Colombia: DHAPP Partnership for Sustainable HIV Epidemic Control among displaced Venezuelans in Colombia

NOTE: Application submissions for this narrative are due by 5pm ET on January 03 2022. Submissions received after the deadline will not be considered for funding.

Introduction

Venezuela's ongoing economic crisis has had devastating effects on the country's health system. Historically Venezuela had one of the most effective HIV programs in the Western hemisphere, but today only 7 percent of Venezuela's 120,000 PLHIV are virally suppressed, mostly through ad-hoc donations of antiretroviral treatment through NGOs. Available mortality estimates indicate that AIDS-related deaths are up over 100 percent in 2018, with an estimated 30 deaths per day due to lack of treatment. Growing threats of drug resistance and mass migrations out of Venezuela threaten regional health security in the Western hemisphere, making it in the interest of the United States and S/GAC to respond. The US Government has a long history of international collaboration and partnerships in the fight against HIV/AIDS, providing funding, technical assistance, and program support. These collaborations are all contributing to HIV epidemic control.

Venezuela's internal crisis has also triggered the most significant mass migration in the history of the Western hemisphere. Over 2,000,000 Venezuelans have fled the country over the past two years, many because of a critical lack of medication and health services. An estimated 1.1 million Venezuelans are currently sheltering in Colombia, with populations mostly concentrated along the border regions and near Bogota. The HIV prevalence among this population is currently unknown, though it is estimated to be significant.

The purpose of this funding opportunity announcement is to support test and treatment efforts in the Venezuelan migrant communities in Colombia and collaborate with the Colombian military through DoD HIV/AIDS Prevention Program (DHAPP). The HIV/AIDS epidemic has been devastating and negatively affected many militaries and other uniformed organizations worldwide by reducing military readiness, limiting deployments, causing physical and emotional decline in infected individuals and their families, posing risks to military personnel and their extended communities, and impeding peacekeeping activities. As HIV management improves, many of these impacts are disappearing; however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries in addition to other long-term chronic disease management issues.

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Over the years, the United States Department of Defense (DoD) HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries to control the HIV epidemic among their respective military services. DHAPP is the DoD implementing agency collaborating with the US Department of State, the Health Resources and Services Administration, Peace Corps, US Agency for International Development (USAID), and the Centers for Disease Control and Prevention (CDC), in the US President's Emergency Plan for AIDS Relief (PEPFAR). DHAPP receives funding for its programs from two sources: a congressional plus up to the Defense Health Program (DHP) and funding transfers from the Department of State for PEPFAR. Working closely with DoD, U.S. Unified Combatant Commanders,

Joint United Nations Programme on HIV/AIDS (UNAIDS), university collaborators, and other nongovernmental organizations (NGOs), DHAPP's mission is to build capable military partners through military-specific, culturally focused, HIV/AIDS cooperation and assistance.

In the Defense Security Cooperation Agency guidance, the US Secretary of Defense has identified HIV/AIDS in foreign militaries as a national security issue. Pursuing HIV/AIDS activities with foreign militaries is clearly tied to security interests, regional stability, humanitarian concerns, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing societies. DHAPP employs an integrated bilateral and regional strategy for HIV/AIDS cooperation and security assistance. DHAPP implements bilateral and regional strategies in coordination with respective Combatant Commands (COCOMs) and Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the US Under Secretary of Defense for Policy and by the Office of the Global AIDS Coordinator (OGAC). DHAPP provides strategic information and supports defense forces in HIV prevention, care, and treatment for HIV-infected individuals and their families.

PEPFAR adopted the United Nations Programme on HIV/AIDS (UNAIDS) global 95-95-95 (formerly 90-90-90) goals that state by 2030: 95% of people with HIV are diagnosed, 95% of them are on antiretroviral therapies (ART) and 95% of them are virally suppressed. Despite tremendous efforts, the global 90-90-90 goals were not realized by 2020. Therefore, UNAIDS developed the Global AIDS Strategy 2021-2026: End Inequalities. End AIDS. This bold approach uses an inequalities lens to close the gaps preventing progress and outlines the 2025 targets: 10-10-10 (less than 10% of persons living with HIV (PLHIV) and key populations (KP) experience stigma and discrimination (S&D); less than 10% of PLHIV, women and girls, and Key Populations at heightened risk for HIV experience gender-based inequalities and Gender-Based Violence (GBV); and less than 10% of countries have punitive laws and policies). In addition to the above-mentioned 95-95-95 treatment goals, there are three more 95% goals including: 95% of people at risk of HIV use combination prevention; 95% of women access sexual and reproductive health services; and 95% coverage of services for eliminating vertical transmission. Lastly, the UNAIDS Global AIDS Strategy established two 90% goals including: 90% of PLHIV receive preventive treatment for TB and 90% of PLHIV and people at risk are linked to other integrated health services.

The PEPFAR Strategy: Vision 2025 will be informed by and closely coordinated with the Global AIDS Strategy 2021-2026 and the post-2022 Global Fund Strategy to optimize complementarity, value for money, and impact. The next PEPFAR Strategy will also support the international community's efforts to put countries on track to reach the Sustainable Development Goal 3 target of ending the global AIDS epidemic as a public health threat by 2030, through the attainment of key milestones by 2025.
"Vision 2025," provides that the United States will achieve sustained HIV epidemic control by supporting equitable health services and solutions, enduring national health systems and capabilities, and lasting collaborations. Specifically, this strategy aims to ensure that, by 2025, all countries it supports have:
1. Reached the global 95-95-95 treatment targets for all ages, genders, and population groups; countries that have already achieved 95-95-95 will be supported to sustain their progress.
2. Dramatically reduced new HIV infections, particularly in priority populations, including adolescent girls and young women, key populations, and children.
3. Institutionalized granular, targeted, and gender-sensitive data use and systems and community-led approaches to monitor and address new HIV infections, especially among key populations and younger populations.

4. Made significant gains toward tackling societal challenges that impede progress in achieving the global 10-10-10 targets, including reducing the number of countries with punitive laws that target key populations; reducing stigma and discrimination that undermine effective responses; and fighting gender-based inequalities and gender-based violence that put adolescent girls and young women at increased risk for HIV.
5. Developed benchmarks supporting an HIV response that ensures enabling policies are adopted and implemented, and that countries and communities can lead with the capacity to deliver prevention and treatment services through domestic systems.

Call for Proposals

Proposals are requested to support Colombia to reach sustainable control of the HIV epidemic through the lens of PEPFAR's Vision 2025 Strategy objectives, the UNAIDS HIV Treatment 95-95-95, Combination Prevention 95, Reproductive Health 95, and Vertical Transmission 95 targets; TB prevention 90 and Integrated Health 90 targets; and the Inequalities 10-10-10 targets. Candidates are expected to be familiar with and to include means of addressing these objectives in their submitted proposals.

PEPFAR Monitoring, Evaluation, and Reporting (MER) indicators are used to set targets, and are collected and reported to efficiently use data to drive decision-making and focus HIV programming to the right populations, and right geographic areas. DHAPP uses the same program indicators for Defense Health Program (DHP) and PEPFAR-funded programs. DHAPP collects MER indicator results on a quarterly semi-annual, and annual basis, depending on indicator and data are reported at the site level to DHAPP. These data allow DHAPP to analyze and evaluate gaps in programming and achievement and identify needs for shifts to reach our shared goals. Due to security sensitivities regarding military site locations and troop movement, all site-level data are analyzed at DHAPP headquarters and only summary data are reported to OGAC so that other USG country team agencies can review military program results aggregated at the national level.

Local, non-governmental partners are encouraged to apply to this announcement. To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and community-based and community-led organizations – regardless of current antiretroviral (ARV) coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term, local partner engagement and impact.

All respondents must demonstrate the active support of the in-country military in the planning and execution of their proposals. This should be done by attaching an appropriate letter of support.

DHAPP, after graduating 30 programs, supported 50 active programs in FY20, mainly through military-to-military cooperation in addition to support to external organizations to assist with specific program requirements or components of proposed programs. Partners in FY20 included 35 NGOs and universities working in 50 countries.

Budget

PEPFAR activities and services and corresponding budgets and expenditures are uniformly organized into a classification structure referred to as PEPFAR Financial Classifications. In this structure, the PEPFAR funded activities and services are classified systematically as interventions, which is a combination of programs (and sub-programs) and beneficiaries (and sub beneficiaries). Budget and program expenditures are further arrayed according to the cost classification. The below link contains the PEPFAR Financial Classifications Reference Guide and summaries of these classification definitions. https://datim.zendesk.com/hc/en-us/articles/360015671212-PEPFAR-Financial-Classifications-Reference-Guide. The estimate budget for this program announcement in the format of the PEPFAR Financial Classifications is as follows:

Estimated Budget to be used as a Framework

Intervention Number	Program Area	Beneficiary	Phase 1	Phase 2	Phase 3	Phase 4	Award Total
PM	*Program Management (Not to exceed amount)	Non-Targeted Pop: Not disaggregated	$ 17,743	$ 17,743	$ 17,743	$ 17,743	$ 70,972
1	C&T: Not Disaggregated-NSD	Priority Pops: Displaced persons	52,843	52,843	52,843	52,843	211,372
2	C&T: Not Disaggregated-SD	Priority Pops: Displaced persons	44,930	44,930	44,930	44,930	179,720
3	C&T: HIV Clinical Services-SD	Priority Pops: Displaced persons	58,075	58,075	58,075	58,075	232,300
4	C&T: HIV Drugs-SD	Priority Pops: Displaced persons	13,714	13,714	13,714	13,714	54,856
5	C&T: HIV Laboratory Services-SD	Priority Pops: Displaced persons	53,486	53,486	53,486	53,486	213,944
6	C&T: HIV Clinical Services-NSD	Priority Pops: Displaced persons	35,476	35,476	35,476	35,476	141,904
7	PREV: Comm. mobilization, behavior & norms change	Priority Pops: Displaced persons	24,280	24,280	24,280	24,280	97,120
8	PREV: Condom & Lubricant Programming-SD	Priority Pops: Displaced persons	23,310	23,310	23,310	23,310	93,240
9	HTS: Facility-based testing-SD	Priority Pops: Displaced persons	76,143	76,143	76,143	76,143	304,572
10							-
11							-
12							-
13							-
14							-
15							-
16							-
17							-
18							-
*Program Management Budget Estimate is NOT TO EXCEED AMOUNT			$ 400,000	$ 400,000	$ 400,000	$ 400,000	$ 1,600,000

Approaches to Reaching Sustainable Epidemic Control

Proposals are requested to support the Colombia to reach sustainable control of the HIV epidemic and focused on the latest PEPFAR guidance and UNAIDS HIV Treatment 95-95-95, Combination Prevention 95, Reproductive Health 95, and Vertical Transmission 95 targets; TB prevention 90 and Integrated Health 90 targets; and the Inequalities 10-10-10 targets.

The Recipient's program should emphasize capacity building across all activities and technical areas. All proposals should detail how the Recipient will engage the partner military leadership as well as personnel at all levels in this work; and, specifically how the partner will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Within the proposal, the Recipient will need to clearly demonstrate effective capacity building activities that lead to annual transitions of specific programmatic capabilities to the military throughout the life of the award.

The Recipient must work in complete coordination with all relevant officials in the partner militaries' HIV prevention and health services, as well as the DHAPP/DoD Program Manager based at the U.S. Embassies in these countries, and other DHAPP supported Recipients working within the country or regionally supporting the country, other bilateral and multilateral agencies with similar objectives and the DHAPP Headquarters Team.

Targets and Benchmarks

Progress towards epidemic control will be successfully measured, in part, through an effective strategic information framework that monitors not only program outputs as compared to planned targets, and benchmarks but also key outcomes and programmatic impact.

Collection and use of disaggregated data that characterizes the populations served in the lowest geographic areas where HIV services are being provided is critical in understanding current program performance and planning for future performance. Consequently, the MER indicators continue to evolve in order to reflect the progression of USG support and global HIV response guidelines. Measuring the impact of support at national and regional above-site levels down to direct services at the site-level is paramount to DHAPP's program implementation and monitoring approach.

MER indicators are not an exhaustive list of all metrics that should be monitored by DHAPP-supported programs. DHAPP also collects a custom indicator. All programs should continually monitor and assess any acute programmatic issues and collect additional data to inform program improvement.

The indicators listed below support a patient-centered program monitoring approach. Per the 2017 WHO Consolidated Guidelines on Person-Centered HIV Patient Monitoring and Case Surveillance, person-centered monitoring refers to a shift from monitoring measuring services (e.g., the number of individuals tested or people on treatment) to monitoring people at the center of their access to linked HIV and health services. In essence, this marks a shift to better support the clients accessing services by focusing more on

their individual health outcomes.

The proposal will address approaches to reaching the following targets and benchmarks for military and civilian populations. Targets are listed using the associated PEPFAR Monitoring, Evaluation, and Reporting Indicator. Please see the most recent Monitoring, Evaluation, and Reporting Indicator Reference Guide for more detail at https://datim.zendesk.com/hc/en-us/articles/360000084446-MER-Indicator-Reference-Guides . Benchmarks are listed based on programmatic needs.

Prevention

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
10. TB_PREV	Proportion of ART patients who started on a standard course of TB Preventive Treatment (TPT) in the previous reporting period who completed therapy		1082

Testing

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
12. CXCA_SCRN	HIV-positive women on ART screened for cervical cancer		302
13. HTS_INDEX	individuals who were identified and tested using Index testing services and received their results		805
14. HTS_RECENT	Number of newly diagnosed HIV-positive persons who received testing for recent infection with a documented result during the reporting period		985
16. HTS_TST_POS	Number of individuals who received HIV Testing Services (HTS) and received their positive test results		985
18. PMTCT_EID	Percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy		100% (2)
20. PMTCT_HEI_POS	Number of HIV-infected infants identified in the reporting period, whose		2

	diagnostic sample was collected by 12 months of age.		
21. PMTCT_STAT	Percentage of pregnant women with known HIV status at antenatal care (includes those who already knew their HIV status prior to ANC)		100% 3584
22. TB_STAT	Percentage of new and relapse TB cases with documented HIV status		100% 29

Treatment

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**
23. CXCA_TX	Percentage of cervical cancer screen-positive women who are HIV-positive and on ART eligible for cryotherapy, thermocoagulation or LEEP who received cryotherapy, thermocoagulation or LEEP		302
24. PMTCT_ART	Percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy		89
25. TB_ART	Proportion of HIV-positive new and relapsed TB cases on ART during TB treatment		29
26. TX_CURR	Number of adults and children currently receiving antiretroviral therapy (ART)		2189
28. TX_NEW	Number of adults and children newly enrolled on antiretroviral therapy (ART)		1082
29. TX_TB	Proportion of ART patients screened for TB in the semiannual reporting period who start TB treatment.		29

Viral Suppression

Technical Area Targets, Year 1			
Indicator	**Label**	**Military Only**	**Civilian**

30. TX_PVLS	Percentage of ART patients with a suppressed viral load (VL) result (<1000 copies/ml) documented in the medical or laboratory records/laboratory information systems (LIS) within the past 12 months		(100%) 2880

Technical Narrative

In alignment with the UNAIDS Global AIDS Strategy, WHO Guidelines, and the PEPFAR Strategy and Guidance, and coupled with DHAPP's vision to build the capacity of military health systems through military-specific and culturally focused services, the recipient will address the technical approach to each area. The Recipient, through capacity building activities with the host military, will be responsible for providing the following in close collaboration with other DHAPP-funded Recipients.

The Recipient will work closely with the Ministry of Defense, Ministry of Health, and medical leadership to make progress on the Minimum Program Requirements outlined in the PEPFAR guidance (https://www.state.gov/wp-content/uploads/2020/12/PEPFAR-COP21-Guidance-Final.pdf)

HIV Testing Services (HTS)
Finding the remaining persons who are living with HIV (PLHIV) is the first priority for reaching HIV epidemic control. Current epidemiology shows that most of those who do not yet know their infection status are men. The Host Military HIV/AIDS program is strategically placed to reach men; therefore, the Recipient will work closely with the Host Military on HTS, particularly index testing and self-testing, in an effort to achieve the "first 95" for military personnel: 95% of all Host Military personnel living with HIV know their status. Recipient will ensure they and the Host Military follow PEPFAR's Guidance on Implementing Safe and Ethical Index Testing.

HTS will focus primarily on index testing to provide high-yield testing to those most at risk for infection. The local epidemiology and situational analysis should guide the use of other testing methodologies to identify those who are living with HIV.

Where possible, a rapid test for recent infection (RTRI) should be conducted for all of those found to be newly positive. Those who test positive are classified as "probable recent HIV infections" until results of viral load are available. The index testing of these persons should receive high priority, and robust efforts should be made to reach all contacts.

Provider-Initiated Testing and Counseling (PITC) will continue in fixed sites for both the military and civilian cohorts. PITC should focus in clinical areas that have shown a high yield, such as tuberculosis (TB) and STI clinics.

The Recipient should work to achieve 100% linkage of HIV-positive individuals identified. Ensuring that any persons with positive results identified are linked to HIV care and treatment is essential to the success of the Host Military program. The Recipient will monitor HIV testing yield, modifying as necessary the strategies or locations that are not identifying cases and/or linking significant numbers of HIV-positive persons to care and treatment.

The Recipient will be responsible for:

- HTS to military bases and facilities:
  - Diagnosing 1082 PLHIV with at least 95% of those diagnosed linked to HIV care while striving for 100% linkage to treatment services and receiving same day initiation of antiretroviral therapy (ART);
  - Index-case testing for all sexual partners of HIV-infected military personnel and civilians;
  - Index-case testing and documentation of HIV status for all children under 19 years of age with HIV- infected mothers; and
- Offering self-testing for partners of index clients if they do not volunteer for partner notification.
- Quality improvement and quality assurance for all Host Military HTS, including continuous training and mentoring and supervision visits, at least quarterly.
- Self-testing should be made available for military personnel, adolescent girls and young women (AGYW) and their partners, male partners of antenatal care (ANC) clients, people who engage in sex work, MSM, and other key and priority populations (e.g., young men and at-risk males) who face high levels of stigma and discrimination. Following self-testing, facility referral and the regular diagnostic algorithm can be used according to national standards. It is also vital to engage community groups to advocate for, design, implement, and analyze the success of HIV Self-Testing (HIVST).
- Conducting proficiency testing for all HTS sites and individuals.
- Tracking PLHIV from HTS to clinical care and treatment services to ensure linkage and retention.
- Linking HIV negative males to VMMC services.

HIV Treatment

ART optimization is a cornerstone of PEPFAR policy, which stipulates that all PLHIV should have access to the most effective, convenient therapy with minimal or no side effects. Optimal ART is critical to lifelong continuity of care and viral load suppression. The following issues should be considered in supporting the treatment of PLHIV in military populations.

- Dolutegravir (DTG)-containing regimens are the preferred first-line ART due to superior efficacy, tolerability and higher threshold for resistance compared to efavirenz (EFV)-containing regimens.

- PEPFAR recommends use of tenofovir disoproxil fumarate/lamivudine/dolutegravir (TLD) as the preferred option for ART for both first- and second-line treatment of adolescents and adults living with HIV ≥ 30kg. PEPFAR further recommends that countries continue with their transition to DTG-based regimens from both first- and second-line regimens. The fixed-dose combination (FDC) of TLD is currently priced as the least expensive option, and it is expected that prices will go down as generic manufacturing scales up. DHAPP recommends TLD as the preferred option for ART, and further recommends that DHAPP-supported programs switch over to TLD as soon as possible in a coordinated fashion as supply becomes available.
- The Panel on Treatment of Pregnant Women with HIV Infection and Prevention of Perinatal Transmission recommends DTG as a Preferred ARV for pregnant and breastfeeding women (PBFW) and also recommends DTG as a Preferred ARV for women who are trying to conceive. This decision was based on updated data showing that that the increased risk of neural tube defects associated with DTG use is small and on the advantages of DTG - including once-daily dosing, being well tolerated, and producing rapid, durable viral load suppression - which are important for maternal health and for prevention of perinatal HIV transmission.
- Starting in COP20 (FY21), programs are expected to provide DTG-based ART to all PLHIV (≥ 4 weeks of age and who weigh ≥ 3 kg).TLD is the preferred regimen beginning at 30kg.
- A priority of HIV programs is to find, diagnose and treat people with tuberculosis (TB) disease and ensure that they become non-infectious. For all those who do not have active tuberculosis, prevention of TB is a priority using nationally approved TB preventive therapy (TPT). The Global AIDS Strategy has set the target of 90% of people living with HIV receive preventive treatment for TB, thus TPTust be scaled up for all PLHIVs as an integral part of the clinical care package. Recipients are expected to increase the use of TB diagnostic testing within DHAPP-supported HIV care and treatment facilities and promote the use of TPT as a routine part of HIV care. In short, all newly-diagnosed HIV persons should be offered TB treatment or preventive therapy, and all persons assessed for TB should be tested for HIV. Women living with HIV (WLHIV) are at high risk of progression from TB infection to disease; thus, it is imperative that PMTCT programs continue to screen for active TB during clinical encounters and ensure linkage to diagnostic testing, treatment and household screening. Treatment guidelines generally recommend the same regimens and dosing for PBFW as for other WLHIV.
- Programs should have clear policies and/or guidelines for the use of TPT, and should plan for programmatic and clinical trainings, procurement and supply management, adequate diagnostic capacity (including specimen transportation) and development of appropriate data collection systems. In Global Fund high-impact countries implementing joint TB/HIV grants, Recipients should also seek opportunities to support effective joint program implementation. Additionally, Recipients should implement TB infection prevention and control activities to minimize the risk of TB transmission and provide safe health seeking environment. This is critical in DHAPP-supported settings where clients at high risk for TB and HIV often co-mingle. It also puts health care workers at increased risk of contracting TB disease. Activities aimed at preventing transmission at facility-level should include administrative and environmental controls, as well as the availability and use of personal protective equipment.
- Cervical cancer screening for HIV-positive women should be integrated into routine HIV treatment services in each country program. According to COP21 guidance, all countries with an HIV prevalence > 5.0% among women aged 15 – 49 should screen for cervical cancer among WLHIV on ART. A “screen-and-treat” approach is recommended for the management of precancerous lesions to maximize opportunities for immediate cryotherapy or thermal ablation

treatment for eligible women without the need for diagnostic pathology confirmation and to reduce interruptions in treatment.

- The Recipient should work with the partner military to offer most clients (adults, children, adolescents/youth, pregnant and breastfeeding women, members of key populations, and foreign nationals) at ART treatment sites 6 months of multi-month dispensing (MMD), or at least 3MMD. Other drugs that the client requires, such as TPT, CTX, family planning commodities and drugs for other conditions should be provided whenever possible for the same duration of dispensing as ARVs. Supply chain support and forecasting should be adjusted accordingly for these medicines as well.
- The Recipient should work with the partner military to establish decentralized drug distribution (DDD), which is a client-centered initiative aimed at reducing ART interruptions, decongesting public facilities, and improving client-centered care, with both clinical and supply chain implications. Programs can achieve greater efficiency, increase convenience for clients, and reduce stigma by integrating a wide array of non-HIV commodities into decentralized sites (e.g., condoms and other family planning commodities, TPT). DDD models can also be used for decentralized PrEP distribution to improve uptake and continuation.
- Judgement-free screening for family planning (FP) should be integrated into the comprehensive clinical package for every PLHIV client (female and male). FP is defined as both preventing unwanted pregnancies through a wide variety of methods and planning safe, spaced pregnancies that prevent any further HIV transmission. If a client is interested in FP services, facilities must have a "warm handshake" model for either offering services or confirmed linkage to quality services.

Viral Load (VL) Suppression

Sustained viral suppression of all PLHIV is the key to HIV epidemic control. DHAPP's priority is access to critical HIV treatment monitoring, which is accomplished via VL testing that should be conducted at least once annually for stable patients and more frequently for new, unstable and pediatric patients. To this end, the Recipient will work closely with the Ministry of Health in Colombia to scale-up VL testing coverage and VL suppression in an effort to achieve 95-95-95 goals for military personnel. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 95: 95% VL suppression among PLHIV taking ART. DHAPP will continue to reduce its overall level of support for CD4 testing in favor of access to VL testing. CD4 count is not needed to determine eligibility for ART (and continued CD4 testing may perpetuate the belief that CD4 count thresholds are criteria for initiating ART) and, as reflected in 2013 WHO guidelines, CD4 is inferior to viral load for treatment monitoring and should be used to diagnose treatment failure only in the absence of routine VL availability.

The Recipient should ensure that the partner military has access to timely VL testing and that capacity exists to test at least 90% of persons currently on ART annually. To ensure this capacity WHO has prequalified dried blood spots (DBS) for VL testing as an alternative specimen type to plasma to increase access to routine VL monitoring. DBS are easy to collect and store under field conditions, with no phlebotomist required for collection. Further, they are easy to transport to centralized laboratories with reduced costs associated with collection materials and transportation under ambient temperature. The DBS technology is applicable to both adult and pediatric populations, with the small volume of blood required for preparing DBS making it especially suitable for pediatric populations.

The use of point of care (POC) platforms in the interim to test and deliver quick results to avoid patient or sample movement should be considered as well. Since POC testing is already being used within the same setting for VL testing among PBFW, extending this use for VL testing among infants and children will satisfy family-centered testing, as well as improved optimization and effective use of these instruments. Considering this, it is recommended that in COP21, POC should be used for VL testing among PBFW and infants and children. POC platforms may also be appropriate for low volume remote DHP military sites (approval will be needed for PEPFAR sites).

The Recipient will ensure that VL results are made available in a reasonable amount of time to both the health care provider and the client**.** These results should be used to ensure that those who are not virally suppressed are linked to adherence support and close follow-up leading to either suppression or ART modification as needed. Those who are suppressed should be encouraged to stay suppressed and should be offered differentiated models of care, including multi-month dispensing of supplies of ART and fast-tracking, as an incentive. They should further be given the message that "undetectable equals untransmittable" (U=U); i.e., a PLHIV with an undetectable VL (defined in most cases as a VL<200c/ml) does not transmit the virus to a partner.

Site Improvement through Monitoring System (SIMS)

The purpose of SIMS is to provide a standardized approach and set of tools for monitoring program quality at DHAPP-supported sites and entities that guide and support service delivery. SIMS assessment results are used to strengthen alignment with global and national standards and facilitate program improvement as a component of an overall quality management strategy. SIMS is also used to identify performance issues that may impact patient outcomes or the integrity of reporting for MER targets or disaggregates. Low final scores (reds and yellows) from these core essential elements (CEEs) highlight potential issues with service delivery, site performance or oversight, and/or documentation of patient results. Site-level triangulation of MER and SIMS data can be used to contextualize performance and could be useful to determine if performance challenges at a site are due to issues related to the underlying quality of service provision.

Site Improvement through Monitoring System (SIMS) aims to: (1) facilitate improvement in the quality of DHAPP-supported services and technical assistance, (2) ensure accountability of U.S. government investments, and (3) maximize impact on the HIV epidemic.

SIMS assessment results confirm compliance to minimum quality assurance standards and identify areas where improvements in DHAPP-supported programs can be made.

The Recipient should make sure that all supported above site and sites are familiar with SIMS standards and make sure that all efforts are taken to be in compliance with these standards. USG personnel will conduct SIMS assessments in accordance with DHAPP guidance and Recipients are responsible for taking corrective action for items within the Recipient SOW and per discussion with DHAPP USG staff.

Client, Patient, and Program Data Monitoring

Successful collection, evaluation, and use of client/patient level data is critical to good patient care and to

the success of the partner military HIV program's ability to monitor progress towards epidemic control. The Recipient will work with the partner military and Ministry of Health (MOH) or other organizations, as appropriate, to support the collection of patient-level data, the clinical and programmatic use of data, and the reporting of site-level data to DHAPP HQ and the partner military leadership.

The Recipient will be responsible for:

- Staffing, support, and mentoring of existing partner military staff for paper and electronic data collection
- Timely, accurate reporting of all indicators required by the partner military and DHAPP
- Ensuring confidentiality and security of data, in line with Ministry of Defense (MOD), Ministry of Health (MOH), and national guidelines through the whole data lifecycle from clinic, to storage, to dissemination and destruction.
- Securing all patient-level and site-level data from dissemination outside of the partner military and DHAPP without prior approval from the partner military and from DHAPP
- Support for paper and electronic data entry, cleaning, reporting, and use
- Ensuring data quality

Data Quality

Ensuring high data quality is a critical component of all Host Military programs and the Recipient should include a strategy for conducting baseline, periodic, and ongoing data quality assessments (DQA). In this way, DHAPP, and the Host Military, can have confidence in the data that it relies on for both target setting and measurement of progress towards programmatic goals. The Recipient should plan on conducting DQAs at the highest volume sites comprising 80% of the total number of people living with HIV and conducting DQA's of non-treatment technical programs, too.

Protocols for DQAs will be reviewed by Host Military, DHAPP HQ, DHAPP PM, and as deemed appropriate by the PM and DO, MOH and local health department staff. A DHAPP DQA template is available upon request. Protocols should start at the point of client/patient contact and follow the client through the workflow and data lifecycle. Both paper and electronic systems must be assessed in the DQA. Discrepancies found during DQAs should be rectified per the DQA protocol at the site and in the systems and reporting.

Virtual Communities of Practice/ECHO Platform

The Recipient should support the development of virtual communities of practice (vCoP) using the ECHO platform. These evidence-based, virtual, face-to-face health workforce development and collaborative problem-solving platforms, serve to create ongoing dialogue and collaboration among key staff in the military health care systems. They provide a consistent platform for conducting low-dose, high-frequency learning and collaboration sessions. The goal is to build a vCoP/ECHO Hub and Spokes for each partner military where DHAPP works in collaboration with DHAPP HQ, field staff and other Recipients working in that country.

DHAPP has collaborated with the ECHO Institute (https://hsc.unm.edu/echo/) to lever their vast experience with vCOPs/ECHOs. Key requirements are equipment and connectivity as well as personnel who can coordinate, manage and lead regular vCoP/ECHO sessions. These roles may need to be performed by the Recipient until they can be transitioned to the partner military. More information is available at https://hsc.unm.edu/echo/get-involved/start-a-hub/ and by contacting the DHAPP ECHO

Coordinator.

Work Plans

The Recipient must submit annual, programmatic and financial, work plans to the DHAPP Program Manager and DHAPP HQ (budget breakdown per activity and for program management is required). Work plans should include an activities implementation timeline as well as monitoring and evaluation timeline.