the PMP will reflect interim and final targets, data sources, collection methods, and baseline information or a timeline for collecting baseline information. The initial PMP will be reviewed and potentially revised annually based on the subsequent annual COP target-setting processes.

Activity-level performance indicators will, at a minimum, include all required and applicable standard indicators as defined by the latest PEPFAR Monitoring, Evaluation and Reporting (MER) Guidance, which provides: indicator definition and unit of analysis; data disaggregation; data sources and collection methods; data analysis methods; and frequency, schedule and reporting responsibilities. Implementing partners will be required on a quarterly basis to enter data into the DATIM platform and review data imported into DATIM by PEPFAR for the sites supported by the activity. These data will also be presented and analyzed in quarterly performance reports to be submitted to USAID within 30 days of the end of the quarter. High Frequency Reporting indicators (for example, number of newly identified HIV-positive individuals and number of individuals newly initiated on treatment), however, shall be required on a monthly basis to ensure adequate data to make real-time shifts in programming to achieve targets. Depending on activity progress, more frequent data collection and analyses may be required.

A regular clinical cascade analysis will be an integral part of the implementing partners' monitoring and evaluation systems. Progress towards achieving treatment saturation and other key program milestones (e.g., district/facility level retention) will be regularly monitored. Data will be analyzed by sex, age, site, entry point (testing), district, district categorization (attained/scale-up/sustained), target population, and other key variables.

In addition, implementing partners will be required to report on custom indicators of interest at the country level or requested by OGAC. These may include, but are not limited to site-level indicators for:

- Human resources for health - numbers by cadre and expenditures;
- Availability of differentiated service delivery models;
- Availability of specific services including: after hours service delivery, services

targeting men or adolescents; and
- Referrals for community services.

In addition to the routine program monitoring using PEPFAR MER and other relevant custom indicators, the implementing partners' monitoring and evaluation systems shall address such topics as:

- Evidence-based implementation and evaluation of comprehensive care, treatment and support service delivery modalities;
- Understanding supply-and-demand side barriers affecting access to testing, care and treatment services;
- Assessing effectiveness and cost-effectiveness of various testing, linkage, treatment adherence, and retention strategies;
- Assessing impact of various models of differentiated care on retention, adherence, and viral suppression;
- Exploring how integration of services may influence PLHIV's perceptions of treatment, care and support quality; and
- Other implementation science questions related to HIV service delivery access and uptake, particularly as they relate to specific barriers or facilitators that affect men, young people, children, and other target population groups.

Data management systems will build on existing information systems and help improve efforts related to data quality assurance. Implementing partners will contribute staff time and vehicles to support the national quarterly supportive supervision. The supervision visit is central to the Department of HIV's program management system including monitoring and evaluation. Site-level data collected through the supervision visit feeds into the MOH's and PEPFAR's quarterly reports. In addition, the Department of HIV uses the quarterly data to create a site-by-site list of quality improvement priorities, which complements the SIMS data collected by USG staff.

The activity will meet PEPFAR's requirement for finer age/sex disaggregated data. Some data entry into the PEPFAR reporting electronic system, DATIM, is automated by the PEPFAR team. Implementing partners will ensure data entry into DATIM where automated import of those data is not possible. Additional data collection and analysis may be required to analyze activity performance and address site-specific challenges. USAID/Malawi will meet with the awardees monthly to review program data and to discuss needed strategic shifts to improve performance and progress toward targets and other benchmarks on a regular basis.

The awardees will also participate in the SIMS process to ensure regular quality assurance monitoring according to the annual targets established in the COP. Implementing partners will support SIMS implementation through facilitation of USG SIMS visits and timely remediation of identified issues.

Monitoring and evaluation of USAID health activities may also include general assessments, observations, and specific indicators to measure and report on the progress of incorporating gender, conflict management, child protection, and environmental compliance as relevant. An environmental mitigation and monitoring plan (EMMP) will be part of the overall activity

monitoring effort.

Awardees will be required to provide expenditure and accrual data to USAID on a quarterly routine basis. PEPFAR is also expected to introduce quarterly expenditure reporting, which will track expenditure by program area, target population, and cost category. In response to evolving PEPFAR guidance, this reporting process will include entry of relevant data into DATIM. The objective of this exercise is to improve budgeting and monitoring of program expenditure by intervention. At present, PEPFAR expenditure reporting requirement is an annual requirement; however, as the quarterly requirement is introduced, implementing partners will be required to report this information through DATIM.

6.2 Electronic Medical Record (EMR)

Point of Care (POC) and eMasterCard systems are available across many USAID supported PEPFAR sites. Implementing partners will work closely with the MOH and PEPFAR Health Information System (HIS) partner to ensure these electronic systems are functional and used for provision of routine patient care and program monitoring including PEPFAR reporting.

6.3 Quality Management (COP Guidance)

Quality management is a key PEPFAR priority strategy for achieving epidemic control. The focus is on how to operationalize an overall quality management program to support implementation of programming with fidelity, scale, and quality. The development and implementation of Continuous Quality Management (CQM) plan is required and will assist in assessing programmatic progress and adjusting as needed in a focused and rapid manner. The CQM plan should aim to understand why facility and community sites may be under-performing, and what is needed to improve implementation fidelity and achieve outcomes that drive sustainable epidemic control.

Continuous Quality Management plans will consider:

- Targeting site visits (including, but not limited to, SIMS) to identify and address QI/QA barriers across high-volume, under-performing sites;
- Integrating and triangulating data streams (MER, SID, SIMS and other data) to understand the root causes of barriers and challenges to program quality monitoring and management;
- Developing & rolling-out a comprehensive CQM plan that delineates clear and reasonable processes to address issues of underperformance;
- Leveraging existing indicators (MER, SIMS, above service delivery benchmarks) and establishing new custom indicators to monitor the progress of the QI process or its outcome to measure the impact of change;
- Reconfiguring and clearly defining implementing partner and local government/local institutions/MOH and site-level staff roles within the CQM plan to increase buy-in, accountability and follow-up; and
- Developing/modifying and implementing a training plan for key QA/QI staff.

At a minimum, a CQM plan will include:

- A quality statement;
- Goals/objectives with timelines;
- Performance measurements/indicators
- Quality improvement activities/processes;
- Designated leaders, roles and accountability;
- Routine data collection and analyses of data on measurable outcomes; and
- A system for ensuring that data feed back into, and are used by, the organization's quality improvement process to assure goals are accomplished.

7. Staffing and Key Personnel

For this important initiative to support the GOM in achieving and sustaining epidemic control, implementing partners are expected to develop an overall staffing pattern that demonstrates the breadth and depth of technical and management expertise and experience required to manage and implement the envisioned activities. USAID/Malawi will review any proposed staffing pattern for in-country work, which will be strongly aligned with the priorities and activities described in this document. The staffing pattern is required to reflect an appropriate mix of skills (both long-term, resident positions and short-term recurring technical support positions). The proposed staffing pattern should include: 1) a brief description of each key position; 2) a skills matrix linking needed skills to each position; and 3) an organogram illustrating the overall staffing pattern.

The elements of the implementing partners' staffing plan should reflect a solid understanding of key technical and organizational requirements of the activities and show an appropriate mix of skills (both long- and short-term), while avoiding excessive staffing.

Implementing partners will be encouraged to identify, where possible (and document where not), qualified Malawian personnel with a proven track record of strong performance who can lead and implement the activity. The implementing partners' staffing pattern is expected to include a Project Director/Chief of Party who will be resident in Malawi and working full-time on the activity. To complement the Project Director, it is anticipated that the staffing pattern as a whole will provide skills in the following areas through short- and long-term personnel:

- Finance/Administration
- HIV and AIDS care and treatment service-delivery
- HIV testing services
- Pediatrics/Adolescent Care and Treatment
- PMTCT and EID
- Differentiated Service Delivery
- TB/HIV programming
- Quality assurance and Improvement
- Health systems strengthening (supply chain, lab, infrastructure, HRH)
- Strategic Information (including operations research).

Positions of Project Director/Chief of Party, Finance and Administration Director, Strategic Information Manager, Senior Technical Advisor – Health Systems Advisor and Senior Technical Advisor – Clinical Care And Treatment Services are considered key for the activity.

7. Reports and Deliverables or Outputs

7.1. Mobilization and Start Up of Implementation

Implementing partners are expected to build on existing USAID supported programming at existing HIV service delivery sites. Activity start-up is expected to require district entry processes and minimal site assessment. Within two months of award, USAID/Malawi expects to receive a detailed first-year work plan and budget for review. A detailed activity Performance Management Plan (PMP) should accompany the first-year work plan. The PMP should encompass both the first and future implementation years.

7.2. Annual Work Plans

Within 60 days of award, implementing partners are expected to submit a comprehensive work plan and budget for the implementation of activities over the relevant fiscal year (October 1st through September 30th). After the first work plan following the award, implementing partners must submit draft Annual Implementation Plan no later than May 1st of each year for the AOR's/USAID's review, and the final Annual Implementation Plan must be submitted no later than August 30th and must be approved no later than September 30th.

In general, the work plans should be broken down by program or implementation focus areas and guided by the relevant Malawi COP submission. Work plans should include costed activities with accompanying budget narratives.

7.3. USAID/PEPFAR Reporting

Implementing partners will provide the required PEPFAR data as needed in a timely manner (through DATIM) to USAID/Malawi for the preparation of the PEPFAR quarterly, semi-annual, annual reports and the Country Operational Plan. The Q3 quarterly report is usually due in July each year and Q1 due in January. The semiannual report is usually due around the beginning of April each year; the annual narrative report and PEPFAR APR data are due in October each year.

7.4. Progress Reports

The Awardees will submit three quarterly performance reports and one annual report per year in addition to program performance data submitted through the DATIM platform. These reports will indicate progress achieved towards benchmarks, highlight tangible results, identify any problems encountered in implementation, and propose remedial actions as appropriate. Annual reports will be submitted within 30 days of the year ending on September 30. Annual reports will include data collected to measure progress against the PMP. The documentation of "success stories" is also part of the annual reporting process.

USAID will convene monthly meetings with implementing partners to review program progress. Implementing partners will also report a subset of data (High Frequency Technical Data Reporting) monthly. USAID also expects to maintain regular communication via phone, email, and ad hoc meetings on a weekly basis to receive informal updates on activity progress, implementation challenges, and administrative issues.

7.5. Financial Information

Implementing partners will be required to provide USAID/Malawi with quarterly financial data including a summary of finances and a pipeline analysis of funds obligated, funds expended, expenses accrued, and funds remaining by budget categories. The financial information will be broken-out by fund category and year of obligation. This reporting will normally be expected by the 15th day of the final month of each quarter. The awardees will also provide expenditure data as required for the PEPFAR Expenditure Reporting exercise, categorizing expenditure by program area, intervention, and further disaggregated by cost category. At present, this exercise is conducted annually but pending PEPFAR guidance may also shift to quarterly.

8. Environmental Compliance and Management

An Initial Environmental Examination (IEE) has been performed for USAID's health program in Malawi. This IEE (2018-2023) addresses the entire portfolio of activities under the USAID/Malawi Health portfolio (that includes HIV clinical services) applying to all health sector activities. The IEE synthesizes current and anticipated health portfolio activities into a set of 13 intervention categories, each of which contains a number of included activities. As with all IEEs, and in accordance with 22 CFR 216, it reviews the reasonably foreseeable effects of each activity on the environment. On this basis, this IEE recommends Threshold Decisions and, in some cases, attendant conditions, for these activities.

In addition, this IEE sets out project-level implementation procedures intended to assure that conditions in this IEE are translated into activity-specific mitigation measures, and to assure systematic compliance with this IEE during activity and project implementation. These procedures are themselves a general condition of approval for the IEE, and their implementation is therefore mandatory. This IEE is a critical element of a mandatory environmental review and compliance process meant to achieve environmentally sound activity design and implementation.

Categorical exclusions were recommended for activities involving: healthcare provider training; healthcare workforce strengthening and development; social marketing, education, and behavior change communication (BCC), excluding wash; small-scale water supply & sanitation; studies, surveys/public health surveillance & other data-gathering assessments, models, & capacity building in support of all areas above; dissemination of resulting information/lessons learned/best practices. In addition to the specific conditions, the applicable negative determinations recommended in this IEE are contingent on full implementation of a set of general monitoring and implementation requirements. These require: (1) IP Briefings on Environmental Compliance Responsibilities; (2) Development of EMMPs; (3) Integration and implementation of EMMPs in work plans and budgets; (4) Integration of compliance responsibilities in prime and sub-contracts and grant agreements; (5) Assurance of sub-awardee, sub-grantee, sub-contractor capacity and compliance; (6) Annual compliance documentation and reporting; (7) 22 CFR 216 documentation coverage for new or modified activities; and (8) compliance with host country requirements.

ANNEX 1: USAID and PEPFAR activities with programmatic relevance to implementing partners' Goal

This list is not exhaustive but intended to provide an overview of other USG investments with programmatic significance to implementing partners. Where there is geographic co-location, implementing partners will coordinate interventions with these partners in order to provide maximum support without duplication of effort to beneficiary districts. In other cases, implementing partners will collaborate with partners providing similar services in different geographic locations to ensure harmonization of USG programming approaches across districts. The annual work plan shall elaborate opportunities for collaboration at district level.

Service Area	Activities	Implementing Partners
HIV Testing and Treatment	● Support delivery of facility-based HIV testing, care and treatment services ● Targeted community outreach for index contact testing, defaulter tracing, etc. ● Laboratory support including sample and result transportation ● Targeted community based/hotspot testing ● Referrals/linkages through peer educators, referral/linkage facilitators, and peer navigators ● HIV Self-testing ● Teen Clubs for ALHIV ● Post-GBV care	● PIH/OHSEC ● Baylor College of Medicine-Children's Foundation of Malawi ● Lighthouse (CDC) ● EGPAF (CDC) ● Gateway (CDC) ● University of Maryland (CDC) ● EPIC
Community HIV services	● Priority population prevention and normative change ● Engagement with traditional and faith leaders, CBOs ● Condom distribution ● AGYW clubs ● OVC Household case management ● APLHIV and adult care and support ● Faith and Community Initiative	● TBD
VMMC	● Static and outreach VMMC service packages ● Community mobilization for VMMC services, and post-operative care, risk reduction	● Jhpiego ● PSI

	● Referrals to other HIV and SRH health services	● JHPIEGO (CDC)
Key Pops	● Comprehensive HIV services for key populations delivered through drop in centers, outreach in hotspots, and supported public and private clinics. ● Routine outreach, condom distribution, prevention in hotspots through peer educators and clinical teams ● Peer navigator support for HIV+ clients clinical care and adherence	● EPIC ● Jhpiego Gateway (CDC) ● Action Aid (Global Fund PR with SRs and SSRs) ●
Condoms	● Condom social marketing and targeted support for public sector distribution	● PSI/EMPOWER
TB and TB/HIV	● Support to National TB Program to strengthen TB case finding and diagnostics, treatment, and prevention efforts ● Intensified case finding at high TB burden facilities ● Strengthen management of Drug resistant TB ● Strengthen TB supply chain system ● Strengthen TB diagnostic Network	● NTP ● PIH ● DAPP
Nutrition	● Develop performance quality standards on nutrition ● Provide community-based management of acute malnutrition (CMAM) ● Community nutrition screening and referral ● Clinic nutrition assessment and referral of patients with acute malnutrition or weight loss to HIV testing or VL testing	Tiwalere II HC4L HP+ ● ONSE follow on
Malaria	● Implement community-based behavior change communication interventions ● Provide case management through health surveillance assistants	● ONSE follow on ● HC4L
Family Planning and Sexual and Reproductive Health	● Provide targeted service delivery ● Support supply chain management systems strengthening ● Advocate for policy development and implementation	● ONSE follow on ● APA (TBD One C follow on) ● HC4L

	● Provide youth friendly integrated HIV, voluntary family planning and SRH services ● Implement mass media umbrella campaign and standardized health communications packages for targeted districts ● Build capacity for health communications at national, district and targeted CSOs	
WASH	● Strengthen GOM systems ● Increase water service delivery to peri-urban and rural areas through rehabilitation or construction of water points ● Support growth of sanitation private sector ● Strengthen communication platforms to improve hygiene behavior	● ONSE follow on
Health System Strengthening	● Strengthen MOH's capacity for supportive supervision, financial management, leadership and management, performance management systems and policy support at national level ● Strengthening district planning and supervision process and capacity development of HRH to deliver high quality services ● Provide salary support to increase the supply of health workers at high priority health facilities and improve HIV service delivery	● ONSE ● ● CHAM (CDC)
Education	● MERIT: Improve reading instruction, increased community support to create a culture of reading and an improved policy environment to improve reading outcomes ● SEED: increase girls' access to secondary schools through school construction in rural areas nationwide, bringing secondary schools closer to where the most vulnerable girls live. Priority will be given to areas with high HIV burdens as well as long distances to secondary schools. ● USAID's AMAA (Give Girls a Chance to Learn) project : seeks to deliver a range of district-specific activities to mitigate the barriers to girls' enrollment and retention in school. The project works in five priority districts including Balaka, Machinga, Phalombe, Mzimba and Chikwawa, targeting girls aged 10-19 in both upper primary and secondary schools.	● SEED ● AMAA
Food Security and Secured Livelihood	DFSA: ● Increased stable and equitable incomes from agricultural and non-agricultural livelihoods for ultra-poor and chronically vulnerable households, women and youth;	● Titukulane (DFSA) ● Feed the Future Malawi Ag Diversification

	● Nutritional status among children under five years of age, adolescent girls and women of reproductive age improved; and ● Increased institutional and local capacities to reduce risk and increase resilience among ultra-poor and chronically vulnerable households in alignment with the National Resilience Strategy (NRS). REFRESH: ● strengthen the fisheries governance and regulatory framework; improve ecosystem-based fisheries management; strengthen decentralization of fisheries management; and catalyze and support commercialization of conservation enterprises to counter unsustainable fishing (lakeshore districts of Karonga, Rumphi, Likoma, Nkhata Bay, Nkhotakota, Salima, Dedza, and Mangochi.) Feed the Future: ● fosters inclusive and sustainable growth in Malawi's agricultural sector and improves the nutritional status of women and children under five through a proven nutrition-sensitive approach of layering agriculture and nutrition behavior change interventions in rural communities, while at the same time increasing the competitiveness of high-value, nutrient-rich value chains through support for agricultural enterprises and increased access to markets and finance.	● REFRESH & Modern Cooking

Annex 2: Table illustrating geographic co-location of USAID Family Health (ONSE) supported districts and implementing partners year one target districts

Given the geographic co-location of these USAID priority health investments, district and site level coordination is critical. This district priority site list is subject to change based on a periodic review of epidemiological and program data (e.g. number of PLHIV, HIV prevalence, treatment coverage) through the COP or OPU process.

Districts	ONSE	APPLICANT HIV C&T Priority Sites
Chitipa	x	x
Karonga	x	x
Nkhotakota	x	x
Salima	x	x
Dowa	x	x
Kasungu	x	x
Mangochi	x	x
Lilongwe	x	x
Balaka	x	x
Machinga	x	x
Mulanje	x	x
Chikwawa	x	x
Phalombe		x
Nsanje		x

Annex 3: **List of supported facilities by district**

This list includes all facilities that are targeted for support by implementing partners for FY21 implementation as defined by COP 20. District categorization and priority site list is subject to change based on a periodic review of epidemiological and program data (e.g. number of PLHIV, HIV prevalence, treatment coverage) through the COP or OPU process.

District	Site Name	District Category
Balaka District	Balaka District Hospital	Sustained
Balaka District	Balaka Opd Health Centre	Sustained
Balaka District	Chiendausiku Health Centre	Sustained
Balaka District	Kalembo Health Centre	Sustained
Balaka District	Kankao Health Centre	Sustained
Balaka District	Kwitanda Health Centre	Sustained
Balaka District	Mbera Health Centre	Sustained
Balaka District	Namanolo Health Centre	Sustained
Balaka District	Namdumbo Health Centre	Sustained
Balaka District	Phalula Health Centre	Sustained
Balaka District	Phimbi Health Centre	Sustained
Balaka District	Ulongwe Health Centre	Sustained
Balaka District	Utale 1 Health Centre	Sustained
Balaka District	Utale 2 Health Centre	Sustained
Chikwawa District	Chapananga Health Centre	Scale Up
Chikwawa District	Chikwawa District Hospital	Scale Up
Chikwawa District	Chipwaila Health Centre	Scale Up
Chikwawa District	Chithumba Health Centre	Scale Up
Chikwawa District	Dolo Health Centre	Scale Up
Chikwawa District	Gaga Health Centre	Scale Up
Chikwawa District	Kakoma Health Centre	Scale Up
Chikwawa District	Kalulu Health Centre, Chikwawa	Scale Up
Chikwawa District	Lengwe Health Centre	Scale Up
Chikwawa District	Makhwira Health Centre	Scale Up
Chikwawa District	Mangulenje Health Centre	Scale Up
Chikwawa District	Mapelera Health Centre	Scale Up
Chikwawa District	Mfera Health Centre	Scale Up
Chikwawa District	Misomali Health Centre	Scale Up
Chikwawa District	Mkumaniza Health Centre	Scale Up
Chikwawa District	Ndakwera Health Centre	Scale Up
Chikwawa District	Ngabu Rural Hospital	Scale Up
Chikwawa District	Ngabu Sda Health Centre	Scale Up
Chikwawa District	St Montfort Hospital	Scale Up

Chikwawa District	Sucoma Clinic Illovo	Scale Up
Chitipa District	Chitipa District Hospital Umoyo Clinic	Sustained
Chitipa District	Kameme Health Centre	Sustained
Chitipa District	Nthalire Health Centre	Sustained
Dowa District	Bowe Health Centre	Sustained
Dowa District	Chankhungu Health Centre	Sustained
Dowa District	Dowa District Hospital	Sustained
Dowa District	Dzaleka Health Centre	Sustained
Dowa District	Madisi Mission Hospital	Sustained
Dowa District	Mponela Rural Hospital	Sustained
Dowa District	Mvera Mission Hospital	Sustained
Karonga District	Atupele Health Centre	Sustained
Karonga District	Chilumba Rural Hospital	Sustained
Karonga District	Iponga Health Centre	Sustained
Karonga District	Kaporo Rural Hospital	Sustained
Karonga District	Karonga District Hospital	Sustained
Karonga District	Kasoba Health Centre	Sustained
Karonga District	Lupembe Health Centre	Sustained
Karonga District	Nyungwe Health Centre	Sustained
Karonga District	St Anne's Health Centre	Sustained
Kasungu District	Bua Dispensary	Sustained
Kasungu District	Chulu Health Centre	Sustained
Kasungu District	Kaluluma Rural Hospital	Sustained
Kasungu District	Kasungu District Hospital	Sustained
Kasungu District	Kawamba Health Centre	Sustained
Kasungu District	Khola Health Centre	Sustained
Kasungu District	Mtunthama Health Centre	Sustained
Kasungu District	Nkhamenya Community Hospital	Sustained
Kasungu District	Ofesi Dispensary	Sustained
Kasungu District	Santhe Health Centre	Sustained
Kasungu District	Simulemba Health Centre	Sustained
Kasungu District	St Andrews Clinic	Sustained
Lilongwe District	African Bible College Clinic	Scale Up
Lilongwe District	Area 25 Health Centre	Scale Up
Lilongwe District	Area 30 Police Clinic	Scale Up
Lilongwe District	Chadza Health Centre	Scale Up
Lilongwe District	Chiwamba Health Centre	Scale Up
Lilongwe District	Daeyang Luke Hospital Public	Scale Up
Lilongwe District	Diamphwi Health Centre	Scale Up
Lilongwe District	Dickson Health Centre	Scale Up

Lilongwe District	Dr David Livingstone Memorial Clinic	Scale Up
Lilongwe District	Dzenza Health Centre	Scale Up
Lilongwe District	Kabudula Rural Hospital	Scale Up
Lilongwe District	Kachere Private Clinic	Scale Up
Lilongwe District	Kang'oma Health Centre	Scale Up
Lilongwe District	Khongoni Health Centre	Scale Up
Lilongwe District	Likuni Mission Hospital	Scale Up
Lilongwe District	Lilongwe City Assembly Chinsapo	Scale Up
Lilongwe District	Malingunde Health Centre	Scale Up
Lilongwe District	Matapila Health Centre	Scale Up
Lilongwe District	Maziko Private Clinic	Scale Up
Lilongwe District	Mbabvi Health Centre	Scale Up
Lilongwe District	Mbwatalika Health Centre	Scale Up
Lilongwe District	Mlale Mission Hospital	Scale Up
Lilongwe District	Mtenthera Health Centre	Scale Up
Lilongwe District	Nkhoma Mission Hospital	Scale Up
Lilongwe District	Nsaru Health Centre	Scale Up
Lilongwe District	Nthondo Health Centre Lilongwe	Scale Up
Lilongwe District	Partners In Hope Clinic Dalitso Clinic (private)	Scale Up
Lilongwe District	Partners In Hope Clinic Moyo Clinic (public)	Scale Up
Lilongwe District	St Gabriel Mission Hospital	Scale Up
Machinga District	Chamba Dispensary	Scale Up
Machinga District	Chikweo Health Centre	Scale Up
Machinga District	Gawanani Health Centre	Scale Up
Machinga District	Kawinga Health Centre	Scale Up
Machinga District	Machinga District Hospital	Scale Up
Machinga District	Machinga Health Centre	Scale Up
Machinga District	Mangamba Health Centre	Scale Up
Machinga District	Mbonechera Health Centre	Scale Up
Machinga District	Mkwepere Health Centre	Scale Up
Machinga District	Mpiri Health Centre	Scale Up
Machinga District	Mposa Health Centre	Scale Up
Machinga District	Namandanje Health Centre	Scale Up
Machinga District	Namanja Health Centre	Scale Up
Machinga District	Nayinunje Health Centre	Scale Up
Machinga District	Nayuchi Health Centre	Scale Up
Machinga District	Ngokwe Health Centre	Scale Up
Machinga District	Nsanama Health Centre	Scale Up
Machinga District	Ntaja Health Centre	Scale Up
Machinga District	Ntholowa Health Centre	Scale Up

Machinga District	Nyambi Health Centre	Scale Up
Mangochi District	Assalaam Clinic	Scale Up
Mangochi District	Billy Riordan Memorial Health Clinic	Scale Up
Mangochi District	Chikole Health Centre	Scale Up
Mangochi District	Chilipa Health Centre Mangochi	Scale Up
Mangochi District	Chilonga Health Centre	Scale Up
Mangochi District	Chiponde Health Centre	Scale Up
Mangochi District	Chiumbangame Health Centre	Scale Up
Mangochi District	Chiunda Health Centre	Scale Up
Mangochi District	Jalasi Health Centre	Scale Up
Mangochi District	Katema Health Centre	Scale Up
Mangochi District	Katuli Health Centre	Scale Up
Mangochi District	Koche Health Centre	Scale Up
Mangochi District	Kukalanga Health Centre	Scale Up
Mangochi District	Lugola Health Centre	Scale Up
Mangochi District	Lulanga Health Centre	Scale Up
Mangochi District	Lungwena Health Centre	Scale Up
Mangochi District	Makanjira Health Centre	Scale Up
Mangochi District	Maldeco Fisheries Clinic	Scale Up
Mangochi District	Malembo Health Centre Mangochi	Scale Up
Mangochi District	Malombe Health Centre	Scale Up
Mangochi District	Malukula Health Centre	Scale Up
Mangochi District	Mangochi District Hospital	Scale Up
Mangochi District	Mase Health Centre	Scale Up
Mangochi District	Mkumba Health Centre	Scale Up
Mangochi District	Monkeybay Community Hospital	Scale Up
Mangochi District	Mpondasi Health Centre	Scale Up
Mangochi District	Mtimabii Health Centre	Scale Up
Mangochi District	Mulibwanji Hospital	Scale Up
Mangochi District	Namalaka Health Centre	Scale Up
Mangochi District	Namwera Health Centre	Scale Up
Mangochi District	Nangalamu Health Centre	Scale Up
Mangochi District	Nankhwali Health Centre	Scale Up
Mangochi District	Nankumba Health Centre	Scale Up
Mangochi District	Nkope Health Centre	Scale Up
Mangochi District	Phirilongwe Health Centre	Scale Up
Mangochi District	St Martins Mission Hospital	Scale Up
Mulanje District	Bondo Health Centre	Scale Up
Mulanje District	Chambe Health Centre	Scale Up
Mulanje District	Chinyama Health Centre	Scale Up
Mulanje District	Chisitu Health Centre	Scale Up

Mulanje District	Chonde Health Centre	Scale Up
Mulanje District	Dzenje Maternity	Scale Up
Mulanje District	Kambenje Health Centre	Scale Up
Mulanje District	Lujeri Health Centre	Scale Up
Mulanje District	Mbiza Health Centre	Scale Up
Mulanje District	Milonde Health Centre	Scale Up
Mulanje District	Mimosa Dispensary	Scale Up
Mulanje District	Mkomaola Health Centre	Scale Up
Mulanje District	Mpala Health Centre	Scale Up
Mulanje District	Mulanje District Hospital	Scale Up
Mulanje District	Mulanje Mission Hospital	Scale Up
Mulanje District	Mulomba Health Centre	Scale Up
Mulanje District	Muloza Health Centre	Scale Up
Mulanje District	Namasalima Health Centre Mulanje	Scale Up
Mulanje District	Namphungo Health Centre	Scale Up
Mulanje District	Namulenga Health Centre	Scale Up
Mulanje District	Naphimba Health Centre	Scale Up
Mulanje District	Thuchila Health Centre	Scale Up
Nkhotakota District	Alinafe Community Hospital	Sustained
Nkhotakota District	Dwambazi Rural Hospital	Sustained
Nkhotakota District	Dwangwa Matiki Clinic	Sustained
Nkhotakota District	Malowa Health Centre	Sustained
Nkhotakota District	Msenjere Health Centre	Sustained
Nkhotakota District	Ngala Health Centre	Sustained
Nkhotakota District	Nkhotakota District Hospital	Sustained
Nkhotakota District	Nkhunga Health Centre	Sustained
Nkhotakota District	St Anne's Mission Hospital	Sustained
Nsanje District	Kalemba Community Hospital	Sustained
Nsanje District	Lulwe Health Centre	Sustained
Nsanje District	Makhanga Health Centre	Sustained
Nsanje District	Masenjere Health Centre	Sustained
Nsanje District	Mbenje Health Centre	Sustained
Nsanje District	Ndamera Health Centre	Sustained
Nsanje District	Nsanje District Hospital	Sustained
Nsanje District	Nyamithuthu Health Centre	Sustained
Nsanje District	Phokera Health Centre	Sustained
Nsanje District	Sankhulani Health Centre	Sustained
Nsanje District	Sorgin Health Centre	Sustained
Nsanje District	Tengani Health Centre	Sustained
Nsanje District	Trinity Mission Hospital	Sustained
Phalombe District	Chiringa Maternity	Scale Up

Phalombe District	Chitekesa Health Centre	Scale Up
Phalombe District	Kalinde Health Centre	Scale Up
Phalombe District	Migowi Health Centre	Scale Up
Phalombe District	Mpasa Health Centre	Scale Up
Phalombe District	Mwanga Health Centre	Scale Up
Phalombe District	Nambazo Health Centre	Scale Up
Phalombe District	Nazombe Health Centre (gogo Nazombe)	Scale Up
Phalombe District	Nkhulambe Health Centre	Scale Up
Phalombe District	Nkhwayi Health Centre	Scale Up
Phalombe District	Phalombe Health Centre	Scale Up
Phalombe District	Phalombe Mission Hospital Holy Family	Scale Up
Phalombe District	Sukasanje Health Centre	Scale Up
Salima District	Chinguluwe Health Centre Salima	Sustained
Salima District	Chipoka Health Centre	Sustained
Salima District	Khombedza Health Centre	Sustained
Salima District	Life Line Salima Health Centre	Sustained
Salima District	Lifuwu Health Centre	Sustained
Salima District	Maganga Health Centre	Sustained
Salima District	Makiyoni Health Centre	Sustained
Salima District	Mchoka Health Centre	Sustained
Salima District	Salima District Hospital	Sustained
Salima District	Senga Bay Baptist Medical Clinic	Sustained
Salima District	Thavite Health Centre	Sustained

MOH-supported (Previously TA) sites - EMR support

District	**Site Name**
Balaka District	Balaka Dream Clinic
Balaka District	Chimatilo Health Centre
Balaka District	Comfort Clinic
Chikwawa District	Alumenda Health Centre
Chikwawa District	Bereu Health Post
Chikwawa District	Kapichira Escom Clinic
Chikwawa District	Majete (epicenter) Health Centre
Chikwawa District	Mwanza Clinic Area 3
Chikwawa District	Nkombedzi Health Centre
Chitipa District	Chambo Health Centre

Chitipa District	Chisasu Health Post
Chitipa District	Ifumbo Health Centre
Chitipa District	Kapenda Health Centre
Chitipa District	Kaseye Mission Hospital
Chitipa District	Mahowe Health Centre
Chitipa District	Misuku Health Centre
Chitipa District	Wenya Health Centre
Dowa District	Chakhadza Health Centre
Dowa District	Chinkhwiri Health Centre
Dowa District	Chisepo Health Centre
Dowa District	Chizolowondo Health Centre
Dowa District	Dzoole Health Centre
Dowa District	Fpam Clinic Dowa
Dowa District	Kasese Health Centre
Dowa District	Kayembe Health Centre
Dowa District	Mbingwa Health Centre
Dowa District	Msakambewa Health Centre
Dowa District	Mtengowanthenga Community Hospital
Dowa District	Mtengowanthenga Dream Project
Dowa District	Mwangala Health Centre
Dowa District	Nalunga Mafika Health Centre
Dowa District	Thonje Health Centre
Karonga District	Blm Karonga
Karonga District	Fulirwa Health Centre
Karonga District	Lwezga Health Centre
Karonga District	Mpata Health Centre
Karonga District	Ngana Health Centre

Karonga District	Sangilo Health Centre
Karonga District	Wiliro Health Centre
Kasungu District	Chamwabvi Dispensary
Kasungu District	Dwangwa Health Centre
Kasungu District	Fpam Clinic Kasungu
Kasungu District	Gogode Dispensary
Kasungu District	Kalikeni Private Clinic
Kasungu District	Kamboni Health Centre
Kasungu District	Kamuzu Academy Clinic
Kasungu District	Kapelula Health Centre
Kasungu District	Kasalika Health Centre
Kasungu District	Linyangwa Health Centre
Kasungu District	Lodjwa Health Centre
Kasungu District	Mdunga Health Centre
Kasungu District	Mkhota Rural Growth Health Centre
Kasungu District	Mnyanja Health Centre
Kasungu District	Mpepa Health Centre
Kasungu District	St Augustine Health Centre
Kasungu District	St Faith Anglican Clinic
Kasungu District	Wimbe Health Centre
Kasungu District	Yankho Private Clinic
Machinga District	Liwonde Medical Clinic
Machinga District	Mlomba Health Centre
Mangochi District	Iba Health Centre
Mangochi District	Kadango Dispensary
Mangochi District	Kapire Dream Centre
Mangochi District	Luwalika Health Centre

Mangochi District	Mama Khadija Private Clinic Namwera
Mangochi District	Nancholi Dispensary
Mangochi District	Ngapani Health Centre
Mangochi District	Sinyala Health Centre
Mangochi District	Sister Martha Hospital
Mangochi District	Somba Health Centre
Mulanje District	Friends Of Mulanje (fomo)
Mulanje District	Minimini Dispensary
Mulanje District	Ruo Dispensary
Mulanje District	Thembe Health Centre
Nkhotakota District	Benga Health Centre
Nkhotakota District	Bua Health Centre
Nkhotakota District	Chididi Health Centre Nkhotakota
Nkhotakota District	Dwangwa Cane Growers Association Clinic
Nkhotakota District	Kapili Health Centre
Nkhotakota District	Kasitu Health Centre
Nkhotakota District	Katimbira Health Centre
Nkhotakota District	Liwaladzi Health Centre
Nkhotakota District	Mazunga Private Clinic
Nkhotakota District	Mpamantha Health Centre
Nkhotakota District	Mtosa Health Centre
Nkhotakota District	Mwansambo Health Centre
Nkhotakota District	World Medical Fund
Nsanje District	Chididi Health Centre Nsanje
Nsanje District	Tikondane Private Clinic
Phalombe District	Chiringa Cham Health Centre
Phalombe District	Mulungu Alinafe Clinic

Salima District	Chagunda Health Centre
Salima District	Chitala Health Centre
Salima District	Kaphatenga Health Centre
Salima District	Katawa Health Centre
Salima District	Ngodzi Health Centre
Lilongwe	Blessings Hospital
Lilongwe	Fpam Clinic Kawale
Lilongwe	Chikowa Health Centre Lilongwe
Lilongwe	Chilobwe Majiga Health Centre
Lilongwe	Chioza Health Centre
Lilongwe	Chiunjiza Health Centre
Lilongwe	Katchale Health Centre
Lilongwe	Mbang'ombe 1 Health Centre
Lilongwe	Mcguire Wellness Center (child Legacy)
Lilongwe	Ngoni Health Centre
Lilongwe	Adventist Health Centre Lilongwe
Lilongwe	Alliance One Clinic
Lilongwe	Limbe Leaf Tobacco Clinic Lilongwe
Lilongwe	Malembo Health Centre Lilongwe
Lilongwe	Ming'ongo Health Centre
Lilongwe	Nambuma Health Centre
Lilongwe	New State House Dispensary
Lilongwe	Tachira Private Clinic

Annex 4: Implementing partners: key indicators and targets
This list highlights the primary performance targets in the anticipated first three months of implementation (starting July 1, 2021). A complete list of MER targets is available in DATIM, PEPFAR's on-line performance reporting platform. These targets are disaggregated by district, site, age, and sex

COMPONENT II

District	Balaka	Machinga	Mangochi	Phalombe	Salima	Total
HTS_TST	10,017	19,449	38,367	12,150	11,000	96,655
HTS_TST_POS	512	1,020	2,360	887	375	5,518
HTS_SELF	1,816	7,540	8,918	2,129	1,896	23,951
HTS_RECENT	367	781	1,793	718	231	4,192
TX_NEW	498	1,032	2,246	842	350	5,242
TX_CURR	21,450	36,826	66,320	38,546	17,069	190,423
PMTCT_STAT	3,721	7,601	13,110	4,328	4,337	35,148
PMTCT_ART	254	382	896	401	174	2,227
PMTCT_EID	251	377	879	390	173	2,190
TB_STAT	78	105	168	52	59	494
TB_ART	27	46	86	28	19	222
TB_PREV (N)	3,638	6,287	10,911	6,639	2,921	30,558
TX_TB (D)	4,550	7,913	13,801	8,309	3,649	40,402

TX_PVLS (N)	19,777	33,297	59,272	35,491	15,771	172,896
TX_PVLS (D)	20,817	35,055	62,390	37,355	16,598	181,988
CXCA_SCRN	360	835	1,198	1,704	362	4,784

COMPONENT I

District	Chikwawa	Chitipa	Dowa	Karonga	Kasungu	Lilongwe	Mulanje	Nkhotakota	Nsanje	Total
HTS_TST	14,628	3,112	7,641	7,997	10,792	27,029	22,205	6,779	10,203	104,714
HTS_TST_POS	1,045	110	197	402	405	1,519	1,915	207	354	5,790
HTS_SELF	5,248	694	1,729	1,324	2,293	6,989	3,423	1,023	1,753	22,824
HTS_RECENT	681	52	97	288	147	1,165	1,577	98	257	4,060
TX_NEW	1,032	86	145	366	300	1,253	1,817	172	334	5,231
TX_CURR	35,956	5,639	7,714	15,509	15,597	50,783	69,159	10,359	21,239	221,743
PMTCT_STAT	4,990	1,166	2,986	2,427	4,037	10,441	6,450	2,614	4,241	37,301
PMTCT_ART	365	26	65	107	111	615	653	87	327	2,236
PMTCT_EID	356	25	65	109	114	610	639	87	318	2,203
TB_STAT	102	16	40	42	59	310	124	58	164	883
TB_ART	44		8	18	19	137	64	18	98	390
TB_PREV (N)	6,013	970	1,260	2,584	2,701	808	11,873	1,845	3,676	31,568

TX_TB (D)	7,575	1,208	1,567	3,241	3,377	10,897	14,925	2,299	4,574	47,483
TX_PVLS (N)	32,515	5,258	7,197	14,182	14,400	46,178	62,851	9,651	19,882	202,826
TX_PVLS (D)	34,225	5,533	7,576	14,932	15,161	48,607	66,154	10,161	20,928	213,504
CXCA_SCRN	930	215		260	358	864	2,665	143	754	5,864

Summary of Activity Objectives and Expected Outcomes

IR	Sub-IR	Expected Outcomes
Identification of PLHIV and at risk individuals and linkage to treatment and prevention increased	**IR 1.1** Cost-effective, strategic HIV case finding, and prevention services implemented	95% of PLHIV know their HIV status
	IR 1.2 Cost-effective linkage systems to treatment and prevention assured	>95% linkage to treatment
Increase Durable Viral Load Suppression	**IR 2.1** Client-centered treatment and Care for adults, children, adolescents and key populations expanded	Differentiated service delivery models are available in ALL supported facilities All patients have access to optimal ARV regimen
	IR 2.2 Patient outcomes for adherence and retention improved	>92% proxy retention >95% viral suppression
	IR 2.3 VL monitoring systems strengthened	>90% annual viral load testing coverage

USAID (J2SR) indicators – Relevant CDCS Indicators

- Incidence of disease disaggregated by type (diarrhea, HIV, malaria, pneumonia, Tuberculosis) (Indicator: NRS, Data: UNAIDS, UNICEF, WHO, MoH)

- PEPFAR Sustainability Indices (Indicator: PEPFAR, Data: HIV/AIDS Sustainability Index and Dashboard (SID))
    - (TX_CURR) Number of adults and children currently receiving antiretroviral therapy (ART) (PEPFAR)
- Percentage of HIV positive Tuberculosis patients initiated or currently on Antiretroviral Therapy (ARVs)
- Number of new services centers offering post GBV services to AGYW (Indicator: AGYW; Data: MoGCSW)
- Percentage of Youth Accessing Youth Friendly Health Services (Indicator: AGYW; Data: YFHS Report)
- Percentage of health facilities providing Youth Friendly Health Services (Indicator: AGYW; Data: YFHS Report)

ANNEX 5: High Frequency Technical Data Reporting

(1) **Reporting Frequency** – Recipient must submit data every four weeks, with results broken out in weekly increments. The Reporting Calendar below is the HFR timeline. Each HFR period is defined as four complete weeks (weeks start on Mondays per ISO 8601), and reporting is due back to the HFR POC as indicated in the table below. The indicators listed in paragraph (c) below will be broken out in weekly increments, with the exception of current on treatment (TX_CURR) and multi-month dispensing (MMD) which will each be reported in one batch for the whole 4-week period. Prior to the end of each Fiscal Year, the Calendar in paragraph (d) below will be replaced with an equivalent calendar for each subsequent Fiscal Year. Quarterly submission of data to DATIM will remain the official system of record for PEPFAR indicators.

(2) **Indicators** - The set of indicators that are subject to HFR are listed below. If the indicators require a change, the award will be modified with the mutual agreement of both parties. The AOR may also request additional data that is useful to monitoring the program. The Recipient must submit the full dataset it collects per the reporting calendar in paragraph (d) below, ensuring the required indicators below are included:

- **Weekly Batches:**
  - HIV testing volume [HTS_TST]
  - HTS_INDEX
  - HIV positive testing volume [HTS_TST_POS]
  - New enrollments on treatment [TX_NEW]
  - Newly initiated on PrEP [PrEP_NEW]

- **Full Period Reporting (1 data point per reporting period):**
  - Current cohort on treatment [TX_CURR]
  - Cervical Cancer Screening and Treatment
  - Multi-month dispensing (MMD custom indicator, collected monthly), disaggregated via:
    - Number of patients receiving 1; 2; 3; 4 or 5; or 6-month ART dispensing

[END OF SECTION A]

SECTION B: FEDERAL AWARD INFORMATION:

1. Estimate of Funds Available and Number of Awards Contemplated

Pursuant to this notice of funding opportunity, USAID intends to award two (2) cooperative agreement(s) as outlined below.

Component	Anticipated Number of Awards and Value
Component One	One (1) estimated at a total cost of $80,000,000.00
Component Two	One (1) estimated at a total cost of $80,000,000.00

Subject to funding availability and at the discretion of the Agency, USAID intends to provide funding not exceeding the amounts listed above over a 5 (five) year period for each component.

2. Start Date and Period of Performance for Federal Awards

The anticipated period of performance is 5 years. The estimated start date will be determined based on timelines in which negotiations and necessary responsibility determinations have been completed.

3. Substantial Involvement

Substantial involvement during the implementation of this Agreement must be limited to the elements listed below:

I. Approval of Recipient Implementation Plans by the AOR.

(a) Recipient must meet the targets that are set out for each Country Operational Plan (COP) Year. If the Agreement Officer (AO) determines that Recipient is not on track to meet targets, or is otherwise noncompliant with the terms of this award, USAID reserves the right to place the Recipient on a Corrective Action Plan (CAP) and/or terminate the agreement in whole or in part pursuant to sections 2 CFR 200.338 through 2 CFR 200.342, Remedies for Noncompliance, or the terms of the award for non-U.S. non-governmental organizations.

(b) Targets for each COP year are documented in PEPFAR's Data for Accountability, Transparency, and Impact (DATIM) system. Recipient must reference DATIM targets and demonstrate at least 80% achievement of annual targets. As the recipient is a PEPFAR partner, the AO will document performance expectations in a letter at the beginning of each COP year for specific indicators. For access to DATIM, please register at register.datim.org and contact your AOR.

(c) Workplan budgets are agreed to in detail on an annual basis to ensure that funds are allocated on a prioritized basis to reach beneficiaries with quality services in alignment with targets set, and ensure that systems are in place to monitor results and finances.

II. Approval of specified key personnel assigned to the positions listed below. The personnel listed below have been approved. All changes thereto must be submitted for the concurrence of the Agreement Officer Representative (AOR) and the approval of the Agreement Officer (AO).

3. Agency and recipient collaboration or joint participation.

The recipient must collaborate with USAID/Malawi in conducting progress review meetings with key stakeholders.

(a) Approval of sub–awards. Pursuant to standard provision titled "Amendment of Award and Revision of Budget (August 2013)"; the Recipient must obtain Agreement Officer's prior approval for any sub-award, transfer, or contracting out of any work under an award. The AOR's concurrence of sub-awards is limited to technical and programmatic matters only; such concurrence does not extend to the contractual, administrative, and financial terms of the sub-award, which must be in accordance with the terms and conditions of this award, unless otherwise approved in advance and in writing by the Agreement Officer.

(b) Approval of the Recipient's monitoring and evaluation (M&E) plan – The AOR must approve the Recipient's M&E Plan, including any significant changes or revisions thereto.

(c) Monitor project implementation, and where necessary authorize specified kinds of direction or redirection because of geographic or programmatic reprioritization as defined through the Office of the Global AIDS Coordinator's Country Operational Plan (COP) process or interrelationships with other projects as described in the Program Description.

4. Authorized Geographic Code

The geographic code for the procurement of commodities and services under this program is **935,** (any area or country including the recipient country, but excluding any country that is a prohibited source).

5. Nature of the Relationship between USAID and the Recipient

The principal purpose of the relationship with the Recipient and under the subject program is to transfer funds to accomplish a public purpose of support or stimulation of the **Client-Oriented Response for Epidemic Control (CORE) Activity** which is authorized by Federal statute. The successful Recipient will be responsible for ensuring the achievement of the program objectives and the efficient and effective administration of the award through application of sound management practices. The Recipient will assume responsibility for administering Federal funds in a manner consistent with underlying agreements, program objectives, and the terms and conditions of the Federal award.

[END OF SECTION B]

SECTION C: ELIGIBILITY INFORMATION:

1. Eligible Applicants

Eligibility for this NOFO is restricted to local (Malawian) and Regional (Southern African Development Community – SADC) organizations. Applications from organizations that have not previously received financial assistance from USAID are welcome if the Applicant determines that it has necessary capacity to implement activities of the magnitude such as this one.

Applicants MUST meet the following criteria that qualifies what a local or regional organization as defined by the President's Emergency Plan For AIDS Relief (PEPFAR).

USAID/PEPFAR defines a "local or regional entity" as an individual, a corporation, a nonprofit organization, or another body of persons that:

(a) Is incorporated or legally organized under the laws of the country or region, and have its principal place of business in the country or region served by the PEPFAR program with which the entity is or may become involved (**in this case Malawi or SADC**).

(b) It is 75% beneficially owned by individuals who are citizens or lawfully admitted permanent residents of that same country or region, per sub-paragraph (a), or by other corporations, partnerships or other arrangements that are local partners under this paragraph.

(c) At least 75% of the entity's staff (senior, mid-level, support) must be citizens or lawfully admitted permanent residents of that same country or region, per sub-paragraph (a), and at least 75% of the entity's senior staff (i.e., managerial and professional personnel) must be citizens or lawfully admitted permanent residents of such country or region; and

(d) Has a Board of Directors and that at least 51% of the members of the Board must also be citizens or lawfully admitted permanent residents of the country or region.

REQUIREMENT: Applicants MUST provide as part of the application package; information and supporting documents that prove qualifications as a local or regional organization in view of the applicable USAID/PEPFAR definition for local organization provided above.

2. Cost Sharing or Matching

Cost share is not required under this funding opportunity. However, Applicants that are willing can propose cost share of any level as their contribution to the intended activity. Note must be taken that cost share, if proposed, is not part of the merit review factors. As such any voluntary proposal to bring cost share will not result in added ratings or scores during technical or

cost review. If proposed cost share funds may be provided directly by the recipient; other multilateral, bilateral, and foundation donors; host governments; and local organizations, communities and private businesses that contribute financially and in-kind to implementation of activities at the country level. This may include contribution of staff level of effort, office space or other facilities or equipment which may be used for the program, provided by the recipient. For guidance on cost sharing in grants and cooperative agreements see 2 CFR 200.306.

[END OF SECTION C]

SECTION D: APPLICATION AND SUBMISSION INFORMATION

1. Agency Points of Contact (POC)

Primary POC:

Name	Gideon Suya
Title	Senior Acquisition and Assistance Specialist
E-mail	gsuya@usaid.gov

Secondary POC:

Name	Sigidi Mbeya
Title	Acquisition and Assistance Specialist
E-mail	smbeya@usaid.gov

2. Questions and Answers

Questions regarding this APS must be submitted in writing through email to gsuya@usaid.gov and smbeya@usaid.gov with a copy to OAA-Malawi-Solicit@usaid.gov no later than the date indicated on the cover letter, or as amended. No telephone contacts will be accommodated. Any information given to a prospective Applicant concerning this NOFO will be furnished promptly to all other prospective Applicants as an amendment to this NOFO, if that information is necessary in submitting applications or if the lack of it would be prejudicial to any other

3. General Content and Form of Application:

Applications must be submitted in two separate parts:

(1) Technical Application and

(2) Cost/Business Application.

4. Application Submission Procedures:

Applications in response to this NOFO must be submitted no later than the closing date and time indicated on the cover letter, as amended. **Late applications will not be reviewed nor considered.** Applicants must retain proof of timely delivery in the form of system generated documentation of delivery receipt date and time/confirmation from the receiving office/certified mail receipt.

Applications must be submitted by component as listed below:

Component	SNU Category	Districts	Districts by Name
1. Component One (1)	Scale Up	3	Lilongwe, Chikwawa, Mulanje,
	Sustained	6	Nsanje, Nkhotakota, Chitipa, Kasungu, Karonga, Dowa.
2. Component Two (2)	Scale Up	3	Machinga, Mangochi, Phalombe,
	Sustained	2	Salima, Balaka.

NOTE: No single Applicant will be awarded both components. Thus, Applicants must choose to apply either for component 1 or component 2, but not both.

5. TECHNICAL APPLICATION FORMAT

Applicants must review, understand, and comply with all aspects of the NOFO. Each Applicant must furnish all information required in this NOFO.

It is the Applicants' responsibility to ensure that all necessary documentation is complete and received on time. The submission should be sent electronically to the contacts provided on the cover letter of the NOFO by the date stated in the letter of invitation to apply and must comply with the specific requirements of the NOFO. Applicants must review, understand, and comply with all aspects of the NOFO. Each Applicant is responsible for all costs related to the preparation and submission of the application.

Applicants are required to follow the instructions provided in this section and below. If a submission is sent by multiple emails, please indicate in the subject line of the email whether the email relates to the Technical or Cost application, and the desired sequence of multiple emails (if more than one is sent) and of attachments (e.g. "No. 1 of 4", etc.). For example, if your cost application is being sent in two emails, the first email should have a subject line which says: "[organization name], Cost Application, Part 1 of 2".

Instructions for Preparation of the Technical Application:

All text must be in Times New Roman 12-point font, with a minimum of 1-inch margins on all sides. The Technical **Application must be submitted in .pdf format and in unlocked MS Word format.** Tables, graphs, and charts may use smaller font, but not less than 8-point may be used for any text. All documentation must be written in English, and the pages must be numbered, including numbered Annexes (e.g. Annex 1). Technical applications must strictly follow the format prescribed below.

Main Body:

The main body of the Technical Application should include the following sections:

- Cover page

- Table of Contents
- Acronym List
- Executive Summary
- Technical Approach
- Management Approach
- Institutional Capability and Past Performance
- Annexes

Description of Required Sections:

Detailed descriptions of each required section of the Technical Application follows. The body of the Technical Application must follow the page limits as indicated in each section. **A maximum of 25 pages are allowed per Technical Application Body, and a maximum of 45 pages for allowable annexes.**

1. Cover Page: – Up to 1 Page

This is a single page that includes: the program title, the Request for Applications number, name and DUNS number of prime Applicant organization, the names of any proposed sub-awardee organizations, the organization's contact person, including his/her title a telephone number, mailing address, email address. Also state whether the contact person is the person with authority to contract for the applicant, and if not, that person should also be listed. The cover page must be signed by these individuals.

NOTE: On the cover letter, Applicants must clearly indicate which component the Applicant is proposing to implement.

2. Table of Contents: – Up to 2 Pages

This section is limited to two pages and must at a minimum include the page numbers for the main section of the Technical Application, including: the Acronym List, Executive Summary, Technical Approach, Management Approach, Institutional Capability and Past Performance. The specific headings for each of the Annexes must be listed.

3. Acronym List: – Up to 2 Pages

This section is limited to two pages and must spell out any acronyms that are utilized in the Technical Application. A table format is acceptable.

4. Executive Summary: – Up to 2 Pages

A two-page maximum brief description of the proposed activities, goals, purposes, and anticipated results, technical and managerial resources of the Applicant's organization, and how the overall activity will be managed. This should give the reader of the application a "snapshot" of what is contained in the application.

NOTE: Page numbers limitations apply to each application by component:

(I). TECHNICAL APPROACH

Up to 12 pages:

This section, together with related supporting technical data in the annex, must include information sufficient to demonstrate how the proposed activities are likely to achieve the program goal and results associated with activity component areas as articulated in the RFA. This section should articulate the following:

(a) Evidence-based design: The proposed interventions must be based on evidence and sound theories of change that illustrate how the proposed activities will lead to attainment of the desired outputs, outcomes, results, and objectives. The Technical Understanding and Proposed Activity section includes the broad technical approaches proposed for the specific results areas. The Applicant is strongly encouraged to propose evidence-based approaches and modalities that align with PEPFAR and national priorities and documented best practice.

(b) Epidemiological and implementation context: The application must demonstrate an understanding of the HIV epidemiological and implementation contexts as they relate to the activity and the specific components for which the application relates. The Applicant must describe how level of effort is aligned with disease burden and service gaps. The Applicant must also describe the challenges associated with delivering an activity of this nature, and how these challenges will be overcome to achieve results.

(c) Population-specific interventions: The Applicant must describe how the activity incorporates interventions that meet the needs of specific populations including children, youth, women, and men. The applicant must consider gender and age appropriate interventions that will improve the continuum of care for different population groups. The Applicant is encouraged to consider innovative approaches to address demand and supply side barriers to service uptake to improve treatment coverage and adherence within different beneficiary population groups.

(d) Integration and capacity building: The Applicant must articulate how the proposed technical approaches will be integrated with other health and social services at the facility and community level to improve beneficiary outcomes and strengthen the capacity of supported facilities to effectively provide services. The Applicant must also describe how the activity will improve capacity of supported facilities to deliver high quality services. The Applicant must prioritize resources for health facility focused interventions. The Applicant must describe its HRH strategy for direct service delivery demonstrating alignment (both in terms of numbers and skills mix) with programmatic priorities. Capacity building support to health facilities must go beyond traditional "roving mentorship" and introduce approaches that demonstrate efficient use of resources for maximum impact.

(e) Performance results management and quality assurance: The Applicant must describe a sound approach to managing for results and ensuring implementation fidelity at site level. The

Applicant must present a clear strategy for measuring progress toward results and making real-time shifts in activity implementation to address performance challenges. Similarly, the Applicant must present a feasible approach to quality assurance and quality improvement.

(II). MANAGEMENT APPROACH

Up to 6 pages:

The Applicant must demonstrate how the proposed management approach will lead to effective and efficient implementation of the proposed program, achieve the activity's objective and results, address cross-cutting issues/themes, and allow flexibility to be responsive to the Malawian context. The Applicant must also describe its proposed plan to manage and optimize use of data as well as how it envisions coordinating with other organizations involved in HIV care and treatment services to avoid duplication of effort, share lessons learned and best practices.

(a) Management and Administrative Structure: Describe the proposed effective, efficient management and administrative structure, including important partnership relationships. If proposing any type of teaming arrangement, whether through a formal legal consortium or a sub/prime structure, this Section must include an outline of the anticipated management arrangements between partners that indicates clear lines of communication; how the prime will assure the effective implementation of all program activities, and mechanisms by which coordination and knowledge flow across any partners will be assured. Teaming arrangements are acceptable, whether through a formal legal consortium or a sub/prime structure, with clear management arrangements and lines of communication between partners, and clarity of how the prime will assure the effective implementation of all program activities. The Applicant must present management and supervision structures that are streamlined and ensure effective oversight of the program while prioritizing direct service delivery through deployment of site-level healthcare workers.

(b) Staffing Plan and Key Personnel: The staffing plan must describe the Key Personnel proposed to manage the activity. **Key personnel must devote one hundred percent (100%) of their effort to the activity or if not state their proposed levels of effort and justify how the effort split will not result in creating oversight gaps during implementation.** The roles and responsibilities for key personnel and other critical staff proposed under the staffing plan and levels of effort should be clearly addressed. Activity staffing must be responsive to the management, administration, and technical requirements of the Applicant's approach, with an optimal configuration for cost containment and quality assurance. The Applicant must include local technical, program and support staff, as well as describe any contractors that may be hired to support delivery of the activity interventions. The staffing plan should also describe how the activity will effectively structure and manage internally for effective activity performance.

Key personnel positions, required attributes, qualifications and experience are as below:

(1). Project Director/Chief of Party:
The Project Director is a critical position and requires an exceptional individual who can provide overall expert leadership, management, and strategic vision to the activity. The Project Director is expected to have the ability to exercise significant delegation of authority, allowing for on-site decisions.

Responsibilities of the Project Director are expected to include:

- Reporting to the HIV/AIDS Team within USAID/Malawi's Office of Health, Population and Nutrition and meeting with USAID on a regular basis;
- Providing leadership and expertise in HIV service delivery and coordination of development assistance efforts for the PEPFAR Malawi program;
- Mentoring, supporting and supervising activity staff and facilitating the development of all activity deliverables, ensuring timely submission and quality of all work plans, reports, and checklist submissions, compliant with the cooperative agreement; and,
- Assuring necessary program planning, development, resource availability and management activities function smoothly and efficiently.

Qualifications and Experience Requirements:
At a minimum, it is expected that the Project Director will have the following qualifications:

- 7-10 years of demonstrated successful leadership in managing large, complex HIV programs within a developing country context;
- Demonstrated leadership in fostering successful partnership approaches and relationships among a variety of varying organizations/institutions;
- Background in clinical service delivery and program management, including the use of data for decision-making;
- Demonstrated experience in working with government and non-governmental organizations to yield results toward common goals;
- Demonstrated ability to communicate effectively orally and in writing; and,
- Demonstrated ability to develop and maintain effective working relationships with senior level government officials, donors, private for profit and non-profit sectors.

(2). Finance and Administration Manager:
This person will be the lead expert for financial operations and administration. He/she will be responsible for efficient resource deployment and use, program budgeting, accounting, and financial reporting systems and ensuring compliance with USAID financial and accounting rules and regulations.

Expected qualifications for the position include:

- A minimum of Bachelor's degree in finance, business administration or a closely related field. A Master's degree is preferred;
- A minimum of eight years of progressively responsible experience in overseeing financial operations and management of large-scale, complex development activities in developing countries;
- A minimum of five years of experience overseeing budgeting, procurement, administration, financial management and reporting of a PEPFAR-funded activity;

- Demonstrated working knowledge of U.S. Government financial and procurement rules and regulations; and,
- Demonstrated written, presentation, communication, and organizational skills in English.

(3). Strategic Information Manager:
The incumbent will be the lead technical expert responsible for all strategic information responsibilities related to the activity, including all monitoring, evaluation, analytics, and reporting of performance and results. S/he will lead activity efforts to strengthen monitoring and evaluation, and performance reporting within the geographic areas of implementation to monitor, document and analyze the performance of HIV services and ensure data quality.

The following are the expected qualifications for the position:
- A Master's degree in public health, epidemiology, social work, monitoring & evaluation, demography, biostatistics, statistics, analytics or a related field;
- A minimum of five years of work experience in designing, establishing, and managing monitoring and evaluation systems, ensuring data quality, and managing data intensive, performance-based programs funded by PEPFAR;
- Demonstrated ability to perform complex data quality analyses and make program recommendations based on findings;
- Demonstrated ability to perform robust data extraction from internal and external information systems; Demonstrated ability to perform complex data analytics utilizing Microsoft Excel and/or business intelligence tools;
- Demonstrated ability to prepare expert quality data visualizations;
- A working knowledge of Malawi's health service information systems and monitoring and evaluation processes as they relate to data collection for performance-based reporting; and
- Demonstrated written, presentation, and communication skills in English.

(4). Senior Technical Advisor – Health Systems:
The incumbent will be the lead technical expert in health systems issues particularly relevant for the HIV/AIDS program. S/he remains current in all USG, PEPFAR and national policies and health systems factors contributing to or hindering the achievement of PEPFAR goals in Malawi including leadership and governance, health workforce capacity development, retention and allocation, health system reform. S/he is well versed in global evidence and best practice for health systems strengthening and provides technical leadership to the activity and to the MOH as appropriate.

The following are the expected qualifications for the position:
- An advanced degree in the medical field, public health or a related field;
- Five to Seven years of progressive Health Systems experience working in Malawi and/or other developing country contexts, and demonstrated technical and management expertise in the field of public health;
- Demonstrated progressive experience working in the field of HIV/AIDS service delivery, policy, and/or research
- Demonstrated skills in monitoring and evaluating health systems strengthening activities;

- Strong leadership, organizational, and interpersonal skills; and
- Demonstrated written, presentation, and communication skills in English.

(5). Senior Technical Advisor – Clinical Care and Treatment Services:
The incumbent will be the lead technical expert in HIV clinical care and treatment and help assure appropriate clinical standards are incorporated and maintained within the service delivery contexts of the activity. S/he remains current in all PEPFAR guidelines for HIV care and treatment and helps determine the clinical factors contributing to or hindering the achievement of PEPFAR targets for care and treatment in Malawi. S/he is well versed in global evidence and best practice for HIV treatment and clinical care and provides technical leadership to the activity and to the MOH as appropriate.

The following are the expected qualifications for the position:

- A Medical Degree;
- Five to Seven years of progressive clinical experience working in Malawi and/or other developing country contexts, and demonstrated technical and management expertise in the field of public health;
- Demonstrated progressive experience working in the field of HIV/AIDS service delivery, policy, and/or research;
- Demonstrated skills in monitoring and evaluating the quality of HIV clinical services;
- Strong leadership, organizational, and interpersonal skills; and
- Demonstrated written, presentation, and communication skills in English.

(c) Stakeholder Engagement: The Applicant must describe an effective approach to engagement with partners including the GoM (all levels), other related USAID/Malawi activities and the full range of PEPFAR and non-PEPFAR implementing partners, as applicable. The Applicant should consider innovative mechanisms for motivating and collaborating with district and facility MOH staff responsible for HIV service delivery as well as mechanisms for effective coordination with other implementing partners to improve service modalities and impact.

(d) Data Management And Reporting: The Applicant must describe the proposed data systems and data management plan, including collection, data quality assurance, and compilation and reporting. This section must include a management structure, staffing, and systems for data analysis and use. The management approach must be described clearly to demonstrate how the Applicant will proactively utilize PEPFAR data to focus site level investments, including human resources, and plans for close monitoring and data driven remediation efforts at site level. The Applicant should also describe systems to ensure timely results reporting to USAID to inform scale-up of best practice and remediation efforts while also meeting PEPFAR reporting requirements. In addition, the Applicant must present a clear, illustrative Performance Monitoring, Evaluation and Learning Plan in the application with appropriate indicators for the Activity objectives, that identifies the data collection method, type, information source, and frequency of collection across all required and proposed custom indicators. The applicant should also describe systems for reporting financial management and expenditure data.

(III). INSTITUTIONAL CAPABILITY AND PAST PERFORMANCE

Up to 2 pages:

Applicants must provide a summary of their institutional capabilities and technical strengths, including unique or specialty areas of technical expertise. In addition, the institutional capabilities and technical strengths of all proposed sub-recipients (if applicable) must also be described. The application must include information on experience demonstrating evidence of relevant technical and managerial expertise to implement this activity. Applicants must include information demonstrating their ability to work with key stakeholders (e.g., government, NGO sector, CBOs, civil society and informal groups and networks).

Detailed information must include an Annex (Annex F) listing of five (5) relevant contracts, grants, or cooperative agreements involving similar or related programs during the past five years. **The reference information for these awards must include the activity location, award number (if available), a brief description of the work performed, and a point of contact with current telephone numbers and email addresses. USAID reserves the right to obtain past performance information from other sources including those not named in the applications.**

5. ANNEXES:

Applicants must provide additional information supporting their application through annexes with consideration to the page limits stated below:

Technical Annexes
Annex A - Supporting Data (up to 7 pages total). This section is optional, and may include any detailed graphs, maps, tables and other related technical information that support the Applicant's technical approach. All supporting data must be clearly referenced in Technical Application and referred to in Annex A (e.g. See Annex A, Figure 1).

Annex B – Draft Work Plan (up to 3 pages). This section will include a draft first year work plan. Table format is acceptable.

Annex C - Organizational chart (up to 2 pages). This section will include a pictorial organogram that demonstrates the organization of staff including reporting relationships and locations.

Annex D - Key Personnel CVs and Letters of Commitment (up to 20 pages). This section must include CVs and letters of commitment for each proposed key personnel candidate. Each key personnel CV may be up to 3 pages in length. Each proposed candidate must sign a letter stating that s/he is committed to serving in the position for which s/he is being proposed and will include the date s/he is available to begin working on the program.

Annex E - Mobilization Plan (up to 3 pages). This section will demonstrate the applicant's proposed mobilization plan describing the steps it will take to initiate all activities, such as hiring staff, renting office space, liaising with sub- awardees, engaging national, provincial and district counterparts, etc.

Annex F – Past Performance Relevant to this RFA (up to 10 pages) This section will provide a detailed list of all relevant contracts, grants, or cooperative agreements involving similar or related programs during the past five years. The reference information for these awards shall include the activity location, award number (if available), a brief description of the work performed, and a point of contact with current telephone numbers and email addresses. A table format is acceptable.

6. BUSINESS (COST) APPLICATION FORMAT:

I. Cost Application Instructions:

The Business (Cost) Application must be submitted separately from the Technical Application. While no page limit exists for the cost application, the Applicant is encouraged to be as concise as possible while still providing all the necessary details. The business (cost) application must illustrate the entire period of performance, using the budget format shown in the SF-424A.

The Cost Application must contain sections which are elaborated below.

II. Cover Page: The Applicants may choose to submit a cover letter for the cost application that will serve as a transmittal letter to the Agreement Officer.

Applicants must submit applications that are directly and fully responsive to the requirements specified in the activity descriptions for the component being applied for and applicable provisions whether US non-governmental organization or non-US non-governmental organization.

The application must be signed by an Authorized Representative of the applying organization. The person signing the application package must have authority to represent and commit the organization to resulting negotiations if the government selects the application for award. It is the Applicant's responsibility to ensure their application is accurate and complete.

The cost application must be submitted in US$ Dollars as one unprotected Excel file (MS Office 2000 or later versions) with visible formulas and references and must be broken out by project year, including an itemization of the federal and non-federal (cost share) amount (if any is proposed). Files must not contain any hidden or otherwise inaccessible cells. Cost applications with hidden cells lengthen the cost analysis time required to make award and may result in rejection of the application. The cost application must have sheets covering the 5-year performance period and additional sheets as necessary to provide cost details or category breakdown.

No single Applicant will be awarded both components. Thus, Applicants must choose to apply either for component 1 or component 2, but not both.

Estimated funding ceilings for the components are as follows:

Component	SNU Category	Districts	Districts by Name	Estimated Funding Cap
Component One (1)	Scale Up	3	Lilongwe, Chikwawa, Mulanje.	$80,000,000.00
	Sustained	6	Nsanje, Nkhotakota, Chitipa, Kasungu, Karonga, Dowa.	
Component Two (2)	Scale Up	3	Machinga, Mangochi, Phalombe.	$80,000,000.00
	Sustained	2	Salima, Balaka.	

1. SF-424 and SF-424A: A budget for each program year with an accompanying detailed budget narrative which provides in detail the total costs for implementation of the program. The budget must be submitted using Standard Form 424 which can be downloaded from the following web site at: http://apply07.grants.gov/apply/FormLinks?family=15

2. Budget Narrative: **The cost application must have an accompanying detailed budget narrative and justification that provides in detail the total program amount for implementation of the program your organization is proposing.** The budget narrative must provide information regarding the basis of estimate for each line item, including reference to sources used to substantiate the cost estimate (e.g. organization's policy, payroll documents, vendor quotes, etc.).

(III). SF 424 Form(s)

The Applicant must sign and submit the cost application using the SF-424 series. Standard Forms can be accessed electronically using the following links:

Instructions for SF-424	https://www.grants.gov/web/grants/forms/sf-424-family.html
Application for Federal Assistance (SF-424)	
Instructions for SF-424A	
Budget Information (SF-424A)	
Instructions for SF-424B	
Assurances (SF-424B)	

Failure to accurately complete these forms could result in the rejection of the application.

a) Budget and Budget Narrative:

The Budget Narrative must contain sufficient detail to allow USAID to understand the proposed costs. The Applicant must ensure the budgeted costs address any additional requirements identified in Section F, such as Branding and Marking. The Budget Narrative must be thorough, including sources for costs to support USAID's determination that the proposed costs are fair and reasonable.

The Budget must include the following worksheets or tabs, and contents, at a minimum:

- Summary Budget, inclusive of all program costs (federal and non-federal), broken out by major budget category and by year for activities implemented by the Applicant and any potential sub-applicants for the entire period of the program. See Section H, Annex 1 for Summary Budget Template

- Detailed Budget, including a breakdown by year, sufficient to allow the Agency to determine that the costs represent a realistic and efficient use of funding to implement the applicant's program and are allowable in accordance with the cost principles found in 2 CFR 200 Subpart E.

- Detailed Budgets for each sub-recipient, for all federal funding and cost share, broken out by budget category and by year, for the entire implementation period of the project.

The Detailed Budget must contain the following budget categories and information, at a minimum:

1) **Salaries and Allowances** – Must be proposed consistent with 2 CFR 200.430 Compensation - Personal Services. The Applicant's budget must include position title, salary rate, level of effort, and salary escalation factors for each position. Allowances, when proposed, must be broken down by specific type and position. Applicants must explain all assumptions in the Budget Narrative. The Budget Narrative must demonstrate that the proposed compensation is reasonable for the services rendered and consistent with what is paid for similar work in other activities of the Applicant. Applicants must provide their established written policies on personnel compensation. If the Applicant's written policies do not address a specific element of compensation that is being proposed, the Budget Narrative must describe the rationale used and supporting market research.

2) **Fringe Benefits** – Allowances and services provided by the Applicant to its employees as compensation in addition to regular wages and salaries are allowable. A detailed cost breakdown by benefit types should be provided.

3) **Travel and Transportation** – Provide details to explain the purpose of the trips, the number of trips, the origin and destination, the number of individuals traveling, and the duration of the trips. Per Diem and associated travel costs must be based on the applicant's normal travel policies. When appropriate please provide supporting documentation as an

attachment, such as company travel policy, and explain assumptions in the Budget Narrative.

4) **Procurement or Rental of Goods (Equipment & Supplies), Services, and Real Property** – Must include information on estimated types of equipment, models, supplies and the cost per unit and quantity. The Budget Narrative must include the purpose of the equipment and supplies and the basis for the estimates. The Budget Narrative must support the necessity of any rental costs and reasonableness in light of such factors as: rental costs of comparable property, if any; market conditions in the area; alternatives available; and the type, life expectancy, condition, and value of the property leased.

   NOTE:
   In accordance with 2CFR 200, "**Equipment**" means tangible personal property (including information technology systems) having a useful life of more than one year and a per-unit acquisition cost which equals or exceeds the lesser of the capitalization level established by the non-Federal entity for financial statement purposes, or $5,000. **All equipment must be listed in a separate budget line item.**

5) **Subawards** – Specify the budget for the portion of the program to be passed through to any subrecipients. See 2 CFR 200.330 for assistance in determining whether the sub-tier entity is a subrecipient or contractor. The subrecipient budgets must align with the same requirements as the Applicant's budget, including those related to fringe and indirect costs.

6) **Construction** – If the Applicant proposes construction (which includes renovation) of facilities/other buildings/structures, or the purchase of prefabricated structures, in order to achieve results, the Applicant must submit an estimate of construction costs (and other details such as locations and type of construction required) and include it as a separate line in its application budget.

In accordance with the USAID Construction policy "Construction" means: construction, alteration, or repair (including dredging and excavation) of buildings, structures, or other real property and includes, without limitation, improvements, renovation, alteration and refurbishment. The term includes, without limitation, roads, power plants, buildings, bridges, water treatment facilities, and vertical structures.

7) **Other Direct Costs** – This may include other costs not elsewhere specified segmented into two categories:

   I. ***Program Costs:*** May include elements such as meeting costs, training sessions, workshops, report preparation, etc. Detailed costs for each element need not be included in the budget as separate line items. Any meeting, workshop, training costs etc. included in the budget may be aggregated to one-line item by element (i.e. all workshops in one line, all trainings in one line, etc.). However, a detailed description of cost buildup for each element must be included in the budget narrative to specify the number of events and the cost categories per one event (such as facility rental,

audio visual rental, meals, local travel for participants, etc.) Explain all assumptions in the budget narrative, including the proposed number of items in each element (such as meals, number of participants, etc.) and annual escalation factors (if any)." Meals and local travel must not be duplicated for the applicant's staff in travel and transportation but must only cover non-applicant or non-partner employees attending the meetings/trainings.

II. ***Operational Costs:*** May include office rent, utilities, communication, maintenance or service costs, costs associated with implementation of Branding and Marking Plan, costs for services not part of the technical scope/delivery of the award (i.e. logistical support services), taxes (if applicable), legal, audit, logistical, passports and visas fees, medical exams and inoculations, environmental impact mitigation costs etc. Explain all assumptions in the budget narrative, including rates, quantity and annual escalation factors (if any).

b) Covered Telecommunication and Video Surveillance Equipment or Services

Effective August 13, 2020, a Recipient must not procure covered telecommunication equipment or services for the implementation of their program using award funds. Standard provision "Prohibition on Certain Telecommunication and Video Surveillance Services or Equipment" applicable to non-US NGOs, implement Section 889(b) of the John S. McCain National Defense Authorization Act (NDAA) for Fiscal Year 2019 (Pub. L. 115-232) that prohibits the use of award funds, including direct and indirect costs, cost share and program income, to procure covered telecommunication and video surveillance services or equipment.

The statute covers certain telecommunications equipment and services produced or provided by Huawei Technologies Company or ZTE Corporation, Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities). Such covered telecommunication equipment or services must not be reimbursed to the Recipient as a direct or indirect cost or accepted as part of cost share. Additionally, the Recipient must not use any program income generated under the award to purchase covered telecommunication equipment or services.

Applicants are requested to provide an IT systems approach that discusses how they will implement this activity, ensuring that they will not utilize USG funds, including cost share and program income, to purchase any covered telecommunication and video surveillance equipment or services.

c) Program Income:

If the successful applicant is a non-profit organization, any program income generated under the award will be added to USAID funding (and any cost-sharing that may be provided, if applicable), and used for program purposes.

d) Approval of Subawards:

Applicants must submit information for all subawards that it wishes to have approved at the time of award of the resulting cooperative agreement. For each proposed subaward the Applicant must provide the following:

- Name of organization;
- DUNS Number;
- Confirmation that the subrecipient does not appear on the Treasury Department's Office of Foreign Assets Control (OFAC) list;
- Confirmation that the subrecipient does not have active exclusions in the System for Award Management (SAM);
- Confirmation that the subrecipient is not listed in the United Nations Security designation list;
- Confirmation that the subrecipient is not suspended or debarred;
- Confirmation that the applicant has completed a risk assessment of the subrecipient, in accordance with 2 CFR 200.331(b);
- Any negative findings as a result of the risk assessment and the applicant's plan for mitigation.

e) Negotiated Indirect Cost Rate Agreement:

The Applicant must submit a Negotiated Indirect Cost Rate Agreement (NICRA) if the organization has such an agreement with an agency or a department of the U.S. Government.

If an Applicant has never received a negotiated indirect cost rate, the recipient may choose to charge a de minimis rate of 10% of modified total direct costs (see 2 CFR 200.414(f)). If the Applicant chooses the de minimis rate, the Agreement Officer shall incorporate the 10% indirect cost rate in the award budget and the recipient must follow the requirements in 2 CFR 200.414(f). **This must be provided for in the cost application**.

Costs must be consistently charged as either indirect or direct costs but may not be double charged or inconsistently charged as both. This methodology once elected must be used consistently for all Federal awards until such time as a non-Federal entity chooses to negotiate an indirect rate, which the non-Federal entity may apply to do at any time. The Applicant's application must clearly show, and the budget narratives must describe which cost elements it charges indirectly and which ones it charges directly. See 2 CFR 200.414(f) for further information. The Agreement Officer will not deny the Applicant the use of the de minimis rate unless the Applicant fails to meet the conditions for its use.

g) Unique Entity Identifier and System for Award Management:

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

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

(ii) Provide a valid unique entity identifier in its application; and

(iii) Always continue to maintain an active SAM registration with current information during which it has an active Federal award or an application or plan under consideration by a Federal awarding agency.

g) Certifications & Assurances:

The Applicant **MUST** complete, sign and return the certifications and assurances downloaded from the link below.

Certifications, Assurances, Representations, and Other Statements of the Recipient" document found at http://www.usaid.gov/sites/default/files/documents/1868/303mav.pdf

h) Branding Strategy & Marking Plan:

The apparently successful Applicant will be asked to provide a Branding Strategy and Marking Plan to be evaluated and approved by the Agreement Officer and incorporated into any resulting award. **PEPFAR funded activities implemented by USAID partners MUST be branded as PEPFAR in addition to having the USAID branding. Branding and marking requirements are stipulated in your awards. Our PEPFAR Coordination office and the Agreements Office take these requirements very seriously. Please take measures to ensure compliance. Please find here the link to PEPFAR branding guidance: https://www.pepfar.gov/reports/guidance/branding/index.htm**

1. **Branding Strategy – Assistance (June 2012)**

(a) Applicants recommended for an assistance award must submit and negotiate a "Branding Strategy," describing how the program, project, or activity is named and positioned, and how it is promoted and communicated to beneficiaries and host country citizens.

(b) The request for a Branding Strategy, by the Agreement Officer from the applicant, confers no rights to the applicant and constitutes no USAID commitment to an award.

(c) Failure to submit and negotiate a Branding Strategy within the time frame specified by the Agreement Officer will make the applicant ineligible for an award.

(d) The Applicant must include all estimated costs associated with branding and marking USAID programs, such as plaques, stickers, banners, press events, materials, and so forth, in the budget portion of the application. These costs are subject to the revision and negotiation with the Agreement Officer and will be incorporated into the Total Estimated Amount of the grant, cooperative agreement or other assistance instrument.

(e) The Branding Strategy must include, at a minimum, all the following:

(1) All estimated costs associated with branding and marking USAID programs, such as plaques, stickers, banners, press events, materials, and so forth.

(2) The intended name of the program, project, or activity.

(i) USAID requires the applicant to use the "USAID Identity," comprised of the USAID logo and brandmark, with the tagline "from the American people" as found on the USAID Web site at **http://www.usaid.gov/branding**, unless Section VI of the NOFO states that the USAID Administrator has approved the use of an additional or substitute logo, seal, or tagline.

(ii) USAID prefers local language translations of the phrase "made possible by (or with) the generous support of the American People" next to the USAID Identity when acknowledging contributions.

(iii) It is acceptable to cobrand the title with the USAID Identity and the applicant's identity.

(iv) If branding in the above manner is inappropriate or not possible, the applicant must explain how USAID's involvement will be showcased during publicity for the program or project.

(v) USAID prefers to fund projects that do not have a separate logo or identity that competes with the USAID Identity. If there is a plan to develop a separate logo to consistently identify this program, the applicant must attach a copy of the proposed logos. Section VI of the RFA or APS will state if an Administrator approved the use of an additional or substitute logo, seal, or tagline.

(3) The intended primary and secondary audiences for this project or program, including direct beneficiaries and any special target segments.

(4) Planned communication or program materials used to explain or market the program to beneficiaries.

(i) Describe the main program message.

(ii) Provide plans for training materials, posters, pamphlets, public service announcements, billboards, Web sites, and so forth, as appropriate.

(iii) Provide any plans to announce and promote publicly this program or project to host country citizens, such as media releases, press conferences, public events, and so forth. Applicant must incorporate the USAID Identity and the message, "USAID is from the American People."

(iv) Provide any additional ideas to increase awareness that the American people support this project or program.

(5) Information on any direct involvement from host-country government or ministry, including any planned acknowledgement of the host-country government.

(6) Any other groups whose logo or identity the applicant will use on program materials and related materials. Indicate if they are a donor or why they will be visibly acknowledged, and if they will receive the same prominence as USAID.

e. The Agreement Officer will review the Branding Strategy to ensure the above information is adequately included and consistent with the stated objectives of the award, the applicant's cost data submissions, and the performance plan.

f. If the Applicant receives an assistance award, the Branding Strategy will be included in and made a part of the resulting grant or cooperative agreement

(END OF PRE-AWARD TERM)

2. **Marking Plan – Assistance (June 2012)**

(a) Applicants recommended for an assistance award must submit and negotiate a "Marking Plan," detailing the public communications, commodities, and program materials, and other items that will visibly bear the "USAID Identity," which comprises of the USAID logo and brandmark, with the tagline "from the American people." The USAID Identity is the official marking for the Agency, and is found on the USAID Web site at **http://www.usaid.gov/branding**. Section VI of the NOFO will state if an Administrator approved the use of an additional or substitute logo, seal, or tagline.

(b) The request for a Marking Plan, by the Agreement Officer from the Applicant, confers no rights to the Applicant and constitutes no USAID commitment to an award.

(c) Failure to submit and negotiate a Marking Plan within the time frame specified by the Agreement Officer will make the Applicant ineligible for an award.

(d) The Applicant must include all estimated costs associated with branding and marking USAID programs, such as plaques, stickers, banners, press events, materials, and so forth, in the budget portion of the application. These costs are subject to the revision and negotiation with the Agreement Officer and will be incorporated into the Total Estimated Amount of the grant, cooperative agreement or other assistance instrument.

(e) The Marking Plan must include all of the following:

(1) A description of the public communications, commodities, and program materials that the applicant plans to produce and which will bear the USAID Identity as part of the award, including:

(i) Program, project, or activity sites funded by USAID, including visible infrastructure projects or other sites physical in nature;

(ii) Technical assistance, studies, reports, papers, publications, audio- visual productions, public service announcements, Web sites/Internet activities, promotional, informational, media, or communications products funded by USAID;

(iii) Commodities, equipment, supplies, and other materials funded by USAID, including commodities or equipment provided under humanitarian assistance or disaster relief programs; and

(iv) It is acceptable to cobrand the title with the USAID Identity and the applicant's identity.

(v) Events financed by USAID, such as training courses, conferences, seminars, exhibitions, fairs, workshops, press conferences and other public activities. If the USAID Identity cannot be displayed, the recipient is encouraged to otherwise acknowledge USAID and the support of the American people.

(2) A table on the program deliverables with the following details:

(i) The program deliverables that the Applicant plans to mark with the USAID Identity;

(ii) The type of marking and what materials the Applicant will use to mark the program deliverables;

(iii) When in the performance period the Applicant will mark the program deliverables, and where the applicant will place the marking;

(iv) What program deliverables the Applicant does not plan to mark with the USAID Identity , and

(v) The rationale for not marking program deliverables.

(3) Any requests for an exemption from USAID marking requirements, and an explanation of why the exemption would apply. The applicant may request an exemption if USAID marking requirements would:

(i) Compromise the intrinsic independence or neutrality of a program or materials where independence or neutrality is an inherent aspect of the program and materials. The applicant must identify the USAID Development Objective, Interim Result, or program goal furthered by an appearance of neutrality, or state why an aspect of the award is presumptively neutral. Identify by category or deliverable item, examples of material for which an exemption is sought.

(ii) Diminish the credibility of audits, reports, analyses, studies, or policy recommendations whose data or findings must be seen as independent. The Applicant must explain why each particular deliverable must be seen as credible.

(iii) Undercut host-country government "ownership" of constitutions, laws, regulations, policies, studies, assessments, reports, publications, surveys or audits, public service announcements, or other communications. The Applicant must explain why each particular item or product is better positioned as host-country government item or product.

(iv) Impair the functionality of an item. The applicant must explain how marking the item or commodity would impair its functionality.

(v) Incur substantial costs or be impractical. The Applicant must explain why marking would not be cost beneficial or practical.

(vi) Offend local cultural or social norms, or be considered inappropriate. The Applicant must identify the relevant norm, and explain why marking would violate that norm or otherwise be inappropriate.

(vii) Conflict with international law. The Applicant must identify the applicable international law violated by the marking.

The Agreement Officer will consider the Marking Plan's adequacy and reasonableness and will approve or disapprove any exemption requests. The Marking Plan will be reviewed to ensure the above information is adequately included and consistent with the stated objectives of the award, the applicant's cost data submissions, and the performance plan.

If the Applicant receives an assistance award, the Marking Plan, including any approved exemptions, will be included in and made a part of the resulting grant or cooperative agreement, and will apply for the term of the award unless provided otherwise.

(END OF PRE-AWARD TERM)

I) Funding Restrictions:

Profit is not allowable for Recipients or subrecipients under this NOFO. See 2 CFR 200.330 for assistance in determining whether a sub-tier entity is a subrecipient or contractor.

Construction is not authorized under the awards resulting from this NOFO unless specifically requested and approved with specific details of amounts and locations. USAID will not allow the reimbursement of pre-award costs under this award without the explicit written approval of the Agreement Officer.

Except as may be specifically approved in advance by the AO, all commodities and services that will be reimbursed by USAID under the award resulting from this NOFO must be from the

authorized geographic code specified in Section B.4 of this NOFO and must meet the source and nationality requirements set forth in 22 CFR 228.

j) Prohibition on Certain Telecommunication and Video Surveillance Services or Equipment (August 2020)

This provision will be included in the resulting cooperative agreements. Applicants must note the obligatory compliance requirement it brings into activity IT resource procurement.

(a). The Recipient is prohibited from using grant funds, including direct and indirect costs, program income, and any cost share to: (1) Procure or obtain; (2) Extend or renew a contract to procure or obtain; or (3) Enter into a contract (or extend or renew a contract) to procure or obtain equipment, services, or systems that use covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system.

(b). Telecommunication costs and video surveillance costs incurred for telecommunications and video surveillance services and equipment such as phones, internet, video surveillance, and cloud servers are allowable except for those referenced in paragraph a. above.

(c). Definitions. The terms used in this provision have the following meanings:

(1) "Covered telecommunication equipment or services" as defined in Pub. L. 115-232, Section 889, means any of the following:

i. Telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities).

ii. For the purpose of public safety, security of government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities).
iii. Telecommunications or video surveillance services provided by such entities or using such equipment.

iv. Telecommunications or video surveillance equipment or services produced or provided by an entity that the Secretary of Defense, in consultation with the Director of the National Intelligence or the Director of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise connected to, the government of a covered foreign country.

(2) "Covered foreign country" is defined in Pub. L. 115-232, Section 889 as the People's Republic of China. (3) "Telecommunications costs" as defined in 2 CFR 200.1 means the cost of using communication and telephony technologies such as mobile phones, land lines, and internet.

d. This provision must be incorporated into all subawards.
[END OF PROVISION]

k) Conscience Clause Implementation (Assistance) – Pre-Award Term (February 2012)

(a) An organization, including a faith-based organization, that is otherwise eligible to receive funds under this agreement for HIV/AIDS prevention, treatment, or care —

1) Shall not be required, as a condition of receiving such assistance— (i) to endorse or utilize a multisectoral or comprehensive approach to combating HIV/AIDS; or (ii) to endorse, utilize, make a referral to, become integrated with, or otherwise participate in any program or activity to which the organization has a religious or moral objection; and
2) Shall not be discriminated against in the solicitation or issuance of grants, contracts, or cooperative agreements for refusing to meet any requirement described in paragraph (a)(1) above.

(b) An Applicant who believes that this NOFO contains provisions or requirements that would require it to endorse or use an approach or participate in an activity to which it has a religious or moral objection must so notify the cognizant Agreement Officer in accordance with the Mandatory Standard Provision titled "Notices" as soon as possible, and in any event not later than 15 calendar days before the deadline for submission of applications under this solicitation. The applicant must advise which activity(ies) it could not implement and the nature of the religious or moral objection.

(c) In responding to the NOFO, an Applicant with a religious or moral objection may compete for any funding opportunity as a prime partner, or as a leader or member of a consortium that comes together to compete for an award. Alternatively, such an Applicant may limit its application to those activities it can undertake and must indicate in its submission the activity(ies) it has excluded based on religious or moral objection. The Applicant's application will be reviewed based on the activities for which an application is submitted for, and will not be reviewed favorably or unfavorably due to the absence of content that is addressing the activity(ies) to which it objected and which it thus omitted. In addition to the notification in paragraph (b) above, the Applicant must meet the submission date provided for in the NOFO.

(END OF PRE-AWARD TERM)

l) <u>Conflict Of Interest Pre-Award Term (August 2018)</u>

(1) Personal Conflict of Interest:

(**a**). An actual or appearance of a conflict of interest exists when an Applicant organization or an employee of the organization has a relationship with an Agency official involved in the competitive award decision-making process that could affect that Agency official's impartiality. The term "conflict of interest" includes situations in which financial or other personal considerations may compromise, or have the appearance of compromising, the obligations and duties of a USAID employee or recipient employee.

(b). The Applicant must provide conflict of interest disclosures when it submits an SF-424. Should the Applicant discover a previously undisclosed conflict of interest after submitting the

application, the applicant must disclose the conflict of interest to the AO no later than ten (10) calendar days following discovery.

(2) Organizational Conflict of Interest

The Applicant must notify USAID of any actual or potential conflict of interest that they are aware of that may provide the Applicant with an unfair competitive advantage in competing for this financial assistance award. Examples of an unfair competitive advantage include but are not limited to situations in which an applicant or the applicant's employee gained access to non-public information regarding a federal assistance funding opportunity, or an applicant or applicant's employee was substantially involved in the preparation of a federal assistance funding opportunity. USAID will promptly take appropriate action upon receiving any such notification from the Applicant.

(END OF PRE-AWARD TERM)

[END OF SECTION D]

SECTION E: APPLICATION REVIEW INFORMATION:

1. Application Review Methodology:

The merit review criteria prescribed here are tailored to the requirements of this NOFO. Applicants must note that these criteria serve to: **(a) identify the significant matters which the applicants should address in their applications, and (b) set the standard against which all applications will be evaluated.**

a) Merit Review:

USAID/Malawi will conduct a merit review of all applications received that comply with the instructions in this NOFO. Applications will be reviewed and evaluated in accordance with the following criteria shown in descending order of importance. The criteria provide for a selection base established before receipt of the applications and are intended to assess how well the applications respond to the technical parameters needed to achieve the objectives of the CORE Activity.

CRITERION 1	**TECHNICAL APPROACH**	**IMPORTANCE or WEIGHT:**	Most Important or equal to 50 percent

When assessing the technical approach, the Selection Committee will consider the following factors:

● **Criterion/Sub Criterion Evidence-Based Design**:

- Demonstrated understanding of the program description; logic, coherence and feasibility of the overall plan to achieve expected results.
- Sound analytical basis and technical soundness of responses.
- Use of methods proven to be successful (based on the scientific literature and documented experience assessing the technical effectiveness of interventions) for HIV service delivery programs
- Technically innovative approaches to increase the availability and use of care and treatment services.

● **Criterion/Sub Criterion Epidemiological and Implementation Context:**

- Understanding of the epidemiological context of the proposed geographic intervention areas and different population groups.
- Clear approach to differentiation of intensity of direct service delivery activities based on the epidemiological and implementation context.
- Feasibility of proposed approaches in the Malawian context and extent to which the proposed activity includes interventions to address health systems and other implementation challenges.

● **Criterion/Sub Criterion Population-Specific Interventions**:

- Extent to which the proposed activity includes approaches to service delivery that are adapted to the needs and service delivery preferences of different age and gender beneficiary populations.
- Demonstrated plans to bring effective innovations to reach specific populations to scale
- Incorporation of gender issues with the technical approaches proposed and understanding of the important role that gender norms play in the HIV and AIDS epidemic in Malawi.

● **Criterion/Sub Criterion Integration and Capacity Building:**

- Description of proposed mechanisms and methods for collaborative implementation with other HIV and AIDS implementation partners and national HIV and AIDS mitigation activities and services.
- Clear approach to strengthening site level linkages to improve the continuum of care for patients within the facility and into the community.
- Innovative and feasible approaches to building capacity of districts and facilities to deliver effective HIV services.
- The degree to which the HRH strategy for direct service delivery demonstrates alignment (both in terms of numbers and skills mix) with programmatic priorities.

● **Criterion/Sub Criterion Performance Results Management and Quality Assurance:**

- Clear monitoring and evaluation plan that includes specific indicators for each result and the application of systems to generate the information needed for evidence-based decision-making at site, district, and program level, implementation management and progress/impact measurement in all areas of implementation. The plan will be evaluated for its ability to inform real-time shifts in human resources and intervention intensity as site level.
- Technical elements of any quality assurance techniques proposed for improving the quality of care and treatment services for HIV clients and how these are related to the programmatic/implementation approaches proposed for community-level care and treatment

CRITERION 2	**MANAGEMENT APPROACH**	**IMPORTANCE or WEIGHT:**	Second ranked in importance or equal to 40 percent

Review of the Applicant's proposed management approach will consider such factors as:

Criterion/Sub Criterion Management and Administrative Structure:

- Experience in organizing and managing large, complex, product-oriented health programs that have achieved high-level impact.

- Administrative and financial systems with demonstrated ability to effectively and efficiently start up and maintain complex management support operations in multiple geographic locations.
- Lines of communication, responsibilities and procedures to ensure the high level of coordination and collaboration with national and local governments and PEPFAR and non-PEPFAR partners.
- Demonstrated capacity for robust oversight of technical and compliance aspects of the activity.
- Capacity for sub-contracting with organizations that could play roles in achieving program results and envisioned partnership approaches as relevant to the proposed approach.
- Provision for rapid start-up and initiation of proposed implementation areas.
- The management and supervision structures are streamlined and ensure effective oversight of the program while prioritizing direct service delivery through deployment of site-level healthcare workers.

Criterion/Sub Criterion Staffing Plan and Key Personnel:

- Overall ability to bring an effective mix of skills, disciplines and experiences for care and treatment services in a variety of facility and to a more limited extent community settings and client-interface environments to include depth of technical expertise in HIV testing services, HIV care and treatment, TB/HIV, cervical cancer, and operational research and strategic information.
- Breadth of experience and competence of the proposed Chief of Party (COP) and lead technical personnel to manage the activity and demonstrated ability to create and maintain a high-performing team.
- Presence of Malawian staff in Key Personnel position
- Qualifications of proposed personnel and appropriateness for the responsibilities of each position.
- Thoroughness and appropriateness of applicant's plan and time frame for fielding key staff members.

Criterion/Sub Criterion Stakeholder Engagement:

- Clear plan for active engagement of intervention districts and facilities for effective operational relationships and sustainability of investments.
- Feasibility and effectiveness of proposed mechanisms for coordinating efforts with other implementing organizations working in the proposed geographic areas and technical domains.

Criterion/Sub Criterion Data use for Performance Management and Quality Assurance:

- Description of how the information generated regularly through the monitoring and evaluation plan will be used to inform work planning and on-going management of implementation activities.

- Strength of proposed data collection and analysis systems and technologies to support robust monitoring and evaluation activities at site, district, and program level and to measure proposed outcomes.
- Adequacy of quality assurance mechanisms to support quality control and improvement of service delivery and measure compliance with national and PEPFAR standards.
- Clear plan for monitoring of cost and cost-effectiveness of interventions.

CRITERION 3	**INSTITUTIONAL CAPABILITY AND PAST PERFORMANCE**	**IMPORTANCE or WEIGHT:**	Third ranked in importance or equal to 10 percent

Assessment of the institutional capability and past performance will focus on:

- The extent to which the Applicant demonstrates soundness of their technical capacity and corporate experience in implementing technical programs relevant to CORE's objectives. Details provided on proposed sub-recipient (if any) experience and how partners will support sustainability of Malawi's national HIV response will also be evaluated.
- USAID may give more weight to performance information that is considered more relevant/more current.
- Performance information will be used for both the responsibility determination and best value decision.

The Applicant's performance information determined to be relevant will be evaluated in accordance with the elements below:

(1) Quality of product or service, including consistency in meeting goals and targets;

(2) Timeliness of performance, including adherence to schedules and other time-sensitive project conditions, and effectiveness of home and field office management to make prompt decisions and ensure efficient completion of tasks;

(3) Business relations, addressing the history of professional behavior and overall business-like concern for the interests of the customer, including coordination among sub-partners and developing country partners, cooperative attitude in remedying problems, and timely completion of all administrative requirements;

(4) Customer satisfaction with performance, including end user or beneficiary wherever possible;

(5) Effectiveness and retention of key personnel, including appropriateness of personnel for the job and prompt and satisfactory changes in personnel when problems with clients where identified.

In cases where (a) an Applicant lacks relevant performance history, or (b) information on performance is not available, then the Applicant will not be evaluated favorably or unfavorably on

performance. The "neutral" rating assigned to any Applicant lacking relevant performance history is a score commensurate with the percentage of points received vs. possible points. Prior to assigning a "neutral" past performance rating, the Agreement Officer may consider a broad range of information related to an Applicant's performance.

b) Application Review and Rating Methodology:

The Review Committee will use an **adjectival approach** when reviewing the received applications. The chart below details the rating scheme and the definitions that apply to the technical factors.

Adjective	Character Definition
Exceptional	An **Exceptional** rating under a selection factor has the following characteristics: ● A comprehensive and thorough application of exceptional merit. ● Application meets and fully exceeds the Government expectations or exceeds the program description requirements and presents very low risk or **no** overall degree of risk of unsuccessful performance. ● Strengths **significantly outweigh** any weaknesses that may exist. ● Includes local organizations in substantial implementation roles. ● Management approach includes capacity-building of one or more local organizations for becoming a primary awardee. ● Has a local organization in a primary awardee role or if the proposed prime awardee is an international or regional organization, a clear plan for transitioning a sub-awardee, local organization into a primary awardee role during the implementation of the activity.
Very Good	A **Very Good** rating under this a selection factor has the following characteristics**:** ● Application demonstrating a **strong** grasp of the requirements. ● Application meets program description requirements and presents a **low** overall degree of risk of unsuccessful performance. ● **Strengths significantly outweigh any weaknesses that exist.** ● Includes local organizations in substantial implementation roles. ● Management approach includes capacity-building of one or more local organizations for becoming a primary awardee.
Satisfactory	A **Satisfactory** rating under a selection factor has the following characteristics: ● Application demonstrating a reasonably sound response and a **good** grasp of the requirements. ● Application meets solicitation requirements and presents a **moderate** overall degree of risk of unsuccessful performance.

	● **Strengths outweigh weaknesses.** ● Includes local organizations in substantial implementation roles.
Marginal	A **Marginal** rating under a selection factor has the following characteristics: ● Application shows a **limited** understanding of the requirements. ● Application meets some or most of the program description requirements but presents a **significant** overall degree of risk of unsuccessful performance. ● Weaknesses **equal or outweigh** any strengths that exist. ● Includes local organizations in minor implementation roles.
Unsatisfactory	An **Unsatisfactory** rating under a selection factor has the following characteristics: ● Application **does not meet** the program description requirements or requires a major rewrite of the application. ● Presents an **unacceptable** degree of risk of unsuccessful performance. ● Deficiencies and significant weaknesses demonstrate a **lack of understanding** of the US Government's needs for the proposed activity. ● Weaknesses and or deficiencies **significantly outweigh** any strengths that exist. ● Does not include local organizations in an implementation role.

c) Cost and Business Application Review:

USAID/Malawi will analyze the cost application of the applicant(s) under consideration for an award as a result of the merit review criteria to determine whether the proposed costs are allowable, allocable and reasonable in accordance with the cost principles found in 2 CFR 200 Subpart E. **There are no points allocated to cost evaluation**. Further to this a cost realism review will also be conducted to determine cost effectiveness and realism, adequacy of budget detail, financial feasibility, and consistency with elements of the technical application will also be conducted.

USAID/Malawi will also consider (1) the extent of the Applicant's understanding of the financial aspects of the program and the Applicant's ability to perform the activities within the amount requested; (2) whether the Applicant's plans will achieve the program objectives with reasonable economy and efficiency; and (3) whether any special conditions relating to costs should be included in the award.

The Agreement Officer will perform a risk assessment (2 CFR 200.205). The Agreement Officer may determine that a pre-award survey is required to inform the risk assessment in determining whether the prospective recipient has the necessary organizational, experience, accounting and operational controls, financial resources, and technical skills – or ability to obtain them – in order

to achieve the objectives of the program and comply with the terms and conditions of the award. Depending on the result of the risk assessment, the AO will decide to execute the award, not execute the award, or award with "specific conditions" (2 CFR 200.207).

[END OF SECTION E]

SECTION F: FEDERAL AWARD ADMINISTRATION INFORMATION

1. Federal Award Notices

Award of the agreement contemplated by this NOFO cannot be made until funds have been appropriated, allocated and committed through internal USAID procedures. While USAID anticipates that these procedures will be successfully completed, potential applicants are hereby notified of these requirements and conditions for the award.

2. Administrative & National Policy Requirements

The resulting award from this NOFO will be administered in accordance with the following policies and regulations.

For US organizations: ADS 303, 2 CFR 700, 2 CFR 200, and Standard Provisions for U.S. Non-governmental organizations.

For Non US organizations: Standard Provisions for Non-U.S. Non-governmental Organizations.

See Annex 2, for a list of the Standard Provisions that will be applicable to any awards resulting from this NOFO.

3. Reporting Requirements

- **Financial Reporting:**

The Recipient must submit quarterly financial reports using the SF 425 form in keeping with 2 CFR 200.327. Electronic submission is preferred. The SF 425 must be submitted to the Agreement Officer Representative 30 days after the end of each quarter. The recipient must submit accruals (accrued expenditure) at least 15 days before the end of the quarter. The recipient should also report expenditures according to PEPFAR guidance, allocating expenditure by program area, beneficiary, and cost category. Expenditure Reporting (ER) will be submitted in DATIM with annual expenditures in FY 20, which could shift quarterly reporting starting in FY 21.

- **Performance Reporting**

The Recipient must submit the following reports:

(A) Annual Work Plans:

The Recipient must submit annual work plans to the AOR.

The Recipient must submit a draft of the annual implementation plan no later than May 1st of each year for AOR/USAID review, and the final annual implementation plan must be submitted

no later than August 30th and must be approved no later than September 30th. The annual work plan must be costed.

I. Content:

The annual work plan must use the Mission work plan template and describe activities to be conducted at a greater level of detail than the agreement program description but must be cross-referenced with the applicable sections in the agreement program description.

The work plan must include the activities planned to be conducted, the site(s) where they will be conducted and annual performance targets, outputs and outcomes consistent with the monitoring and evaluation plan and include proposed international travel.

All work plan activities must be within the scope of the agreement. Work plan activities must not alter the agreement program description or terms and conditions of the cooperative agreement in any way; such changes may only be approved by the Agreement Officer, in advance and in writing. Thereafter, if there are inconsistencies between the work plan and the agreement's program description or other terms and conditions of this agreement, the latter will take precedent over the work plan.

II. Submission:

The Recipient must submit copies of the final work plans as follows: one copy to the AOR, and one copy to the Agreement Officer. Electronic submissions are preferred over hard-copy.

III. **Revisions:**

If revisions to the annual work plans are necessary, the Recipient must submit a revised work plan or a modification to the work plan in writing. The modification or revision will not be effective until it has been accepted and approved by the AOR in writing.

(B) Activity Monitoring and Evaluation Plan (AMEP):

Per ADS 201.3.12.6, it is mandatory that activity designs "address gender issues in a manner consistent with the analytical work performed during strategic plan development." The Mission recognizes the significant role that gender and gender imbalances play in the HIV and AIDS epidemic and gender disparities in access to services as well as patient outcomes. USAID/Malawi is committed to promoting gender equity within all health activities.

Gender inequities, poverty, and economic vulnerability, including food insecurity, along with cultural factors and low education levels, have put women and girls at heightened risk of HIV acquisition, sexual and physical abuse, discrimination, and even mortality. HIV incidence in adolescent girls in particular is high relative to incidence in young men of the same age cohort. The activity will explicitly ensure that the needs and challenges facing women and adolescent girls are addressed in the design of HIV prevention and treatment service delivery models. At the same time, men in Malawi are less likely to know their HIV status and to be virally suppressed

than women. The activity will also strengthen male-friendly services and approaches to overcome the specific barriers men encounter when seeking HIV services. Male involvement to support family and community health needs including the prevention of GBV in communities as well as within their household will be emphasized. The activity will develop and/or deliver integrated counseling content and related services to help address gender-specific issues and cross-generational audiences. Patient confidentiality and engagement in their care is critical to ensure that harmful gender norms do not deter or stigmatize patients seeking or receiving high quality care. The activity will consider the findings of the PEPFAR Gender Assessment (2015) and explore the feasibility of implementing key recommendations including increasing the capacity of health workers to address gender-related barriers to care and consideration of gender-related factors in testing and retention strategies and development of alternative service delivery models. Gender disaggregated data will be a standard component of activity monitoring information systems to ensure that all population groups are effectively served. This activity will conform to PEPFAR guidance regarding the age and sex disaggregation of standard Monitoring, Evaluation, and Reporting (MER) indicators. Quarterly collection and analysis of these program data will ensure robust monitoring of program efforts to improve uptake of services among high priority target groups including men age 15-45 and young women 15-25. These data will support course correction and programmatic interventions to improve service uptake and patient outcomes among these population groups.

(D) Quarterly Performance Reports:

1) The Recipient must submit one copy of a concise and brief quarterly program performance report to the AOR, and one copy to the Agreement Officer. Electronic submissions are preferred over hard-copy. The performance reports will reflect on detailed data on project achievements.
2) Reporting periods are USG fiscal year quarters.
3) The due-date for these program performance reports is not later than 30 days after the end of each reporting period. However, if the reporting period ends before 45 days from the effective date of this award, or less than 30 days from the estimated completion date of this award, no submission will be required. All other reporting requirements must, however, apply.

At a minimum quarterly reports must include the following:

- Discussion of the overall performance of the program, including details of any discrepancies between expected and actual results.
- Details of achievements for each activity implemented under each component, how this relates to the work plan and work plan timeline, and how this relates to planned targets and tracking the achievements against the Activity MEP.
- Discussion on how activities are impacting gender equality and empowerment as well as other cross cutting issues of sustainability, integration and private sector engagement.
- Identify problems or issues encountered, including issues adhering to the work plan/timeline, how they were or will be resolved and, if/as required, recommended USAID/Malawi Mission-level intervention to facilitate timely resolution.
- Discussion of sub-grant component and progress towards the Activity MEP.
- Description of assessment and surveillance data used to measure results.

- Success stories and an explanation of successes achieved, constraints encountered, and adjustments made for achieving program objectives.
- A comparison of actual accomplishments, both for the reporting period and cumulatively, with the established goals and objectives, and expected results; the findings of the investigator; or both.
- Data (both qualitative and quantitative) must be presented using established baseline data and indicators as identified in the Activity MEP and be supported by a brief narrative.
- Reasons why the established goals/targets were not met (if applicable), the impact on the program objective(s), and how the impact has been/will be addressed.
- Calendar for next quarter's activities.

Additional guidance on the format and content of quarterly reports prescribed by USAID/Malawi will be provided by the AOR.

(E) PEPFAR Performance Reporting:

This activity is primarily funded through the annual PEPFAR Country Operational Plan. As such, the Recipient must report against agreed upon annual targets on a semi-annual and annual basis. Each reporting period, USAID sets submission deadlines, which are generally 30 days prior to the end of the reporting periods (i.e. March and September).

In addition, the Recipient must report annually on program expenditures. Specifically, the recipient must use the form PEPFAR Program Expenditures (DS-4213 OMB 1405-0208) as a part of completing the PEPFAR Annual Progress Report at the end of each USG fiscal year (September 30).

(F) High Frequency Technical Data Reporting:

(1) **Reporting Frequency** – Recipient must submit data every four weeks, with results broken out in weekly increments. The Reporting Calendar below is the HFR timeline. Each HFR period is defined as four complete weeks (weeks start on Mondays per ISO 8601), and reporting is due back to the HFR POC as indicated in the table below. The indicators listed in paragraph (c) below will be broken out in weekly increments, with the exception of current on treatment (TX_CURR) and multi-month dispensing (MMD) which will each be reported in one batch for the whole 4-week period. Prior to the end of each Fiscal Year, the Calendar in paragraph (d) below will be replaced with an equivalent calendar for each subsequent Fiscal Year. Quarterly submission of data to DATIM will remain the official system of record for PEPFAR indicators.

(2) **Indicators -** The set of indicators that are subject to HFR are listed below. If the indicators require a change, the award will be modified with the mutual agreement of both parties. The AOR may also request additional data that is useful to monitoring the program. The Recipient must submit the full dataset it collects per the reporting calendar in paragraph (d) below, ensuring the required indicators below are included:

- **Weekly Batches:**
    - HIV testing volume [HTS_TST]
    - HTS_INDEX

- HIV positive testing volume [HTS_TST_POS]
- New enrollments on treatment [TX_NEW]
- Newly initiated on PrEP [PrEP_NEW]

- **Full Period Reporting (1 data point per reporting period):**
  - Current cohort on treatment [TX_CURR]
  - Cervical Cancer Screening and Treatment
  - Multi-month dispensing (MMD custom indicator, collected monthly), disaggregated via:
    - Number of patients receiving 1; 2; 3; 4 or 5; or 6-month ART dispensing

(4) **Calendar Dates:** -

FY2020 HFR REPORTING CALENDAR

Reporting Period	Weeks Included W1	W2	W3	W4	Submission Date
1	Sep 30	Oct 07	Oct 14	Oct 21	Nov 11
2	Oct 28	Nov 04	Nov 11	Nov 18	Dec 09
3	Nov 25	Dec 02	Dec 09	Dec 16	Jan 06
4	Dec 23	Dec 30	Jan 06	Jan 13	Feb 03
5	Jan 20	Jan 27	Feb 03	Feb 10	Mar 02
6	Feb 17	Feb 24	Mar 02	Mar 09	Mar 31
7	Mar 16	Mar 23	Mar 30	Apr 06	Apr 28
8	Apr 13	Apr 20	Apr 27	May 04	May 26
9	May 11	May 18	May 25	Jun 01	Jun 23
10	Jun 08	Jun 15	Jun 22	Jun 29	Jul 21
11	Jul 06	Jul 13	Jul 20	Jul 27	Aug 18
12	Aug 03	Aug 10	Aug 17	Aug 24	Sep 15
13	Aug 31	Sep 07	Sep 14	Sep 21	Oct 13

(G) Annual and/or Final Report:

1) The Recipient must submit an electronic version of the annual and final reports to each of the following:

   i) Agreement Officer's Representative (AOR);
   ii) Agreement Officer (AO);
   iii) USAID Development Experience Clearinghouse, Submission instructions can be found in the Standard Provision of this Cooperative Agreement entitled "Submissions to the Development Experience Clearinghouse and Data Rights."

The annual report must cover the period October 1st through September 30th of each year, or parts thereof and submitted to the AOR not later than October 31st of each year. The Annual and Final Reports must contain the information required in the Quarterly Performance Report, cover

the entire period of the Agreement, and must be submitted no later than 90 days after the Agreement completion date. The Annual and Final reports replace the Quarterly Performance Report for that quarter. The Annual and Final reports must emphasize quantitative as well as qualitative data that reflect program results using the baseline data and indicators established for the program.

(2) In accordance with the previously mentioned Standard Provision, each document submitted should include the following information: a) descriptive title; b) author(s) name; c) award number; d) sponsoring USAID office; e) date of publication; and f) software name and version (if electronic document is sent).

(F) Monthly reporting: In addition to required quarterly reporting, the recipient must provide monthly, data-driven updates on performance of key indicators, by district, sex, and age as well as implementation progress on programmatic priorities.

4. Program Income

The Recipient will account for Program Income in accordance with 2 CFR 200.307. Program Income earned under this award shall be added to the project.

5. Environmental Compliance

(a) HIV activities are covered under the approved Health, Population and Nutrition (HPN) Portfolio Initial Environmental Examination (IEE) 2018-2023. This IEE may be found on the internet at: https://ecd.usaid.gov/document.php?doc_id=51714 . The IEE determined that a **Categorical Exclusion** for activities being proposed under this award be made. This is because the actions will not have a direct effect on the natural or physical environment.

(b) In addition, the recipient must comply with host country environmental regulations unless otherwise directed in writing by USAID. In case of conflict between host country and USAID regulations, the latter shall govern.

(c) As part of its initial Work Plan, and all Annual Work Plans thereafter, the recipient, in collaboration with the USAID AOR and Mission Environmental Officer or Bureau Environmental Officer, as appropriate, will review all on-going and planned activities under this cooperative agreement to determine if they are within the scope of the approved IEE. If the recipient plans any new activities outside the scope of the approved IEE, it must prepare an amendment to the IEE for USAID review and approval. No such new activities must be undertaken prior to receiving written USAID approval of environmental documentation amendments. Any ongoing activities found to be outside the scope of the approved IEE must be halted until an amendment is submitted and written approval is received from USAID.

(d) As required by ADS 204.3.4, the USAID/Malawi team and the implementing partner will actively monitor and evaluate whether the conditions of the IEE are being implemented effectively, and whether there are new or unforeseen consequences arising during activity implementation that were not identified and reviewed in the IEE. If new or unforeseen

consequences arise during activity implementation, the team will suspend the activity and initiate further review in accordance with 22 CFR 216. USAID monitoring for environmental compliance will be included in regular site visits.

[END OF SECTION F]

SECTION G: FEDERAL AWARDING AGENCY CONTACT(S)

1. AGENCY POINT OF CONTACT:

Applicants must submit application packages to the attention of:

Dion Glisan
Supervisory Agreement Officer
Office of Acquisition and Assistance (OAA)
USAID/Malawi,
P O Box 30045,
Lilongwe 3, Malawi.
dglisan@usaid.gov

2. QUESTIONS AND ANSWERS:

Questions regarding this Notice of Funding Opportunity (NOFO) must be submitted electronically through email to: OAA-Malawi-Solicit@usaid.gov with a copy to gsuya@usaid.gov and smbeya@usaid.gov no later than the date and time indicated on the cover letter of this NOFO or as amended.

[END OF SECTION G]

SECTION H: OTHER INFORMATION

DUTY AND TAX EXEMPTION:

When an organization receives USAID funding to operate in Malawi, it must register the activity with the Malawi Government in order to receive duty free privileges and tax exemption waivers and refunds. It is important to note that tax exemption is granted to the award (activity), and not the organization.

Once an activity has been registered for duty free and tax exemption status, the following procedure should be followed to request duty free clearance of purchased commodities/goods: Note that waiver of duty free for commodities/goods is done up front.

Once an activity has been registered for tax exemption with the Malawi Ministry of Finance (MoF) through the relevant line ministry, the activity implementing organization needs to apply to the Commissioner General for VAT exemption. The Malawi Revenue Authority (MRA) Commissioner General will grant an approval letter which will be taken to the USAID Desk Officers at the MRA.

VAT Processing Roles and Responsibilities

Role of the Implementing Partner / Grantee:

(a) Partner makes payments for services/small purchases and goods.
(b) Partner records all the payments net of VAT as an expense in their accounting records.
(c) Partner prepares claims forms for submission to MRA (see Chapter 4)
(d) Partner maintains a record of all taxes claimed for VAT reimbursement and waivers
(e) It is the responsibility of the partners to ensure that receipts are valid and meet the requirements of the MRA

Role of USAID/Malawi:

(a) USAID AOR/COR endorses the MRA forms and provides an endorsement letters to USAID/ Executive Officer (EXO) for signature.
(b) The USAID/EXO signs the cover letter as supporting documentation and returns the forms and letter to the Partner for submission to MRA.
(c) USAID/OFM through the AOR/COR provides guidance and serves as a point of contact, along with the AOR, to assist with technical VAT related matters.

Role of MRA

(a) MRA reviews and makes payments, directly to the partner, when applicable.
(b) MRA communicates any disallowances or required submission changes directly to the partner.

[END OF SECTION H]

ANNEX 1 - SUMMARY BUDGET TEMPLATE:

Applicants must submit cost applications / budgets using SF-424A and submit it along with necessary support documents and budget narratives / notes.

Summary Budget

Cost Category	**Breakdown by Activity Year**					Total 5 Year
	Yr. (1)	Yr. (2)	Yr. (3)	Yr. (4)	Yr. (5)	
(a). Personnel						$0
(b). Fringe Benefits						$0
(c). Travel & Transportation						$0
(d). Equipment						$0
(e). Supplies						$0
(f). Contractual						$0
(g). Construction						$0
(h). Other Direct Costs						$0
(i). Total Direct Costs						$0
(j). Indirect Charges						$0
(k). Total Activity Amount	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Each year's budget as shown above, must have a corresponding independent detailed worksheet where detailed annual budget is worked out.

ANNEX 2 - STANDARD PROVISIONS:

Administration of awards resulting from this NOFO will be in accordance with USAID standard provisions based on type of organization selected either U.S. or non-U.S. Nongovernmental organization.

Mandatory Standard Provisions for Non-U.S. Nongovernmental Organizations (NGOs):

M1. Allowable Costs (December 2104)

M2. Accounting, Audit, and Records (October 2017)

M3. Amendment of Award and Revision of Budget (August 2013)

M4. Notices (June 2012)

M5. Procurement Policies (June 2012)

M6. USAID Eligibility Rules for Procurement of Commodities and Services (May 2020)

M7. Title to and Use of Property (December 2014)

M8. Submissions to the Development Experience Clearinghouse and Data Rights (June 2012)

M9. Marking and Public Communications under USAID-Funded Assistance (December 2014)

M10. Award Termination and Suspension (December 2014)

M11. Recipient and Employee Conduct (June 2018)

M12. Debarment and Suspension (June 2012)

M13. Disputes and Appeals (December 2014)

M14. Preventing Transactions with, or The Provision of Resources or Support to, Sanctioned Groups and Individuals (May 2020)

M15. Trafficking in Persons (April 2016)

M16. Voluntary Population Planning Activities – Mandatory Requirements (May 2006)

M17. Equal Participation by Faith-Based Organizations (June 2016)

M18. Nondiscrimination (June 2012)

M19. USAID Disability Policy - Assistance (June 2012)

M20. Limiting Construction Activities (August 2013)

M21. USAID Implementing Partner Notices (IPN) Portal for Assistance (July 2014)

M22. Pilot Program for Enhancement of Grantee Employee Whistleblower Protections (September 2014)

M23. Submission of Datasets to the Development Data Library (October 2014)

M24. Prohibition on Requiring Certain Internal Confidentiality Agreements or Statements (May 2017)

M25. Child Safeguarding (June 2015)

M26. Mandatory Disclosures (July 2015)

M27. Nondiscrimination Against Beneficiaries (November 2016)

M28. Conflict Of Interest (August 2018)

M29. Prohibition on Certain Telecommunication and Video Surveillance Services or Equipment (August 2020)

Required as Applicable Standard Provisions For Non-U.S. Nongovernmental Organizations:

RAA1. Advance Payment and Refunds (December 2014)

RAA2. Reimbursement Payment and Refunds (December 2014)

RAA3. Indirect Costs – Negotiated Indirect Cost Rate Agreement (NICRA) (December 2014)

RAA4. Indirect Costs – Charged As A Fixed Amount (Nonprofit) (June 2012)

RAA5. Indirect Costs – De Minimis Rate (May 2020)

RAA6. Universal Identifier And System Of Award Management (July 2015)

RAA7. Reporting Subawards And Executive Compensation (December 2014)

RAA8. Subawards (December 2014)

RAA9. Travel And International Air Transportation (December 2014)

RAA10. Ocean Shipment of Goods (June 2012)

RAA11. Reporting Host Government Taxes (June 2012)

RAA12. Patent Rights (June 2012)

RAA13. Exchange Visitors and Participant Training (June 2012)

RAA14. Investment Promotion (November 2003)

RAA15. Cost Share (June 2012)

RAA16. Program Income (August 2020)

RAA17. Foreign Government Delegations to International Conferences (June 2012)

RAA18. Standards for Accessibility for the Disabled in USAID Assistance Awards Involving Construction (September 2004)

RAA19. Protection of Human Research Subjects (June 2012)

RAA20. Statement for Implementers of Anti-Trafficking Activities on Lack of Support for Prostitution (June 2012)

RAA21. Eligibility of Subrecipients of Anti-Trafficking Funds (June 2012)

RAA22. Prohibition on the Use of Anti-Trafficking Funds to Promote, Support, or Advocate for the Legalization or Practice Of Prostitution (June 2012)

RAA23. Voluntary Population Planning Activities – Supplemental Requirements (January 2009)

RAA24. Conscience Clause Implementation (Assistance) (February 2012)

RAA25. Condoms (Assistance) (September 2014)

RAA26. Prohibition on the Promotion or Advocacy of the Legalization or Practice of Prostitution or Sex Trafficking (Assistance) (September 2014)

RAA27. Limitation on Subawards to Non-Local Entities (July 2014)

RAA28. Contract Provision for DBA Insurance Under Recipient Procurements (December 2014)

RAA29. Contract Award Term and Condition for Recipient Integrity and Performance Matters (April 2016) Award Term and Condition for Recipient Integrity and Performance Matters (APRIL 2016)

RAA30. Protecting Life in Global Health Assistance (May 2019)

The full text of the provisions can be found at:

https://www.usaid.gov/sites/default/files/documents/303mab.pdf.

Applicants are strongly encouraged to thoroughly read and be familiar with these standard provisions as they will be applicable to the resulting cooperative agreements and certain requirements may influence the cost application.

[END OF THE REQUEST FOR APPLICATION DOCUMENT]